Implementation Plan for the Healthy Workers initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:

1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and

1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

The measures funded through this Agreement include provisions for the particular needs of socio-economically disadvantaged Australians, and those, especially young women, who are vulnerable to eating disorders.

2. The Healthy Workers initiative provides funding to support implementation of healthy lifestyle programs in workplaces across Australia.

3. Under the Healthy Workers initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the Northern Territory, represented by the Minister for Health (known as the Parties to this Implementation Plan).

5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion of the specified program, including the acceptance of final performance program reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.

7. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the Northern Territory is limited to payments associated with performance benchmarks achieved by the Northern Territory by the date of effect of termination of this Implementation Plan.

8. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

9. The maximum possible financial contribution to be provided by the Commonwealth for the Healthy Workers initiative is $2,990,000. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.

10. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule ($ million)

Facilitation Payment		Due date	Amount
(i)	Facilitation payment	July 2011	$0.35
(ii)	Facilitation payment	July 2012	$0.65
(iii)	Facilitation payment	July 2013	$0.31
(iv)	Facilitation payment	July 2014	$0.19
Reward Payment *		Due date	Amount
(v)	Reward payment	2013-2014	$0.60
(vi)	Reward payment	2014-2015	$0.90

* note the actual amount of reward payment is conditional on assessment of achievement against performance benchmarks as set out in the National Partnership

11. Any Commonwealth financial contribution payable will be processed by the Commonwealth Treasury and paid to the Northern Territory Treasury in accordance with the payment arrangements set out in Schedule D of the *Intergovernmental Agreement on Federal Financial Relations*.

OVERALL BUDGET

12. The overall program budget (exclusive of GST) is set out in Table 2.

Table 2: Overall program budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
Implementation of Healthy Territory Workers	0.35	0.65	0.31	0.19	1.50

Notes: reward payments have not been budgeted at this stage

13. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the Northern Territory will not be required to pay a refund to the Commonwealth if the actual cost of the program is less than the agreed estimated cost. Similarly, the Northern Territory bears all risk should the costs of the program and/or a project(s) exceeds the estimated costs. The Parties acknowledge that this arrangement provides the maximum incentive for the Northern Territory to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

14. ***Healthy Territory Workers* Program**

15. The objective of this program is to assist priority NT workplaces to improve the health of their employees through the development and implementation of multi-strategy health promotion programs aimed at promoting healthy behaviours and creating supportive workplace environments.

16. ***Healthy Territory Workers*** is inclusive of the following activities:

a) *Healthy@Work* - develop and implement a multi-strategy healthy worker program, primarily for indigenous employees within the Northern Territory Department of Health and Families.

b) *Construction Health Improvement Program (CHIP)* – develop and implement a multi-strategy workplace health program for male construction workers in targeted sites across the NT

ACTIVITY DETAILS

17. **Overview:** *Healthy@Work* will focus on improving the health of Northern Territory Department of Health and Families (DHF) employees in urban and remote settings, with a particular focus on indigenous employees. This program will be developed and implemented within the DHF - the largest government employer in the Northern Territory. There will be a specific focus on indigenous employees (approximately 10% of the DHF workforce is indigenous).

Healthy@Work will be a multi-strategy workplace activity. Key components of *Healthy@Work* may, subject to consultation with staff, include:

- Developing and implementing a holistic health screening and referral program;
- Developing and implementing rolling indigenous health education sessions, making use of national social marketing materials from the *MeasureUp* and *Tomorrow People* campaigns;

- Establishing an overarching health promoting workplace policy;
- Profiling the positive health behaviours of existing NTG employees, primarily indigenous staff; and
- Building the capacity of relevant health professionals to promote healthy workplace behaviours and environments among NTG employees.

Participation will be open to existing and new employees, with a particular emphasis on promoting the activity to indigenous staff.

A Healthy Workplace Program Officer will be appointed within DHF to oversee the abovementioned activities. The Program Officer will initially be responsible for:

- Establishing a Steering Group tasked with overseeing the planning and delivery of the activity. This will comprise key stakeholders from across DHF and within NTG.
- Establishing relevant networks and relationships internal and external to DHF to facilitate the delivery of key components of the activity
- Consulting with DHF staff, particularly indigenous employees about their perceived health needs to assist with the development and implementation of the activity.
- Planning, developing, implementing and evaluating all components of *Healthy@Work* using the Quality Improvement Program Planning System (QIPPS)
- Conducting process, impact and outcome evaluation for all components of *Healthy@Work*
- Purchasing in services, when and where required
- Encouraging staff participation through the promotion of *Healthy@Work*

18. Outputs:

The outputs for this activity include:

- Appointment of a Healthy Workplace Program Officer
- Establishment and maintenance of a Steering Group
- Number of staff participating in various components of *Healthy@Work*
- Range, number and quality of the various components of *Healthy@Work*, such as health education sessions
- Training opportunities provided to health professionals and NTG staff
- Establishment and implementation of a Health Promoting Workplace Policy
- Numbers of service delivery partners involved

19. Outcomes: Anticipated outcomes for this activity among participating DHF employees, include:

Short-Term: (July 2012)

Increased capacity within DHF to provide a healthy workplace environment

Increased awareness of healthy eating, physical activity and smoking cessation messages

Medium Term (July 2013)

Establishment and maintenance of processes and policies that facilitate a healthy workplace environment

Increased opportunities to participate in physical activity and healthy eating practices within and through the workplace

Improved compliance with DHF Smokefree Policy

Monitoring the implementation of workplace components in the NT Tobacco Action Plan

Long-Term (July 2014-15)

Improved application of processes and policies that facilitate a healthy workplace environment

Reduction in proportion of smoking

Increased fruit and vegetable consumption

Increased proportion of staff participating in moderate physical activity

Reduced rate of increase in overweight and obesity

20. **Rationale:** The primary focus of this program will be on indigenous employees. There is strong and compelling evidence to suggest that the Australian indigenous population have the poorest health outcomes in Australia, particularly in relation to chronic disease prevalence. They fair worse in relation to all performance benchmarks. This activity is premised on an assumption that the current indigenous health burden in the NT will transfer into workplace settings (in contrast to community settings) as indigenous employment increases in line with other COAG targets. Currently there is limited evidence about how best to support the health needs of indigenous employees. This program is innovative and will require a flexible approach to its implementation. Evaluation data from this multi-strategy project will provide a much needed empirical evidence-base about a worksite health program tailored to the needs of indigenous employees.

    If the activity is successful and reward funding is received then DHF will consider expanding the program to other NTG agencies.

21. **Contribution to performance benchmarks:** It is envisaged that this activity will contribute to a reduction in smoking, increased physical activity and increased fruit and vegetable consumption among indigenous employees in the DHF, where health concerns associated with such performance benchmarks are more pronounced.

22. **Policy consistency:** The policy framework clearly identifies access and equity as key issues and meets all requirements associated with the Healthy Worker scoping statement and guiding policy principles. This activity is explicitly aimed at preventing a widening of the gap in health outcomes between indigenous and non-indigenous Australians engaged in employment. This activity is consistent with targets in other COAG agreements aimed at closing the gap in indigenous disadvantage. This activity is also consistent with NTG policy positions such as the *DHF Aboriginal and Torres Strait Islander Strategic Workforce Plan 2008-2011, DHF Cultural Security Policy*, *NT Public Sector Indigenous Employment and Career Development Strategy 2010-2012, NT Tobacco Action Plan* and the *NT Chronic Conditions Prevention and Management Strategy*.

23. Target group(s): This activity will primarily be tailored to meet the health needs of existing and new indigenous DHF employees. Approximately 10% (427 employees) of the DHF workforce identify as indigenous.

24. Stakeholder engagement: An initial consultation process is already underway as part of the program development. Further consultation and engagement with indigenous workers from urban and remote settings across DHF will occur upon program commencement. A Steering Group will also be established to provide advice and guidance throughout the duration of the project.

25. Risk identification and management: Developing a *Healthy@Work* activity that responds to the priority health needs of the DHF indigenous workforce and which fits within the policy parameters of the NPA funding could be problematic. A comprehensive consultation process with indigenous employees at the outset of the program design will mitigate such risks. Finding suitably qualified staff to facilitate the project may be problematic (e.g. health promotion is on the NT workforce shortage list). A capacity building element has been included to mitigate such risks. Also, as this activity is confined to DHF employees, the chance of large scale behaviour change against the Performance Benchmarks being measurable across the whole population is impractical.

DHF has internal processes for risk management.

26. Evaluation: A program plan will be developed using the Quality Improvement Program Planning System (QIPPS). This will utilise existing evaluation infrastructure detailed in the *DHF Corporate Plan 2009-2012*. The development of the program plan will be guided by a consultation process and the Steering Group, and timelines will be established during this period. This planning process will subsequently provide a framework to conduct a comprehensive evaluation process incorporating process, impact and outcome measures specific to the activity. Reporting will be against this plan.

27. Infrastructure: At this stage of development, this activity does not require initial infrastructure investment. However, key stakeholders may identify that investment in infrastructure is required during the initial consultation and planning process.

28. Implementation schedule:

Table 3: Implementation schedule

Deliverable and milestone	Due date
(i) Healthy Workplace Program Officer recruited and trained and Steering Group established	30th September 2011
(ii) Consultation conducted and initial program plan developed	30th December 2011
(iii) Key components of *Healthy@Work* will be implemented within DHF	30th June 2012
(iv) Expansion of *Healthy@Work* and an interim process and impact evaluation report completed	30th June 2013
(v) Final evaluation report completed	30th June 2015

Notes: Annual activity reports will be completed as required

29. Activity budget:

Table 4: Activity project budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	0.19	0.33	0.19	0.19	0.90

30. Activity: Construction Health Improvement Project (CHIP)

31. Overview: The Construction Health Improvement Project (CHIP) activity aims to develop and implement a multi-strategy workplace health program, primarily for male construction workers in targeted construction sites across the NT. This project will run for three years and will be lead by Unions NT in partnership with the Construction, Forestry, Mining and Energy Union (CFMEU), Australian Metal Workers Union (AMWU), Electrical Trades Union (ETU) and the NT Department of Health and Families.

Key components of *CHIP* are, subject to consultation with key stakeholders, likely to include:

- Offering workplace health checks (similar to the Tradies Tune-Up)
- Promoting the use of existing health services and programs
- Supporting construction businesses of all sizes to develop healthy workplace policies
- Exploring options to embed a healthy workplace focus through enterprise bargaining processes
- Increasing access to drinking water (bubblers) on work-sites
- Providing on-site smoking cessation support services and subsidised Nicotine Replacement Therapy (NRT)
- Promoting smokefree workplaces
- Encouraging healthy eating practices within work-sites by working with ‘smoko’ (lunch) trucks and surrounding businesses
- Developing an industry-based healthy workplace awards program in the NT
- Providing on-site health education seminars during work-time
- Offering ongoing health coaching for staff
- Promoting the use of web-based health information, interactive websites, e-learning opportunities and health assessment tools, such as the M5 Health Online resource developed by the Royal Australian College of General Practitioners and the Men’s eHealth Network interactive website developed by Vario Health Institute.
- Promoting the use of national health promotion social marketing resources that relate to modifiable lifestyle risk factors
- Providing opportunities for structured physical activity within and through the workplace
- Ensuring key union events have a health promoting orientation (e.g. May Day)

A Healthy Workplace Project Officer will be employed by Unions NT to oversee the abovementioned activities. The co-ordinator will initially be responsible for:

- Establishing a Reference Group tasked with overseeing the planning and delivery of the activity. This will comprise key union officials, health professionals and construction industry representatives.

- Establishing relevant networks and partnerships with and between Unions NT, CFMEU, AMWU, ETU and DHF, to facilitate the delivery of key components of the activity.
- Consulting with the construction industry about their perceived health needs to assist with the development and implementation of relevant interventions.
- Planning, developing, implementing and evaluating all components of *CHIP* by using the DHF subscription of the Quality Improvement Program Planning System (QIPPS).
- Conducting process, impact and outcome evaluation for all components of *CHIP*.
- Purchasing in services, when and where required.
- Encouraging construction workers and their line management to participate in *CHIP*.

32. Outputs:

The outputs for this activity include:

- Appointment of a Healthy Workplace Project Officer
- Establishment and maintenance of a Reference Group
- Number of construction workers participating in various components of *CHIP*
- Range, number and quality of the various components of *CHIP*, such as health education seminars
- Establishment and implementation of processes and policies that facilitate a healthy workplace environment
- Number of identified healthy workplace champions
- Numbers of partners involved
- Nature of partnerships established

33. Outcomes: Anticipated outcomes for this activity among participating construction workers, include:

Short-Term: (July 2012)

Increased capacity within the construction industry to provide healthy workplace environments

Increased awareness of healthy eating, physical activity and smoking cessation messages

Enhanced opportunities to participate in physical activity and adopt healthy eating practices within and through the workplace

Establishment of partnerships that support the various components of the activity

Medium Term (July 2013)

Establishment and maintenance of processes and policies that facilitate a healthy workplace environment

Increased opportunities to participate in physical activity and adopt healthy eating practices within and through the workplace

Maintenance of partnerships that result in healthy lifestyle options

Long-Term (July 2014)

Improved application of processes and policies that facilitate a healthy workplace environment

Reduction in proportion of smoking

Increased fruit and vegetable consumption

Increased proportion of staff participating in moderate physical activity

Reduced rate of increase in overweight and obesity

Sustainable partnerships that provide healthy lifestyle options

34. Rationale: Evidence in men's health literature suggests that construction workers (and blue collar workers more broadly) have poor health lifestyle behaviours that are consistent with idealised forms of masculinity (Courtenay 2000; O'Brien et al 2005, 2007, 2009; PWC 2010). This literature also suggests that men from working class backgrounds delay seeking help for health concerns and often fail to engage in preventative health programs. An exception, relates to engaging men in workplace settings – whereby workplaces are considered to be effective settings to engage men in discussion about their health. The recently released *National Male Health Policy* affirms this observation. It advocates for workplaces to promote men's health and provides case studies of existing workplace health promotion programs targeted at men in Australia. This activity will build on the evidence generated from these case studies. This activity is aligned to an action aimed at improving men's health and wellbeing in the *DHF Corporate Plan 2009-2012*. This activity will be complemented by strategic support from the recently established Men's Health Strategy Unit within DHF.

35. Contribution to performance benchmarks: It is envisaged that this activity will contribute to a reduction in smoking, increased physical activity and increased fruit and vegetable consumption among a selection of the construction industry in the NT. Existing data suggests that the prevalence of modifiable lifestyle risk factors among this population is higher than the national average.

36. Policy consistency: The policy framework clearly identifies access and equity as key issues and meets all requirements associated with the Healthy Worker scoping statement and guiding policy principles. This activity aims to promote and encourage healthy behaviours among men in the construction industry – an industry where the prevalence of modifiable lifestyle risk factors associated with the NPA is higher than the national average. This activity is also consistent with the recently released *National Male Health Policy* and with key elements of *Taking Preventative Action* – the Australian Government's response to the National Preventative Health Taskforce. At a jurisdictional level the activity complements the focus on men's health in the *DHF Corporate Plan 2009-2012* and the recent establishment of a Men's Health Strategy Unit. There is also potential to align the roll-out of this program with key infrastructure developments in the NT, such as .Territory Growth Towns and the development of the City of Weddell.

37. Target group(s): The target group is primarily male construction workers living in the NT. A report completed for the Australian Government by Price Waterhouse Coopers identified that construction workers residing in the NT had a significantly higher prevalence rate for smoking, overweight and obesity (both measured and self-reported), and risky or high risk alcohol

consumption when compared to the national average. Where possible construction organisations working in the City of Palmerston will be targeted to complement investments in the Healthy Communities and Healthy Children's initiatives.

38. Stakeholder engagement: Initial meetings were held with the President of Unions NT and the NT Sub-Branch Organiser of the Construction, Forestry, Mining and Energy Union (CFMEU). In-principle support for this activity has since been approved by the Unions NT Council. This will initially be a partnership between Unions NT, CFMEU, AMWU, ETU and DHF. A meeting has been scheduled with the Master Builders Association to progress further partnership discussions. It is envisaged that Unions NT will be the lead partner during the roll-out of this activity and will identify the key construction sites where this activity will be implemented. A Reference Group will be established to provide advice and guidance throughout the duration of the project.

39. Risk identification and management: Finding suitably qualified staff/agencies with expertise in health promotion, workplace health and/or men's health to facilitate and deliver the project may be problematic (e.g. health promotion is on the NT workforce shortage list). A capacity building element has been included to build capacity in engaging men in workplace settings to mitigate such risks. Also, as this activity is confined to employees in the construction industry, the chance of large scale behaviour change against the Performance Benchmarks being measurable across the whole population is impractical.

40. Evaluation: A program plan will be developed using the Quality Improvement Program Planning System (QIPPS). This is consistent with quality improvement tools advocated in the *DHF Corporate Plan 2009-2012*. The development of the program plan will be lead by CFMEU in partnership with DHF. Respective timelines will be established during this period. This planning process will provide a framework to conduct a comprehensive evaluation process incorporating process, impact and outcome measures specific to the activity.

41. Infrastructure: At this stage of development, this activity does not require initial infrastructure investment. However, key stakeholders may identify that investment in infrastructure is required during the initial consultation and planning process.

42. Implementation schedule:

Table 3: Implementation schedule

Deliverable and milestone		Due date
(i)	Healthy Workplace Co-ordinator Recruited and Reference Group Established	30th December 2011
(ii)	Program plan developed in partnership with CFMEU	30th June 2012
(iii)	The implementation of CHIP will commence in pilot sites. An interim process and impact evaluation report will be completed	30th June 2012
(iv)	Expansion of CHIP to include additional construction sites (possibly in Alice Springs and a remote Territory Growth Town)	30th June 2013
(v)	Final evaluation report completed	30th June 2014

43. Activity budget:

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	0.16	0.32	0.12	0.000	0.60

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

44. The Commonwealth is responsible for reviewing the Northern Territory's performance against the program and activity outputs and outcomes specified in this Implementation Plan and providing any consequential financial contribution to the Northern Territory for that performance.

Role of the Northern Territory

45. The Northern Territory is responsible for all aspects of program implementation, including:

(a) fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;

(b) completing the program in a timely and professional manner in accordance with this Implementation Plan; and

(c) meeting all conditions of the National Partnership including providing detailed annual report against milestones and timelines contained in this Implementation Plan, performance reports against the National Partnership benchmarks, and a final program report included in the last annual report that captures lessons learnt and summarises the evaluation outcome.

46. The Northern Territory agrees to participate in the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

47. The Northern Territory will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 December 2013 and 31 December 2015:

a) Increase in proportion of adults participating in the Healthy Territory Worker program at unhealthy weight held at less than five per cent from baseline by 2013; proportion of adults at healthy weight returned to baseline level by 2015.

b) Increase in mean number of daily serves of fruits and vegetables consumed by adults participating in the Healthy Territory Worker program by at least 0.2 for fruits and 0.5 for vegetables from baseline by 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015.

c) Increase in proportion of adults in the Healthy Territory Worker program participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline by 2013; 15 per cent from baseline by 2015.

48. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Australian Health Minister's Conference.

49. The performance reports are due within two months of the end of the relevant period.

ATTACHMENT A

National Partnership Agreement on Preventive Health

HEALTHY WORKERS

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

This document, developed in consultation with states and territories, is designed to provide guidance in developing jurisdictional implementation plans and encourage a consistent approach to the implementation of the Healthy Workers initiative under the National Partnership Agreement on Preventive Health (NPAPH).

1.2 Objectives

The objective of the NPAPH is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in adults, children and young people through the implementation of programs in various settings. The NPAPH provides funding for:

- settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives and focusing on improving poor nutrition, and increasing physical inactivity. For adults also focusing on smoking cessation and reducing harmful and hazardous alcohol consumption;
- social marketing for adults aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the National Preventive Health Agency and research fund.

1.3 Outputs

To support these objectives the Healthy Workers initiative will fund:

(i) States and territories to facilitate delivery of healthy living programs in workplaces:

a) focusing on healthy living and covering issues such as physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking cessation;
b) meeting nationally agreed guidelines for addressing these issues, including support for risk assessment and the provision of education and information;

c) which could include the provision of incentives either directly or indirectly to employers;
d) including small and medium enterprises, which may require the support of roving teams of program providers; and
e) with support, where possible, from peak employer groups such as chambers of commerce and industry.

(ii) Commonwealth to develop a national healthy workplace charter with peak employer groups, to conduct voluntary competitive benchmarking, supporting the development of nationally agreed standards of workplace based prevention programs and national awards for healthy workplace achievements. Commonwealth in consultation with the states and territories, may consider taking responsibility for national employers.

1.4 Evidence Base

The workplace is a setting where most adults spend around half of their waking hours, and there is potential through the workplace to reach a substantial proportion of the population who may not otherwise respond to health messages, may not access the primary health care system, or may not have time to make sustained changes to their behaviour, such as participating in more regular exercise.

Nearly 11 million Australian adults are in paid employment, with around 70 per cent in full time employment.[1] Approximately five million (2004-05) Australian employees are overweight or obese (of whom 1.3 million are obese). Obesity was associated with an excess 4.25 million days lost from the workplace in 2001.[2] Obesity rates are highest among mature age workers aged 45-64, who comprise almost a third of the labour force. As obese people age, sick leave increases at twice the rate of those who are not obese.[3] Research indicates that sedentary lifestyles can also lead to more work-related illness and prolonged recovery periods as well as increased morbidity and mortality.[4]

Key factors emerging from the international and national literature that can determine the success and sustainability of workplace health promotion programs include:

- *Management involvement and support* from senior management through to middle and line mangers across an organisation ensures equal access, opportunity and support to all workers, regardless of position or job type.
- *Integrated workplace health promotion* with existing business planning and values.
- *Well established project planning and implementation* and a participatory approach helps to create employer and worker ownership and longer term success.
- *Effective and consistent communication* of the aims and purpose of the program from employers to workers builds positive engagement.
- *Multi-component programs* can ensure a variety of behavioural risk factors, issues and strategies are addressed to increase participant engagement with different preferences and health needs and ensure lasting change.
- *Monitoring and evaluation* of all program components should be established during program planning and inception.

---

[1] Workforce statistics form the ABS, cited in: *Overweight and Obesity: Implications for Workplace Health and Safety And Workers' Compensation*, Australian Safety and Compensation Council, August 2008, p 8-9.

[2] Overweight and Obesity: Implications for Workplace Health and Safety And Workers' Compensation, Australian Safety and Compensation Council, August 2008, p 8-9.

[3] An American study reported that the profile of obese workers with respect to cardiovascular risk factors as well as work limitations resembled that of workers as much as 20 years older. Also see Overweight and Obesity: *Implications for Workplace Health and Safety And Workers' Compensation*, Australian Safety and Compensation Council, August 2008.

[4] McEachan, Lawton et al. 2008

PART 2: HEALTHY WORKERS

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

For the purposes of the Healthy Workers initiative, the following terms are defined:

Access and equity is about ensuring that individuals and populations are not further disadvantaged in a health and social sense through the programs and activities delivered as part of the NPAPH. It requires consideration of a range of factors that can impact on access to, reach of and appropriateness of programs for certain populations, removing or reducing barriers to health and access to health-based activities. Programs must support equity of outcomes for all by increasing opportunities and removing or reducing barriers for participation. There are a number of interacting factors at both the organisational and individual level that must be considered in addressing access and equity, for example:

- the type of organisation, industry or enterprise and the structural characteristics of the workforce (does the business operate 24 hours per day or involve shift work; are those working in the industry full-time, part time, seasonal or casual; is the workforce or worker geographically isolated or mobile);
- the size of the organisation or enterprise, relative capacity and decision making autonomy to take up and implement programs and make organisational change;
- consideration of the characteristics of workers at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. For example, the workforce of mining operations can be physically isolated, largely male and may be drawn from culturally and linguistically diverse backgrounds. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals and organisations (e.g., were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[5]

Healthy living programs are those programs that cover physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking. The use of the term 'program(s)' is inclusive of activities targeting individual workers, groups of workers and activities that are of an organisational wide, enabling or capacity building nature. It also includes workplace policy enhancement, system change and minor supporting infrastructure improvements directly related to the implementation in the specific setting that are made to facilitate and support the health of workers and associated behavioural changes. The following language will be used to describe the hierarchy of elements of the NPAPH:

1. NPAPH initiatives, such as Healthy Workers;
2. jurisdictional programs (i.e., state and territory programs or activities implemented according to an agreed plan); and
3. activities within jurisdictional programs, local government programs or pilot programs.

Primary and secondary prevention definitions are drawn from *The Language of Prevention,* National Public Health Partnership 2006[6] and in the context of Healthy Workers mean:

---

[5] www.socialinclusion.gov.au/Documents/SIToolKit.pdf

- *Primary prevention* - limiting the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departure from good health, control exposure to risk and promote factors that are protective of good health; and
- *Secondary prevention* - reduction of progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.

Quality assurance frameworks, accreditation and standards are currently being developed by the Australian Government under the NPAPH. Programs and program providers (whether this is the employer or a third party on behalf of the employer) will be encouraged to have regard to relevant accreditation processes in order to receive funding under the initiative from jurisdictions. Note that once these processes are fully established consideration will be given to making them a requirement.

Workers, for the purpose of this initiative, are defined as individuals of working age currently in paid employment in Australia. The primary target age range for this initiative is 35 to 55 years. Other age ranges outside of this group in the workplace context can also be considered. It is acknowledged that there are differing arrangements in jurisdictions relating to age for entry into the workforce and that there is no compulsory retirement age.

2.2 Scope

Consistent with the objectives and expected outcomes of the NPAPH, the policy scope for the Healthy Workers initiative is summarised below:

2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of smoking, poor nutrition, physical inactivity and hazardous and harmful alcohol consumption through sustained behaviour and organisational changes in working Australians and their workplaces.

2.2.2 The wider community, children and those who are unemployed or in an unpaid position are not a specific target population under this initiative. However, if a program through a participating worker or workplace, can also reach families, or other members of the community then this is encouraged.

2.2.3 The primary target age range for this initiative is people in paid employment aged 35 to 55 years old. Other age ranges outside of this group can also be considered. A lower and upper age limit is not specified under the initiative.

2.2.4 Programs should focus on preventive health activities. Programs with a tertiary management focus (i.e. managing existing chronic conditions) are not within the preventive scope of the initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs will attract funding.

2.2.5 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.

2.2.6 Health promotion programs can be implemented in and through workplaces with workers as the primary target audience. There must be a direct connection with the workplace. For example, policies on food and vending machines in the workplace or a lunchtime walking group organised by workers and undertaken during working hours. A community program that is attended by a worker on the weekend, and does not have the support or endorsement of an employer (e.g., a subsidy) and is otherwise unconnected with employment, would be out of scope.

---

[6] National Public Health Partnership (2006); *The Language of Prevention, Melbourne*

2.2.7 Needs assessments can include consideration of the policy environment, workplace culture and infrastructure as they relate to the delivery of a program. An audit of policies and infrastructure that support healthy lifestyle choices and work-life balance to identify areas for development and determine appropriate activities could be implemented as part of a program. For example, in considering the implementation of an active transport to work program, an audit may identify whether supporting infrastructure such as bike racks in the workplace are available.

2.2.8 Investment in substantial built environment or hard infrastructure improvements is beyond the scope of the NPAPH. Substantial infrastructure improvements (i.e., change facilities and shower blocks) will need to be funded by the employer. Minor infrastructure (i.e., bike racks) may be permitted following consultation with the Commonwealth.

2.2.9 Whilst volunteers are not a specific target population under the initiative, if volunteers are in the workplace they should not be excluded from participating in programs.

2.2.10 Funding may be used, among other things, to provide direct incentives to employers to provide programs (e.g. through the provision of subsidies to purchase programs; develop jurisdiction wide programs that can be picked up by employers; or to assist existing providers) or adapt existing programs to suit a wider range of workplaces or to target specific groups.

2.2.11 Programs should cover a range of businesses regardless of size. Large business should not be the sole focus of programs and consideration should be given to the needs of small to medium enterprises.

2.3 Policy Principles

General

2.3.1 Programs under the initiative should be focused on primary and secondary prevention.

2.3.2 Funding for programs should be invested in:

- significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
- new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
- programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and
- programs that have a high likelihood of being sustainable beyond the funding received under this initiative, should the program be effective and there is a demonstrated continuing need.

2.3.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.

2.3.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.

2.3.5 Participation in NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new workplace legislative requirements or policies (e.g., food supply, no smoking, alcohol management policies, banning of alcohol).

2.3.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions or behaviours.

2.3.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

2.3.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.

2.3.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues, and different industry and workforce requirements).

2.3.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation, should not be permitted.

2.3.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.

2.3.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. schools, early childhood settings or other organisations in the community).

2.3.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.

2.3.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And in addition for the Healthy Workers initiative

2.3.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.

2.3.16 Programs should recognise the diversity of workplaces in Australia and the diversity of Australian workers.

2.3.17 Employers should consider the effect of programs across their entire workforce where an employer operates in more than one jurisdiction to ensure that all employees have the opportunity to access programs.

2.3.18 Inter-jurisdictional collaboration should be considered when the employer has a workforce operating in a number of jurisdictions or is a national employer.

2.3.19 Activities and programs implemented by each jurisdiction will need to be accessible and appropriate for small to medium enterprises, as well as large businesses.