

Implementation Plan for the Healthy Workers initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

NOTE: The Australian Government may publish all or components of this jurisdictional implementation plan, following initial consultation with the jurisdiction, without notice in public documents pertaining to the National Partnership Agreement.

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:
 - 1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and
 - 1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

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

2. The Healthy Workers initiative provides funding to support implementation of healthy lifestyle programs in workplaces across Australia.
3. Under the Healthy Workers initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the State of Victoria represented by Hon. David Davis MLC, Minister for Health (known as the Parties to this Implementation Plan).
5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion of the specified program, including the acceptance of final performance program reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.
7. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the State is limited to payments associated with performance benchmarks achieved by the State by the date of effect of termination of this Implementation Plan.
8. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

9. The maximum possible financial contribution to be provided by the Commonwealth for the Healthy Workers initiative is \$71.18 million. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.
10. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

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

Facilitation Payment		Due date	Amount
(i)	Facilitation payment	July 2011	\$8.25
(ii)	Facilitation payment	July 2012	\$15.39
(iii)	Facilitation payment	July 2013	\$7.45
(iv)	Facilitation payment	July 2014	\$4.51
Reward Payment *		Due date	Amount
(v)	Reward payment	2013-2014	\$14.24
(vi)	Reward payment	2014-2015	\$21.35

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

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

OVERALL BUDGET

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

Table 2: Overall program budget (\$ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
(i) Health promoting workplaces program	3.495	4.475	4.475	4.475	16.92
(ii) Workplaces as part of communities	4.665	4.665	4.665	4.665	18.66
TOTAL	8.16	9.14	9.14	9.14	35.59*

Notes: Facilitation payment only. Does not include Victorian government funding.

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

PROGRAM OVERVIEW AND OBJECTIVE

14. **Healthy workers and workplaces Victoria**

15. The objective in this program is to develop health promoting organisations and improve the participation in health promoting activities and practices of the employees in these organisations.

16. **Healthy workers and workplaces Victoria** is inclusive of the following mutually supportive activities:

Activity 1: Health promoting workplaces program

- a. Organisational capacity development for health
- b. Interventions to improve health in the workplace

Activity 2: Workplaces as part of communities: reaching small and medium sized workplaces

NB: The ‘healthy workers and workplaces Victoria’ does not aim to duplicate existing workplace health effort currently funded in Victoria but aims to expand and enhance on these efforts to provide a comprehensive, effective and sustainable approach to healthy workplaces and workers in Victoria. The ‘healthy workers and workplaces Victoria’ is complemented by the activities of **WorkSafe Victoria** (see www.workhealth.vic.gov.au) which at present include WorkHealth checks, health coaching for medium to high risk individuals, ‘how to’ tools and resources and workplace health promotion grants.

17. The contact for this program is the Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487)

ACTIVITY DETAILS

18. **Activity 1: Health promoting workplace program**

19. **Overview:**

A health promoting workplaces approach will be a key component of the Healthy Worker initiative in Victoria. A number of large employers, identified using intelligence from the Victorian Population Health Survey (VPHS), WorkHealth check data and Victorian Employers' Chamber of Commerce and Industry (VECCI), will be invited to participate in a four year strategy to develop as health promoting organisations. These employers will be selected across government, manufacturing, banking and finance, construction, retail and food sectors. The specific workplaces and locations will be across both metropolitan and regional Victoria.

A Workplace Health and Wellbeing Partnership will be established and chaired by the Department of Health commencing late 2010 to select, invite and engage worksites; develop the intervention; and establish a partnership program of work.

The worksites will be intensively supported to adopt a comprehensive approach to prevention that will include selection from a specified range of evidence-based interventions that will reduce the risk factors for chronic disease among workers, in particular, physical inactivity and fruit and vegetable consumption, rates of smoking, and risky drinking. These interventions will be guided by the emergent 'Environments for Health Promoting Workplaces' Framework and WorkHealth resources and tools for employers (Victorian government funded initiatives). The workplaces will demonstrate the value of a broad approach to workplace health promotion.

The program will use a participatory approach to design and implementation, involving workplace stakeholders, including employees, managers and unions. Where possible, the programs will involve features that ensure cost effectiveness, which may include group-based activities, using both facilitators and peer-based training, and incentives.

Five fulltime "Health and Wellbeing Coordinator" positions will be available to coordinate the workplace programs. A number of employment options will be considered, including being employed in the organisation and linked for professional support and supervision with VECCI and the department of health regionally. The program will be resourced for two components of activity: 1) organisational capacity development for health, and 2) interventions to improve health, each of which have been shown to be essential components of successful interventions.

Organisational capacity development for health will involve, as required (dependant on context of each organisation):

- Leadership and organisational engagement and building, for example:
 - Senior management sign-up to program and commitment to participate in interventions
 - Senior management participating in "Leadership for Health" (support for best-practice line management)
 - Senior management participation on the Health and Wellbeing Partnership (HWP)
 - Staff representative supported to participate on the Health and Wellbeing Partnership Advisory Group
 - Staff Health Advisory Committee established (or utilisation of an existing staff health committee) to oversee the program of work
- Resource allocation, for example
 - Healthy workplace kit and other resources available to employers
 - Small grants available to employers

- ‘Environments for Health Promoting Workplaces’ available to the HWP Partnership, Coordinator and workplace
- External program resources e.g. WorkHealth checks (WorkSafe), Quit programs, Lifestyle Modification Programs
- Workplace-based data collected and communicated with employees
- Ongoing workforce learning and development, for example:
 - Learning and development seminars/series across the organisation regularly updating on health messages and the progress of the program
 - Marketing of the program and findings as they emerge

A range of evidence-informed interventions, in combination, provide the greatest likelihood for health gain of workers, comprising:

- A physical activity policy
 - Physical activity on work and in employees own time eg encouraging walking challenges and promoting stair usage
- Healthy catering and food policy
 - At meeting and work functions
 - Healthy vending machine and canteen policy (healthy choice guidelines)
- Healthy food choice and preparation demonstrations in the workplace as a platform for broader health promotion and as means to engage workers
- Smoking cessation programs for workers and their families
 - Provision of Nicotine Replacement Therapy vouchers to employees participating in the program
- Use of the online self-assessment and brief intervention tool for risky drinking
- Health messaging through mass media e.g. 3 months of messages on alcohol and health, on drinking water, fruit and vegetable consumption
- Access to WorkHealth checks (WorkSafe)
- Access to a range of Healthy Living Programs in the workplace, via phone (coaching), and in the community

Workplaces will be funded to adopt all or most of the interventions for full effect. The above interventions have strong evidence of effectiveness (Bellew, 2008; Chau, 2009)

20. **Outputs:**

Output	Quantity	Quality	Timeframe
Activity 1: Number of health promoting workplaces and workers	Approx. 5 large organisations with between 3,000 and 10,000 employees (depending on final detailed costing)	See evaluation, outcomes & performance benchmark measurement.	2014/15 – Final report

Note: Victoria is undertaking a significant dose to population approach ie. This initiative is aimed at a significant dose of intervention rather than a significant population reach with less dose.

21. **Outcomes:**

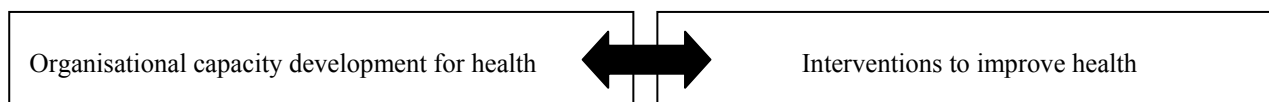
Activity	Long term outcomes (2014/15)
Activity 1: Health promoting workplaces program	<ul style="list-style-type: none"> • Proportion of adults at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by adults to meet targets • Increase in proportion of adults participating in moderate physical activity each day by 15 per cent

22. **Rationale:**

Adopting a capacity building model (Hawe et al 1997, Health Promotion Strategy Unit, 1999) and applying critical success factors for effective health promotion in workplaces (Bellew 2008) is essential to building sustainable health promoting workplaces (see figure 1).

Workplaces are complex ecological systems (Hawe et al 2009) requiring matched investment in organisational capacity and capability as well as multiple health promotion interventions.

Figure 1: Capacity and intervention relational model for health improvement



The most promising approaches to preventing chronic disease among workers and resulting in a productive workplace are those that achieve a balance between encouraging healthy behaviour among employees and addressing underlying workplace and organisational factors (Anderson et al, 2009; Robroek et al, 2009). This creates a supportive environment where workers are better able to make healthy choices. This means that the focus is broader than individual attitudes and behaviour, and also aims to address the workplace environment. The World Health Organisation’s Healthy Workplaces Model for Action describes the four key areas that can be influenced in healthy workplace initiatives: the physical work environment; the psychosocial work environment; personal health resources; enterprise involvement in the community (WHO, 2010).

The Victorian Department of Health commissioned a rapid review of the research on chronic disease prevention programs in the workplace, which identified that most of the evidence for workplace health promotion comes from North America or Europe, while this does not impact on the findings of the

review, it does highlight the need for well designed Australian-specific workplace health promotion studies (Bellew, 2008). The NPAPH provides such opportunity. A similar review by Chau (2009) also recommended the need for more Australian workplace health promotion studies.

References:

Anderson, LM. et al. The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity: A Systematic Review. *American Journal of Preventive Medicine* 2009; 37(4).

Bellew B. 2008. Primary prevention of chronic disease in Australia through interventions in the workplace setting: An evidence check rapid review brokered by the Sax Institute for the Chronic Disease Unit, Victorian Government Department of Human Services.

Chau J. 2009. Evidence module: Workplace physical activity and nutrition interventions. Physical Activity Nutrition and Obesity Research Group, University of Sydney.

Hawe P, Noort M, King L, Jordens C. 1997. Multiplying health gains: The critical role of capacity-building within health promotion programs. *Health Policy* 39, 29-42.

Hawe P, Shiell A, Riley T. Theorising interventions as events in systems. *American Journal of Community Psychology*, 2009, 43:267-276.

Health Promotion Strategy Unit. 1999. A framework for building capacity to improve health. NSW Health, Sydney.

Robroek et al (2009) Determinants of participation in worksite health promotion programmes: a systematic review. *International Journal of Behavioral Nutrition and Physical Activity* 2009, 6:26.

World Health Organisation (2010). Healthy workplaces: a model for action For employers, workers, policy-makers and practitioners. www.who.int/occupational_health/.../healthy_workplaces_model.pdf Accessed 7.7.10

23. Contribution to performance benchmarks:

See outputs, outcomes and evaluation sections.

24. Policy consistency:

NPAPH and Healthy Workers Scoping Statement and Guiding Policy Principles

The health promoting workplace program is consistent with the objectives of the NPAPH to improve nutrition, increase levels of physical activity, reducing harmful/hazardous consumption of alcohol and smoking cessation. It is also consistent with the outputs, scope and policy principles of the Healthy Workers initiative as detailed in the Healthy Workers Scoping Statement and Guiding Policy Principles (see attachment A).

This activity is consistent with broader Victorian preventive health reforms, policies and specific directions in workplace health in Victoria.

25. Target group(s):

It is anticipated that the program will initially involve up to 5 organisations with between 3,000 to 10,000 workers. As this initiative adopts a 'whole of organisation' capacity building approach, it is anticipated that the total number of workers involved with these workplace programs will range from 15,000 to 50,000.

Organisations will be drawn from government, manufacturing, banking and finance, construction, retail and food sectors, and from metropolitan and regional Victoria.

26. Stakeholder engagement:

The health promoting workplace program will be negotiated through a Workplace Health and Wellbeing Partnership (to be established) and through the existing WorkSafe and Department of Health collaborative, and the WorkHealth Advisory Group (WAG). This partnership is to be established and chaired by the Department of Health commencing late 2010 to select, invite and engage worksites/organisations; develop the intervention; and establish a partnership evaluation program.

The selection of the five large organisations to host the program of work will be based on intelligence from VPHS, WorkHealth health-check data and VECCI to determine outcome impact potential, workplace capacity and readiness, and future sustainability promotion.

The department has established a technical advisory group to guide the design of the NPAPH, based on evidence, and in the evaluation. Members of the group have expertise in health economics, health inequalities, obesity prevention, complex community interventions and interventions in a variety of settings such as workplaces and includes Professor Boyd Swinburne (Deakin University), Professor Penny Hawe (University of Calgary), Professor Alan Shiell (University of Calgary), Professor Rob Carter (Deakin University), Professor Elizabeth Waters (University of Melbourne), Professor Tony La Montagne (University of Melbourne) and Dr Sharon Goldfeld (Department of Education and Early Childhood Development).

Dame Carol Black was also consulted and supports the programs detailed.

27. Risk identification and management:

Risk	Level	Mitigation strategy	Responsibility/timeline
Delay in recruiting businesses	Medium	Maintain regular engagement with existing stakeholders and use networks to identify suitable businesses The department has a strong relationship with VECCI	Prevention and Population Health Branch (PPHB)
Recognising the existing workplace health promotion activity in Victoria, the challenge of duplicating messages across agencies and confusing employers	Medium	Use a participative and collaborative process to engage with stakeholders Maintain on-going cross-agency meetings, including regular DH-WorkSafe team meetings and the WorkHealth Advisory Group meetings	PPHB
Delays in recruitment or failure to attract suitable staff	Medium	Investigation of workforce requirements will be undertaken in late 2010	PPHB

Staff turnover and knowledge retention	Low	Knowledge retained at workplace level with senior management and staff health advisory committee, at regional level with regional public health team and state level through HWP partnership	PPHB
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28. Evaluation:

Activity	Methodology	Timeframe
<p>Activity 1: Health promoting workplaces program:</p> <p>As Healthy Workers activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Workers Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it. While not yet fully articulated, it is also intended that the Victorian evaluation approach should contribute to a National approach where possible.</p>	<p>In addition to the 2008 and 2011 Victorian Population Health Survey (VPHS)-LGA behavioural measures, a baseline survey, will cover key behavioural mediator variables (not currently measured) such as awareness, instrumental and affective attitudes, perceived control and self-efficacy and behavioural intentions.</p> <p>These measures will be taken in selected target intervention communities, and in selected comparison communities, to create a quasi-experimental design, to allow for assessment of both between and within area effects between 2011 and 2013.</p> <p>Process review and discrete program level evaluation in selected organisations participating in the program will be designed to provide lessons learnt/ insights.</p>	<p>2011 Behaviour change baseline using VPHS-LGA. Larger area worker profiles will be investigated for initiative evaluation utility.</p> <p>2014 Post-test using VPHS-LGA</p> <p>2010/2011 Baseline mediator survey in selected intervention and comparison areas.</p> <p>2013 Post-test mediator survey in selected intervention and comparison areas</p> <p>2010-2013 Qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with selected target communities and in selected organisations)</p> <p>2014 Evaluation Report and peer-reviewed publications</p>

29. Infrastructure:

If required, additional infrastructure for Activity 1: Health promoting workplaces program will be provided by the Prevention and Population Health Branch, Victorian Department of Health.

30. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
Activity 1: Health Promoting Workplaces Program	
i. State Workplace Health and Wellbeing Program Advisory Group established	July 2011
ii. Workplace/org sites selected, negotiated and agreed	July 2011
iii. Workplace Health and Wellbeing Coordinator positions recruited	July 2011
iv. Organisation/workplace baseline data and evaluation established	July 2011
v. Communications strategy developed and implemented advising all organisation of the program	August 2011
vi. Workplan of rollout of interventions developed: for healthy living programs on site and in the community e.g. quit smoking; healthy eating and physical activity policy guidelines; risky drinking brief intervention online	Nov 2011 to 2014

31. **Responsible officer and contact details:**

The Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487).

32. **Activity budget:**

Table 4: Activity project budget (\$ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	3.495	4.475	4.475	4.475	16.92
Notes: Facilitation payment only.	Does not include	Victorian government			funding.

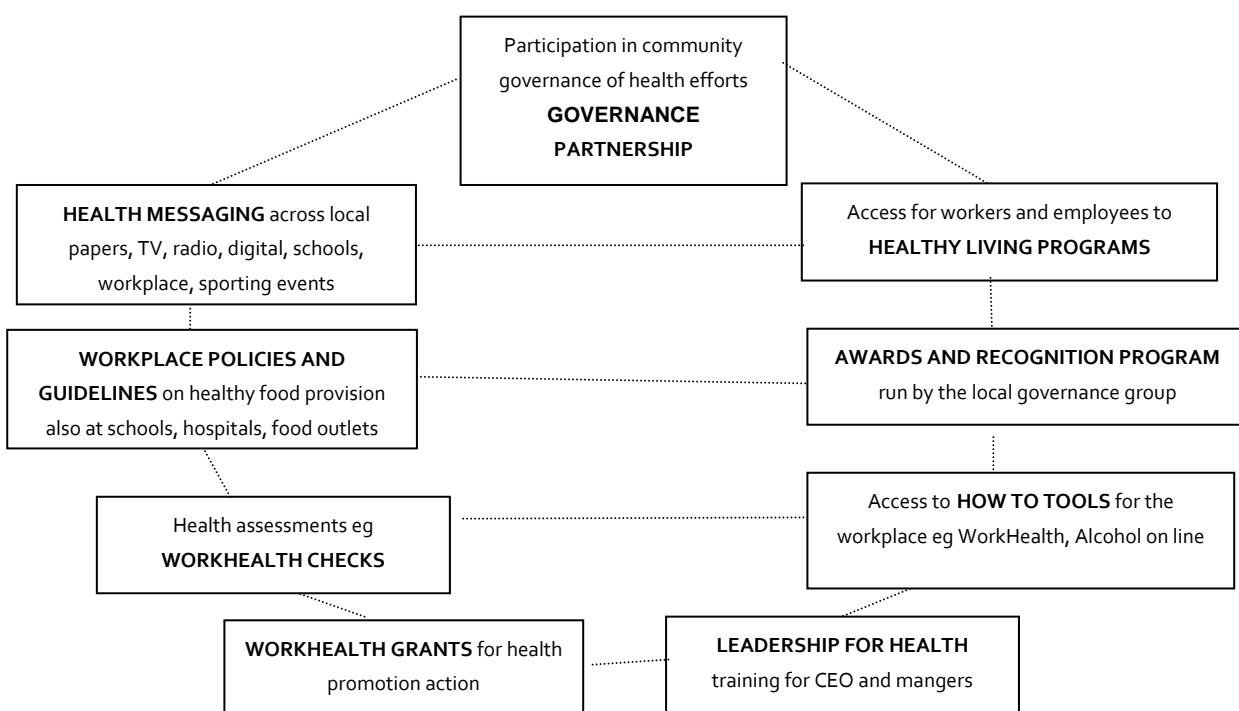
Activity 2: Workplaces as part of communities: reaching small and medium sized workplaces

33. **Overview:**

Complementing the large business program across the state will be a community approach to workplace health. A community-level approach is likely to reach more small and medium sized enterprises through a combination of workplace specific and broader community strategies (see Figure 2).

A comprehensive system of options would need to be available to employers and workers to be prompted to think about and take action on health. Single strategies are ineffective on their own. For example, when an employee is hearing and seeing messages about a healthy diet they may also want to access a healthy cooking class to develop further skills and knowledge on health living.

Figure 2: A comprehensive set of strategies to take action on preventive health for employers and employees at community and organisational levels



A first step in a community-level approach to worker health is employer engagement (through local VECCI offices or local business co-ordination programs) in the governance of health improvement across a community. Employer representatives would be invited to participate on the local governance group operating in their community alongside representatives from local government, local health services, schools, and the non-government sector.

Employers would also have access to a prestigious leadership development program in their community which enables “Leadership for Health”.

WorkHealth checks could be offered in community locations for workers from small and medium enterprises. “How to” tools and resources could be made available to all employees in the specified community. A workplace health promotion fund could be made available to encourage a change in workplace policies and practices in the workplaces in these communities. WorkHealth coaching and other life style modification programs would be offered to those workers assessed as being at high risk of diabetes. Additionally, healthy living programs (community education and peer education programs)

such as Foodcents or Family Food Patch could be accessed by workers and their families in the community.

Workplaces, hospitals and health services, school, councils and food outlets within these communities would be encouraged and supported to adopt the Department of Health, Healthy Choices: Food and Drink Guidelines (adapted from Healthy Choices: Food and Drink Guidelines for Victorian Public Hospitals).

This would be complemented by intensive social marketing over a four year period 2011-2015. This program would be complemented by MeasureUp.

34. Outputs:

Output	Quantity	Quality	Timeframe
Activity 2: Number of communities comprising targeted small and medium sized workplaces	Approximately 25 to 35 communities of target with populations ranging from 10,000 to 70,000 (depending on final detailed costing and adjacent geo-locations)	See evaluation, outcomes & performance benchmark measurement.	2014/2015 – Final report

Note: Victoria is undertaking a significant dose to population approach ie. This initiative is aimed at a significant dose of intervention rather than a significant population reach with less dose.

35. Outcomes:

Activity	Long term outcomes (2014/15)
Activity 2: Workplaces as part of communities: reaching small and medium sized workplaces	<ul style="list-style-type: none"> • Proportion of adults at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by adults to meet targets • Increase in proportion of adults participating in moderate physical activity each day by 15 per cent

36. Rationale:

The Victorian business community is dominated by small business. Small and medium businesses have long been recognised as offering specific challenges to engaging workers in health promotion (Goertzel, 2008). There are a number of barriers in small businesses that mean that many primary prevention interventions in the workplace setting is not a possibility. Therefore, a broad approach that steps beyond the workplace is required to comprehensively improve the health of Victorian workers. It is timely to consider how workplace health promotion best applies to small and medium-sized enterprises who are part of a community, and possibly better able to take up interventions *offered across the community* rather than always within the four walls of the workplace. For example, employees may want to take part in a lifestyle modification program or join a local quit smoking program offered at a community health centre, managers may be able to access business school programs on “leading for health”.

Employees will also be exposed to intensive mass media with health promoting messages across their community. Messaging in schools can “target” parents with children being the vector for message transmission.

Community-level interventions in preventive health are increasingly being utilised across Australia and internationally - Colac Be Active Eat Well in Victoria (Sanigorski et al, 2008), EPODE in France (Roman et al, 2009), OPAL (Obesity Prevention and Lifestyle) in South Australia. Other countries are also investing in community-based interventions to address obesity. The United Kingdom is investing £30 million pounds sterling over three years in nine communities to address obesity as part of their *Healthy Weight, Healthy Lives* strategy. The United States has recently announced Communities Putting Prevention to Work, an initiative to support community-level interventions in selected communities to address obesity.

The Victorian Department of Health (Centre for Allied Health, 2009) commissioned a rapid review of the research evidence on community level interventions to reduce obesity which supports their effectiveness when based on the following core elements: integrated and comprehensive program, across multiple settings; using multiple interventions, targeting change at the individual, group and organisation levels; involves the community in planning, implementation and evaluation, and; uses multiple individual-level intervention strategies.

The success of ‘healthy workers and workplaces’ in Victoria will be determined by integration with a comprehensive and complementary program of interventions that employers and employees can access in the community as well as creating supportive environments for individuals and families to adopt healthier lifestyles. ‘Healthy workers and workplaces’ in Victoria requires integration with the broader directions of the NPAPH in Victoria. The approach in Victoria will be a significant and sustained whole-of-community approach to settings that influence behaviour change. This sees sustained, consistent and coordinated action across community, family, council(s), schools, early childhood settings, health services and workplaces. This is complemented by the same levels of action at a state level.

An evaluation strategy across all partnership initiatives has been developed (see evaluation section). Funding will be allocated across the initiatives for evaluation. The collective benefit to each partnership initiative is therefore greater than the individual contribution. The Victorian government is committed to research and evaluation to deliver the best possible outcomes for Victorians as demonstrated in the establishment of the Centre of Excellence in Intervention and Prevention Science (CEIPS).

References:

The Centre for Allied Health Evidence. 2009. Community-based interventions: A rapid review. A technical report prepared for Department of Health, Victoria.

Cross-Government Obesity Unit, Department of Health and Department of Children, Schools and Families. 2008. *Healthy Weight, Healthy Lives: a Cross –Government Strategy for England*. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf

Goetzel RZ, Ozminkowski RJ. The health and cost benefits of worksite health promotion programs. *Annual Review of Public Health* 2008;29:303-23.

Roman M, Lommez A, Tafflet M, Basdevant A, Oppeert JM, Bresson JL, Ducimetiere P, Charles MA, Borys JM. Downward trends in the prevalence of childhood overweight in the setting of 12 year school and community-based programmes. *Public Health Nutrition* 2009 12 (10) 1735-42.

Sanigorski AM, Bell AC, Kremer PF, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. *International Journal of Obesity*. 2008; 79: 1-8.

US Department of Health and Human Services. 2010. Communities Putting Prevention to Work. www.cdc.gov/chronicdisease/recovery/

37. Contribution to performance benchmarks:

See outputs, outcomes and evaluation sections.

38. Policy consistency:

NPAPH and Healthy Workers Scoping Statement and Guiding Policy Principles

Workplaces as part of communities is consistent with the objectives of the NPAPH to improve nutrition, increase levels of physical activity, reducing harmful/hazardous consumption of alcohol and smoking cessation. It is also consistent with the outputs, scope and policy principles of the Healthy Workers initiative as detailed in the Healthy Workers Scoping Statement and Guiding Policy Principles (see attachment A).

This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in workplace health.

39. Target groups:

Targeted effort will be directed towards approximately 25 to 35 Victorian communities, a combination of metropolitan and regional, with high-risk profiles (based on the Victorian Population Health Survey 2008, Victorian Best Start and Neighbourhood Renewal data, WorkHealth data) and sufficient capacity to utilise external support.

40. Stakeholder engagement:

‘Workplaces as part of communities’ will be negotiated through the WorkSafe and Department of Health collaborative and the WorkHealth Advisory Group (WAG).

The department has established the Victorian Local Government Health and Wellbeing Planning Advisory Group to provide direction and high-level strategic advice and recommendations on government policy and planning including the NPAPH.

The department has established a technical advisory group to guide the design of the NPAPH, based on evidence, and in the evaluation. Members of the group have expertise in health economics, health inequalities, obesity prevention, complex community interventions and interventions in a variety of settings such as workplaces and includes Professor Boyd Swinburne (Deakin University), Professor Penny Hawe (University of Calgary), Professor Alan Shiell (University of Calgary), Professor Rob Carter (Deakin University), Professor Elizabeth Waters (University of Melbourne), Professor Tony La Montagne (University of Melbourne) and Dr Sharon Goldfeld (Department of Education and Early Childhood Development).

41. Risk identification and management:

Risk	Level	Mitigation strategy	Responsibility/timeline
Managing local government expectations/issues re community selection	Medium	Consulting with MAV and LG Advisory Group Joint DH-MAV position Working with regional public health teams who have direct ongoing relationships with local government through Municipal Public Health Planning	Prevention and Population Health Branch (PPHB)
Delays in establishing governance at the community level and undertaking local level planning	Medium	Regional public health teams engaged in program	PPHB
Lack of engagement of small and medium businesses	Medium	Ensure chamber of commerce are participating on local governance Maintain engagement of VECCI and other key groups Ongoing monitoring at local community level	PPHB
Recognising the existing workplace health promotion activity in Victoria, the challenge of duplicating messages across agencies and confusing employers	Medium	Use a participative and collaborative process to engage with stakeholders Maintain on-going cross-agency meetings, including regular DH-WorkHealth team meetings and the WorkHealth Advisory Group meetings	PPHB

42. **Evaluation:**

Activity	Methodology	Timeframe
<p>Activity 2: Workplaces as part of communities: reaching small and medium sized workplaces</p> <p>As Healthy Workers activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Workers Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it. While not yet fully articulated, it is also intended that the Victorian evaluation approach should contribute to a National approach where possible.</p>	<p>In addition to the 2008 and 2011 Victorian Population Health Survey (VPHS)-LGA behavioural measures, a baseline survey, will cover key behavioural mediator variables (not currently measured) such as awareness, instrumental and affective attitudes, perceived control and self-efficacy and behavioural intentions. The approach will learn from published and peer-reviewed USA 5-A-Day and similar evaluation research.</p> <p>These measures will be taken selected target intervention communities, and selected comparison communities, to create a quasi-experimental design, to allow for assessment of both between area and within area effects between 2011 and 2013.</p> <p>Process review and discrete program level evaluation in selected areas from the outset using qualitative designs, will be design to provide lessons learnt/ insights.</p>	<p>2011 Behaviour change baseline using VPHS-LGA</p> <p>2014 Post-test using VPHS-LGA</p> <p>2010/2011 Baseline mediator survey in selected intervention and comparison areas.</p> <p>2013 Post-test mediator survey in selected intervention and comparison areas</p> <p>2010-2013 Qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with selected target communities)</p> <p>2014 Evaluation Report and peer-reviewed publications</p>

43. **Infrastructure:**

If required, additional infrastructure for Activity 2: Workplaces as part of communities: reaching small and medium sized workplaces will be provided by the Prevention and Population Health Branch, Victorian Department of Health.

44. Implementation schedule:**Table 3: Implementation schedule**

Deliverable and milestone	Due date
Activity 2: Workplaces as part of communities	
(i) Selection of communities and sign-up of LGAs	July 2011
(ii) Community governance group established	July 2011
(iii) Community - organisation/workplace baseline data and evaluation established	2011
(iv) Preventive health promotion positions established	2011
(v) Communications strategy developed and implemented	August 2011
(vi) Community action and workplan of interventions developed: for healthy living programs on site and in the community e.g. quit smoking; healthy eating and physical activity policy guidelines; risky drinking brief intervention online	2011 to 2014

Notes: This Activity will be delivered and coordinated with Activity 2 of the Healthy Children Initiative.

45. Responsible officer and contact details:

The Prevention and Population Health Branch, Department of Health Victoria (ph 03 9096 1487)

46. Activity budget:**Table 4: Activity project budget (\$ million)**

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	4.665	4.665	4.665	4.665	18.66

Notes: NPAPH facilitation payments only. Does not include Victorian government funding

ROLES AND RESPONSIBILITIES**Role of the Commonwealth**

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

Role of the State

48. The State is responsible for all aspects of program implementation, including:
- (a) fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;
 - (b) completing the program in a timely and professional manner in accordance with this Implementation Plan; and
 - (c) meeting all conditions of the National Partnership including providing detailed annual report against milestones and timelines contained in this Implementation Plan, performance reports against the National Partnership benchmarks, and a final program report included in the last annual report that captures lessons learnt and summarises the evaluation outcome.
49. The State agrees to participate in the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

50. The State will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 June 2013 and 31 December 2014:
- a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015.
 - b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2013; 0.6 for fruits and 1.5 for vegetables by 2015.
 - c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2013; by 15 per cent by 2015.
 - d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015.
 - e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015.
 - f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2013; 15 per cent from baseline by 2015.
 - g) Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

51. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Australian Health Minister's Conference.
52. The performance benchmarks for the State will be monitored and independently assessed by the COAG Reform Council.
53. The performance reports are due within two months of the end of the relevant period.

National Partnership Agreement on Preventive Health

HEALTHY WORKERS

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

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

1.2 Objectives

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

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

1.3 Outputs

To support these objectives the Healthy Workers initiative will fund:

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

- a) focusing on healthy living and covering issues such as physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking cessation;
- b) meeting nationally agreed guidelines for addressing these issues, including support for risk assessment and the provision of education and information;
- c) which could include the provision of incentives either directly or indirectly to employers;

- d) including small and medium enterprises, which may require the support of roving teams of program providers; and
- e) with support, where possible, from peak employer groups such as chambers of commerce and industry.

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

1.4 Evidence Base

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

Nearly 11 million Australian adults are in paid employment, with around 70 per cent in full time employment.¹ Approximately five million (2004-05) Australian employees are overweight or obese (of whom 1.3 million are obese). Obesity was associated with an excess 4.25 million days lost from the workplace in 2001.² Obesity rates are highest among mature age workers aged 45-64, who comprise almost a third of the labour force. As obese people age, sick leave increases at twice the rate of those who are not obese.³ Research indicates that sedentary lifestyles can also lead to more work-related illness and prolonged recovery periods as well as increased morbidity and mortality.⁴

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

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

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

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

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

⁴ McEachan, Lawton et al. 2008

PART 2: HEALTHY WORKERS

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

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

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

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

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

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

Primary and secondary prevention definitions are drawn from *The Language of Prevention*, National Public Health Partnership 2006⁶ and in the context of Healthy Workers mean:

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

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

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

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

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

2.2 Scope

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

- 2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of smoking, poor nutrition, physical inactivity and hazardous and harmful alcohol consumption through sustained behaviour and organisational changes in working Australians and their workplaces.
- 2.2.2 The wider community, children and those who are unemployed or in an unpaid position are not a specific target population under this initiative. However, if a program through a participating worker or workplace, can also reach families, or other members of the community then this is encouraged.
- 2.2.3 The primary target age range for this initiative is people in paid employment aged 35 to 55 years old. Other age ranges outside of this group can also be considered. A lower and upper age limit is not specified under the initiative.
- 2.2.4 Programs should focus on preventive health activities. Programs with a tertiary management focus (i.e. managing existing chronic conditions) are not within the preventive scope of the initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs will attract funding.
- 2.2.5 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.
- 2.2.6 Health promotion programs can be implemented in and through workplaces with workers as the primary target audience. There must be a direct connection with the workplace. For example, policies on food and vending machines in the workplace or a lunchtime walking group organised by workers and undertaken during working hours. A community program that is attended by a worker on the weekend, and does not have the support or endorsement of an employer (e.g., a subsidy) and is otherwise unconnected with employment, would be out of scope.
- 2.2.7 Needs assessments can include consideration of the policy environment, workplace culture and infrastructure as they relate to the delivery of a program. An audit of policies and infrastructure that support healthy lifestyle choices and work-life balance to identify areas for development and determine appropriate activities could be implemented as part of a

program. For example, in considering the implementation of an active transport to work program, an audit may identify whether supporting infrastructure such as bike racks in the workplace are available.

- 2.2.8 Investment in substantial built environment or hard infrastructure improvements is beyond the scope of the NPAPH. Substantial infrastructure improvements (i.e., change facilities and shower blocks) will need to be funded by the employer. Minor infrastructure (i.e., bike racks) may be permitted following consultation with the Commonwealth.
- 2.2.9 Whilst volunteers are not a specific target population under the initiative, if volunteers are in the workplace they should not be excluded from participating in programs.
- 2.2.10 Funding may be used, among other things, to provide direct incentives to employers to provide programs (e.g. through the provision of subsidies to purchase programs; develop jurisdiction wide programs that can be picked up by employers; or to assist existing providers) or adapt existing programs to suit a wider range of workplaces or to target specific groups.
- 2.2.11 Programs should cover a range of businesses regardless of size. Large business should not be the sole focus of programs and consideration should be given to the needs of small to medium enterprises.

2.3 Policy Principles

General

- 2.3.1 Programs under the initiative should be focused on primary and secondary prevention.
- 2.3.2 Funding for programs should be invested in:
 - significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
 - new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
 - programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and
 - programs that have a high likelihood of being sustainable beyond the funding received under this initiative, should the program be effective and there is a demonstrated continuing need.
- 2.3.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.
- 2.3.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.
- 2.3.5 Participation in NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new workplace legislative requirements or policies (e.g., food supply, no smoking, alcohol management policies, banning of alcohol).
- 2.3.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions or behaviours.
- 2.3.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

- 2.3.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.
- 2.3.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues, and different industry and workforce requirements).
- 2.3.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation, should not be permitted.
- 2.3.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.
- 2.3.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. schools, early childhood settings or other organisations in the community).
- 2.3.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.
- 2.3.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And in addition for the Healthy Workers initiative

- 2.3.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.
- 2.3.16 Programs should recognise the diversity of workplaces in Australia and the diversity of Australian workers.
- 2.3.17 Employers should consider the effect of programs across their entire workforce where an employer operates in more than one jurisdiction to ensure that all employees have the opportunity to access programs.
- 2.3.18 Inter-jurisdictional collaboration should be considered when the employer has a workforce operating in a number of jurisdictions or is a national employer.
- 2.3.19 Activities and programs implemented by each jurisdiction will need to be accessible and appropriate for small to medium enterprises, as well as large businesses.