OECD Health Policy Studies

Promoting Health and Well-being at Work

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Foreword

For many years, the OECD has been highlighting the economic impact of investing in prevention for unhealthy lifestyles and chronic diseases. Unhealthy lifestyles, including smoking, poor diets, harmful alcohol use and physical inactivity are responsible for 76% of all deaths occurring in the population of working age, between ages 20 and 64, in OECD countries. Well-designed prevention policy packages help improve population health, reduce health expenditure, and improve employment and work productivity.

The report "Promoting health and well-being at work: policy and practices" places a spotlight on workplaces, which are an ideal location to spread and implement health promotion and well-being activities in the working-age population, as populations across the OECD countries age and face an increasing burden of unhealthy lifestyles and chronic diseases.

Findings from the report support an integrated approach of the promotion of health and well-being into occupational safety and health actions. Combined with the prevention of occupational risks, workplace health and well-being programmes can improve employees' lifestyles, health and well-being while also producing benefits for the employers. Previous OECD modelling work indicates that scaling up interventions reducing sedentary behaviour and promoting physical activity at the workplace could improve employment and productivity resulting in the equivalent of an additional 37 000 full-time equivalent workers per year in 30 OECD countries, with a positive economic return of USD 4 for each USD 1 invested.

This report analyses policy levers implemented in ten countries, including G7 countries and three other OECD countries in the Asia and Pacific region, to support and incentivise employers to promote employee health and well-being. These levers include regulation, financial incentives, guidelines, as well as certification and award schemes. The report also explores how governments can facilitate Environmental, Social and Governance (ESG) investment to encourage health promotion at work.

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Table of contents

Foreword 3

Acknowledgements 4

Abbreviations and acronyms 9

Executive summary 11

1 Promoting health, healthy lifestyles, and well-being at work 13

1.1. Introduction 16
1.2. Population ageing and chronic diseases, including mental health conditions, affect the health and the productivity of workers 18
1.3. Workplaces offer opportunities for promoting healthy lifestyles and preventing chronic diseases and mental health disorders 22
1.4. Governments have many policy levers to promote health and well-being through the workplace 25
1.5. Regulations set a minimum standard for specific health issues at work 27
1.6. Financial incentives help employers promote health through work 29
1.7. Dissemination of information and guidance increases awareness and lowers barriers for employers to implement best practices 31
1.8. Certification and award schemes incentivise employers to support health and well-being of the workers 32
1.9. Companies that promote employee health and well-being are likely to attract growing interest from investors that prioritise environmental, social and governance (ESG) aspects 33
1.10. Conclusion 36
References 36
Note 42

2 Health and well-being of the workforce 43

2.1. Introduction 45
2.2. How does the nature of work affect the relationship between work and health? 45
2.3. What is the share of people exposed to risk factors for chronic diseases in the working-age population? 49
2.4. What is the share of people experiencing physical or mental health conditions in the working-age population? 52
2.5. What is the burden of disability from chronic diseases in the working-age population? 55
2.6. What are the effects of unhealthy lifestyles, poor health and poor well-being on workforce participation and productivity? 57
2.7. Conclusion 67

References 68
Annex 2.A. Supplementary files 77

3 Workplace-based programmes to promote health and well-being 80
3.1. Introduction 82
3.2. Why health and well-being programmes at the workplace are needed? 83
3.3. What are the motivations for employers to implement and invest in WHWP for their employees? 85
3.4. What is the size of the potential target population? 89
3.5. What type of health and well-being programmes do companies implement? 91
3.6. Conclusion 100
References 100
Notes 106

4 Government policies to promote health and well-being at work: An analysis of ten OECD countries 107
4.1. Introduction 110
4.2. Labour and workplace legislation and health system characteristics set the foundation for the range of policy levers available to governments to promote health at work 112
4.3. Workplace regulations set minimum standards on employers' responsibilities to ensure health and safety in the workplace 116
4.4. Paid sick leave and return-to-work regulation play an indispensable role in preventing ill-health and health promotion at the workplace 126
4.5. Financial incentives can encourage employers to go beyond minimum standards by actively promoting health and well-being 131
4.6. Governments play an important role in facilitating best practices by disseminating information, tools and guidelines working with other stakeholders 136
4.7. Certification and award schemes can recognise employers prioritising health and well-being 141
4.8. The public sector can lead by example by being an exemplary employer and promoting health and well-being in the workplace 144
4.9. Conclusion 146
References 146
Notes 153

5 Special focus on steering investment in companies that promote employee health and well-being 154
5.1. Introduction 156
5.2. Investors recognise the value of companies that prioritise the health and well-being of their employees 156
5.3. A lack of standardised information creates challenges for investors with an interest in companies that promote employee health and well-being 159
5.4. Governments – together with other stakeholders – are closing the gap by encouraging the disclosure of standardised information and indicators on health and well-being at the workplace 161
5.5. Other financing mechanisms, such as social impact bonds, are a tool for governments to raise finances dedicated to health promotion at the workplace 166
5.6. Conclusion 167
References 167
Notes 170

FIGURES

Figure 1.1. Rationale for the analysis: integrating health and well-being promotion into the prevention of occupational safety and health risks 18
Figure 1.2. Snapshot on risk factors across the OECD, 2019 or latest year available 19
Figure 1.3. Total employment 22
Figure 1.4. Workplace sedentary behaviour programmes increase the number of full-time equivalent workers per year by improving workforce's health 23
Figure 1.5. Proportion of responding companies reporting workplace health programmes, by type of risk factors 24
Figure 1.6. Determinants of health and well-being promotion through work 26
Figure 1.7. A range of regulations are used to address specific health issues at work 27
Figure 1.8. Financial incentives for employers beyond insurance-based incentives are limited 29
Figure 1.9. Companies receiving awards for their workplace health programmes have seen a greater increase in their stock value compared to companies in the S&P 500 34
Figure 1.10. Governments can facilitate investment in health-promoting companies 35
Figure 2.1. Poor quality working environments have an adverse impact on health at the workplace 47
Figure 2.2. Share of workers suffering or struggling with life 53
Figure 2.3. Incidence of all types of cancer, people aged 20-64, 2020 53
Figure 2.4. Share of people having a long-standing illness or health problem, by education level, people aged 16-64, EU countries, 2020 54
Figure 2.5. The burden of disability by NCD group, ages 20-64, OECD countries, 2019 55
Figure 2.6. The burden of NCDs-related disability in ages 20-64, by country, 2019 56
Figure 2.7. Health, well-being and work are interrelated 58
Figure 2.8. The impact of diseases caused by alcohol consumption on employment and productivity 63
Figure 2.9. Prevalence of absence due to illness among people with and without mental distress 66
Figure 3.1. Objectives related to the Health and Productivity Management programme in Japan 85
Figure 3.2. Increases in workforce resulting from workplace sedentary behaviour programmes 87
Figure 3.3. Total employment 90
Figure 3.4. Number of companies by sector 93
Figure 3.5. Proportion of companies reporting WHWP, by type of risk factors 94
Figure 3.6. Proportion of companies reporting WHWP, by type of programmes 99
Figure 4.1. Determinants of health and well-being promotion through work 116
Figure 4.2. Employees working excessively long hours remains widespread 119
Figure 4.3. Simplified process of stress check implementation for employers 121
Figure 4.4. Coverage of smoking bans at the workplace vary significantly 124
Figure 4.5. Process for employer recognition (awards and certification) in the Health & Productivity Management Programme 142
Figure 4.6. The public sector accounts for around one-seventh of total employment across the ten countries studied 145
Figure 5.1. Companies receiving awards for their workplace health programmes have seen a greater increase in their stock value compared to companies in the S&P 500 158
Figure 5.2. Investment in health-promoting companies can create a virtuous cycle 159
Figure 5.3. Examples of company-level indicators related to health and well-being in the workplace 160
Figure 5.4. Companies rewarded with H&PM stock selection in 2021 saw their stock value increase by more than the average of companies in the Tokyo Stock Exchange between 2011-21 165

Annex Figure 2.A.1. Estimated treatment cost associated to NCDs and mental health conditions among people aged 20-64, OECD countries, 2020 77

TABLES

Table 1.1. Summary of the associations between lifestyle risk factors, NCDs and labour market outcomes 20
Table 2.1. Heatmap for lifestyle risk factors 50
Table 2.2. Summary of the associations between lifestyle risk factors, NCDs and labour market outcomes 60
Table 4.1. Description of national strategies relating to health and well-being in the workplace 113
Table 4.2. Health system characteristics influence the role of the employer in financing health care 115

Table 4.3. Regulation on weekly working hours and compliance 117
Table 4.4. Regulation on smoking in enclosed workplaces 123
Table 4.5. What does legislation say about alcohol consumption at the workplace? 126
Table 4.6. Comparison of paid sick leave systems across OECD countries 127
Table 4.7. Variations in reasonable workplace accommodation regulation across countries 129
Table 4.8. Institutional setup of workers' compensation boards and accident insurance systems 131
Table 5.1. Initiatives to promote standardisation and disclosure of company-level information and indicators on health and well-being at the workplace 162

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Abbreviations and acronyms

AUD	Australian dollar
BMI	Body Mass Index
CAD	Canadian dollar
CDC	Centers for Disease Control and Prevention
CVD	Cardiovascular Diseases
DALYs	Disability-Adjusted Life Years
EAP	Employee Assistance Programme
ESENER	European Survey of Enterprises on New Emerging Risks
ESG	Environmental, Social and Governance
EU	European Union
EU-OSHA	European Agency for Safety and Health at Work
EUR	Euro
G7	Group of 7
GBP	British pounds
GDP	Growth Domestic Product
GDPR	General Data Protection Regulation
GP	General Practitioner
GRI	Global Reporting Initiative
H&PM	Health and Productivity Management
IARC	International Agency for Research on Cancer
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
INAIL	National Institute for Insurance against Accidents at Work (of Italy)
ISO	International Organization for Standardization
ITC	International Tobacco Control Policy Evaluation Project
JPY	Japanese Yen
KOSHA	Korean Occupational Safety and Health Agency
KRW	Korean won

LYs	Life Years
METI	Ministry of Economy, Trade and Industry (of Japan)
MHLW	Ministry of Health, Labour and Welfare (of Japan)
MSD	Musculoskeletal Disorders
NCD	Non-Communicable Diseases
NIOSH	National Institute for Occupational Safety and Health (of the United States)
OSH	Occupational Safety and Health
PAHO	Pan-American Health Organization
PHE	Public Health England
SMEs	Small and Medium Sized Enterprises
SPHeP-NCD	Strategic Public Health Planning for Non-Communicable Diseases
TUC	Trades Union Congress
UKHSA	UK Health Security Agency
WDI	Workforce Disclosure Initiative
WHO	World Health Organization
WHU	Work and Health Unit
WHWP	Workplace Health and Well-being Programmes

Executive summary

Policies to promote employee health and well-being not only protect from occupational risks, but also provide benefits for individuals and employers. While employment, safe working environment and work conditions are important determinants for employee health and well-being, lifestyle habits are also key contributors. Unhealthy lifestyles, such as sedentary behaviour, overweight, smoking, harmful alcohol use and stress, are major causes of chronic diseases and thus affect the health of employees and negatively impact workplace productivity. For instance, the productivity losses associated with obesity-related diseases are equivalent to 54 million fewer full-time workers across 52 OECD, European Union, Group of 20 countries, which is similar to the number of employed persons in Mexico.

Combined with the prevention of occupational risks, workplace health promotion programmes benefit employees, while also producing benefits for the employers.

- **Workplace-based programmes can reach out up to 610 million people employed** in the formal sector in OECD countries. About two-thirds of these people are employed in small and medium sized enterprises (SMEs) that are less likely than large companies to implement such programmes due to limited resources and lack of scale in absence of specific incentives.
- **Workplace health promotion programmes are worth the investment**. Employers who implement workplace health and well-being programmes, in addition to preventing occupational risks, can reduce health care spending, decrease sickness absenteeism and increase work productivity. For instance, based on OECD models, scaling up programmes to address sedentary behaviours and promote physical activity at work could improve employment and productivity equivalent to having an increase of 37 000 workers per year in 30 OECD countries, with a positive economic return of USD 4 for each USD 1 invested. Promoting employees' health also strengthens corporate image – which helps recruit and retain talent – and may increases employees' satisfaction and work engagement.
- **Employees generally benefit from workplace programmes**, with evidence suggesting that such programmes improve lifestyles and health (e.g. smoking cessation, healthier weight) in the short and medium-term. High participation is crucial for maximising the potential effectiveness of such programmes. Organisational factors – such as integrated approach into OSH prevention, and healthy workplace culture – also contribute to the success of workplace health-promoting programmes.
- **A growing number of companies are implementing health promotion programmes** across European countries. The European Survey of Enterprises on New and Emerging Risks shows that 32% of the respondent companies implemented measures raising awareness of nutrition among employees in 2019, compared to 28% in 2014.

Governments use a range of policy levers to support employers in promoting health and well-being in the workplace.

As identified in an analysis of ten countries, including the Group of 7 (G7) and OECD countries in the Asia and Pacific region, a number of policy levers can help to promote health, healthy lifestyles and well-being at work:

- **Workplace regulations** set minimum standards in terms of preventing risks and managing health, safety and well-being at work, and feature prominently in efforts to prevent long working hours, limit smoking, and promote timely return-to-work following sickness absence. In some countries such as federal governments, sub-national authorities may play an important role in OSH regulation and enforcement.
- **Financial incentives** include lower insurance premiums, tax credits and subsidies for employers of SMEs. These incentives are important levers for governments to encourage and facilitate employers – particularly in SMEs – to go beyond basic accident prevention and safety, and to promote health and well-being at the workplace.
- **Disseminating information and guidance** developed together with other stakeholders, such as charities, trade unions and employer associations, can facilitate the promotion of health and well-being at the workplace. This can increase awareness – especially for stigmatised health issues such as mental health-related issues – and increase understanding among employers and managers of effective measures. Guidance related to COVID-19 has also been widely disseminated to employers, typically related to sanitary measures, ventilation, teleworking, facilitation of sick leave and self-isolation.
- **Certification and award schemes** provide reputational benefits for employers, by certifying that employers meet certain standards relating to health and well-being promotion at work, such as the Health and Productivity Management programme in Japan. These schemes often go hand-in-hand with the disclosure of information on company-led programmes and health and well-being in the workplace, which can be used to inform both policy and employer interventions, although collection of such data can raise concerns about data protection and privacy in some countries.

Government efforts to promote health and well-being at work can be amplified by attracting environmental, social and governance (ESG) investments towards companies that prioritise employee health and well-being.

Institutional investors and private funds are seeking to direct investment towards companies that promote the health and well-being of their employees, in particular, investment that is aligned with ESG and human capital considerations. Such investments can encourage employers to implement health and well-being programmes.

- **Investors may consider companies that promote employee health and well-being to be more valuable**. In the United States, between 2001 and 2014, companies that were awarded for their workplace health programmes saw their combined stock value appreciated up to three times more than companies comprising the Standard & Poor's 500 Index. In Japan, companies certified by the Health and Productivity Management programme also perform better on the Tokyo Stock Exchange.
- **Attracting ESG investments requires making comparable data available** on health and well-being at work that would allow investors to differentiate between companies that effectively promote the health and well-being of their employees and those that do not. To this end, governments and other stakeholders are taking a step forward: regulatory changes that require companies to report information on health and well-being programmes, as well as voluntary initiatives promoting information disclosure. Standard-setting initiatives, such as the Global Reporting Initiative, play an important role in harmonising and standardising the disclosure mechanisms through work across countries and companies.

1 Promoting health, healthy lifestyles, and well-being at work

Marion Devaux, Shunta Takino and Michele Cecchini

This chapter summarises the key findings of this report. It first explores the links between work and employee health and well-being. It then discusses the potential of interventions in the workplace to promote health and well-being. It also describes policy levers implemented in G7 and three other OECD countries in the Asia and Pacific region to support and incentivise employers to promote health and well-being in the workplace. Finally, it examines how companies that promote employee health and well-being can attract investors that prioritise environmental, social and governance (ESG) considerations, and what initiatives exist to facilitate such investments.

Key findings

The relationship between health and work goes in both directions. Employment and work conditions affect people's health, and health conditions affect employment and workers' productivity. The rise in unhealthy lifestyles and related chronic diseases poses a threat to the health of the workforce and damages labour market outcomes.

- Characteristics of work, including a safe work environment, job quality, job strain, work organisation, occupation and sector of employment, and employment type all shape and influence workers' health. For instance, according to data from the European Working Conditions Survey, in 2015, workers with a poor working environment (40%) were more than twice more likely to report that work had a negative impact on their health than workers in a good working environment (15%). Differences in the nature of work by socio-economic status also contribute to the social gradient in health, as individuals of lower socio-economic status are more likely to have less secure jobs and lower quality jobs that, in turn, have an adverse impact on health.
- Major risk factors for non-communicable diseases (NCDs), such as overweight, smoking, harmful alcohol use, and high levels of stress, are widespread in the adult population. For instance, two in five full-time employees (42%) reported being stressed in OECD countries in 2017-19, a leading risk factor for mental health conditions, cardiovascular diseases and musculoskeletal disorders. Long COVID-19 has added to the burden of long-standing illnesses and is estimated to affect around 10% of people infected by the coronavirus.
- Having unhealthy lifestyles and NCDs is associated with a lower probability of being employed and lower work productivity when employed. For instance, smokers are estimated to take 28% more days off work than ex-smokers in the United States, and this difference is 18% in France, Germany, Italy, Spain and the United Kingdom, based on 2013 data. The productivity losses due to NCD-related presenteeism – that is reduced productivity while at work – tend to be two to three times higher than that of absenteeism, in 12 OECD and G20 countries.

Combined with the prevention of occupational risks, workplace health promotion programmes benefit employees, improving their lifestyles, health and well-being, while also producing benefits for the employers.

- Workplace-based programmes can reach out up to 610 million people employed in the formal sector in OECD countries. About two-thirds of these people are employed in small and medium sized enterprises (SMEs) that are less likely than large companies to implement such programmes due to limited resources and lack of scale in absence of specific incentives.
- Workplace health promotion programmes are worth the investment. They can reduce health care spending, decrease sickness absenteeism and increase work productivity. For instance, based on OECD modelling-based analyses, scaling up interventions addressing sedentary behaviour and promoting physical activity at work could improve employment and productivity equivalent to having an increase of 37 000 workers per year in 30 OECD countries, with a positive economic return of USD 4 for each dollar invested. Promoting employees' health also strengthens corporate image – which helps recruit and retain talent – and increases employees' satisfaction and work engagement.
- Employees generally benefit from workplace programmes, with evidence for improved lifestyles and health (e.g. smoking cessation, healthier weight) in the short and medium-term. High participation is crucial for maximising the potential effectiveness of such programmes.

Organisational factors – such as an integrated approach to occupational safety and health prevention, and a healthy workplace culture – also contribute to the success of workplace health-promoting programmes.

- A growing number of companies are implementing health promotion programmes across European countries. For instance, according to the European Survey of Enterprises on New and Emerging Risks, 32% of the respondent companies reported they implemented measures raising awareness of nutrition among employees in 2019, compared to 28% in 2014.
- An OECD analysis of data from 114 companies worldwide participating in the 2020 Workforce Disclosure Initiative shows that health and well-being programmes usually offer support for various risk factors for NCDs. Mental health and stress programmes were the most often reported programmes, with more than two-thirds (68%) of participating companies, although the data do not report the uptake by or experiences of employees. The data also show how companies adapted their responses to ensure health and safety at work during the COVID-19 crisis, including in particular, mental health support, measures to limit the propagation of the virus, such as enabling teleworking and enhancing hygiene and financial support, such as salary guarantees.

Governments use a range of policy levers to support employers in promoting health and well-being in the workplace, as identified in an analysis of ten countries, including G7 countries and OECD countries in the Asia and Pacific region:

- **Workplace regulations** set minimum standards in terms of preventing risks and managing health, safety and well-being at work, and feature prominently in efforts to prevent long working hours, limit smoking, and promote timely return-to-work following sickness absence. Regulations on maximum working hours exist in six of the ten countries. All ten countries limit smoking at work, with Australia, New Zealand and the United Kingdom enforcing a comprehensive workplace smoking ban. Employer-paid sick leave systems exist in six of the ten countries reviewed, while gradual return-to-work mechanisms exist in only two countries. In some countries such as federal governments, sub-national authorities may play an important role in occupational safety and health regulation and enforcement.
- **Financial incentives** include lower insurance premiums, tax credits and subsidies for employers of SMEs. In all ten countries reviewed, employers with a better record of ensuring worker health and safety can benefit from lowered accident insurance premiums. Corporate tax credits for expenditure related to workplace health and well-being were identified at the national level in France, Germany, Italy and the United Kingdom. Subsidies for employers to promote health and well-being at work were identified in at least four countries (either national or sub-national level).
- **Disseminating information and guidance** developed together with other stakeholders, such as charities, trade unions and employer associations, can facilitate the promotion of health and well-being at the workplace. This can increase awareness – especially for stigmatised health issues – and increase understanding among employers and managers of effective measures. Government-developed tools for employers to diagnose gaps in their workplace health programmes were identified in France, Germany, the United Kingdom and the United States. Guidance related to COVID-19 has also been widely disseminated to employers, typically related to sanitary measures, ventilation, teleworking, facilitation of sick leave and self-isolation.
- **Certification and award schemes** provide reputational benefits for employers, by certifying that employers meet certain standards relating to health and well-being promotion at work. For example, the Health and Productivity Management Programme in Japan is a particularly

large-scale certification and award scheme covering more than 80% of the largest publicly owned companies in the Nikkei 225. These schemes often go hand-in-hand with the disclosure of information on company-led programmes and health and well-being in the workplace, which can be used to inform both policy and employer interventions, although collection of such data can raise concerns about data protection and privacy in some countries.

The special focus looks at how to attract investors and private funds to steer their investment towards companies promoting health and well-being among their employees, as this can amplify and reinforce government efforts to promote health and well-being at work. It draws on the growing interest in using environmental, social and governance (ESG) and human capital considerations to guide investments.

- Institutional investors and private funds, looking for sustainable and socially responsible investments, seek to invest in companies that prioritise the health and well-being of their employees. In the United States, between 2001 and 2014, companies that were awarded for their workplace health programmes saw their combined stock value appreciated up to three times more than companies comprising the Standard & Poor's 500 Index. Evidence in Japan also suggests that companies certified by the Health and Productivity Management Programme also perform better on the Tokyo Stock Exchange.
- Supporting ESG investments can create a virtuous cycle, where the incentive for companies to promote employee health is amplified. This is because a company that promotes the health and well-being of employee is rewarded not only with a healthier workforce, but also with an increased likelihood of receiving investment.
- A key limitation to unlocking this virtuous cycle is the lack of comparable information on health and well-being at work that would allow investors to differentiate between companies that effectively promote the health and well-being of their employees and those that do not. Governments and other stakeholders are closing this gap through regulatory changes that require companies to report information on health and well-being programmes, as well as voluntary initiatives promoting information disclosure. Standard-setting initiatives, such as the Global Reporting Initiative, play an important role in harmonising and standardising the disclosure mechanisms through work across countries and companies.

1.1. Introduction

Health and well-being are fundamental for enjoying a good and productive life. While health and well-being impact employment prospect and productivity at work, they are conversely affected by the nature of work. For instance, people living with a chronic disease are less likely to be employed than those with no disease, and have more work absence and are less productive (OECD, 2019[1]; OECD, 2021[2]). Conversely, the nature of work, such as for example high job strain, influences employees' health and well-being, the latter being related to the physical, psychological, emotional and psychosocial experiences lived at work, encompassing physical and mental health, and job satisfaction.

As adults spend a large portion of their lives in employment, workplace-based actions are crucial for ensuring employee health and safety and are increasingly considered as key for promoting health, healthy lifestyles and well-being, in particular to influence choices favouring healthier lifestyles across the work-life continuum from the first job to retirement. Employers have long had statutory requirements to protect workers against occupational risks for health and safety (such as chemicals, carrying heavy loads, etc.). Yet employers do not necessarily take the next step of actively promoting healthy lifestyles, health and well-being in the workplace. There are further opportunities for workplaces to

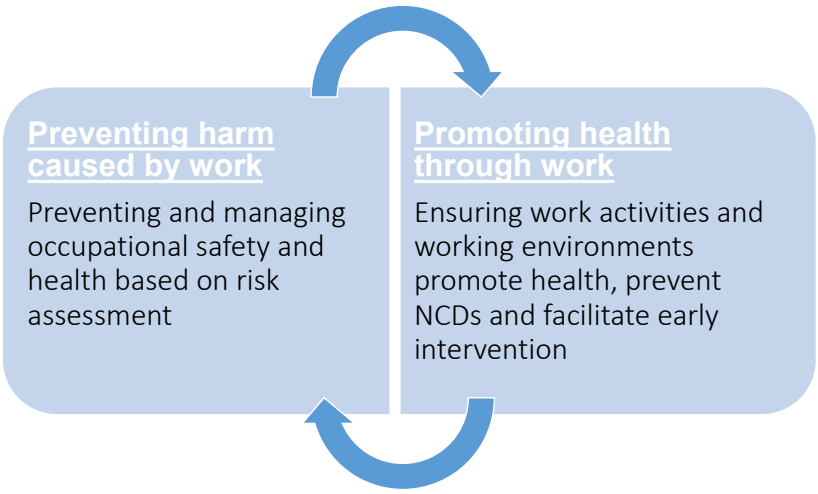
expand the outreach of health promotion interventions, in particular towards workers with increased health risks, and to adapt to enable workers with disabilities, including chronic diseases, to continue working. To achieve this goal, efforts to improve health in the workplaces have to adapt to the changing world of work, recognising the rising number of employees in non-standard forms of employment (i.e. part-time, temporary or self-employed workers), often undertaking new forms of work (such as gig workers, platform workers).

Megatrends such as population ageing, the spread of chronic health conditions, and the challenges these pose for the financial sustainability of the health system place even greater importance on promoting health and preventing non-communicable diseases (NCDs) through work. The workforce is ageing: by 2050, more than four in ten individuals in the world's most advanced economies will be older than 50 (OECD, 2020[3]). Older workers are more likely to live with one or multiple chronic diseases that limit their participation in work and social activities. In response to these trends, there is rising consciousness among employees, employers and investors of the importance of a healthy workforce, which was amplified in the wake of the COVID-19 pandemic.

Governments can steer employers to promote the health and well-being of their employees in the workplace. The benefits of early action to promote safety, health and well-being of employees are large for society-at-large, given that the economic costs of poor health include reduced workforce productivity, pressures on the social security system and increased health care expenditure. Governments therefore have an important role of supporting employers to scale up actions to promote the health and well-being of their employees, to promote effective return-to-work following sickness absences and to accommodate workplaces for those with chronic conditions.

This report supports the inclusion of active health promotion at work in the existing framework for occupational health and safety. This action enlarges the scope of actions from occupational hazards protection to health promotion, such as workplace interventions to prevent behavioural lifestyle risk factors for NCDs (Figure 1.1). The objectives of this report are to examine the potential of promoting health and well-being at the workplace, and highlight the policy levers available to governments to support employers to promote the health and well-being of their employees. Section 1.2 outlines the bi-directional relationship between health and work, and explains how the rise in unhealthy lifestyles and their related chronic diseases has negative impacts on the health of the workforce and productivity. Section 1.3 highlights that workplace programmes can reach a wide range of individuals across OECD countries, and thus improve employees' lifestyles, health and well-being, while also producing benefits for the employers. Section 1.4 describes how health promotion at work fits in the national contexts of ten countries studied, including the Group of 7 (G7) and three other OECD countries in the Asia and Pacific region (Australia, Korea, and New Zealand). Sections 1.5 to 1.8 examine four types of policy levers, including regulation, financial incentives, dissemination of information, and certification and award schemes. Section 1.9 explains how companies that promote employee health and well-being are likely to attract growing interest from investors and discusses how governments – working together with other stakeholders – can trigger socially responsible investment towards health-promoting companies. Section 1.10 presents concluding remarks.

Figure 1.1. Rationale for the analysis: integrating health and well-being promotion into the prevention of occupational safety and health risks



1.2. Population ageing and chronic diseases, including mental health conditions, affect the health and the productivity of workers

The relationship between health and work is bidirectional. Employment and working conditions affect people's health (both physically and mentally), and conversely, health conditions impact employment and productivity at work (James, Devaux and Sassi, 2017[4]). This section recognises the former (Section 1.2.1), and then focusses on the latter, in order to highlight the importance of promoting health and well-being of working-age people (Section 1.2.2), but also for better labour market outcomes (Section 1.2.3).

1.2.1. The nature of work can have a profound effect on health

Characteristics of work, including safe work environment, job quality, job strain, work organisation, occupation and sector, and employment type all shape and influence employee health (Saint-Martin, Inanc and Prinz, 2018[5]). A safe workplace, free from recognised hazards, is essential for protecting from work-related diseases and injuries, ensuring employee safety and health. While being in good quality work in general protects against ill-health, not all jobs are equally health-promoting. High job strain – which is characterised by low autonomy, repetitive work, long working hours and high frequency of workplace conflicts – is a major risk factor for ill-health (OECD, 2018[6]). For instance, based on analysis of data from the 2015 European Working Conditions Survey, in Europe, around 40% of workers reporting a poor working environment said that their work had a negative impact on their health, compared to 15% among workers with a good working environment (OECD, 2018[6]). Differences in the nature of work by socio-economic status also contribute to the social gradient of health, as individuals of lower socio-economic status are more likely to have less secure jobs and lower quality jobs that have an adverse impact on health (Institute of Heath Equity and Public Health England, 2015[7]).

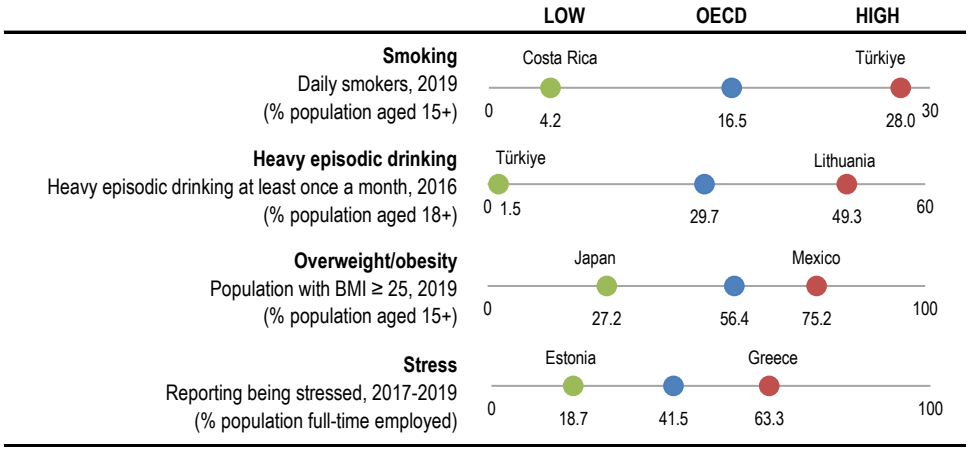
Trends in the world of work – including the rise of new forms of employment and teleworking – are also having an impact on employee health. For instance, although the rise of teleworking and hybrid work only affects a small proportion of the total workforce (OECD, 2021[8]), it presents new challenges for employee health in workplaces that are affected. In particular, gig and platform workers who may be difficult to reach by workplace actions, are at risk of work-related stress, income insecurity and poor work-life balance. While well-managed telework can bring valuable flexibility, it can also present challenges such

as increasing the risk of irregular hours and the blurring of work-life boundaries, which can be a risk factor for mental distress and anxiety (OECD, 2021[9]).

1.2.2. Unhealthy lifestyles and NCDs are widespread in the working-age population

Unhealthy lifestyles, such as overweight, smoking, harmful alcohol use, and high levels of stress -which are major risk factors for NCDs – are widespread in the adult population. In OECD countries, more than 16% of the adult population smoked daily in 2019, and nearly 30% reported heavy episodic drinking at least once a month in 2016 (Figure 1.2). Overweight, which also includes obesity, affected more than half of the adult population (56%) in 2019 (OECD, 2021[10]), increasing the risk of diabetes, cardiovascular diseases (CVDs) and cancers. In 2017-19, two in five full-time employees (42%) reported being stressed (Gallup Analytics, 2021[11]), a leading risk factor for mental health conditions as well as CVDs and musculoskeletal disorders (MSDs).

Figure 1.2. Snapshot on risk factors across the OECD, 2019 or latest year available



Note: Heavy episodic drinking is drinking more than 60 grammes of pure alcohol per drinking session.
Source: OECD Health Statistics 2021 for obesity/overweight and smoking; (OECD, 2021[2]) for heavy episodic drinking; (Gallup Analytics, 2021[11]) for level of stress.

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Long COVID-19 is adding to the burden of diseases in the working age population. Long COVID-19 symptoms – such as fatigue, breathlessness, chest pain or anxiety that last weeks or months – are adding to the burden of long-standing illnesses, as it is estimated to affect about 10% of people infected by the coronavirus (Rajan et al., 2021[12]). Long COVID-19 symptoms are more often associated with age, being female, overweight, prior hospitalisation for COVID-19, and a number of symptoms in the acute phase (OECD, 2021[10]).

NCDs, including mental health conditions and substance use disorders, greatly affect the population in working age (20 to 64 years), with disparities across population groups. The chronic conditions that are the most often reported by working-age people are mental health disorders and MSDs. For instance in EU countries, about 43% of adults in working age reported suffering from MSDs (Eurostat, 2022[13]), while 45% faced risk factors for their mental well-being at work (e.g. time pressure, work overload, job security, etc.) (Eurostat, 2021[14]). When looking at the burden of disability – that accounts for premature death and the years lived with limitations – cancers rank first. Data from the Global Burden of Diseases shows that nearly three-quarter of the burden of NCD-related disability in the age group 20-64 is caused by five conditions: cancers (17%), MSDs (17%), mental health disorders (12%), CVDs (11%), substance

use disorders (7%) and diabetes (7%) (IHME, 2020[15]). There are also important social inequalities in health. Individuals with lower education tend to report more NCDs than individuals with higher education. For instance, in EU member states, among people aged 16 to 64, those with lower education were 39% more likely to report a long-standing illness or health problem than those with higher education in 2020 (Eurostat, 2022[13]). In the United States, in a sample of 30-64 year-olds, people with less than a bachelor's degree had greater multi-morbidity than those with a bachelor's degree or higher (Johnson-Lawrence, Zajacova and Sneed, 2017[16]). In Canada, nearly 18% of adults with less than high school education reported being diagnosed with at least two chronic diseases, compared to 7% of those with post-secondary graduate education, in 2019 (Public Health Agency of Canada, 2021[17]).

1.2.3. Unhealthy lifestyles and NCDs are related to negative labour market outcomes

Evidence shows that having unhealthy lifestyles and NCDs is associated with a lower likelihood of being employed and less productivity when at work. People affected by one or multiple chronic diseases are often limited in their participation in social activities and work, potentially affecting employment prospect and productivity at work. An extensive review of the literature was carried out to examine the association between lifestyle risk factors, NCDs and labour market outcomes. Findings show that people with unhealthy lifestyles and NCDs have a lower probability of being employed and are less productive when at work (Table 1.1). For instance, smokers are estimated to take 28% more days off work than ex-smokers in the United States, and this difference is 18% in France, Germany, Italy, Spain and the United Kingdom, based on the 2013 National Health and Wellness Survey. Women with obesity are 68% more likely to miss work than women with a healthy weight, while this is not observed in men. The productivity losses associated with obesity-related diseases are equivalent to 54 million fewer full-time workers across 52 OECD, EU and G20 countries, which is similar to the number of employed persons in Mexico (OECD, 2019[1]). In addition to absenteeism, health issues can result in reduced productivity while at work, also known as presenteeism. When assessing the economic impact of NCDs in 12 OECD and G20 countries, the productivity losses due to presenteeism are two to three times higher than that due to absenteeism (Rasmussen, Sweeny and Sheehan, 2016[18]).

Table 1.1. Summary of the associations between lifestyle risk factors, NCDs and labour market outcomes

	Employment	Absenteeism	Presenteeism
Obesity	People with obesity are less likely to be employed as compared to individuals with healthy weight. (Campbell et al., 2021[19])	Higher BMI increases risk of sickness and disability by 8% per 1 kg/m2 BMI increase (Campbell et al., 2021[19]). **(causal**) Women with obesity are 68% more likely to miss work than women with healthy weight, this effect is non significant among men (Destri et al., 2021[20])	Presenteeism was found to be more prevalent among workers with obesity and overweight as compared to those with healthy weight (Keramat et al., 2020[21])).
Smoking	Smokers who are seeking reemployment, 27% were re-employed a year after job loss, compared to 56% of non-smokers (Prochaska et al., 2016[22]).	Current smokers in the US have 28% more absenteeism than former smokers; in five European countries, the difference is 18% while it is 61% in China (Baker et al., 2017[23]).	Current smokers have 28%, 18% and 16% more presenteeism than former smokers, respectively in the US, five European countries and China (Baker et al., 2017[23]).
Alcohol	Problem drinking reduces employment (MacDonald and Shields, 2004[24]), and is linked to job loss (Airagnes et al., 2019[25]).	Former drinkers and heavy drinkers work annually 1-1.5 month less over the 20-year observation period, compared with moderate drinkers (Böckerman, Hyytinen and Maczulskij, 2017[26]).	A large body of evidence exists in support of alcohol-related presenteeism, but that this is weakened by low research quality and a lack of longitudinal designs (Magnus Thørrisen et al., 2019[27])

	Employment	Absenteeism	Presenteeism
Diabetes	Lower probability of employment (Devaux and Sassi, 2015[28]); and longer period of unemployment (Rodríguez-Sánchez and Cantarero-Prieto, 2017[29]).	2-10 more days of sickness absences (**causal**) (Breton et al., 2013[30]).	Less workhour productivity when diabetic with symptoms: Individuals with diabetes and neuropathic symptoms are found to be 18% more likely to lose more than 2 hours of work per week due to illness when compared to their non-diabetic counterparts (**causal**) (Breton et al., 2013[30]) (Mori et al., 2020[31]).
Cancer	Lung cancer survivors are 61% more likely to be unemployed (Vayr et al., 2019[32]).	Cancer survivors take 12 times more sick leave in the first year post-diagnosis than healthy workers, with sick leaving remaining still higher than the healthy average worker in the subsequent years (Sjövall et al., 2012[33])	Cancer patients and cancer survivors are more likely to experience presenteeism than controls, due to chronic symptoms associated cancer with treatment (Soejima and Kamibeppu, 2016[34]).
Cardiovascular diseases (CVD)	Workers with CVD were 2.5 times more likely to leave employment due to disability, 1.3 times more likely to take early retirement (Kouwenhoven-Pasmooij et al., 2016[35]).	CVD workers missed 92 days compared to 11 days missed by non-CVD workers (Calvo-Bonacho et al., 2014[36]).	The productivity loss among workers with CVD is twice higher from presenteeism than from absenteeism (Gordois et al., 2016[37]).
Mental health conditions	60% of people with moderate mental health conditions are employed compared to 70% of those with no mental distress (OECD, 2021[9]).	Employees living with mental health conditions are more likely to be absent compared to those without mental health conditions; 12 additional days of sickness absence per year (OECD, 2021[9])).	The productivity loss among workers with a mental health conditions is partially attributable to presenteeism. It is not clear if the impact of mental health conditions on presenteeism outweighs the impacts on absenteeism, and this may differ across countries (OECD, 2012[38]).
MSDs	Workers with MSD are less likely to be in fulltime employment (Summers, Jinnett and Bevan, 2015[39]); Working-age men/women with arthritis are 20%/25% less likely than their counterparts without arthritis to be economically active (Lubeck, 2003[40]).	The number of days missed peaked at 147 days per year in the group diagnosed with rheumatoid arthritis, compared to 59 days in the general population (Neovius, Simard and Askling, 2011[41]).	For the workers who experience clinically meaningful back pain, almost 80% of them also report productivity loss due to presenteeism, with 4.4 hours missed per worker over a two-week period (Dall et al., 2013[42]).

Source: Authors.

The observed negative labour market outcomes of unhealthy lifestyles and NCDs may reflect a true effect of unhealthy lifestyles and related health conditions on disabilities and work, or discrimination towards people with unhealthy lifestyles and NCDs. For instance, people with obesity are less likely to be employed, and when employed, they earn less than those with healthy weight. Evidence found that this reflects both a causal effect of obesity and its related health conditions on labour market outcomes, as well as discrimination and stigmatisation towards obese people. In this case, discriminatory hiring against obese persons and sorting into jobs with less customer contact – and thus lower wages- can explain poorer labour market outcomes for obese people (Averett, 2019[43]). That said, obesity appears to exert a causal effect on employment status, largely by affecting an individual's health (diseases) rather than through increased unemployment arising from social discrimination (Campbell et al., 2021[19]).

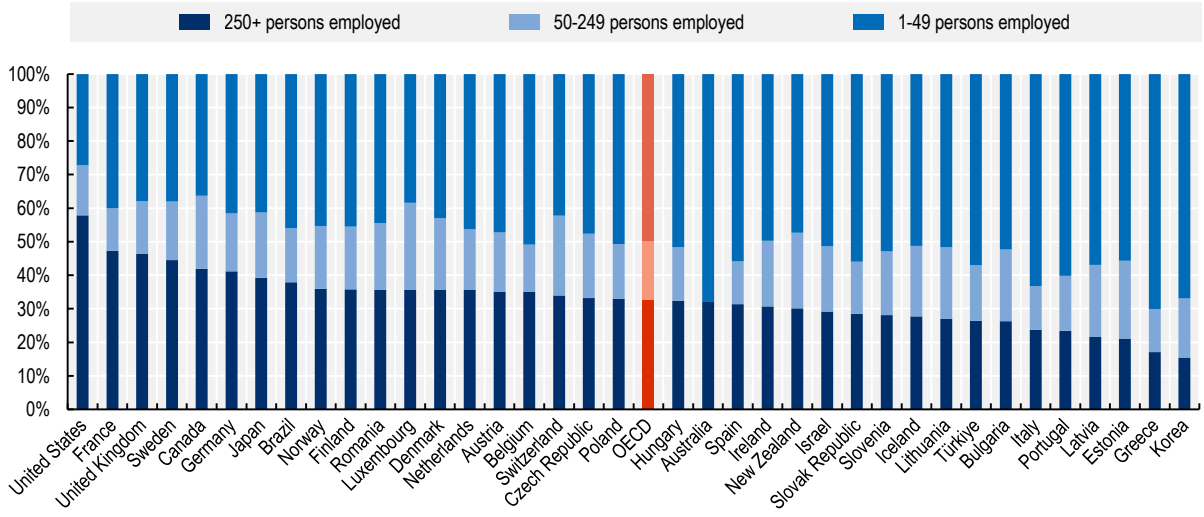
As the evidence on health and well-being of the working-age population points to a significant impact of health on productivity, employers have a role to play not only to maintain good health and well-being of their employees, but also to increase labour participation and productivity. The following section examines the potential of workplace-based interventions to enhance the health and well-being of employees.

1.3. Workplaces offer opportunities for promoting healthy lifestyles and preventing chronic diseases and mental health disorders

Workplace-based health and well-being programmes show great potential in terms of population outreach. In OECD countries, 610 million people are employed in the formal sector, making a sizeable population target for workplace health programmes. About one-third (201 million) are employed in large companies, while about two-thirds (409 million) are employed in small and medium sized enterprises (SMEs) (Figure 1.3). SMEs face greater challenges in implementing such programmes because of the cost of the programmes, insufficient human resources and lack of programme knowledge.

Figure 1.3. Total employment

Total employment (persons employed) by size of companies



Note: The number of employees in Canada, Japan, and the United Kingdom includes all persons, workers and employees, covered by a contractual arrangement and working in the unit who receive compensation for their work, whether full-time or part-time.
Source: OECD Business Statistics by Employment Size Class, (2022[44]).

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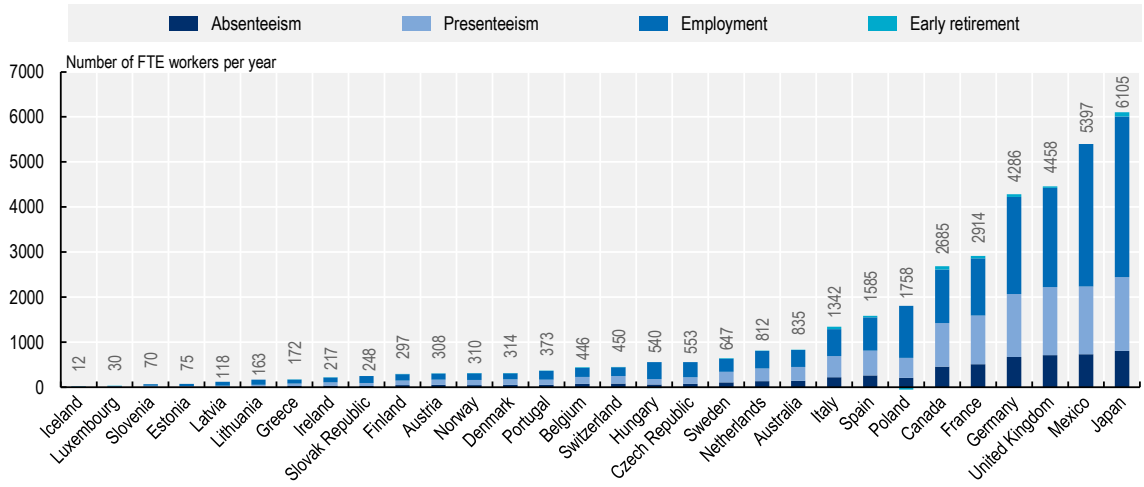
Although workplace health programmes are designed principally to benefit employees, they bring benefits to both employees and employers. For employees, workplace programmes can improve lifestyles (e.g. smoking cessation, healthier weight) and health in the short and medium-term, although robust evidence is lacking on their long-term effects (Sidossis et al., 2021[45]). Employee participation is crucial for maximising the potential impact of such programmes. For employers, workplace health and well-being programmes can reduce health care spending, decrease sickness absenteeism and increase work productivity. For instance, studies with a follow-up period of one to seven years indicate that for each dollar invested in workplace health and well-being programmes, employers can save between USD 1.5 and USD 5.6 in health care spending (Mattke et al., 2014[46]; Chapman, 2012[47]; Baicker, Cutler and Song, 2010[48]). Moreover, workplace programmes improving lifestyles, health and well-being, help reduce sick leave absenteeism by 25% (Chapman, 2012[47]) and thus, increase productivity. For instance, modelling work indicates that scaling up interventions reducing sedentary behaviour and promoting physical activity at the workplace could improve employment and productivity resulting in the equivalent of an additional 37 000 full-time equivalent workers per year in 30 OECD countries, for a cost between USD PPP 1 and 2 per capita (OECD, 2019[1]). Taking into account the impacts on health and life expectancy, savings in

health expenditure and labour market cost, this programme would return USD 4 in the form of economic benefit for each dollar invested. Workplace programmes can also strengthen corporate image, which helps to recruit and retain talent, as individuals increasingly expect their employers to take into consideration their health and well-being.

Figure 1.4. Workplace sedentary behaviour programmes increase the number of full-time equivalent workers per year by improving workforce's health



Note: FTE means full-time equivalent. Labour market inputs include employment and productivity when employed. They are expressed in the number of full-time equivalent workers and are calculated for the working-age population. OECD analyses based on the OECD SPHeP-NCDs model, which forecast the evolution of NCDs and risk factors and their related costs over the next 30 years.
Source: OECD, The Heavy Burden of Obesity, (OECD, 2019[1]).

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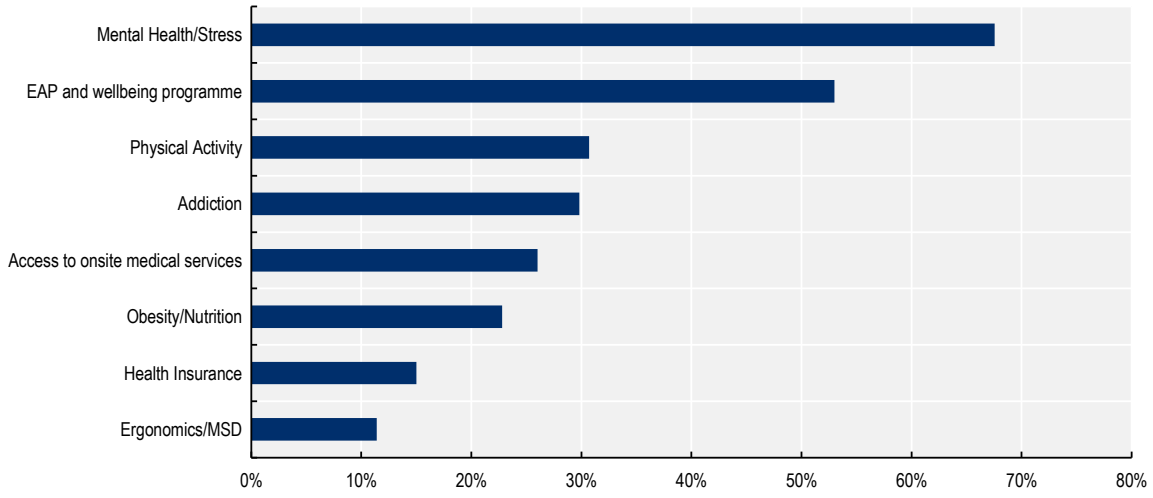
The success of workplace health-promoting programmes relies in part on organisational factors such as an integrated approach into occupational safety and health prevention, and a healthy workplace culture. The starting point for workplace programmes that aim to promote employee health, healthy lifestyles and well-being, relies on good prevention and management of occupational risks. Growing evidence shows that an integrated approach of health promotion to occupational safety and health has greater outcomes, such as improved health behaviours, employee participation, reductions in injury illness and disability, reducing costs, and enhancing productivity (Tamers et al., 2019[49]). Another important condition for the success of workplace health programmes is a healthy workplace culture to create the enabling factors for employee uptake. Recent evidence showed that health and well-being outcomes across a wide range of workplace interventions are mediated by workplace culture change, such as job control, organisation support, work climate, management style, flexibility, work time expectation, supervisor support, line manager's attitude and actions (Quigley et al., 2022[50]).

Workplace health programmes usually offer support for various risk factors for NCDs. Data from the 2020 Workforce Disclosure Initiative survey illustrates the variety of health and well-being programmes implemented by 114 worldwide large-size companies. These companies represent 11 sectors of the industry (communication services, customer discretionary, consumer staples, energy, financials, industrials, information, technology, materials, real estate, utilities), and cover 19 countries (Australia, Belgium, Canada, China, Denmark, Finland, France, Germany, Italy, Japan, Mexico, Netherlands, Norway, South Africa, Spain, Sweden, Switzerland, the United Kingdom, and the United States), with a large number of companies (55 out of 141) being established in the United Kingdom. More than two-thirds (68%)

of participating companies reported offering stress and mental health programmes, although the data does not report on the actual uptake by employees (Figure 1.5). About 80% of the surveyed companies reported adopting actions that widen health-related choices of individuals, for instance by offering healthier food options in the cafeteria, providing sit-stand desks, or offering addiction management programmes. Such workplace programmes have increased over time, across European countries. For instance, according to the European Survey of Enterprises on New and Emerging Risks, 32% of the respondent companies reported they implemented measures raising awareness of nutrition among employees in 2019, compared to 28% in 2014 (ESENER, 2019[51]). During the COVID-19 crisis, employer ability to respond to employee needs was challenged (Box 1.1).

Figure 1.5. Proportion of responding companies reporting workplace health programmes, by type of risk factors



Note: MSD musculo-skeletal disorders. EAP Employee Assistance Programme are employee benefit programmes aiming to address a wide range of issues (e.g. mental and emotional well-being, financial). Well-being programmes include financial counselling, various leave options, additional services to accommodate particular needs. As companies may offer several answers, the sum is higher than 100%.
Source: OECD analysis based on 2020 WDI data.

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Box 1.1. Health and safety measures in the early phase of the COVID-19 crisis

During the COVID-19 pandemics, companies had to adapt policies to protect their employees from the spread of the virus. According to the 2020 Workforce Disclosure Initiative data, from the very beginning of the COVID-19 pandemic, many employers showed to effectively respond to employee needs offering health-related measures such as enabling teleworking, enhancing hygiene measures to limit the propagation of the coronavirus, and mental health support.

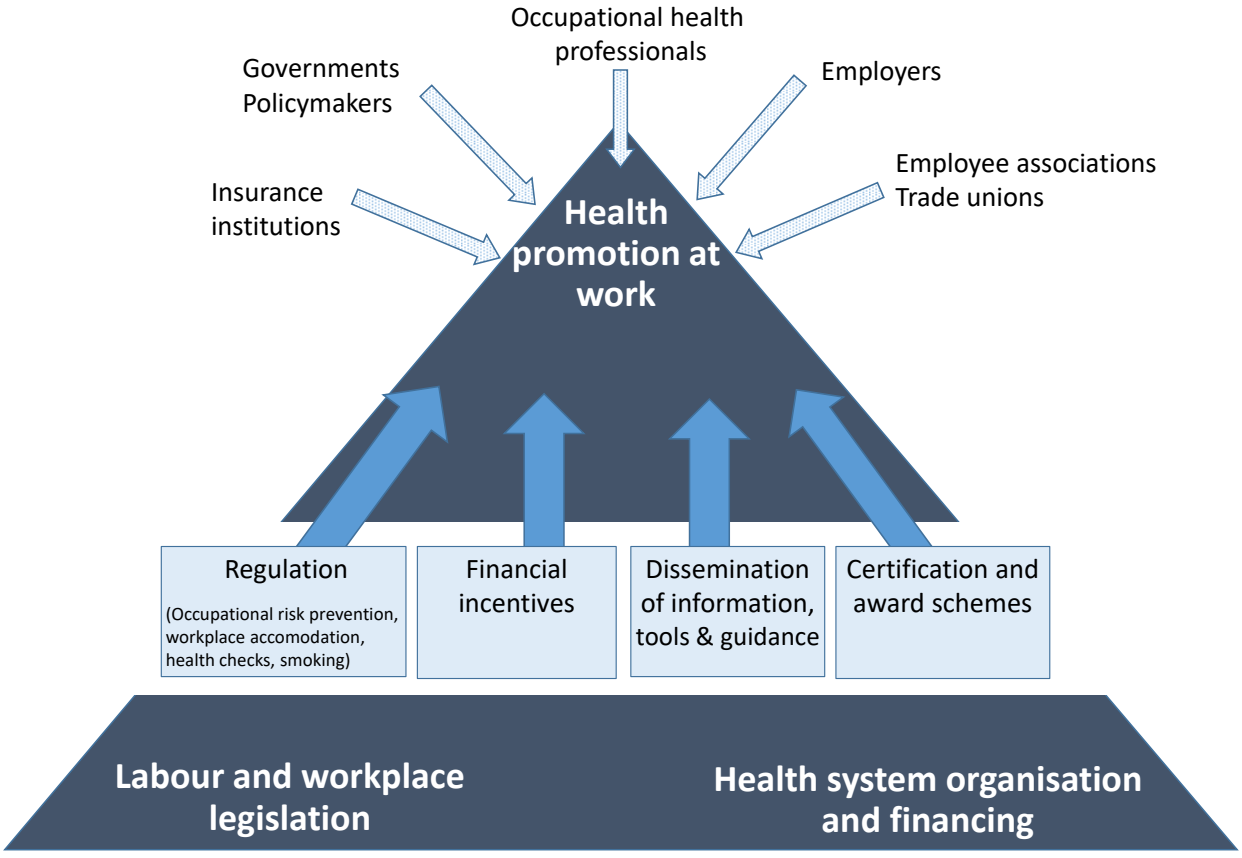
Long COVID-19 represents an additional challenge for employers, as employees previously infected by the virus may suffer for long-standing illnesses -such as fatigue, breathlessness, chest pain or anxiety. A survey of 804 organisations in the United Kingdom, representing more than 4.3 million employees, found that 46% of organisations have employees who have experienced long COVID in the last 12 months, and that 26% of employers include long COVID among their main cause of long-term sickness absence (CIPD, 2022[52]).

In many circumstances, employers will see the promotion of health and well-being of their employees as a priority, but this is not always the case. Barriers, such as the cost of the programmes, insufficient human resources and lack of programme knowledge often hinder employers, in particular in SMEs, to implement health and well-being programmes for their employees. Governments can support employers to promote the health and well-being of their employees in the workplace through a mix of regulations, financial and non-financial incentives, as discussed in the next section.

1.4. Governments have many policy levers to promote health and well-being through the workplace

The responsibility for promoting health and well-being at work lies in the domain of both health policy and labour market policy. As shown in Figure 1.6, labour and workplace legislation and health system characteristics set the foundation for the range of policy levers available to governments to promote health at work. The policy levers identified across the ten countries studied in detail (Australia, Canada, France, Germany, Italy, Japan, Korea, New Zealand, the United Kingdom, and the United States) include (i) regulation, (ii) financial incentives, (iii) dissemination of information, and (iv) certification and award schemes. Government efforts to promote health and well-being at work can be amplified by attracting investors and private funds that seek to align their investments with sustainability and societal values, to invest in companies that prioritise the health and well-being of their employees. Figure 1.6 also shows the range of stakeholders involved in health promotion at work, which in addition to governments and policy makers, includes occupational health professionals – who play a key role to diagnose risks and health problems in companies, identify needs and solutions – insurance institutions, employers, employees, trade unions and social partners. Collective bargaining, for instance, plays an important role in wage-setting, job security and working time arrangement, all of which are issues that are closely related to health and well-being (OECD, 2019[53]).

Figure 1.6. Determinants of health and well-being promotion through work



Source: Authors.

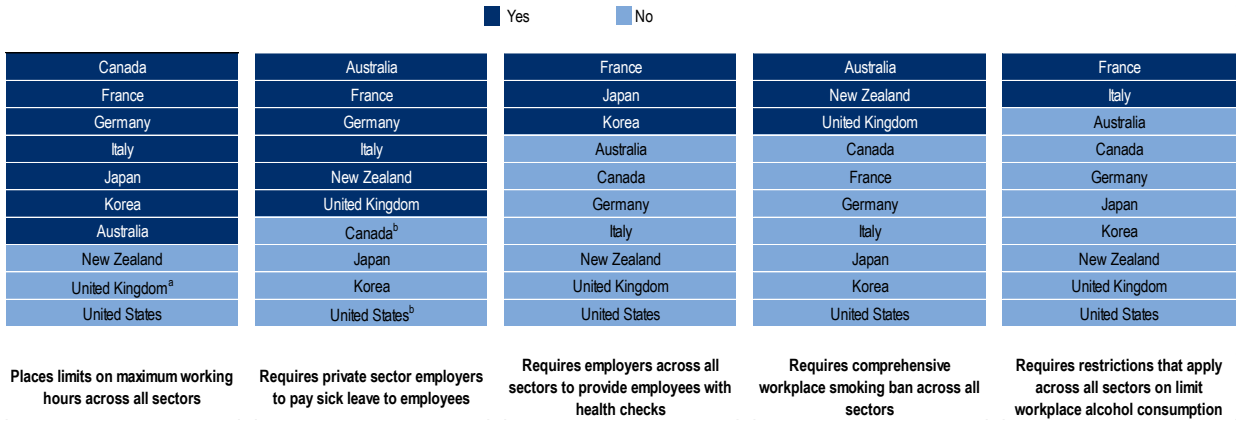
Standards and legislation relating to health and safety at work have existed for decades at the international, national and sub-national level (Department for Work and Pensions, 2021[54]). An example is the 1989 European Union Framework Directive on safety and health at work. In more recent years, new considerations for health promotion – adding to accident prevention and safety – have been included in national occupational health and safety strategies (such as in Germany) or within broader health promotion strategies (such as in Japan). One challenge that remains is in ensuring clarity on the responsibility of health promotion at work, as a lack of clarity can result in weak co-ordination and a lack of attention placed on this issue (OECD, 2021[9]).

The institutional and financial arrangements of health promotion at the workplaces also result in significant heterogeneity across countries. For example, whereas in some countries such as Japan, occupational physicians are a hub through which workers access support including specialised treatment (OECD, 2019[55]), in others such as the United Kingdom, general practitioners play a more prominent role in referring individuals with health issues to access appropriate treatment (OECD, 2020[56]). In countries with a national health system (e.g. Australia, Canada, Italy, New Zealand and the United Kingdom), individuals are also entitled to health care based on residency and health care services is mostly financed by government schemes and thus employers tend to play a smaller role. By comparison, in countries where employers contribute to the cost of health insurance for employees (e.g. the United States), employers have a stronger incentive to promote the health and well-being of their employees.

1.5. Regulations set a minimum standard for specific health issues at work

Beyond legislation on the prevention of occupational risks and the promotion of health at work, regulations also exist on specific issues such as working hours, workplace health checks, smoking and alcohol consumption at the workplace, all of which are important areas to set a foundation for health promotion through work. The review based on ten countries identifies a range of regulations related to health at work, which management and enforcement may be under the responsibility of sub-national authorities in countries with decentralised governments. As shown in Figure 1.7, while most of the ten countries studied set maximum working hours and mandate employer-paid sick leave, other regulatory measures such as health check requirements and measures to control workplace alcohol consumption control are less common. While almost all countries restrict smoking in the workplace in some capacity, only three have a comprehensive ban that applies across the country.

Figure 1.7. A range of regulations are used to address specific health issues at work



Note: [a] The United Kingdom has maximum hours but there is an option allowing employees to opt-out, which is typically included in contracts.
[b] Canada and the United States require private sector employers to pay sick leave to employees in a number of sub-national regions.
Source: Information presented on maximum working hour regulation is from the OECD Policy Questionnaire on Working Time Regulation, 2020, the findings of which are published in Employment Outlook, OECD (2021[8]). Information presented on sick leave is from Towards equitable and adequate paid sick leave, OECD (Forthcoming[57]). Information presented on smoking bans is from the Global Health Observatory, World Health Organization (2021[58]) complemented and updated with information from national sources. Information presented on health checks and alcohol consumption is based on a review of national sources by authors.

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The review of regulation policies identified the following more detailed findings:

- **Regulating hours:** six of the ten countries studied (Canada, France, Germany, Italy, Japan, and Korea) specify maximum weekly working hours (OECD, 2021[8]). When enforced and complemented with supporting measures, such regulation can protect employees from working excessively long hours.
- **Monitoring employee health:** three of the ten countries (France, Japan and Korea) place requirements for employers to ensure their employees receive health checks or screenings across all sectors. This may reflect differences in the role of primary care and concerns over privacy and discrimination based on health or disability status (Box 1.2).
- **Prohibiting smoking:** three countries have comprehensive smoking bans in enclosed workplaces (Australia, New Zealand, and the United Kingdom) (World Health Organization, 2021[58]), and four prohibit smoking in enclosed workplaces except in designated rooms (France, Italy, Japan and

Korea). Comprehensive smoking bans are significantly more effective than partial bans at reducing exposure to second-hand smoke (Ward et al., 2013[59]).

- **Limiting alcohol consumption:** no country prohibits alcohol consumption in the workplace across all sectors. Regulations prohibiting alcohol consumption exist primarily for jobs where influence of alcohol can increase injury risk (e.g. construction work) or where impairment due to alcohol can threaten public safety (e.g. bus driver).

Box 1.2. Employee data protection and privacy

Practices and rules about collection and disclosure of employee health data differ across jurisdictions due to varying approaches to data protection and privacy. For instance, in Japan, employers are authorised to collect data on employee health and well-being outcomes as this is a key aspect of the implementation of annual health checks. In the United States, employers are only permitted to ask employees to take health examinations and collect information on the findings if this need is directly related to the employee's responsibilities or the duties of the employer. In the European Union, the General Data Protection Regulation (GDRP) recognises data concerning health as a special category of data. This places strict limitations on collection of information on employee health by employers, with specific limitations such as cases where collection of health data is necessary for carrying out contractual obligations (e.g. the provision of sick leave) or for public health and safety purposes (European Union, 2016[60]).

The issue of how to protect employee data privacy while also meeting public health objectives has received renewed attention during the COVID-19 crisis. Information not collected previously such as previous and current coronavirus infection status, vaccination status for COVID-19 and temperature checks, all became valuable for employers seeking to minimise infection risk among their on-site employees. For instance, employers in the United Kingdom have been able to ask employees about their COVID-19 vaccination status on the condition that this is to protect the health and safety of other employees (Information Commissioner's Office, 2022[61]). In Germany, meanwhile, employers were generally forbidden to ask employees about their vaccination status except in certain industries, but this was overruled by a later decision in March 2022, which allows for employers to request their employees to provide information on their 3G status (vaccinated ("geimpft"), recovered ("genesen") or negative test result ("getested")) as a public health measure (Federal Ministry of Health, 2022[62])

Regulation around sick leave, return-to-work and workplace accommodations play a particularly important role in health at the workplace, by supporting people experiencing ill-health or health conditions to remain in employment. While these measures are primarily changes in regulation, they can also create and be supported by financial incentives.

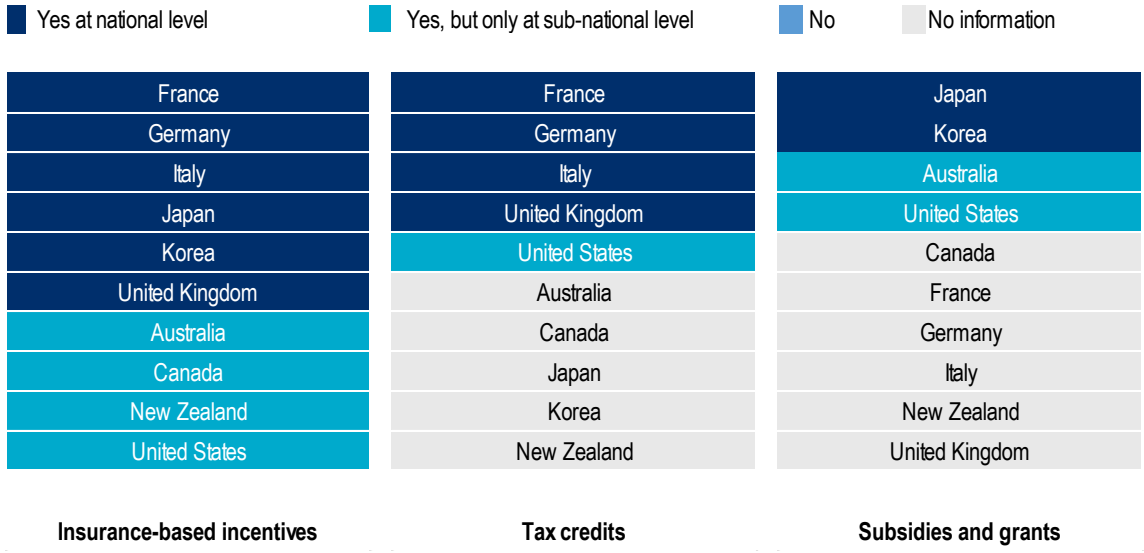
- **Paid sick leave:** six countries provide employer-paid sick leave at the national level (varying from 3 days to 196 days) (OECD, Forthcoming[57]). Paid sick leave usually consists of a period of employer-paid sick leave combined with a period of government- or tax-funded paid sickness benefit. Employer-paid sick leave must be of sufficient duration to create sizeable incentives for employers to prevent sickness, absence from work, and promote timely return-to-work of employees (OECD, Forthcoming[57]).
- **Workplace accommodations:** all ten countries require employers to make adjustments or accommodations for workers with disabilities (Department for Work and Pensions, 2021[54]). Eligibility should also be extended to also include workers with health conditions (OECD, Forthcoming[57]). Accommodation typically involves an increase in flexibility provided to employees rather than significant increases in expenditure (OECD, 2021[63]).

- **Gradual return-to-work mechanisms:** only Germany and the United Kingdom provide mechanisms to facilitate employees who have been absent from work to initially return to work with reduced hours or lighter working duties, with a view to phased return to regular duties. Such mechanisms can help facilitate return-to-work while also promoting recovery from ill-health (OECD, 2021[9]). Most countries also require employers to take measures to facilitate return-to-work.

1.6. Financial incentives help employers promote health through work

Financial incentives are important levers for governments to encourage and facilitate employers to go beyond basic accident prevention and safety, and to promote health and well-being through the workplace. Whereas regulation is usually suitable to set a minimum standard for employers to comply with, financial incentives can support employers looking to go beyond their legal responsibilities, by proactively promoting the health and well-being of their employees. Financial incentives and support are particularly important for micro, small and medium-sized enterprises. Three main types of financial incentives were identified, namely, insurance premium variation, tax credits, and subsidies and grants. As shown in Figure 1.8, accident insurance-based incentives were identified in all the ten countries studied, while tax credits and subsidies and grants were identified in half or less of the ten countries.

Figure 1.8. Financial incentives for employers beyond insurance-based incentives are limited



Note: No information indicates that no such measure could be identified in the review by the authors. Where financial incentives are implemented at the sub-national level, this figure does not differentiate between those cases where coverage is national (i.e. the entire country) and those where coverage only includes certain regions, territories and states.
Source: Information presented is based primarily on authors' review of national sources. For European countries, authors drew first on Economic incentives to improve occupational safety and health: a review from the European perspective, European Agency for Safety and Health at Work (2010[64]), and updated information based on a review of national sources.

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The review of financial incentives identified the following more detailed findings:

- **Insurance-based incentives**: all ten countries have accident insurance systems or workers' compensation insurance boards, which reward companies that promote better health among their employees with lower insurance premiums. While such assessments are often limited to the past record of employers in preventing accidents and injuries, the responsibility of insurance institutions can extend further. In Italy, the National Institute for Insurance against Accidents at Work (INAIL) provides a reduction in the insurance premium for employers participating in a programme to promote health in the workplace through measures such as healthy diets, and subsidies for projects to promote health and safety in the workplace (2022[65]). Health insurance companies also play a notable role in France, Germany and Japan, where employers and employees together contribute to health insurance, and in the United States, where employers are required to provide health insurance coverage for employees.
- **Tax credits**: four of the ten countries (France, Germany, Italy and the United Kingdom) provide tax credits at the national level related to health and well-being, and such credits are also available at the sub-national level in several states in the United States (Lankford, Kruger and Bauer, 2009[66]). Compared to subsidies, tax credits are often easier to implement administratively, as they can be included within existing mechanisms relating to tax reporting mechanisms. Tax credits specific to promoting active commuting to work also exist in France and the United Kingdom. In Germany, employers can receive a tax exemption for expenditures up to EUR 600 (USD 710) per employee per year to promote health at the workplace, with measures eligible including programmes to promote healthy diets, physical activity, stress management and addiction treatment (Federal Ministry of Health, 2022[67]).
- **Subsidies and grants**: subsidies and grants were identified in two countries at the national level (Japan and Korea) and two other countries at the sub-national level (Australia and the United States). Subsidies are usually targeted at SMEs (Box 1.3), but also often only available to a very limited number of employers, especially if they are provided as competitive grants. In Japan, subsidies are available for SMEs implementing a Mental Health Promotion Plan and for those ensuring employees with health conditions can balance their work with accessing medical treatments and supports (Japan Organisation of Occupational Health and Safety, 2021[68]).

Box 1.3. Enablers for SMEs to implement workplace health and well-being programme

While about 409 million of workers are employed in SMEs in OECD countries, this potential target is less accessible because SMEs face more barriers when implementing health and well-being programmes for their employees than large companies. These barriers include, for instance, programme-related cost, insufficient human resources, and lack of programme knowledge.

Government leadership can support SMEs in the process of implementing health programmes by investing in the training and employment of occupational health professionals to strengthen occupational health services, and developing national accreditation for providers of health and well-being services to frame the supply side (Saint-Martin, Inanc and Prinz, 2018[5]). Another avenue of actions is through better supply chain arrangements. If large businesses engage with their supply chain – both upstream and downstream – then occupational health and safety improvements can be fostered in SMEs (EU-OSHA, 2018[69]). Finally, governments can trigger SMEs to implement health and well-being programmes by offering subsidies to SMEs and by creating certified recognition programmes for employers who invest in health and well-being promotion for their employees (Section 1.8).

1.7. Dissemination of information and guidance increases awareness and lowers barriers for employers to implement best practices

Governments can also facilitate employers in implementing workplace health and well-being programmes through **dissemination of information on the benefits for employers** to invest in health of their employees and through providing guidelines and other tools that can support the implementation of good practices by employers. This can increase awareness – especially for stigmatised health issues such as mental health (OECD, 2021[9]) – and increase the understanding among employers and managers of effective measures. While such initiatives are a low cost way for governments to increase awareness and facilitate employer action, the **involvement of non-governmental stakeholders – including charities, trade unions and employer associations – helps** ensure widespread outreach to employers and when developing health and well-being promotion tools and guidelines for them.

All ten countries studied provide information at the national level on health, safety and well-being in the workplace, typically through their agencies dedicated to occupational safety and health. Some countries also have dedicated agencies for researching and disseminating information on health in the workplace with an increasing focus on health promotion and early intervention. At the international level, the European Agency for Safety and Health at Work (EU-OSHA) plays a large role in both researching on the effectiveness of interventions to promote health at work and in disseminating this information to relevant stakeholders including employers.

Self-assessment tools, which allow employers to diagnose the extent to which they are effectively promoting health and well-being among employees, are available in at least four of the ten countries (France, Germany, the United Kingdom and the United States). In the United States, the Centre for Disease Control and Prevention (CDC) developed a Worksite Health ScoreCard, which allows employers to assess the extent to which they have implemented evidence-based measures to promote the health and well-being of employees by filling out a questionnaire. The ScoreCard includes questions related to many areas, including weight management, physical activity, high blood pressure, tobacco use, musculoskeletal disorders, stress, sleep and maternal health (Centers for Disease Control and Prevention, 2022[70]).

Information and guidance on the COVID-19 crisis has been widely disseminated to employers. Guidance covers issues relating to slowing the spread of the coronavirus such as ventilation, teleworking and sanitary measures, but also other impacts of the pandemic such as ensuring employee well-being, managing stress and supporting workers experiencing long COVID. In particular, in order to support workers experiencing long-lasting health impacts of COVID-19 infections, guidance has been issued to employers in at least three countries (Japan, the United Kingdom, and the United States) as well as by EU-OSHA.

1.8. Certification and award schemes incentivise employers to support health and well-being of the workers

Governments can recognise employers that put in place best practices by providing them with certifications and awards, thus incentivising employers to promote health and well-being in the workplace. Some schemes are government-led, ranging from large-scale national schemes such as the Health and Productivity Management (H&PM) programme in Japan to smaller schemes such as the Corporate Health Standard in Wales (United Kingdom). Non-governmental stakeholders, including private sector actors and non-profit organisations, have also developed such schemes.

The purpose of award and certification schemes is to create reputational benefits for employers promoting health and well-being in the workplace. There are at least three important criteria to ensure the credibility and usefulness of such schemes. Schemes must be: (1) sustainable and sufficiently long-lasting to develop a good reputation; (2) visible and disseminated to relevant stakeholders; and (3) be based on sound evidence that can effectively differentiate higher-performing employers implementing good practices compared to employers simply meeting legal obligations.

It is important to make a distinction between certification and award schemes. Whereas certification shows that an employer meets a certain standard of health and well-being promotion at work, award schemes are typically competition-style schemes, where recognition is only available to a limited number of employers. A limitation of certification and award schemes (and especially award schemes) is that they are exclusive, and usually only accessible to higher-performing employers, and may thus offer little incentive for health promotion in workplaces where it is not considered a priority. Some schemes such as the H&PM programme in Japan, combine aspects of both certification and award schemes. Launched in 2014 by the Ministry of Economy, Trade and Industry (METI), H&PM provides certification for employers meeting a minimum standard in promoting health and well-being at work, and the top 500 SMEs and top 500 large enterprises receive an additional award (2021[71]). Japan also has similar recognition schemes to promote physical activity and bicycle commuting.

Certification and award schemes go hand-in-hand with collection of more granular information on health and well-being in the workplace, which can be used to widen the evidence base to inform both policy and employer interventions. This is because certification and award schemes are typically based on information shared by employers on the health and well-being outcomes of employees and the specific measures and programmes they implement. The H&PM programme, for instance, provides a wealth of information relating to employer motivations and the relationship between health interventions at the workplace and health outcomes, given the scale of the programme. Even with smaller programmes such as the Workplace Well-being Awards, organised by Mind in the United Kingdom, there are opportunities to identify innovative practices that could be disseminated to employers seeking inspiration. The collection of employee health data nonetheless raise concerns about data protection and privacy in some countries (Box 1.2).

1.9. Companies that promote employee health and well-being are likely to attract growing interest from investors that prioritise environmental, social and governance (ESG) aspects

Institutional investors and private funds are seeking to direct investment towards companies that promote the health and well-being of their employees, in particular, investment that is aligned with ESG and human capital considerations (Box 1.4). According to an estimate by the Global Intangible Finance Tracker,[1] intangible assets such as human capital, employee health and culture hold more than half (54%) of a company's market value (Brand Finance, 2021[72]). Investors are also increasingly seeking to invest in companies that prioritise the health and well-being of their employees (BlackRock, 2022[73]), especially in the wake of the COVID-19 pandemic, which has placed a spotlight on the importance of the health and well-being of employees.

Box 1.4. Environmental, social and governance (ESG) criteria

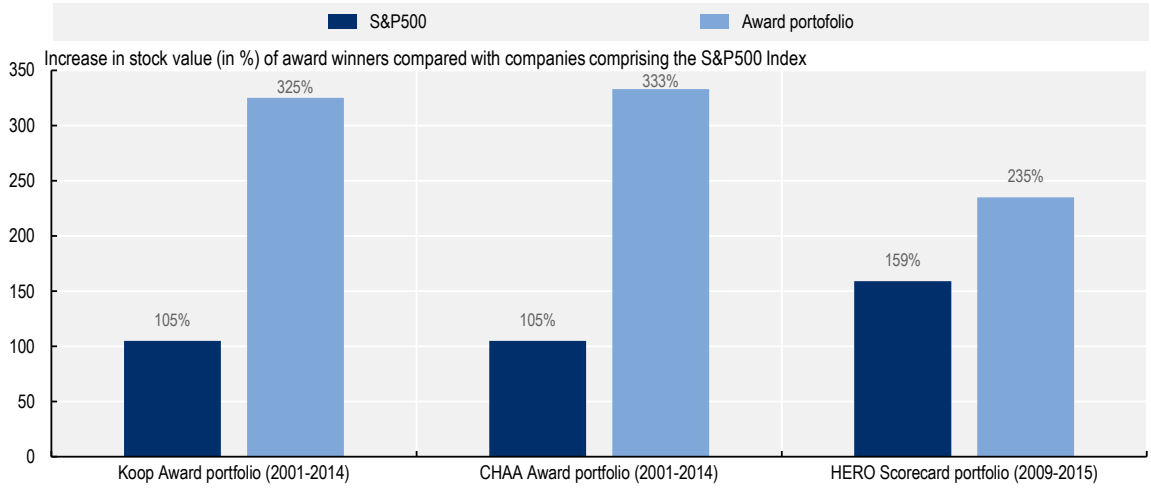
ESG criteria are used by institutional investors and private funds as they seek to align their investments with sustainability and societal values. The environmental 'E' pillar encompasses the effect that companies' activities have on the environment (directly or indirectly). The 'E' pillar is being increasingly used by investors who seek long-term value and alignment with the green transition (OECD, 2021[74]). The social 'S' pillar encompasses how a company manages relationships with employees, suppliers, customers, and the communities where it operates. It includes workforce-related issues (such as health, diversity, training), as well as broader societal issues such as human rights. The governance 'G' pillar encompasses a company's leadership, executive pay, audits, internal controls, transparency policies for public information, codes of conduct or shareholder rights.

Investors are increasingly considering ESG factors when evaluating companies. ESG investing is expected to represent one-third of the global assets under management by 2025 (Bloomberg, 2021[75]), and as of 2020, over USD 30 trillion in assets incorporate ESG assessments (OECD, 2020[76]).

There are many ESG ratings providers, each using different data sources, methodologies and frameworks to establish ratings (Boffo and Patalano, 2020[77]). The growing demand for ESG investing is hampered by a lack of transparency, international inconsistencies and comparability challenges, and this is a risk that also exists for health and well-being indicators.

At least two motivations steer investors towards health-promoting companies. First, **investors may consider companies that promote the health and well-being of its employees to be more valuable**. While no causal relationship can be asserted, evidence from US studies shows that the stock values of companies awarded for their workplace health programmes outperformed the companies comprising the Standard and Poor's 500 (S&P500) index, and the result holds across award schemes calculated through different approaches (Figure 1.9). Between 2001 and 2014, companies that were awarded for their workplace health programmes saw their combined stock value appreciate up to three times more than companies comprising the S&P500 index (Goetzel et al., 2016[78]; Grossmeier et al., 2016[79]; Fabius et al., 2016[80]). There is also promising evidence that suggests that in Japan, companies that have been certified in the H&PM programme also perform better on the Tokyo Stock Exchange (Ministry of Economy Trade and Industry of Japan, 2021[71]). While further examination and greater evidence is required to claim that workplace health promotion results in higher financial performance, this finding is consistent with the discussion in Section 1.2, which showed that poor health in the labour market results in a significant decrease in productivity among workers.

Figure 1.9. Companies receiving awards for their workplace health programmes have seen a greater increase in their stock value compared to companies in the S&P 500



Note: S&P500 refer to companies comprising the Standard and Poor's 500 Index, which includes the 500 largest companies listed on stock exchanges in the United States. CHAA Corporate Health Achievement Award. HERO Health Enhancement Research Organization. The period over which stock value increases are compared, is 2001-14 for both the Koop Award and the CHAA Award, but is less than half the length (2009-15) for the comparison of stock values for the HERO Scorecard. This may explain the smaller differential between the stock values of companies comprising the S&P 500 and HERO award-winners.

Source: Goetzel, R. et al. (2016[78]), "The Stock Performance of C. Everett Koop Award Winners Compared With the Standard & Poor's 500 Index", https://doi.org/10.1097/JOM.0000000000000632; Grossmeier, J. et al. (2016[79]), "Linking workplace health promotion best practices and organizational financial performance: Tracking market performance of companies with highest scores on the HERO Scorecard", https://doi.org/10.1097/JOM.0000000000000631; Fabius, R. et al. (2016[80]), "Tracking the Market performance of companies that integrate a culture of health and safety: An assessment of corporate health achievement award applicants", https://doi.org/10.1097/JOM.0000000000000638.

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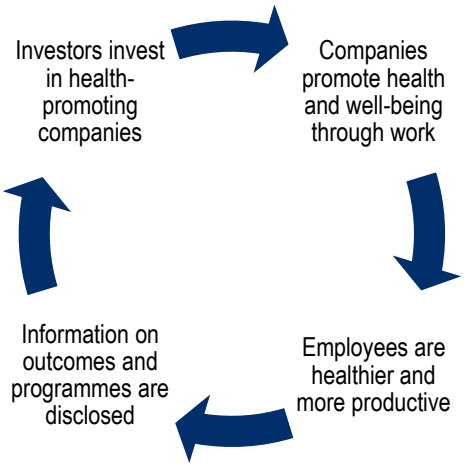
Second, **information on company-led initiatives to promote health and well-being of the workforce is likely to be of interest for investors** that look for sustainable, socially responsible investment. The health and well-being of employees, often incorporated within considerations around human capital, is increasingly seen as an important pillar of the non-financial performance of companies (Siegerink, Shinwell and Žarnic, 2022[81]). The importance of the health and well-being of employees beyond the immediate health impacts was put into further spotlight by the COVID-19 pandemic, which began as a health crisis, but soon became a broader social, labour market and economic crisis.

As shown in Figure 1.10, as both investors and companies value the health and well-being of employees, this can create a virtuous cycle, where the incentive for employers to promote employee health is amplified. This is because an employer that promotes the health and well-being of employees is rewarded not only with a healthier workforce, but also with an increased likelihood of receiving investment. The **key obstacle to this is that investors are unable to differentiate effectively between employers/companies that actively promote the health and well-being of its employees and those that do not**. This is due to a general lack of information on the health and well-being of the workforce, and the absence of standardised disclosure and reporting mechanisms that either require or incentivise employers to provide information on their health and well-being programmes. Given the global nature of investment, it is important to standardise and harmonise practices across countries on disclosure mechanisms to allow for international comparison of company performance on health promotion.

Figure 1.10. Governments can facilitate investment in health-promoting companies



Source: Authors.

Governments can thus play an important role – working together with relevant stakeholders – to promote the disclosure and reporting of employers/companies efforts towards the health and well-being of employees. Besides providing impetus for other companies to learn and emulate good practices, this has the potential in turn, to steer investment towards employers/companies that promote the health and well-being of their employees.

While efforts to disclose data on health and well-being of the workforce remain scarce, there are initiatives emerging in some jurisdictions, which are classified into three categories. These are (1) government-led reforms for mandatory disclosure, (2) voluntary initiatives to promote disclosure often led by investors, and (3) efforts to standardise and harmonise disclosure mechanisms across countries and companies. Examples of initiatives from each category are described below.

- **Government-led reforms for mandatory disclosure**: these are only just emerging such as in the United States or limited in scope such as in the European Union. In the United States, the Workforce Investment Disclosure Act – which was introduced in the Senate in 2021 – would require, if it were passed, publicly traded companies to disclose a range of human capital metrics, including workforce turnover rates, skills and development training, workforce engagement, pay and benefits, and workforce health and safety (United States Congress, 2021[82]). In the European Union, the Directive for Non-Financial Reporting requires large companies to disclose their measures to address social and environmental challenges, which includes issues related to employee health and well-being (European Union, 2013[83]).
- **Voluntary initiatives to promote disclosure:** non-governmental stakeholders such as investors and charities often lead these initiatives, which exist across many of the ten countries studied. The Workforce Disclosure Initiative, which is led by a charity group and financially supported by the UK Government, has developed a reporting mechanism for companies to disclosure their approaches to human capital and workforce issues (ShareAction, 2022[84]). The Japanese Government also discloses information on measures implemented and health outcomes reported by companies that participate in the Health & Productivity Management Programme for companies that are listed in the Nikkei 225, which includes 80% of the largest publicly-owned companies in Japan (Ministry of Economy Trade and Industry of Japan, 2021[71]).
- **Initiatives to standardise and harmonise disclosure mechanisms**: such initiatives, which are typically led by organisations with a standard-setting influence, can standardise the indicators that companies report on to allow for comparability across countries and companies. For instance, the Global Reporting Initiative, which sets standards used by 75% of the world's largest companies in their ESG reporting (KPMG, 2020[85]), includes the implementation of health promotion programmes in its reporting guidelines on occupational health and safety, which was released in 2018 (Global Reporting Initiative Standards, 2018[86]).

1.10. Conclusion

Safety, health and well-being of employees are valuable to all stakeholders, including employees, employers, governments, investors and society-at-large. Integrating health and well-being promotion to the prevention of occupational safety and health risks contributes to greater results for the benefits of employee and employers. Workplaces are an ideal location to spread and implement health promotion and well-being activities in the working-age population, not least as populations across the OECD countries age and face an increasing burden of unhealthy lifestyles and chronic diseases. A range of policy levers is available to governments to incentivise employers to promote health and well-being among workers. These include regulation (such as regulation of working hours and smoking bans), financial incentives (such as insurance premium deductions, tax credits and subsidies to SMEs), dissemination of good practices to employers, and certification and award schemes to recognise employers that excel in health promotion. Regulation and dissemination of good practices are more widely used as policy levers across the ten countries than financial incentives and certification and award schemes among the ten countries studied. While the assessment presented in this report focussed on G7 and three OECD countries in the Asia and Pacific region, there are initiatives aimed at promoting health and well-being at the workplace in other OECD countries not reviewed here.

The rise of ESG criteria, which are increasingly used by investors to determine whether companies are sustainable and socially responsible, presents an opportunity to amplify government efforts to promote health and well-being in the workplace. Employee health and well-being should be of interest to both investors and employers as it is a key element of the 'S' social pillar of ESG and as a healthy workforce is the foundation for a successful company. The special focus chapter of this report therefore looks at how to steer investment in companies that promote employee health and well-being. A key issue that emerges from this is the need for mechanisms for disclosure of information on health and well-being that are of interest to investors. It also raises questions about what indicators should be disclosed and how to ensure investors are able to make comparisons between the performance of different companies.

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Note

[1] The Global Intangible Finance Tracker report, produced by Brand Finance, ranks the world's largest companies by intangible asset value. Intangible assets fall into three categories – rights (including leases, agreements, contracts), relationships (including a trained workforce), and intellectual property (including brands, patents, copyrights).

2 Health and well-being of the workforce

Marion Devaux and Alena Piatrova

This chapter presents the most recent data on health and well-being in the working-age population in OECD countries. It first recognises the importance of employment and working conditions on employee health and well-being. It then highlights widespread population exposures to lifestyle risk factors for health – such as obesity, smoking, harmful alcohol use, and level of stress – and assesses the distribution of non-communicable diseases (NCDs), including mental health conditions, in the working-age population. The chapter also sheds light on the disabilities caused by NCDs in the working-age population. Lastly, it assesses the effects of unhealthy lifestyles and NCDs on workforce participation and productivity.

Key findings

The nature of work, including safe work environment, job quality, work organisation, employment type and sector, and new forms of employment, influences employee health and well-being.

- Around 40% of European workers with a poor working environment reported that their work had a negative impact on their health in 2015. This was more than double the proportion (15%) among workers with a good working environment.
- Evolutions of the world of work – including new forms of employment and teleworking in the post COVID-19 pandemic – add new considerations for safety, health and well-being of the workforce, in particular with income insecurity and poor work-life balance.

Beyond work-related risks for health, lifestyle behaviours are key determinants of health in the working-age population, with 76% of all deaths in working-age people caused by smoking, poor diets, harmful alcohol use and physical inactivity. A sizeable part of the adult population is exposed to unhealthy lifestyles. Precisely, in OECD countries:

- Overweight and obesity, smoking, harmful alcohol use, and high levels of stress are major risk factors for non-communicable (NCDs) including cardiovascular diseases (CVDs), cancers, diabetes, musculoskeletal disorders (MSDs) and mental health conditions, that affect working-age people.
- More than half of the adult population (56.4%) is overweight or obese. Individuals with lower education are more likely to live with overweight or obesity, especially women.
- One in six adults (16.5%) smoke in OECD countries. In the majority of OECD countries, smokers can smoke at the workplace. In general, men and individuals with lower education are more likely to smoke.
- Nearly one in three adults (29.7%) report heavy episodic drinking at least once a month. After-work drinking can be seen by some workers as a means to socialise with colleagues. Women with higher education are 60% more likely to drink weekly than women with lower education, while this link is weaker in men.
- Two in five full-time employees (41.5%) reported being stressed. High levels of stress are leading causes for mental health conditions as well as CVDs and MSDs.

NCDs, including mental health conditions, greatly affect people in working age.

- In EU countries, about 43% of adults in working age reported suffering from MSDs, while 45% faced risk factors for mental health well-being.
- Every year, 3.2 million new cases of cancer are diagnosed in the OECD population of working age.
- Women and individuals with lower education level tend to report higher prevalence of chronic diseases than men and individuals with higher education, respectively, highlighting social inequalities in health.
- People affected by one or several chronic diseases may be limited in their participation in social activities and work, cannot fully enjoy their lives, and may have their quality of life altered.
- Cancers, MSDs and mental health conditions cause nearly half of the burden of disability in the working-age population. In addition, 47% of this burden falls onto the working ages (20-64).
- Long COVID-19 symptoms, such as fatigue, breathlessness, chest pain or anxiety that last weeks or months, affect about 10% of people who have been infected by COVID-19, especially older people, women, and those with overweight. Long COVID-19 is associated with absence from work and longer time before returning to work.

Conversely, health status affects work participation and productivity. Specifically, unhealthy lifestyles and NCDs have detrimental labour market outcomes, reflecting either a true effect of health conditions on employment and productivity, or discrimination towards people with unhealthy lifestyles and diseases, or both.

- Obesity is related to reduced employment prospects, and negatively affects productivity at work. Women with obesity are 68% more likely to miss work than women with a healthy weight, while this is not observed in men. The productivity loss associated with obesity-related diseases is equivalent to 54 million fewer full-time workers across 52 OECD, EU, G20 countries, which is similar to the number of employed persons in Mexico.
- Smoking has a negative effect on productivity of employees in the workplace through increased absenteeism and presenteeism, while also decreasing the likelihood of re-employment. For instance, current smokers in the United States have 28% more absenteeism than former smokers; this difference is 18% in five European countries while it is 61% in China.
- Evidence for direct associations between alcohol use and labour market outcomes has been debated, while a clearer pattern emerges between alcohol-related diseases and negative labour market outcomes.
- Having at least one NCD is associated with a reduced probability of being employed, for instance, workers with CVDs are 2.5 times more likely to leave employment due to disability.
- Having a NCD is correlated with additional days of sickness absence, varying for instance, from 2-10 additional days per year for workers with diabetes up to 80 days for workers with CVDs. Cancer survivors take 12 times more sick days in the first year post-diagnosis than healthy workers.
- Having a NCD tends to be associated with lower productivity at work. For instance, nearly 80% of workers who experience back pain also report working less than intended, with about one day missed per month. In general, the productivity loss due to presenteeism is higher than that due to absenteeism.

2.1. Introduction

Health and well-being are fundamental for enjoying a good and productive life. While health and well-being impact employment prospects and productivity at work, they are conversely affected by the nature of work. **This chapter aims to stress the importance of promoting health and well-being for the health benefits of working-age people, but also for better labour market outcomes**. Section 2.2 recognises the two-way relationship between health and work, and highlights how the nature of work affects health and well-being. Section 2.3 assesses adult's exposure to risk factors for health, while Section 2.4 analyses the distribution of chronic diseases, including mental health conditions, in the working-age population. Section 2.5 focusses on the burden of disability due to chronic diseases, and finally, Section 2.6 assesses the labour market outcomes of poor health.

2.2. How does the nature of work affect the relationship between work and health?

The relationship between health and work is bidirectional. The nature of work, including safe work environment, job quality, job demands, work organisation, employment type and sector, and new forms of employment, shapes and influences employee health (Saint-Martin, Inanc and Prinz, 2018[1]). Conversely, ill-health and health conditions can have negative impacts on the productivity of employees and their participation in the labour market (as discussed in section 2.6). This section focusses on the various aspects of work that can affect employee health and well-being (Box 2.1).

Box 2.1. Definition of well-being

This report captures some aspects of the well-being of employees through various lenses (e.g. physical and mental health and job satisfaction). Throughout the report, well-being of employees refers to a general feeling of satisfaction and fulfilment in and through work that encompasses but goes beyond the absence of physical and mental health problems. Well-being at work relates to an individual experience (either physical, emotional or psychological) of situations and constraints of the work environment. For instance, well-being at work makes a person be motivated and more prone to taking initiative. Therefore, well-being at work is directly related to the level of work productivity. Other definitions of employee well-being may vary, including experience beyond work. For instance, the US National Institute for Occupational Safety and Health defines worker well-being as a subjective and objective phenomenon inclusive of experiences both within and beyond work contexts (Chari et al., 2018[2]).

The OECD Framework for measuring well-being and social progress refers to well-being as a multi-dimensional concept that spans across income, jobs, health, housing, social connections and other dimensions (OECD, n.d.[3]). The component of well-being captured in this report refers to as "subjective well-being" of the OECD Well-Being Framework, where subjective well-being measures refer to a specific category of self-reported measures that evaluate good mental states, including all of the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences.

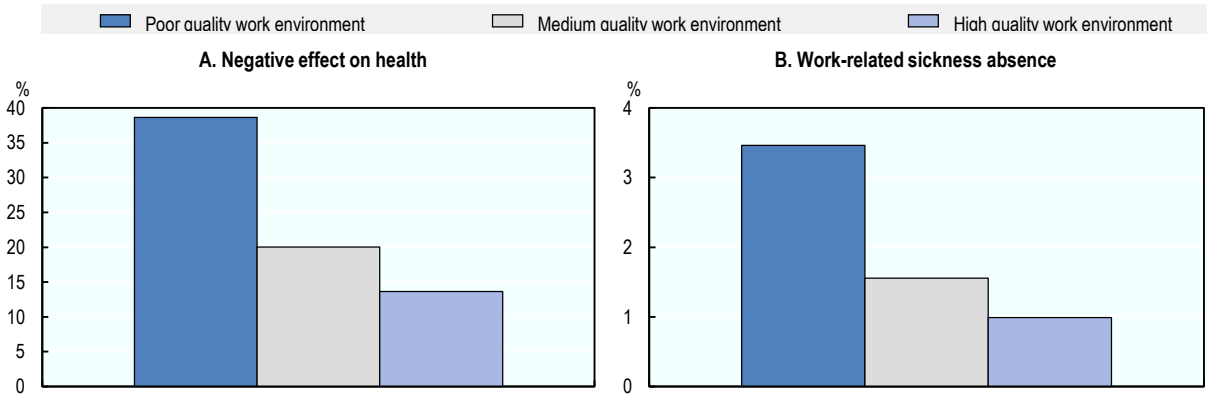
Safe work environment is essential for ensuring employee health and protecting from occupational diseases and injuries. Standards and legislation relating to health and safety at work have existed for decades at the international, national and sub-national level, requiring employers to ensure a safe work environment, free of recognised occupational hazards (such as chemicals, heavy load carriage, work stress and strain) (Chapter 4). Work-related diseases and injuries accounted for 1.9 million deaths worldwide in 2016, of which occupational injuries represent 360 000 deaths (WHO and ILO, 2021[4]). A number of diseases, including cancer, respiratory diseases, cardiovascular diseases (CVDs), musculoskeletal disorders (MSDs) and mental health disorders, can be caused or made worse by occupational safety and health risks. Workplace exposures that contribute to the development of diseases include: dangerous substances (e.g. chemical and biological agents, including carcinogens), radiation, physical factors (including vibration, noise, manual lifting, sedentary work), and organisational and psychosocial risk factors (e.g. shift work, stress).

Job quality is a determinant for employee health and well-being. While being in good quality work generally acts to protect against ill-health, not all jobs are equally health-promoting. A poor quality and insecure job with inadequate pay and no access to sick pay, for example, is likely to offer little protection against ill-health and instead may have adverse impacts on health. Job quality that encompasses adequate earnings, job security, and good-quality working environment, are essential for ensuring health and well-being of workers (James, Devaux and Sassi, 2017[5]; Saint-Martin, Inanc and Prinz, 2018[1]). Differences in the nature of work by socio-economic status also reflect in the social gradient of health. Individuals of lower socio-economic status are more likely to have less secure jobs and lower quality jobs that have an adverse impact on health (Institute of Heath Equity and Public Health England, 2015[6]; Saint-Martin, Inanc and Prinz, 2018[1]). **High job strain is a major cause of health problems, both mentally and physically.** A working environment characterised by high job strain (i.e. where demands on employees exceeds the resources available to the employee), as defined the by the OECD's Job Quality Framework (OECD, 2018[7]), can also have a negative impact on health. As shown in Figure 2.1, analysis of data from the 2015 European Working Conditions Survey, shows that around 40% of workers reporting a poor working environment said that their work had a negative impact on their health. This is more than double the proportion (15%) among workers with a good working environment. Characteristics of working environments with high job strain include low autonomy, physically demanding work, long working hours,

night shifts, and high frequency of workplace conflicts. In particular, **long working hours are harmful to health**. There is strong evidence that long working hours can increase the risk not only of accidents, but also a wide range of health issues, such as stress, mental health conditions, stroke and heart diseases (James, Devaux and Sassi, 2017[5]). The **organisation of work** – ranging from the leadership of senior management to the managerial practices of immediate line managers – also has a strong impact on job quality and subsequently health. For instance, social supports, including community, co-workers, and management support and recognition, have a positive effect on worker well-being and reduced stress.

Figure 2.1. Poor quality working environments have an adverse impact on health at the workplace

Self-reported health and incidence of sickness absence by work environment quality in the EU-28, 2015



Note: Based on proportion of respondents reporting that work has a mainly negative effect on their health and self-reported information on the number of days of sickness absence. In a poor quality work environment, there are more job demands than job resources; in a high quality work environment, there are more job resources than job demands; and in a medium quality work environment individual job demands equal individual job resources.

Source: OECD (2018), Good Jobs for All in a Changing World of Work: The OECD Jobs Strategy, OECD Publishing, Paris, https://doi.org/10.1787/9789264308817-en. OECD calculations based on the 6th European Working Conditions Survey (2015).

StatLink https://stat.link/wbqumo

Evolutions of the world of work – including new forms of employment and teleworking- add new considerations for health and well-being of the workforce. Non-standard employment – such as part-time, temporary or self-employed employment, in particular new forms of work (such as gig workers, platform workers) – is becoming more widespread and creates new opportunities and challenges for the world of work. For instance, flexible hours and shorter working hours can help to achieve better work-life balance. However, workers, especially casual and on-call workers, have limited control over when and how often they work, resulting in work-related stress, income insecurity and poor work-life balance (ILO, 2017[8]). In addition, the rise of teleworking, in the post COVID-19 pandemic, adds new considerations as also discussed in Chapter 4. For instance, while well-managed telework offers benefits (such as flexible working arrangements), it may also pose new challenges (such as long working hours, social isolation and mismanagement) putting employees' physical and mental health at risk.

Employment type and sector also affect employee health. Health risks at work vary by occupation type and sector, resulting in diverse health needs of employees depending on the nature of occupational health risks, be it physical, mental or psychosocial, to which they are likely to be exposed to through work. As an example, although both health care workers and agriculture workers may be at high risk of musculoskeletal disorders, the repetitive motions they execute are not the same, as such the prevention measures need to be adapted to the sector (OSHA-EU, 2019[9]). The health care sector, which employs a large share of the total workforce, has specific health risks in particular concerning MSDs and mental health conditions (see Box 2.2).

Box 2.2. Health risks faced by the health care workforce

In European Union, health care sector includes 10% of the total employment force, which includes work in hospitals, health care facilities, in-home and community care (OSHA-EU, 2014[10]). Assuring good working conditions is essential to providing safe care to patients and to the reputation of the health sector – and hence the ability to recruit people to this type of employment as well as retain health care professionals throughout their working lives. This is a particularly acute challenge for health care workers in the long-term care sector, which is characterised by high insecurity; high incidence of non-standard forms of work (temporary contracts, part-time contracts and shift work); and significant physical and psychosocial risk factors (OECD, 2020[11]). In general, MSDs and mental health conditions are two particularly important types of illness affecting the health and well-being of many health care workers and causing a significant impact on their productivity.

Musculoskeletal disorders

Sectors characterised by demanding physical effort, like the health care sector, have higher prevalence of MSDs than occupations that require less physical effort. Based on European Working Conditions Survey data, 47% of employees working in the human health and social work activities experience back pain, while 46% experienced upper limb pain in the past 12 months (OSHA-EU, 2019[9]). Furthermore, findings from Danish Working Environment and Health study from 2018 showed that 37% of nurses and 46% of social and health care assistants experienced musculoskeletal pain on weekly frequency, compared to 32.5% of employees from general working population (National Research Centre for the Working Environment, 2018[12]).

Mental Health

Poor mental health in the health and social care industry has been well documented. Heavy workloads, long shifts, a fast pace, lack of physical or psychological safety, chronicity of care, moral conflicts, perceived job insecurity, workplace conflicts, and lack of social support, are risk factors that add to the mental hardships experienced by health and social care professionals (Søvold et al., 2021[13]). The workers from the health and social sector are particularly affected by poor mental health. For instance, in the United Kingdom, the rates of poor mental health in the health care industry is a third higher than the average rates across all industries (de Bienassis, Slawomirski and Klazinga, 2021[14]).

Prior to the COVID-19 pandemic, across OECD countries, on average almost half (46%) of long-term care workers were exposed to mental health risks, including severe time pressure or overload of work, violence or threat of violence, harassment or bullying (OECD, 2020[11]). Furthermore, risk of psychiatric illness among physicians were high, with suicide rates reported to being 5-7 times that of the general population (Ventriglio, Watson and Bhugra, 2020[15]).

During the COVID-19 pandemic, many of the existing mental health concerns among health and social care workers became exacerbated from the intensification of the risks caused by the unprecedented demand put on the health systems. During the first wave, the limited availability of protective equipment and high risk of infection for medical workers added to the mental distress provoked by the pandemic. In fact, evidence from a systematic review covering health care workers from 21 countries identified high prevalence of moderate depression (21.7%), anxiety (22.1%) and post-traumatic stress disorder (21.5%) among health care workers during the pandemic (Li et al., 2021[16]). In 2020, 58% of the respondents of a US physicians survey reported feeling burned out, showing an increase of 12 percentage points as compared to 2018 (40%) (The Physicians Foundation, 2020[17]). The same study highlights that 18% of physicians have increased their use of medications, alcohol or illicit drugs as a result of COVID-19's effects on their practice or employment situation, raising concerns about risks of substance use. A Canadian study found that frontline workers were more likely than others to report suicide ideation since the COVID-19 pandemic began (Liu, Capaldi and Dopko, 2021[18]).

Note: More details can be found in the discussion paper by OSHA-EU: Musculoskeletal disorders in health care sector.

Source: European Agency for Health and Safety (2020[19]).

Well-being of employees is interrelated with work conditions, including job quality, and mental health. There is a clear relationship between workplace stressors (e.g. high job demands, long working hours, low job control, job insecurity) and mental health. High work intensity coupled with limited control over one's work, poor work-life balance and weak support from co-workers and management, deteriorate workers' health and well-being (Saint-Martin, Inanc and Prinz, 2018[1]). Workplace stressors are shown to increase the odds of reporting poor physical health or having a physician-diagnosed illness (Goh et al., 2015[20]). Conversely, workers who experience high job satisfaction as well as feeling engaged by their work, also report experiencing less anxiety and stress, and connect it to better mental health. For instance, in a US study, employees who perceived their work as both meaningful and satisfying, reported less anxiety and stress (Allan et al., 2016[21]).

Employee health and well-being is thus significantly associated with safe work environment, work conditions and more generally the nature of work. Beyond work environment, employee health and well-being are also affected by lifestyle habits that individuals carry in their daily life, inside and outside workplaces, and that are key risk factors for chronic diseases such as diabetes, cancer, cardiovascular diseases. The next section explores these risk factors in the working-age population.

2.3. What is the share of people exposed to risk factors for chronic diseases in the working-age population?

Lifestyle behaviours and working conditions are key determinants of health in the working-age population. Main drivers of non-communicable diseases (NCDs), including comorbidities,[1] are population ageing and unhealthy lifestyles such as unhealthy diet, physical inactivity, sedentary behaviours, smoking, and harmful alcohol use. The Global Burden of Diseases data show that **smoking, poor diets, harmful alcohol use and physical inactivity are responsible for 76% of all deaths** occurring between ages 20 and 64 in OECD countries in 2019 (IHME, 2020[22]). In particular, smoking and poor diets account for 53% of that burden. In the work-health nexus, occupational risks exposure (e.g. chemicals, heavy load carriage, work stress and strain) is another main health determinant to consider. For instance, long working hours and workplace exposure to air pollution are responsible for, respectively, 750 000 and 450 000 deaths worldwide (WHO and ILO, 2021[4]). The rest of this section examines population exposures to four main risk factors for NCDs (overweight and obesity, smoking, harmful alcohol use and level of stress) in OECD countries. Table 2.1 summarises this data and classifies countries by level of risk exposures. The first three indicators include the overall adult population (because the data on working-age population was not available), while the indicator on level of stress focusses on full-time employees.

Table 2.1. Heatmap for lifestyle risk factors

	Proportion of overweight and obesity, 2019 (or nearest year)	Proportion of smoker, 2019 (or nearest year)	Proportion of heavy episodic drinking, 2016 (or nearest year)	Proportion of full-time employees reporting stress, 2017-19
Australia	65.2	11.2	36.0	41.3
Austria*	51.1	20.6	33.2	41.7
Belgium	55.4	15.4	32.2	43.3
Canada	59.8	10.3	21.2	50.3
Chile	74.2	24.5	21.6	42.0
Colombia			15.3	40.0
Costa Rica		4.2	13.9	47.7
Czech Republic*	58.4	18.1	42.1	31.5
Denmark*	51.0	16.9	29.8	19.0
Estonia	51.3	17.9	41.8	18.7
Finland	67.6	13.0	28.3	40.0
France	49.0	24.0	31.2	47.0
Germany	60.0	18.8	34.2	46.7
Greece*	57.2	24.9	23.6	63.3
Hungary	67.6	24.9	33.5	38.3
Iceland*	65.4	8.2	28.0	37.5
Ireland	61.0	14.0	37.8	51.0
Israel	50.9	16.4	17.1	36.7
Italy*	46.4	18.6	22.1	58.0
Japan	27.2	16.7	22.8	45.0
Korea	33.7	16.4	30.5	40.0
Latvia	58.7	22.6	44.3	27.3
Lithuania*	55.0	18.9	49.3	33.0
Luxembourg*	48.4	16.8	48.4	48.0
Mexico	75.2	7.6	18.1	43.0
Netherlands*	48.4	15.4	27.5	30.3
New Zealand	65.1	12.5	32.0	36.7
Norway*	48.0	9.0	32.0	41.3
OECD	56.4	16.5	29.7	41.5
Poland*	53.3	17.1	35.1	24.7
Portugal	67.6	14.2	26.6	47.7
Slovak Republic*	57.7	21.0	36.2	48.0
Slovenia*	56.5	17.4	37.5	34.7
Spain*	50.2	19.8	25.6	46.0
Sweden*	49.1	10.4	28.0	38.3
Switzerland*	41.8	19.1	35.6	38.0
Türkiye	64.4	28.0	1.5	60.3
United Kingdom	64.2	15.8	29.8	43.3
United States	73.1	10.9	26.1	57.7

Note: * Measured overweight and obesity, rather than self-reported. Countries are grouped by the level of risk exposure (light blue for lower risk levels, and dark blue for higher risk levels). Heavy episodic drinking is defined as at least 60 grammes or more of pure alcohol on one occasion.
Source: OECD Health Statistics 2021 for obesity/overweight and smoking; (OECD, 2021[23]) for heavy episodic drinking; (Gallup Analytics, 2021[24]) for level of stress.

StatLink https://stat.link/2vembh

More than half of the adult population (56%) was living with overweight or obesity on average across OECD countries, in 2019. This proportion varies from 27% in Japan to 75% in Mexico (Table 2.1); with in general, men displaying higher rates than women (OECD, 2021[25]). Individuals with lower incomes were two to three times more likely to live with overweight or obesity than those with higher incomes, especially among women (OECD, 2019[26]). Overweight and obesity are major risk factors for NCDs including diabetes, CVDs and certain cancers. Overweight-related diseases are expected to cause life expectancy to be 2.7 years shorter, than it otherwise would be, on average in OECD countries over the next 30 years (OECD, 2019[26]). Poor diet – such as high consumption of sugar, fat and salt- accompanied with lack of physical activity and sedentary lifestyles have contributed to growing obesity rates. Overweight and obesity rates have been increasing over the last decades, making overweight a top public health challenge. Over the next 30 years, overweight and obesity will be responsible for 70% of all treatment cost for diabetes, 23% of treatment costs for CVDs and 9% of cancers, on average per year. In total, OECD countries will spend 8.4% of their health budget to provide treatment for overweight-related NCDs (OECD, 2019[26]).

One in six adults smoke in OECD countries. In the majority of countries, smokers can smoke at the workplace. Eighteen OECD countries do not have national ban on smoking in indoor offices, while 6 countries have designated smoking rooms allowed under legislation and 14 countries have a national ban (WHO, 2020[27]). Smoking is a leading cause of multiple diseases such as cancers, CVDs, respiratory diseases, and premature mortality. Yet, 16.5% of people aged 15 or over smoked daily across OECD countries in 2019 (Table 2.1). Smoking rates are not spread evenly in the population. In general, men smoke more than women (OECD, 2021[25]). And, individuals with lower education smoke more than individuals with higher education, with an 8-percentage point difference on average across OECD countries in 2017 (OECD, 2019[28]). Smoking-related diseases incur medical expenditure and lost productivity cost. The total economic cost of smoking is estimated at USD PPP 1 852 billion in 2012, which corresponds to 1.8% of the world's annual Growth Domestic Product (GDP). In high-incomes countries, this is estimated at 2.2% of GDP (Goodchild, Nargis and Tursan D'espaignet, 2016[29]).

Nearly one in three adults report heavy episodic drinking in OECD countries. In 2016, 30% of adults in OECD countries engaged in heavy episodic drinking at least once within a month – that is drinking at least 60 grammes of pure alcohol per drinking occasion, or the equivalent of more than 80% of a bottle of wine or 1.5 litres of beer per occasion (Table 2.1). Men have higher rates of heavy episodic drinking than women in all countries (OECD, 2021[23]). Individuals with higher incomes tend to consume more than those with lower incomes, this association being especially strong among women. However, the disparities in alcohol-related harms are to the disadvantage of people with lower socio-economic status. In some countries, alcohol consumption is part of the workplace socialisation mechanism (Pidd et al., 2006[30]). After-work drinking may be seen by some as a mean to socialise with colleagues, potentially increasing opportunities for professional contacts, networking, work responsibilities and promotion. While some studies supported that moderate drinking was associated with higher earnings (MacDonald and Shields, 2001[31]; Peters, 2004[32]; Lee, 2003[33]; Hamilton et al., 1997[34]), more recent studies suggest this association would be an artefact (Lye and Hirschberg, 2010[35]). Women who are increasingly represented at higher socio-economic positions, tend to drink as much as men. This is also reflected in drinking disparities: in OECD countries, women with higher education are 60% more likely to drink weekly than women with lower education, while this link is weaker in men (OECD, 2021[23]). Harmful alcohol use is responsible for heart diseases and strokes, liver cirrhosis, certain cancers, injuries -such as road traffic crashes-, and foetal alcohol syndrome. Over the next 30 years, harmful alcohol use will be annually responsible for 87% of all treatment cost for alcohol dependence, 35% of treatment costs for cirrhosis and a significant share of treatment costs for injuries, cancers and other diseases. In total, about 2.4% of annual health expenditure will be devoted to treating alcohol-related diseases in OECD countries (OECD, 2021[23]).

Two in five full-time employees report stress in OECD countries. Occupational psychosocial risks and stress are leading factors for mental health conditions as well as CVDs and MSDs. Long working hours

(over 55 hours per week) are associated with a 17% higher risk of death from heart diseases (Li et al., 2020[36]). Across OECD, about 10% of employees usually work 50 hours or more per week (OECD, 2020[37]). Long-term stress increases the risk of mental health problems such as anxiety and depression, substance use problems, sleep problems, pain, physical tension, and heart diseases. Two in five full-time employees (42%) in OECD countries reported being stressed[2] in 2017-19 (Gallup Analytics, 2021[24]), with variation from less than 20% in Estonia and Denmark to more than 60% in Türkiye and Greece (Table 2.1).

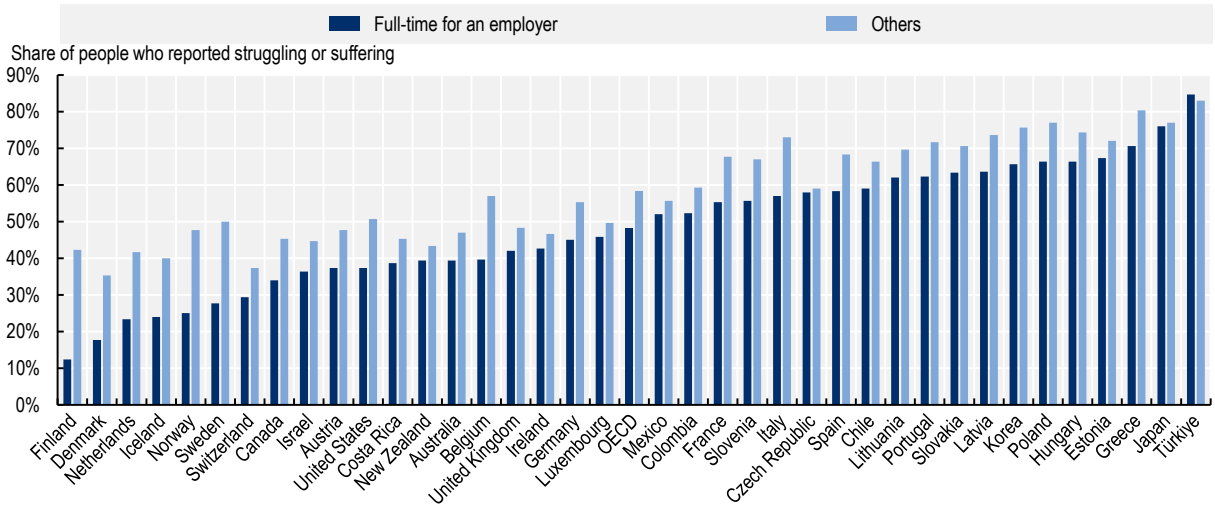
2.4. What is the share of people experiencing physical or mental health conditions in the working-age population?

In the world of work, the two most predominant conditions reported by workers are MSDs and mental health conditions. For instance, when interviewed about their most serious work-related conditions, workers in the EU were most likely to report MSDs and mental health conditions (European Agency for Safety and Health at Work, 2021[38]).

MSDs are highly prevalent in the population of working age. MSDs are injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs. Work-related MSDs include, for instance, back pain, diseases of the neck, upper and lower limbs. The labour market and working conditions have evolved, in particular toward more digitalisation and faster and more complex work, which has led to more repetitive tasks and more work in prolonged static positions, for instance while sitting at an unadjusted workstation or in a home office (European Agency for Safety and Health at Work, 2021[38]). Occupational ergonomic stressors such as repetitive motions, forceful extensions, non-neutral postures and vibrations from tools are risk factors for MSDs. In the European Health Interview Survey (EHIS) 2019, the interviewees were asked to report chronic diseases they had over the past 12 months. MSDs were the most commonly cited. Precisely, among those aged 15-64, 43% reported low back disorders, neck disorders or arthrosis, in 2019 (Eurostat, 2022[39]).

Poor mental well-being affects close to half the working population. Mental health conditions are estimated to affect around one in five people at any given time (Steel et al., 2014[40]), and an even greater proportion of individuals – including among workers – report high levels of mental distress. In EU countries, nearly half (45%) of the employed people reported facing risk factors for their mental well-being at work (Eurostat, 2021[41]). The risk factors for mental well-being at work that were commonly cited, were time pressure, work overload, dealing with difficult customers, patients, pupils and job insecurity (Box 2.1). About the same proportion (48%) of the full-time employed workers declared suffering or struggling with life, in OECD countries (Figure 2.2). This varies widely across countries, from less than 20% in Finland and Denmark, to more than 70% in Greece, Japan and Türkiye. This proportion is 58% among people that are not in full-time employment. The COVID-19 crisis has further intensified the mental distress that many workers face and further deepened the challenges facing individuals with mental health conditions. Across all OECD countries where data were available, population mental health – captured by prevalence of symptoms of anxiety and depression – deteriorated at the onset of the COVID-19 crisis (OECD, 2021[42]; OECD, 2021[43]). Although trends in mental health differ across countries and surveys, a survey by Eurofound has found that the mental well-being of employees was lower in spring 2021 than in both spring and summer 2020 (Eurofound, 2021[44]). In Canada, the proportion of adults with symptoms of depression, anxiety or posttraumatic stress disorder, raised from 21% to 25% between fall 2020 and spring 2021 (Statistics Canada, 2021[45]).

Figure 2.2. Share of workers suffering or struggling with life



Note: The 'others' category includes all other categories of people (e.g. part-time employed, self-employed, unemployed, out of the workforce).
Source: Gallup analytics, average of 2017-19. (Gallup Analytics, 2021[24]).

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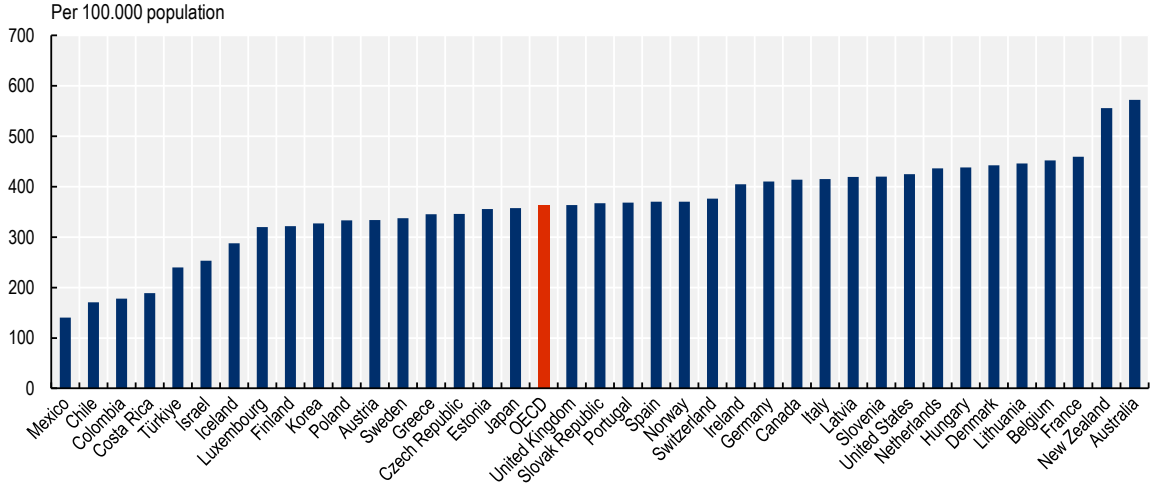
Cancer is another prevalent health condition in the working-age population. Cancer is a leading cause of mortality, accounting for a quarter of all deaths in OECD countries in 2017. Common cancers are lung cancer, colorectal cancer, breast cancer and prostate cancer. These four represent more than 40% of all cancers diagnosed in OECD countries (OECD, 2019[28]). Among people of working age (20-64), the incidence rate of all types of cancers varies from 140 per 100 000 in Mexico to over 500 per 100 000 in New Zealand and Australia, with an average across OECD countries around 362 per 100 000 population (Figure 2.3). This corresponds to more than 3.2 million new cancer cases[3] diagnosed every year in the population of working age in OECD countries. Earlier diagnosis and treatment significantly increases cancer survival rates. For example, Australia and New Zealand which have the highest rates of cancer incidence, have below average mortality rates, and above average five-year net survival (OECD, 2019[28]).

Figure 2.3. Incidence of all types of cancer, people aged 20-64, 2020



Note: Crude rate.
Source: (IARC, 2022[46]).

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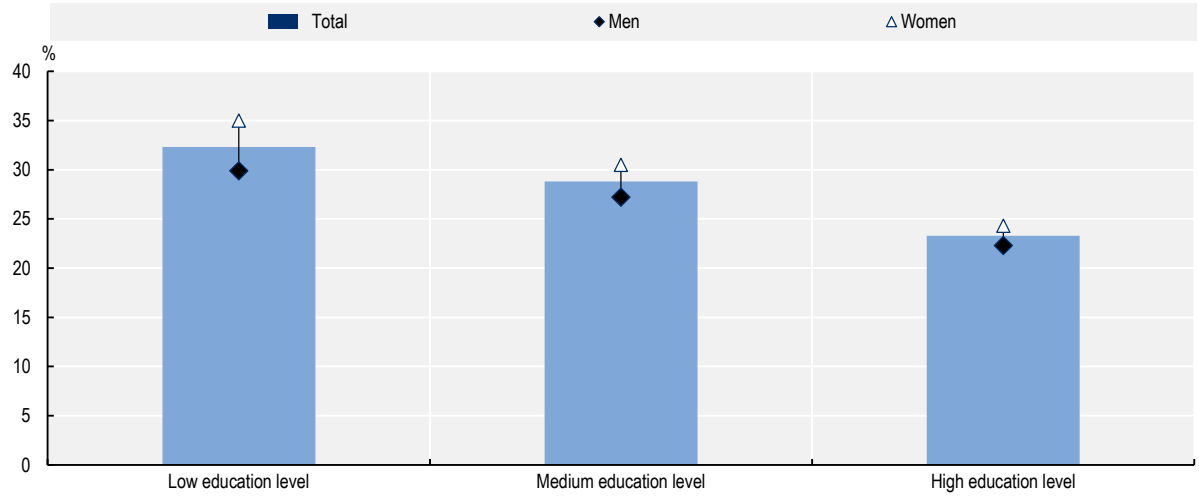
Beyond MSDs, mental health conditions and cancers, other chronic diseases and conditions affect people of working age. In the EHIS 2019 survey, when asked about their chronic diseases, people of working age reported -beyond MSDs- high blood pressure (13% of those aged 15-64), high blood lipids (9%), respiratory diseases (8%) and diabetes (4%) (Eurostat, 2022[39]). The presence of multiple chronic diseases is common, and increasing with age. Almost one in four people of working age (24%) lived with two or more chronic conditions across OECD countries in 2014 (OECD, 2019[28]).

Women and individuals with lower education level tend to report more chronic diseases. Health conditions are unevenly spread across genders and education levels. Among people of working age, in EU countries, women reported more often than men having a long-standing illness or health problem. The gender gap was 3 percentage points (29% of working-age women versus 26% of working-age men) in 2020 (Eurostat, 2022[39]). There are also important social inequalities in health. People with lower education were 39% more likely to report a long-standing illness or health problem than those with higher education (32% of those with primary level of education versus 23% of those with tertiary education) (Figure 2.4). Both men and women display similar patterns of social inequalities in health. Such social inequalities in health are also found in OECD non-EU countries. For instance, in the United States, in a sample of 30-64 years-olds, people with less than bachelor's degree have greater multimorbidity than those with bachelor's degree or higher (Johnson-Lawrence, Zajacova and Sneed, 2017[47]). In Canada, nearly 18% of adults with less than high school education reported being diagnosed with at least two chronic diseases, compared to 7% of those with post-secondary graduate education, in 2019 (Public Health Agency of Canada, 2021[48]).

Figure 2.4. Share of people having a long-standing illness or health problem, by education level, people aged 16-64, EU countries, 2020



Note: Low education level refers to "Less than primary, primary and lower secondary education (levels 0-2)"; Medium educational level "Upper secondary and post-secondary non-tertiary education (Levels 3 and 4)"; and High education level "Tertiary education (Levels 5-8)".
Source: (Eurostat, 2022[39]) based on the European Union Statistics on Income and Living Conditions survey 2020.

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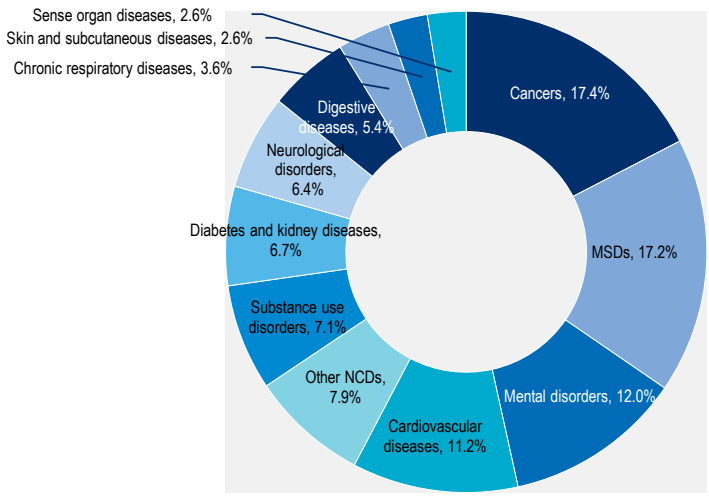
Public budget spent on treating NCDs is large. An analysis based on the OECD SPHeP-NCD model estimated the treatment cost for NCDs among people of working age (Annex 2.A). In total across 38 OECD countries, USD PPP[4] 562 billion are spent annually on treating NCDs in people aged 20-64 years, which is similar to the GDP of Sweden.

2.5. What is the burden of disability from chronic diseases in the working-age population?

The burden of disability affects as much the working-age people as older people. People living with one or multiple chronic diseases are likely to develop impairments as the diseases progress, which may limit their participation in social activities and work, alter their quality of life and prevent them from fully enjoying their lives. The burden of disease borne by individuals is measured using the disability-adjusted life years (DALYs), a measure taking into account both premature mortality and quality of life. It is estimated that 339 million disability-adjusted life years[5] (DALYs) are lost every year because of chronic conditions in OECD countries, this represents 85% of the total burden of any diseases in OECD countries. **Nearly half of the disability burden (47.4%) occurs in ages 20-64**, while another 47.4% is concentrated in ages 65 and above, and 5.2% in ages under 20 (IHME, 2020[22]). While workers are projected to work longer and the workforce is ageing, the burden of NCDs-related disability is a key challenge for the world of work and for societies more in general.

The burden of disability from chronic conditions in people of working age is caused primarily by cancers, MSDs and mental health conditions. The Global Burden of Diseases data show that in 2019, across OECD countries, the top-three leading disability causes in people aged 20-64 were cancers, MSDs, and mental health conditions, followed by CVDs, substance use disorders, and diabetes and kidney diseases (Figure 2.5). Cancers and MSDs account respectively for 17.4% and 17.2% of the burden of NCDs-related disability in the age group 20-64, while mental conditions and CVDs account respectively for 12.0% and 11.2%. Other groups of chronic diseases cause between 2% and 8% of the burden. Cancers rank as the top leading cause of disability. Compared to MSDs and mental health conditions – that were often reported in working-age people (Section 2.2) – cancers can cause premature mortality and heavily weigh on years lived with disability.

Figure 2.5. The burden of disability by NCD group, ages 20-64, OECD countries, 2019



Source: (IHME, 2020[22]).

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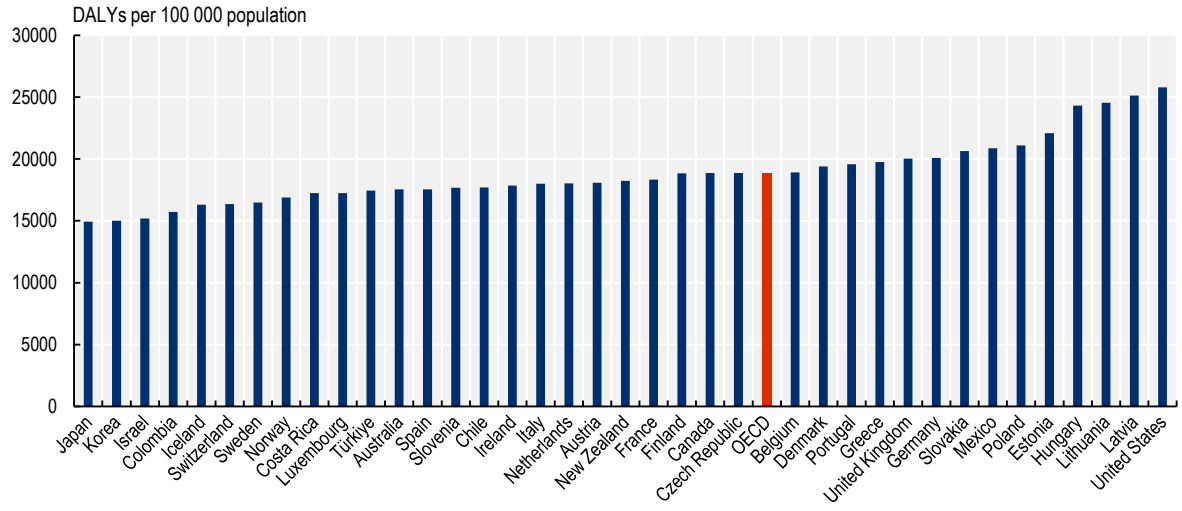
Nearly 19 000 life years in good health per 100 000 population are lost due to chronic conditions every year in the OECD population aged 20-64. The burden of NCDs-related disability in the population aged 20-64 is measured at 18 860 DALYs per 100 000 population on average across OECD countries in 2019. About 60% of this burden is attributable to years lived with disability while 40% is attributable to years of life lost. In other words, 60% of this burden is caused by lower quality of life due to diseases, while 40% is caused by premature deaths. This estimate varies widely across OECD countries. The largest rates are found in the United States, Latvia, Lithuania and Hungary with more than 24 000 DALYs per 100 000 population, while Japan and Korea have lower rates (with 15 000 or less per 100 000 population) (Figure 2.6).

Figure 2.6. The burden of NCDs-related disability in ages 20-64, by country, 2019



Source: (IHME, 2020[22]).

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Long COVID-19 symptoms that last weeks after the infection has gone can cause long-lasting impacts on the health of workers. Although the burden of COVID-19 is outside the scope of this report, post-COVID syndrome or long COVID can have long-lasting impacts on the health of workers. These long-term symptoms include fatigue, breathlessness, chest pain or anxiety, which can result in extended absence from work and an increased risk of exit from the labour market altogether (Box 2.3). Long COVID-19 symptoms affect about 10% of people infected by the coronavirus. While the full scope of the labour market impacts of long COVID remain unclear, given the large number of workers potentially affected, it is an emerging issue in workplace health.

Box 2.3. Long COVID-19 and its consequences

Long COVID-19 is characterised by a range of symptoms – including fatigue, breathlessness, chest pain or anxiety – that can last weeks after first being infected with COVID-19. People affected by long COVID have more difficulties returning to normal life, with potential long-lasting social and work consequences.

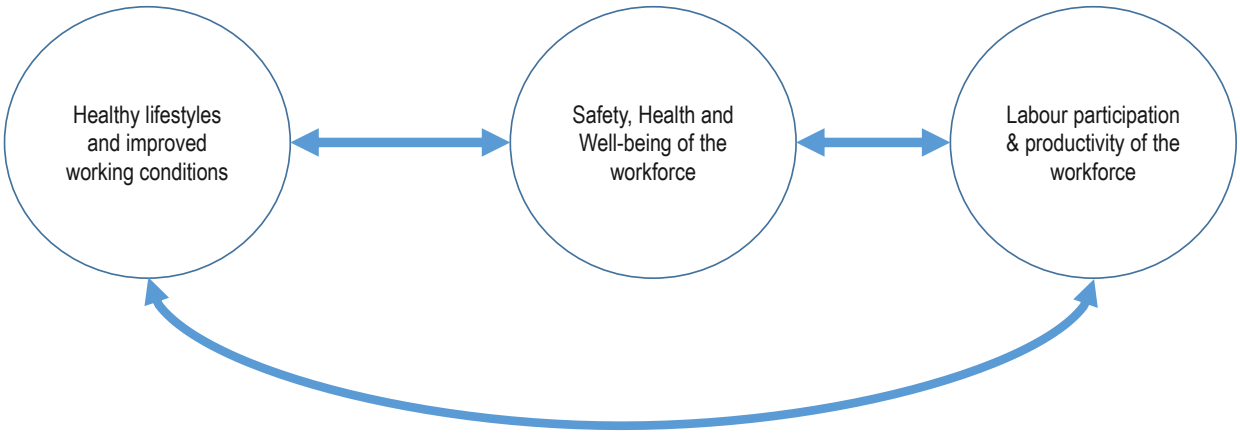
The prevalence of long COVID cases differs widely across studies depending on study design, populations analysed and other factors (OECD, 2021[25]). A study that summarises results from Europe, the United States and China, concluded that around one-quarter of people with COVID-19 have continuing symptoms 4-5 weeks after testing positive, and about one in ten experience symptoms after 12 weeks (Rajan et al., 2021[49]). At the population level, 2% of the population in the United Kingdom (1.3 million people) self-reported long COVID as of December 2021 (Office for National Statistics, 2022[50]). Long COVID-19 symptoms are more often associated with age, being female, overweight, prior hospitalisation for COVID-19, and a number of symptoms in the acute phase (OECD, 2021[25]). A recent UK study identified that the prevalence of self-reported long COVID was greatest in people aged 35 to 69 years, females, people living in more deprived areas, those working in health care, social care, or teaching and education, and those with another activity-limiting health condition or disability (Office for National Statistics, 2022[50]).

Long-COVID can have consequences on employment and labour productivity, for instance on sickness absence and time to return to work. Evidence from France suggests that 31% of people previously employed did not return to work 3-4 months after COVID-19 hospital admission (Garrigues et al., 2020[51]). A US study found that 23% of those previously working could not return to their job for health reasons 60 days after hospital discharge. Among those who returned to work, 26% either worked reduced hours or had modified duties for health reasons (Chopra et al., 2020[52]). A Danish study found that patients with COVID-19 have a lower chance of returning to work 3 months after positive test, with the lowest chance in patients admitted to an intensive care unit department (Jacobsen et al., 2022[53]).

2.6. What are the effects of unhealthy lifestyles, poor health and poor well-being on workforce participation and productivity?

This section examines the effects of unhealthy lifestyles, poor health and poor well-being on labour participation and productivity of the workforce,[6] and reports the related indirect cost. The framework for this analysis considers that occupational and lifestyle risk factors are main drivers for chronic diseases, which in turn affect workforce participation and productivity. There is also potentially a direct (bi-directional) relationship between risk factors and workforce participation and productivity (Figure 2.7). The health conditions studied here have multifactorial components, including individual modifiable lifestyles, social determinants, and environmental and occupational exposures, which can all interrelate, delivering a complex picture with multiple layers.

Figure 2.7. Health, well-being and work are interrelated



Source: Authors.

People living with at least one NCD are less likely to be employed than those with no such condition, and are less productive at work, due to increased sickness absenteeism and presenteeism (Box 2.4). In particular, while employed, individuals living with a least one chronic disease, have nearly 3 additional days of missed work per year, and those with at least two chronic diseases have 7 additional missed days, across European countries (Feigl et al., 2019[54]). The risk of discrimination against workers with NCDs cannot be overlooked. Negative labour market effects of unhealthy lifestyles and NCDs may reflect a true effect of unhealthy lifestyles and related health conditions on disabilities and work, or discrimination and stigmatisation towards people with unhealthy lifestyles and NCDs (see section 2.6.2), or both.

2.6.1. Summary of findings

Table 2.2 presents a summary of the associations between lifestyle risk factors and NCDs on the one hand, and labour market outcomes on the other. Labour market outcomes are measured along three dimensions: employment, absenteeism, and presenteeism. The labour market outcomes of NCDs are specific to disease characteristics (e.g. type and phase of the disease, complication), and thus, the review of the associations between NCDs and labour market outcomes is presented by disease. A great number of NCDs and related risk factors such as substance use disorders,[7] lifestyle behaviours related to diet, sedentary behaviour, physical activity and sleep are likely correlated with labour market outcomes. However, the review presented here mainly focusses on five major NCDs (diabetes, cancer, CVDs, mental health conditions and MSDs), and three key behavioural risk factors (obesity, smoking, and harmful alcohol consumption), while updating a previous OECD work (Devaux and Sassi, 2015[55]). In most cases, the causal link cannot be asserted, although a few studies suggest evidence for a causal relationship as indicated in the table below. Other factors, such as age, gender, level of health literacy, can alter the association between labour and diseases.

Box 2.4. Measuring presenteeism

Measuring the loss of individual productivity due to presenteeism is a difficult task, unlike absence related productivity loss, there are no compensation claims from absences that may be recorded. Primarily, loss of productivity due to presenteeism is estimated based on self-reported data collected from employees, these measurements rely on personal perceptions and ability to recollect the levels of effort and engagement in the workplace over a particular period of time (Johnston et al., 2019[56]). Additional difficulty is presented by the variety of measurements collected across different countries (Knies et al., 2012[57]). The two most commonly cited presenteeism measures are the Stanford Presenteeism Scale (SPS-6) and WHO's Health and Work Performance Questionnaire (HPQ).

- **Stanford Presenteeism Survey** (SPS-6): This is a self-reported tool, which includes six items of 5-point scales with responses ranging from: strongly disagree to strongly agree options. The questionnaire originally includes the wording "health problem", which can be changed to any health condition (depression/anxiety, musculoskeletal pain, cardiovascular conditions etc.) (Garrow, 2016[58]). In addition, countries are able to adapt the questionnaire to their cultural needs and translate it easily to any language (Hutting et al., 2013[59]).
- **WHO's Health and Work Performance Questionnaire** (HPQ): This is also a self-reported tool which aims to obtain three types of information: screening information about the prevalence and treatment of the commonly occurring health problems; information about three types of workplace consequences (sickness absence, presenteeism, and critical incidents); and basic demographic information (Garrow, 2016[58]). HPQ questionnaire is designed to visualise presenteeism as a measure of actual performance in relation to potential performance. Additionally, HPQ responses in conjunction of master database for HPQ allows advanced statistical imputation for more complex estimates of presenteeism. Finally, this tool includes memory-priming questions for improved accuracy and imputation and consistency checks for question that are left unanswered (Garrow, 2016[58]).

Cross-country comparisons in the level of presenteeism are scarce due to the lack of uniform measures used throughout the world. However, two European surveys can be cited: the 2010 Eurobarometer survey measured the proportion of workers who were not absent *in the past four weeks* but who accomplished less than they would like as a result of an emotional or physical problem. The average proportion stood at 35% (OECD, 2012[60]). The 2015 Eurofound's European Working Conditions Survey measured the proportion of people who have worked while they were sick *over past 12 months*. The average proportion was 42% across OECD European countries (Eurofound, 2016[61]). In addition, a report for the US Chamber of Commerce examines the cost of absenteeism and presenteeism due to NCDs across 18 countries, and shows that the productivity losses amount to 3.5% to 5.5% of GDP (Rasmussen, Sweeny and Sheehan, 2016[62]).

Presenteeism and absenteeism are related, although it is difficult to define the nature of the relationship for at least two reasons. First, the relationship between both phenomena varies across health conditions (Goetzel et al., 2004[63]), and across countries. In particular, a study of the economic impacts due to NCDs found that the costs arising from presenteeism are two to three times higher than that from absenteeism. More precisely, the costs from presenteeism were twice higher in Colombia, and up to three times higher in Japan (Rasmussen, Sweeny and Sheehan, 2016[62]). Second, while evidence suggests that both phenomena substitute each other (Caverley, Barton Cunningham and MacGregor, 2007[64]), other studies finds that they are complementary, as workers who use presenteeism behaviours also demonstrate absenteeism behaviours at the same time (Gosselin, Lemyre and Corneil, 2013[65]). Hence, it appears important to monitor both presenteeism and absenteeism behaviours. Evolutions in presenteeism have to be interpreted in the light of that of absenteeism, and vice-versa. For instance, increases in absenteeism may not be a poor outcome if there are accompanied with reductions in presenteeism.

Table 2.2. Summary of the associations between lifestyle risk factors, NCDs and labour market outcomes

	Employment	Absenteeism	Presenteeism
Obesity	People with obesity are less likely to be employed as compared to individuals with healthy weight. (Campbell et al., 2021[66])	Higher BMI increases risk of sickness and disability by 8% per 1 kg/m2 BMI increase (Campbell et al., 2021[66]). **(causal**) Women with obesity are 68% more likely to miss work than women with healthy weight, this effect is non significant among men (Destri et al., 2021[67])	Presenteeism was found to be more prevalent among workers with obesity and overweight as compared to their those with healthy weight (Keramat et al., 2020[68])).
Smoking	Smokers who are seeking reemployment, 27% were re-employed a year after job loss, compared to 56% of non-smokers (Prochaska et al., 2016[69]).	Current smokers in the US have 28% more absenteeism than former smokers; in five European countries, the difference is 18% while it is 61% in China (Baker et al., 2017[70]).	Current smokers have 28%, 18% and 16% more presenteeism than former smokers, respectively in the US, five European countries and China (Baker et al., 2017[70]).
Alcohol	Problem drinking reduces employment (MacDonald and Shields, 2004[71]) and is linked to job loss (Airagnes et al., 2019[72])	Former drinkers and heavy drinkers work annually 1-1.5 month less over the 20-year observation period, compared with moderate drinkers (Böckerman, Hyytinen and Maczulskij, 2017[73]).	A large body of evidence exists in support of alcohol-related presenteeism, but that this is weakened by low research quality and a lack of longitudinal designs (Magnus Thørrisen et al., 2019[74])
Diabetes	Lower probability of employment (Devaux and Sassi, 2015[55]); and longer period of unemployment (Rodríguez-Sánchez and Cantarero-Prieto, 2017[75]).	2-10 more days of sickness absences (**causal**) (Breton et al., 2013[76]).	Less workhour productivity when diabetic with symptoms: Individuals with diabetes and neuropathic symptoms are found to be 18% more likely to lose more than 2 hours of work per week due to illness when compared to their non-diabetic counterparts (**causal**) (Breton et al., 2013[76]) (Mori et al., 2020[77]).
Cancer	Lung cancer survivors are 61% more likely to be unemployed (Vayr et al., 2019[78]).	Cancer survivors take 12 times more sick leave in the first year post-diagnosis than healthy workers, with sick leaving remaining still higher than the healthy average worker in the subsequent years (Sjövall et al., 2012[79])	Cancer patients and cancer survivors are more likely to experience presenteeism than controls, due to chronic symptoms associated cancer with treatment (Soejima and Kamibeppu, 2016[80]).
Cardiovascular diseases (CVD)	Workers with CVD were 2.5 times more likely to leave employment due to disability, 1.3 times more likely to take early retirement (Kouwenhoven-Pasmooij et al., 2016[81]).	CVD workers missed 92 days compared to 11 days missed by non-CVD workers (Calvo-Bonacho et al., 2014[82]).	The productivity loss among workers with CVD is twice higher from presenteeism than from absenteeism (Gordois et al., 2016[83]).
Mental health conditions	60% of people with moderate mental health conditions are employed compared to 70% of those with no mental distress (OECD, 2021[84]).	Employees living with mental health conditions are more likely to be absent compared to those without mental health conditions; 12 additional days of sickness absence per year (OECD, 2021[84])).	The productivity loss among workers with a mental health conditions is partially attributable to presenteeism. It is not clear if the impact of mental health conditions on presenteeism outweighs the impacts on absenteeism, and this may differ across countries (OECD, 2012[60]).
MSDs	Workers with MSD are less likely to be in fulltime employment (Summers, Jinnett and Bevan, 2015[85]); Working-age men/women with arthritis are 20%/25% less likely than their counterparts without arthritis to be economically active (Lubeck, 2003[86]).	The number of days missed peaked at 147 days per year in the group diagnosed with rheumatoid arthritis, compared to 59 days in the general population (Neovius, Simard and Askling, 2011[87]).	For the workers who experience clinically meaningful back pain, almost 80% of them also report productivity loss due to presenteeism, with 4.4 hours missed per worker over a two-week period (Dall et al., 2013[88]).

Source: Authors.

2.6.2. Obesity

Obesity is clearly related to reduced employment prospects, in particular by increasing the risk of obesity-related diseases. People with obesity are less likely to be employed than those with healthy weight (Devaux and Sassi, 2015[55]; Campbell et al., 2021[66]), and they have higher likelihood to exit from paid employment (Robroek et al., 2013[89]). The employment status of people with overweight and obesity is often influenced by the negative and discriminatory views of employers, as individuals with excess weight are erroneously attributed as being less productive (Rooth, 2009[90]). Such discrimination results in employers giving lesser opportunities for the same positions to people with obesity and overweight compared to their healthy weight peers, such as discriminatory hiring and sorting into jobs with less customer contact (Averett, 2019[91]). That said, obesity appears to exert a causal effect on employment status, largely by affecting an individual's health (diseases) rather than through increased unemployment arising from social discrimination (Campbell et al., 2021[66]).

Obesity negatively affects productivity at work, in particular with greater sickness absence. A study based on the UK Biobank data found that higher BMI causally increases risk of sickness and disability by 8% per 1 kg/m^2 BMI increase (Campbell et al., 2021[66]). People with obesity and overweight have greater sick leave trends compared with those with healthy weight, especially among women. In a large Portuguese population-based prospective study, women with obesity are 68% more likely to miss work than women with healthy weight, with significant increases in likelihood of absenteeism observed in women in both white- and blue-collar professions (82% and 48%, respectively) (Destri et al., 2021[67]). Although similar trends were observed among men (12%), the differences were not significant. Similar outcomes are observed in the presenteeism rates for people living with obesity and overweight (Janssens et al., 2012[92]), however presenteeism is more prevalent among people with obesity than for people with overweight (Keramat et al., 2020[68]). The excess weight put a strain on many daily activities in the workplace, which can lead to limiting certain work-related functions of the employees. A 2019 OECD report estimates that obesity-related diseases reduce employment by about 0.43% annually, and increase sickness-related absenteeism by 0.38% and presenteeism by 0.81% among those who are employed. The associated productivity loss is equivalent to 54 million fewer full-time workers across 52 OECD, EU, G20 countries, which is similar to the number of employed persons in Mexico. Overall, overweight-related diseases make GDP 3.3% lower than it would be if people were not overweight, on average in OECD countries (OECD, 2019[26]).

2.6.3. Smoking

Tobacco smoking has a negative effect on productivity of employees in the workplace through increased absenteeism and presenteeism, while also decreasing a likelihood of re-employment. Smoking is associated with certain personal and societal consequences, which are reflected in the workplace outcomes of an employee. Smoking results in worker's loss of productivity from tobacco-use associated illnesses, frequent smoke breaks, increased accidents during work time, and is a source of higher costs in particular due to higher insurance premiums, increased fires and fire insurance costs, negative effect on non-smokers colleagues, and early retirement (Bunn et al., 2006[93]). Current smokers have more absences per year than non-smokers or former smokers, however the amounts of days missed vary depending on the country, since work-cultures and leave policies differ from one country to another. For instance, in the US, current smokers have 28% more absenteeism than former smokers; in five large European countries,[8] the difference is 18% while it is 61% in China (Baker et al., 2017[70]). Additionally, studies show that smokers who quit smoking, 0-4 years after, experience much lower absenteeism than their pre-cessation outcomes, and these rates become comparable to never-smokers (Baker et al., 2017[70]; Yun et al., 2016[94]).

Workers who smoke are also more likely to take breaks during work, which can result in reduced productivity. This is due to the need by the workers to take more breaks due to dependence on nicotine.

In the US, five European countries and China, current smokers have respectively 28%, 18% and 16% more presenteeism than former smokers (Baker et al., 2017[70]). A Japanese study looking at the presenteeism among workers found that current smokers were 7% more likely to exhibit presenteeism than former smokers, while the difference between former smokers and never-smokers was not significant (Suwa et al., 2017[95]). Smoking cessation has a positive impact on the at-work activity impairment among smokers, through the reduction in presenteeism. Those who quit smoking 0-4 years ago had lower presenteeism, ranging from 9% to 18% across countries, compared to current smokers (Baker et al., 2017[70]).

Smoking is also likely to have an undesirable effect on the ability for smokers to re-enter in employment. In a US study, among individuals who were unemployed and in active search for re-employment, 27% of smokers were re-employed one year after, compared to the 56% of non-smokers (Prochaska et al., 2016[69]). The same study also shows that smokers were more likely to be chronically unemployed, and were reported to have lower income than non-smokers. Contributing factors to the wage gap between smokers and non-smokers are education and inconsistent time preference (Hotchkiss and Pitts, 2013[96]).

2.6.4. Harmful alcohol use

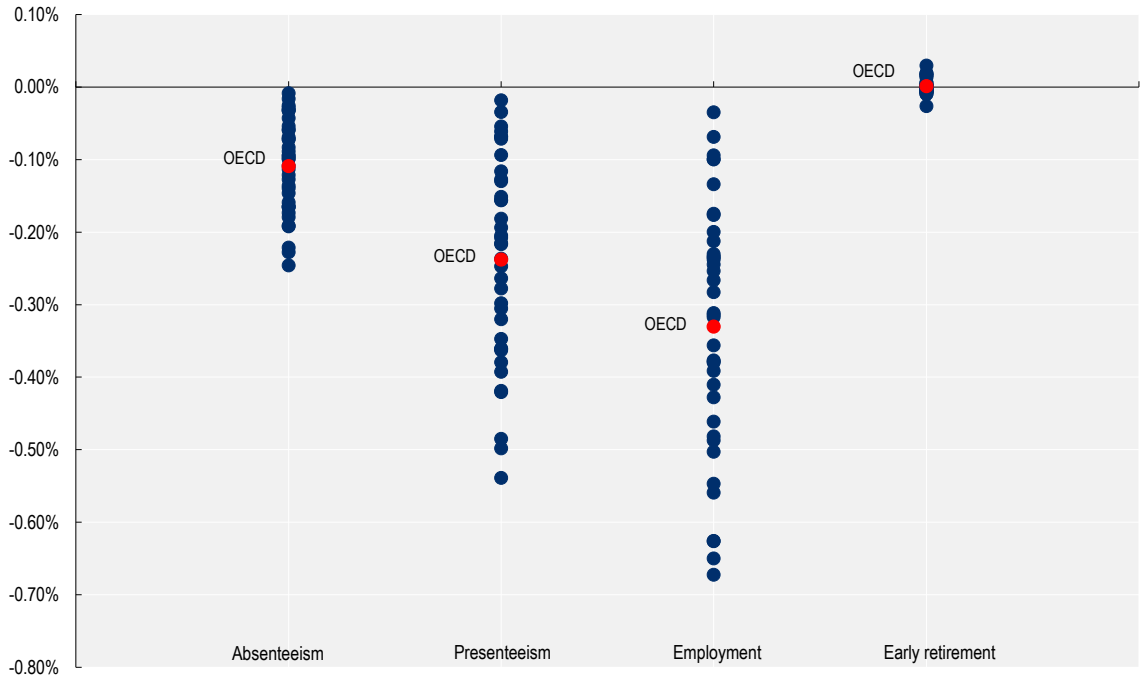
Evidence for direct associations between alcohol use and labour market outcomes has been debated, while a clearer pattern emerges between alcohol-related diseases (e.g. alcohol use disorders) and negative labour market outcomes. As highlighted in (OECD, 2021[23]), the relationship between alcohol consumption and labour market outcomes is complex, because, first, it can be affected in both directions. Second, some cofounders may not be taken into account in studies, and this may hide or make false a relationship between alcohol consumption and labour market outcomes. While some studies found no significant relationship between alcohol abuse[9] and employment (Feng et al., 2001[97]), other research points to some associations. For instance, a study based on English data shows that problem drinking[10] reduces by 7% to 31% the probability of being in employment in both men and women (MacDonald and Shields, 2004[71]). A Norwegian study found that frequent alcohol consumption and problematic alcohol use – defined by physiological and physical symptoms of drinking- were associated with increased risk of unemployment (Kaspersen et al., 2016[98]). A recent French study also found that problematic drinking is associated with job loss (Airagnes et al., 2019[72]). While evidence suggests that heavy drinking and problematic drinking reduce employment, low levels of alcohol consumption can be associated with better labour market outcomes. For instance, in a Swedish study, women with long-term light drinking[11] have better employment opportunities than any other group, including former drinkers, former abstainers, long-term heavy drinkers and abstainers (Jarl and Gerdtham, 2012[99]). Whether this reflects some sort of true causal effect (e.g. occasional drinkers can be more likely to socialise and build stronger networks, which in turn can help improve their employment prospects), or whether light drinking is simply a proxy for good health, remains to be established (OECD, 2021[23]).

Evidence suggests that higher levels of alcohol consumption are associated with more sickness absence and presenteeism. A recent systematic review and meta-analysis shows that heavy drinkers are more likely to have sickness absence than low-risk drinkers[12] (odds ratio= 2.34 [1.17-4.65]) when abstainers are excluded (Hashemi et al., 2022[100]). When abstainers are included, it is important to distinguish people who never drank in life and those who quit drinking, as only former drinking is associated with sickness absence (Kaila-Kangas et al., 2018[101]). A Finnish study found that former drinkers and heavy drinkers work annually 1-1.5 month less over the 20-year observation period, compared with moderate drinkers[13] (Böckerman, Hyytinen and Maczulskij, 2017[73]). Besides, a recent systematic review concludes that a large body of evidence exists in support of alcohol-related presenteeism,[14] but that this is weakened by low research quality and a lack of longitudinal designs (Magnus Thørrisen et al., 2019[74]). A quantitative assessment by the OECD estimates that alcohol-related diseases (e.g. alcohol dependence,

cirrhosis, etc.) reduce employment by about 0.33% annually, and reduce labour force productivity by 0.11% due to sickness-related absences, and by 0.24% due to presenteeism, while the effect on early retirement is generally negligible (Figure 2.8). These effects translate into a reduction in the workforce by the equivalent of 33 million fewer full-time workers, across 52 OECD, EU, G20 countries. At the macroeconomic level, alcohol-related diseases make GDP 1.6% lower than it would be otherwise, on average in OECD countries (OECD, 2021[23]).

Figure 2.8. The impact of diseases caused by alcohol consumption on employment and productivity

Percentage difference in labour market inputs due to diseases caused by alcohol consumption above 1 drink per day for women and 1.5 drinks per day for men, per capita, average 2020-50



Note: Labour market inputs include employment and productivity when employed. They are expressed in the number of full-time equivalent workers and are calculated for the working-age population. OECD analyses based on the OECD SPHeP-NCDs model, which forecast the evolution of NCDs and risk factors and their related costs over the next 30 years.
Source: OECD (2021[23]), *Preventing Harmful Alcohol Use*, https://doi.org/10.1787/6e4b4ffb-en.

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2.6.5. Diabetes

People living with diabetes are less likely to be employed than those with no such condition. A review of evidence from European countries, Australia, Canada, Mexico, and the United States shows that people with diabetes are less likely to be employed, and the more severe the symptoms caused by the disease, the stronger the association (Devaux and Sassi, 2015[55]). Moreover, diabetes is associated with long-term unemployment (Rodríguez-Sánchez and Cantarero-Prieto, 2017[75]).

The relationship between diabetes and lost productivity (absenteeism and presenteeism) is strong, and it intensifies with the complications caused by diabetes and their severity. The more severe the

gravity of diabetic symptoms and its associated complications (dry mouth, polyuria, hypoglycaemia, diabetic painful neuropathy, and mood disorders), the more sick days are taken by employees, and they are less likely to be productive at work. A systematic review revealed that individuals with diabetes have 2 to 10 more days of absence per year than individuals without diabetes, the number of missed days being greater when associated with diabetes related complications (e.g. neuropathy, depression) (Breton et al., 2013[76]). Regarding presenteeism, individuals with diabetes and neuropathic symptoms are found to be 18% more likely to lose more than 2 hours of work per week due to illness when compared to their non-diabetic counterparts. A Japanese study also confirms the presence of more detrimental effects on work performance associated with diabetes complications. Once diabetes is combined with its complications and requires treatment, then presenteeism losses become visibly higher (Mori et al., 2020[77]).

2.6.6. Cancer

Cancer has a negative impact on the employment status both on those living with cancer, as well as recent and long-term survivors. The impact on these labour market outcomes varies depending on the characteristics of cancer diagnosis (i.e. cancer type and stage) as well as the individual's age and gender. A meta-analysis covering a number of OECD countries has found that after diagnosis and treatment, lung cancer survivors were 61% more likely to be unemployed than the general population (Vayr et al., 2019[78]). Cancer patients who undergo chemotherapy or other forms of therapies can develop treatment-induced peripheral neuropathy. These patients also have lower employment rates than those without neuropathy (Blinder and Gany, 2019[102]). Patients that had developed cancer in childhood and are long-term survivors continue experience negative impact on employment. A meta-analysis found that childhood cancer survivors were 1.5 times more likely to be unemployed than controls (Mader, Michel and Roser, 2017[103]).

Absence and presenteeism in the wake of a cancer diagnosis is an anticipated outcome of the disease, with diminishing effects after the five-year survival period. An analysis of Swedish health care and social insurance data has found that cancer patients took more sick leave in the one year following diagnosis compared to those without cancer. Lung cancer patients appear among the most affected, and took on average 12 times more sick days compared to those without cancer in this period, with 63% still on sick leave one year after diagnosis (Sjövall et al., 2012[79]). Sick leave is part of the path for cancer patients and survivors, with clear variability of sick leave depending on the stage, type and treatment regime of the cancer diagnosed. Although survivors diagnosed in the past five years report taking more absence leave than those without a health condition, this trend becomes insignificant after the five-year survival period (Soejima and Kamibeppu, 2016[80]).

Presenteeism is reported more frequently in cancer survivors diagnosed in the past five years than in healthy population, although no causal inferences can be made (Soejima and Kamibeppu, 2016[80]). Cancer survivors report having greater fatigue/exhaustion, work-related impairment in executive function, working memory and attention compared to controls. These chronic negative symptoms contribute to the association of cancer with presenteeism. Several factors like age at the time of diagnosis, gender, lifestyle choices (i.e. smoking, harmful alcohol use and insufficient sleep), are known risk factors for presenteeism among cancer survivors (Soejima and Kamibeppu, 2016[80]).

2.6.7. Cardiovascular diseases

CVDs can significantly impair workers' ability to remain in employment, and increase absenteeism and presenteeism incurred from need to recover from the illness or surgery. Workers with CVDs are less likely to remain in employment in the long-term. A European study looking at the impacts of CVDs on early exit from employment found that workers with CVDs were 2.5 times more likely than those without such conditions to leave employment due to disability, and 1.3 times more likely to take early retirement (Kouwenhoven-Pasmooij et al., 2016[81]). Evidence shows that workers who suffered a first or a recurrent severe CVD event are completely unable to participate in employment and thereby permanently exit labour market (Li et al., 2016[104]).

CVD events can occur suddenly and the ability of workers to perform their duties can be affected over a prolonged period. A Spanish study shows that CVD workers missed 92 days compared to 11 days missed by non-CVD workers (Calvo-Bonacho et al., 2014[82]). In a systematic review, the loss of productivity among workers who experience CVDs is twice higher from presenteeism than from absenteeism (Gordois et al., 2016[83]). The rates of absenteeism and presenteeism differ from country to country as well as with difference between the cardiovascular conditions as they can vary in severity (Gordois et al., 2016[83]). Work hours lost by the caregivers of patients in recovery from CVDs also contribute to the total labour market costs. For instance, in a study from Portugal, while stroke patients lose about 65 working days due to both absenteeism and presenteeism in the first year following stroke, caregivers lose 12 days for providing support to stroke patients (Marques et al., 2021[105]).

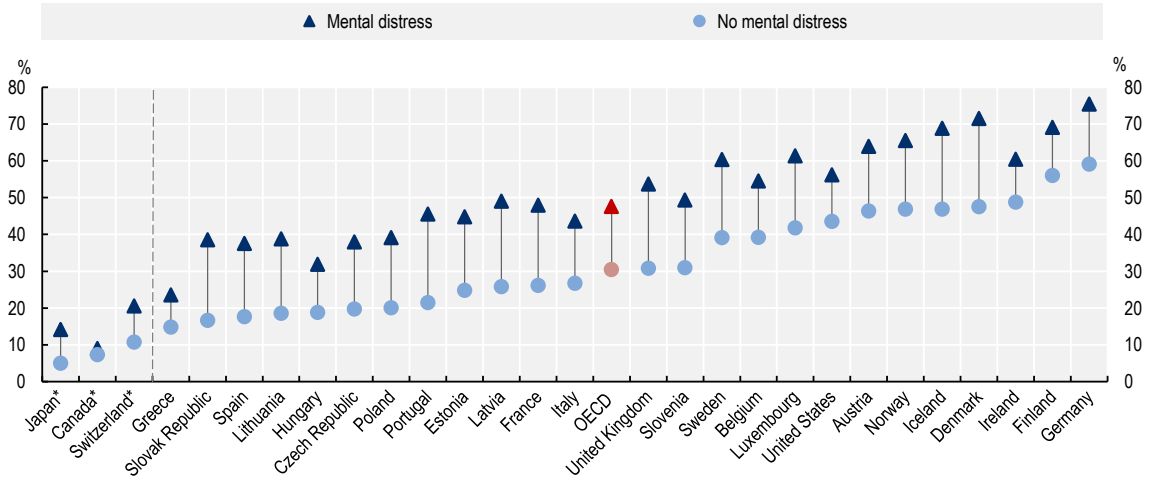
2.6.8. Mental health conditions

Mental health conditions are strongly associated with lower employment, and many individuals with mental health conditions are unable to find or keep jobs. Across OECD countries, 60% of people with moderate mental health conditions are employed compared to 70% of those without a mental health condition.[15] The employment gap is 10 percentage points for those with a moderate mental health condition and about 25 percentage points for those with a severe mental health condition. Individuals with a mental health condition are also almost twice as likely (85% higher) to be unemployed, indicating that many are either looking for jobs without success and/or are transitioning into and out of work more often (OECD, 2021[84]).

Poor mental health has considerable impacts on prevalence of sick leave and lost productivity. Across OECD countries, almost half (47.6%) of people with mental health conditions were absent from work at least once over the previous year, compared with just under a third (30.4%) of those without such conditions (Figure 2.9). The average number of missed days among workers with mental health conditions (33.6 leave days per year) was also greater than among those without such a condition (21.4 days) (OECD, 2021[84]). Even while at work, many individuals experiencing mental health conditions may be less likely to be productive at work. For instance, workers with a severe mental disorder were more than three times as likely as those without any such disorder to accomplish less than they would like because of either emotional or physical health problems (88% versus 26%) (OECD, 2012[60]). In total, the labour market costs of poor mental health exceed 1.5% of GDP across European countries (OECD, 2021[84]).

Figure 2.9. Prevalence of absence due to illness among people with and without mental distress

Share of workers who have been absent from work at least once over the past 12 months, by mental health status, 2012-16



Note: (*) Data for Japan and Switzerland use a reporting period of four weeks; Canada uses a reporting period of one week.
Source: (OECD, 2021[84]), *Fitter minds, Fitter jobs*; Analyses based on National Surveys.

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It is not clear if the impact of mental health conditions on presenteeism outweighs the impacts on absenteeism, and this may differ across countries. In Japan, individuals with mental health conditions take around 17 days off work on average, which is around half of the OECD average (OECD, 2021[84]). Yet one estimate from pharmaceutical companies has found that the cost of presenteeism was almost six times as high as that of absenteeism due to mental health conditions (Nagata et al., 2018[106]). High levels of presenteeism may indicate stigma associated with mental health conditions, and that workers feel unable to request absence due to mental health issues. By comparison, the Australia Productivity Commission has estimated the cost of absenteeism to stand at AUD 9.6 billion (USD 7.2 billion), slightly higher than the cost of presenteeism at AUD 7.0 billion (USD 5.3 billion) (Australia Productivity Commission, 2020[107]).

2.6.9. Musculoskeletal disorders (MSD)

MSDs are among the primary causes for work disability, sick leaves from work, and loss of productivity. Estimations for the total cost of lost productivity attributed to MSDs among European working-age people account for as much as 2% of GDP (Bevan, 2015[108]). In the United States, MSDs are also recognised as a leading cause for lost workdays, accounting for 31% of all cases of occupational diseases and injuries with days away from work in 2015 (U.S. Bureau of Labor Statistics, 2016[109]).

Rheumatoid arthritis, a highly-prevalent MSD, severally affects the ability of workers to remain in full-time long-term employment, most often leading to reduced hours worked or resulting in disability and consequently loss of employment. Rheumatoid arthritis (RA) is a MSD often cited in the literature as having an effect on work productivity. The estimations on work loss due to RA can range from 36% to 85% of people of working age living with RA (Burton et al., 2006[110]). Every third new patient with RA eventually becomes disabled due to the condition, however people living in lower-GDP countries remain in the workforce but with high degrees of disability (Sokka et al., 2009[111]). A survey of Irish workers reported that 67% of those unemployed or in part-time employment had to reduce or leave their jobs due to their arthritis (Summers, Jinnett and Bevan, 2015[85]). Findings on US data show that working-age men

with arthritis are 20% less likely than men of the same age without arthritis to be economically active, while this association is 25% among women (Lubeck, 2003[86]).

MSDs are the largest cause of work absenteeism, with poorly adapted working conditions being associated with the development of these disorders. A Swedish study shows that the average annual days on sick leave and disability pension increased in patients newly diagnosed with RA compared to the general population, in the year prior to the diagnosis and the four following years after diagnosis. The number of days missed peaked at 147 days per year in the RA diagnosed group, compared to 59 days in the general population (Neovius, Simard and Askling, 2011[87]). Back pain is also strongly linked with loss of work productivity through high rates of presenteeism. A study on back pain found that nearly 80% of workers who experienced clinically meaningful back pain also reported productivity loss due to presenteeism, with 4.4 hours missed per worker over a two-week period (Dall et al., 2013[88]).

Job satisfaction, a core element of well-being at work, is correlated with lower MSD pain. A Polish study on men working in forestry industry found that there was significant correlation between overall job satisfaction and musculoskeletal pain (Lachowski et al., 2017[112]). The lower the level of job satisfaction, the more frequent the experiencing of MSDs. Similar conclusions were observed in Korean emotional labourers,[16] where job satisfaction was strongly correlated to musculoskeletal pain, with lower pain among those with higher subjective job satisfaction (Baek et al., 2018[113]).

Job engagement is negatively affected by lifestyles and psychosocial well-being in the presence of musculoskeletal pain. Job engagement can be defined as a positive and fulfilling work-related state of mind that is characterised by vigour, dedication, and absorption (Schaufeli et al., 2002[114]), and is used as a proxy for productivity at work. Engaged employees produce better business outcomes, with an 18% gap in productivity between the top and bottom engaged employees (Gallup, n.d.[115]). While job engagement is not directly associated to MSD pain (Knardahl, 2017[116]), evidence shows that psychological and lifestyle factors (e.g. psychological traits, leisure time physical activity, and work and family stress) are correlated with job engagement in the presence of MSD pain, suggesting a mediation effect (Malmberg-Ceder et al., 2017[117]).

2.7. Conclusion

While the nature of work, including safe work environment, job quality, work organisation, employment type and sector, and new forms of employment, is an important determinant of employee health and well-being, lifestyle habits are also key contributors to employee health and well-being. Lifestyle risk factors – smoking, poor diets, harmful alcohol use and physical inactivity – are responsible for 76% of all deaths in working-age people in OECD countries and are leading causes for the occurrence of chronic conditions such as CVDs, cancers, diabetes, MSDs, and mental health conditions. About 43% and 45% of European adults in working age reported suffering from MSDs and facing risk factors for mental health well-being (including mental health), suggesting a need for further preventative actions at the workplace. People affected by one or several chronic diseases may have reduced quality of life. Nearly half of the burden of disability in the working-age population is caused by cancers, MSDs and mental health conditions. And, 47% of this burden fall into the working ages (20-64). Chronic diseases and risk factor exposures negatively affect individual's labour participation and productivity, potentially reducing the performance of the workplace. The following chapter examines the potential of workplace-based interventions to enhance the health and well-being at the workplace.

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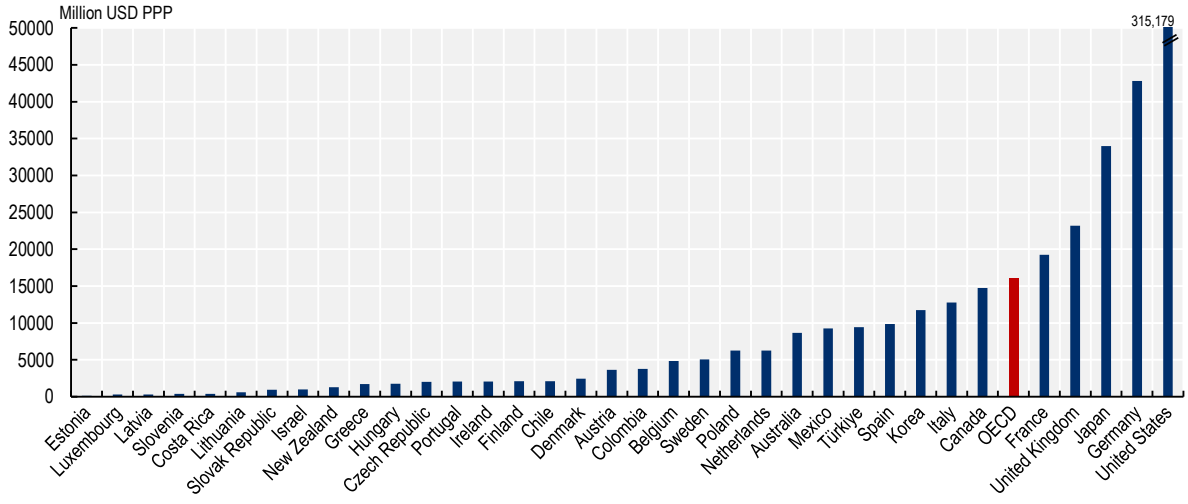
Annex 2.A. Supplementary files

Estimating the health care expenditures related to NCDs treatment in people aged 20-64

The cost of treating NCDs in the working-age population is large. An analysis based on the OECD SPHeP-NCD model estimated the treatment cost for NCDs among people aged 20-64 (Annex Box 2.A.1). In total across OECD countries, USD PPP 562 billion are spent annually on treating NCDs in people aged 20-64, which is similar to the GDP of Sweden. More than half of this amount is driven by the expenditure in the United States (more than USD PPP 300 billion) (Annex Figure 2.A.1). Expenditures on disease treatment greatly vary by country, reflecting variations in population size and prices.

Annex Figure 2.A.1. Estimated treatment cost associated to NCDs and mental health conditions among people aged 20-64, OECD countries, 2020



Source: OECD SPHeP-NCDs model, 2020.

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Annex Box 2.A.1. The OECD SPHeP-NCD model

The OECD SPHeP-NCDs model is an advanced systems modelling tool for public health policy and strategic planning. It is used to predict the health and economic outcomes of the population of a country or a region up to 2050. The model consolidates previous OECD modelling work into a single platform to produce a comprehensive set of key behavioural and physiological risk factors (e.g. obesity, physical activity, alcohol consumption, blood pressure) and their associated NCDs and other medical conditions. The model covers 52 countries, including OECD member countries, G20 countries, EU27 countries and OECD accession and selected partner countries.

For each of the 52 countries, the model uses demographic and risk factor characteristics by age- and sex-specific population groups from international databases. These inputs are used to generate synthetic populations, in which each individual is assigned demographic characteristics and a risk factor profile. Based on these characteristics, an individual has a certain risk of developing a disease each year. Individuals can develop 12 categories of disease (such as diabetes, stroke, ischaemic heart disease, cancer, depression, dementia, musculo-skeletal disorders (e.g. low back pain, rheumatoid arthritis), chronic obstructive pulmonary diseases, cirrhosis, alcohol dependence, injuries). Incidence and prevalence of diseases in a specific country's population were calibrated to match estimates from international datasets (IHME, 2020[22]; IARC, 2020[118]).

For each year, a cross-sectional representation of the population can be obtained, to calculate health status indicators such as life expectancy, disease prevalence and disability-adjusted life years using disability weights.

Health care costs of disease treatment are estimated based on a per-case annual cost, which is extrapolated from national health-related expenditure data. The additional cost of multi-morbidity is also calculated and applied. The extra cost of end-of-life care is also taken into account.

The labour market module uses relative risks to relate disease status to the risk of absenteeism, presenteeism (where sick individuals, even if physically present at work, are not fully productive), early retirement and employment. These changes in employment and productivity are estimated in number of full-time equivalent workers and costed based on a human capital approach,[1] using national average wages.

For more information on the OECD SPHeP-NCDs model, see the SPHeP-NCDs Technical Documentation, available at: http://oecdpublichealthexplorer.org/ncd-doc.

[1] The human capital approach is based on assumptions simplifying the economic dynamics leading to economic losses – including, for example, assumptions about reserve labour force, friction costs, and the impact on reserve wages.

Notes

[1] People living with multiples chronic diseases.

[2] Survey respondents are asked if they experienced stress yesterday.

[3] Resulting from the average incidence rate multiplied by the OECD population of working age (that corresponds to 64.8% of the OECD total population of 1 369 million people in 2020).

[4] Purchasing power parity.

[5] DALYs are used to measure total burden of disease – both from years of life lost and years lived with a disability. One DALY equals one lost year of healthy life.

[6] The workforce or labour force is the labour pool either in employment or in unemployment.

[7] For instance, opioids – initially used to treat acute and chronic pain, but with the risk of dependence, dose increase and death- are causing a rising epidemic in North America. Employer costs related to the opioid crisis, include increased spending on health care, lost productivity, and increased disability and workers' claims, estimated nearly USD 150 billion in 2019 (Davenport, Caverly and Matthews, 2020[122]).

[8] The United Kingdom, France, Germany, Italy, and Spain.

[9] Defined in this study as a combination of criteria of alcohol abuse (DSM-IV criteria) and harmful consumption.

[10] Defined in this study by either physiological and physical symptoms, frequency or quantity of drinking.

[11] Defined in this study as below 20 grammes of pure alcohol per week for women (and 40 g for men).

[12] In this study, low-risk drinking refers to consumption below 20 grammes of pure alcohol per day, while risky drinking to consumption above 20 g per day.

[13] In this study, moderate drinking corresponds to consumption below 280 grammes per week for men and 190 g for women, while heavy drinking to more than 280/190 g.

[14] higher levels of alcohol consumption were associated with higher levels of impaired work performance.

[15] Individuals in the bottom quintile of scores on mental health status were classified as indicating "mental distress" or exhibiting symptoms of a "mental health condition". This is based on the evidence that around 1 in 5 people experience a mental health condition at any given time (Steel et al., 2014[40]). Where appropriate, individuals in the bottom 10% were classified as indicating "severe mental distress" or "severe mental health conditions", whereas individuals in the 10% to 20% range are classified as indicating "moderate mental distress" or "moderate mental health conditions". The data on mental health from European OECD countries are primarily obtained from the Patient Health Questionnaire-8, a battery of questions to assess extent of symptoms of depression, as this is the question on mental health included in the European Health Interview Survey. This method allows for cross-country comparison and is less affected by stigma and cultural differences, which can result in variations in extent of under-reporting of symptoms. However, this also means that it cannot be said with certainty that an individual classified as having a mental health condition for the purposes of this analysis actually has a mental health condition.

[16] Employees perform emotional labour when they regulate their emotions to meet organisation-mandated rules and achieve professional goals. Examples of emotional workers are frontline, public-facing job interacting with clients, customers and patients.

3 Workplace-based programmes to promote health and well-being

Marion Devaux, Alena Piatrova and Pedro Isaac Vazquez-Venegas

This chapter provides insight on why health and well-being programmes at the workplace are needed, lays out the motivations for employers to invest in programmes to promote healthy lifestyles among employees, and assesses the potential reach out of these programmes. Finally, based on 2020 survey data, it describes the type of health and well-being programmes implemented by employers.

Key findings

Workplace-actions are essential for ensuring employee health and safety and they are an ideal means to promote health and well-being given that adults spend a large portion of their lives at work.

- Population ageing, spread of chronic conditions in the working-age population and the rise in health consciousness among employers and employees – in particular, after the COVID-19 pandemic – are key drivers for the demand for workplace health and well-being programmes.
- Workplaces can expand the outreach of health promotion interventions, beyond primary care services, communities and schools, in particular towards workers with health risks and low access to health care.

Motivations for employers to invest in health and well-being programmes for their employees are driven by several factors, including economic rationale, reputation motives, employee satisfaction, and external incentives.

- Workplace health and well-being programmes can lower health care cost and productivity losses. Such programmes reduce medical treatment costs, showing positive cost benefit ratios. Studies with a follow-up period of one to seven years indicate that for each dollar invested in workplace health and well-being programmes, employers can save between USD 1.5 and USD 5.6 in health care spending.
- Moreover, workplace programmes improving lifestyles, health and well-being, can reduce sick leave absenteeism by 25% and thus, increase work productivity. Scaling up interventions addressing sedentary behaviour and promoting physical activity at the workplace would increase work productivity by the equivalent of 37 000 full-time equivalent workers to the workforce per year in 30 OECD countries and would return USD 4 in the form of economic benefit for each dollar invested.
- Companies that offer health and well-being programmes can improve their corporate image, improving attraction and retention of talent.
- Employers that offer health and well-being programmes can increase employee satisfaction and motivation to perform work. Higher employees' satisfaction and performance can improve services to customers, and in turn increase customer loyalty and revenues for the company.
- Support programmes led by governments or health insurance companies can motivate employers to buy in health and well-being programmes.

Workplace-based programmes that promote health and well-being among employees have a great potential coverage.

- Across OECD, 610 million people are employed in the formal sector, representing a sizeable potential population target for workplace-based interventions. About two-thirds are employed in small and medium-sized enterprises (SMEs), while one-third are in large size companies.
- SMEs are less likely than large companies to offer health and well-being programmes, partly because of the programme-related cost, insufficient human resources and lack of programme knowledge. However, a number of facilitators, especially directed at SMEs, can help the adoption of workplace health and well-being programmes, including strengthening occupational health services, developing national accreditation for health and well-being providers, integrating occupational health rules in the supply chains, creating certified recognition programmes for employers, and offering subsidies for SMEs.

- Employee participation is key for maximising the effectiveness of workplace health and well-being programmes. The drivers for higher participation of employees are strong organisational programme support, low fees paid by the employee, and closer connections among employees.

Various types of workplace health and well-being programmes have been implemented, mostly by large companies, while their implementation raises some considerations.

- Data from the 2020 Workforce Disclosure Initiative survey illustrates the variety of health and well-being programmes implemented by 114 worldwide large size companies.
- More than two-thirds of the companies (68%) reported they provided their employees with programmes addressing stress and mental health disorders. More than half (53%) offered an Employee Assistance Programme or a well-being programme, while less than one-third offered programmes related to physical inactivity, addiction to tobacco and alcohol, obesity and nutrition, or ergonomics. The data does not report on the actual uptake by the employees, which makes it hard to assess the actual reach out of the programmes.
- The success of workplace health-promoting programmes relies in part on organisational factors such as an integrated approach to occupational safety and health prevention and a healthy workplace culture.
- The implementation of such programmes raises questions on actual uptake by the employees and on the effect of the programmes, which can be blurred by the heterogeneity in programmes and studies. A great number of studies support that workplace programmes can improve lifestyles and health outcomes in the short and medium-term, while evidence is less conclusive on their long-term effects.
- 80% of the WDI surveyed companies reported to adopt actions that widen an individual's health related choices, for instance, by offering healthier food options in cafeteria, providing sit-stand desks, or offering addiction management programmes. Smaller proportions reported to provide health information, training, and financial incentives. As many programmes use new technology and digital tools, some concerns may be raised about data protection and privacy, and quality of health information.
- During the COVID-19 crisis, companies had to adapt to protect their employees from the spread of the virus, ensuring health and safety at work. COVID-19 responses included enabling teleworking, enhancing hygiene measures to limit the propagation of the coronavirus, providing financial protection – such as salary guarantees – and by offering mental health support. In particular, 53% (19 out of 66) of the WDI surveyed companies reported to offer mental health programmes as a COVID-19 response.

3.1. Introduction

Workplace health and well-being programmes primarily aim to improve employee's lifestyle behaviours at work, in order to avoid or postpone the occurrence of chronic diseases (e.g. such as mental health disorders, musculoskeletal disorders, obesity). These programmes need to be founded on a solid occupational safety and health management system, based on risk assessment. In particular, the European Agency for Safety and Health at Work (EU-OSHA) underlines that these programmes are only effective when occupational hazards are managed successfully (EU-OSHA, 2010[1]). The role of occupational health professionals is paramount to diagnose risks and health problems in companies, help better define the needs and respond by targeting adequate workplace health and well-being programmes. The involvement of employees and managers, in a participatory process, is also key for successful workplace programmes, and efforts to build a healthy workplace culture are essential to advance employee health and well-being (Box 3.1).

Box 3.1. A workplace culture for health and well-being

The WHO Healthy Workplace model combines health protection and health promotion approaches. The WHO Healthy Workplace model defines that workers and managers can together influence the health, safety and well-being of the workers and the sustainability of the workplace, by considering four dimensions: physical work environment, psychosocial work environment, personal resources, and enterprise community involvement (Joan Burton, 2010[2]). An important feature of this model is the participatory process that involves employees at all levels to determine needs and solutions. Within this framework, the **culture of health and well-being in an organisation** is a key element for building physical and psychosocial work environment. Recent evidence showed that health and well-being outcomes across a wide range of workplace interventions are mediated by workplace culture change, such as job control, organisation support, work climate, management style, flexibility, work time expectation, supervisor support, line manager's attitude and actions (Quigley et al., 2022[3]). Such organisational changes are essential as they are the enabling conditions for a change.

This chapter offers an analysis of workplace health and well-being programmes (WHWP) that aim to promote employee health, healthy lifestyles and well-being, on top of an effective occupational health and safety management system (not discussed in this chapter). Section 3.2 examines the reasons why these programmes are needed. Section 3.3 lays out the motivations for employers to invest in programmes to promote healthy lifestyles among employees. Section 3.4 evaluates the potential reach out of these programmes. Finally, Section 3.5 describes the type of health and well-being programmes implemented by employers, using 2020 survey data.

3.2. Why health and well-being programmes at the workplace are needed?

With an ageing workforce, employers have a role to play to maintain good health and well-being of their employees. By 2050, more than four in ten individuals in the world's most advanced economies are likely to be older than 50 (OECD, 2020[4]). Older workers are more likely to live with one or multiple chronic diseases (Chapter 2). Employers who prevent occupational risks and implement workplace health and well-being programmes can create healthy working environment, by offering employees the support they need to maintain good levels of physical health, mental health and well-being – for instance, by ensuring employees feel seen, heard, appreciated and that their work has meaning (OECD, 2020[4]). **As adults spend a large portion of their lives in employment, workplace-based actions are essential for ensuring health and safety at work and are increasingly considered as a potentially effective tool to influence choices favouring healthier lifestyles** across the work-life continuum from the first job to retirement. For example, well-being-centred policies can achieve dietary improvements – through changes in the selection of daily menus and snacks provided in workplace cafeterias -, promote physical activity, reduce sedentary behaviour and sitting time through dedicated education, behavioural programmes and provision of sit-stand workstations, or tackle harmful alcohol consumption through services offered by schemes like Employee Assistance Programmes (EAP) (Box 3.2). Additionally, employers have started implementing workplace wellness programmes, which may provide various educational materials, classes, seminars, group activities, individual counselling sessions and incentives of different kinds to encourage participation (such as rewards and reimbursements).

Box 3.2. Employee Assistance Programme (EAP)

EAPs have their origin in the United States at the beginning of the 20th century, with the first programmes to address alcoholism at work. From the 1970s, when the US Government created the National Institute on Alcoholism and Alcohol Abuse (NIAAA), there was an acceleration of the spread of the EAP concept throughout diverse workplace settings.

EAP is a voluntary, work-based programme that offers free and confidential assessments, short-term counselling, referrals, and follow-up services to employees who have personal and/or work-related problems. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, psychological disorders, health care concerns, work relationship issues, financial or non-work related legal issues, and family problems.

EAPs are employee benefit programmes commonly proposed by companies in the United States and the United Kingdom, but are also available in over 150 countries.

Workplaces are complementary to primary care services, communities and schools for the purpose of health promotion reach out. People with lower income have lower access to health care specialists and lower uptake of preventive services compared to those with higher income (OECD, 2019[5]). Not only specific health policies can help address these inequalities, but also workplace-based interventions can play a role to target people at risk. Workplaces provide a unique setting to reach out to individuals at potential health risk, including workers who do not often access health care services and those with low health literacy who often need the most support but receive the least (Saint-Martin, Inanc and Prinz, 2018[6]). A study based in an immigrant-dense community in Sweden found that screening diabetes at the workplace is more efficient than in the community and primary care settings (Shahim et al., 2018[7]). The cost of identifying one person with diabetes was 14 times lower in the workplace than in the primary health care centre (EUR 8 (USD 9.5) versus EUR 112 (USD 132) per case diagnosed, respectively). Workplace interventions, because they can reach out to individuals with lower access to health care and more health risks, can help to some extent break the link between health and socio-economic inequalities, at least for people who are in work. Evidence from a systematic review also supports that workplace health promotion programmes may contribute to reducing socio-economic inequalities in health behaviours. Precisely, the study identified six studies with 18 comparisons that provided quantitative information on workplace programme effects, of which 13 comparisons showed equal effectiveness across socio-economic groups, and 5 comparisons showed significantly higher effect sizes among workers in a low socio-economic position (Van De Ven, Robroek and Burdorf, 2020[8]). These findings only apply to people who are in work. Other types of intervention are necessary to address broader health inequalities, in particular targeted to unemployed people, who are more likely to be in worse health and die prematurely than those in more favourable socio-economic circumstances.

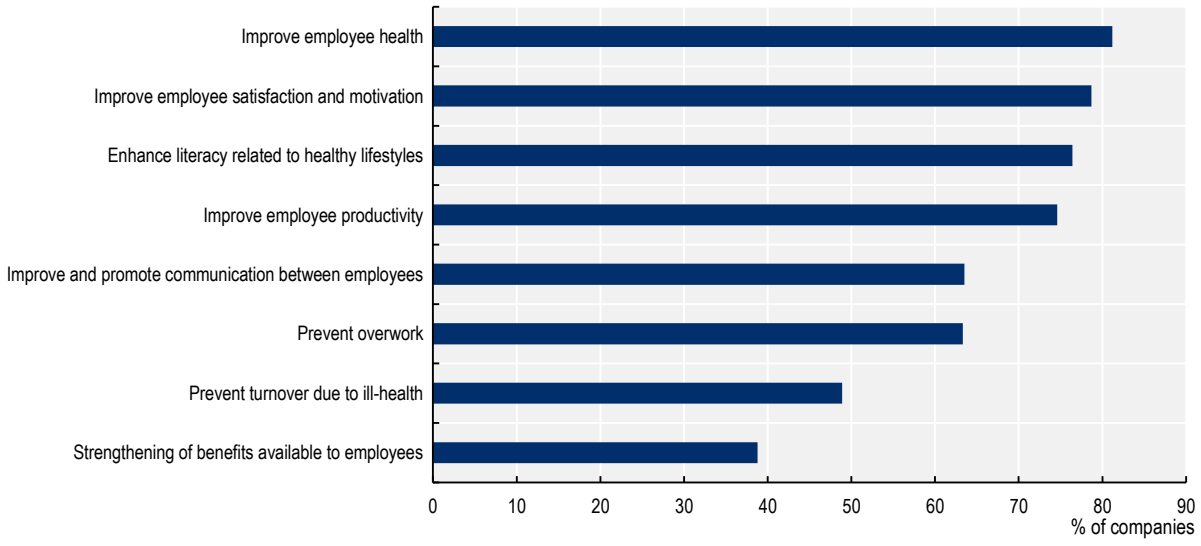
Interest in workplace health and well-being programmes (WHWP) is clearly growing. The history of the demand for WHWP varies by country, in particular due to national context and health system characteristics. For instance, in the United States, health coverage is largely employment-based. Employers substantially contribute to the cost of health insurance for their employees, and may use WHWP as a means for reducing medical costs. It is common that US companies offer programmes to promote health and well-being at work to their employees. In a nationally representative study of US worksites, almost half of worksites offered some type of health promotion or wellness programmes to employees (Linnan et al., 2019[9]). In the Nordic countries, well-established occupational health services and the importance of work-life balance contributed to make health promotion a natural component of workplace setting. In Japan, as the country does not have a traditional primary care and/or general practitioners as many other countries do, occupational doctors are the primary contact for employees – including

employees with chronic disease- to access health care services. Despite these differences in national settings, countries face common challenges regarding ageing population and the spread of chronic conditions in the working-age population (Chapter 2). These challenges combined with the rise in health consciousness among employers and employees – possibly reinforced after the COVID-19 pandemic – are key drivers for the growing demand for WHWP. In 2020, the global corporate wellness market[1] was valued at USD 40.2 billion, and it is estimated to expand at a compound annual growth rate of 8.2% from 2021 to 2028 (Transparency Market Research, 2022[10]).

3.3. What are the motivations for employers to implement and invest in WHWP for their employees?

Employers who intend to implement health and well-being programmes can be motivated by a number of reasons. When interviewing US employers who did implement programmes, cost control over health care spending is the most cited objective, followed closely by other motives. A 2020 survey from the Integrated Benefits Institute questioned more than 300 Chief Finance Officers (CFOs) in the United States about the metrics they used to track whether their company's health benefits strategy meets its goals. The most cited metric was health care spending (55% of the respondents). Besides costs, the focus was on employee participation (54%), employee satisfaction with benefits (49%), performance indicators -such as sickness absence, attraction and retention- (45%) and health status of employees (36%), while only 29% of respondents reported they tracked financial return on investment (IBI, 2020[11]). In countries where corporate health insurance plays a smaller role than in the United States, motivations for employers may be different. In Japan, the companies that signed up to the Health and Productivity Management (H&PM) governmental programme aim for strengthening management strategy, with the top-two objectives being to improve employee health and improve employee satisfaction and motivation, as indicated in a survey of 2 523 employers (Figure 3.1).

Figure 3.1. Objectives related to the Health and Productivity Management programme in Japan



Note: Survey of 2 523 companies in Japan in 2020.
Source: (Ministry of Economy Trade and Industry, 2021[12]).

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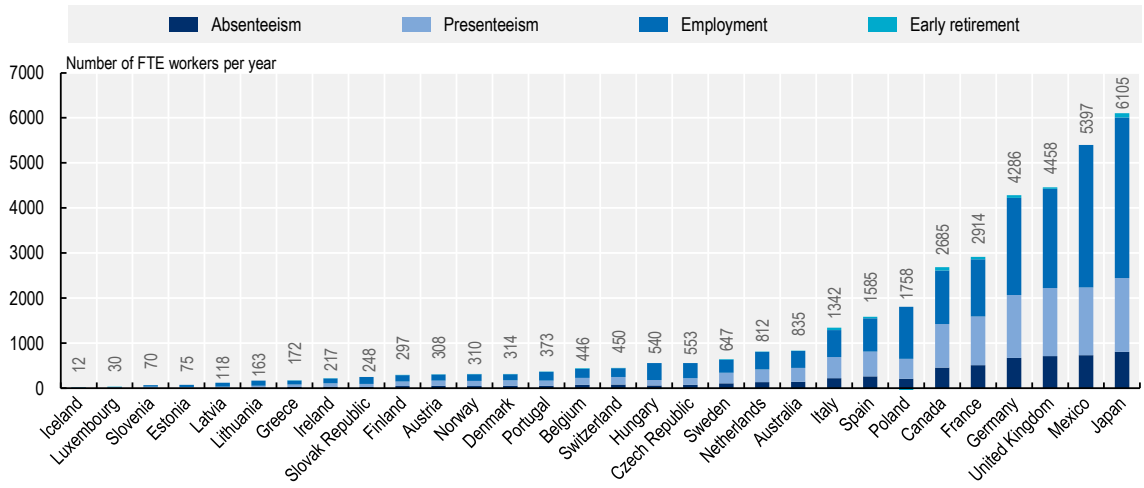
The remainder of this section presents the four main motivations for employers to implement and invest in WHWP, namely: i) employers can lower health care costs and productivity losses; ii) employers can improve their corporate image and their ability to attract and retain talent; iii) employers can increase employee satisfaction and motivation to perform work, and iv) external incentives from governments and health insurance companies can boost employer's motivation.

3.3.1. Employers can lower health care costs and productivity losses by implementing WHWP

WHWP reduce medical treatment costs, showing positive cost benefit ratios. Evidence, mostly from the United States, shows that the cost of wellness programmes paid by the employer is generally paid off by savings in medical spending. The amount of the returns varies across studies. For instance, a 2010 meta-analysis found that for every dollar spent on workplace wellness programmes, medical costs fall by about USD 3.3 (Baicker, Cutler and Song, 2010[13]). Research by RAND Corporation found that workplace wellness programmes followed for seven years reduce the employer's average health care costs by about USD 30 per member per month, equivalent to an economic return[2] of USD 1.5 for every dollar invested (Mattke et al., 2014[14]). In a systematic review and meta-analysis, the economic benefits[3] are up to USD 5.6 for each dollar invested (Chapman, 2012[15]). The RAND study also showed that disease management programmes have a higher return on investment (USD 3.8 for 1) than lifestyle management programmes (USD 0.5 to 1) – the former are designed for employees who have a chronic disease, whereas the latter are designed for employees with health risks, such as smoking and obesity, to help them reduce those risks and prevent the occurrence of chronic diseases.

WHWP that manage to improve lifestyles, health and well-being, have the potential to reduce absenteeism and increase work productivity. Evidence suggests that workplace health promotion programmes can improve work ability and reduce sickness absences (Murphy et al., 2018[16]; Kuoppala, Lamminpää and Husman, 2008[17]; Rongen et al., 2013[18]). In particular, workplace-based lifestyle management programme significantly reduces sickness absence by slightly more than *one hour* per employee-year (Mattke et al., 2014[14]). A 2012 meta-analysis based on 62 studies concluded that WHWP is associated with an average 25% reduction in sick leave absenteeism (Chapman, 2012[15]). Translated into monetary terms, for every dollar spent on workplace wellness programmes, the employer can save USD 2.7 in absenteeism costs (Baicker, Cutler and Song, 2010[13]). An OECD analysis showed that programmes addressing workplace sedentary behaviour by encouraging movement and reducing sitting time – such as making sit-stand workstations and treadmill desks available to employees – would improve employment and reduce absenteeism and presenteeism, by adding to the workforce the equivalent of 37 000 full-time equivalent (FTE) workers per year in 30 OECD countries (Figure 3.2). The cost of implementing workplace sedentary behaviour programmes is estimated between USD PPP 43 and USD PPP 144 per target person across the countries studies (equivalent to USD PPP 1 to 2 per capita). Taking into account the impacts on health and life expectancy, savings in health expenditure and labour market cost, this programme would return USD 4 in the form of economic benefit (i.e. Growth Domestic Product) for each dollar invested (OECD, 2019[19]).

Figure 3.2. Increases in workforce resulting from workplace sedentary behaviour programmes



Note: Labour market inputs include employment and productivity when employed. They are expressed in the number of full-time equivalent workers and are calculated for the working-age population. OECD analyses based on the OECD SPHeP-NCDs model, which forecast the evolution of non-communicable diseases (NCDs) and risk factors and their related costs over the next 30 years.
Source: OECD (2019[19]), *The Heavy Burden of Obesity*, https://doi.org/10.1787/67450d67-en.

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3.3.2. Companies implementing health and well-being programmes are viewed as attractive and responsible employers

Companies implementing health and well-being programmes are generally favourably seen by potential and current employees, which helps improve their corporate image and their ability to attract and retain talent (EU-OSHA, 2012[20]; OECD, 2019[21]). Higher turnover rates are associated with high cost of replacement, including recruiting and training costs, but also with loss of productivity and loss of engagement from other employees. The cost of replacing an employee can range from 1.5 to 2 times the employee's annual salary. In the United States, the cost of voluntary turnover is estimated at USD 1 trillion every year (Gallup, 2019[22]). Companies that are attractive enough to retain talent can avoid these increased costs.

3.3.3. Companies implementing health and well-being programmes can increase employee's satisfaction and motivation for work

Companies that provide upgraded health benefits to their employees can increase employee's satisfaction and motivation to perform work. Improved employee job satisfaction and commitment to the organisation may improve employee service to customers and in turn, increase customer's loyalty (EU-OSHA, 2012[20]). A meta-analysis of more than 300 studies found a significant positive correlation between employee job satisfaction and employee productivity (correlation r = 0.2) and customer loyalty (r = 0.31), and a negative correlation with staff turnover (r = -0.25) (Krekel, Ward and De Neve, 2019[23]).

3.3.4. External support programmes led by governments or health insurance companies can boost employers' motivation

Support programmes led by governments or health insurance companies can also motivate employers to implement health and well-being programmes. A report from the European Agency for Health and Safety at Work (EU-OSHA) suggests that support programmes by national and local government (e.g. such as guidelines) encourage employers to implement workplace health programmes, especially for small and medium-sized enterprises (SMEs) which may have only limited resources and expertise to design and implement such types of programmes (EU-OSHA, 2012[20]). For instance, the United Kingdom and Canada have implemented a framework to assist employers to better assess musculoskeletal disorders (MSDs) risks at work, and provide guidelines for best practice interventions tailored for the assessed risks. Another example is Japan where the government provides incentives for employers to promote health and well-being at the workplace within the H&PM programme (Chapter 4). Government-led initiatives to support WHWP are further discussed in Chapter 4. In some countries, support from health insurance companies can be a practical lever for organisations and business to implement and invest in workplace health promotion activities. An example is the Vitality programme that originated from a private health insurer in South Africa, and then was rolled out across a range of enterprises worldwide, including Japan, the United Kingdom, the United States and China, and covers now more than 20 million people. Companies that subscribe to Vitality provide their employees with access to a health programme based on targets and rewards for healthy living (Box 3.3).

Box 3.3. Privately managed health prevention programme in South Africa

Discovery Health, a private health insurer, has developed and has been running one of the most well-known examples of a privately-managed health prevention programme. The Vitality programme was first rolled out in South Africa to be subsequently extended to other markets, including the United Kingdom, the United States and China (Lambert and Kolbe-Alexander, 2013[24]). Participation in the programme is voluntary and membership is offered for a nominal fee equivalent to about USD 20 per month. However, in some cases, the fee paid by the participant is significantly smaller. For example, in the United States, almost 90% of the membership fee for the Vitality programme is covered by the employers (Lambert and Kolbe-Alexander, 2013[24])

This incentive-based programme rests on four pillars: assessment and screening, healthy choices, health knowledge and physical activity. Beneficiaries are encouraged to participate in different health-related activities such as health checks, exercising and healthy eating. Those who are sufficiently active are given bonus points, which can be exchanged for various rewards, such as upgrades in Vitality health status, free beverages or movie tickets, or discounts at various participating businesses. In addition, gym memberships are subsidised, and fruit and vegetable purchases are eligible for a cash rebate. It was found that the cash rebate has been effective in increasing expenditure on healthy foods by 9.3%, and decreasing spending on less healthy food by 7.2% (Sturm et al., 2013[25]). The Vitality programme combined with the Apple Watch leads to a 34% increase in physical activity level, corresponding to 4.8 extra days of physical activity per month (Vitality Group, n.d.[26]). The Vitality programme was also found to reduce medical care costs, which created an additional incentive for private insurers to invest in prevention. For example, compared to Vitality members not participating in the programme, participants have about 15% lower hospital-related costs for cancer, 21% lower hospital costs for endocrinal and metabolic syndrome, and 7% lower for cardiovascular diseases (Patel et al., 2010[27]).

Source: (OECD, 2019[19]), *The Heavy Burden of Obesity*, https://doi.org/10.1787/67450d67-en.

External support to employers can be paid off as promoting health and well-being at the workplace have wider economic benefits. Governments that take actions to incentivise employers to implement WHWP (as discussed in Chapter 4) can get economic returns. Beyond the profits for the employer, workers and the society-as-a-whole can also benefit from WHWP. These benefits are difficult to measure as they occur most likely in the long term (e.g. delayed chronic diseases and additional years lived in good health). The OECD SPHeP-NCDs framework aims to take into account the future benefits of public health interventions, at the population level. More precisely, a voluntary workplace wellness programme[4] (that includes health risk assessment, classes, materials, group activities, counselling and environmental changes in the workplace) would save each year USD 260 million in health expenditure – broadly corresponding to the annual spending on preventive care in Lithuania or Slovenia – and would increase labour productivity by adding up to 38 000 workers to the workforce each year in 36 OECD, G20 and EU countries (due to increased employment and reduced absenteeism and presenteeism). Combining the effects on life expectancy, health expenditure, employment and productivity, workplace wellness programmes pay-off. The total return in GDP across the 36 countries is roughly equal to the total cost of implementing the policy in all countries (OECD, 2019[19]). Another example is alcohol brief intervention at the workplace, which aims to detect and advice employees with harmful alcohol use. Alcohol brief intervention would save each year USD 205 million in health expenditure – corresponding to the annual spending on preventive care in Lithuania or Slovenia-, and would add up to 49 000 workers to the workforce annually in 48 OECD, G20 and EU countries (OECD, 2021[28]).

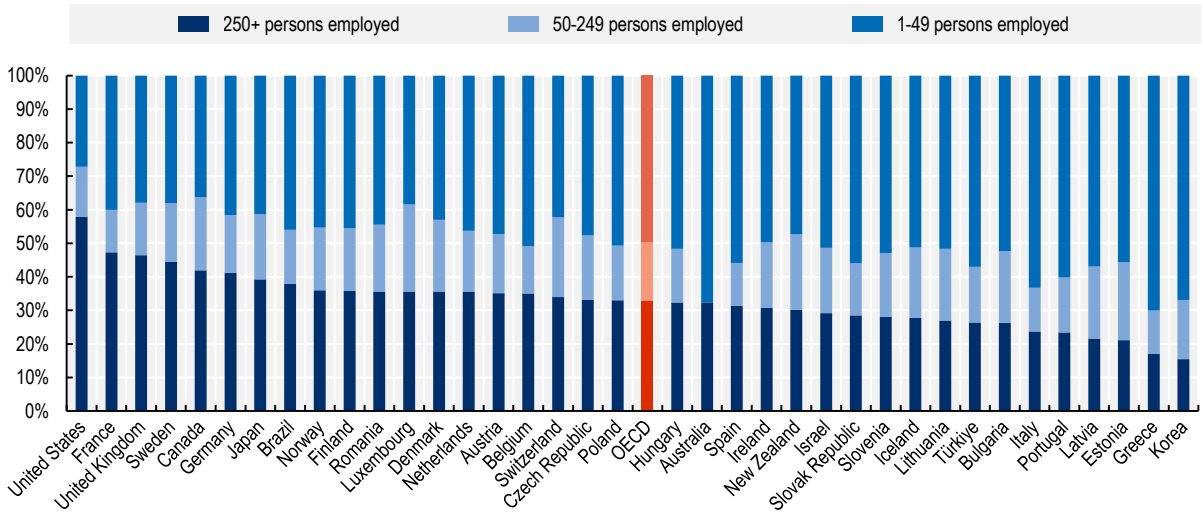
3.4. What is the size of the potential target population?

In OECD countries, 610 million people are employed in the formal sector, making a sizeable potential target for workplace-based interventions. In 2020, 66% of the working-age people were employed in OECD countries, with variations from 46% in Türkiye to 80% in Iceland (OECD, 2021[29]). At the OECD level, this represents 610 million employed persons in total. Employed persons could potentially benefit from a workplace-based health and well-being programme, if the company offers such programmes.

Large companies[5] are more likely than SMEs to offer health and well-being programmes. Business size was the most important predictor of whether a programme was offered according to evidence from Australia, Germany and the United States (Taylor et al., 2016[30]; Beck et al., 2015[31]; Mattke et al., 2014[32]). In particular, in the United States, 33% of the smallest firms (50-100 employees) have a wellness programme, compared to 80% of the larger ones (over 1 000 employees); of those, 60% of the smallest employers and 90% of the larger employers used incentives, mostly monetary, to promote programme uptake. Several reasons explain why SMEs are less likely to take up health and well-being programmes than large companies; these include programme cost, insufficient knowledge about cost-effectiveness, immaturity of management organisation, insufficient human resources, delayed adoption of new technologies and equipment, lack of employee's interest, and employee's concerns about privacy. Nevertheless, when compared to larger firms, SMEs may be in a good position to successfully adopt WHWP. Their potential advantages include less bureaucracy, easier implementation, greater personal accountability of employees, and potential for team bonding (McCoy et al., 2014[33]). Across OECD, one-third of workers – 201 million people – are employed in large companies, while two-thirds – 409 million people – are employed in SMEs. This data varies by country, with 58% of the workers employed in large companies in the United States to less than 20% in Greece and Korea (Figure 3.3). As employees in large companies are more likely to be offered a WHWP, they represent a more reachable target for WHWP.

Figure 3.3. Total employment

Total employment (persons employed) by size of companies



Note: The number of employees in Canada, Japan, and the United Kingdom includes all persons, workers and employees, covered by a contractual arrangement and working in the unit who receive compensation for their work, whether full-time or part-time.
Source: OECD Business Statistics by Employment Size Class, (2022[34]).

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The potential of WHWP for SMEs is significant too. About 409 million workers are employed in SMEs in OECD countries. This potential target is, however, less accessible because SMEs face more barriers when implementing WHWP than large companies, due to programme-related cost, insufficient human resources, and lack of programme knowledge. Government leadership can support SMEs in the process of implementing WHWP by strengthening occupational health services, developing national accreditation for health and well-being providers, involving the supply chains, and by creating certified recognition programmes for employers and offering subsidies to SMEs (further discussed in Chapter 4).

- First, the **accessibility and quality of occupational health services** are strong determinants of employers' motivation and ability to promote health at the workplace. This is especially important for SMEs that often lack financial and human resources to engage health specialists or advisors. Investing in the training and employment of occupational health specialists help protect and promote health, prevent work-related illness and promote return to work after illness.
- Second, developing a **nationally recognised system of quality standards and formal accreditation for providers** of health and well-being services may facilitate user buy-in and foster the implementation of workplace programmes (Saint-Martin, Inanc and Prinz, 2018[6]).
- Third, the supply chain can play an important role on occupational safety and health provision in micro and small businesses. If large businesses engage with their supply chain, both upstream and downstream, then occupational health and safety improvements can be fostered in SMEs. For instance, examples in the construction sector show that occupational safety and health rules can be integrated in the general planning of construction processes, involving small businesses in the supply chain (EU-OSHA, 2018[35]). Strengthened inspection and enforcement can help to step up the implication of the supply chains. European survey data show that compliance with legal obligations and fear of fines from the inspectorate are the most important drivers of action (EU-OSHA, 2019[36]).

- Last, to overcome the affordability issue, governments can incentivise SMEs to implement WHWP through **subsidies** targeted at SMEs and by creating **certified recognition programmes for employers**, as discussed in Chapter 4. For instance, in Japan, where SMEs play a substantial role in the national economy and employ a large share of the workforce, the government has launched the H&PM certified recognition programme (Chapter 4). The number of SMEs applying for recognition programme has been significantly progressing. More precisely, the number of companies applying for the H&PM certificate has grown from 397 to 12 255 SMEs over the period 2016-21 (Ministry of Economy Trade and Industry, 2022[37]).

Not only the size of the target population but also the participation rate of employees matter to make the full potential of WHWP. To maximise effectiveness, WHWP need a meaningful participation rate of employees. A German study of 61 companies found that employee participation in corporate wellness programmes varied between 0.07% to 100% across companies, with a mean participation at 15% (Lier, Breuer and Dallmeyer, 2019[38]). Several factors can explain such variations in participation rate, including company characteristics, type of programmes, and country setting. For instance, the German study identified strong programme support by the organisation,[6] low employee co-payment and closer connections among employees (proxied by the size of the company) as drivers of employee participation. In SMEs, closer connections among employees build personal accountability and encourage participation in WHWP (McCoy et al., 2014[33]). The national legal and policy context is also a determining factor (Chapter 4). For instance, in Japan, employers are required to provide a core health check-up annually to full-time employees, and virtually all employees participate (OECD, 2019[21]).

3.5. What type of health and well-being programmes do companies implement?

WHWP vary by worksites (sector of industry, work environment and culture), by design (type of intervention, follow up) and by target (health behaviour). This section presents a range of WHWP, highlighting good practices and challenges, including programmes that address occupational risk factors (e.g. psychosocial risks) (3.5.1) and programmes that aim to adopt healthier behaviours (3.5.2). Finally, it highlights the variety of levers used in workplace programmes to drive employee behavioural change (3.5.3).

3.5.1. Addressing occupational risk factors

Work environments can expose employees to potential risks for health. As highlighted in Chapter 2, work-related diseases and injuries accounted for 1.9 million deaths worldwide in 2016, of which occupational injuries represent 360 000 deaths (WHO and ILO, 2021[39]). A strong occupational safety and health management system is paramount to prevent and manage occupational diseases and injuries. On top of this, dedicated health promotion actions can address occupational risk factors, such as for mental health disorders and MSDs. Early intervention to prevent occupational psychosocial risks (e.g. work-related stress, long working hours), de-stigmatisation around mental health issues, integrated delivery of health and employment services, return to work programmes to rehabilitate workers who were out of work because of a disease, are different avenues to prevent and treat mental health disorders. The *Bell Let's Talk* programme in Canada is a good example of how employers can help raise awareness and tackle stigma about mental health issues (Box 3.4). Programmes for MSDs prevention can take the form of ergonomics, work breaks and/or physical exercises, and they mostly vary by sector of industry, work environment and by work culture. Such variety in MSDs interventions makes it difficult to draw solid conclusions on their effectiveness from systematic assessments (Hoe et al., 2018[40]).

Box 3.4. Bell Let's Talk programme to raise awareness about mental health issues in Canada

Bell Canada or Bell is a Canadian telecommunications company, with more than 52 000 team members. In 2010, Bell Canada launched the 'Bell Let's Talk' mental health programme to encourage discussion and increase awareness and acceptance of mental health issues. It is today the largest-ever corporate initiative supporting Canadian mental health. The programme was created around four strategies to promote mental health awareness: fighting mental health stigma, improving access to care, supporting research, and leading example of mental health in the workplace. The initiative includes a mandatory leader training, an employee and family assistance programme, psychological care benefits, employee awareness and educational initiatives, and a return-to-work programme. Bell monitors the effectiveness of the programme, tracking over 90 key performance indicator, such as short-term disability, long-term disability, usage of benefits and programmes supporting mental health, and employee engagement.

Since the start of the 'Bell Let's Talk' programme in 2010, Bell has seen a positive return on investment. In 2018, for every dollar (USD 1) invested in workplace mental health programmes, USD 4.10 were returned in benefits. Bell measured a 190% increase in the usage of benefits and programme compared to the level of 2010. Data also show a 50% reduction in mental health-related short-term disability relapse and reoccurrence, and a 20% reduction in short-term disability claims in 2018 compared to the 2010 baseline (Deloitte Insights, 2019[41]).

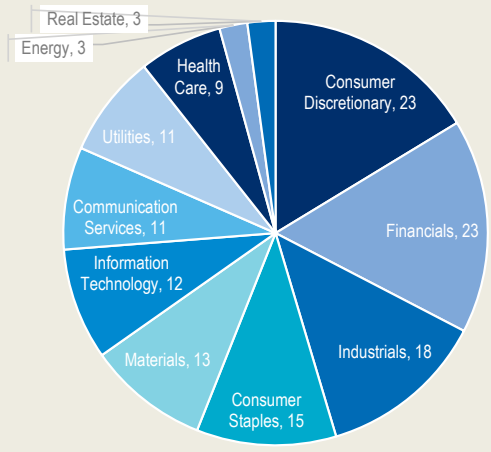
Most employers take actions to reduce psychosocial risks at work, while MSDs risk prevention is less often cited. The 2020 Workforce Disclosure Initiative (WDI) data shows that all the 114 companies reported providing at least one health and well-being programme to their employees (ShareAction, 2022[42]) (Box 3.5). Nearly seven out of ten companies (68%) offer a mental health or stress programme to their employees (Figure 3.5). More than half (53%) offer EAP or well-being programme.[7] Other programmes proposed to employees focussed on physical inactivity (31%), addiction to tobacco and alcohol (30%), access to onsite medical services (26%), obesity and nutrition (23%), health insurance coverage (15%) and ergonomics and MSDs (11%).

Box 3.5. Workforce Disclosure Initiative (WDI) 2020 data

The WDI aims to improve corporate transparency and accountability on workforce issues, provide companies and investors with comprehensive and comparable data and help increase the provision of good jobs worldwide. ShareAction, a not-for-profit organisation, carries out the WDI survey annually since 2017.

In 2020, 141 global (worldwide) companies took part in the WDI survey – a 20 percent increase on 2019. These companies represent 11 sectors of the industry (communication services, customer discretionary, consumer staples, energy, financials, industrials, information, technology, materials, real estate, utilities) (Figure 3.4). The survey covers 19 countries (Australia, Belgium, Canada, China, Denmark, Finland, France, Germany, Italy, Japan, Mexico, Netherlands, Norway, South Africa, Spain, Sweden, Switzerland, the United Kingdom, and the United States), with a large number of companies (55 out of 141) being established in the United Kingdom. The analysis presented in this report is based on the data of 114 companies for which data was complete.

Figure 3.4. Number of companies by sector



Source: Authors' work based on 2020 WDI data.

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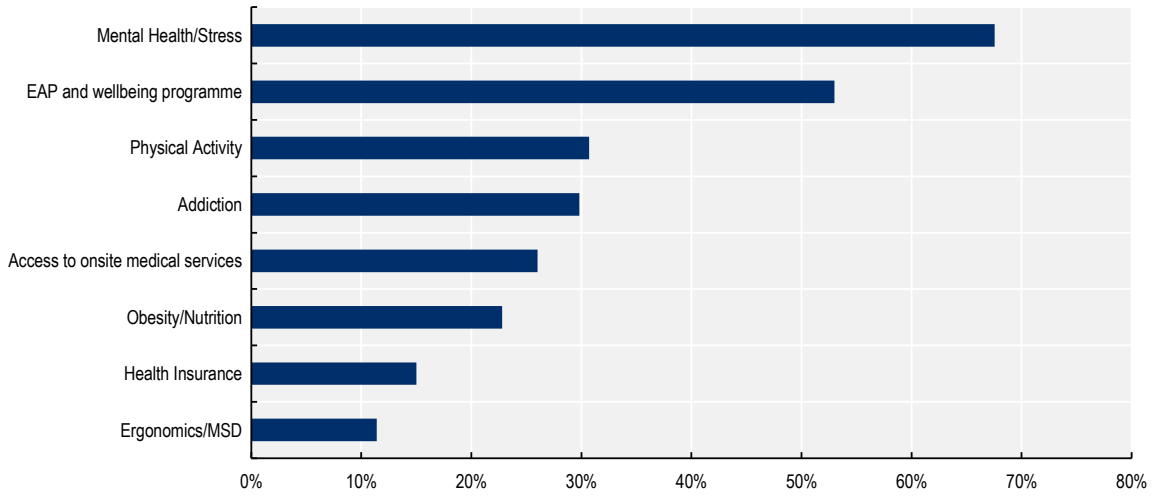
Figure 3.5. Proportion of companies reporting WHWP, by type of risk factors



Note: MSD musculo-skeletal disorders. EAP Employee Assistance Programme. Well-being programmes include financial counselling, various leave options, additional services to accommodate particular needs. As companies may offer several answers, the sum is higher than 100%.
Source: OECD analysis based on 2020 WDI data.

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A limitation with data reported by employers is that it cannot capture employee perspectives on health and safety at work, including on uptake and the appropriateness and adequacy of measures taken. Evidence shows that there can be significant disconnects and misalignment between employer and employee perspectives, which suggest that provision of health support by employers is not matching the expectations of employees in many cases. A survey of human resources (HR) leaders and employees in Australia, Canada, the United Kingdom and the United States found that, while almost half (47%) of HR leaders said they strongly agreed that their company supported employee well-being, less than a quarter (24%) of employees said that they strongly agreed that their company supported employee well-being (Achievers Workforce Institute, 2022[43]). This employee-employer gap also exists in mental health, despite this being an area where employers report implementing many measures to support employees as shown in Figure 3.5. Comparing surveys of employers and employees in the United States by McKinsey & Company, whereas 65% of employers reported that employee mental health was supported either “well” or “very well”, only 51% of employees held the same view (McKinsey & Company, 2021[44]). A similar trend can be seen from the Achievers Workforce Institute survey, which found that 40% of HR leaders said that their company offered employees with resources to support mental well-being, whereas only 18% of employees reported that they felt supported at work in managing mental well-being (Achievers Workforce Institute, 2022[43]).

Further to ensuring health and safety at work, **employer responsiveness to employee’s needs was challenged during the COVID-19 crisis.** Companies had to adapt to protect their employees from the spread of the virus. From the very beginning of the COVID-19 pandemic, many employers showed to effectively respond to employee needs offering both health-related measures and financial support (Box 3.6). Long COVID-19 represents an additional challenge for employers, as employees previously infected by the virus may suffer for long-standing illnesses. A survey of 804 organisations in the United Kingdom, representing more than 4.3 million employees, found that 46% of organisations have employees who have experienced long COVID in the last 12 months, and that 26% of employers include long COVID among their main cause of long-term sickness absence (CIPD, 2022[45]).

Box 3.6. Companies adapted their responses to employee needs in the early phase of the COVID-19 pandemic

During the COVID-19 crisis, companies had to adapt to protect their employees from the spread of the virus, ensuring health and safety at work. The WDI data contains an ad-hoc questionnaire related to COVID-19 measures implemented in the early phase of the pandemic in 2020. Sixty-six out of the 141 surveyed companies provided answer to the COVID-19 related questions.

Mental health programmes were the most often cited measures across all sectors (35 out of 66 companies, 53%), with four specific sectors being largely represented: financials (23%), consumer discretionary (20%), industrials and utilities (both at 11%). Enabling teleworking conditions in order to reduce the presence of workers onsite and limit propagation of the virus was cited by 36% of companies, especially from four sectors: communication services, consumer discretionary (non-essential and luxury goods and services), information technologies and finally utilities. Enhanced hygiene measures and social distancing were explicitly mentioned by 29%, mostly cited by the utilities sector (basic amenities such as water, electricity and sewage). About 21% of companies cited COVID-19 medical upkeep such as company-paid tests and vaccination. Finally, temporary closures of facilities due to government imposed sanitary measures for non-essential businesses were reported by 6% of the companies, mostly by consumer discretionary company (representing 50% of those who responded).

In addition to health-related measures, company's responses to COVID-19 largely rely on financial protection of employees, which indirectly had protective effects on their mental health and well-being. Wealth, income and work are key dimensions of people's well-being (OECD, 2020[46]). For instance, in the 2020 WDI data, 56% of companies introduced an extended paid sick leave as a response to COVID-19, in order to assure that employees feel allowed to not going to work either because they are ill themselves or because they need to take care of others. Furthermore, 54% of companies provided some form of financial safety net to protect employees from financial hardship. These measures consist of emergency employee funds, salary guarantees, burial funds, and cash transfers to employees that were in positions of precarity due to the COVID-19 pandemic and qualified for the allocation of relief funds.

3.5.2. Making lifestyles healthier

Workplace-based programmes can focus on various behavioural risk factors, such as smoking, harmful alcohol use, physical inactivity, poor diet, or a combination of these. As highlighted in the 2020 WDI data, 31% of the 114 large company employers reported having implemented programmes to increase physical activity, 30% to combat addiction, and 23% to address obesity and nutrition. Across Europe, health promotion actions at the workplace have increased over time, according to the EU-OSHA's European Survey of Enterprises on New and Emerging Risks (ESENER). For instance, 32% of the respondent companies reported they implemented measures raising awareness of nutrition among employees in 2019, compared to 28% in 2014 (ESENER, 2019[47]). A number of programmes led by public or private employers illustrate good practices of WHWP, such as the Healthy Lifestyle Incentive Programme in the Salt Lake County (Box 3.7) and the smoking cessation programme at General Electrics (Box 3.8). Additional examples of good practices on promoting healthy lifestyles are collected by the European network of workplace health promotion (ENWHP), a not-for-profit association, which aims to facilitate dissemination of good workplace health practices in Europe (ENWHP, 2022[48]).

Box 3.7. The Healthy Lifestyle Incentive Programme in the Salt Lake County in the United States

The Healthy Lifestyle Incentive Programme (HLIP) is an occupational health intervention for all employees of the Salt Lake County in the state of Utah in the US. Its aim is to curb the increasing trends in rates of obesity, diabetes, heart disease and cancer, and their contingent costs. The programme includes free annual screenings, tailored feedback on screening results and incentives awarded within a token economy system that grants points to employees who engage in a set of health promoting activities (Neville, Merrill and Kumpfer, 2011[49]).

At the end of each programme year, points are exchanged by cash at the rate of USD 1 per 5 points with a typical cash award of between USD 75 and USD 250 per employee. If at the initial screening employees had cholesterol, blood pressure, proportion of body fat, and tobacco use under pre-set thresholds, they were awarded points. If, during the year, participants attended a 10-week weight loss or tobacco cessation class, had a mammogram or prostate exam, had follow-up for elevated cholesterol or blood pressure, and reported 20 days of exercise, they were awarded points as well.

For the period that goes from 2004 to 2008, the HLIP had a total cost of about USD 1.3 million. By assuming that participants would have generated the same average costs as non-participants if they had not taken part in the programme, the costs averted in medical and drug prescription claims were estimated to be about USD 4.8 million. Net savings generated by the programme were about USD 3.5 million, or USD 3.85 dollars saved per USD 1 spent in the implementation of the programme (Merrill et al., 2011[50]).

Box 3.8. Smoking cessation programme at General Electric in the United States

In 2008, a trial for a smoking cessation programme took place at General Electric Corporation. The trial intended to financially reward employees to help them quit. The trial was successful, and GE generalised the programme to its 152 000 US employees (Schilling, 2009[51]).

The financial incentives were structured as follows: USD 100 for completion of a smoking-cessation programme, USD 250 for cessation of smoking within 6 months after study enrolment, as confirmed by a biochemical test, and USD 400 for abstinence for an additional 6 months after the initial cessation, as confirmed by a biochemical test. Both the incentivised group and the control group enjoyed the same generous GE health benefits package, which covers tobacco cessation pharmaceuticals but does not pay for smoking cessation programs.

Results showed that after 12 months, the incentivised group had a smoking cessation rate three times higher than the control group (14.7% vs. 5.0%) (Volpp et al., 2009[52]). Evidence from the Netherlands also supports that financial incentives, in addition to training programmes (consisting of a 90-min session of smoking cessation group training at the workplace per week for 7 weeks), are effective to help employees quit smoking (van den Brand et al., 2018[53]).

Organisational factors contribute to the success of workplace lifestyle-promoting programmes, such as the development of a healthy workplace culture (discussed above in Box 3.1) **and the integration of surrounding work-related exposure and hazards into the programme**. The starting point for workplace programmes aiming to promote employee health, healthy lifestyles and well-being, relies on good prevention and management of occupational risks. Growing evidence shows that an integrated approach of health promotion to occupational safety and health has greater outcomes such as improved health behaviours, employee participation, reductions in injury illness and disability, reducing costs, and enhancing productivity (Tamers et al., 2019[54]). In the United States, the National Institute of Occupational Safety and Health (NIOSH) supports the *Total Worker Health*®[8] approach that integrates protection from work-related safety and health hazards with promotion of injury and illness-prevention efforts to advance employee well-being. For instance, the *Total Worker Health*® smoking cessation programme recommends an integrated approach to addressing not only personal factors (e.g. access to tobacco cessation pharmaceuticals) but also work-related hazards, such as chemical exposure that may exacerbate respiratory conditions, lack of control over work and work schedules. Addressing occupational risk factors and ensuring the workplace is safe increase employee buy-in for health promotion efforts (NIOSH, 2015[55]).

Evidence from the literature suggests that employees who benefit from a workplace programme modify health behaviours, although the heterogeneity across studies makes it difficult to draw solid conclusions. The literature research identified a large number of studies looking at the effects of workplace health programmes on health behavioural changes. For instance, smoking cessation programmes, in particular those entailing financial incentives, are effective to help employees quit smoking and remain abstinent after 12 months (van den Brand et al., 2018[53]; Volpp et al., 2009[52]; Cahill, Hartmann-Boyce and Perera, 2015[56]). A systematic review and meta-analysis, based on seven RCTs, showed that workplace interventions were effective in reducing alcohol consumption compared to usual care, although the quality of the studies was relatively low. Workplace interventions were effective in particular among the heavier drinkers with a reduction of 2.6 standards units of alcohol per week (Yuvaraj et al., 2019[57]). A two-year multicomponent workplace programme which included actions to promote a healthy diet, including through information events and education awareness campaigns, was found to increase consumption of fruit and vegetables by 0.3 servings a day (Afshin et al., 2015[58]). A systematic review and meta-analysis found that educational and behavioural strategies addressing sedentary behaviour significantly reduced sitting time by 16 min per eight-hour workday, environmental strategies by 73 min (which include the provision of sit-stand workstations and treadmill desks), and multi-component intervention by 89 min (Chu et al., 2016[59]). Similarly, evidence from a randomised controlled trial (RCT) found that workplace sedentary programmes based on organisational, educational and behavioural changes significantly reduced sitting time by 22 min per day, and up to 64 min when associated with a sit-stand desk (Edwardson et al., 2022[60]). While interventions to address sedentary behaviour are important for office-based workers, those working in more physically demanding jobs need different strategies to ensure health-enhancing physical activity and sufficient recovery time between tasks. A workplace wellness programme, entailing health risk assessment for employees, group activities, individual counselling about healthy lifestyles, and provision of performance-related bonuses or reimbursements to encourage participation, reduced Body Mass Index (BMI) after 12 months (Penalvo et al., 2017[61]). These findings are further supported in an umbrella review of the effectiveness and cost-effectiveness of workplace health promotion programmes (including single or combined lifestyle programmes), summarizing the conclusions of 60 meta-analysis and systematic reviews. This review found strong evidence of a favourable effect of workplace well-being programmes on health behaviours (physical activity, smoking cessation), on health outcomes of weight and BMI, stress/distress, anxiety/depression, and mental well-being (Murphy et al., 2018[16]). But, studies that assess WHWP, differ by design (type of intervention, follow up), worksites, populations examined, target (health behaviour), and by outcome measures. While some studies assess the effect on employee participation, some other look at health behaviour changes (or intention to change), and others at absenteeism. Overall, the variety in the

programmes and their assessment makes difficult to summarise the evidence in a systematic way (Wolfenden et al., 2018[62]).

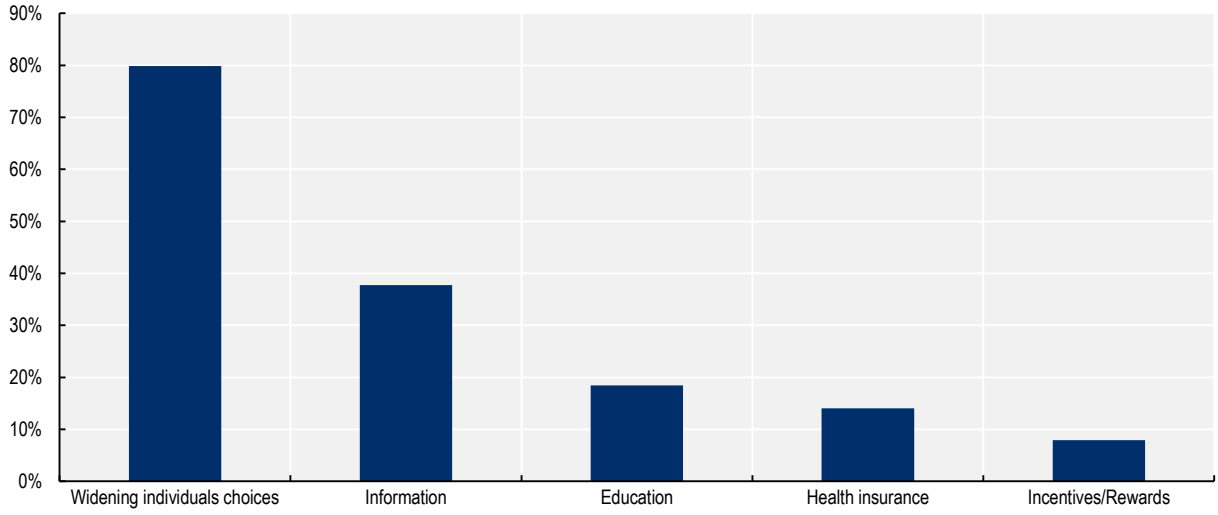
While some evidence supports changes in health behaviours on the short- and medium-term (up to 12 months), evidence for the long-term is scarcer. There are a few studies that could follow WHWP for a long period of time, and further research is needed on longer follow-up periods (Sidossis et al., 2021[63]). For instance, the long-term participation in the Healthy Lifestyle Incentive Programme implemented in the Salt Lake County improved BMI, blood pressure and cholesterol 8 years after enrolment (Neville, Merrill and Kumpfer, 2011[49]). In general, questions remain on the long-term effectiveness and sustainability of such programmes. It is likely that participants may get used to the programme or even lose interest in it. The initial effect of the intervention then tends to level off after a certain period of time. Renewing the programme, boosting personal accountability and monitoring outcomes over time can help to avoid lassitude of participants, and foster participation on the long-term. Also, to maintain interest in the programme, the interventions can be further tailored to specific individuals based on their risk factors or attitudes, or by increasing health literacy among employees (OECD, 2019[21]).

3.5.3. A variety of levers for behavioural change can be used to improve health and well-being of employees

WHWP can take various forms. A variety of levers can help to drive behavioural change towards healthy lifestyles. These were categorised into four main groups (Sassi and Hurst, 2008[64]). First, public health actions that widen an individual's choices, for instance, by offering healthier food options in cafeteria, providing sit-stand desks, or offering addiction management programmes such as EAP. Second, actions that influence individual's choices through persuasion, provision of information, or other suitable means (other than prices), like programmes that offer points and rewards to employees, such as the Healthy Lifestyle Incentive Programme in the Salt Lake County (Box 3.7). Third, actions that change the price of selected choice options, such as for instance financial incentives for smoking cessation (Box 3.8). Fourth, actions that restrict the choices by banning selected choice options, such as smoking bans (which is the responsibility of governments rather than the employer in many countries, as discussed in Chapter 4).

Widening individual's choices is the type of intervention most frequently reported by the employers of the WDI survey, followed by information campaigns and education. As shown in Figure 3.6, in the 2020 WDI data, 80% of the companies reported to offer health and well-being programmes that widen individual's choices, such as healthier food options at the workplace, addiction management, or EAP. Nearly two in five companies (38%) provide health information to their employees in the forms of pamphlets, awareness campaigns, and informative website and newsletters. About 18% provide education programmes through workshops, training, and seminars. Fourteen percent reported to provide health insurance coverage to its employees to support their access to medical care. About 8% offer financial incentives or rewards such as discount for gym membership or rewards for healthy behaviours (Figure 3.6).

Figure 3.6. Proportion of companies reporting WHWP, by type of programmes



Note: As companies may offer several answers, the sum is higher than 100%.
Source: OECD analysis based on 2020 WDI data.

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New technology and digital tools can simplify the delivery and management of WHWP. As of 2021, there are 6.4 billion smartphone users around the world (Statista, 2022[65]), corresponding to 80% of the global population owning a smartphone. Stakeholders involved in the design, implementation and evaluation of health programmes can benefit from this trend by adopting new digital tools to simplify and optimise the adoption of WHWP. For example, paper-based screening surveys can be easily moved to digital web-based supports, personalised information on health habits can be delivered by means of automatically generated messages, and incentive systems to reward healthy behaviours can be more readily and precisely managed by integrating them into digital environments. There are great opportunities for digital tools for health risk prevention and diseases management when promoted at the workplace, as illustrated in the Choose Well 365 programme implemented in a hospital workplace in the United States (Box 3.9). But a number of concerns have to be taken into consideration, for instance about data protection and privacy, and health regulation to avoid misleading health claims.

Box 3.9. The Choose Well 365 programme, in the United States

The Choose Well 365 randomised clinical trial was implemented at a hospital workplace in Massachusetts in the United States (Thorndike et al., 2021[66]). Its goal was to promote healthier dietary choices at the canteen by means of modifications of the choice environment, tailored feedback, and monetary incentives. The programme was run for a period of 12 months. The programme consisted in a food tag system in which items were labelled green if they were deemed "healthy", yellow if considered "less healthy" and red if "least healthy". Workers underwent an initial electronically-delivered screening that included indicators such as body-weight, fasting glucose and lipid-profile, and that asked the participants on their wish to maintain or lose weight.

Employees in the intervention group received automatically generated e-mails twice a week. The first e-mail contained information on the food purchase at the canteen during the prior week- proportion of food items purchased by tag colour, calories purchased and performance with reference to the calorie budget. The second e-mail contained two personalised health tips on healthy eating, physical activity, or disease prevention, and a simple and healthy recipe.

A USD 20 incentive was awarded to employees the first time they passed the 40%, 60%, or 80% thresholds of monthly green purchase. If a participant maintained green purchases above a new threshold without passing the next threshold, or if they stay above 80% of green tag food purchases, they earned USD 5 for the month. Employees below the 40% threshold at baseline could earn the most money – USD 115 – during the intervention.

Results showed that, at 12 months, the intervention group, compared with baseline, had significantly decreased purchase of red- labelled items, decreased calories purchase per day by 49.5 kcal and significantly improved the proportion of green items purchased.

3.6. Conclusion

Population ageing, the spread of chronic conditions and the rise in health consciousness among employers and employees – in particular, after the COVID-19 pandemic- are key drivers for the demand for workplace health and well-being programmes. There are multiple motivations for employers to invest in health and well-being programmes for their employees, including economic rationale, reputation motives, employee satisfaction, and external incentives. Workplace health and well-being programmes have a great potential in terms of population outreach and benefits for employers and employees. Regulation and incentives led by governments (discussed in the next chapter) are key levers for making the full potential of workplace health and well-being programmes.

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Notes

[1] Service types include health risk assessment, fitness, smoking cessation, health screening, weight management, nutrition, stress management, disease management, vaccination, etc.

[2] Only for medical cost savings.

[3] This calculation is based on 44 studies, with an observation period of a minimum of 12 months in duration. The savings were limited to a single economic variable (mostly medical cost savings), and were divided by the entire programme cost.

[4] It is assumed that this intervention would reach its maximum effectiveness 12 months after implementation (body mass index reduction by up to 0.64kg/m2), and then completely disappear after 36 months.

[5] As per the OECD definition, small-sized companies (1-49 employees), medium size (50-249 employees) and large sized companies (250+ employees).

[6] Measured as the degree to which the company leadership team supports the corporate fitness programme and promotes its success.

[7] Financial counselling, various leave options, additional services to accommodate particular needs.

[8] *Total Worker Health*® is a registered trademark of the U.S. Department of Health and Human Services.

4 Government policies to promote health and well-being at work: An analysis of ten OECD countries

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This chapter examines policy levers that governments can use to promote health and well-being through the workplace in ten OECD countries, including the Group of 7 (G7) (Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States) and the OECD countries in the Asia and Pacific region (Australia, Korea and New Zealand). After setting out the legal and policy context, it provides a comparative analysis of workplace regulations, return-to-work legislation, financial incentives, and other measures that governments can and are taking at both the national and sub-national level.

Key findings

As the impacts of ill-health and poor well-being in the workplace have a broader economic impact that can be accounted for by employers, policies – at both the national and sub-national level – play an important role in facilitating employers in promoting health and well-being in the workplace. The differing delineation of responsibilities between government, employers and insurance institutions across the ten countries studied in this chapter shapes the policy levers available to government. The ten countries studied are the G7 countries (Canada, France, Germany, Italy, Japan, the United Kingdom and the United States) and three OECD countries in the Asia and Pacific region (Australia, Korea and New Zealand).

Workplace regulations set minimum standards in terms of health, safety and well-being in the workplace, and are an important foundation for health and well-being promotion:

- Working hour regulations specify a maximum number of hours that employees can work in six of the ten countries. Such regulation, when enforced and complemented with supporting measures, can protect employees from working excessively long hours, which is a psychosocial risk factor.
- Employee health checks or screenings are only a requirement in three of the ten countries (France, Japan and Korea), although sector- and industry-specific requirements are common. This reflects differences in policy contexts, considerations over potential drawbacks of testing and worker rights to privacy for sensitive information.
- Smoking in the workplace is regulated in all ten countries as a public health measure, but only three of the countries have comprehensive smoking bans in enclosed workplaces (Australia, New Zealand, and the United Kingdom). Comprehensive smoking bans can be effective in reducing exposure to second-hand smoke. There is significant variation across the ten countries in their approach to e-cigarette use in the workplace.
- Only two countries (France and Italy) regulate consumption of alcohol at work across all jobs and all tasks. Alcohol consumption regulation is typically limited to safety-sensitive industries in the other countries.

Sick leave and return-to-work legislation and policies hold the key to preventing avoidable sickness absence and facilitating timely return-to-work.

- Employer-paid sick leave legislation, which is only available at the national level in six of the ten countries, can create financial incentives for employers to prevent absence from work and promote timely rehabilitation if the duration of employer responsibilities is sufficiently long.
- The COVID-19 crisis has triggered a number of governments – at the national and sub-national level – to consider redesigning or strengthening their legislation relating to sick leave, especially as allowing workers to stay away from work can slow down the outbreak of infectious diseases.
- Requirements to promote timely return-to-work and make accommodations for workers with health conditions are commonplace, although requirements to make accommodations are too often limited to employees with disabilities and does not refer to those with health conditions.
- Gradual return-to-work mechanisms, identified in two countries, aim for return to work through the initial provision of reduced working hours and lighter working duties, with a view to a phased return to regular duties.

Financial incentives are an important lever for governments to encourage and facilitate employers to go beyond basic accident prevention and safety, and to comprehensively promote health and well-being in the workplace.

- Lower insurance premiums from accident insurance systems are granted to employers with a better record of ensuring worker safety in all ten countries. Many insurance institutions – both health insurance and accident insurance – also provide further benefits and advantages for employers who engaged in additional action to promote workplace health and well-being.
- Tax credits, in the form of exemptions from corporate tax for expenditure related to workplace health and well-being, are available in at least four of the ten countries at the national level (France, Germany, Italy and the United Kingdom). Tax credits specific to promoting active commuting to work are available in two countries (France and the United Kingdom).
- Subsidies for employers to promote health and well-being in the workplace are less widely available and often specifically for small and medium-sized enterprises (SMEs), given the specific challenges they face. Subsidies are often only available to a very limited number of employers and thus do not affect the decisions of most employers with regard to health and well-being promotion.

Disseminating information, tools and guidance to promote health and well-being in the workplace is a low-cost way for governments to increase awareness and facilitate employer action.

- The involvement of non-governmental stakeholders – including charities, trade unions and employer associations – helps ensuring widespread outreach to employers and when developing health and well-being promotion tools and guidelines for them.
- Self-assessment tools, which allow employers to diagnose the extent to which they are effectively promoting health and well-being among employees, are available in at least four of the ten countries (France, Germany, the United Kingdom and the United States).
- Provision of guidance on health issues that remain stigmatised such as mental health (e.g. depression or anxiety) can be particularly important to ensure employers and line managers develop an understanding of what appropriate steps they could take to support workers.
- Information and guidance on the COVID-19 crisis has been widely disseminated. Guidance covers issues relating to slowing the spread of the coronavirus such as ventilation, teleworking and sanitary measures, but also other impacts of the pandemic such as ensuring employee well-being, managing stress and supporting workers experiencing long COVID.

Certification and award schemes can reward employers that promote health and well-being among their employees.

- Certification and award schemes have been increasingly developed both by governments and the non-governmental sector, and can provide reputational benefits by certifying that employers meet certain standards relating to health and well-being promotion at work. The Health and Productivity Management Programme (H&PM) in Japan is a particularly large-scale scheme, with around 7.7 million employees working for certified companies.
- These schemes often go hand-in-hand with the disclosure of information on company-led programmes and health and well-being in the workplace, which can be used to inform both policy and employer interventions, although collection of such data can raise concerns about data protection and privacy in some countries.

The public sector, which accounts for one in seven workers (14%) on average in the ten countries studied, has an important role to play in promoting health and well-being at work. It is a leading employer that can showcase good workplace health and well-being promotion practices for the private and other non-governmental sectors to follow.

4.1. Introduction

Governments play an important role in steering employers to promote the health and well-being of their employees in the workplace through a mix of regulations, incentives and the dissemination of information. In many circumstances, self-interested employers will see the promotion of health and well-being of their employees as a priority as discussed in Chapter 3, but this may not always be the case. Moreover, the costs of a lack of action to promote health and well-being that falls directly on employers accounts for only a fraction of the total economic cost, which includes reduced employment, pressures on the social security system and increased costs for health systems as discussed in Chapter 2.

The responsibility for employers to protect the health and safety of their employees is well-established both in international and legal policy contexts, but this is often narrow and limited to preventing accidents, injuries and deaths related to work, and misses the opportunities that the workplace presents as an ideal location for intervention and early action to prevent ill-health. This chapter, in line with the report-at-large, looks primarily at how policy levers can encourage employers to use the workplace as an arena for the promotion of healthy lifestyles and practices that are conducive to good health and well-being.

This chapter covers policies in ten countries consisting of the G7 countries and three additional OECD countries in the Asia and Pacific Region (Australia, Canada, France, Germany, Italy, Japan, Korea, New Zealand, the United Kingdom, and the United States). This allows for comparison across countries that have differing legal and policy contexts, but nonetheless share a commitment to promoting health and well-being at the workplace. This review does not aim to be exhaustive, and similar initiatives aimed at promoting health and well-being also exist in many other OECD countries such as the examples described in Box 4.1. This chapter reviews the levers used by the government of the ten countries to support companies to implement health and well-being programme for their employees, beginning by setting out differences in legal and policy contexts (Section 4.2). It then looks at (4.3) regulatory measures related to health and well-being at work, (4.4) paid sick leave and return to work policies, (4.5) financial incentives for employers to implement health and well-being programmes, (4.6) dissemination of information, (4.7) certification and award programmes, and (4.8) the potential of public employment to lead by example.

Box 4.1. Health promotion and well-being at work in other OECD countries

The review presented in this chapter focuses on 10 OECD countries, including countries part of the Group of 7 and OECD countries in the Asia-Pacific region. However, similar initiatives aimed at promoting health and well-being also exist in many other OECD countries such as in Costa Rica, Ireland, Poland and Portugal.

Costa Rica

The Occupational Health Council (OHC), as a technical body attached to the Ministry of Labour and Social Security (MTSS), has a mandatory leading role to execute prevention actions and co-ordination among the State, employers and workers representatives, to encourage a decent, safe and inclusive working culture and environment. OHC has supported the regulation to promote and strengthen well-being in the workplace, especially the Executive Decree 4135-MTSS-MCJ-MEP-MIDEPOR "Development of Intersectoral Community and Labor Well-being Promoting Interventions", and the Executive Order No.-027-S-MTSS on the Promotion of Well-being through the Adoption of Healthy Eating Habits, Physical and Mental Health, Physical activity and Work Recreation and Free Tobacco Smoke Spaces. OHC has also a key role in dissemination of information on promoting health through work. Specifically, OHC co-ordinates activities and public efforts that aim to improve health and safety conditions at work in all work centres, and encourages healthy practices in work environments and centres. Costa Rica commemorates the Well-being Week every year in September, an event established and promoted by PAHO/WHO, that aims to mobilise stakeholders to raise awareness and

encourage change towards healthy lifestyles, environments, and policies. As part of the local activities, recognition is expected to be granted to community and labour initiatives that show achievements in promoting healthy lifestyles, in accordance with the criteria established in the Ecological Blue Flag Program (national award scheme) in the category of community health.

Ireland

In Ireland, the Healthy Workplace Framework 2021-25 aims to support the growth of effective approaches to enhance health and well-being in the workplace. It recognises that workplaces have the potential to impact on the lives of a significant proportion of the population, with over 2 million people in employment in Ireland. The Framework has seven key objectives: 1. Build implementation structures, 2. Raise awareness, 3. Drive engagement, 4. Transform culture, 5. Provide supports, 6. Share good practice, and 7. Drive quality improvement and ensure sustainability. The Framework is underpinned by robust evidence and public consultation as well as ongoing engagement with key stakeholders including the Health Service Executive (HSE), health and safety, human resources, occupational health, and academia. The Department of Health and the Department of Business, Enterprise, and Innovation oversaw the development of this Framework. While many workplaces in Ireland have already embraced the health and well-being agenda, the development of this new Framework creates an opportunity to ensure it becomes embedded in the culture of all workplaces.

Poland

The Ministry of Health of Poland and Nofer Institute of Occupational Medicine in Lodz (NIOM) have been undertaking for years numerous initiatives to promote healthy lifestyles in the work environment, as part of the National Health Programmes for 2016-20 and 2021-25. A first example is the project on promoting physical activity and healthy diet in the world of work, run over 2016-20 by the National Centre for Workplace Health Promotion (NCWHP) located in NIOM, with the objective to improve competencies of employers and health managers about programmes promoting healthy eating and physical activities to tackle obesity and overweight. A second project was about promoting healthy and active ageing in employees, co-ordinated by NCWHP under the 2016-20 national programme, with the objective to educate employers, managers, human resource and occupational health specialists about creation and implementation of worksite programmes aimed at managing the health of ageing employees. A third example is a project in continuation of the two aforementioned, carried out over 2021-25 by NIOM. In particular, it relies on consultation centres that propose free consultations for employers and workplace health management professionals – by multidisciplinary team of NIOM experts – on environmental (including lifestyle-related factors) and occupational health determinants, planning, developing and implementing strategies to promote the health of ageing employees. Additional activities include development and implementation of educational materials, tools and campaigns for employees, employers, and occupational health professionals.

Portugal

In Portugal, the "Legal Regime for the Promotion of Safety and Health at Work" is specific to work legislation since 2009, which includes the development of health promotion activities among the main activities under the responsibility of the occupational safety and health services. By law, smoking is not allowed in enclosed workplaces. However, smoking may be permitted in designated areas expressly provided for this purpose as long as they comply with specific legal requirements. Detection of alcohol and illicit substance use may be carried out through toxicological tests in a limited number of professions linked to high levels of safety and performance, and according to well-defined parameters approved by the organisation/enterprise. Tests are undertaken only at the request and/or responsibility of the occupational health doctor. There is no comprehensive national law limiting or prohibiting alcohol and illicit drugs consumption at the workplace, but several regulations apply at the local administration level, such as city halls.

Source: For Ireland: www.gov.ie/en/publication/445a4a-healthy-workplace-framework/; for Poland: https://www.imp.lodz.pl/, https://promocjazdrowiawpracy.pl/, https://www.pracanazdrowie.pl.

4.2. Labour and workplace legislation and health system characteristics set the foundation for the range of policy levers available to governments to promote health at work

Standards and legislation relating to health and safety at work have existed for decades at the international, national and sub-national level, which underpin and shape the promotion of health, safety and well-being in workplaces. In many cases, such standards place a focus on traditional occupational safety and health approaches and are thus concerned with the prevention of work-related accidents, injuries and fatalities. At the international level, these include the 1981 Occupational Safety and Health Convention of the International Labour Organization, and the 1989 EU Framework Directive on Safety and Health at Work for three member countries of the EU. Specifically, in the European Union, Occupational Safety and Health (OSH) is regulated by the Framework Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work, and other related EU OSH directives, which are transposed by the EU Member States into their national laws, regulations and administrative provisions. Member States can adopt more stringent measures, going beyond the minimum requirements provided for in the abovementioned Directives. In countries with decentralised governments, OSH regulation and enforcement may be under the responsibility of sub-national authorities, which is recognised in this chapter. For instance, in Australia, state and territory governments regulate and enforce the work health and safety laws in their jurisdiction. In Canada, each provincial department is responsible for the administration and enforcement of OSH act and regulations.

In all ten countries, employers play a primary role in financing and organising measures relating to health and safety at the workplace, and this is typically enshrined in national legislation. In many countries, such as France, Germany, Italy and Japan, employers are specifically required to provide occupational health services to employees. In Japan, this requirement only applies to employers with more than 50 employees as small and medium-sized enterprises (SMEs) can access regional occupational health centres that are funded by government and can provide advice and guidance for both employers and employees. While such services have traditionally focused on preventing work-related accidents, injuries and fatalities, they have broadened their scope in some cases to also include health promotion.

The shift to focusing on health promotion and well-being and going beyond traditional occupational safety and health is more visible when looking at action plans and programmes that set out priority areas and are shown in more detail in Table 4.1. Workplace health and well-being considerations may be included in occupational health and safety strategies such as in Germany, or within broader health promotion strategies such as in Japan. In Germany, the Occupational Safety and Health Strategy includes traditional issues such as safe handling of carcinogenic materials in its objectives for 2019-24, but also broader issues such as the prevention of psychosocial strain and musculoskeletal disorders. In Japan, while the Occupational Safety and Health Strategy is relatively narrow, the National Health Promotion Movement in the 21st Century action plan includes measures to eliminate passive smoking in the workplace and address long working hours. In Italy, strategies on health at the workplace are included in the broad National Prevention Plan, but there are also three condition-specific national strategies, which are on the prevention of musculoskeletal disorders at work, work-related stress and occupational carcinogens/cancers.

Table 4.1. Description of national strategies relating to health and well-being in the workplace

Country	Name of relevant strategies	Description of strategies
Australia	Australian Work and Safety Strategy 2012-22	The strategy seeks to promote "healthy, safe and productive working lives" for all workers and across all sectors. There are three targets to be achieved by 2022 which are to reduce (1) worker fatalities due to injury by at least 20%, (2) incidence rate of claims resulting in one or more weeks off by at least 30%, and (3) incidence rate of claims for musculoskeletal disorders resulting in one or more weeks off work by at least 30%. The National Preventive Health Strategy for 2021-30 also includes workplace objectives including to promote physical activity and elimination of exceptions to the prohibition of smoking in workplaces.
Canada	Not applicable	Strategies are developed at the provincial and territorial level. For example, Ontario has a five-year Prevention Works Strategy for 2021-26, which includes a specific focus on eliminating barriers for SMEs to ensure health and safe workplaces. Quebec also updated its OSH legislation in 2022, which will among other changes, mean that employers have to provide prevention programmes and psychological health is fully embedded in OSH.
France	4th Occupational Health Plan 2021-25 (*Plan santé au Travail)*	The plan focuses on prevention and sets up ten operational objectives across one cross-cutting axis – tackle deadly and serious work accidents – and four strategic axes cantered on addressing emerging occupational health issues such as gender-related violence. The plan was developed jointly by the government, public health agencies and social partners.
Germany	Joint German Occupational Safety and Health Strategy 2019-24 (Gemeinsame Deutsche Arbeitsschutzstrategie)	The objectives of the plan are to ensure safe handling of carcinogens and good work organisation to prevent psychosocial strain and musculoskeletal workload. The plan was jointly developed by the national government, the 16 states and accident insurance institutions.
Italy	National Prevention Plan 2020-25 (Piano Nazionale della Prevenzione)	There is an objective relating to workplace health in the National Health Plan. There are elements relating to accident and injury prevention, but also references to health promotion in the workplace in a changing world of work. The plan also mentions standards such as the *Total Worker Health®* approach in the United States and the Healthy Workplace Model of the World Health Organization. There are also two condition-specific national strategies, which are on the prevention of musculoskeletal disorders at work and work-related stress.
Japan	National Health Promotion Movement in the 21st Century (Healthy Japan 21) 13th Occupational Safety & Health Program 2018-22	Japan has both a health promotion plan (Healthy Japan 21) with a workplace element and a specific OSH strategy. Healthy Japan 21 includes targets specific to coverage of mental health supports in workplace settings, incidence of long working hours, and exposure to second-hand smoke at the workplace that will apply through to end-2023. The OSH strategy focuses primarily on accident prevention (e.g. hazardous materials), although with specific health considerations such as occupational back pain and job-related anxiety.
Korea	4th Labor Welfare Promotion Plan 2017-21 National Safety Control Plan 2020-24	The Labour Welfare Promotion plan supports the creation of safe workplace and the improvement of workers' health. To this end, the government strives to improve working environment (harmful and hazardous facilities) and provides mental health and psychological therapeutic services to emotional workers. Priorities include a) to create a safe workplace through intensive industry-specific management of risk factors, b) to reduce the maximum working hours to a 52 hours per week, c) to build a supportive environment to enhance equity in workers' health management, and d) to prevent suicide by providing mental health services. Korea also has a National Safety Control Plan that provides direction on measures to prevent industrial accidents.
New Zealand	Health and Safety at Work Strategy 2018 – 2028	This strategy places the emphasis on the importance of ensuring health as much as safety of workers. The strategy outlines health risks primarily related to workplace accidents and injuries, but also includes a specific reference to work-related stress.
United Kingdom	Shaping Future Support: The Health and Disability Green Paper 2021	This strategy has an emphasis on helping prevent workers with a health condition or disability from falling out of work and supporting them in their return-to-work. The government's strategy to prevent ill-health related job loss is also due to be published in 2022 as a response to a consultation on how employers can support people at work with health conditions. These two strategies, when combined, covers the areas included in the previous 2017 strategy, Improving Lives: The Work, Health and Disability Green Paper.
United States	National Institute for Occupational Safety and Health (NIOSH) Strategic Plan 2019-24	The plan includes seven strategic goals including the reduction of occupational diseases such as chronic diseases (cancer, cardiovascular diseases, adverse reproductive outcomes), hearing loss, immune, infectious, & dermal disease, musculoskeletal disorders, respiratory disease, traumatic injuries, and the promotion of safe and healthy work design and well-being. Along with the Healthy Work Design and Well-Being Program, NIOSH also has a *Total Worker Health®*[1] Agenda which includes programmes and measures to promote worker well-being by creating safer and healthier work environments.

Source: International Comparison of Occupational Health Systems and Provisions: A Comparative Case Study Review, Department of Work and Pensions (2021[1]); national legislation.

As the range of strategies presented in Table 4.1 shows, the delineation of responsibilities for promoting health and well-being at work varies widely across the ten countries studied. Responsibility for health and well-being at work can fall under the responsibility of either the health agency, the labour agency or a mix of both. In the United States, the National Institute for Occupational Safety and Health (NIOSH) is part of the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services. By contrast, in Korea and New Zealand, the Korea Occupational Safety and health Agency (KOSHA) and WorkSafe operate under the direction of the Ministry of Employment and Labour and the Ministry of Business, Innovation and Employment respectively. In many cases, it is unclear where the responsibility for the promotion of health and well-being at work lies, which can result in a lack of co-ordination and attention across government (OECD, 2021[2]). To address this issue, the United Kingdom, for example, launched a Work and Health Unit (WHU) in 2015 as a joint unit of the Department of Work and Pensions and the Department of Health and Social Care, with the aim of promoting cross-sectional collaboration on health and work. The WHU has subsequently led a number of reviews and analyses on the promotion of health and well-being at the workplace to inform policy making.

In addition to governments and policy makers, other stakeholders play an important role in shaping health promotion at work; these includes insurance institutions, employers, employees, trade unions and social partners. For instance, trade unions play an important role in ensuring good working conditions and guaranteeing employee health and safety through promoting collective bargaining. The difference in the proportion of employees who are members of trade unions, despite a crude measure, gives some indication as variability across countries in trade union arrangements. While trade union density lies on average at around 18% among the ten countries studied, it is lowest at 10.3% in France and highest at 32.5% in Italy (OECD and AIAS, 2021[3]).

Collective bargaining plays an important role not only in wage-setting, but also in setting other conditions of employment such as job security, working time and occupational safety and health, all of which are issues that are closely related to health and well-being (OECD, 2019[4]). The role of trade unions in working hour regulation, for example, are described in detail in Section 4.3.1. Trade unions are also involved in international level discussions on workplace health promotion. For instance, the European Trade Union Confederation has contributed to the EU Strategic Framework on Health and Safety at Work 2021-27. Trade unions and their networks may also run their own programmes and research, building on their role of strengthening employee-employer relations. A notable example is the Health Workplaces Project launched in 2013 by the Trades Union Congress, a national trade union centre in England and Wales. The TUC has since increased the involvement of employees in health promotion initiatives working together with the National Health Service and other major employers. As a result of participating in the project, 40% employers reported a fall in sickness absence while more than 70% of employers and 90% of employees reported the workplace was a better place to work (TUC, 2013[5]).

The institutional arrangements of health systems results in significant differences in the role of employers in promoting the health and well-being of employees across the ten countries. For example, workplaces may play a larger role in Korea and Japan where primary care services are less prominent features of the health system as this can result in the decentralisation of the health system (OECD, 2019[6]). In other countries, general practitioners or primary care physicians deliver interventions that might otherwise be well-suited for implementation in workplaces, and typically act as gatekeepers to specialist care. In five of the countries, there are requirements to receive a referral to a specialist (Australia, Canada, Italy, New Zealand and the United Kingdom). In the remaining three countries, there are incentives to register with a primary health care physician (Germany), incentives to receive a referral to a specialist from a primary care physician (the United States) or incentives for both (France) (OECD, 2020[7]).

Health system characteristics also influence the role of the employer in financing health care as shown in Table 4.2. Five of the ten countries operate a national health system that entitle individuals to health care based on residency (Australia, Canada, Italy, New Zealand and the United Kingdom). In these countries, health care services is mostly financed by government schemes and thus employers tend to play a minimal

role. Employers may also provide private health insurance as an employee benefit and this is common especially in Canada. By comparison, France, Germany and Japan have multi-payer health insurance systems where employers and employees together pay contributions for health insurance. The United States is an exception as it has no universal health coverage. Despite employers being required to provide health insurance coverage for employees as part of the Affordable Care Act, only around 55% of the US population receive employment-sponsored health insurance. Employers also purchase health care directly for employees, although this accounts for a very small proportion of health care expenditure and no more than 1.2% of expenditure across any of the ten countries studied. The role of accident and workers' compensation insurance is discussed in Section 4.5.1 on insurance-based incentives, as these all interact directly with employers across the ten countries studied.

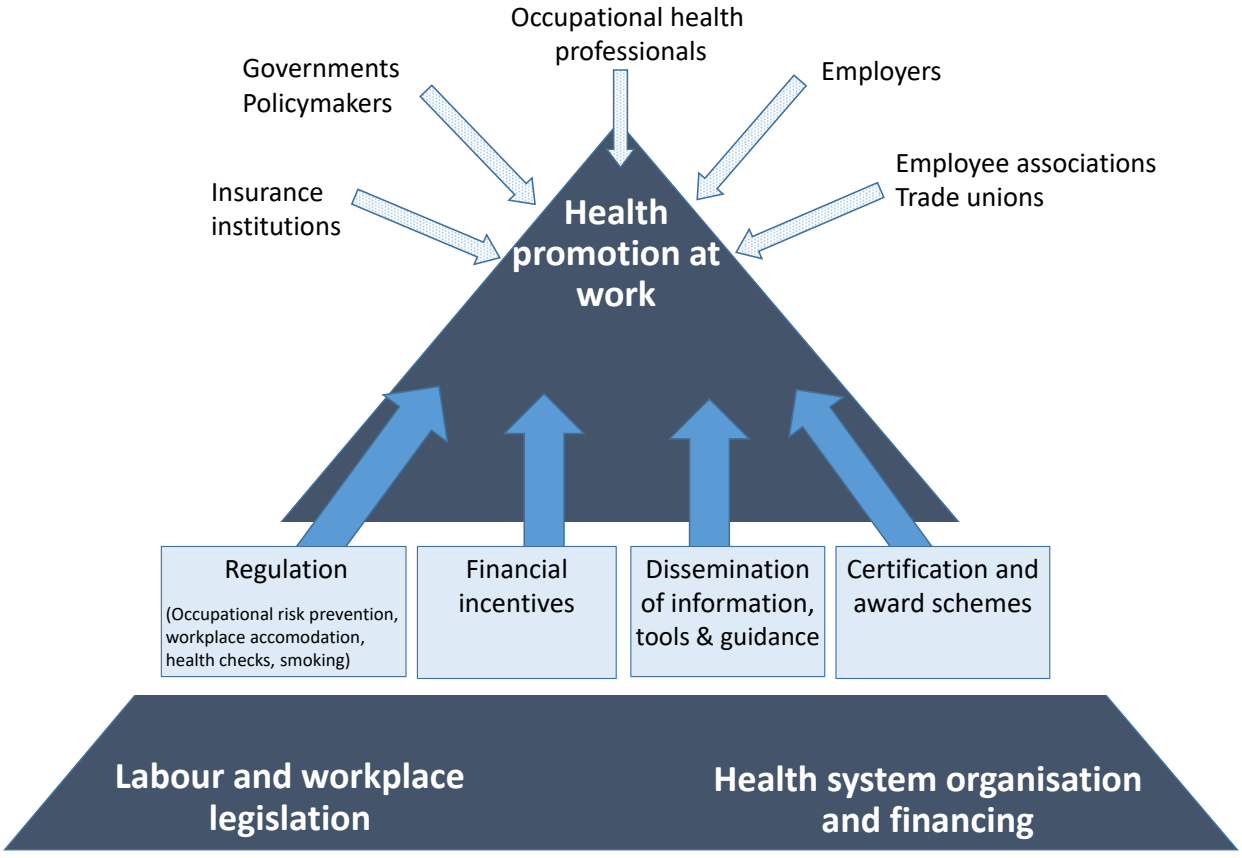
Table 4.2. Health system characteristics influence the role of the employer in financing health care

	Health system type	Role of employer
Australia	Universal national health system.	Voluntary private insurance is purchased by individuals. Complementary private insurance is held by 46% of the population.
Canada	Universal national health system covering medically necessary hospital and physician services.	Employment-sponsored insurance is common to provide complementary coverage to the universal health system. Complementary private insurance held by 67% of the population
France	Multi-payer insurance model.	Employer and employee both pay public health insurance contributions. Employers are also required to make voluntary private insurance available to all employees.
Germany	Multi-payer insurance model. Most are covered by public health insurance (88%), with the rest covered by substitutive private health insurance.	Employers pay half of the public health insurance contributions for most employees.
Italy	Universal national health system.	Voluntary private insurance may be provided by employers.
Japan	Multi-payer insurance model. Combination of employment-sponsored insurance and residence-based insurance. There is also a non-contributory public assistance system for those who face financial challenges.	Employment-sponsored health insurance held by 59% of the population. Voluntary private insurance is rarely offered by employers.
Korea	Single-payer insurance model.	Employer and employee both pay health insurance contributions. Most households hold some form of complementary health insurance.
New Zealand	Universal national health system.	Complementary private insurance held by 33% of the population. It is usually purchased by individuals.
United Kingdom	Universal national health system.	Complementary private insurance held by 10.5% of the population. Private insurance may be provided as an employee benefit.
United States	No universal health coverage. Around 92% of the population estimated to be covered by health insurance.	Private health insurance held by 67% of the population. Employment-sponsored health insurance held by 55% of the population.

Source: Health Systems Characteristics Survey; OECD, (2020[8]); Country Health Profiles, OECD, (2021[9]); International Health Care System Profiles; The Commonwealth Fund (2020[10]); Health Systems Institutional Characteristics: A Survey of 29 OECD Countries; Paris, Devaux and Wei (2010[11]).

Figure 1.6 shows the role that labour and workplace legislation and health systems play in setting the foundation for health and well-being at work and shaping the range of policy levers available to governments to promote health at work. These policy levers, which are described in the rest of this chapter, include (i) regulation, (ii) financial incentives, (iii) dissemination of information, and (iv) certification and award schemes. Figure 1.6 also highlights the role of stakeholders including occupational health professionals – who play an important role to diagnose risks and health problems in companies, identify needs and solutions – governments and policy makers, insurance institutions, employers, employees, trade unions and social partners.

Figure 4.1. Determinants of health and well-being promotion through work



4.3. Workplace regulations set minimum standards on employers' responsibilities to ensure health and safety in the workplace

Laws and regulations, when clear and well-designed, play an important role in setting legal standards relating to health in the workplace. General principles around employer responsibilities for employee health have already been discussed within the framework of occupational safety and health laws in Section 4.2, and thus this section looks at more issue-specific regulations that require employers to take actions relating to employee health and well-being in four areas. These are working hours (4.3.1), health check-ups (4.3.2), smoking at work (4.3.3), and alcohol consumption at work (4.3.4). Regulations relating to sick leave, return-to-work and reasonable accommodations for workers with health conditions is covered in Section 4.4.

While regulations can also only play a partial role in promoting health and well-being, it is primarily geared towards preventing accidents and work-related injuries. This is because regulation only sets out a minimum standard that employers are required to meet, which usually relate to workplace hazards, and there is no incentive to take further steps beyond this minimum standard. A combination of the threat of fines and the possibility for labour inspections play an important role in deterring employers from violating these regulations. Many governments also provide information and guidance to employers on how to ensure they are compliant with regulations as discussed in the sections below.

4.3.1. Working hour regulations to prevent excessively long working hours that can be detrimental to health are widespread

As discussed in Chapter 2, the health risks of excessively long working hours are well-established. A joint WHO/ILO analysis has shown that the disease burden that can be attributed to exposure to long working hours is higher than that of any other occupational risk factors. Most of the ten countries studied therefore have some form of regulation combined with supporting measures to minimise incidence of employees working excessively long working hours as shown in Table 4.3. Most countries set regulation on statutory normal working hours, which is supplemented by a statutory limit on maximum working hours including overtime (OECD, 2021[12]). **From a public health perspective, the priority is to prevent excessively long working hours as opposed to reducing median weekly hours, and thus the focus is placed on maximum working hour regulation.**

Table 4.3. Regulation on weekly working hours and compliance

Country	Normal weekly working hours	Maximum weekly working hours (including overtime)	Measures to enforce compliance
Australia	38 hours	No statutory limit	Employers are required to record working hours.
Canada	40 hours	48 hours	Employers are required to record working hours. The labour inspectorate can implement escalating compliance and enforcement actions including fines of up to CAD 250 000 (USD 200 00) for recurring offences.
France	35 hours[a]	48 hours	Employers are required to record working hours. Breach of working time regulation can result in fines ranging from EUR 45 000 to EUR 225 000 (USD 53 000 to 266 000) and potential imprisonment for individuals responsible.
Germany	No legal limit[a]	48 hours	Employers are required to record working hours. Breach of working time regulation can result in fines up to EUR 15 000 (USD 18 000) and potential imprisonment for individuals responsible.
Italy	40 hours[a]	48 hours	Employers are required to record working hours. Violations can result in administrative fines of up to EUR 10 000 (USD 12 000) depending on the number of breaches and the amount of extra time
Japan	40 hours[a]	51.25 hours[b]	Employers are required to record working hours. The Labour Standards Inspection Office carries out targeted inspections. Violations can result in an imprisonment of up to six months for individuals responsible or a fine up to JPY 300 000 (USD 2 700). Subsidies available.
Korea	40 hours	52 hours	Breach of working time regulation can result in fines and potential imprisonment for individuals responsible. Subsidies available.
New Zealand	40 hours	No statutory limit	Employers are required to record working hours.
United Kingdom	No legal limit	No statutory limit[c]	Targeted labour inspections including by specifically trained working-time officers. Improvement notices can be escalated to fines and imprisonment for individuals responsible.
United States	40 hours	No statutory limit	Employers are required to record working hours.

Note: Regulation on weekly hours is usually applied based on average hours over a certain number of weeks. The regulation shown above relates to statutory rules on working hours.
[a]In these countries, the OECD Policy Questionnaire was also able to find the most frequent or the average clause in terms of working hours among all workers covered by collective bargaining, which differ slightly from the statutory working hours.
[b]In Japan, statutory working hours are 40 hours per week, and the overtime limit is set at 45 hours per month and 360 hours per year in principle. Therefore, 51.25 hours per week is just a rough standard.
[c]There is a statutory limit on weekly working hours in the United Kingdom but individuals can opt out, and most contracts include such provisions.
Source: OECD Policy Questionnaire on Working Time Regulation, 2020.

As shown in Table 4.3, the most common limit on maximum weekly working hours is 48 hours (Canada, France, Germany and Italy). This is aligned with the EU's Working Time Directive, which requires that average weekly working hours must not exceed 48 hours including overtime. The United Kingdom also has a statutory limit of 48 hours per week, but most contracts include provisions where employees opt out of this limit, and hence, it is shown as having no statutory limit. Korea has a slightly higher limits at 52 hours, and the country has implemented reforms to reduce incidence of excessively long working hours in recent years. The impact of Korea's reform to phase in a reduction in maximum weekly hours from 68 to 52 hours is discussed in more detail in Box 4.2.

Box 4.2. Korea's working time reform to reduce maximum weekly working hours from 68 to 52

While the incidence of long working hours has declined significantly in recent decades, in 2019, almost one in five workers (18%) in Korea still reported working more than 55 hours per week, significantly above the OECD average of 10%. Long working hours affect health, productivity and well-being, and could also be linked to the high rates of fatal accidents and injuries at work in Korea. It also hinders work-life balance. For example, it can create obstacles to working for women who are pregnant or workers with caring responsibilities. The government thus subsequently launched a working time reform to reduce the incidence of long working hours through reducing the maximum statutory weekly working hours from 68 to 52 hours per week, which was implemented between 2018 and 2022. This brings the regulation on maximum weekly working hours in Korea more closely in line with the ten countries studied.

The reform consisted of a reduction of the maximum weekly overtime hours from 28 to 12, while the normal weekly working hours were kept at 40 hours per week. Recognising that fulfilling this requirement would be more challenging for SMEs, the reform was implemented in a gradual manner, with larger employers subject to the regulation first. Since July 2018, all firms, state and local governments, and public institutions with at least 300 regular employees were required to comply with the new working hour regulation, with active enforcement taking place in July 2019. This reform was extended to workplaces with 50 to 299 regular employees in January 2020, then to workplaces with 5 to 49 regular employees in July 2021. The government also put in place support measures to promote compliance including subsidies. Firms that fulfilled the requirements, could receive grants up to KRW 800 000 (Korean won) (USD 700) per month (up to two years) as compensation for the indirect cost, and a further KRW 400 000 (USD 350) per month (up to 80% of the employer's payment and up to two years) to compensate employees for a reduction in their wages. These subsidies were boosted if firms achieved compliance with the new weekly limit before it was legally required.

While a full picture is yet to emerge, preliminary evidence suggests that the reform may be effective and receives public backing. For example, the percentage of workers who worked more than 52 hours a week decreased gradually from 15.1% in 2017 to 6.8% in 2021. In a survey in 2021 by the Ministry of Employment and Labour, three in four respondents (78%) considered the reform to be a "good thing", and an overwhelming majority (88%) reported that their workplace was either "strictly complying" or "complying in some degree" with the new regulation (2022[13]). Challenges nonetheless remain in ensuring the successful implementation of the regulation, including ensuring that coverage of the new regulation applies to a sufficient number of workers. In 2021, around two in five workers were still not covered by the regulation due to exemptions. The incidence of long working hours within this group of exempt workers is also high compared to sectors where the new regulation applies (2020[14]).

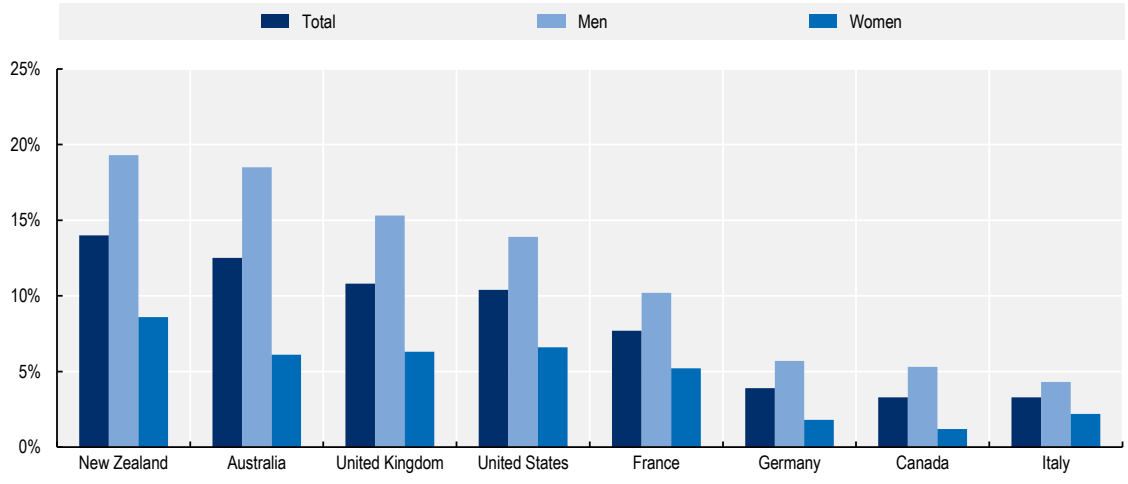
Source: Hijzen and Thewissen (2020[14]), The 2018-21 working time reform in Korea: A preliminary assessment; Ministry of Employment and Labor of Korea (2021[15]; 2022[13]), "52-Hour Work Week Receives "Thumbs Up" among 77.8% of Korean Workers", https://www.moel.go.kr/english/news/moelNewsDetail.do?idx=3062, and "The Work Hours Reduction System will Extend its Reach from Next Year", https://www.moel.go.kr/english/news/moelNewsDetail.do?idx=3061.

It is important to note, however, that while Table 4.3 presents statutory working hours, **working time is an area where rules negotiated through collective bargaining are particularly important, as this results in significant variation in practices depending on local and sector-specific needs** (OECD, 2019[4]). While the upper limit on maximum hours is bound either by the statutory or collectively agreed level at the central level in Germany and Korea, there is a possibility to exceed the upper limit on maximum hours based on collective agreements at the sub-national level or in individual contracts in the other eight countries (OECD, 2021[12]). For instance, in Germany, collective agreements signed in 2018 pointed to a shift towards unions representing metal workers calling for greater individual choice over working hours rather than a reduction in working hours that apply across all workers in the sector (OECD, 2019[4]).

Despite regulation, excessively long working hours nonetheless remain relatively widespread across the countries studied as shown in Figure 4.2, and is higher among men than women among all countries studied.[2] Although in countries with no statutory limits on maximum weekly working hours (Australia, New Zealand, United Kingdom and the United States), the proportion of employees working more than 50 hours per week exceeds 10%, there is still a sizeable proportion of employees reported to be working more than 50 hours in other countries with a 48 hour weekly limit. While there is no comparable data from Japan and Korea, it is well-established in both countries that excessively long working hours is considered an issue with significant health costs that requires policy attention (Hijzen and Thewissen, 2020[14]; OECD, 2018[16]).

Figure 4.2. Employees working excessively long hours remains widespread

Proportion of employees reporting working more than 50 hours per week by gender



Note: Data refer to 2020 except for Australia (2018).
Source: OECD Better Life Index, 2020, stats.oecd.org.

StatLink https://stat.link/512ztr

Governments face an uphill challenge in enforcing compliance with working time regulations. Employers are typically required to record working hours, and compliance is enforced through a mix of targeted inspections and the threat of potential fines and imprisonment for the individuals responsible. In a recent assessment by the ILO on the implementation of international instruments on working time arrangements, trade unions across many countries reported that the lack of clear delineation of responsibilities hampered inspection efforts, and that in many cases, there has been insufficient resources dedicated to tackle violations of working time regulation (ILO, 2018[17]). Where inspections are held, violations of working hour regulation may still occur regularly. For example, of the 24 042 workplaces that

the Labour Standards Inspection Offices in Japan visited in April 2020 to March 2021, more than one in three (37.0% or 8 904 workplaces) were found to have illegal overtime work. Of those found to have illegal overtime work, around one in three (33.5% of those will illegal overtime work or 2 982 workplaces) were found to have employees working in excess of 80 hours of overtime per month (MHLW, 2021[18]).

Governments also provide softer supporting measures to facilitate a reduction in incidence of long working hours. Among the countries studied, Japan and Korea are the only countries that have recently provided grants and subsidies for employers seeking to reduce excessively long working hours. In Japan, there is a subsidy for SMEs to implement work style reforms to reduce overtime work and promote take-up of annual leave. In Korea, as discussed in Box 4.2, the government supported the firms that reduced working hours to 52 hours per week in accordance with the working hour reform. Information is also widely disseminated in some countries to encourage compliance. In Korea, SMEs are able to receive free counselling support from labour experts on how to reform their workplace policies, while in the United States, the Department of Labor has developed a dedicated mobile timesheet app that employers and employees can use to keep track of working hours.

4.3.2. Countries rarely place requirements for health check-ups of employees due to employee privacy concerns

While health check-ups and examinations at the workplace can promote early identification of ill-health and thus facilitate intervention and treatment, this is rarely reflected in national policies. This may reflect drawbacks of health checks, differences in legal and policy contexts and concerns over employee privacy. Among the ten countries studied, while many have sectoral regulation requiring examinations of workers in hazardous circumstances, only three (France, Japan and Korea) require the provision of health check-ups to employees across sectors on a regular basis.

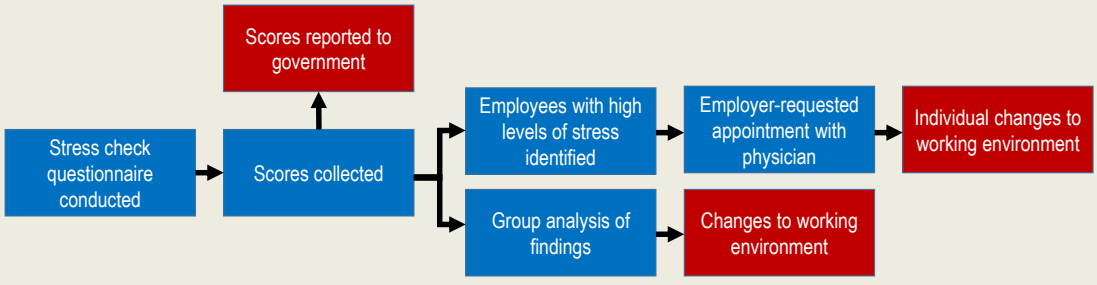
Japan has the strictest requirements, with employers obliged to offer a core health check-up (*ippan kenshin)* to all employees upon hiring and on an annual basis thereafter. These check-ups must include at least a standardised set of items that cover employee-reported items such as medical history, but also weight, vision, hearing, blood pressure, urinary sugar and uric protein tests (OECD, 2019[6]). All employers with more than 50 employees are required to report this information, and any employer failing to provide a core health check-up to their employees is subject to a fine of up to JPY 500 000 (Japanese Yen) (USD 4 600). SMEs can also apply for subsidies to finance the implementation of the health check-ups. Since 2015, all employers in Japan with more than 50 employees are also required to offer a stress check to their employees. The stress check consists of a questionnaire, which when filled by employees, provides insights for employees themselves, employers and policy makers as shown in the flow chart presented in Box 4.3. Employees receive individual scores, based on which they can alter their behaviours, and employers can make adjustments at both the individual and organisation-level based on the results. Employers then send their anonymised data to the government, which provides evidence on the uptake and usefulness of the stress check.

Box 4.3. Employers in Japan are required to conduct annual stress checks of their employees

All employers with more than 50 employees in Japan are required to evaluate the stress levels of their employees since December 2015. In 2020, 84.9% of employers offered the stress check, varying from 79.6% among employers with 50-99 employees to 97.3% for employers with more than 1 000 employees (2020[19]). The stress check aims to increase awareness of stress among employees such that they can take measures to prevent a deterioration of their mental health at the individual level, while also providing data for employers to assess how they can address psychosocial risk factors at work.

As shown in Figure 4.3, all employees are asked to fill the stress check questionnaire, and the results are used to make changes to the working environment at both the individual and company-wide level. The Ministry of Health, Labour and Welfare recommends that employers use a 57-item questionnaire with a four-point Likert-type scale, which is based on a questionnaire designed by the National Institute for Occupational Safety and Health in the United States. The recommended questionnaire captures a range of factors including work-related issues, individual factors and relationships with work colleagues.

Figure 4.3. Simplified process of stress check implementation for employers



Source: Based on information from Kawakami and Tsutsumi (2016[20]), The Stress Check Program: a new national policy for monitoring and screening psychosocial stress in the workplace in Japan, https://doi.org/10.1539/joh.15-0001-ER.

Individuals identified as having high levels of stress can request an interview with a physician. If requested, the employer is then required to arrange an appointment and make changes to the individual's working conditions as recommended by the physician. In 2017, 0.6% of employees receiving the stress check requested such an appointment. This low proportion may be indicative of continued stigma surrounding stress, especially as more than 10% of employees are identified as having high levels of stress in surveys (2020[21]). Measures are also in place to support the implementation of the stress check. Subsidies are available to SMEs to help them implement the stress check, and additional funds available in cases where a high-risk employee requests an appointment with a physician. A dedicated website for employers provides software to support implementation of the stress check and interpret results. Information on the value of the stress check and how to promote mental health at work is also available in the *Kokoro no Mimi* (Ears of the Mind) online portal.

The effectiveness of the stress check is also contingent on employers conducting data analysis of their findings and to using this to make changes to the working environment. The government has thus funded guides targeted at employers on how to make effective adjustments to the working environment, including through the involvement of employees. SMEs can also apply for subsidies to improve the working environment or to implement mental health promotion plans in the workplace. The proportion of employers reporting analysing the data from the stress check to make adjustments to the working environment has increased over time from 37% in 2016 to 67% in 2020 (2020[19]).

Source: Data reported from Inoue (2020[21]), Improvements in the working environment: information based on group analysis of stress checks, https://www.mhlw.go.jp/content/000715404.pdf; Ministry of Health, Labor and Welfare (2020), Implementation of stress check System [*Stress check seido no jisshi joukyou*], https://www.mhlw.go.jp/content/11303000/000805299.pdf.

In France, there is a requirement for a visit for information and prevention of ill-health with an occupational physician within three months of employment, and every five years thereafter. However, there is no obligation to go beyond by asking employees about their health status or by providing them with information and guidance during such visits. While such an arrangement may be non-intrusive and lower cost, this also means that the measures that can be recommended by the occupational physician are almost entirely dependent on the self-reporting of health by employees. In Korea, employers have an obligation to ensure their employees receive a general health check-up at least once every one or two years, although, in practice, employees receive their check-up through the National Health Insurance Service and not at the expense of the employer.[3]

Health check-ups at the workplace can only be effective if there is a pathway that begins with identifying signs of ill-health and includes follow-up support and interventions. This means that any workplace health check-up scheme needs to be linked to the health system, and account for the potential increase in access to health services that may result from such a measure (WHO Regional Office for Europe, 2020[22]). For example, a standalone workplace health check-up scheme may result in cases where employees identified as at-risk face long waiting lists or have to rely on out-of-pocket payments. In Japan, employees who are identified as being at risk of cardiovascular and cerebrovascular diseases in the core health check-up can request a free secondary-check up and health guidance from a physician on nutrition, physical activity and day-to-day life. As discussed in Box 4.3, follow-up mechanisms similarly exist for individuals identified as having high levels of stress through the annual stress check.

Differences in the role of the primary care sector across the ten countries may partially explain why some countries require workplace health check-ups but others do not. As discussed in Section 4.2, the delivery of public health interventions in the workplace may be more common in Japan and Korea, where primary care does not function as the sole gatekeeper to secondary and specialist care. For instance, in Japan, patients are not required to register with a single general practitioner (GP). This may also partially explain why employers are required to ensure their employees receive a regular health check, whereas conducting such checks in other countries may result in duplication of services offered by primary care physicians. It should be kept in mind when introducing workplace health checks that screening programmes can have both public health benefits as well as potential drawbacks such as over-diagnosis (where a condition or risk factor is identified that would not cause any harm) and overtreatment (where individuals receive more extensive or invasive treatment than is required) (WHO Regional Office for Europe, 2020[22]).

The lack of compulsory workplace health checks is also likely due to concerns over privacy and discrimination based on health or disability status. In many countries, employers are advised to collect the minimum possible data on the health of their employees to conduct their core functions and responsibilities as an employer such as to protect their health and safety. In the United States, employers are only permitted to ask employees to take health examinations and collect information on the findings if this need is directly related to the employee's responsibilities or the duties of the employer. In the European Union (and hence in France, Germany and Italy), the General Data Protection Regulation recognises data concerning health as a special category of data (European Union, 2016[23]). This places strict limitations on collection of information on employee health by employers, with specific limitations such as cases where collection of health data is necessary for carrying out contractual obligations (e.g. the provision of sick leave) or for public health and safety purposes.

In all the countries studied, there are nonetheless specific regulations requiring the surveillance and monitoring of the health of employees (health monitoring) and exposure to potential health risks (exposure monitoring) in workplaces where toxic or hazardous substances are handled. In Australia, for example, there are specific monitoring requirements if there is a significant risk of exposure to lead, asbestos or any other hazardous chemical. In the United States, most states also participate in a programme operated at the federal level by the CDC through which they provide data on blood lead levels. The data provided from states are then used to determine reporting requirements and regulation on lead exposure.

The issue of what information employers can collect on employee health has also been subject to attention during the COVID-19 crisis, as **information not usually collected previously such as previous and current infection status; vaccination status for COVID-19 and temperature checks became valuable for employers seeking to minimise infection risk** among their on-site employees. Employers in both the United Kingdom and the United States have been able to ask employees about their COVID-19 vaccination status on the condition that this is to protect the health and safety of other employees (Information Commissioner's Office, 2022[24]; U.S. Department of Health & Human Services, 2022[25]).

4.3.3. All countries consider the regulation of smoking in workplaces to be an important public health measure

Regulations to prohibit smoking at the workplace can improve public health outcomes, primarily by lowering exposure to second-hand smoke, and to some extent, by creating a supportive environment to reduce or quit smoking for existing users. A meta-analysis of 21 countries has found consistent evidence across countries that general smoking bans improve cardiovascular health outcomes and lower deaths from smoking-related illnesses and health conditions (Frazer et al., 2016[26]). It is important that comprehensive smoking bans are implemented guarantee as evidence show that these are more effective at reducing second-hand smoke exposure than partial bans. For instance, a review of seven European countries finds that PM2.5 levels,[4] which are often used as measure of second-hand smoke, reduced more in hospitality workplace settings in countries that introduced comprehensive bans (e.g. Ireland and Scotland) than other countries (Ward et al., 2013[27]). Workplace smoking bans may also incentivise existing smokers to quit or reduce their use as discussed in Chapter 3.

Smoking in enclosed workplaces is regulated in all ten countries, but most do not prohibit smoking entirely as shown in Table 4.4. **The most common policy among the ten countries studied is to prohibit smoking in enclosed workplaces except in designated smoking rooms** (France, Italy, Japan and Korea). While this is preferable to no limitations on smoking, it can only partially eliminate exposure to second-hand smoke (Cains et al., 2004[28]; Yamato et al., 2000[29]). By comparison, Australia, New Zealand and the United Kingdom are the three countries that prohibit smoking entirely in all enclosed workplaces, while in Canada, comprehensive workplace smoking bans are in place in most jurisdictions that together cover 95% of the population. In the United States, smoking in enclosed workplaces is also prohibited in a majority of states. Germany differs from all other countries in that smoking is not prohibited within enclosed workplaces and there is only a right for non-smokers to be protected from exposure to second-hand smoke.

Table 4.4. Regulation on smoking in enclosed workplaces

Country	Is smoking prohibited in all enclosed workplaces?	Do the measures cover vaping and e-cigarettes?
Australia	Yes	Separate regulation. Since 2021, e-cigarettes containing nicotine may only be accessed legally with a prescription.
Canada	Regulation at sub-national level. Prohibited entirely in 7 out of 13 jurisdictions, which account for 95% of the population.	In many jurisdictions, smoking regulation also applies to vaping and use of e-cigarettes..
France	Partially. Smoking is only permitted in designated smoking rooms.	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes.
Germany	No. Employers have a duty to protect non-smoking employees from exposure to tobacco, but there is no explicit prohibition.	N/A. There is no explicit prohibition of tobacco.
Italy	Partially. Smoking is only permitted in designated smoking rooms.	No. E-cigarette use and vaping is considered outside the scope of existing regulation.
Japan	Partially. Smoking is only permitted in designated smoking rooms.	Designated e-cigarette rooms can be established in addition to designated smoking rooms. E-cigarette rooms differ in that consumption of food and drinks is permitted.

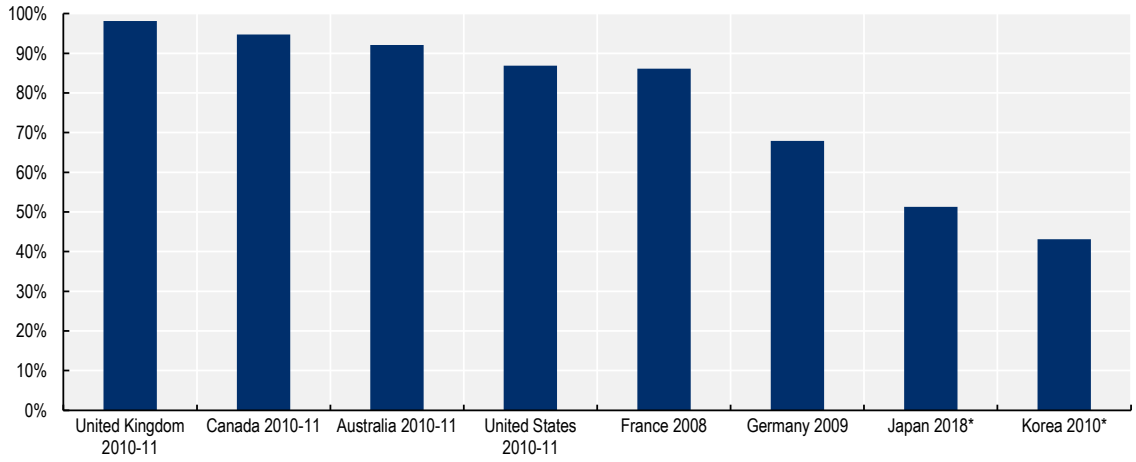
Country	Is smoking prohibited in all enclosed workplaces?	Do the measures cover vaping and e-cigarettes?
Korea	Partially. Smoking is permitted in designated smoking rooms. It is otherwise prohibited in all workplaces within buildings that have a floor area exceeding 1 000 square metres.	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes
New Zealand	Yes	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes
United Kingdom	Yes	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes.
United States	Regulation at sub-national level. Prohibited entirely in a majority of states.	In many states, smoking regulation also applies to vaping and use of e-cigarettes.

Source: The Global Health Observatory, World Health Organization (2020[30]); national sources.

In countries where workplace smoking is not fully prohibited, employers nonetheless retain the right to prohibit smoking within their own workplaces. This explains the significant variation in the implementation of smoking bans in enclosed workplaces. Data from the International Tobacco Control Policy Evaluation Project (ITC) shows that workplace smoking bans are reported by almost all smokers and ex-smokers in countries with comprehensive bans (Australia, New Zealand, and the United Kingdom) (Figure 4.4). By comparison, there is significant variation in prevalence of reported workplace smoking bans in other countries, ranging from a high of 86.9% in the United States to around 50% or less in Japan and Korea. Both Japan (2020) and Korea (2012) introduced measures to prohibit smoking at the workplace except in designated smoking rooms after the surveys were conducted.

Figure 4.4. Coverage of smoking bans at the workplace vary significantly

Proportion of current and ex-smokers who reporting that their workplace has a comprehensive smoking ban



Note: *Legislation was introduced in both Japan (2020) and Korea (2012) after the surveys, which prohibited smoking in the workplace except in designated smoking rooms as explained in Table 4.4. Data from Korea are from male respondents only.
Source: Smoke-Free Policies: ITC Cross-Country Comparison Report (2012); Use of Heated Tobacco Products within Indoor Spaces: Findings from the 2018 ITC Japan Survey (2019[31])

StatLink https://stat.link/yh9jpa

Most countries also put in place supporting measures to ensure compliance, including fines to enforce implementation and requirements to signpost restrictions on smoking. For example, in the United Kingdom, all workplaces must display the “no smoking” sign and employers have a duty to stop

people found to be smoking in the workplace. Employers that do not display the sign can be fined up to GBP 1 000 (British pounds) and employers who do not stop people smoking in the workplace can be fined up to GBP 2500. Japan is the only country among those studied that provides subsidies to ensure compliance, in this case specifically for SMEs up to JPY 1 million (USD 9 100) to adapt their practices to meet changes in regulation, including by establishing designated smoking rooms. There are also a wide range of other measures taken by governments to support employers in reducing smoking at work such as financial incentives for smoking cessation programmes and dissemination of best practices. As these measures are not directly related to the implementation of regulations on workplace smoking, they are discussed in further detail in the sections on financial incentives (4.4) and dissemination of guidelines (4.6).

A contentious issue among the ten countries studied is how vaping and the use of e-cigarettes in the workplace should be regulated. The WHO advocates for the strict regulation of e-cigarettes, noting that their use in areas where smoking is otherwise forbidden could contribute to the renormalisation of smoking in public, and that the use of e-cigarettes is increasingly shown to have harmful effects, in particular, for cardiovascular health (2021[32]). France and Korea extend most or all of their regulation on workplace smoking to include vaping, while Australia forbids the sale of e-cigarettes containing nicotine without a prescription. In contrast, Italy, Japan and the United Kingdom have more lenient approaches to workplace vaping to varying extents as shown in Table 4.4. The difference in approaches between smoking and vaping is particularly stark in the United Kingdom, where policy makers have so far decided that e-cigarettes should not be covered by smoke-free legislation. In the United Kingdom, since 2017, Public Health England (PHE) – since replaced by the UK Health Security Agency (UKHSA) – has regularly collected updated evidence on the health effects of e-cigarette consumption. The UKHSA advises that the e-cigarette consumption is not risk free and non-smokers should not start vaping but, if properly regulated, e-cigarettes are far less harmful than smoking (2020[33]). The latest evidence review from the UKHSA also finds that e-cigarettes can be an effective tool to facilitate smoking cessation (McNeill et al., 2021[34]).

4.3.4. Countries tend to leave decisions on consumption of alcohol to employers except in specific high-risk sectors

The consumption of alcohol is less heavily regulated among the countries studied compared to smoking. This may be as alcohol consumption at work may have less visible harmful impacts on bystanders in most jobs and industries. It may also reflect the tolerance and/or normalisation of consumption of alcohol both at work and work-related events (OECD, 2020[35]), and thus a view that strict regulation would result in excessive intrusion into private lives and lifestyle choices.

In all ten countries studied, consumption of alcohol in the workplace is not explicitly prohibited across all jobs and tasks. As shown in Table 4.5, in most countries, there is only a duty for workers and employers alike to manage health and safety at work, with decision around the provision and consumption of alcohol left to employers or in some cases to collective bargaining agreements. The exceptions are for tasks and jobs where working while under the influence of alcohol entails a high risk of injuries and accidents (e.g. construction workers at risk of falls), and jobs or tasks where impairment due to alcohol consumption can threaten public safety and endanger lives (e.g. bus or train driver).

France and Italy stand in contrast to other countries as they provide more explicit regulation designed to restrict harmful alcohol consumption in the workplace that applies to all jobs and sectors. In France, consumption of all alcoholic beverages other than wine, beer, cider and perry (*poiré*) is forbidden in the workplace. In Italy, while the law does not explicitly rule out consumption for all jobs and during all tasks, the provision of alcohol in the workplace is limited to the canteen, where only wine and beer may be served.

Table 4.5. What does legislation say about alcohol consumption at the workplace?

Country	What does legislation say about consumption of alcohol at the workplace?
Australia	No explicit prohibition of alcohol consumption at work that applies across all jobs and during all tasks. There is a legal limit on blood alcohol levels in jobs with high risk of accidents (e.g. heavy industry) or where others' health and safety can be jeopardised (e.g. public transport).All workers have a duty to manage their own health and all employers have a duty to manage health and safety risks for workers, which may include excess alcohol consumption.
Canada	No explicit prohibition of alcohol consumption at work that applies across all jobs and during all tasks. Employers may conduct testing for alcohol use in safety-sensitive positions (positions in which "incapacity due to impairment could result in direct and significant risk of injury to the employee, others or the environment) in limited circumstances.
France	No alcoholic beverage other than wine, beer, cider and perry/poiré. Employers may also limit or prohibit consumption of alcohol to protect the health and safety of workers, provided the measure is proportionate to the aim sought. Workers intoxicated with alcohol are also not allowed to enter workplaces.
Germany	Alcohol consumption at work is considered an internal issue that is regulated by employers together with trade unions and work councils. There is a limit on blood alcohol levels in jobs where others' safety is at risk (e.g. public transport).
Italy	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. It is strictly forbidden to take or provide alcohol during working activities where the work entails a high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. transport). A zero tolerance rule on blood alcohol levels applies for professional drivers. Serving of alcoholic beverages is prohibited at work, with the exception of canteens, where only wine and beer may be served.
Japan	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. There is a limit on blood alcohol levels in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).
Korea	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. There is a limit on blood alcohol in jobs where others' safety is at risk (e.g. public transport).
New Zealand	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. There is a limit on blood alcohol in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).Workers have a duty to manage their own health and employers have a duty to address worker health hazards, which may include excess alcohol consumption.
United Kingdom	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. There is a limit on blood alcohol in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).Workers have a duty to manage their own health and employers have a duty to prevent worker health/safety risks, which may include excess alcohol consumption.
United States	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. Employers in safety- and security-sensitive industries such as public transport and defence are required to conduct drug-testing, including for alcohol. Employers in public transportation are required to also run awareness-raising sessions on alcohol consumption. .

Source: Review of national regulation on alcohol consumption at work.

Alcohol testing at work is not widely implemented across the analysed countries. To some extent, and similarly to other forms of health checks as discussed in Section 4.3.2, concerns over intrusion into employee privacy may be among the reasons underlying a reduced use of alcohol testing at work. The use of alcohol testing – much like requirements to prohibit alcohol – is therefore usually limited to industries where working under the influence of alcohol can pose a threat to public safety. In the United States, for example, while there is no general provision that allows for alcohol testing at work, an estimated 12.1 million transportation employees categorised as performing safety-sensitive functions are subject to some form of alcohol and drug testing (US Department of Transportation, 2022[36]).

4.4. Paid sick leave and return-to-work regulation play an indispensable role in preventing ill-health and health promotion at the workplace

Preventing avoidable sickness absence from work due to ill-health is key to promoting health and well-being at the workplace. This applies both to preventing occurrence/recurrence of sickness absence and the promotion of timely return-to-work. While taking sickness absence, where required, should be facilitated, avoidable long-term absence from work due to sickness can have long lasting effects on labour market outcomes. Evidence from a number of OECD countries – including Belgium, the Netherlands, the

United Kingdom – shows that return-to-work becomes increasingly difficult as the duration of absence extends and especially so after three months of absence which in turn, increases the likelihood of labour market exit (OECD, 2015[37]). For example, in the United Kingdom, while 5.6% of workers on long-term sickness absence for four weeks leave work, this more than doubles to 12.2% for workers on absence for three to six months (UK Government, 2019[38]). For some workers, such as those with mental health conditions, prolonged absence from work can also be detrimental and contribute to exacerbation of health issues. There are a range of policy levers that can be used to prevent avoidable sickness absence and promote early return-to-work through employer involvement, including the provision of employer-paid sick leave and regulation to facilitate return-to-work.

4.4.1. Requirements for employers to provide paid sick leave could be strengthened to create stronger incentives for employers to prevent ill-health among their employees

Paid sick leave – which usually consists of a combination of a period of employer-paid sick leave and thereafter a period of government- or tax-funded sickness benefit as shown in Table 4.6 – can promote better health outcomes at the individual level by allowing sick workers to recover at home and ensuring they can access medical support. In the absence of paid sick leave, workers are often left with a choice of either forgoing income for the benefit of their health, or continuing to receive income yet at the risk of further deterioration of health. In Korea, for example, nine days of unpaid sickness absence can result in income loss equivalent to the monthly rent or mortgage payment (Gould and Schieder, 2017[39]; OECD, forthcoming[40]).

Table 4.6. Comparison of paid sick leave systems across OECD countries

Country	Minimum number of days of employer-paid sick leave	Number of days of sickness benefit financed by tax or government expenditure	Minimum proportion of previous salary paid by employer
Australia	10	182	100%
Canada	Provincial	105	-
France	60[a]	364	40%[b]
Germany	42	546	100%
Italy	3	180	100%
Japan	-	546	-
Korea	-	-	-
New Zealand	10	No limit	100%
United Kingdom	196	-	Statutory Sick Pay
United States	State	State	-

Note: "-" means no minimum entitlement. [a]: duration depends on tenure, [b]: employer-paid sick leave tops up sickness benefits, which already covers half of the previous salary.
Source: Towards equitable and adequate paid sick leave (OECD, forthcoming[40]), national sources.

Paid sick leave also has a broader impact on public health beyond the individual as it can mitigate the spread of infectious diseases. Individuals without access to paid sick leave are more likely to continue to attend work while sick (DeRigne, Stoddard-Dare and Quinn, 2016[41]), which in turn, can result in sick workers passing on infectious diseases in the workplace. Estimates during the H1N1 pandemic in 2009-10, there were around 5-7 million additional individuals infected with H1N1 in the United States due to employees who had not fully recovered from influenza-like illness going to work (Kumar et al., 2012[42]). There is also emerging evidence from the COVID-19 pandemic, which shows that access to paid sick leave has played an important role to allow workers who are suspected to – or who have – contracted SARS-CoV-2 to quarantine or self-isolate to minimise infection risk (OECD, 2022[43]).

As shown in Table 4.6, most of the countries studied have a combination of employer-paid sick leave and sickness benefit for workers on sickness absence. The **period of employer-paid sick leave is of particular relevance for this chapter, as it creates a financial incentive for employers to promote better health among their employees.** This operates through two channels. First, it creates incentives for employers to promote health and well-being at work and prevent sickness absence, regardless of whether this is exacerbated directly by the working environment or not. Second, it can – if the duration is sufficiently long – create incentives for employers to promote the timely return-to-work of employees on sickness absence.

Across the ten countries studied, as shown in Table 4.6, while most countries provide some form of paid sick leave, **the maximum entitled employer-paid sick leave at the national level for private sector employees tends to be very short and thus insufficient to create strong financial incentives to reduce or prevent sickness absence**. Canada, Korea, Japan and the United States are the only countries with no minimum entitled employer-paid sick leave at the national level, and account for around half of the OECD countries that have no such arrangement (OECD, forthcoming[40]). In Canada and the United States, however, employers must provide paid sick leave in certain regions, provinces and states. In Canada, employer-paid sick leave is available in three provinces and territories (British Columbia, Quebec and Prince Edward Island), while in the United States, 14 states and the District of Columbia have legislation on employer-paid sick leave. It is worth noting that workers in the public sector in Korea are covered by a paid sick leave scheme that provides full salary replacement for up to 60 days of sick leave per year and partial salary replacement for up to two years of sick leave (OECD, forthcoming[40]).

Even in the countries studied where employers have to provide sick pay for a longer duration, the financial incentive mechanism is dampened as employers are only responsible for covering a limited proportion of previous salaries. In the United Kingdom, sick workers are paid for 28 weeks from their employers, although employers are only required to pay the Statutory Sick Pay, as opposed to replacing a proportion of the previous salary. In France, meanwhile, minimum employer contributions depend on employee tenure, but typically continue for around two months, and are provided in combination with contributions from social security. Evidence from Switzerland and the Netherlands, two countries with a long duration of employer-paid sick leave, stronger employer contributions to pay, when implemented with supporting measures, can stimulate engagement from both employers and insurers to prevent ill-health and support rehabilitation and return-to-work. For example, in the Netherlands, since reforms to increase employer obligations to pay at least 2 years of sick leave at 70% of the salary[5] in the 1990s, both labour market exit rates and sickness incidence have decreased significantly (Hemmings and Prinz, 2020[44]).

The duration of employer-paid sick leave also differs across occupations and employment status with temporary workers often not covered in such schemes across OECD countries (OECD, forthcoming[40]), whereas many have mandated longer periods of employer-paid sick leave in the public sector. As discussed in further detail in Box 4.4, paid sick leave has played a particularly important role in protecting jobs, incomes and the health of workers who have fallen ill during the COVID-19 pandemic, and this has contributed to long-term policy changes in a few countries.

Box 4.4. COVID-19 is reshaping policies on sick leave and could help increase the role of employers in promoting employee health and well-being

In response to COVID-19, many OECD countries strengthened arrangements to provide paid sick leave, and this played a key role in protecting incomes, health and jobs amidst the pandemic and its broader impacts (OECD, 2020[45]). Many countries, especially those with less extensive sick leave legislation, put in place emergency measures to extend sickness benefits in case of absence due to contracting the coronavirus or self-isolation and quarantining requirements. In a few countries, measures went yet further by applying to indirect impacts of the pandemic on health and availability for work such as absence arising from mental health issues or disruptions to care and schooling. In most cases, however, the primary burden of increased paid sick leave lay on governments themselves as opposed to on employers.

This spotlight placed by the COVID-19 crisis on access to paid sick leave is also driving structural and long-term changes, with a number of countries seeking to place stronger incentives for employers to prevent sick leave. In New Zealand, employer-paid sick leave was extended from 5 to 10 days in July 2021, in part due to the recognition of the importance of sick pay amidst the COVID-19 crisis. In British Columbia (Canada), the regional government introduced 5 days of employer-paid sick leave in January 2022 to cover both full and part-time employees. These are encouraging developments that point to an increased recognition of the value of employer-paid sick leave in promoting the health and well-being of employees.

4.4.2. Regulations often place obligations on employers to promote timely return-to-work including to make accommodations and develop return-to-work plans

Regulations can also play a prominent role in promoting rehabilitation of workers absent from work due to ill-health, including by requiring employers to make accommodations for workers with health conditions and implement measures to promote a timely return-to-work. Such measures are particularly important in the ten countries studied, since as shown in Table 4.7, in most of these countries, employer-paid sick leave either does not exist or is very limited in duration, and thus reinforcing measures can help to facilitate timely return-to-work.

Table 4.7. Variations in reasonable workplace accommodation regulation across countries

Country	Which employees must employers make reasonable accommodations for?
Australia	Employees with a health impairment or disability.
Canada	Employees with a health impairment or disability.
France	Employees with an impairment or disability.
Germany	Employees with disabilities or with a long-term illness.
Italy	Employees with disabilities and impairments, but not workers with health conditions.
Japan	Employees with disabilities or with a long-term illness.
Korea	Employees with disabilities and impairments, but not workers with health conditions.
New Zealand	Employees with disabilities and health conditions. Broadly defined.
United Kingdom	Employers with disabilities, but not workers with health conditions.
United States	Employees with disabilities and impairments, but not workers with health conditions.

Source: International Comparison of Occupational Health Systems and Provisions: A Comparative Case Study Review, Department of Work and Pensions (Department for Work and Pensions, 2021[1]); national sources.

Workplace accommodations, which can involve changes in the workplace such as responsibility modifications, working time arrangements or changes to the broader working environment, play an important role in return-to-work and are often requirements placed on employers. As shown in Table 4.7, in all of the ten countries examined, employers are obligated to make adjustments or accommodations to workers with disabilities. However, this does not usually extend to workers with health conditions or workers experiencing sickness, illness or injury in most countries. Expanding eligibility of workplace adjustments to workers with health conditions is important, as many such workers would benefit from targeted support, even if they would not be classified as having a disability. Evidence also suggests that accommodation costs are often minimal, as accommodation typically involves an increase in flexibility provided to employees rather than an increase in expenditure (OECD, 2021[46]).

Gradual return-to-work mechanisms aim to facilitate employees who have been absent from work, often due to ill-health or illness, to return to work through the initial provision of reduced working hours and lighter (or different) working duties, with a view to a phased return to regular duties. For instance, adapting working hours, work tasks, equipment or job roles, that are often low cost measures, was found to help people suffering from chronic conditions, such as musculoskeletal disorders (MSDs), to stay at work (Davis et al., 2020[47]; EU-OSHA, 2021[48]). Many European OECD countries facilitate gradual return-to-work through regulation that ensures workers can continue to receive a proportion of paid sick leave (OECD, forthcoming[40]). Among the ten countries studied, only Germany and the United Kingdom have such regulation. In both countries, employees that return to work with reduced working hours, continue to be eligible for employer-paid sick pay for those hours they are not working as a result of ill-health.

The increased implementation of gradual return-to-work mechanisms reflects the growing evidence that such mechanisms go hand-in-hand with recovery from a range of health conditions, including mental health conditions and musculoskeletal disorders. Evidence from Germany suggests that the use of gradual return-to-work reduces the duration of sickness absence, especially for employees on long-term sickness absence and workers with mental health conditions (Schneider, Linder and Verheyen, 2016[49]). In Norway, where gradual return-to-work is compulsory for employees after eight weeks of sickness absence, these schemes are estimated to reduce lost working hours due to sickness absence by 12% to more than 50% with differences across studies (OECD, forthcoming[40]).

Most of the ten countries studied also place other obligations on employers to take measures to facilitate return-to-work. **One common measure across OECD countries is to require the development of return-to-work plans.** In Germany, employers are required to invite all employees who have been absent for more than six weeks during a 12-month period to a meeting to discuss and develop return-to-work plans. In Australia, employers are required to implement return-to-work plans in most states and territories, and in South Australia, the employer is required to appoint a Return to Work Co-ordinator if they have more than 30 employees. This does not in practice translate to return-to-work plans being in place for all employees who are absent from work. In the National Return to Work Survey in Australia in 2018, less than two-thirds (65%) reported that they had a return-to-work plan (Social Research Centre, 2018[50]). In France and Japan, meanwhile, employers are required to take measures to make reasonable accommodations based on guidance from an occupational physician.

A few countries also provide financial incentives that **reward and incentivise employers specifically to facilitate return-to-work**. In the United Kingdom, employers can apply for tax relief for medical treatments up to GBP 500 per employee that are recommended by a health care professional to facilitate return-to-work. To be eligible, the employee must be assessed by a heath professional to be unfit for work for at least four weeks without medical treatment or have already been absent from work due to injury or illness for four weeks. As discussed in Box 4.6, a limited number of subsidies are also available in Tasmania (Australia) for employers specifically seeking to improve return-to-work outcomes. Broader financial incentives discussed in Section 4.4 relating to health and well-being promotion such as in Germany, Japan and Italy could also be used to facilitate return-to-work.

4.5. Financial incentives can encourage employers to go beyond minimum standards by actively promoting health and well-being

Financial incentives go beyond stipulating the minimum standards for employers and thus can encourage employers to proactively promote health and well-being at work. Such incentives are particularly important for micro, small and medium-sized enterprises. For example, governments may not wish to require employers to put in place accommodations for employees to cycle to work, but they may wish to provide grants, tax breaks or other financial incentives to facilitate cycling to work. When looking at measures that promote health and well-being and go beyond preventing accidents and work-related injuries, financial incentives play a more significant role.

The use of financial incentives remains relatively limited in the studied countries with the notable exception of insurance-based incentives (4.5.1), which is consistent with findings from a prior review by the European Agency on Health and Safety at Work on existing economic incentives to improve occupational health and safety (EU-OSHA, 2010[51]). The other tools available, including tax credits (4.5.2) and subsidies (4.5.3) are then discussed in detail. Financial incentives to facilitate or ensure fulfilment of regulation are not covered in this section but in Section 4.3 on workplace regulations. Incentives relating exclusively to return-to-work, rehabilitation and sick leave are discussed in Section 4.4.

4.5.1. Insurance-based incentives vary in scope and form depending on legal and policy contexts

Insurance institutions, typically in the form of workers' compensation insurance boards and accident insurance systems, play an important role in creating incentives for preventing work-related accidents. **The responsibility of such institutions and the rules under which they operate are determined by government legislation, and especially in countries where insurance institutions are public agencies** (as shown in Table 4.8)**.** Accident insurance institutions reward companies that have a better record of preventing accidents and ill-health by offering lower insurance premiums. In a number of countries, the responsibility of insurance institutions extends further to facilitating timely return-to-work and workplace health promotion, and boards may even offer subsidies for implementing programmes related to health promotion and the prevention of ill-health.

Table 4.8. Institutional setup of workers' compensation boards and accident insurance systems

	Provider of insurance	Does government permit premium differentiation based on occupational health and safety outcomes?
Australia[a]	Public/Private	Yes, depends on insurance provider
Canada	Public	Yes, based on claims history
France	Public	Yes, based on claims history but only for firms with 200+ employees
Germany	Public	Yes, based on claims history and differs widely across industries/sectors
Italy	Public	Yes, based on claims history
Japan	Public	Yes, based on claims history
Korea	Public	Yes, based on claims history
New Zealand	Public	Yes, based on claims history
United Kingdom	Private	Yes, depends on insurance provider
United States[b]	Public/Private	Yes, based on claims history for public funds

Note: [a] workers' compensation boards are regulated at the secondary level of government (states and territories). Some states/territories have public/monopolistic schemes, while others have private/competitive schemes. [b] There are workers' compensation funds in each state, but some give the option for employers to purchase coverage from a private insurance provider.
Source: EU-OSHA, 2018, Economic incentives to improve occupational safety and health: a review from the European perspective; national sources.

As shown in Table 4.8 (column 2), all ten countries have schemes to differentiate insurance premiums between employers based on occupational health and safety outcomes, most notably, the frequency of work-related injuries and ill-health. These are often referred to as "experience-rating" approaches as they rely on the performance of employers in previous time periods. Such mechanisms can create financial incentives to promote employee health as employers with stronger outcomes are rewarded with lower insurance premiums, and those with poorer outcomes will face additional costs. For example, in the United States, insurance premiums are calculated at the state level, and are most often based on a combination of occupation and an "experience modification factor" which can increase or decrease the premium based on the history of previous workers' compensation claims compared to the average in the industry or claims category.

Insurance premiums may also be differentiated based on ongoing initiatives or future performance. In Italy, the National Institute for Insurance against Accidents at Work (INAIL) is running a "Swing for Prevention" (*Oscillazione per prevenzione*) campaign, under which employers carrying out interventions related to health promotion in the workplace are eligible to receive an insurance premium reduction. These measures can be wide-ranging, ranging from programmes for healthy diets and canteen use to campaigns to prevent smoking and harmful consumption of alcohol and drugs (2022[52]). In Alberta (Canada), SAFE Work certification is available in a number of industries, in which if employers are able to receive a certain standard in ensuring a safe and healthy workplace, they are eligible for a rebate of either 15 percent of the premium paid to the workers' compensation board or up to CAD 3 000 (Canadian dollars) (USD 2 400) for smaller employers.

Workers' compensation boards and accident insurance institutions also go beyond insurance premium variation and provide occupational health services or subsidies for employers to prevent work-related injuries. In Italy, in addition to insurance premium variation, from 2010 to 2022, INAIL issued 14 calls to encourage the implementation of interventions in the field of health and safety at work, and allocated over EUR 2.7 billion (euro) (USD 3.2 billion) in funding to such projects over this period, reaching almost 190 000 companies through the scheme. In Germany, prevention of work-related accidents and health hazards is embedded as the key objective of accident insurance institutions by government regulation, and thus these insurance institutions typically offer prizes, awards and recognition of high-performing companies, as well as services – such as counselling and training – and even subsidies for employers implementing prevention measures to fulfil their obligations. In France, the public accident insurance has subsidies for SMEs with less than 50 employees that are investing in equipment or actions to avoid work-related accidents. SMEs with less than 200 employees in France can also apply for a prevention contract, an agreement under which employers are able to receive an advance on expenditure relating to preventing accidents and ill-health, which is then converted into a grant if employers are able to meet the objectives agreed.

Health insurance institutions can also play a sizable role in incentivising employers to promote the health and well-being of employees in countries where health insurance is typically provided by the employer (e.g. Germany, United States) as discussed in Section 4.2. The 2015 Prevention Act in Germany requires health insurance funds have been required to spend EUR 7 (USD 8.28) per insured person on prevention measures, of which at least EUR 2 (USD 2.37) have to be spent on workplace measures. The introduction of this act coincided with a more than three-fold increase in expenditure per insured person on workplace health promotion between 2015 and 2019 by health insurance funds (Gerlinger, 2021[53]). The role of private health insurance companies is also discussed in Chapter 3.

4.5.2. Tax credits are used in a select number of countries

Tax credits, which usually take the form of reductions or exemptions from corporate tax, provide governments with a means to incentivise employers to invest in workplace health and well-being. Compared to subsidies, tax credits are often easier to implement as they can be included within existing

mechanisms relating to tax reporting mechanisms. Four of the ten countries studied (France, Germany, Italy and the United Kingdom) provide tax credits at the national level related to health and well-being and such credits are also available at the sub-national level in several states in the United States. In most cases, these measures have been introduced over the past decade (with the exception of Germany), suggesting that there is a growing emphasis on using such measures to incentivise employers to invest in employee health and well-being.

In Germany, a tax exemption introduced in 2008 provides employers with an exemption for health and well-being expenditures up to EUR 600 (USD 710) per employee per year (Federal Ministry of Health, 2022[54]). These measures can be wide-ranging and go beyond the provision of medical treatments, and thus can be used for expenditures related to the implementation of programmes to facilitate physical activity, healthy diets, addiction treatments and stress management. In Italy, a series of laws passed from 2016 onwards have expanded the scope of tax reductions for employers to include issues related to corporate welfare and employee health. In the United Kingdom, a corporate tax exemption of up to GBP 500 per year per employee was introduced in 2015 for medical treatments to support employees return-to-work as discussed in more detail in Section 4.4.

Tax credits have also been increasingly seen as a means to incentivise employers to invest in wellness programmes in the United States among lawmakers, although there has not been agreement to their implementation at the federal level or in most states. In 2009, a bill with bipartisan support called the Healthy Workforce Act was introduced but not passed. It would have provided a tax credit to employers for the costs of implementing workplace wellness programmes across the United States.[6] At the state level, a review of legislation found that 34 bills had been introduced for tax credits for employers to implement workplace wellness activities in 2001 to 2006, but that none had been passed (Lankford, Kruger and Bauer, 2009[55]). These examples show that while there is an appetite among some lawmakers for tax credits to employers implementing workplace wellness programmes, barriers remain, most notably in relation to cost. A more recent review of state legislation as of 2014 found that only four states (Georgia, Indiana, Maine and Massachusetts) have tax credits for employers promoting workplace wellness programmes (Pomeranz et al., 2016[56]).

France and the United Kingdom have exemptions designed specifically to facilitate cycling to work at the national level. In France, employers are able to pay employees up to EUR 500 (USD 592) per year for commuting by bicycle or car-sharing schemes as part of the Sustainability Mobility Package (Forfait Mobilité Durable).[7] This tax credit was introduced exclusively for commuting by bicycle in 2015 with a limit of EUR 200 (USD 237) per year as a public health measure, but was extended in 2020 to have broader sustainability objectives. An assessment of a trial of the tax exemption found that it resulted in a 125% increase in the share of commuting by bicycle after one year (ADEME - Agence de la Transition Écologique, 2016[57]). Employers providing bicycles to their employees for free are also able to receive a tax exemption for 25% of the cost of purchasing a fleet of bicycles for employees. In the United Kingdom, through the Cycle to Work Scheme, since 1999, employers can hire bicycles and safety equipment on behalf of an employee as a tax-free benefit. If the employer wishes to recoup the costs of hiring a bicycle, deductions can be made from the employee's gross salary, resulting in an exemption from the employee's income tax and contributions to National Insurance. Although employers can also apply for a tax exemption for payments to cover employee commutes in Germany and Japan, these are not explicitly or exclusively for commuting by bicycle or other methods that promote physical activity.

4.5.3. Subsidies are used in a targeted manner and often to support SMEs

While governments provide subsidies and grants to employers in all ten countries, they are typically targeted towards SMEs and often implemented at the sub-national level**.** As SMEs face barriers to implement workplace health and well-being programmes, dedicated subsidies are one of the facilitators to help them invest in these programmes (Box 1.3). **One main point of difference between subsidies and**

tax credits is that the former is often only available to a limited number of recipients and is thus more exclusive and limited in scope. Of the ten countries studied, only two (Japan and Korea) provide subsidies to employers to promote employee health and well-being at the national level, although many are related to accident injury and prevention and limited in scale. There are also many initiatives at the sub-national level and a select number of initiatives relating to health promotion are discussed below.

Box 4.5. Barriers and facilitators for small-medium enterprises (SMEs) to implement workplace health and well-being programme

In general, SMEs are less likely than large companies to implement health and well-being programmes for their employees, because of a number of barriers, such as the cost of the programmes, insufficient human resources and lack of programme knowledge (Chapter 3).

A number of facilitators, especially directed at SMEs, can help the adoption of workplace health and well-being programmes. These include strengthening occupational health services, offering subsidies for SMEs (such as subsidies described in Section 4.5.3 or subsidies to implement reforms to reduce overtime work (Section 4.3.1)), creating certification and award programmes for employers dedicated to SMEs (Section 4.8), developing national accreditation for health and well-being providers (Saint-Martin, Inanc and Prinz, 2018[58]), and integrating occupational health planning in supply chain arrangements (EU-OSHA, 2018[59]).

In Japan and Korea, subsidies are primarily designed to support implementation of good practices and facilitate compliance with regulation. In Japan, there are at least two subsidies that go beyond accident prevention and seek to facilitate workplace health promotion. SMEs implementing a Mental Health Promotion Plan can apply for a subsidy of up to JPY 100 000 (USD 911), and employers implementing measures to ensure employees with health conditions can balance their work with accessing medical treatments and supports are also eligible for a subsidy of up to JPY 200 000 (USD 1 821) (Japan Organisation of Occupational Health and Safety, 2021[60]). There are also subsidies in Japan to facilitate implementation of the stress check and health check-ups as discussed in 4.3.2, and subsidies for the recruitment of occupational physicians or nurses in the workplaces as required by occupational safety and health regulation. In Korea, there are also a range of subsidies to support good practices, although these are primarily centred on preventing accidents and injuries. For example, the Health Stepping Stone project is primarily for the implementation of exposure screening and health screening, while the Clean Workplace Project provides subsidies to prevent industrial accidents such as deaths and fatal accidents. Korea also provides subsidies for workplaces that are implementing measures to ensure compliance with the working time reform initiated in 2018 (Box 4.2).

Subsidies at the sub-national level that incentivise employers to promote health and well-being also play a role in Australia and the United States. These subsidies are typically not to support employers in meeting their obligations as employers, but rather to **implement innovative or new practices to promote health and well-being in the workplace**. In Australia, the two grant programmes identified that go beyond accident and hazard prevention focus on mental health, musculoskeletal disorders and return-to-work, which are discussed in more detail in Box 4.6, with a focus on subsidising innovative programmes. In Western Australia, grants are available for employers seeking to address work-related psychological hazards and promote mental well-being in the working environment. In Tasmania, the grant programme is specifically for the prevention of musculoskeletal disorders and the improvement of return-to-work outcomes, with grants capped at AUD 50 000 (Australian dollar) (USD 37 600) per organisation. In Indiana (United States), the local government provides grants of up to USD 10 000 for employer initiatives to promote wellness with a broader focus on initiatives relating to healthy lifestyle choices, increased physical activity, facilitation of breastfeeding and stress reduction.

Box 4.6. Australia's two sub-national subsidies for employers implementing innovative measures to promote health and well-being at work

In Australia, two grant programmes, implemented at the sub-national level, support employers to implement innovative or new practices to promote health and well-being in the workplace, the first being related to mental health, and the second to musculoskeletal disorders and return-to-work.

2021-25 Mentally Healthy Workplaces Grant, Western Australia

This grant programme launched in 2021 provides funding to a limited number of organisations for up to four years in Western Australia that implement initiatives to manage psychosocial hazards at work and promote good practices to support mental health and well-being at work. Some of the outcomes sought include reduced rates of bullying and prevention of workplace stressors, increased mental health literacy and a commitment to improving workplace culture from leadership of the organisation. Criteria for assessment are clearly set out in guidelines for the grant programme, and include a demonstration of an innovative or original approach to promoting mental health in the workplace.

The initiative is led by the Department of Mines, Industry Regulation and Safety, although funding can be given to organisations across all sector. *Mates in Construction* – a charity promoting suicide prevention in the construction sector – and to *Steering Health Minds* – a collaboration in the transport industry to promote mental health have each received AUD 250 000 (USD 190 000) in funding already as part of an election commitment. A further AUD 500 000 (USD 376 000) has been allocated for those applying for the grant. Successful applicants receive guaranteed funding of up to AUD 175 000 (USD 131 000) for year one. Funding for years two to four is subject to evaluation and dependent on meeting criteria agreed to in the grant agreement.

2022 Healthier Safer and Productive Workplaces Grants, Tasmania

This grant programmes provides funding to workplaces and researchers in Tasmania developing and implementing innovative solutions to prevent MSDs and/or to improve return-to-work outcomes for injured workers. All applicants have to specify in what way they perceive their solution to be innovative, and some measures cited include solutions to increase employer participation in the return-to-work process, reduce stigma associated with work-related injuries, and to tackle cultural restraints or language barriers that can hinder return-to-work. The guidelines explicitly mention that measures designed to ensure compliance with legal obligations or that do not differ from current practices will automatically be excluded. Organisations – including employers – can receive up to AUD 50 000 (USD 37 600) in funding, and researchers can receive up to AUD 100 000 (USD 75 100).

Source: Mentally Healthy Workplaces Grant Program (Government of Western Australia, 2022), https://www.dmirs.wa.gov.au/dmirs/mentally-healthy-workplaces-grant-program; 2022 Healthier Safer and Productive Workplaces Grants Program (WorkSafe Tasmania, 2022), https://worksafe.tas.gov.au/topics/services-and-events/2022-healthier-safer-and-productive-workplaces-grants-program.

Subsidies may also be provided to employer organisations, research institutions, and even employees themselves to implement good practices. In the United States, the Susan Harwood Workplace Safety and Health Grants provides annual grants to non-profit organisations that provide training to employers and workers on health at the workplace, with a thematic focus on preventing infectious diseases including COVID-19 for 2022. Successful applicants can receive grants of up to USD 160 000 and the total grants available each year are worth around USD 3 million in total. In Québec (Canada), there are grants available for unions and employer associations seeking to provide training or educational activities relating to workplace health and safety. Organisations that provide research or training are also eligible for the

aforementioned grants in Australia for mentally healthy workplaces (Western Australia) and for healthy workplaces (Tasmania) which are discussed in Box 4.6.

A major limitation in existing subsidies and financial incentives directed at employees is that they may only be accessible to individuals with a disability. Broadening eligibility for subsidies to also include individuals with a health condition could be valuable, as many workers with a health condition would benefit from targeted support. This distinction can be seen when comparing Australia and the United Kingdom's approach to financial supports for employees looking to stay in work. Whereas the Employee Assistance Funds in Australia provides financial support exclusively to workers classified as living with a disability (OECD, 2015[61]), the Access to Work grant in the United Kingdom provides financial assistance both for workers with a health condition and for those living with a disability. The importance of including workers with health conditions in accommodation measures is also discussed in Section 4.4.2.

4.6. Governments play an important role in facilitating best practices by disseminating information, tools and guidelines working with other stakeholders

Governments can also facilitate employers in implementing workplace health and well-being programmes through dissemination of information on the benefits for employers to invest in health of their employees and through providing guidelines and other tools that can support the implementation of good practices by employers. While uptake of guidelines is voluntary, this also allows for the inclusion of measures that promote health and well-being in the workplace and go beyond legal requirements that are usually set out in occupational safety and health regulations. Such guidance and tools may also be used for certification and award programmes as discussed in further detail in Section 4.7.

All ten countries provide information at the national level on health, safety and well-being in the workplace, typically through their agencies dedicated to occupational safety and health, and most provide specific tools such as self-assessment tools and guidelines for employers at either or both the national or sub-national level. Some countries also have dedicated agencies for researching and disseminating information on health in the workplace with an increasing focus on health promotion and early intervention. At the international level, the European Agency for Safety and Health at Work (EU-OSHA), plays a large role in both researching on the effectiveness of interventions to promote health at work and in disseminating this information to relevant stakeholders including employers.

At least four countries (France, Germany, the United Kingdom and the United States) provide tools for employers to assess the extent to which they are promoting health and well-being of employees. In France, the National Research and Safety Institute (IRS), which is responsible for researching on occupational health and safety, has developed a self-assessment questionnaire, which medium- and large-sized enterprises can use to diagnose gaps in workplace health promotion. The questionnaire includes questions for employees relating to self-reported health, work demands and the broader working environment. In the United States, the CDC developed a Worksite Health ScoreCard, which allow employers to assess the extent to which they have implemented evidence-based measures to promote the health and well-being of employees by filling out a questionnaire. The ScoreCard includes questions related to many areas, including weight management, physical activity, high blood pressure, tobacco use, musculoskeletal disorders, stress, sleep and maternal health (Centers for Disease Control and Prevention, 2022[62]). Participating employers in Japan's Health and Productivity Management programme (see Box 4.9) also receive a scorecard diagnosing areas of improvement based on their responses to a questionnaire.

Guidelines on how employers can promote health and well-being in the workplace are provided by governments at both the national and sub-national level. In Germany, the Businesses do Health (*Unternehmen unternehmen Gesundheit*) brochure developed by the Federal Ministry of Health outlines the responsibilities of employers, financial supports available to employers, intervention options and examples of good practices in workplaces (Federal Ministry of Health, 2022[63]). In the United Kingdom,

beyond guidelines provided by the Health and Safety Executive, there is also a National Institute for Health and Care Excellence (England), a public body dedicated to developing guidelines relating to health and clinical practices. In Australia, at least five states and one territory (Queensland, South Australia, Tasmania, Victoria, Western Australia and the Australian Capital Territory) provide guidelines for employers on how to promote health and well-being in the workplace. In the United States, the National Institute for Occupational Safety and Health (NIOSH) makes available several resources that employers and employees can use to promote a safe and healthy work environment, including Fundamentals of *Total Worker Health®*, Promising Practices, Let's Get Started with *Total Worker Health®* Approaches, and the NIOSH Worker Well-Being Questionnaire (WellBQ).

The involvement of non-governmental actors such as charities, trade unions and business associations in both the development and dissemination of guidelines is common across all countries studied, and is key to ensuring uptake and use of guidelines by employers, given the close associations and connections that these organisations may have with employers. For example, in the United Kingdom, the Prime Minister commissioned a report in 2017 on promoting mental health in the workplace (Thriving at Work), which was conducted by a mental health campaigner and business leader together with the CEO of Mind, the mental health charity (Stevenson and Farmer, 2017[64]). All recommendations were subsequently accepted by the government, and Mind subsequently developed a guide for employers on how to meet and implement the six core standards for mental health in the workplace. Guidelines and tools are also developed independently by non-governmental actors and independently of government. In Australia, the National Workplace Initiative illustrates the collaboration across sectors. The National Workplace Initiative is led by the National Mental Health Commission in collaboration with the Mentally Healthy Workplace Alliance made up of national organisations from business, union, government, workplace health and mental health sectors. The National Workplace Initiative is an AUD 11.5 million investment (USD 8.6 million) by the Australian Government to create a nationally consistent approach to mentally healthy workplaces.

Guidelines and tools are often targeted at specific health issues including MSDs and mental health conditions. As discussed in Chapter 2, MSDs and mental health conditions are among the leading causes of work-related health issues. At the international level, EU-OSHA is running a campaign on MSDs at work called Healthy Workplaces Lighten the Load for 2020-22 and has disseminated information and guidance to employers. At the national level, the Health and Safety Executive in the United Kingdom has developed a digital assessment tool that combines a range of questions to assess the risks for musculoskeletal health of specific tasks. Employers seeking detailed findings can purchase a premium version of the tool. At the sub-national level in Canada, guidance is available in the provinces of British Columbia and Ontario. Guidance in British Columbia released in 2010 by the Workers' Compensation Board provides information to support employers to identify risk factors, develop appropriate measures to reduce risk, and respond to injuries and symptoms of MSDs among employees. In Ontario, an MSD Prevention Guideline was established in 2007 and has been updated since. An online portal for guidance is now available, which industry- and occupation-specific guidelines and a range of tools available to employers (Centre of Research Expertise for the Prevention of Musculoskeletal Disorders, 2022[65]).

Mental health also features prominently in government guidance on health at work before the COVID-19 pandemic and this trend has continued since. In Germany, as part of the New Quality of Work Initiative (INQA) funded by the Federal Ministry of Labour and Social Affairs, the federal government runs psyGA, a portal targeted to SMEs on measures to promote mental health at the workplace (2022[66]). The tools offered as part of psyGA include a campaign toolbox based on an award-winning initiative at Siemens released in 2022, and a benchmarking tool that allows employers to assess their performance on workplace mental health and identify areas for improvement (Federal Ministry of Labour and Social Affairs, 2022[67]). Meanwhile, Canada's National Standard for Psychological Health and Safety in the Workplace were the first national guidelines on mental health in the workplace released in 2013, and since being introduced, the government has developed tools to guide implementation such as videos and sharing of promising practices (OECD, 2021[2]). An Ipsos poll in 2017 found that employees working for organisations

that implement the Standard are far less likely to say their workplace is psychologically unhealthy or unsafe (5%) compared to organisations not implementing the Standard (13%). The poll also found that implementation of the Standard also results in a decrease in absence from work among employees who report experiencing depression (Ipsos Public Affairs, 2017[68]).

The dissemination of information and guidance has also played an important role in preventing and reducing transmission of the SARS-CoV-2 virus among employees in all ten countries studied. Guidance has typically related to sanitary measures; facilitation of teleworking (Box 4.7); facilitation of sick leave and self-isolation (Box 4.4); encouraging vaccine uptake and air quality and ventilation. While such guidance has typically been designed to slow transmission of SARS-CoV-2, they also apply to other infectious diseases. For example, in the United States, the Clean Air in Buildings Challenge introduced in March 2022 is encouraging employers to follow guiding principles to reduce risk of transmission of viruses and other contaminants indoors through creating an indoor air action plan, ensuring fresh air ventilation, strengthening air filtration and cleaning, and communicating to the broader community. Another example is the Australian National Workplace Initiative that provides organisations with detailed guidance to address emerging issues surrounding COVID-19 and workplace mental health. Examples of topics covered include, among others, setting up sustainable hybrid work environments, and resources for people in high-pressure executive roles, and bespoke guides for SMEs.

Box 4.7. Ensuring that teleworking contributes to health and well-being through measures such as "the right to disconnect"

The onset of the COVID-19 crisis saw a sudden rise in teleworking to limit the spread of the novel coronavirus, which required policies and legislation to facilitate this shift. In many cases, employers were required to implement teleworking arrangements for their employees to the extent possible. For instance, in France, requirements for employers to enforce teleworking where possible were in place for many periods of the pandemic, with these restrictions amended depending on the epidemiological situation, and social partners played a key role in clarifying the interpretation of rules around teleworking (International Organisation of Employers, 2021[69]). In Australia, France and the United Kingdom, nearly half (47%) of workers reported teleworking during periods of lockdown in 2020, although the increase seen was less sharp in countries such as Japan which did not institute a national lockdown (OECD, 2021[70]). Governments across all ten countries studied in this chapter facilitated this shift including through guidance and informational campaigns, the establishment of a right to telework, and adaptations to legislation, and promoting the use of digital technology (OECD, 2021[71]).

While most countries have scaled back efforts to facilitate or require teleworking as epidemiological circumstances have improved, it is likely to persist in some form as workers seek greater flexibility such as through hybrid working in the world of work. For instance, based on a survey conducted by the Eurofound, around 60% of the workforce in the European Union are estimated to want to work from home (either daily or several times a week) after the pandemic (Eurofound, 2022[72]). It should be kept in mind nonetheless that not all jobs can be done remotely, and it is estimated that only around one-third of jobs across OECD countries can be done fully remotely (OECD, 2020[73]).

As teleworking is set to stay in some capacity, whether full-time or more often as part of a hybrid working arrangement, the focus is increasingly shifting towards ensuring that such work remains conducive to good health and well-being in the workplace. This is because while teleworking brings opportunities for working arrangements, it also comes with new complications for both physical and mental health. Teleworking can increase risk of blurring of boundaries between work and the home and detachment from work, both of which are risk factors for poor mental health (OECD, 2021[2]), raise the risk of musculoskeletal strain resulting from unsuitable home work environments (EU-OSHA, 2022[74]), and even increase the likelihood of physical inactivity.

One common measure, which has picked up momentum during and in the aftermath of the COVID-19 crisis, is the introduction of a "**right to disconnect**", the idea of which is to enshrine the right for workers to disconnect outside their working hours without any repercussions. Of the ten countries studied, France and Italy already had a right to disconnect in place prior to the COVID-19 pandemic (OECD, 2021[2]), while Ontario (Canada) introduced such legislation in December 2021. In December 2020, the European Parliament also called for the European Commission to propose legislation to introduce the right to disconnect, with mental health considerations a key driver. Legislation alone, however, is likely to be insufficient, and supporting measures to translate the right to disconnect from an ambition to a reality will be necessary. In one national survey of employees by a trade union in France in 2021, a majority of employers (60%) did not have a system to ensure the right to disconnect, even though France was the first country to introduce such legislation in the world (General Confederation of Labour - CGT, 2021[75]).

An emerging area where governments have been providing guidance to employers in the wake of the COVID-19 crisis is on how to support workers experiencing long-lasting health impacts from SARS-Cov-2 that lasts beyond the period of initial illness. As discussed in Chapter 2, long COVID is estimated to affect around 10% of individuals infected, and in the United Kingdom, is estimated to affect as much as 2% of the general population (Office for National Statistics, 2022[76]). **At least three countries (Japan, the United Kingdom, and the United States) and the European Agency for Safety and Health at Work provide guidance to employers on supporting workers experiencing long COVID.** Such guidance usually includes a mix of information on long COVID and the wide-ranging potential symptoms; recommendations to conduct an occupational health assessment; and guidance on how to support return-to-work. Paid sick leave systems can also play an important role in ensuring workers are able to work while recovering from long COVID as discussed in Section 4.4. The development of guidelines and reforms to support workers with long COVID could also have spill-over benefits, as this can create an environment where workers with other chronic health conditions can remain in work with the support of their employers.

Awareness-raising tools are useful for certain health issues that are surrounded by stigma in the workplace such as mental health and sexual health. If there is stigma associated with a health condition, employees are less likely to seek the support they need for fear of discrimination and judgment, and managers are less likely to know how to raise the issue with employees if they identify potential symptoms. There is clear evidence from across countries on the stigma surrounding mental health. In a 2019 survey by Ipsos MORI and King's College London, among the nine of the ten countries studied where data was collected,[8] less than two-thirds (62%) of respondents stated that mental illness is an illness like any other (2019[77]). This stigma extends to the workplace. For example, more than a third of respondents to a survey in Australia in 2013 reported that they would never disclose talking about mental health at work, even if it would be appropriate to do so (Mental Health Australia, 2013[78]). Another issue surrounded by stigma is menopause. Reducing stigma and increasing support for women experiencing menopause in the workplace can support workforce participation and have positive impact on women's overall health and well-being. In Australia, the National Women's Health Strategy 2020-30 recommends actions to improve awareness and encourage further research and support services for menopause, including examining the overall impact of menopause on work. The example of workplace policies to accommodate the needs of workers who experience menopausal symptoms in the United Kingdom is discussed in more detail in Box 4.8.

It is also important for guidelines and tools to emphasise line management in health promotion. Previous OECD work on mental health has shown line management to be particularly important in promoting employee health as called for in the Recommendation on Integrated Mental Health, Skills and Work Policy (OECD, 2021[2]). Evidence from the Netherlands and the United States also shows that line manager involvement can reduce sickness absence and improve the well-being of employees (Quigley et al., 2022[79]; Hendriksen et al., 2016[80]), while workplace conflicts – often the result of poor management – are a major risk factor for mental ill-health (OECD, 2015[37]). Although senior executives and directors play an important role in creating a culture of health, there is no guarantee that this will trickle down and reach

employees if line managers are not adequately aware or lack an understanding of health issues. Line managers need to not only show an understanding of health issues, but also understand their crucial role in designing work in a way that is conducive to good employee health and well-being (OECD, 2021[2]).

Box 4.8. Supporting workers experiencing menopausal symptoms in the workplace in the United Kingdom

Supporting women and other workers experiencing menopausal symptoms in the workplace has been the subject of growing attention among all stakeholders in the workplace – employers, trade unions, policy makers, charities and the public sector – in the United Kingdom. In 2019, a survey by Bupa, an international health insurance company based in the United Kingdom, found that almost 1 million women had already left the workforce early because of a lack of support for menopausal symptoms. A survey of employers in 2021 by the Chartered Institute of Personnel Development, a human resources association, also found that less than only a quarter (24%) of employers among their membership reported having a framework, policy or guidance to support workers experiencing menopause.

As women across the ten countries studied work longer than before, the importance of supporting workers through menopause has become increasingly important as many more women experience menopause at work. In the United Kingdom alone, there are more than 4.3 million women aged 50 and above in employment, and this age group has accounted for more than two-thirds of women's employment between 1994-2014. Menopause, which is a natural stage for women when their oestrogen levels decline and after which no periods occur, typically starts between the ages of 45 and 55, and can be accompanied by mild to severe symptoms such as lowered concentration, poor memory, tiredness and feelings of depression, all of which can have an impact on individual's working lives. In a survey by the Women and Equalities Committee in September 2021, a vast majority of workers experiencing menopause stated that menopause had not affected their ability to work and almost one-third had taken time off work due to symptoms.

Existing legislation – most notably the Equality Act 2010 and the Health and Safety at Work Act 1974 – largely forbids discrimination against workers experiencing menopause, but there have also been calls to develop specific legislation requiring employers to have a menopause policy to prevent discrimination against workers experiencing menopause. Acas, a publicly funded organisation that seeks to improve work through better employment relations, provides guidance for employers on supporting workers going through menopause. Both the Chartered Institute for Personnel Development and Bupa, the health insurance company, provide guidelines for employers and line managers on how to support workers experiencing menopause.

The public sector has also begun to implement menopause support and accommodation measures in recent months. In March 2022, the Mayor of London announced that menopause support would be made available to all workers in City Hall, the headquarters of the regional government for Greater London, through a policy, which was developed together with UNISON, the UK's largest union. Measures to be implemented include the provision of temperature-controlled areas, flexibility to allow for breaks during times where symptoms become severe, and the right to time off from work to attend medical appointments. In Northern Ireland, the Civil Service also announced a Menopause Policy in March 2022, to follow up on its awareness-raising event on "Making the Menopause Mainstream".

As awareness and understanding of the impact on menopause on the workplace has grown, the UK Government has committed to reviewing existing legislation and policy on this issues. In July 2021, the Women and Equalities Committee opened an inquiry regarding menopause and the workplace in the United Kingdom, and this was followed by the launching of a Menopause Taskforce in February 2022.

Source: UK Parliament (2022), Menopause and the workplace: inquiry, https://committees.parliament.uk/work/1416/menopause-and-the-workplace/.

4.7. Certification and award schemes can recognise employers prioritising health and well-being

Governments can recognise employers that put in place best practices by providing them with certification and award. A variety of schemes are introduced (4.7.1), ranging from large-scale national schemes such as Health and Productivity Management (H&PM) in Japan to smaller schemes such as the Corporate Health Standard in Wales (United Kingdom).

4.7.1. Well-implemented certification and award schemes can help to create reputational incentives for employers to promote employee health and well-being

The purpose of certification and award schemes is to create reputational benefits for employers promoting health and well-being in the workplace. There are at least three important criteria to ensure the credibility and usefulness of such schemes. Schemes must be (1) sustainable in the long-run and sufficiently long-lasting; (2) visible and disseminated to relevant stakeholders; and (3) they must be based on sound evidence that can effectively differentiate higher-performing employers implementing good practices compared to employers simply meeting legal obligations. Certification and award schemes are however exclusive as they are mainly accessible to higher-performing employers, and may offer little incentive for health promotion in workplaces where it is not considered a priority. This is especially the case for competition-style awards, whereas certification is usually contingent on meeting a certain standard of health and well-being promotion at work. Award and certification schemes are often classified as non-financial incentives as they incur no direct cost on governments themselves beyond those related to administration, although some may come with small monetary awards.

Japan has the most extensive range of government-led certification and awards including at both the national and sub-national level. The most prominent of these is the Health and Productivity Management programme (H&PM) launched in 2014 by the Ministry of Economy, Trade and Industry (METI), which is the largest-scale award and certification system across the ten countries studied. As discussed in Box 4.9, this programme provides certification for employers meeting a minimum standard in promoting health and well-being at work, and the top 500 SMEs (“Bright 500”) and top 500 large enterprises (“White 500”) are then provided with particular award. Japan also has similar recognition schemes to promote physical activity and bicycle commuting. The Sports Yell Company programme launched in 2017 by the Japan Sports Agency provides certification for employers that promote sports. Measures recognised as good practices in the Japan Sport Agency’s guidelines include the organisation of employee walking campaigns, corporate stretching and yoga programmes and health promotion seminars. The Ministry of Land, Infrastructure, Transport and Tourism (MLIT) also introduced a scheme with a similar recognition mechanism in 2020 to certify employers that support employees to use their bicycles to commute as Bicycle Commuting Promotion Companies. According to METI, there were also close to 100 programmes to reward companies for promoting health in the workplace at the sub-national level of government throughout Japan in 2021.

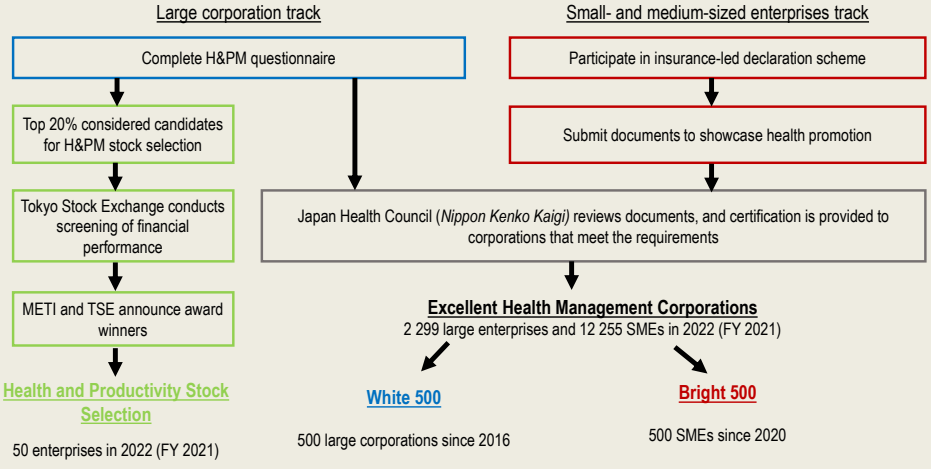
Box 4.9. Health and Productivity Management Programme (H&PM) in Japan

In 2014, the Ministry of Economy, Trade and Industry (METI) launched the Health and Productivity Management Programme (H&PM). The programme provides both certification and awards for employer who take measures to promote health and well-being at the workplace, and also aims to incentivise investment in such health-promoting corporations. As shown in the flow chart below, employers that meet a certain standard are certified as Excellent Health Management Corporations. Whereas large corporations are required to fill a dedicated H&PM questionnaire, SMEs only need to submit written evidence for assessment, given that the questionnaire requires detailed information that may not be collected regularly by smaller companies. The top 500 SMEs are then awarded the "Bright 500" status and the top 500 large corporations are awarded the "White 500 Corporation" status. A selection of companies are also chosen for stock selection, a mechanism designed to facilitate investment in these companies, as described in more detail in Box 5.4 of Chapter 5.

Since being implemented, participation in H&PM has increased significantly both among SMEs and large corporations. In 2016, the first year in which certification was issued, only 318 SMEs and 235 large corporations received Excellent Health Management certification, but this had increased to 12 255 SMEs and 2 299 large corporations by financial year 2021. Around 7.7 million workers or 13% of Japanese employees thus work for H&PM certified companies.

Figure 4.5 shows the process through which employers are certified or awarded. Employers applying for certification and awards are assessed primarily based on descriptions of programmes they implement to promote health among employees. This includes but is not limited to measures to increase health literacy, promote physical activity, support smoking cessation and support balancing of work with medical treatments. In addition to quantitative indicators such as stress check and health check-up completion rates and the prevalence of smoking and exercise habits, indicators for presenteeism and absenteeism have been added to recent H&PM surveys for large corporations. By comparison, the disclosure mechanism for SMEs is less burdensome and relies on applying SMEs declaring what measures they are taking to promote health and well-being in the workplace.

Figure 4.5. Process for employer recognition (awards and certification) in the Health & Productivity Management Programme



Source: Ministry of Economy, Trade and Industry of Japan (2021[81]) , *Enhancing Health and Productivity Management Programme* [Kenkō keiei no suishin ni tsuite], https://www.meti.go.jp/policy/mono_info_service/healthcare/downloadfiles/211006_kenkokeiei_gaiyo.pdf.

Information on the implementation of H&PM provides useful insights for employers, policy makers and experts on the promotion of health and well-being in the workplace. Aggregated information from H&PM provides data on the impact of H&PM implementation on health and labour market outcomes, as well as employer motivations and mechanisms to promote health and well-being (see Chapter 3). For example, high-performing companies based on survey results have lower rates of smoking, hypertension (high blood pressure) and hyperglycaemia (high blood pressure) among other outcomes. There also seem to be significant monetary benefits for employers. Employer medical expenditure for employee health is considerably lower in higher-performing companies, and turnover rates in Excellent Health Management Corporations (5.4%) were about half of the turnover rates in companies across Japan (11.4%), suggesting that H&PM implementation enhances employee retention and loyalty. Large corporations also receive an individualised feedback sheet based on their responses to the H&PM survey that helps them to diagnose areas for improvement.

Source: Ministry of Economy, Trade and Industry of Japan (2021), Enhancing Health and Productivity Management Programme [Kenkō keiei no suishin ni tsuite], https://www.meti.go.jp/policy/mono_info_service/healthcare/downloadfiles/211006_kenkokeiei_gaiyo.pdf.

Recognition schemes in other countries at the national level tend to be much smaller in scale and often take the form of **award schemes with a competition-style model in which only a small number of organisations receive recognition**. While such schemes may only incentivise a select number of firms already invested in promoting heath at the workplace, they may foster innovative practices. In Germany, the Federal Ministry of Labor and Social Affairs, the State Committee for Occupational Safety and Safety Technology and the German Statutory Accident Insurance have recognised exemplary commitment to health promotion at work through the German Occupational Safety and Health Awards. The competition has been held every two years since 2009, and the focus is aligned with goals agreed to in the national Joint Occupational Health and Safety Strategy, which currently include designing workplaces to reduce musculoskeletal loads, promote mental health and ensuring safe handling of carcinogenic and hazardous substances. New Zealand has also had a Health and Safety Award since 2005, although the award is only available to a small number of organisations each year. In 2022, for example, there are only nine categories of awards for organisations. In the United States, while most schemes are run at the state level or by non-profits, the federal government operates a Safe-in-Sound Excellence in Hearing Loss Prevention Award for employers that have demonstrated significant achievements towards reducing noise exposure and preventing hearing loss among employees.

Certification and award schemes are also provided at the sub-national level in countries including Australia, the United Kingdom and the United States. Two schemes in Wales (United Kingdom) and Canberra (Australia) are worth noting as they follow a certification model and could have a significant impact if scaled up. In Wales (United Kingdom), employers following the Corporate Health Standard can be given five different levels of awards based on their performance. This programme has since been paused, in part due to challenges posed by the COVID-19 crisis, and it is currently under review with a view towards a relaunch. The Healthier Workplace Recognition Scheme in Canberra (Australia) operates similarly with five different levels of recognition, although unlike the Welsh scheme, moving up levels of recognition is reliant on a proven long-term commitment and continued participation in the scheme over consecutive years. Awards are also available in other states and territories of Australia including New South Wales and Victoria, although these take the form of competitive awards that are only available to a small number of organisations.

A wide range of awards and certifications have also been developed by non-governmental stakeholders including private sector actors and non-profit organisations. In France, *Harmonie Mututelle,* a private insurance firm, holds an annual prize for health-promoting companies. In 2020, 30 initiatives were rewarded with a small monetary prize. In Germany, the Corporate Health Award, which is operated by a private company, has provided awards to companies showcasing excellence in health management in the

workplace since 2009. Mind, the UK-based mental health charity, runs a Workplace Well-being Index, which employers can participate in to increase their understanding of employee perceptions of mental health programmes in the workplace, learn from a network of employers, and gain public recognition of commitment to well-being in the workplace. The Workplace Well-being Index showcases the potential for governments to work closely with non-governmental stakeholders. While operated by a charity, its roots lay in a report commissioned in 2017 by the Prime Minister on how to better promote mental health for all in the workplace. The six core standards for employers that were established in the report are the criteria used in the Workplace Well-being Index.

4.7.2. Certification and award schemes can be associated with the disclosure of information on company-led programmes and health and well-being in the workplace

Certification and award schemes also go hand-in-hand with collection of more granular information on health and well-being in the workplace, which can be used to widen the evidence base to inform both policy and employer interventions. This is because recognition schemes are typically based on information shared by employers on the health and well-being outcomes of employees and the specific measures and programmes they implement. The H&PM programme, which is described in detail in Box 4.9, provides a wealth of information relating to employer motivations and the relationship between health interventions at the workplace and health outcomes, given the scale of the programme. Even with smaller scale programmes such as Mind's Workplace Well-being Awards, there are opportunities to identify good and innovative practices that could be disseminated to other employers seeking inspiration. While ensuring that employee privacy rights are protected may be a challenge, the release of such information may also be able to increase transparency and facilitate investment in health promoting companies as discussed in Chapter 5.

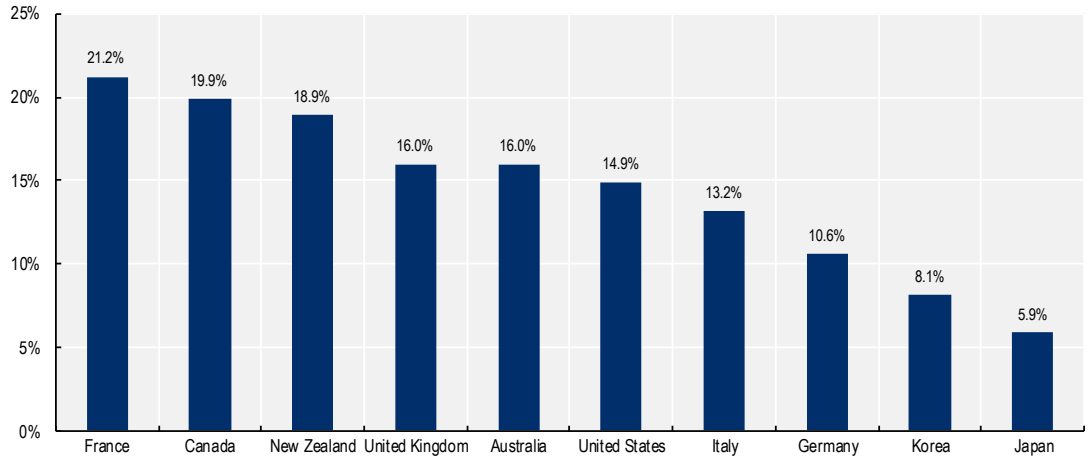
4.8. The public sector can lead by example by being an exemplary employer and promoting health and well-being in the workplace

The public sector has an important role to play in promoting health and well-being at work as it accounts for a large proportion of total employment, and as the government – through its greater influence on the public sector – can set a standard for other employers in non-governmental sectors to follow. This section begins by considering the importance of promoting health and well-being in the public sector, and then looks at both strategies and programmes designed to promote health and well-being in the public sector.

Promoting health and well-being among employees in the public sector is necessary because of the large contribution of the public sector to total employment. As shown in Figure 4.6, government employees accounted for around one in seven employees across the ten countries studied, ranging from as high as 21.2% in France to 5.9% in Japan as of 2019 (OECD, 2021[82]). In many of these countries, specific public agencies are also the largest employers, giving them a significant role in promoting health and well-being at work. The Department of the Defense in the United States employs around 3 million people (2021[83]), making it the largest employer in the world. Meanwhile, the National Health Service, which provides universal health care in the United Kingdom, employs around 1.4 million people, making it the largest employer in Europe (2022[84]).

Figure 4.6. The public sector accounts for around one-seventh of total employment across the ten countries studied

Employment in general government as a proportion of total employment, 2019



Note: Data for Japan are from 2017. Data for Australia are calculated based on data from the Australian Bureau of Statistics for 2021. Data for New Zealand are from Te Ratonga Tūmatanui | The Public Service for 2021.
Source: Government at a Glance, OECD (2021[82]). National sources for Australia and New Zealand.

StatLink https://stat.link/fbg21h

At least two countries (France and Korea) have strategies specific to the promotion of health and well-being among government employees at the national level. In France, the inaugural Occupational Health Plan for the Public Service (*Plan Santé au travail dans la Fonction publique)* sets out 30 actions to be taken between 2022 and 2026 across five separate areas with a focus on prevention. It integrates lessons learnt from the COVID-19 crisis, and thus includes commitments to strengthen psychosocial risk prevention through the roll-out of mental health first aid, strengthening of data on occupational health, and the development of preventative medicines (Minister of Transformation and Public Service, 2022[85]). In Korea, efforts to promote health in the workplace are based on the Guidelines for Public Officials' Health Management, a document released in 2009 by the Ministry of Interior and Safety. The guidelines call for the expansion of health care support facilities in public agencies, including fitness centres and gyms, refresh zones and counselling centres, and the organisation of campaigns to improve awareness and understanding of health in the workplace.

Strategies to promote health and well-being in the public sector at the sub-national level also exist in Australia and the United States. The regional Government of Western Australia (Australia) sets out a vision for ensuring public sector health and safety to ensure compliance with the principles set out in the Australian Work Health and Safety Strategy 2012-22. North Carolina (United States) also has a Worksite Wellness framework that introduces measures related to smoking cessation, improving nutrition, encouraging physical activity that state government agencies are expected to consider. There are also leading examples within state agency. For instance, the U.S. CDC/NIOSH provides its own workforce with programmes, practices, and policies that prevent injury and illness while promoting health and well-being, under the Healthiest NIOSH programme (NIOSH, 2022[86]).

4.9. Conclusion

Governments – at both the national and sub-national level – play a significant role in facilitating, incentivising and supporting employers to promote the health and well-being of employees, working closely with other stakeholders. At the bare minimum, governments must continue to ensure employers are meeting minimum standards of health and safety regulation and addressing work-related health issues. Yet governments can also go further to support employers to promote the health and well-being of employees. Governments can use a range of reinforcing and complementary measures to support employers. These include regulations relating to working hours and smoking; financial and non-financial incentives to facilitate investment of employers in employee health and well-being; dissemination of information, tools and best practices to guide employers; recognition of high-performing employers; and the reform of sick leave and return-to-work systems. Governments can also showcase good practices in promoting health and well-being of employees in the public sector by acting as an exemplary employer, and set an example for employers in the private sector to follow.

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Notes

[1] *Total Worker Health*® is a registered trademark of the U.S. Department of Health and Human Services.

[2] This may mean that men are more at risk of health issues related to excessively long hours of paid work, but women are significantly more likely to work more hours of unpaid work than men in all countries studied. When both paid and unpaid work are accounted for, it is estimated that women work longer each day than men in all of the ten countries studied with the exception of New Zealand.

[3] In Korea, employers are required to ensure their employees receive a general health check-up once every one or two years, but this may not be at the expense of the employer. While the Occupational Health and Safety Act stipulates that a workers' general health check-up is compulsory, it also states that it may be substituted by a health check-up offered under the National Health Insurance Service, which is not provided at the expense of the employer.

[4] $PM_{2.5}$ refers to particulates, whose diameter is 2.5 μm or smaller. Smoking is a major generator of $PM_{2.5}$, and $PM_{2.5}$ levels are therefore used as a reliable measure of the extent of exposure to tobacco smoke.

[5] In the Netherlands, employers have an obligation to pay at least two years of sick pay at 70% of the previous salary. The duration can be longer and the rate of replacement of previous salary can be higher under certain circumstances.

[6] Slightly different versions of the bill – but with the core principle of tax credits for workplace wellness programmes – were later introduced, but these were also not passed.

[7] When first introduced, the ceiling for tax exemption for commuting to work by bicycle was EUR 400 per year. This was subsequently increased to EUR 500 per year in January 2021.

[8] All of the ten countries other than New Zealand were included as this was a report to inform policy at the G20 level. The average presented is thus of the remaining nine countries.

5 Special focus on steering investment in companies that promote employee health and well-being

Shunta Takino and Pedro Isaac Vazquez-Venegas

Investors integrating human capital and environmental, social and governance (ESG) criteria in investment decisions show a growing interest in companies that promote the health and well-being of their own employees. This special focus chapter provides a description of developments to steer investment towards companies that promote the health and well-being of employees. It also maps ongoing initiatives to facilitate standardised disclosure and reporting by companies on how they are promoting the health and well-being of their employees.

Key findings

Investing in companies that promote health and well-being ensures that investments are socially responsible and aligned with environmental, social and governance considerations (ESG). Such practices may also be financially profitable for investors.

- A growing number of investors is seeking to promote socially responsible and sustainable investments, for example on those in line with the Sustainable Development Goals. This is reflected in the growing consideration of human capital and ESG criteria in investment decisions.
- The effective implementation of workplace health and well-being programmes is correlated with stronger financial performance, although further evidence is needed to determine if this relationship is causal. In the United States, between 2001 and 2014, the stock value of companies awarded for their workplace health programmes appreciated up to three times more than the group of companies comprising the Standard & Poor's 500 Index. In Japan, between 2011-21, the stock value of the group of companies selected for the Health and Productivity Stock Selection in 2021 outperformed the average of companies comprising the Tokyo Stock Exchange.

Steering investment in health-promoting companies can create a virtuous cycle that amplifies the incentive for companies to promote the health and well-being of their employees. The lack of standardised information and data allowing the identification of health-promoting companies limits the possibility for this virtuous cycle from being unlocked.

- If investment can be steered towards health-promoting companies, this creates a virtuous cycle because a company that promotes the health and well-being of employees is rewarded not only with a healthier workforce, but also with an increased likelihood of receiving investment.
- Information that offers insight into how well companies are promoting the health and well-being at the workplace falls into three categories. These are (1) labour market outcomes related to productivity, (2) health status of employees and (3) the implementation of health promotion programmes by companies.
- The protection of data privacy and preventing discrimination must be a key consideration when collecting or processing any personal data, especially in relation to health and well-being. Existing regulations such as the General Data Protection Regulation (GDPR) forbid the collection of health data at the individual level except under certain exemptions.

Governments thus have an important role – working together with relevant stakeholders – to encourage the disclosure and reporting of companies' efforts to promote health and well-being at the workplace. It is important that companies not only report relevant information, but also that standardised and harmonised mechanisms and indicators are used. Three types of initiatives were identified which include:

- **Government-led reforms for mandatory disclosure:** in the United States, a bill has been introduced to the Senate but not yet passed, which would require disclosure of a range of human capital metrics. The European Union has reporting requirements on non-financial performance, but these are limited and not centred on employee health and well-being.
- **Voluntary initiatives to promote disclosure:** these are widespread and led by a range of stakeholders and often involve governments, charities and investors. ShareAction, a charity promoting responsible investment, heads the Workforce Disclosure Initiative, whereas the Japanese Government leads the Health and Productivity Management Programme in Japan.

- **Initiatives to standardise and harmonise disclosure mechanisms**: such initiatives are typically led by organisations with a standard-setting influence, which in turn enhances comparability across countries and companies. The Global Reporting Initiative, which sets standards used by 75% of the world's largest companies in their ESG reporting, includes the implementation of health promotion programmes in its reporting guidelines.

5.1. Introduction

Institutional investors and private funds are showing a growing interest to direct investment towards companies that promote the health and well-being of their employees, and the COVID-19 pandemic has placed an additional spotlight on the importance of the health and well-being at the workplace. This special focus chapter begins by looking at how and why investors are increasingly interested in employee health and well-being (Section 5.2), then discusses how a lack of standardised information, data and metrics hampers efforts to invest in companies that promote health and well-being at work (Section 5.3). Section 5.4 proposes a categorisation of disclosure mechanisms – both voluntary and obligatory – as well as efforts to standardise and harmonise indicators used across countries. Section 5.5 highlights other financing mechanisms such as social impact bonds in the case of financing health prevention and return-to-work programmes, and Section 5.6 concludes the chapter.

5.2. Investors recognise the value of companies that prioritise the health and well-being of their employees

Investing in companies that guarantee safety at work and promote health and well-being, ensures that investments are socially responsible and aligned with environmental, social and governance criteria (ESG) (described in more detail in Box 5.1) and with the Sustainable Development Goals. While the use of ESG criteria by investors has been mainstreamed with over USD 30 trillion in assets incorporate ESG assessments (OECD, 2020[1]), the focus has primarily been placed on the environmental 'E' pillar.

Box 5.1. What are environmental, social and governance (ESG) criteria?

ESG criteria are used by institutional investors and private funds as they seek to align their investments with sustainability and social goals.

- The environmental 'E' pillar encompasses the effect that companies' activities have on the environment (directly or indirectly). The 'E' pillar is being increasingly used by investors who seek long-term value and alignment with the green transition (OECD, 2021[2]).
- The social 'S' pillar encompasses how a company manages relationships with employees, suppliers, customers, and the communities where it operates. It includes workforce-related issues (such as health, diversity, training), as well as broader societal issues such as human rights.
- The governance 'G' pillar encompasses a company's leadership, executive pay, audits, internal controls, transparency policies for public information, codes of conduct or shareholder rights.

To ride the wave of ESG investments, there has thus been a call from investors, health experts and other stakeholders to better integrate employee health and well-being and broader public health considerations within ESG criteria. This could be in part addressed by strengthening the social 'S' pillar and human capital considerations which have remained underdeveloped within ESG criteria (Siegerink, Shinwell and Žarnic,

2022[3]). This underdevelopment of the 'S' pillar is in part due to the challenge of quantifying social impact, but it may also reflect biases towards data that already exists or is easier to collect for companies. Others have called for the addition of a separate health 'H' pillar. For instance, the initial report of a four-year partnership between Legal & General, a UK-based asset management company, and the Institute of Health Equity at University College London, outlines that the expansion of ESG to "ESHG" could be an important measure to ensure businesses play a role in promoting health and reducing health inequities (Institute of Health Equity, 2022[4]).

Some companies – recognising the importance of employee health – are also integrating health and well-being in their ESG reporting. In 2020, Centene, which is among the 100 largest companies in the United States, added health to its ESG reporting in line with its commitment to *"cultivate healthier lives"*, and thus since then, it has published an annual report on its ESHG performance to the community and investors (Centene, 2021[5]). Johnson & Johnson, the pharmaceutical and health multinational corporation, also includes employee health within its Health for Humanity 2025 Goals, and in 2021, identified indicators to be used to assess their progress in ensuring the healthiest workforce possible (Johnson & Johnson, 2022[6]).

Many investors also see employee health and well-being as a key component of human capital (defined in Box 5.2) which is another area of growing interest among investors. There is increasing awareness that the performance of companies hinges on their employees. According to an estimate by the Global Intangible Finance Tracker,[1] intangible assets such as human capital, employee health and culture hold more than half (54%) of a company's market value (Brand Finance, 2021[7]). A separate assessment by Ocean Tomo[2] has also found that intangible assets account for 90% of the market value of the Standard and Poor's 500 (S&P 500), the stock market index tracking the 500 largest publicly traded companies in the United States, and for 74% of the market value of the S&P Europe 350 (2021[8]).

Box 5.2. What is human capital?

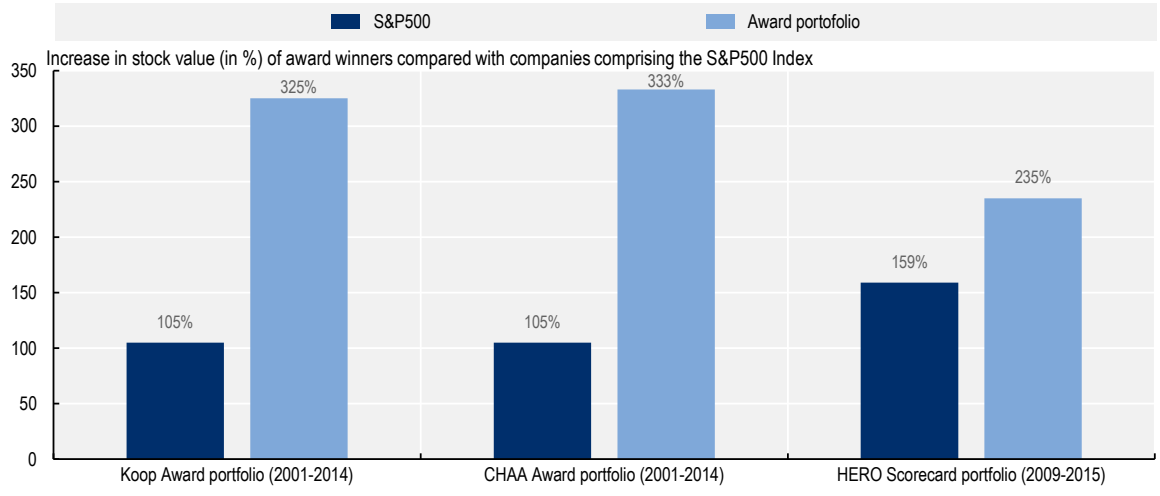
Human capital refers to "the stock of knowledge, skills and other personal characteristics embodied in people that help them to be more productive" (Botev et al., 2019[9]). As discussed in Chapter 2, health status – including physical and mental health – directly affects productivity, and is thus by definition, an important component of human capital. In the OECD Well-being Framework, premature mortality, smoking prevalence, and obesity prevalence are thus all included as human capital indicators (OECD, 2020[10]). In the context of efforts to assess the performance of companies by their human capital, proposed and existing indicators include a range of measures that are closely related to health, such as turnover rates, incidence of sickness absence, and working hours.

The world's leading investment funds and asset management companies have clearly outlined their expectation that companies disclose their human capital. This has at time extended to include considerations around employee health and well-being. For instance, BlackRock, one of the largest investment management companies worldwide, states in a document outlining its approach to human capital management from 2022 that it "believes that companies that successfully engage and support their workforce, are better positioned to deliver sustainable financial returns" (BlackRock, 2022[11]). The document cites the importance for businesses to create a healthy workplace culture and to support the physical and mental health and safety of employees through measures such as paid sick leave and counselling support.

The implementation of workplace health programmes is also correlated with stronger financial performance, potentially attracting investors and private funds. As shown in Figure 5.1, studies suggest an association between the implementation of workplace health and well-being programmes and stock market performance at the company level, according to data from three types of workplace health programme

award or self-scoring measures (Goetzel et al., 2016[12]; Grossmeier et al., 2016[13]; Fabius et al., 2016[14]). For instance, the stock performance of recipients of the C. Everett Koop National Health Award – which provides awards for companies with outstanding measures to improve health promotion in the workplace – appreciated three times more than the average among companies comprising the Standard and Poor's (S&P) 500 Index in the period from 2001 to 2014 (Goetzel et al., 2016[12]). This association also holds for two other measures, the Corporate Health Achievement Award (CHAA) that rewards employee health programme, and the Health Enhancement Research Organization (HERO) Scorecard that is based on self-scoring of the health programme performance by employers themselves. The lower effect of the HERO Scorecard may also be the result of a shorter time period. As discussed in Box 5.4, there is also promising evidence that suggests that companies that have been chosen for Stock Selection in the Health & Productivity Management Programme in Japan perform better on the Tokyo Stock Exchange (Ministry of Economy Trade and Industry of Japan, 2021[15]). The evidence from the United States and Japan should be interpreted with caution as the association of health promotion and financial performance is not evidence of a causal relationship. Such an association may also reflect strong business management and leadership that is conducive both to the implementation of effective workplace health programmes and to increases in profitability and revenue (O'Donnell, 2016[16]).

Figure 5.1. Companies receiving awards for their workplace health programmes have seen a greater increase in their stock value compared to companies in the S&P 500



Note: S&P500 refer to companies comprising the Standard and Poor's 500 Index, which includes the 500 largest companies listed on stock exchanges in the United States. CHAA Corporate Health Achievement Award. HERO Health Enhancement Research Organization. The period over which stock value increases are compared, is 2001-14 for both the Koop Award and the CHAA Award, but is less than half the length (2009-15) for the comparison of stock values for the HERO Scorecard. This may explain the smaller differential between the stock values of companies comprising the S&P 500 and HERO award-winners.

Source: Goetzel, R. et al. (2016[12]), "The Stock Performance of C. Everett Koop Award Winners Compared With the Standard & Poor's 500 Index", https://doi.org/10.1097/JOM.0000000000000632; Grossmeier, J. et al. (2016[13]), "Linking workplace health promotion best practices and organizational financial performance: Tracking market performance of companies with highest scores on the HERO Scorecard", https://doi.org/10.1097/JOM.0000000000000631; Fabius, R. et al. (2016[14]), "Tracking the Market performance of companies that integrate a culture of health and safety: An assessment of corporate health achievement award applicants", https://doi.org/10.1097/JOM.0000000000000638.

StatLink https://stat.link/gpv25z

As shown in Figure 5.2, if both investors and companies value the health and well-being of employees, this can create a virtuous cycle, where the incentive for companies to promote employee health and well-being is amplified. This is because a company that promotes the health and well-being of employees is rewarded not only with a healthier workforce, but also with an increased likelihood of receiving investment. However, one main challenge prevents the unlocking of this virtuous cycle. This is the lack of standardised disclosure mechanisms to ensure information on health outcomes and programmes are comparable across companies. This information is necessary for investors to differentiate companies that implement best practices to promote health and well-being from those that do not. The next sections look at this challenge (Section 5.3) and existing initiatives that seek to address it (Section 5.4).

Figure 5.2. Investment in health-promoting companies can create a virtuous cycle

Source: Authors.

5.3. A lack of standardised information creates challenges for investors with an interest in companies that promote employee health and well-being

The lack of standardised ESG indicators, metrics[3] and ratings[4] on health and well-being at work, and the shortage of information on health and well-being of employees are key factors that limit investment in companies that promote the health and well-being of its employees. This section looks at this issue in relation to ESG investment broadly, before looking specifically at the challenges associated with collecting and then disclosing data related to health and well-being at work.

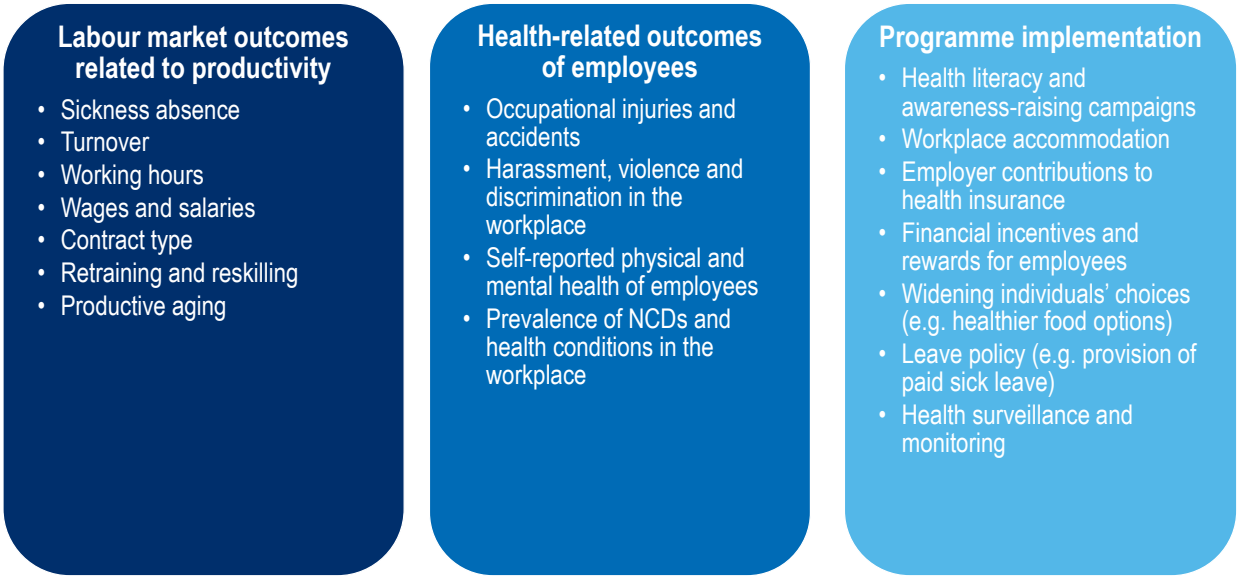
The growing demand for ESG investing is currently hampered by a lack of transparency, international inconsistencies and comparability challenges, and this is a risk that also exists for health and well-being indicators. There are many ESG ratings providers, each using different data sources, methodologies and frameworks to establish ratings (Boffo and Patalano, 2020[17]). This leaves the concept of ESG-promoting companies subject to interpretation rather than objective standards, and can result in companies seeking to show that they are more sustainable than they are in reality, a practice often dubbed as “ESG-washing” or “greenwashing” when used in relation to the environmental pillar. In its review of ESG and climate-themed equity funds in 2021, InfluenceMap, an independent think tank, found that more than two-thirds of ESG funds (71%) were not aligned with the global climate targets (InfluenceMap, 2021[18]). There has been less of a “health-washing” issue thus far. This may merely reflect the lack of integration of employee health and well-being considerations within ESG criteria thus far, as there is currently very little collection of standardised information on employee health and well-being that gives a good overview of employer performance. This is, however, an evolving area with a number of initiatives to promote the standardisation of indicators on employee health and well-being, such as the one led by the OECD on the

measurement framework for understanding the non-financial performance of firms (Siegerink, Shinwell and Žarnic, 2022[3]), further discussed in Section 5.4.

As shown in Figure 5.3, there are a range of indicators that could provide insight into the health and well-being of employees at the company level, and these fall into three broad categories.

1. **Labour market outcomes related to productivity** are indicators of work productivity related to employee health and well-being such as sickness absence, working hours and turnover. It may also include indicators on productive ageing, a concept that refers to engaging in productive activities at older ages, applied here in the context of work. These indicators may already be collected by employers in an anonymised form and thus easier to disclose, and are often used as indicators to measure the human capital performance of companies. The weakness with such indicators is that they provide limited insight into employee health.
2. **Health and well-being outcomes** are direct indicators of health and well-being such as the incidence of accidents and injuries, or self-reported physical and mental health. While these indicators are useful to show the actual health of employees, many companies do not or are unable to collect or process such data on grounds of employee privacy, even in cases where the data are de-identified[5] or anonymised. The collection of such data – if not well-managed – also opens the risk of discrimination of employees by their health status. Even in cases where collection of health data is permissible, it would place an additional burden on companies to collect new data, as companies do not usually collect such data.
3. **Indicators related to the implementation of health and well-being programmes by companies** show to what extent companies are implementing measures to promote health and well-being in the workplace. The issue with such indicators is the risk of "health-washing" especially if indicators rely heavily or solely on company-reported information. It is therefore important to be able to assess whether programmes implemented are actually implemented, if they are evidence-based and if they account for and reflect employee experiences and perspectives. This could be for instance to consider not only whether a company reports offering mental health support for workers, but also whether it integrates data on employees' participation levels and experience as to whether the support they receive is adequate.

Figure 5.3. Examples of company-level indicators related to health and well-being in the workplace



Note: Figure developed based on the range of indicators used in disclosure mechanisms which are described in Table 5.1.

A key consideration when collecting or processing any data on employee health and well-being is how to ensure the protection of privacy and prevent discrimination against individuals with health issues. The use of health data is unlikely to be straightforward, and it would be limited to cases where employees voluntarily participate in a workplace health programme and consent to the use of their data. For example, under the General Data Protection Regulation (GDPR), the framework for data protection in the European Union, any data related to an individual's physical or mental health is considered personal and protected data, and cannot be processed unless specific exemptions apply or the employee provides explicit permission (European Union, 2016[19]). Although one of the cases where an exception applies is if processing is necessary "for the purposes of preventive or occupational medicine", data collection for the purposes of providing insights into the performance of companies promoting employee health would not be covered under such an exemption. Without adequate measures, there is also potential that employers could use employee health data to inform their decisions about whether to retain, dismiss or promote employees, which would result in discrimination (Esmonde, 2021[20]). For instance, in the United States, although the American with Disabilities Act prohibits discrimination on the basis of disability in employment, only one state (Michigan) and several cities prohibit discrimination on the grounds of weight (Eidelson, 2022[21]).

5.4. Governments – together with other stakeholders – are closing the gap by encouraging the disclosure of standardised information and indicators on health and well-being at the workplace

Governments – working with relevant stakeholders such as the finance sector, rating agencies, investors, employers, and employee associations – are addressing the lack of standardised indicators on health and well-being at the workplace by facilitating the disclosure of standardised information and indicators. An overview of initiatives identified that seek to close this gap is presented in Table 5.1, and through this exercise, three types of initiatives were identified. These are:

- **government-led regulatory reforms** to require disclosure on human capital indicators related to health and well-being;
- **voluntary initiatives** (often led by non-governmental stakeholders) that seek to promote disclosure on health and well-being programmes implemented by companies; and
- **initiatives that seek to standardise indicators and disclosure mechanisms** used to assess company performance in promoting health and well-being in the workplace.

A key limitation identified with disclosure mechanisms (whether regulatory or voluntary) is that they primarily target large corporations and are less accessible and available for small and medium-size enterprises (SMEs). For instance, SMEs may have weaker incentives to invest in strengthening their non-financial and ESG disclosure given that the initial costs of such disclosure may outweigh the benefits in the short-term. Past OECD evidence has also shown that ESG reporting favours larger companies over SMEs and this bias could also apply to reporting on health and well-being (Boffo and Patalano, 2020[17]). This is reflected in existing initiatives, which tend to primarily target larger corporations, with limited impact on SMEs. The Directive for Non-Financial Reporting of the European Union only applies to the companies with more than 500 employees, while the Corporate Mental Health Benchmark focuses explicitly on the 100 largest UK-limited companies. This also points to the importance of initiatives that seek to standardise indicators and disclosure mechanisms ensuring accessibility to SMEs and levelling the playing field.

Table 5.1. Initiatives to promote standardisation and disclosure of company-level information and indicators on health and well-being at the workplace

	Name	Description	Organisation	Stage and scale	Scope
Category 1. Government-led regulatory reforms to require	Workforce Investment Disclosure Act, United States (2021[22])	Aims to make it mandatory for employers to disclose, information regarding workforce management policies, practices and performance.	Legislation introduced to the Senate of the United States.	The bill was introduced to the Senate in 2021. As of May 2022, it has not been discussed or approved.	Labour market outcomes, health and well-being outcomes, and programme implementation
	Non-Financial Reporting Directive, European Union (2013[23])	Requires companies to disclose information on their operations and ways of managing social and environmental challenges. Mandatory for specific enterprises	European Commission	Applies to large public-interest companies with more than 500 employees, which equates to around 11 700 –companies and groups across the EU.	Labour market outcomes and health and well-being outcomes.
Category 2: voluntary initiatives that seek to promote disclosure on health and well-being	Health & Productivity Management, Japan (see Box 5.4 for details)	Provides certification and awards (for 500 SMEs, 500 large enterprises and around 50 for Stock Selection) for companies promoting health in the workplace in Japan. Specific focus on nudging investment to health-promoting companies.	Led by Ministry of Economy Trade and Industry, with involvement of Tokyo Stock Exchange.	Launched in 2014, as of 2022, more than 2000 large enterprises and 12 000 SMEs had been certified. The next stage is to include the health of employees in supply chains in company assessment.	Labour market outcomes related to health and well-being, health and well-being outcomes, and programme implementation
	Workforce Disclosure Initiative, United Kingdom (ShareAction, 2022[24])	Performs an annual survey for companies interested in reporting on transparency and accountability related to workforce Issues	Led by a charity (ShareAction) and partially funded by the Foreign, Commonwealth and Development Office of the United Kingdom.	Launched in 2017. The survey received responses from 140 companies in 2020 and 178 responses in 2021.	Primarily programme implementation (Some use of health outcomes and labour market outcomes)
	Corporate Mental Health Benchmark UK 100, United Kingdom (CCLA, 2022[25])	Uses published information to assess the mental health promotion practice of companies.	CCLA, charity fund manager in the United Kingdom	The first edition, published in 2022, includes the 100 biggest companies of the UK	Health and well-being outcomes and programme implementation
	WELL Building Standard Certification (IWBI, 2022[26])	It proposes counseling, support and certification for improving health, safety, equity and performance outcomes in the workplace.	International WELL Building Institute, corporation	It aims to work with companies of any size. The standard was launched in 2004 and has reached about 2000 organisations.	Labour market outcomes, health and well-being outcomes, and programme implementation
Category 3: Initiatives that seek to standardise indicators used to assess company performance	Global Real Estate Sustainability Benchmark Standard (GRESB, 2022[27])	GRESB standards measure performance of individual assets and portfolios within the Real State and Infrastructure industries. GRESB collects data and provides business intelligence.	Global Real Estate Sustainability Benchmark, composed of an independent foundation and a for profit corporation.	Health and Well-being indicators were integrated into the Stakeholder Engagement aspect, included in 2018.	Programme implementation.
	Global Reporting Initiative and Culture of Health for Business (COH4B) (GRI, 2020[28])	GRI Standard 403 provides guidelines on disclosure on occupational safety and health, including on worker health promotion. GRI is also working to contribute to a common framework for businesses to report on their culture of health in a partnership with the Robert Wood Johnson Foundation.	Global Reporting Initiative, non-governmental standard-setting organisation.	Around three-quarters of the G250 – the largest companies worldwide by revenue – use GRI. Standard 403 was first published in 2018	Labour market outcomes, health and well-being outcomes, and programme implementation

	Name	Description	Organisation	Stage and scale	Scope
	WISE framework for "Scope 1" social performance. (Siegerink, Shinwell and Žarnic, 2022[3]).	Proposes a conceptual framework and set of indicators to measure the impact of business action on the well-being of their employees.	OECD	Released in 2022. The framework is aspirational and efforts will be made to continue to address measurement gaps.	Health and well-being outcomes.
	Sustainability and Accountability Standards Board Standards (SASB, 2020[29])	A set of standards designed for specific industries rather than to assess particular topics. Existing standards incorporate employee health and safety considerations but with a focus on preventing injuries, fatalities and illness.	Value Reporting Foundation, global non-profit organisation.	Standards were first published in 2015 and as of 2021,1325 companies worldwide reported using SASB standards.	Health and well-being outcomes
	ISO 45 000 family of standards	This group of standards aims to enable any company to put in place occupational health and safety management systems.	International Standards Organization, standard-setting organisation	These standards initially focused on occupational safety and health alone, but the latest standard (ISO 450 003) looks more broadly at mental health and well-being at work.	Programme implementation

Note: Information collected and categorisation of initiatives by authors.

Government-led reforms can make it mandatory for companies to disclose certain information related to health and well-being. Such initiatives are, however, in their infancy or very limited in coverage, which may reflect a reluctance to enforce disclosure and the administrative work this entails upon companies. In the United States, the Workforce Investment Disclosure Act proposal introduced to the Senate in 2021 would – if passed – make it compulsory for publicly traded companies to disclose human capital metrics, including many indicators related to workforce health (United States Congress, 2021[22]). The information proposed for disclosure not only includes labour market outcomes related to health and well-being (such as retention rate; lost time due to injuries, illness and death; and leave entitlements), it also proposes disclosure of information on "engagement, productivity and mental well-being of employees" and "total expenditure on workplace health, safety and well-being programmes." By comparison, the Directive for Non-Financial Reporting of the European Union already requires large companies to disclose information on their practices to manage social and environmental challenges, although the focus on employee health is very limited, and it merely requires a non-financial statement with no requirements to disclose specific information (European Union, 2013[23]).

There are a wide range of voluntary disclosure initiatives, which invite companies to disclose information on health and well-being. Many of these voluntary initiatives are embedded in award and certification schemes, which are discussed in detail in Chapter 4. Voluntary initiatives are typically led by, or involve, investors and asset management companies. A notable example is the Workforce Disclosure Initiative, which is led by ShareAction, a charity group and financially supported by the UK Government, and invites companies to disclose information on what measures they are taking to address workforce issues (Box 5.3). The Corporate Mental Health UK 100 Benchmark, led by CCLA, a large charity fund manager, differs in the mechanisms it uses, as instead of asking for disclosure, it uses publicly available information to assess the mental health promotion practices of companies (CCLA, 2022[25]). Meanwhile, the Health and Productivity Management Programme in Japan, which is described in Box 5.4, also involves the Tokyo Stock Exchange, but is led by the government.

Box 5.3. The Workforce Disclosure Initiative, a charity-led voluntary disclosure initiative

The Workforce Disclosure Initiative (WDI) was created to improve the transparency and accountability on workforce issues within the corporate sector. Spearheaded by the ShareAction, a charity group, WDI is partially funded by the UK Government's Foreign, Commonwealth and Development Office. WDI invites companies to disclose information on what measures they are taking to address workforce issues in ten areas of management – "governance, risk assessment, contractual status and remuneration, gender diversity, stability, training, well-being and rights issues" – including in their supply chains (ShareAction, 2022[24]). Within the area of well-being, information requested from companies is primarily based on programme implementation (see data analysis in Chapter 4). For instance, disclosing companies are asked about how they identify and manage health and safety risks; whether they provide a health and well-being plan; and what measures they are taking to mitigate the impact of COVID-19 on employee health. There are also some questions related to outcomes such as the number of cases of work-related injuries and ill-health, although these are limited to issues around the prevention of accidents, illnesses and deaths. WDI has been collecting information on workforce measures annually since 2017, with the number of companies disclosing information increasing from 34 companies to 173 worldwide companies over the course of five years. While WDI originated in the United Kingdom, it has expanded in recent years including through partnerships in Canada and Australia.

Box 5.4. The Health & Productivity Management Programme (H&PM), a government-led voluntary initiative in Japan

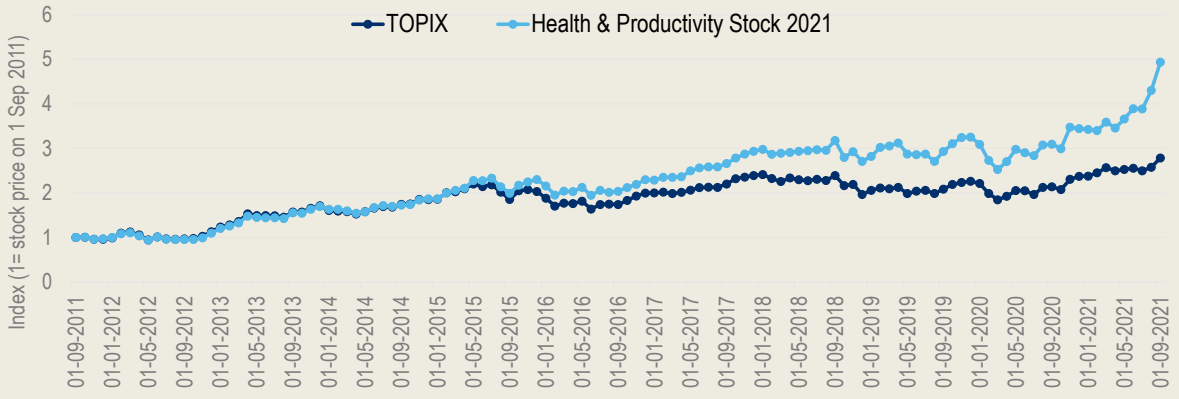
The Health & Productivity Management Programme, which is described in Box 4.8 in Chapter 4, is an example of a certification and award scheme launched in 2014 by the Ministry of Economy, Trade and Industry (METI) that also includes a heavy emphasis on facilitating investment in large companies that promote the health and well-being of their employees. To participate in this voluntary scheme, large companies are required to respond to a questionnaire annually, which acts to promote standardisation of the information reported by companies. The questions cover a vast range of areas including labour market outcomes related to productivity (e.g. indicators for absenteeism and presenteeism), health and well-being outcomes (e.g. prevalence of smoking and exercise habits since financial year 2016) and programme implementation (e.g. measures taken to increase literacy, promote physical activity and support smoking cessation). The uptake and results of health and stress checks that employers are required to offer in Japan by law which are described in Chapter 4, are also included in the survey.

METI recently began to publicly release the information reported by large corporations – with their approval – in order to increase transparency, while also giving investors an insight into which companies may be taking greater steps towards promoting the health and well-being of their employees. A total of 2000 companies agreed to disclosure of their evaluation sheets for 2021 based on the H&PM survey, which includes 634 listed companies and around 70% of the largest publicly owned companies in Japan (Nikkei 225) (2022[30]). The results for each of these companies are now available on the METI website.

METI also awards specific companies for the Health and Productivity Stock Selection. This is an award given jointly by METI and the Tokyo Stock Exchange for a select number of employers that score in the top 20% of H&PM screened by METI, but are also considered financially profitable.[6] The idea behind this is to signpost investment towards companies with Health and Productivity Stock Selection. 50 enterprises were announced as having been chosen for Stock Selection in 2022 (based on financial year 2021) (2022[31]). Although no causal relationship can be assumed as described in Section 5.2, companies selected for Stock Selection seem to perform well in the Tokyo Stock Exchange. As shown in Figure 5.4,

between 2011-21, the stock value of the group of companies selected for the Health and Productivity Stock Selection in 2021 outperformed the average of companies comprising the Tokyo Stock Exchange.

Figure 5.4. Companies rewarded with H&PM stock selection in 2021 saw their stock value increase by more than the average of companies in the Tokyo Stock Exchange between 2011-21



Note: The index was created using the companies' closing price on the first day of each month, using 1 September 2011 as the baseline (1.0). TOPIX refers to the average stock price of the companies comprising the Tokyo Stock Exchange. Four companies that had no baseline data, such as newly listed companies are excluded.
Source: Ministry of Economy Trade and Industry of Japan (2021[15]), Enhancing Health and Productivity Management Programme [Kenkō keiei no suishin ni tsuite].

The ministry has also collected information from major institutional investors in Japan on what information they would like to be able to have access to better differentiate companies that promote the health and well-being of companies and those that do not. In a 2021 survey covering 16 major institutional investors, more than two-thirds of surveyed investors stated that overtime hours (88%), worker engagement (88%) and turnover rates (81%) should be disclosed by companies when evaluating health management. Half or more of the surveyed investors also stated that health literacy of employees (56%), the execution rate of the stress check (56%) and presenteeism and absenteeism rates (both 50%) should also be disclosed (Ministry of Economy Trade and Industry, 2021[32]). The collection of such information could allow for the fine-tuning and adjustment of the questions included in the H&PM survey in future years.

The third category of initiatives are those that seek to standardise and harmonise practices across countries and companies on disclosure mechanisms of company performance. Organisations such as the International Organization for Standardization (ISO) and the Global Reporting Initiative (GRI) – which sets standards used by 75% of the world's largest companies in their ESG reporting – play a sizable role in this area given their global reach. ISO offers a collection of domain specific standards, whereas GRI proposes universal and topic specific standards (KPMG, 2020[33]). While these organisations have in the past assumed a focus on accident and injury prevention, they are now bridging this gap and introducing aspects of health promotion. For instance, ISO developed a new standard in 2021 – ISO 45 003 – which focuses on the management of psychosocial risks in the workplace (ISO, 2021[34]), while GRI integrates the expectation that companies implement voluntary health promotion programmes within its occupational health and safety reporting guidelines – GRI 403 (GRI, 2018[35]). GRI has also partnered with the Robert Wood Johnson Foundation, in order to align GRI 403 with a complementary framework on Culture of Health for Business (GRI, 2020[28]). The OECD Centre on Well-being, Inclusion, Sustainability and Equal Opportunity (WISE) is also developing a framework to assess the non-financial performance of companies, and this framework includes components related to health and well-being outcomes in the workplace (Siegerink, Shinwell and Žarnic, 2022[3]).

By encouraging the disclosure of standardised information and indicators on health and well-being at the workplace, governments can steer investors to invest in health-promoting companies and thus activate the virtuous cycle of health and productivity benefiting to both employees and employers. Another, different mechanism to finance health promotion at work, social impact bonds, is discussed in Section 5.5.

5.5. Other financing mechanisms, such as social impact bonds, are a tool for governments to raise finances dedicated to health promotion at the workplace

Public-private partnership financing mechanisms, such as social impact bonds or health impact bonds, also hold potential to support government expenditure to promote health and well-being at work. Social impact bonds are issued by governments to seek financing for projects with positive social outcomes (such as access to education or improving food security, but also workforce development). While social impact bonds are referred to as "bonds", they are not actual bonds, but rather represent contracts based on future social outcomes (OECD, 2019[36]). If social outcomes improve, investors receive their initial investment plus a financial return, measured as a fraction of the public sector saving. As the terms of payment depends on the successful delivery of outcomes, social impact bonds are considered an example of a pay-for-success approach. When the outcomes relate to health and social sector, social impact bonds are called health impact bonds. While evidence is still emerging, health impact bonds can help to finance prevention of chronic conditions and return-to-work programmes targeted at high-risk populations who face socio-economic disadvantages (see Box 5.5).

Box 5.5. Examples of social impact bonds and health impact bonds

The first social impact bond for health was launched in the United States in 2013, when the California Endowment, a private health foundation, provided funding of USD 600 000 over two years to Social Finance, Inc. and Collective Health to implement a project to reduce chronic asthma in low-income children residing in Fresno, California (Social Finance, 2013[37]). Evidence from the first year of the pilot found that rates of asthma-related hospital visits declined, and an analysis estimated that for every one dollar spent, almost four dollars (USD 3.63) was saved in health care costs.

According to the Impact Bond Global Database, in early 2022, there are 138 impact bonds in 26 countries worldwide, with USD 441 million capital raised and benefitting to more than 1.7 million people (Social Finance, 2022[38]). The database highlights 22 examples of health impact bonds, and two examples related to chronic diseases prevention and employment are described below.

In New Zealand, a mental health and employment social impact bond was launched in 2017 (for a duration of 5 years), with a capital of NZD 1.5 million (USD 1 million). The programme aims to help 1 700 people diagnosed with a mental health condition to return to work in six Auckland suburbs (Social Finance, 2022[38]; New Zealand Ministry of Health, 2019[39]). It provides a holistic employment service to jobseekers, including pre-employment screening and assessment, preparation for work, job matching and placement, and post-placement support. The client is the New Zealand Ministry of Social Development. APM Workcare Ltd is the service provider of vocational rehabilitation and disability services, and also one of the investors. The three other investors are a private philanthropic fund, Wilberforce Foundation, a health care company, Janssen, and an investment fund, Prospect Investment Management Ltd. The programme is still ongoing, and evaluation is not yet available. The two metrics by which success will be measured are the percentage of people that enter employment, and the extent to which employment is sustained. Potential benefit of the programme include the direct benefits from the cessation of jobseeker benefit payment and expected income tax gain from work, that will serve to reimburse the investors.

In the Netherlands, the Cancer and Work Health Impact Bond was launched in 2017 (for a duration of 3 years), with a capital of EUR 640 000 (USD 758 000) (Social Finance, 2022[38]; ABN AMRO, 2018[40]). The programme aims to help 140 cancer survivors return to work, providing a newly developed intensive

rehabilitation programme over 2 years. The intervention hinges on exercise, both physically and mentally, at home and at work, and enrols coaches to guide participants through the programme. The key players are: the insurer De Amersfoortse (the client), the occupational health and safety service ArboNed and the rehabilitation agency Re-turn (the operational practitioners), and the ABN AMRO Social Impact Fund and Start Foundation (the investors). The investors offered the finance for the rehabilitation programme and they will not receive any return until the envisaged results – evaluated based on whether participants have returned to work – have been reached. The client will then pay the investors based on the savings it has achieved on policies for absenteeism insurance. Evaluation on social and financial performance is not yet available.

5.6. Conclusion

The rising interest among investors in human capital and ESG criteria provides an opportunity to steer investment towards companies that promote the health and well-being of employees. This presents the opportunity of a virtuous cycle where companies that promote the health and well-being of employees are rewarded both with a healthier workforce and with investment. The challenge that remains to unlock this virtuous cycle is to develop and agree on a set of standardised disclosure mechanisms and indicators that allow investors to differentiate between companies across different countries.

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Notes

[1] The Global Finance Tracker is an annual review which highlights important trends in the value of companies in the form of their intangible assets. It is conducted by Brand Finance, a consultancy firm that estimates to the value of brands.

[2] Ocean Tomo is a company that provides a range of financial services related to intellectual property and other intangible assets to client companies, governments and institutional investor's.

[3] e.g. data and standards used for assessing, comparing, tracking performance of companies relative to ESG factors.

[4] Including scoring and ranking.

[5] De-identification refers to the "process by which a set of a personal health data is altered, so that the resulting information cannot be readily associated with particular individuals." (OECD, 2022[41])

[6] The requirement is that the return on equity (RoE) is at least 0% or in other words not negative.

OECD Health Policy Studies

Promoting Health and Well-being at Work

POLICY AND PRACTICES

Policies to promote employee health and well-being not only protect from occupational risks, but also provide benefits for individuals and employers. Unhealthy lifestyles, characterised by high levels of stress, sedentary behaviour and poor eating habits, affect the health of employees and negatively impact workplace productivity. Governments play a key role in promoting health and well-being in the workplace. This report analyses policy levers used by governments to incentivise employers to promote health and well-being at work in ten countries, including G7 countries and OECD countries in the Asia/Pacific region. These include regulation, financial incentives, guidelines, and certification and award schemes. The report also explores how governments can facilitate Environmental, Social and Governance investment to encourage health promotion at work.

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