Chapter 1

Australia

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After reading this chapter you should be able to:

- Identify core strategies that are the focus of Australia's workplace health promotion efforts
- Describe Australia's historical evolution of workplace health promotion
- Explain the different approaches employed by corporate health promotion efforts throughout Australia
- Review the central disease-states and health issues driving Australia's health promotion needs
- Name the components of, and the associated funding sources for, Australia's healthcare system
- Discuss the impact of culture on Australia's health status and health promotion efforts

Table 1-1 **Select Key Demographic and Economic Indicators**

Nationality	Noun: Australian(s) Adjective: Australian
Ethnic groups	White 92%, Asian 7%, Aboriginal and other 1%
Religion	Catholic 25.8%, Anglican 18.7%, Uniting Church 5.7%, Reformed 3%, Eastern Orthodox 2.7%, other Christian 7.9%, Buddhist 2.1%, Muslim 1.7%, other 2.4%, unspecified 11.3%, none 18.7% (2006 Census)
Language	English 78.5%, Chinese 2.5%, Italian 1.6%, Greek 1.3%, Arabic 1.2%, Vietnamese 1%, other 8.2%, unspecified 5.7% (2006 Census)
Literacy	Definition: age 15 and over can read and write Total population: 99% Male: 99% Female: 99% (2003 est.)
Education expenditure	4.5% of GDP (2005) Country comparison to the world: 86

continued

Table 1-1 **Select Key Demographic and Economic Indicators,** *continued*

Government type	Federal parliamentary democracy
Environment	Soil erosion from overgrazing, industrial development, urbanization, and poor farming practices; soil salinity rising due to the use of poor quality water; desertification; clearing for agricultural purposes threatens the natural habitat of many unique animal and plant species; the Great Barrier Reef off the northeast coast, the largest coral reef in the world, is threatened by increased shipping and its popularity as a tourist site; limited natural fresh water resources
Country mass	Total: 7,741,220 sq km Country comparison to the world: 6 Land: 7,682,300 sq km Water: 58,920 sq km *Note:* includes Lord Howe Island and Macquarie Island
Population	21,515,754 (July 2010 est.) Country comparison to the world: 54
Age structure	0–14 years: 18.4% (male 2,033,106/female 1,929,863) 15–64 years: 67.8% (male 7,397,562/female 7,197,829) 65 years and over: 13.5% (male 1,306,329/female 1,607,146) (2010 est.)
Median age	Total: 37.5 years Male: 36.8 years Female: 38.3 years (2010 est.)
Population growth rate	1.171% (2010 est.) Country comparison to world: 108
Birth rate	12.39 births/1,000 population (2010 est.) Country comparison to world: 162
Death rate	6.81 deaths/1,000 population (July 2010 est.) Country comparison to world: 146
Net migration rate	6.13 migrant(s)/1,000 population (2010 est.) Country comparison to the world: 11
Urbanization	Urban population: 89% of total population (2008) Rate of urbanization: 1.2% annual rate of change (2005–2010 est.)
Gender ratio	At birth: 1.06 male(s)/female Under 15 years: 1.05 male(s)/female 15–64 years: 1.03 male(s)/female 65 years and over: 0.84 male(s)/female Total population: 1 male(s)/female (2010 est.)

continued

Table 1-1 **Select Key Demographic and Economic Indicators,** *continued*

Infant mortality rate	Total: 4.67 deaths/1,000 live births Country comparison to the world: 195 Male: 5.08 deaths/1,000 live births Female: 4.33 deaths/1,000 live births (2010 est.)
Life expectancy	Total population: 81.72 years Country comparison to the world: 8 Male: 79.33 years Female: 84.25 years (2010 est.)
Total fertility rate	1.78 children born/woman (2010 est.) Country comparison to the world: 156
GDP—purchasing power	$824.3 billion (2010 est.)
Parity	Country comparison to the world: 19
GDP—per capita	$38,800 (2009 est.) Country comparison to the world: 23
GDP—composition by sector	Agriculture: 4.1%
Agriculture—products	Wheat, barley, sugarcane, fruits, cattle, sheep, poultry
Industries	Mining, industrial and transportation equipment, food processing, chemicals, steel
Labor force participation	11.45 million (2009 est.) Country comparison to the world: 44
Unemployment rate	5.7% (2009 est.) Country comparison to the world: 51
Industrial production	-4.1% (2009 est.) Growth rate
Distribution of family income (GINI index)	30.5 (2006)
Investment (gross fixed)	28.5% of GDP (2009 est.) Country comparison to the world: 32
Public debt	17.6% of GDP (2009 est.) Country comparison to the world: 108
Market value of publicly traded shares	$NA (December 31, 2009)
Current account balance	$-29.89 billion (2009 est.) Country comparison to the world: 182
Debt (external)	$920 billion (December 31, 2009 est.) Country comparison to world: 11

continued

Table 1-1 **Select Key Demographic and Economic Indicators,** *continued*

Debt as a % of GDP	———
Exports	$160.5 billion (2009 est.) Country comparison to the world: 23
Exports—commodities	Coal, iron ore, gold, meat, wool, alumina, wheat, machinery, and transport equipment
Export—partners	Japan 22.2%, China 14.6%, South Korea 8.2%, India 6.1%, United States 5.5%, NZ 4.3%, United Kingdom 4.2% (2008)
Imports	$160.9 billion (2009 est.) Country comparison to the world: 21
Import—commodities	Machinery and transport equipment, computers and office machines, telecommunication equipment and parts; crude oil and petroleum products
Import—partners	China 17.94%, United States 11.26%, Japan 8.36%, Singapore 5.54%, Thailand 5.8%, Germany 5.3%, United Kingdom 4.3% (2009)
Stock of direct foreign investment at	
Home	$295.9 billion (December 31, 2009 est.) Country comparison to the world: 15
Abroad	$226.7 billion (December 31, 2009 est.) Country comparison to the world: 15

Source: CIA. (2010). *The world factbook.* Retrieved August 31, 2010, from www.cia.gov

Introduction

Australia is, by international standards, a very healthy country. The World Health Organization (WHO) stated that "Australia consistently ranks in the best performing group of countries for healthy life expectancy" (Department of Health and Aging, n.d.)

However, Australia still has major health issues. The increasing prevalence of problems such as obesity and diabetes and the inability of past methods to deal with these and other major health issues has some in the health field predicting that life expectancy rates will level out and may even start to diminish. In addition, life expectancy of the indigenous population is 17 years less than the nonindigenous population. Inequality in life expectancy also exists between rich and poor as well as between rural and city dwellers. A healthcare system that is under increasing strain is placing more and more pressure on both the private sector and government at all levels to take steps to improve the health of all Australians.

Historically, health promotion strategies have largely followed the medical model of prevention; that is, primarily risk reduction through behavior change targeted at a specific health problem. However, the limited success of this approach to deal with many major lifestyle-related health problems in the long term is now fueling the push for a different approach. Could this be the trigger for greater acceptance of the wellness movement, which emphasizes life enrichment of the whole person rather than purely risk reduction?

Wellness as a term, way of life, and health paradigm has been very slow to be embraced by individuals, organizations, the healthcare system and both levels of government since its first flicker of life in Australia more than 30 years ago. In fact, the current health crises and the media attention they are receiving may also prove to be what is needed for many more decision makers to realize the importance of the workplace as a health promotion setting. Perhaps this may also reignite the workplace health promotion flame which sparked in the late 1970s, caught fire in the mid-1980s (mainly government agency promoted), but failed to burn any brighter until relatively recently with the emergence of a growing number of private providers offering health services to the workplace.

"It is estimated that currently over 1,500 corporate and government employers provide health assessments and intervention programs for over 400,000 employees" (National Preventative Health Taskforce, 2009, p. 52). This data appears to be an increase of that reported in the 1991 survey (return percentages reported only) commissioned by the National Coordinating (formerly Steering) Committee for Health Promotion in the Workplace (1993). Yet this current figure represents only about 3.6% of Australian workers (National Preventative Health Taskforce, 2009). More fuel is necessary to start the "bush fire" in order for workplace health promotion to deliver the outcomes it is capable of achieving in reducing the growing cost of ill health in Australia.

Prevailing Health Issues and Risk Behaviors

The National Preventative Health Taskforce was established in April 2008 by the Australian central government. The theme was, "Australia: the Healthiest Country by 2020." The initial discussion paper outlined a number of prevailing health issues and risk behaviors that need to be addressed. The central issues nominated are obesity, tobacco, and alcohol. The reason for this is that, "put together, smoking, obesity, harmful use of alcohol, physical inactivity, poor diet and the associated risk factors of high blood pressure and high blood cholesterol cause approximately 32% of Australia's illness" (National Preventative Health Taskforce, 2008, p. 7).

Smoking

Out of a total population of around 20 million, there are at least 2.9 million adult Australians who smoke on a daily basis. While this constitutes a 30% decline since 1976, approximately half of these smokers who continue to smoke for a prolonged period will die early.

Smoking-related illness costs up to 5.7 billion AUD (Australian dollars) per year in lost productivity. In addition, the smoking rate for young people is still cause for concern. Of similar concern is the over 50% smoking rate of indigenous Australians (National Preventative Health Taskforce, 2008, p. 8).

Obesity

The number of Australians who are overweight or obese has been increasing dramatically since 1980, and it is predicted that if the trend continues, nearly 75% of Australians will be overweight or obese by 2025. The current estimated figure of overweight and obesity stands at over 60% (National Preventative Health Taskforce, 2008, p. 7). Of particular concern is the percentage of children who are either overweight or obese. The 2007 National Children's Nutrition and Physical Activity Survey reports this percentage as 25% (National Preventative Health Taskforce, 2008, p. 7). This is a huge increase from the 1960s figure of 5%. Thus, it is reasonable to predict that life expectancy figures for Australia will fall in the future.

Alcohol

While the majority of the Australian population drink alcohol at levels below long-term risk or harm, a major problem exists with young adults and Australia's Aboriginal population. The annual costs of harmful consumption of alcohol are huge. They consist of costs associated with crime, health, loss of productivity, and road trauma. Collectively, this adds up to a total of over 10 billion AUD.

The taskforce's emphasis on smoking, obesity, and alcohol is not at the exclusion of ongoing concerns related to other major health issues, such as the aging of the Australian population, cancer (skin, breast, and prostate), diabetes, road-related accidents and fatalities, and mental health issues. For example, the key findings from the National Survey on Mental Health and Wellbeing found that 1 in 5 Australians aged 16–85 years had a mental health disorder in 2007 (Australian Bureau of Statistics, 2007).

Healthcare System

The Australian healthcare system is based on a combination of a universal public health system called Medicare and a private health insurance sector. Medicare provides health care that is designed to be largely affordable and accessible to all Australians and can be provided free of charge at the point of care. Doctors in private practice are free to determine the number of rebatable services they provide and the fees they charge to patients. Individuals, who are charged by the doctor for a consultation, claim the standard fee back through Medicare. The Medicare benefits paid are based on a percentage of the Medicare schedule fee.

Medicare also provides free in-hospital services in public hospitals for patients who choose to be treated as public patients. Under Medicare, public patients in public hospitals are not charged for medical services or hospital accommodation costs. This, however, has caused a supply and demand problem, leading to extensive waiting periods in some cases.

The Pharmaceutical Benefits Scheme is the other component of the public healthcare system. This scheme subsidizes a high proportion of prescription medication bought from pharmacies.

The overall public healthcare program is financed through the general taxation system, which includes the Medicare levy, based on an individual's taxable income. This is set at 1.5% above a threshold income level and 2.5% for those people without private health insurance (Department of Health and Ageing, n.d.).

The Private Health Insurance Administration Council (PHIAC) is an independent statutory authority that regulates the private health insurance industry. The overall policy is controlled by the Australian government. Private health insurance covers individuals and families for hospital treatment in the private hospital sector, as well as for a range of ancillary treatments such as dentistry, optometry, physiotherapy, etc. The PHIAC *Annual Report 2007–08* indicated that "44.7% of Australians were covered with private health insurance" (Private Health Insurance Administration Council, 2008, p. 3). The level of coverage for individuals and families depends on the specific policy and the premium paid.

Private health insurance continues to be offered on a community-rated basis wherein discrimination between policy holders on the basis of age, health, gender, race, etc, is prohibited by legislation. In support of this principle, insurers must participate in risk equalization arrangements that share the cost burden of higher-risk policy holders across all insurers. Some categories of Australians, such as members of the armed forces and veterans, are covered by additional special arrangements, while remaining eligible for mainstream Medicare coverage.

Compulsory workers' compensation insurance also covers work-related injuries and illnesses. The annual premium for this insurance is paid by an employer and is calculated by the past number and cost of claims. A small number of (mostly) large organizations are self-insurers. In addition, injuries from motor vehicle accidents may be covered by compulsory third-party motor vehicle insurance. This insurance premium is paid by vehicle owners as a component of vehicle registration.

Influence of Culture and Mentality

Knowledge and understanding of the culture and mentality of the Australian population is critical when interpreting its health data as well as when investigating the history and the current status of workplace health promotion.

It is said that Australians have very strong attitudes and beliefs that have been developed by the difficulty in subduing the land. Australian settlers experienced great hardship and had to support each other in order to survive. The battle against the elements by Australia's

working class led to the nickname "Aussie battlers." *Mateship* has been a central tenet of survival in the harsh environment. It can be defined as the code of conduct that stresses equality and friendship. Mateship has been extremely significant in relation to the armed forces and may also explain why sport plays such a central role in the Australian culture. One result of the prevalence of a mateship culture in Australian society is that Australians are expected to behave with humility and not think of themselves as better than their peers. A consequence of this is that even living a healthy lifestyle could be seen as putting oneself above the rest of the group.

Supporting the underdog and the belief in a "fair go" are key parts of Australian culture and Australian society. This can be seen in the existence of strong public health and education systems and the existence of equal opportunity legislation. It is an idea that involves everyone having an equal chance to achieve their goals and reach their potential.

There are, however, problems associated with this culture and mentality. Peer pressure can be extremely influential. The culture of binge drinking associated with the youth culture and sport (particularly codes of football) is a major problem and a regular topic of concern for health organizations. Peer pressure plays a big role in this, as it also does in the uptake of smoking by youth. Peer pressure and the existing Australian culture may also influence the relatively slow uptake and low level of involvement of employees in many workplace health promotion programs.

Australian society is one of great contrasts when it comes to attitudes of health. On one hand, Australians worship sporting success and a healthy, fit body, and on the other hand, a large stomach (beer gut) is seen as a status symbol by some members of society.

Drivers of Workplace Health Promotion

Unlike the situation that exists in other parts of the world, especially the United States, Australian employers do not have any responsibility regarding the payment for their employees' health insurance. The majority of employers do, however, have responsibility for the payment of a worker's compensation scheme premium. This premium covers the cost of workplace accidents and injury (physical and psychological) as well as any injury sustained while the worker is travelling to and from work. Some employers have chosen for their organizations to be self-insured. However, they are still legally committed to the same level of care of their employees as those employers who are covered by the worker's compensation scheme. Occupational health and safety is therefore a strong workplace health driver in Australia. This is enshrined in both national and state government legislation. The Australian Safety and Compensation Council (ASCC) is Australia's national body that leads and coordinates national efforts to prevent workplace death, injury, and disease in Australia (Australian Government, n.d.).

The traditional driver for workplace health promotion programs has been through health and safety legislation. It has, however, been largely confined to the prevention of physical accidents at work, the emphasis being on safety, not health per se. Employers are legally required to

provide for the safety of their employees but not legally required to provide specifically for their health, with the exception that unsafe practices and work environments can affect one's health (in other words, risk management, not health promotion).

Until recently, the issue of psychological injury has been largely ignored. The driver from the psychological injury perspective has been the cost associated with worker's compensation claims. While these claims are fewer in number than the physical injury claims, in general, they are twice the cost. This has led to the introduction of a number of programs offering support to organizations and to individuals within an organization who are suffering from psychological injury with the view of developing preventative strategies.

Programs and Good Practices

A brief trip through history is necessary to understand the current position of workplace health promotion in Australia.

Pioneers

Dr. Brian Furnass, a physician who worked in the 1970s as the director of the university health services at the Australian National University, became very interested in the concept of wellness and visited the United States in 1975 to research the wellness movement. Dr. Furnass and his coauthors of the book, *The Magic Bullet: The Social Implications and Limitations of Modern Medicine,* had a clear vision that the practice of medicine relied too much on the magic bullet (taking a tablet) and too little on assisting people with the more difficult task of living well.

A small number of private companies offering executive medical and health checks existed in the major cities from the late 1970s. For example, the Heart Beat Centre, based in Brisbane, was offering these services and more as health management programs to industry. Companies involved in that program were given Australian business awards for innovative workplace initiatives early in the 1980s (personal papers).

In 1982, the Australian College of Occupational Medicine (ACOM) released its first position paper on health promotion in industry. In association with trade unions and the Confederation of Australian Industry, ACOM released its second "Health Promotion in Industry" report in 1990 (The Australian College of Occupational Medicine, 1990). It provided direction to industry on cost-effective use of resources directed to worker health and safety.

In the mid-1980s, medical insurance companies were establishing fitness centers for policy holders and selling health programs to businesses as part of company insurance packages. During this time, the Commonwealth Department of Sport, Recreation, and Tourism published a booklet linking fitness and productivity. Funding was made available by this department in 1984–1985 for employee fitness and recreation initiatives. This department also promoted the

national "Health and Fitness at Work—It Works" program. Contained in the program booklets was a list providing details of more than 20 workplace health promotion programs around Australia (Department of Sport, Recreation, and Tourism, n.d.).

In the late 1980s, the newly established National Steering (later Coordinating) Committee on Health Promotion in the Workplace published a newsletter to encourage more health promotion programs at work and to provide better access to resources for those in the workplace wanting to develop programs. This Committee also promoted a national program called "Health at Work." The program information kit listed the details of a number of current programs around the country (National Coordinating Committee for Health Promotion in the Workplace, n.d.).

In the 1990s, governments at all levels in Australia continued to publish documentation on an ad hoc basis about the benefits of maintaining a healthy workforce. This coincided with the gradual development of commercial organizations offering to companies a range of health services, primarily health assessments for employees.

Twenty-First Century

From the beginning of the 21st century, there has been an increase in awareness and knowledge of the need for faster return to work after injury. That, coupled with the increased awareness of the true cost of workplace issues such as stress, absenteeism, presenteeism and the concern for work–life balance, highlighted the need for the development and implementation of more appropriate responses.

The National Preventative Health Taskforce notes that "given the huge preventable losses of workplace productivity due to obesity, tobacco, and alcohol, the private and public sectors have key roles as employers and the promotion of much healthier workplaces" (National Preventative Health Taskforce, 2008, p. viii). The report goes on to suggest that a new program offered by the Victorian government offers an excellent example to model.

The WorkHealth Program

This Victorian WorkHealth program is a government-funded program that gives employers the opportunity to offer their employees workplace-based health checks. The funding is based on the size of the firm. For businesses with an annual payroll of less than 10 million AUD, employers are fully reimbursed by the state government. If the business has an annual payroll greater than 10 million AUD, employers are required to make a contribution of 30.00 AUD per worker towards the cost of the health checks (WorkHealth, n.d. b).

Australian Unity

One example of a WorkHealth program is that offered by Australian Unity, a national health, financial services, and retirement living organization with more than 1,200 employees across 17 main sites. Its program covers a range of activities including an online health assessment

tool with health information and newsletters, a health expo offering health assessments, health information seminars, and healthy cooking demonstrations. In addition, there is a range of employee-led programs. These programs cover funded community work, social events, an employee assistance program, ergonomic assessments, massage, and physical activity events (WorkHealth, n.d. a).

Queensland Department of Education, Training, and the Arts Workforce Health Management Program

One of the best programs associated with the reduction of psychological injuries within an organization is the Workforce Health Management program offered to the staff of the technical training institutes within the Department of Education, Training, and the Arts in Queensland. The program was designed to develop a range of prevention, response, and recovery activities as a means of reducing the number and cost of psychological injuries. The program relied on the development of local committees and offered a wellness program, additional capability development for rehabilitation coordinators, mental health first aid training, early intervention, and intensive case management. None of the staff referred to the program in 2005–2006 progressed to a psychological-based worker's compensation injury. Return on investment (ROI) based on the number and potential cost of affected staff without program intervention was calculated to be 5:1.

Greenslopes Private Hospital Staff Wellness Program

Greenslopes Private Hospital in Brisbane was accredited as a WHO Health Promoting Hospital in 2005. The Greenslopes Private Hospital staff wellness program commenced in 2001. Revenue from the state-of-the-art on-site gymnasium, established in 2003, supplemented by grants from hospital executives, is the main funding for the program. Permanent staff are able to salary sacrifice their gym membership, meaning that their gym membership can be deducted from their salary. The program was integrated with human resources, occupational health and safety, staff development, the social club, and library into the new Worklife@GPH initiative in 2005. The program has won the following awards: ACCI/BCI National Work and Family Award 2005 (<500 employees) and National Human Resources Award for Best Health and Wellbeing Strategy (winner—2006 and 2007, finalist—2008 and 2009). Wellness services available to staff through the program include Club Wellness (gymnasium), Wellness Assist (free confidential counseling), Financial Wellness (free financial planning), Greenslopes Nutrition at Work, Wellness2Go (wellness ideas for department meetings), Night Owl (specifically for night-shift workers), health promotion events, health risk management, vaccinations, corporate sporting events, massage therapy, weight management, work–life balance, team building, car servicing, and access to a justice of the peace. A wellness advisory group and a team of wellness ambassadors ensure the program is needs based, participatory, and empowering. The program is regularly evaluated at both the organizational and individual levels to ensure it meets the needs of employees and maximizes ROI (K. Walton, personal communication, September 21, 2009).

Blue Care Lifestyle Program

Blue Care is an organization that provides care, support, and education to all members of the community, including frail aged, people with disability, and people requiring nursing or allied health support following release from hospital. The Central Queensland Fraser Coast district of Blue Care has entered into a partnership with Central Queensland University to provide a staff wellness program (Caring for the Carers) for more than 11,000 of their staff employed over an area roughly one third the size of the state. The program promotes "a lifestyle wellness journey much richer than the standard diet and exercise regimes" ("Caring for the Blue Care carers," 2009). The 12-month program, commenced in August 2009, is being developed and coordinated by a Central Queensland University masters student. The student is supported by trained volunteer ambassadors in the 29 Blue Care hubs across the region. Utilizing an online wellness inventory and relevant online questionnaires, an employee's health and wellness status and level of motivation to change are assessed. The inventory then guides the employee to "create a tailored personal wellness plan and provides resources to help reach wellness goals" (Blue Care, 2008, p.8). A major resource is remote access to accredited wellness coaches.

Queensland University of Technology Wellness Matters Program

The Queensland University of Technology Wellness Matters program had its beginnings in the mid-1990s. With the assistance of the head of the School of Human Movement Studies, the Health Promotion subcommittee of the University Health and Safety committee, after years of applying, gained funding for the appointment of a full-time health promotion coordinator. The program is based within the university human resources department and the manager reports to the deputy HR director of health and safety.

Program services delivered to Queensland University of Technology's more than 6,000 full-time-equivalent employees situated on 3 campuses include seminars and workshops, health and wellness appraisals, an extensive and varied range of physical activity sessions, Just Walk It program, Walk Australia program, Make My Day program, personal wellness coaching, personal training, special interest groups such as Queensland University of Technology bicycle user group, weekly health challenges and tips, and community healthy activity involvement.

The program is offered as an individual staff member or as a faculty/division program such as the faculty of Built Environment and Engineering BEEWell program. An advisory board and a large number of volunteer wellness ambassadors assist in delivery, evaluation, and reshaping program offerings to meet employees' and the university's health and wellness requirements. Faculty/division often provide additional program funding to the centrally provided budget (for the last 8 years), otherwise activities run on a cost-recovery basis (Queensland University of Technology, 2009).

Other Programs

There are numerous other small, medium, and large company programs that could have been reported here, but many are not reported or recorded anywhere. Many companies contract external organizations to provide a full range of services. The number of these organizations has risen dramatically since 2002. Once again, there is no compilation of these organizations. There is a need for an inventory of current Australian programs and organizations. It is hoped that in the near future this will happen in Australia, or that more Australian companies will input their program data into existing surveys of workplace health promotion programs, such as the annual Buck Consultants' Global Health Promotion and Workplace Wellness Survey (Buck Consultants, 2009).

Outcomes and Indicators

The National Preventative Health Taskforce discussion paper (2008) provides a number of examples where health promotion programs in Australia have been successful. One example is the reduction in smoking (75% of men in the 1950s to less than 20% in 2009). This has dramatically reduced the deaths of men from lung cancer and heart disease. Road trauma deaths on Australian roads have dropped 80% since 1970. Australia's commitment to improving immunization levels has resulted in eliminating a number of serious health problems. Immunization is one aspect of the healthcare system that has been readily integrated into workplace health. A growing number of workplaces, including some that do not have a structured health promotion program, provide flu shots for employees every winter. Reductions in sick leave, attributed to this practice, are quoted to be as high as 36%.

This raises another pressing issue. Publication of workplace health promotion program outcome claims are a matter of concern. Generally, there is a distinct lack of scientifically based evaluation of workplace programs in Australia. This is due to a number of factors. First, there is a relative immaturity in the area (in research and development, not time). Second, there is the fact that historically, nearly all university health promotion degree courses were initially structured to provide students with the skills to evaluate the more common traditional community health programs. Third, workplace health promotion is not a well established or recognized profession in Australia, and many organizations, while well intentioned, employ other professionals (health or business) to manage/coordinate their programs. This may be due to a lack of knowledge on the organization's part or a lack of suitably qualified professionals in the job marketplace at the time. Consequently, more sophisticated workplace relevant evaluation tools such as cost benefit ratio, ROI, and net present value are not a component of many currently existing programs.

Unfortunately, the lack of application of higher order, specific workplace health promotion program evaluation measures often leads to the reporting of questionable and unsubstantiated claims regarding the outcomes of programs. One immediate positive effect of such reporting of

these successes could be to encourage other companies considering implementing a workplace program to do so. However, if similar results, often expected in the same short time period, are not forthcoming, the organization may cancel the program. This has been known to create an attitude by management of "been there, done that, and it didn't work" if a program is mooted in the future.

The dearth of reported, evidence-based results from Australian workplace health promotion programs was especially evident when the National Preventative Task Force primarily referenced overseas research (United Kingdom and United States) to support its position that workplaces could be settings for action in making Australia the healthiest country by 2020. That position was, "A large number of studies now point to the economic return on investment that can accrue through investments in employee health programs" (National Preventative Health Taskforce, 2009, p. 51).

The other major issue regarding workplace health promotion programs is that many are self-funded. Governments at all levels over the years have run hot and cold on the issue, and so consistent government funding has not been available. On the other hand, private enterprise understandably requires assurances regarding its ROI before committing to funding a program. Hence, in the absence of government support and funding, ROI was and still is a key factor in the sustainability of health promotion programs in the workplace in Australia.

Yet the ROI of many programs was not and still is not evaluated. For many organizations, an investment in a health promotion program is an add-on and readily sacrificed during difficult economic circumstances, especially if there is no evidence to show ROI. It is often seen as nice to have, but not an essential part of organizational business. In fact, sometimes a program is initiated just so someone can "tick a box." Thus, while many health and wellness program providers quote various dollar values regarding ROI, there is speculation about the accuracy of much of this information relevant to Australian workplaces.

There are some who still argue that prevention programs do not work, and that it is impossible to bring about behavior changes in a whole population. While some of this criticism comes from those with a vested interest (tobacco companies, etc.), others are concerned about controlling people's behavior through legislation and the often long delay in achieving results. Many practitioners in the field would agree that it will take up to 5 years for sufficient cultural change to occur in a workplace to allow the full benefits of a program to be evident and truly evaluated. For some organizations, this is far too long (most programs are initially funded from 6 weeks to 1 year) and funding is then placed elsewhere.

Existing Research

Subsequent to the demise of the National Coordinating (formerly Steering) Committee for Health Promotion in the Workplace and its associated state bodies in the mid-1990s, there has been no government-funded workplace health promotion body in Australia. The Health & Productivity Institute of Australia (HAPIA), a peak nongovernment body for corporate

wellness providers has been established only recently. The publication of a national workplace health promotion newsletter (commenced in 1989) also ceased with the demise of the National Coordinating Committee. Consequently, in the past, the small number of science-based workplace health promotion research projects that were carried out were primarily reported in more relevant and more prestigious overseas publications. Therefore, little workplace health promotion information was readily available in the public domain. Consequently, many Australian companies never heard of workplace health promotion, let alone became aware of the benefits a successful and sustainable program could provide.

For more than 2 decades, there have been reports published biennially on the status of health in Australia, the most recent being in 2008 (Australian Institute of Health and Welfare, 2008). However, advances in information searching technology have been influential in increasing the awareness of Australians about workplace health promotion around the globe. Reports including *Preventing Noncommunicable Diseases in the Workplace Through Diet and Physical Activity: WHO/World Economic Forum Report of a Joint Event* (WHO, 2008); *Working Towards Wellness: The Business Rationale* (World Economic Forum, 2008b); *Working Towards Wellness: Practical Steps for CEOs* (World Economic Forum, 2008a); and *Building the Case for Wellness* (PricewaterhouseCoopers, 2008) are now more readily accessible and are being studied by more individuals who are in positions to further the Australian workplace health promotion field. Whereas 30 years ago it was rare to do so, now many Australian companies access workplace health promotion material from overseas organizations such as WELCOA; Partnership for Prevention; The National Business Group on Health; The Institute for Health and Productivity Management; European Network for Workplace Health Promotion; The Health Communication Unit at the Centre for Health Promotion, University of Toronto; and University of Michigan Health Management Research Center, to name a few.

The downside of this is similar to the premise one size does not fit all. What works in other countries, especially the United States, does not necessarily work in Australia due to cultural, social, business, and financial dissimilarities. This highlights the necessity for Australia to further develop its own specific workplace health promotion research, culture, community, scientific base, organization(s), and publishing outlet(s).

There has been a recent increase in Australian-based workplace health promotion research reports. These include *The Case for Work/Life Balance: Closing the Gap Between Policy and Practice* (Hudson, 2005), *The Health of Australia's Workforce* (Medibank Private, 2005), *Sick at Work* (Medibank Private, 2007), *Economic Modelling of the Cost of Presenteeism in Australia* (Econtech, 2007), *The Cost of Workplace Stress in Australia* (Medibank Private, 2008), *Workplace 2012: What Does It Mean for Employers?* (Mercer, 2008), and *The Future@Work Health Report* (Wesley Corporate Health, 2006). This latter report outlines the key findings of Wesley Corporate Health's health data on 8,600 employees as well as Australian and overseas workplace health studies. It presents the health and business case for a healthy workplace environment and reveals workplace strategies to address the major health risks affecting today's workforce.

Conclusion

There is still a great deal to be done if Australia is going to win the battle against the major health risks its society faces. Like most other western nations, it is losing the battle against the lifestyle-generated diseases. A problem with risk reduction programs is that many Australians have an attitude of, "It could never happen to me." They have become immune to information about the dangers of particular lifestyle choices and generally believe that it must only apply to someone else. A new approach is needed.

The National Preventative Health Taskforce (2009) road map for action provides some cautious hope. Among its recommendations are a number relating to workplaces (pp. 52–53):

- The National Partnership on Preventative Health has allocated 290 million AUD to fund states and territories to facilitate delivery of healthy living programs in workplaces.
- The Australian government will develop a national healthy workplace charter with peak employer groups.
- The proposed establishment of a national leadership program—a network of senior employer and employee champions of work health initiatives.
- A process to identify models of good practice in public sector organizations for replication—public sector organizations to set an example. Investigation into incentive processes for workplaces to implement programs. These proposed incentives would come from changes to tax laws and tax concessions (fringe benefit tax and GST free), and/or legislation for a program levy requiring employers to commit a percentage of payroll to implementing workplace health promotion programs.

A further suggestion was for the "development of a national trial of integrated workplace health programs based on the U.S. National Institute for Occupational Safety and Health (NIOSH) WorkLife Initiative involving partnerships between state and territory occupational health service, volunteer enterprises, and nominated research centres" (National Preventative Health Taskforce, 2009, p. 52). However, the question has to be asked—Why use an international model when enough evidence-based programs exist in Australia to develop the best aspects of all into a unique Australian program template? It is recognized that U.S. and Australian drivers of workplace health promotion are dissimilar.

A positive of the proposed national trial is that it should provide the vehicle for initiating much-needed Australian workplace health promotion scientific research. However, the recommended action is traditional and historical in its occupational health and safety approach. If indeed Australia is seeking a fresh approach, one such approach would be *not* to work through the occupational health and safety domain. Why not capitalize on the emerging awareness of the wellness paradigm?

Dr. Don Ardell, a prolific writer in the health and wellness field in the United States, consistently argues that the traditional medical approach to worksite health promotion programs has failed to deliver the change in lifestyles required for a healthy society. He claims that

"worksite risk reduction or prevention programs are a good thing for employees from a medical standpoint, but they do not offer favorable opportunities for staff and others to learn life enrichment skills" (Ardell, 2009). The National Wellness Institute of Australia supports the view that a balanced focus on nine components of wellness (i.e., physical, social, emotional, work, spiritual values, intellectual, cultural, environmental, and financial) is important for workplace health promotion programs to be successful and sustainable (National Wellness Institute of Australia, n.d.).

Parallel to the call by the National Preventative Health Taskforce to all Australians to take action to make Australia the healthiest country (National Preventative Health Taskforce, 2009), workplace health professionals have the opportunity to heed this call to advance their field. Now is the most opportune time since the loss of momentum in the mid-1990s to do so. The newly formed Health and Productivity Institute of Australia, which aims to be the "peak body of Corporate Wellness Providers in Australia" (Health and Productivity Institute of Australia, n.d.), can have a pivotal role to play in this process. Increased interaction by stakeholders with overseas workplace health and wellness professionals through conferences, webinars, research groups, and discussion boards and forums via web-based modalities such as IDWellness, will further enhance the development of the emerging profession (IDWellness, n.d.).

Summary

Despite being a healthy country by international standards, Australia still has major health issues. While in the past there have been notable successes through traditional health promotion programs, a different approach needs to be considered. Could that be wellness?

Except for a 10-year period in the 1980s, Australian workplaces have not been utilized as a major setting to implement health promotion. The historical drivers for health promotion in the workplace have come through health and safety legislation, largely confined to the prevention of physical accidents. Until recently, the issue of psychological injury has been largely ignored in the workplace programs.

The Australian healthcare system (private and public, e.g., Medicare) removes the necessity for employers to budget for employee medical costs. There is, however, a new awareness by employers of the true cost of worker's compensation claims from workplace issues such as stress, presenteeism, and poor work–life balance. This has triggered renewed interest in workplace health promotion programs.

Concurrently, there is a government push to address the increasing cost of worsening health issues. The National Preventative Health Taskforce has established a central focus on reducing obesity, smoking, and the harmful use of alcohol. Strategies recommended in the taskforce's road map to make Australia the healthiest country by 2020 include many relevant to workplace health promotion. The future of workplace health promotion in Australia depends on the profession promoting itself as a respected vehicle to help achieve the government's vision.

Fostering the quantity and science of Australian workplace health promotion research is one way to achieve this goal. The development of a powerful professional body representing the majority of individuals and organizations involved in Australian workplace health promotion is another.

Review Questions

1. What are the central issues of the National Preventative Health Taskforce?
2. What are the components of the Australian healthcare system and how are they funded? Regulated? Managed?
3. How does the Australian culture of mateship affect population health and health promotion efforts?
4. What is the traditional focus of Australia's workplace health promotion programs?
5. Name five major historical publications that contributed to the current position of Australia's workplace health promotion status.
6. What is the significance of outcome indicators for Australia's workplace health promotion programs?
7. What view is supported by the National Wellness Institute of Australia in regard to workplace health promotion programs?
8. Identify three statistical facts that describe the health and wellness of Australia's population.
9. Describe the difference between Australia's universal public health system and its private health system.
10. Explain the components of an effective Australian workplace health promotion initiative.

References

Ardell, D. (2009, May 15). *Ardell wellness report*. Retrieved September 20, 2009, from http://www.seekwellness.com

Australian Bureau of Statistics. (2007). *National survey of mental health and wellbeing: Summary of results* (No. 4326.0). Canberra, Australia: Author.

Australian College of Occupational Medicine. (1990). *Health promotion in industry*. Victoria, Australia: ACOM.

Australian Government. (n.d.). *The Australian Safety and Compensation Council*. Retrieved September 18, 2009, from http://www.workplace.gov.au/workplace/Individual/Employee/OHS/SafeWorkAustralia.htm

Australian Institute of Health and Welfare. (2008). *Australia's health 2008*. (Cat. no. AUS 99.) Canberra, Australia: AIWH.

Blue Care. (2008). Program helps keep life balanced. *Blue Print, 14*, 8–9.

Buck Consultants. (2009). *Global wellness*. Retrieved September 18, 2009, from https://www.bucksurveys.com/bucksurveys/dividNavSurveysdiv/Global Wellness/tabid/72/Default.aspx

Caring for the Blue Care carers. (2009, September 10). *Rockhampton Morning Bulletin*, p. 34.

Department of Health and Aging. (n.d.). *Australia's health system.* Retrieved September 20, 2009, from http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-Australias-health-system-2

Department of Sport, Recreation, and Tourism. (n.d.). *Health & fitness at work—It works! information folder*. Canberra, Australia: Author.

Econtech. (2007). *Economic modelling of the cost of presenteeism in Australia*. Sydney, Australia: Medibank Private.

Health and Productivity Institute of Australia. (n.d.). *About us*. Retrieved September 20, 2009, from http://www.hapia.com.au/about/html

Hudson. (2005). *The case for work/life balance: Closing the gap between policy and practice.* Canberra, Australia: Author.

IDWellness. (n.d.). *Home*. Retrieved September 2, 2009, from http://idwellness.org

Medibank Private. (2005). *The health of Australia's workforce*. Sydney, Australia: Medibank Private.

Medibank Private. (2007). *Sick at work.* Sydney, Australia: Medibank Private.

Medibank Private. (2008). *The cost of workplace stress in Australia.* Sydney, Australia: Medibank Private.

Mercer. (2008). *Workplace 2012: What does it mean for employers?* Adelaide, Australia: Mercer.

National Coordinating Committee for Health Promotion in the Workplace. (n.d.). *Health at work: Information kit.* Canberra, Australia: National Heart Foundation of Australia.

National Coordinating Committee for Health Promotion in the Workplace. (1993). Workplace health promotion in selected industries. *Health at Work Newsletter, 16,* 2–16.

National Preventative Health Taskforce. (2008). *Australia: The healthiest country by 2020—A discussion paper prepared by the National Preventive Health Taskforce.* Canberra, Australia: Australian Government Publishing Service.

National Preventative Health Taskforce. (2009). *Australia: The healthiest country by 2020—National preventative health strategy—The roadmap for action.* Canberra, Australia: Australian Government Publishing Service.

National Wellness Institute of Australia. (n.d.). *What is wellness?* Retrieved September 18, 2009, from http://www.wellnessaustralia.org

PricewaterhouseCoopers. (2008). *Building the case for wellness.* London, England: PricewaterhouseCoopers, LLC.

Private Health Insurance Administration Council (PHIAC). (2008). *Annual report 2007–08.* Canberra, Australia: Australian Government Publishing Service.
Queensland University of Technology. (2009). *Wellness matters.* Retrieved September 19, 2009, from http://www.wellness.qut.edu.au

Wesley Corporate Health. (2006). *The Future@Work health report.* Brisbane, Australia: Author.

WorkHealth. (n.d. a). *Australian unity.* Retrieved September 19, 2009, from http://www.workhealth.vic.gov.au/wps/wcm/connect/WorkHealth/Home/How/Information+and+resources/Case+studies/Case+study/Australian+Unity

WorkHealth. (n.d. b). *What is WorkHealth?* Retrieved September 19, 2009, from http://www.workhealth.vic.gov.au/wps/wcm/connect/WorkHealth/Home/Why/What%20is%20WorkHealth/

World Economic Forum. (2008a). *Working towards wellness: The business rationale.* Cologny/Geneva, Switzerland: Author.

World Economic Forum. (2008b). *Working towards wellness: Practical steps for CEOs.* Cologny/Geneva, Switzerland: Author.

WHO (World Health Organization) and World Economic Forum. (2008). *Preventing noncommunicable diseases in the workplace through diet and physical activity: WHO/World Economic Forum Report of a Joint Event.* Geneva, Switzerland: Author.