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THE WORK FOUNDATION
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The Way Forward:

Policy options for improving workforce health in the UK

The first white paper of the Health at Work Policy Unit

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About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at The Work Foundation, it draws on The Work Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence- based voice capable of articulating the views of all stakeholders.

The Work Foundation transforms people's experience of work and the labour market through high quality applied research that empowers individuals and influences public policies and organisational practices. For further details, please visit www.theworkfoundation.com.

Executive summary

This first paper from The Work Foundation's Health at Work Policy Unit aims to stimulate discussion and debate about policy measures which could be adopted to increase the number of employers who are active and effective in developing and implementing workplace health and wellbeing programmes. Although Dame Carol Black's 2008 report, 'Working for a healthier tomorrow' encouraged policy makers and practitioners to develop and implement initiatives to improve workforce health and wellbeing, and our awareness of the issues has increased over the last decade, a number of barriers to innovate, implement and evaluate such initiatives have been recognised.

The demographics of the UK workforce are changing: the workforce is ageing and having to work longer. In addition there is an increasing number of employees with a long standing health problem or disability (both physical and mental conditions). This presents both an organisational productivity challenge and a major burden for society due to increased healthcare costs, increased welfare payments, reductions in income tax receipts and increased sickness absence. A number of policy documents and practical initiatives from government (such as the Fit Note) have emphasised the importance of tackling employee ill-health, and the evidence suggests that organisations which have successfully implemented health and wellbeing interventions have reported a reduction in sickness absence and improvements in staff turnover, employee satisfaction and a decrease in accidents and injuries reported. Therefore the question remains: If the business case has been made in such a compelling way, why then are a large number of organisations still not investing in health and wellbeing? And what role, if any, does the government have in improving the situation?

To explore the barriers that employers face when carrying out health and wellbeing programmes both a review of the literature and employer based interviews were used. Barriers were identified at three stages (planning; implementation; and, evaluation and continued management):

Barriers at the planning stage:

- *Making a business case:* there is often a failure to capture and articulate the economic benefits of health and wellbeing in a way that resonates with business and is integrated in and tailored to individual business needs. Without this there is little hope in engaging business leaders to invest in workplace health and wellbeing.

- *Employee engagement and assessment:* if there is a lack of employee interest and reduced participation on the part of high-risk employees, health promotion programmes may not be successful. Consultation without action can lead to limited employee engagement with health and wellbeing programmes.

- *Senior management engagement:* there is currently limited senior management engagement with workplace health and wellbeing, and without this initial buy-in, it is difficult to sustain health and wellbeing programmes.

- *Culture:* organisations must invest in building a culture of wellness to achieve optimal results from health and wellbeing programmes.

- *Resources:* budgetary constraints followed by having sufficient physical resources are hurdles when carrying out health and wellbeing programmes, especially in SMEs.

Barriers faced at the implementation stage:

- *Communication:* lack of effective communication about features and benefits of health and wellbeing programmes limits employee and management engagement and motivation towards these initiatives and prevents an organisational shift towards participation.

- *Resources:* health and wellbeing programmes should be implemented through coordinated and coherent action and clear accountability, with joined up thinking between the range of stakeholders who have a responsibility for promoting workforce health and wellbeing.

Barriers faced at the evaluation and continued management stage:

- *Management of the evaluation:* evaluations of health and wellbeing programmes can be difficult, especially without good baseline data, however if organisations fail to capture all the benefits of their programmes then making a business case for further interventions or development of programmes becomes difficult.

Consequently, there is a need to further develop initiatives that can encourage or incentivise more employers to improve the health and wellbeing of their employees. It seems obvious that the government would be in favour of encouraging more employers to invest in more workplace health interventions. However, this is problematic as the benefits of health and wellbeing programmes accrue unevenly across a number of stakeholders, including: businesses, individual employees, their families, the NHS, HM Treasury and the DWP. It could be argued, therefore, that it is rational for employers to under-invest in workforce health if they receive only a proportion of the returns. Thus if the government wishes to see the wider societal benefits of improved workforce health and productivity, they too must be willing to invest more in well-targeted measures to improve the incentives for employers to act.

For organisational health and wellbeing programmes to be adopted and implemented successfully there are a number of steps that employers must take to overcome some of these barriers:

- Develop a health and wellbeing strategy which demonstrates how optimal employee health and wellbeing can support the delivery of operational objectives, high-value customer service, higher productivity or other drivers of competitive advantage.

- Invest in evidence-based interventions and execute them.

- Measure and report outcomes.

However, this paper argues that – given the public health benefits which could be realised by a step-change in the number of employers becoming active investors in workforce health – it is in the government's interests to consider doing more to incentivise and 'co-produce' better health outcomes for working age people. After a decade of steady progress, during which awareness, evidence and the number of government initiatives have increased, we now face another decade of challenges which, in our view, require more momentum, some boldness among policy makers and some public investment. Having reviewed a range of options from within the UK and from overseas, we have identified a broad range of measures which policy makers should consider when attempting to encourage employers to do more to promote health and wellbeing in their workforces. These include:

- *Fiscal incentives:* introducing tax incentives for health and wellbeing programmes as at present many employer sponsored health interventions are taxed as benefits in kind. Other fiscal incentives can include matched funding, where a government grant is equally matched by employer investment, tax credits (in the form of tax relief on employer National Insurance contributions), or to develop a structure of authorised providers who provide a menu of pre-approved and evidence-based programmes.

- *Levy systems:* A small levy is paid by eligible organisations, and those who implement organisational health and wellbeing programmes can claim grants that are paid for by the levy.

- *Incentivising collaboration through local 'budget-pooling':* encouraging stakeholders with overlapping interests to collaborate more, enabling legislation and budget-pooling at a local level.

- *Responsible Procurement:* public sector organisations could procure the services of organisations that have reputable policies with regard to organisational health and wellbeing.

- *Regulation:* this involves regulating the health and wellbeing measures that employers should provide. The provision of certain interventions could become compulsory or require employers to report on how they have used them.

- *Regulation for reporting:* There may be a case for increased regulation in what organisations should disclose and report regarding health and wellbeing measures

and practices they undertake.

- *Benchmarking:* a lighter approach to data reporting, allowing organisations to enhance self-assessments of health and wellbeing practices through closely monitoring what is being done in their and other organisations.

- *Investor's Perspective:* requiring investors to use organisational health and wellbeing data to gain insights into how organisations treat and value their staff and the overall health and wellbeing of their staff when deciding whether or not to invest in an organisation.

- *Kite-Marking:* quality standards developed to raise the attention and quality of employee health and wellbeing outcomes amongst those who sign up to accreditation awards.

- *Organisational pledges:* organisations can make pledges that encourage them to develop a commitment to workplace health and wellbeing (e.g. Workplace Health Charter, Public Health Responsibility Deal, Time to Change).

Our recommendations as to how to remove organisational barriers to the implementation of health and wellbeing programmes include:

- Debate amongst all stakeholders in this arena needs to move on from narrow discussions about 'making the business case', to broader discussions about the range of policy options set out in this paper.

- The approach taken should require action from the range of stakeholders who benefit from health and wellbeing interventions at work (employers, the NHS and DWP, individuals, and their families) and not weigh too heavily on any one.

- The government should do more to actively promote the issue of health at work, bringing these options into mainstream policy debate.

- The government should offer clearer, more up to date and proactive advice and guidance, for example through reviewing the content and use of the HSE stress management standards, and the active promotion of NICE guidance and public health guidance from PHE and others.

- The business case for a healthy workforce should be made in a way which speaks to employers and is tailored to their organisation in order to encourage them to take more voluntary action; regulation in most cases is a second rate option.

- A number of employer-led voluntary options already exist, and these should be encouraged and expanded upon. The form of measurement used should be further developed and streamlined as far as possible:

    - Benchmarking
    - Investors Perspective
    - Organisational Pledges
    - Kite-marking/accreditation.

- At the same time, the government should review the feasibility of using targeted incentives (e.g. through tax relief on National Insurance Contributions) in order to redress market failures and to encourage more employers to act and invest in workplace interventions.
- A number of options for this should undergo feasibility testing to understand exactly how they could be implemented:
    - Fiscal incentives
    - Levy system
    - Budget-pooling.
- Government should reform its procurement processes in order to include a consideration of workforce safety, health and wellbeing when deciding on suppliers. A number of options for how this is implemented should be explored (e.g. through an accreditation system, through a more detailed set of labour standards criteria, etc.).

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Chapter 1 Introduction

The economic and social imperative to improve workforce health and wellbeing has been the focus of intense analysis and debate in clinical, academic, business and policy arenas over the last decade. Considerable progress has been made in deepening our understanding that work is an important social determinant of health, that 'good work' is good for our health (Parker & Bevan, 2011), and that sickness absence and presenteeism can have negative consequences for the employee, the employer and for wider society (Black & Frost, 2011). Steps have also been taken to understand that the focus should not only be on the mitigation of risks to physical health at work (a Health & Safety approach), but that the psychosocial environment at work and the ways the workplace can support and promote healthier lifestyles should also be part of the landscape. As our workforce ages, retires later and risks the more frequent development of chronic and work-limiting health conditions, the pressure to invest more energy and resources in measures to prevent and manage the health, work ability and productivity of the UK's working age population will become more intense.

As we face this challenge, we should remind ourselves that we have a decade of progress to build upon. Dame Carol Black's 2008 report – *Working for a Healthier Tomorrow* – galvanised policy makers and practitioners into action and initiatives such as the Fit Note, increased support for small businesses, training for GPs, the Access to Work programme, the Responsibility Deal, a range of supported employment initiatives and – most recently – the new Fit for Work Service. As ever, a major challenge is to join up these initiatives, lend them more coherence, invest in (and 'scale-up') those which deliver the best results and make it easier for each of the stakeholders who can contribute to the fulfilment of the ambitions Dame Carol set out, to deliver still more in the decade to come.

An important priority here is to maximise the adoption of evidence-based initiatives to improve workplace wellbeing. It remains an area where employer engagement and investment is patchy and where ambiguities still remain regarding the direction of policy in this area and the roles of the government and other stakeholders in the health and wellbeing at work agenda.

This paper – the first of a series planned by The Work Foundation's Health at Work Policy Unit – aims to stimulate discussion and debate about policy measures which might be adopted to increase the number of employers who are active and effective in workplace health promotion. It asks the question, if the business and policy case have already been made, then why are a large number of organisations still not investing in health and wellbeing? In response, it examines some of the organisational, cultural and financial barriers employers face when assessing the potential benefits of adopting workplace health and wellbeing initiatives and then reviews a number of options that policy makers should consider as they seek to nurture progress in this field.

We recognise that there are no simple answers and that the pressures on business, GPs and government are intense and unpredictable. Part of the problem has been that, while awareness of the need to act on workforce health has increased immeasurably, our collective 'bandwidth' and capacity to innovate, implement and evaluate has – if anything – narrowed in the wake of the financial crisis. If government is to do more, we recognise that it has to be a catalyst and facilitator – deploying 'light-touch' and smart measures to enable employers and others to play a bigger part in helping the UK workforce to remain as fit and productive as possible.

Government as Catalyst?

So why might the government want employers to do more? There are several reasons. For example, the two biggest health problems experienced by working age people are Musculoskeletal Disorders (MSDs) (31m lost working days each year) and mental illness (70m lost working days each year). Despite some improvements, they are still not adequately addressed by the NHS among people of working age whose lost productivity may undermine the performance of their employer and increase healthcare costs if their absence becomes long-term. It could be argued that greater investment by employers in prevention, early detection, sign-posting and timely referral via workplaces – even if work is not the primary cause of ill-health – makes good sense, especially as the new Fit for Work Service will only offer help once someone has been absent for 4 weeks.

Another reason is that the workplace is a good (and under-utilised) arena for the delivery of public health messages and interventions (e.g. health risk assessments, education, supporting lifestyle change, promoting exercise and healthy eating, and supporting smoking cessation). There is a wider public benefit for society at large, as well as 'private benefit' for business, if more employees get access to such interventions through their work. It is likely that, with greater investment by employers in lifestyle-related interventions, there would be less sickness absence and a reduced burden on Primary Care.

Put this way, it seems obvious that government would be in favour of encouraging more employers to invest more in workplace health interventions. But, in reality, this is a problematic area, for several reasons:

1. The costs of ill health in the workforce are spread across range of stakeholders – this means that no single stakeholder has an over-riding incentive to invest in improving matters because of the fragmented way that the benefits or returns to this investment accrue. Indeed, the benefits to wider society of investing in workforce health exceed the benefits to any individual stakeholder – including employers;

2. In fact, employers might argue that there are few incentives to making such investments by themselves if the main beneficiaries are to be individuals and their families, the NHS (through lower healthcare costs), the DWP (through lower welfare costs) and HM Treasury (through higher income tax receipts). Although many businesses take their wider societal obligations seriously, it can be hard to make a

compelling argument that they should spend money on interventions from which they are not the main beneficiaries.

3. As Ed Bramley-Harker has previously concluded, there remains a significant and potentially dysfunctional market failure in workplace health interventions which means that, left to themselves, it can be rational for employers to under-invest in workforce health (Bramley-Harker, et al., 2006). This is not great news for those of us who argue that the business case for employer investment is ‘compelling’ and irresistible.

The conclusion from all this is that, if government wishes to see the wider societal benefits of the improved workforce health and productivity which result from high quality employer-based interventions, it must be prepared to invest more in well-targeted measures which improve the incentives for employers to act in their own interests and in the interests of society at large.

In the next chapter we review the state of the ‘business case’ arguments for further employer investment in workforce health.

Chapter 2 Making the business case for investing in workforce health

The problem

The health of the working population is vital to the economy and to society, but due to changing demographics of the workforce, western societies are facing great challenges to maintain economic growth and competiveness. The workforce is ageing; in the UK by 2024 nearly 50 per cent of the adult population will be 50 and over (Taylor, 2007). As a result, the workforce is older and sicker, with more people living with a long standing health problem or disability. In the UK, around one in three adults reported in 2009 that they had a long standing illness or disability, compared with around one in four adults (21 per cent) in 1972 (ONS, 2011).

Ill health in the working age population represents a major economic burden for society due to increased healthcare costs, lost productivity, increases in welfare payments, reductions in income tax receipts and increases in long-term sickness absence. Mental health problems have increasingly become a common cause of long-term and short-term sickness absence: they are now the main reason for sickness absence alongside musculoskeletal conditions. The Office of National Statistics (ONS) states that 15.2 million workdays were lost due to stress, anxiety or depression in 2013 (ONS, 2014) costing just over £1,000 per employee and £26 billion to the UK economy (BITC, 2014). People with mental health conditions often suffer from other long-term health issues that can have a significant impact on their everyday lives (National Healthy Worksite, 2012). Chronic pain, for example, is the most common co-morbidity in many conditions and has been cited as the number one cause of adult disability in the U.S. (American Chronic Pain Association, 2011). In the UK, an average 42 per cent of people with chronic pain are unable to work due to their condition and even if they are able to work, chronic pain inhibits their ability to do their job at least a third of the time. Back pain alone is estimated to cost the UK economy £12.3 billion per year (Pfizer, 2010).

The policy response

Over the last two decades there has been a growing understanding of the importance of the health and wellbeing of employees and it has become increasingly important that both policy makers and organisations understand their role in developing workplace health and wellbeing initiatives.

There have been a number of policy documents and guidance which have emphasised the importance of tackling ill-health at work.

- *Choosing Health* (Department of Health, 2004): This white paper highlighted

employers as key stakeholders in the protection and promotion of employee health and wellbeing. It also highlighted that workplaces are an under-utilised setting for promoting health and wellbeing and argued that promoting health and wellbeing is not something that individual employees can achieve for themselves, but they need the assistance from employers, the government and trades unions.

- *Health, work and well-being – Caring for our future* (Department for Work & Pensions, 2005): This government strategy placed responsibility for wellbeing in the hands of a number of stakeholders, including employers. It aspired to a society where health is not adversely affected by work and the workplace can be used to promote individual health and wellbeing. It proposed that advice and support enabling employees to return-to-work and to increase job retention should be available to all and intended to increase the number of employees with access to occupational health support and to reduce the number of people who suffer from work-related ill-health.

- *Working for a healthier tomorrow* (Black, 2008): This review of the working age population suggested a shift in attitudes in the workplace would be necessary to ensure that both employees and employers recognise the importance of preventing work-related ill-health. It also highlighted the key role that the workplace can play in promoting good health (page 10). The report argued there was a greater need to develop a robust business model for measuring and reporting the benefits of any interventions or investments for employer health. This evidence could then be used in developing the business case for future wellbeing programmes.

The business case

The health of employees is a major factor in an organisation's competitiveness. Employees in good health can be up to three times more productive as those in poor health; they can experience fewer motivational problems; they are more resilient to change; and they are more likely to be engaged with the business's priorities (Vaughan-Jones & Barham, 2010). In the 2008 Black review, it was calculated that improved workplace health could generate the government cost savings of over £60 billion, the equivalent of nearly two thirds of the NHS budget for England. Organisations that have successfully undertaken financial evaluations of their health and wellbeing programmes have identified the financial benefits. They have found a causal link between programme costs and intermediate financial benefits. They have also monitored the change in the key financial variables before and after programme implementation (Global Corporate Challenge (GCC), 2013). A review of 55 organisations in the UK which had implemented a variety of health and wellbeing interventions, found that 45 per cent experienced a reduction in days lost through sickness absence with an average reduction of 30-40 per cent. The same review also found improvements in staff turnover, employee satisfaction and a decrease in accidents and injuries reported (PwC, 2008).

The reasons why employers invest in workplace health are often wider than just reducing the costs of sickness absence. In some cases health promotion activity can be motivated by no

more than a desire to comply with health and safety requirements or the need for the business to discharge its legal duty of care. For many businesses there is a strong ethical or moral case for investing in workforce health, i.e. they feel strongly that is the right thing to do (Vaughan-Jones & Barham, 2010). Others invest through 'enlightened self-interest' – being able to demonstrate an array of workplace health interventions to prospective and current employees supports the development of a distinctive employer 'brand' and may contribute to improved employee engagement. According to a world-wide survey involving 378 organisations (GCC, 2013), the main reasons employers report developing wellness strategies were: improving employee health (69 per cent), improving work engagement (68 per cent), reducing sickness absence (36 per cent) and increasing productivity (27 per cent).

The current picture

In light of this evidence, there is a strong business and policy case to invest in employees' health and wellbeing. During the last ten years an increasing number of companies are recognising the benefits that these programmes bring. Although understanding of the importance of investing in the health and wellbeing of employees has risen, the question still remains: if the business and policy case have already been made, why then are a large number of organisations still not investing in health and wellbeing?

To understand and answer this question, we need to look more closely at what the organisational barriers for the implementation of health and wellbeing practices are, and recommend ways for how these can be removed.

Chapter 3 Organisational barriers to investing in health and wellbeing interventions

In order to explore which barriers employers face to implementing health and wellbeing programmes, we have used a range of literature and employer based interviews.

When examining the literature it became apparent that in order for health and wellbeing interventions to be successful, they should be tailored to each company's needs. For example, the PwC (2008) report, *Building the business case for wellness*, found that successful implementation of wellbeing programmes is more likely when they have been designed to meet the needs of the employees and the organisation.

In order to support this need for 'tailor made' programmes, a number of different frameworks have been proposed, through which employers can develop their own bespoke interventions. The Centre for Disease Control and Prevention's (CDC) (2013) framework highlighted that a co-ordinated approach will be more successful when a wider context of the work organisation and environment has been taken into consideration in the design of the health and wellbeing programmes. Their systematic process of building a workplace health and wellbeing promotion programme, emphasises four main steps: Assessment, Planning, Implementation and Evaluation. PwC (2008) 'Building a Wellness Case' project developed a framework which suggests three main steps that have to be in place for a successful programme: plan, implement, execute and manage.

By reviewing these models we have developed our own framework, through which we will consider the barriers which employers face to implementing health and wellbeing interventions. Our framework consists of three main stages:

- The planning stage: this involves developing the components of a workplace health and wellbeing programme including determining the goals of the programme, and which interventions should be prioritised. This should be strongly related to employee needs and suited to specific work environment.

- The implementation stage: this involves putting the strategies and interventions in place within the organisation. At this stage it is important to make the resources available to all employees.

- The evaluation and continued management: this should take place once a programme is implemented in order to examine its effectiveness. It is important to assess how well health and wellbeing programmes can be sustained over time and how they have been received by both employees and senior management. This stage can also highlight whether there has been a return on investment.

Barriers faced at the planning stage

1) Making the business case:

There is often a failure to articulate the economic benefits of health and wellbeing interventions in a way that resonates with business and is integrated in and tailored to individual businesses' needs. Evidence from the literature and our expert interviews highlight the importance of developing an appropriate business case. Robertson and Cooper (2010) argue that the critical role of the business case is to bring together the research evidence and to integrate it with the organisational needs. Without this business case Robertson and Cooper suggest that there is limited hope of engaging business leaders with the idea of investing in health and wellbeing. Similarly, Lee, Blake and Lloyd (2010) argued that organisations need to consider the business implications of implementing health and wellbeing programmes as well as the social and ethical arguments of doing so. As one of our interview participants told us:

"there is something very important about each individual organisation and making and understanding its own commercial drivers…there's something about really making a very clear link between the organisation's own business case, understanding really what it is that is to get the biggest impact"

When making the business case, developing economic costs of current poor health related behaviours, and potential savings in the change of behaviour that any interventions can bring, may serve as a powerful justification for organisations (Lee, Blake & Lloyd, 2010), especially if the interventions may reduce costs related to sickness absence and reduced productivity. However, Lee, Blake and Lloyd (2010) pointed out that it can be very difficult to produce an individual business case for workplace health and wellbeing because there are both direct and indirect costs and the less tangible benefits may be much harder to measure. The role of developing the business case was also highlighted in 'Best practice in promoting employee health and wellbeing in the City of London' (City of London Corporation, 2014), whose qualitative interviews suggested that developing a sophisticated understanding of the key aspects which link staff health and wellbeing to the business agenda i.e. showing the links between improved staff engagement and productivity, is really important. However, respondents also highlighted that this could be hard because of the difficulties in tangibly measuring effectiveness and isolating the impact that the specific health and wellbeing intervention had. The need to make an effective business case is especially relevant in these uncertain economic times.

The importance of making the business case relevant to the organisation was highlighted in the interviews. One interviewee when discussing a successful health and wellbeing intervention said:

"The business case was there to be found if you looked for it. We published very strongly to show that the organisations that improve health and safety of their staff did deliver better patient care….there are cases there if you go and look for it"

Another interviewee argued that, in comparison to other organisations, the business they worked for had relatively low sickness absence, and so consequently implementing health and wellbeing interventions to improve sickness absence were not that important. However, as their organisations had specific issues with mental health and engagement, this was what their business case had to focus on:

"our challenges are different…so for us the business case is a lot more to do with how we make our people more resilient, linked to greater higher levels of engagement and therefore greater performance…we had a lot of material that links the engagement levels of our people to the success of our business…in keeping with that we are positioning wellbeing as being very much integral to the organisation"

2) Employee engagement and assessment:

A common barrier to the success of health promotion programmes is a lack of employee interest, and the reduced participation on the part of high-risk employees. Linnan, et al. (2008) examined data to monitor the prevalence of worksite health promotion programmes, and found that lack of employee engagement is often a cause of unsuccessful programmes. This implies that organisations need to gain full engagement from their employees to identify which strategic health and wellbeing goals are necessary for an organisation, and what health and wellbeing interventions should be used. This was made clear when one of the interview participants stated:

"…direct involvement of the workforce…we had a group that involved unions, frontline staff, HR and the operational management…they would meet on a regular basis to decide what the shape of the programme was and to basically propose areas for potentially taking the programme…it's absolutely vital that it's [workplace wellbeing programme] *not done to you, it's done with you"*

Robertson and Cooper (2010) suggest that one of the biggest pitfalls for wellbeing initiatives is consultation without action, where staff complete a number of wellbeing surveys, but fail to see any plan for moving the improvements forward. This can result in limited employee engagement in programmes. Bellew (2008) reported a range of organisational factors which are important in the successful implementation of health promotion in the workplace, which included: engaging staff in helping to plan the programme, focussing primarily on employees' needs and ensuring that there is commitment to the programme. In the report for the City of London Corporation (2014), the results clearly supported the involvement of employees in identifying and designing workplace programmes. They highlighted varying levels of engagement, from those who were merely continually asked what they would like introduced to those who were involved in an ongoing way, where staff demand and consultation informed provision.

When describing a successful implementation of a health and wellbeing programme, one interviewee stated:

"We co-designed everything that we did initially with the trades unions and so that started it off…we were then still working very closely with the trades unions as representatives of the workforce to articulate what the needs were or the needs are…this is important to help us to develop credibility"

3) Senior management engagement:

At present health and wellbeing issues are not being taken seriously enough by many of those at the top and being discussed as a boardroom issue, but are resigned to a human resources issue only.

Robertson and Cooper (2010) highlighted the importance of developing the business case in a way that could particularly resonate with senior management and help alter beliefs about the benefits of investing in wellbeing interventions. There were many examples in the literature where reduced engagement from senior management was cited as a barrier to health and wellbeing interventions (for example, Chu & Dwyer, 2002; Bellew, 2008; Blake & Lloyd, 2008; Goetzel & Ozminkowski, 2008; Lee, Blake & Lloyd, 2010; Mellor, et al., 2011). Blake and Lloyd (2008) stated that high-level managerial support from the outset was essential for the success of health and wellbeing practices. This would ideally include a director level individual to champion the cause, and gaining endorsement from the CEO and organisational board. They believed that without this managerial buy-in, any health and wellbeing programme could not be sustained. This was re-iterated in our interviews:

"...you need board level commitment to buy-in, so it is supported from a senior level. You need to get operational management on side to actually understand the basis of the programme"

However, this was not always easy to do, as managers could be very busy, and so the role of the business case was to have it written in such a way that senior management would engage in the programme, and see health and wellbeing as a priority:

"With senior people, one of the big issues is just having too much to do. Yes, of course I would like to do this stuff on wellbeing, but I've got a hundred and four other things to do, and there just isn't time to devote attention to it…we've got to get it higher on their list of priorities…and you need someone to understand this particular business [wellbeing]*…you need an advocate, people who understand what the issues are and the senior leaders who want to do it"*

Having an understanding about health and wellbeing and the implications for business outcomes is then key. Mellor, et al., (2011) reported cases where senior management failed to implement wellbeing practices as they held the belief that the problem of stress in the workplace could not be solved, with Goetzel and Ozminkowski (2008) indicating that a subset of senior managers were still not convinced that wellbeing programmes could deliver on the promise that they can reduce workplace risk factors and achieve a positive return on investment. They also reported some managers believed that organisations should not

interfere with worker's health habits and medical decision making because these actions became similar to playing 'big brother'.

When discussing a health and wellbeing programme implementation success, one interviewee described how subsets of managers were trained in wellbeing, providing them with dedicated help and resources so that they could understand how important health and wellbeing was – especially in developing mental resilience. This highlights the importance of engaging with the managers to fully understand their role.

The City of London Corporation report (2014) discussed senior management engagement as key in the implementation of mental health interventions. It was often reported that mental health training among managers was inconsistent. In some cases there was a degree of unwillingness to engage with mental health issues and a reluctance to draw attention to mental ill-health among employees, however, in interviews this seemed to be linked with a desire to avoid stigmatisation for those with mental health disorders, and not a denial of the importance of wellbeing programmes to support those with mental health issues.

The HSE (2007) highlighted that a lack of management engagement or 'gate keeping' was particularly evident in SMEs, with the lack of training and understanding of the role of health and wellbeing not only limiting their engagement in health and wellbeing issues, but also undermining any initiative to implement programmes for improvement.

4) Culture:

Often health and wellbeing programmes are not implemented successfully because there is not an organisational culture of taking health and wellbeing at work seriously.

This links strongly to the need for senior management to engage. Mattke, et al., (2013) stated that leaders must invest in building a culture of wellness to achieve optimal results from health and wellbeing programmes, and create a culture where health and wellbeing can readily be discussed. The importance of a wellbeing culture was explored by one interviewee who had successfully implemented a health and wellbeing programme:

"We are also positioning wellbeing as really very much integral both to our organisational vision and also to our employee value proposition. Part of that is about doing the right thing…We recognise as an employer that we have a responsibility to help them, and so again, in terms of our people strategy, wellbeing and resilience is positioned right up their with our top priorities"

Blake and Lloyd (2008), however, highlighted that the health and wellbeing culture in an organisation can be limiting, especially if members of staff who do engage with workplace health activities were often subject to criticisms for concentrating on health and wellbeing instead of their work. In their study they also reported a disapproving attitude from other employees despite the government policies to improve health behaviours in the workplace. The City of London Corporation report (2014) stated that workplace health and wellbeing

interventions are likely to be taken-up by organisations who already value and understand 'healthful behaviours', and thus if there is not a culture of health and wellbeing in an organisation, establishing and implementing wellbeing programmes may be difficult.

Goetzel, et al., (2014) reported that one component of successful wellbeing programmes is related to establishing a culture of health. This means the message should be more than convincing employees that they should be taking better care of themselves, but to create an environment where leading a healthy lifestyle becomes the default option. The role of the managers and organisational leaders was highlighted as important, and Goetzel, et al., (2014) stated that companies where leaders created a culture of health because it was seen as the right thing to do reported business gains, including reduced accident rates, low turnover and high morale. They also reported research which indicated that organisations that build a culture of health, including a focus on the wellbeing and safety of the workforce also yielded greater value for their investors.

5) Resources:

Successfully establishing the financial case for health and wellbeing programmes is crucial as employers want to receive a return on investment for interventions.

In the GCC report (2013), budgetary constraints, closely followed by having the sufficient resources, were seen as the biggest hurdles to implementation. Linnan, et al., (2008) also mentioned limited funding as a barrier to the success of health and wellbeing promotion programmes. This was also highlighted in the sickness absence review (Black & Frost, 2011) which discussed how the tax system could discourage employers from investing early in wellbeing programmes and early medical interventions, even when organisations can see the advantage of their use. The review also highlighted concerns that the government were considering the removal of tax relief on employee assistance programmes (EAPs), one of the most common health-related benefits offered by organisations. At the time, Mind (2011) reported concerns that removing the tax relief on EAPs might undermine employer prioritisation for mental health, and consider them as a discretionary rather than essential to have.

The government's response to the sickness absence review (DWP, 2013) stated that there would be retention to the tax relief of EAPs (although this would be kept under review). Although the government recognised the important role that employers had in employee health and wellbeing, and wanted to encourage employers to fund appropriate health related interventions, the government felt that the recommendation that all health and wellbeing interventions should be tax free was too broad.

The issue of tax disincentives was discussed by one of the interviewees when discussing how the government could help in overcoming barriers to health and wellbeing support:

"...one of the things they can do is actually not actively put barriers in the way. So removing some of the tax on provision on some of these things is really important, because even

though there is a tax break in the health and work service, it's not a global tax break and doesn't cover all areas."

The Health and Safety Executive (2007), published a report specifically focussing on the health, safety and wellbeing programmes implemented by SMEs, stating that although small businesses have an understanding of the role of health and wellbeing and the potential benefits of the business, the nature of the enterprises and the limited resources (both financial and human) meant that they were unlikely to be able to support health and wellbeing programmes regardless of the good intentions and processes of the business. As a result of often being pushed for time, money and resources, health and wellbeing in SMEs is not high on the priority list. The results from their research suggested that SMEs with fewer staff spent significantly less time on health and safety and wellbeing issues, suggesting that limited physical resources and time were factors impeding the implementation and development of wellbeing programmes. This research was supported by the summary of evidence submitted to Dame Carol Black's review of the health of Britain's working age population (2008) which also highlighted that SMEs reported not having the resources to run health promotion activities and initiatives or healthcare services. Therefore both lack of funding and lack of physical resources (especially highlighted in SMEs) can be viewed as barriers to the implementation of workplace wellbeing programmes.

Barriers faced at the implementation stage

1) Communication:

Lack of effective communication about health and wellbeing programmes limits employee and management engagement with them, and prevents a cultural shift. PwC (2008) highlighted that effective communication acts to enable the successful implementation of workplace health and wellbeing initiatives. Their report advises that communication is key because employees need to understand the importance of the health and wellbeing programme, how it will affect them, and importantly how and where they can access the wellbeing information and resources. If this does not occur than employees might lack the motivation and the engagement to participate in the scheme. Mattke, et al., (2013) undertook five workplace case studies to draw important lessons for wellbeing programme implementation. The development of effective communication strategies was a major factor that arose. All five of the organisations discussed the communication strategies that led to successful implementation, including, face-to-face interaction, mass dissemination, the use of bulletin boards and the intranet. Some of the organisations also held 'wellbeing events' to highlight the importance of employee health and wellbeing and to raise the profile of health and wellbeing activities. Using multiple communication methods, especially for organisations with a large or geographically dispersed workforce, was recommended. The role of communication was reiterated in the interview data:

"…we have a long track record of providing really good quality information, resources, guidance to people and a very well advanced intranet office in particular…a lot of the way we communicate with them is on our intranet…it provides a massive amount of resources…a

huge range of practical tools, guidance resources…"

Robertson and Cooper (2010) also stated that communication with employees was important so that their engagement with wellbeing initiatives could be measured. The views of the workforce are important in order to determine what will drive further engagement with health and wellbeing schemes and what areas can be further developed. The authors highlighted the role of line-managers in discussing health and wellbeing, with Gilbreath and Benson (2004) suggesting that the line management role in developing wellbeing engagement should not be ignored. Consequently, if there is limited organisational communication regarding the workplace health and wellbeing practices, this may be a barrier to their effective implementation and uptake.

2) Resources:

The role of organisational resources is also important in the implementation of health and wellbeing programmes. Chu and Dwyer (2002) recommended that their implementation should be co-ordinated by members within the organisation. In their research, successful implementation was aided by a selected employee working party that monitored the uptake of any initiative. As a result, they were able to respond to queries and could provide the necessary information to both employees and management. However, for this to work there already needed to be a health and wellbeing culture and leadership engagement highlighting that successful implementation could really only occur if there has been successful planning. For example, the City of London Corporation report (2014) stated that successful implementation will only occur if there was joined up thinking between the range of stakeholders who have responsibility for the promotion of health and wellbeing across the organisations.

Barriers faced at the evaluation and continued management stage

1) Management of the evaluation:

A barrier to improving, expanding and creating a culture of change across sectors and supply chains, is the effective evaluation and continued change management of health and wellbeing programmes. This is important in order to investigate their organisational worth and think of ways programmes can be improved.

Evidence from the literature suggests that evaluation of health and wellbeing programmes can be very difficult. The CIPD (2007) stated that one of the difficulties in even preparing business cases was the failure to evaluate health and wellbeing initiatives in terms of their implications for improved productivity, reduced sickness absence and other associated organisational benefits. However, as Lee, Blake and Lloyd (2010) point out, organisations require a holistic evaluation and cost-effectiveness strategy which can capture long-term less tangible gains, including: improved corporate image, corporate social responsibility and changes in employee morale and satisfaction. If organisations fail to evaluate initiatives, or do not capture all the benefits that health and wellbeing initiatives provide, then making

business cases for further interventions or development of schemes are difficult.

Even if organisations do collect evaluation data, what they do with it, and how applicable it will be to other organisations is an issue of contention. As previously stated, there is no one-size fits all health and wellbeing programme and so there are difficulties in proving that an outcome reported from one organisation will occur in another, especially as organisational culture, size, baseline wellbeing levels, etc., also need to be accounted for. An interviewee stated:

"One of the problems is that some of the companies don't necessarily publish their data…we have much data internally but we don't publish it externally…and some will not believe it unless they saw it in their own organisation, so they won't believe data that comes from elsewhere"

Goetzel, et al., (2014) argued that workplace health and wellbeing programme success depends on ongoing measurement and evaluation to be built into programme design and implementation. They state that tracking programme metrics ensures that success is not left to chance, but is based on feedback loops and standard business practices that are focussed on quality improvement (page 933).

Bevan (2003) provided a range of methodological reasons as to why evaluations of workplace health and wellbeing programmes can be difficult and why caution should be expressed when reviewing evaluation evidence. For example, using programme uptake or participation as a measure of success does not necessarily equate to behaviour change or lead to a reduction in sickness absence. In fact, it may be the case that those least in need of the wellbeing scheme are the ones who participate most frequently. This suggests that a more thorough evaluation of who participates in health and wellbeing programmes is required, and uptake should be only one source of evidence for evaluation. Evaluations may also include an attribution error, where if outputs are only restricted to a limited range of explanatory variables, it then becomes difficult to be able to draw definitive conclusions about cause and effect. Additionally, even if changes are reported in employee behaviour, there is still difficulty in determining whether the changes would have occurred without the use or implementation of the health and wellbeing scheme. Bevan (2003) also mentions the 'time-lag' effect, which calls into question what the time difference should be between the introduction of a health and wellbeing programme and any measurable behavioural change. Even if a health and wellbeing programme evaluation has shown success in changing employee behaviours, studies are rarely longitudinal, and therefore there are very few cases of sustained behavioural change, which as Bevan (2003) argues is what is needed to lead to direct tangible bottom-line outcome benefits. He concluded that the evidence of 'success' of workplace health and wellbeing initiatives is still relatively patchy, and therefore as engaging in practices to promote employee wellbeing is important organisationally, individually and economically, organisations may have to implement them in 'good faith'.

So the barriers faced by employers to justifying, implementing and sustaining investment in workplace wellbeing initiatives – even if they accept that there may be business benefits to

them doing so – can be considerable. Some may never invest, but it is more likely that there are many more who need a ‘nudge’ to do more or who would respond to more explicit incentives or campaigns if they felt that government was committed to support them. The next chapter of this paper is devoted to looking at some of the options that the government has in this domain.

Chapter 4 Ways Forward?

The business and policy case for improving the health of the working age population was reviewed in Chapter 2, highlighting that positive employee health and wellbeing can have demonstrable benefits for the individual, the organisation and for the wider economy and society. However, as Chapter 3 highlighted, even with this knowledge and evidence, and despite the success to date in raising the profile of the issue, a number of barriers remain to the more widespread and comprehensive implementation of workplace health and wellbeing interventions. Consequently, there is a need to develop further initiatives that educate, encourage or incentivise more employers to play an active part in improving the health and wellbeing of employees in their organisations,

For any organisational health and wellbeing programme to be adopted and implemented successfully, there are a number of steps that employers must take that will help overcome some of the barriers discussed in the previous chapter:

1. *Develop a health and wellbeing strategy which demonstrates how optimal employee health and wellbeing can support the delivery of operational objectives, high-value customer service, higher productivity or other drivers of competitive advantage*

If health and wellbeing was more explicitly embedded into organisational strategy and goals, then this would aid the development of a culture of health and wellbeing, allowing for greater discussion about health and wellbeing benefits and further communication of any health and wellbeing practices that the organisation implements. This means articulating more clearly how the physical and psychological wellbeing of the workforce can help deliver business objectives or can be a source of competitive advantage. For example, many businesses see the strong link between employee engagement and business performance (Cartwright, 2014). It is equally important that they understand that wellbeing and engagement are closely linked. Developing a health and wellbeing strategy also includes engaging senior management support, including the training of senior management staff to not only understand the business case for improving employee health and wellbeing (increased productivity, engagement and profit, reduced sickness absence, and increasing an organisations competitive advantage), but also help them to understand the importance of recognising poor employee health and wellbeing and enable ‘good work’ and ‘good management’ which improves job quality and produces psychologically healthy workplaces (Cooper & Bevan, 2014).

2. *Invest in evidence-based interventions and execute them*

More employers need to embrace ‘good work’ practices with regards to employee health and wellbeing, removing implementation barriers and preventing factors that lead to ‘bad work’ in the workplace. There are a range of evidence-based interventions that employers can invest

in, including:

- Improving line management (developing trust with employees, providing development and growth opportunities, and training to recognise potential risk factors for poor employee health and wellbeing and discussing improvements)
- Implementing early intervention practices – early identification and referral
- Implementing evidence-based Occupational Health Services and Employee Assistance Programmes
- Understanding and implementing the NICE Health and Wellbeing at work guidelines (NHS Trusts that implemented these guidelines reported significantly improved employee health and wellbeing)
- Implementing measures informed by the HSE Stress Management standards (demonstrating good practice in evaluating workplace health and wellbeing, assessing work demands and discussing with employees the best practical interventions to implement).

In general, these guidelines advocate enlightened, people-focused, empathetic management styles which are just as strongly linked to high-performance work practices as they are to employee wellbeing.

3. *Measure and report outcomes*

Organisations need to start collecting data that will help them have an understanding of current employee health and wellbeing, and from this develop a range of metrics and interventions that can be used to improve health and wellbeing and support investment in measures to continually improve these interventions. Outcome measures can include:

- Sickness absence (including measures of frequency, incidence and duration)
- Lost productivity (including reduced continuity of customer service, patient care, etc.)
- Presenteeism (though recognising that phased return to work may be a positive form of presenteeism)
- Voluntary resignation
- Ill-health retirements
- Referral times to Occupational Health
- Time taken to return to work.

Many organisations are ‘data poor’ in the field of wellbeing at work. This can mean that they fail to quantify the costs of ill-health, absence and lost productivity, and therefore, are more likely to be unaware of the benefits of prevention or simple measures to improve attendance and workforce health.

How might policy help more progress to be made?

In the following section we set out a range of measures which policy makers should consider when attempting to encourage or incentivise employers to do more to promote health and wellbeing in their workforces. None of them is a 'magic bullet' and we are aware that this is not an easy problem to solve. Nonetheless the policy goal should be to get those employers who are already doing something to do more and to get those employers who do nothing to do a few basic things.

1) Fiscal incentives

A barrier to the implementation of workplace health and wellbeing programmes discussed earlier was the limited funding which employers are able to make available for such programmes. Many have questioned whether some aspects of the tax system were discouraging employers from investing in early interventions, even if they do recognise advantages of their use. At present, many employer sponsored health interventions are taxed as benefits in kind. The argument for providing tax incentives for health and wellbeing programmes suggest that if such initiatives become tax free, then the demand for them will rise. Indeed, Simon Stevens (CEO of NHS England) has recently suggested that employers could receive tax breaks for setting up jogging clubs, group weigh-ins and slimming clubs to help combat obesity, which is resulting in increased sickness and rising health costs. In this proposal, he used himself as an example arguing that he lost three stone when his employers (in the USA) had tax breaks for interventions which helped employees meet healthy living targets (including weight loss). From an employers perspective, if they feel that the government wants them to implement initiatives that go beyond 'benefits in kind' or their legal duty of care, and, to have a wider societal impact and public health benefits, then it might be argued that the bargain should involve some help or a 'nudge' from the government itself. This may then encourage organisations who might not have considered health and wellbeing interventions to do so.

Bramley-Harker, Hughes and Farahnik (2006) set out a number of different forms which such fiscal incentives could take. One option could be 'matched funding', where a government grant is equally matched by employer investment. This option would mean that government could specify precise eligibility criteria for employers to gain funding, however this would also be more administratively complex and so could discourage some potential beneficiaries. Another option could be tax credits (in the form of tax relief on employer National Insurance contributions), this would offer support with fewer strings attached and could be a more immediate and direct way for employers to take advantage of the incentive. However as the eligibility criteria for the tax credits would be broader, it might result in more spill over of public spending for peripheral purposes, rather than solely on evidence-based health and wellbeing interventions. A way to more effectively regulate for either option would be to establish a structure of authorised providers who provide a menu of pre-approved and evidence-based programmes; this would also ensure that these programmes do not put a further burden on the NHS, by developing the capacity for provision elsewhere. With a system of pre-approved providers in place, both of these options offer a viable way that fiscal

incentives could be implemented.

The issue of tax incentives was also raised in the Sickness Absence Review (2011), so this is not a new idea. Policy makers have in the past questioned whether tax incentives would be cost-effective in relation to health and wellbeing interventions in the workplace mainly due to the 'deadweight' argument; i.e. employers who are already interested in and investing in workplace interventions for health will continue to do so regardless of the incentive and would, in effect, be receiving a subsidy for what they are already doing. However, the research conducted by Bupa (2012) suggested that organisations with tax incentives would provide more support and develop more generous schemes. The additional argument is that organisations that do not currently have health and wellbeing schemes may not be incentivised to introduce schemes, especially if the supposed incentive is minimal. For tax breaks to be considered seriously, there is need to demonstrate the effectiveness of tax incentives, for example through evidence from other countries that have used them and shown that they do have a positive impact on workplace health and wellbeing, or through longitudinal research testing the relationship between tax incentives, organisational investments in health and wellbeing programmes (plus the sustainability of these programmes over time) and employee outcomes. There is also a need for further evidence of the use of tax breaks on the 'net' increase in employers adopting evidence-based interventions and not just as a subsidy for existing initiatives.

Introducing tax incentives remains a feasible option, however it seems that the issue of deadweight costs and the lack of evidence that significant differences will be made will need to be overcome to persuade policy makers to make this recommended change. A strong case can be made for tax incentives to be part of a 'new deal' with employers which explicitly recognises that their own investment in workforce health generates public health benefits and that the State should play a part in incentivising these investments.

Advantages: Tax incentives for EAPs have proved helpful to employee health and wellbeing. There has been support for tax incentives abroad. Implementation only requires a change to a clause in the finance bill. A simple but bold move that would send a clear message to employers about the need for a change in behaviour around workplace health. A blanket approach which could benefit any type of employer regardless of size, particularly due to the lack of paperwork involved, would encourage employers to place health and wellbeing at the centre of their business plan and would show employers that government valued the public health benefits of workplace interventions.

Disadvantages: Government will need to be persuaded that the loss of revenue is offset by a reduction is sickness absence and gains in productivity. A need for more robust evidence indicating that tax incentives will make significant benefits to workplace health, consequently more research may be required to convince politicians and policy makers. Issues still remain concerning deadweight costs and the additionallity argument.

2) Levy systems

For many years governments have struggled to encourage business to invest in skills training for employees rather than 'living off the market' (i.e. recruiting rather than training). It is recognised that a highly skilled and engaged workforce is crucial to economic growth and prosperity and that incentivising employer investment is an essential part of the policy 'mix' available to government. One option which was used for many years (between 1965-1985 following the 1964 Industrial Training Act) was a 'levy system' for industrial training. A parallel argument might be made for workforce health and wellbeing, which also contributes to labour productivity and competitiveness. For example, the Construction Industry Training Board (CITB) Levy is a charge that must be paid by eligible construction businesses. The CITB justifies this levy as they argue that it ensures that there is sufficient training and skills development in the construction industry. Employers who train their workforce can claim grants, paid for by the Levy – employers that pay the Levy, but do not regularly train their staff help support those that do train, and this then drives up overall standards and the skills supply available to the sector. The CITB offers industry-specific training not available elsewhere (so specialist trades get the training provision and apprenticeships they need); and the Levy helps prevent skills gaps and shortages, so that the investment in skills and training in maintained during the peaks and troughs of industry output (Catherall & Rhodes, 2014). Employers who do train, qualify and up-skill their workforce receive grants that can be used for further training, supply apprenticeships, a range of other services and qualifications and provide a company development adviser that visits the company to help employers plan their training needs. Using this system, the CITB has the ambition to create a sector that will become world class, skilled, productive, safe and sustainable.

The CITB model is however a sectoral scheme, and a similar scheme to incentivise workplace wellbeing interventions may not work sectorally. Other mechanisms for developing an equivalent health and wellbeing 'levy' would have to be explored, consulted on and probably piloted. For example, Health and Wellbeing Boards, supported by Public Health England may want to develop or pilot a levy scheme or a modern equivalent with eligible organisations in geographical area or region. The amount paid might be based on the number of employees in the organisation. Employers who then implement evidence-based workplace health and wellbeing interventions will receive a grant to further develop, or introduce initiatives to continue to improve employee health and wellbeing. Alternatively, Local Enterprise Partnerships could be used to develop a levy in the areas they cover.

In New Zealand the Accident Compensation Corporation (ACC) has a work levy based on accident rates across industrial sectors. The 'experience' based charge is designed to make the levy system fairer and reward businesses with safer workplaces, and encourages a focus on improving workplace safety. The experience rating is designed to take into account a business's claims history when the ACC sets the levy, and employers who have lower-than-average injury rates, with better-than-average rehabilitation or return to work rates may receive a discount on their ACC work levy. It is thought that this levy encourages businesses to focus on injury prevention in the workplace and helping injured employers return to work as quickly and safely as possible.

Advantages: Evidence from other levy systems that this mechanism can work to change employer behaviour and drives up overall standards. It might target employers beyond the usual suspects to introduce wellbeing interventions; by pooling resources of a large number of employers those who are normally held back through a lack of resources may be motivated to act.

Disadvantages: May be met with resistance from organisations as too punitive and interventionist and bureaucratic. Would benefit from piloting.

3) Incentivising collaboration through local 'budget-pooling'

A familiar challenge in the health and work policy arena is that of siloed thinking and siloed budgeting. It is argued that real improvements in workforce health are unlikely to happen unless we find ways of getting stakeholders with overlapping interests to collaborate more. Officials in HM Treasury are frequently told by advocates of 'spend to save' collaboration that, if they let the NHS spend (invest) more in workforce health interventions (e.g. early interventions, rehabilitation, etc.) then the savings to the Department for Work & Pensions (DWP) in reduced welfare payments would deliver an attractive 'return on investment'. Who could argue with that? Well, there at least three pragmatic difficulties with this argument:

a. HM Treasury invariably needs a higher quality of 'proof' that the promised return on investment will actually materialise than is often available. They might concede (in a rare moment of weakness) that there are latent benefits to be realised but they will hardly ever accept that these benefits can be 'cashed-out' in the way their advocates claim. They are probably right to take this position.

b. Ministerial budgets are rarely diverted to projects or initiatives whose benefits will accrue mainly to Ministers in other Departments – especially in times of austerity. It is not that Ministers – even in the cosiest Coalition – are ideologically opposed to collaboration in principle. It is just that there are no incentives (but plenty of brickbats) for them to allocate funding to such risky ventures.

c. Even if the return on investment from a collaboration is highly likely to be delivered, and even if Ministers in different Departments do forge a collaboration which puts energy and commitment behind an initiative (see, for example Norman Lamb MP and Lord Freud's collaboration to invest in mental health and work pilots following the publication of the Rand Europe (2014) report, if the results of these initiatives cannot be guaranteed to deliver within an electoral cycle, them it will be harder to get them off the ground.

In reality – and compared with the challenge of getting Whitehall Departments to join forces and budgets – collaboration between **local stakeholders (including employers) and agencies** of government may be a more realistic model and one worth exploring in more detail. Especially as a few models and templates in the workforce health domain exist already.

Below is an example from Sweden illustrating that, with enabling legislation, budget-pooling at local level can deliver better employment outcomes for people with long-term health conditions.

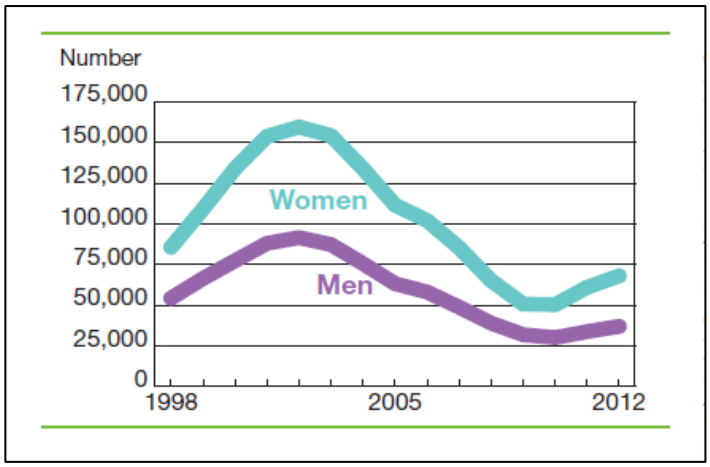
Example: Local budget-pooling for vocational rehabilitation in Sweden

In Sweden, cross-sectoral initiatives have been the subject of much evaluation. The SOCSAM scheme allowed social insurance and social services to voluntarily move up to 5 per cent of their budgets, along with a matched contribution from health services, to a pooled budget to jointly manage rehabilitation services to help individuals on long-term sick leave return to employment (see diagram below for more details). It was evaluated in eight localities and compared with experience elsewhere in the country where schemes were not introduced. Along with funding, joint financial management arrangements were set up, helping to foster the development of joint services and a more holistic approach to activities. The evaluation found that interdisciplinary collaboration between health and social care professionals improved compared to control areas (Hultberg, Lonnroth & Allebeck, 2003). This Swedish experience also suggests joint funding arrangements and collaboration at local or regional level, where institutional structures are closer to stakeholders and have a better understanding of local problems, can be effective. Following evaluation, a new scheme to support cooperation across these sectors was rolled out on a voluntary basis nationwide (Stahl, et al., 2010).

Since the early 1990s, there have been extensive experiments in Sweden with inter-sectoral collaboration in the field of vocational rehabilitation. As in many other countries, the responsibility for rehabilitation is divided between welfare institutions belonging to different sectors and levels of society. Between 1993 and 1997 there was an experiment where resources for rehabilitation were transferred from the national social insurance system to the health care system in five localities, with the aim of reducing the costs of sickness benefits. Between 1994 and 2002 the experiment was extended in eight municipalities to include social services and the national employment service. In this experiment, there was financial coordination between the different institutions involved and inter-sectoral collaboration in cross-boundary groups or teams. Both of these experiments were evaluated and initial positive results led to the 2003 Act on Financial Coordination of Rehabilitation Measures. Although not binding, this legislation made it possible for institutions in the rehabilitation field – the national employment service, the national social insurance administration, the regional health services and municipal social services – to form local associations for financial coordination.

Evaluations studies of these arrangements show that significant reductions (see Box 1) in long-term sick leave can be achieved by local collaboration and financial coordination. While more evidence needs to be gathered, the improvement in job retention and return to work – especially for people with MSDs – is encouraging.

Box 1 Long-term sickness claims: 1998-2012



Source: Swedish Social Insurance Authority 2013

Source: McDaid D, *Joint budgeting: can it facilitate intersectoral action?* In D McQueen, et al., (Eds), Intersectoral Governance for Health in All Policies: Structures, actions and experiences, The European Observatory on Health Systems and Policies, Observatory Studies no 26, 2012.

So how could this approach be adapted for the UK context and how could employers be involved more directly as partners or stakeholders? One approach might be to pilot a number of budget-pooling models which involve matched funding between local agencies (including private sector providers where they can add value) and employers – perhaps managed through Public Health England (PHE), Health & Wellbeing Boards and Local Enterprise Partnerships (LEPs). These pilots would target evidence-based interventions both in workplaces and among those claiming ESA with both a public health and workplace health focus. The pilots would test both the mechanisms for budget-pooling and the outcomes of specific local job retention and rehabilitation pilots on work outcomes.

Advantages: An equitable approach to shared budgeting and investment would encourage genuine local collaboration

Disadvantages: May need enabling legislation, as in Sweden. Hard to evaluate costs and benefits and to make attributions if the outcomes are positive. Needs change in culture and mind-set to devote resources to initiatives which have wider public benefit. Need to learn lessons from previous attempts (e.g. in Child Protection, health & social care integration).

4) Responsible procurement

If the government wish to highlight the importance of health and wellbeing in the workplace, then there is an argument that public sector organisations should qualify the 'most economically advantageous tender' principle when undertaking public procurement, and ensure that they procure the services of organisations that have reputable policies with regards to organisational health, safety and wellbeing. Public sector clients should ask

questions about a supplier's health and safety record, their level of sickness absence, the incidence of mental illness and physical illness in the organisation, and what level of investment in workplace health and wellbeing has been undertaken and what other interventions have been implemented. An example of responsible procurement (although not in the health and wellbeing domain) was provided recently by Ed Miliband[1], who suggested that organisations who are seeking to work with the government will have to pay their lowest waged employees the living wage instead of the minimum wage (the living wage is currently £1 higher than the minimum wage). Similarly, there have been cases where some public sector buyers have specified that when they procure for services that an Investors in People, or some other form of accreditation, is necessary to ensure that they are procuring responsible organisations (for example, Procurement for Housing[2]). Additionally, other organisations require ISO:9000 quality management[3] accreditation to get on framework agreements, or lists of preferred suppliers.

Policy makers may be resistant to this approach on the grounds of costs, especially if this reduces competitive intensity and results in rising costs to the public sector. However, it can be argued that if labour standards improve for organisations that are encouraged to implement health and wellbeing schemes, then costs elsewhere (e.g. health costs and health risks) are likely to reduce.

Advantages: There is evidence to suggest that interventions like this can raise labour standards. Sends a clear signal from government about the importance they are attaching to wellbeing at work: leading by example.

Disadvantages: There could be concerns that this could result in a reduction of competitive intensity or that businesses will seek ways of demonstrating minimal compliance with this requirement and resort to tokenism.

5) Regulation

A more interventionist approach to encouraging employers to provide health and wellbeing interventions would be to regulate which measures they must provide. This approach would provide more weight than current guidelines, such as those from NICE guidance and the HSE management standards, by making the provision of certain interventions compulsory or by requiring employers to report on how they have used them. For example, in the UK it could be that, subject to a review of how it is working, regulation could be used to strengthen links between employers and the Fit for Work Service. It could be made compulsory for employers to refer employees who are absent for more than four weeks to the Fit for Work Service, especially if the voluntary approach currently being used proves ineffective. Other

[1] http://press.labour.org.uk/post/86155311399/only-labour-will-tackle-the-scandal-of-low-pay (accessed 16 October)
[2] http://www.procurementforhousing.co.uk/who-we-are/sustainable-procurement-policy/ (accessed 16 October)
[3] http://www.iso.org/iso/iso_9000 (accessed 16 October)

regulatory approaches could be that employers must work with the Fit for Work Service and sign up to and pay for return to work plans. Given that it is now more than a decade since the development of the HSE Stress Management Standards, it may also be timely to revisit whether they, or the guidance to employers on how to use them, need to be revisited to ensure that they remain 'fit for purpose'.

A more interventionist regulatory approach is already taken in countries such as the Netherlands and Japan. In the Netherlands, employers are liable to pay for up to two years of sick pay at 70 per cent of the previous salary. There is also a strict, state-enforced process for employers and employees to discuss return to work (Black & Frost, 2011). Measures include: by week six of absence employers must pay for an independent occupational health physician, by week eight they must agree to a rehabilitation plan, and then only after 91 weeks if an individual is assessed as unfit for work they may then be transferred onto the state-administered benefits system. In Japan, regulation goes further in not only encouraging practices which manage return to work but in also regulating for preventative measures. For example, organisations which employ more than fifty people must contract an occupational physician, and those who employ more than one thousand, must provide this specialist full-time. Occupational physicians are responsible for on-site safety inspections, education of employees and provision of annual health check-ups (Zheltoukhova, Bevan & Waterson, 2012).

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

Advantages: A blanket approach that would force all businesses to comply with certain practices, potentially making a larger impact than voluntary options.

Disadvantages: Ambitious recommendation that will require a decisive shift in public policy. Potentially not cost effective, as it would involve large scale enforcement. May engender grudging compliance rather than win over hearts and minds.

6) Regulation for reporting

If the government understands and accepts that quality of employment and an employee's health and wellbeing has implications for business performance and social outcomes, then there may be a case for increased regulation in what organisations should disclose and report regarding health and wellbeing measures and practices they undertake. Developing a regulatory regime where reporting is required will challenge organisations subject their

practices to greater public scrutiny and, in doing so, may encourage behaviours which make their activities more robust and contribute to their reputation for being a responsible employer providing a great place to work. Although some measures that can improve employee wellbeing, such as high levels of autonomy and high levels of line management, may beyond regulatory interventions, other measures such as the use of Occupational Health Services, sickness absence levels (including long-term absence), referrals to the Fit for Work service or OH, what employment health and wellbeing promotion activities and employee benefits are in place are possible measures for reporting. Organisations could also be required to publish staff survey data including the level of employee engagement, security, fairness and trust in operational management and senior leadership, together with other measures such as voluntary resignations.

Any listed company is already under obligation to report a business review (Companies Act, 2006), this should include the financial accounts of the business for the annual year, a fair review of the company's business and a description of the principle risks and uncertainties facing the company. Additionally a company must also report the main trends and factors that are likely to affect the future development, performance and position of the company's business, including the company's employers and social and community issues. It could be argued that this includes reports about employee health and wellbeing; however, this is not directly stipulated. Therefore, there may be some merit in amending the Companies Act adding the requirement to report employee health and wellbeing measures, especially if they represent a tangible 'risk or uncertainty'.

This is not a new idea, of course. Accounting for People (DTI, 2003) recommended that information regarding human capital management should be included in Operating and Financial Reviews that might become mandatory for UK companies. The mandatory reporting of human capital management gave support to organisations (or individuals) who regarded people as a valuable asset for management. Organisations reported benefits to this, including transparency in reporting, reputation gains and gaining a superior assessment of an organisation's performance, and the proposals were passed into law, however, the requirement was soon abandoned.

Advantages: Reporting regulation is just a development of existing organisational reporting, although a little more specific. It is a feasible option, only requiring an amendment to an existing Act.

Disadvantages: Organisations will complain about the burden this can have on business, and may be resistant to report such measures, especially if this has negative implications for stakeholder investment. May conflict with issues regarding confidentiality. Organisations may be averse to reporting if there is lack of guidance in the reporting process. Organisations may just see this as 'an add-on' to what they already have to report, and may not act on the reporting findings. Work would need to be conducted on a standard set of indicators to report on and how they should be interpreted.

7) Benchmarking

Benchmarking offers a 'lighter-touch' approach compared with compulsory data reporting, in comparison to regulating reporting under the Companies Act, but allows organisations to enhance their organisational self-assessment in relation to health and wellbeing practices, through closely monitoring what is done in their organisation as well as similar organisations. Business in the Community have developed a 'Workwell Benchmark' (2013) to encourage more organisations to address the effective use of data collecting and reporting to demonstrate effective business practices, to improve the health and wellbeing of their employees, and to drive business performance improvements. They argue that organisations who take part in the Workwell benchmarking process can receive feedback on the strengths and gaps in wellbeing initiatives, and the data will give organisations the opportunity to see how they are doing with regards to health and wellbeing in comparison to their peers and competitors. Additionally, when undertaking benchmarking, organisations will be able to track their progress on the Workwell measures, to reinforce and develop good practice, and drive continuous improvement.

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

Advantages: Organisations of any size are able to take part. Allows for the development of organisational good practice in health and wellbeing initiatives, and encourages continuous improvement. Approach does not involve naming and shaming if there is a failure to report, however lead companies can get a badge of recognition.

Disadvantages: Policies have the potential to be effective, but this depends on how well the reporting is implemented in the organisation, and senior management's willingness to engage with the reporting process. There needs to be strategic ownership in the reporting to avoid duplication or repetition of data. Metrics have to be carefully chosen. Difficulty in collating all the appropriate health and wellbeing measures. May have a policy/practice effect – research has indicated that effective reporting is low, and target setting against relevant key performance indicators is still in its infancy (Towers Watson, 2014). Reporting on mental health remains low, suggesting difficulties of disclosure in this area. This may not attract new businesses to implement health and wellbeing interventions, but only serve for those already implementing them to certify it.

Other mechanisms

1) Investor's perspective

If public reporting regarding organisational health and wellbeing is encouraged, this could be a means by which investors gain insights into how organisations treat and value their staff and the overall health and wellbeing of their staff when deciding whether or not to invest in an organisation. Through seeking greater public disclosure from companies that they engage with, investors are indicating that they are interested in the way organisations manage human capital, and that this may have a direct bearing on how an organisation is able to grow and develop and deliver investor or shareholder returns. Their premise is that organisations that have positive staff health and wellbeing should have improved productivity, staff motivation and engagement should result in improved margins, innovation and reputation.

For example, the FTSE4Good Index was launched in 2001, and measures the environmental and social performances of companies that are listed on stock exchanges worldwide (Slager, 2012). Organisations who meet the FTSE4Good Index inclusion criteria are automatically included on this index. The Index is reviewed two times a year, and companies are included or excluded on their performance related to the Index criteria. In a report exploring the impact of the FTSE4Good Index, Slager (2012) highlighted that engagement had a considerable impact on organisational behaviours, policies and management systems so that organisations remained on the Index inclusion criteria. Similarly the Dow Jones Sustainability Index, launched in 1999, evaluates the sustainability performance of the largest 2,500 companies listed on the Dow Jones Global Total Stock Market Index. As with the FTSE4Good Index, the trend with the Dow Jones Sustainability Index is to reject organisations who do not behave in an ethical manner (including management and labour practices). Organisations must continue to improve their plans and policies to remain on this index which is monitored and updated yearly.

Thus, investors could be encouraged to only invest in organisations that have positive health and wellbeing practices and reporting in place, and comply with the established inclusion criteria.

Advantages: Potentially a small change with a big impact; this would require little action from government but would allow the market to encourage more health and wellbeing interventions. Would encourage employers to place health and wellbeing at the centre of their business plan.

Disadvantages: This might not affect the behaviour of smaller companies who are less interested in investors' behaviour.

2) Kite-marking

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

An example of kite-marking is the Investors in People (IiP) Standard, developed in 1990 as national framework aiming to improve business performance by linking staff development to business objectives. To gain IiP Standard accreditation, organisations must demonstrate their commitment to invest in people to achieve business goals, have a training plan in place that demonstrates how training and development activities contributed to the needs of business and how these were reviewed to show and accommodate any changes in business objectives, to demonstrate actions taken to develop workforce skills and training and development activities in place to support changes in job role, and to demonstrate that companies had evaluated progress towards the goals, values achieved and any future needs (Hoque, 2003). Once accreditation had been secured, the organisations are re-assessed every three years. A recent evaluation of the IiP Standard (UKCES, 2013) highlighted that organisations do change practices to meet the Standard, including: improving performance management systems (e.g. modifying appraisals); introducing training for a broader range of staff; and intensifying communication about business strategies. Other improvements included substantial changes to investment in leadership and management development. Investors in People also developed a People Health and Wellbeing Good Practice Award that aimed to help organisations align employee wellbeing and performance. This could be achieved as part of the Standard, or done as a stand alone assessment. The award provided a more in-depth focus on issues such as effective planning, supportive management, supportive culture, work-life balance and evaluation.

Advantages: Organisations of any size are able to take part. Allows for the development of organisational good practice in health and wellbeing initiatives.

Disadvantages: This may not attract new businesses to implement health and wellbeing interventions, but only serve for those already implementing them to certify it.

3) Organisational pledges

In an attempt to remove barriers to the implementation of health and wellbeing programmes organisations can make pledges to encourage the organisations to develop a commitment to workplace health and wellbeing. A number of pledges are currently available:

Workplace Health Charter: This is a statement of intent showing an organisation's commitment to the health and wellbeing of its staff. Organisations can conduct a self-assessment to discover what they are already doing to meet the charter and where there are gaps that need improvement. The charter is relevant to all NHS Trusts as long as they can

demonstrate their commitment to the health and wellbeing of their staff. The charter provides a clear set of wellbeing standards to be met, which takes a holistic approach incorporating both physical and mental health, health promotion and ways that can evaluate the information and services that are available. The aim of the pledge is to develop best practice about health and wellbeing in the workplace. The three areas that are focussed upon are leadership, culture and communication; these cover issues such as: mental health and stress, awareness of drug and alcohol abuse, sickness and absence management, healthy eating and physical activity. Organisations must gather a portfolio of evidence to show what they have done/are doing towards the charter, and once awarded the charter is valid for 2 years before reassessment is necessary.

Public Health Responsibility Deal: The aim of this voluntary partnership is for businesses and influential organisations to work in collaboration to improve public health at work. This is done by creating the right environment for individuals to make informed choices that lead to healthier lives. Partners who wish to sign up to the responsibility deal confirm they are committing to the core aims and to take action in support of them where they can. The core aims are: recognising they have a vital role to play in improving everyone's health; encouraging and enabling people to adopt a healthier diet; fostering a culture of responsible drinking; encouraging and assisting people to become more physically active; and, actively supporting the workforce to lead healthier lives. When signing up to the deal, organisations have to monitor their progress to establish accountability by confirming that the pledged actions have been completed. An evaluation also has an important role to play, as this displays what the implications of the deal have been for changing behaviour and improving health outcomes. Organisations must also publish progress against the pledges that they are committed to, and indicate how they intend to report progress on other pledges. Updates have to be submitted to the Department of Health on an annual basis, and progress can also be checked on-line.

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

Advantages: Organisations of any size are able to take part. Allows for the development of organisational good practice in health and wellbeing initiatives. Signposts employers towards high quality and evidence-based guidance and facilitates exchange of good practice.

Disadvantages: Organisations may view these as another monitoring activity, and be disinterested in the pledges – especially if there is no 'wellbeing lead' pushing the matter forward. This may not attract new businesses to implement health and wellbeing interventions, but only serve for those already implementing them to certify or get endorsement for what they are already doing.

Chapter 5 Conclusions

Improving the health and wellbeing of the workplace does make business sense. As discussed, employees in good health are more productive, motivated, engaged and resilient. Additionally, organisations who have undertaken evaluations of implemented health and wellbeing initiatives have identified financial benefits. Improving workplace health can also lead to government cost savings and wider public health benefits. However, this paper has also demonstrated that there are many barriers to both the initial uptake and the implementation of workplace health and wellbeing initiatives. This indicates that when considering methods to support employers to improve the health and wellbeing of their employees, highlighting the business case is not enough, and targeting employers alone will only do so much.

If the Bramley-Harker, et al., (2006) analysis is correct, and the benefits of implementing workplace initiatives are spread across a number of stakeholders: individuals, their family, the NHS and the DWP, then it could be argued that it is rational for employers to limit their involvement in workplace health and wellbeing interventions. Therefore, to resolve the problem of how to support employers to improve the health and wellbeing of the employees, to reduce (the related) sickness absence and costs incurred to both the organisation and the wider society, there is a need to co-produce workforce wellbeing with a range of stakeholders, including the government, especially if they are wanting to improve wider public health benefits. As workplaces are an area where public interventions can happen (and in which there is some evidence of success), there is need for a new deal, or a redefined relationship between the government and the employer to ensure that any interventions are similarly beneficial for both

A number of options for what this could look like have been discussed in this paper and our recommendations for how each should be taken forward are set out below.

	Feasibility: *a) Could it be implemented relatively quickly?* *b) Could it be implemented with little cost?*	*Effectiveness:* *a) Would it encourage employers already doing it to do more?* *b) Would it encourage employers not already doing it to start?*	*Quality:* *a) Would it encourage more evidence-based interventions?*
1. Fiscal Incentives	• Further research is needed in order to convince the government of its potential impact. • Costs of this approach are high.	• Likely to encourage employers already implementing interventions to do more • Unlikely to encourage those who are not doing so to start.	• Would depend on the type of fiscal incentive used. If the incentives were linked to a pre-approved supplier list with a pre-approved menu of interventions, it has the potential to encourage high quality interventions.
2. Levy System	• Trialling of this option is needed in order to better understand how it could be implemented e.g. through the HWS? Through local authorities? • Costs depend on how payment of the levy is apportioned between government and employers.	• Has the potential to both, a) encourage those already offering workplace interventions to expand these, and b) encourage employers who haven't previously considered it to start.	• As with the above, there is potential to link this option with a pre-approved list of suppliers to encourage quality. In order to access grants/loans from the fund, employers would have to choose from that list.
3. Incentivising collaboration through local 'budget-pooling'	• Trialling of this option is necessary to understand the best way to implement it. • It has the potential to reduce some costs through centralised resourcing.	• Has the potential to build effective links at a local level, encouraging those already offering workplace interventions to do more • In particular it would potentially be able to better reach out to smaller businesses locally not currently involved with this agenda.	• Through better collaboration at a local level this could allow a more tailored approach. E.g. a pre-approved list of providers/programmes relevant to the needs of that region could be developed.

4. Responsible procurement	• This would be relatively easy to implement, as the structure for government procurement is already in place. • Costs will vary according to how complex the criteria which are used to procure are.	• This would not necessarily encourage those already implementing health and wellbeing interventions to do more • It could encourage some mid-large sized employers not currently implementing them to do so, but has less potential to influence small employers.	• This could encourage high quality interventions if the criteria by which the procuring process happens are highly detailed. • Another option which could encourage quality would be to link procurement with an accreditation standard.
5. Regulation	• A cultural shift in how health at work is viewed would be necessary in order to get government on side and implement statutory changes.	• This approach would not necessarily be effective in either getting employers to do more or getting new employers on board.	• This approach could regulate for certain types of interventions only. The problem would be however in the compliance with that regulation. • In addition, its rigidity would not allow for tailored interventions relevant to each employer's needs.
6. Compulsory reporting	• Could be implemented relatively easily through the expansion of the Companies Act. • It has the potential to be cost effective if the onus is on the employers to record and report. Lack of compliance could increase costs.	• This has the potential to encourage those already implementing health and wellbeing interventions to do more. • As with responsible procurement, it could encourage some mid-large sized employers not currently implementing measures to do so, but has less potential to influence small employers.	• The risk with this approach is that there is no certain link between better reporting and better quality interventions, unless this approach is coupled with better education and guidance on which interventions work.

Options	*Feasibility:* *a) Could it be implemented relatively quickly?* *b) Could it be implemented with little cost?*	*Effectiveness:* *a) Would it encourage employers already doing it to do more?* *b) Would it encourage employers not already doing it to start?*	*Quality:* *a) Would it encourage more evidence-based interventions?*
1. Benchmarking	• This approach is already taking place, therefore a model already exists which could be transferred/ expanded fairly easily. • As a voluntary, non-governmental scheme the costs are very low.	• Could encourage employers already offering workplace interventions to do more as they seek competitive advantage. • However it would not necessarily encourage those not yet doing it to do so.	• As with compulsory reporting, the risk with this approach is that there is no definite link between better reporting and more evidence based interventions, unless better education and guidance is given alongside it.
2. Investor's Perspective	• This would be low cost, but could take some time to implement. • The benchmarking model which already exists would need to be reviewed and expanded so that investors had ready access to the data.	• This approach would only encourage companies on the stock market to improve their health and wellbeing approaches. It therefore may encourage those already involved to do more, but would struggle to get employers not yet interested in health and wellbeing to change their behaviour.	*See above.*

3. Kite-marking and Accreditation	• This is already in existence, so would be relatively easy to implement, but would be high cost.	• This approach runs the risk of only allowing companies already implementing health and wellbeing interventions to gain recognition of this, but neither encourage them to do more, nor encourage further take up of health and wellbeing initiatives.	• This approach allows the possibility to encourage only evidence based health and wellbeing interventions, by restricting the criteria to gain accreditation.
4. Organisational Pledges	• As with benchmarking, this option already exists so would be fairly easy to simply expand. It is also voluntary and therefore would be low cost.	*See above*	• Similarly to the above, pledges could be limited so that employers only pledge to carry out interventions from a of pre-approved list of options.

Key

- This option satisfies this criterion
- This option has the potential to satisfy this criterion
- This option is highly unlikely to meet this criterion

Recommendations

- Debate amongst all stakeholders in this arena needs to move on from narrow discussions about ‘making the business case’, to broader discussions about the range of policy options set out in this paper.

- The approach taken should require action from the range of stakeholders who benefit from health and wellbeing interventions at work (employers, the NHS and DWP individuals, and their families) and not weigh too heavily on any one.

- The government should do more to actively promote the issue of health at work, bringing these options into mainstream policy debate.

- The government should offer clearer, more up to date and proactive advice and guidance , for example through reviewing the content and use of the HSE stress management standards, and the active promotion of NICE guidance and public health guidance from PHE and others.

- The business case for a healthy workforce should be made in a way which speaks to employers and is tailored to their organisation in order to encourage them to take more voluntary action; regulation in most cases is a second rate option.

- A number of employer-led voluntary options already exist, and these should be encouraged and expanded upon. The form of measurement used should be further developed and streamlined as far as possible:

    - Benchmarking

    - Investors Perspective

    - Kitemarking/ accreditation

    - Organisational Pledges

- At the same time, the government should review the feasibility of using targeted incentives (e.g. through tax relief on National Insurance Contributions) in order to redress market failures and to encourage more employers to act and invest in workplace interventions.

- A number of options for this should undergo feasibility testing to understand exactly how they could be implemented:

    - Fiscal incentives

    - Levy system

    - Budget-pooling

- Government should reform its procurement processes in order to include a consideration of workforce safety, health and wellbeing when deciding on suppliers. A number of options for how this is implemented should be explored (e.g. through an accreditation system, through a more detailed set of labour standards criteria, etc.).

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