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The background of the cover features a close-up of several interlocking brass gears. Overlaid on the gears is a large, vibrant chrysanthemum flower with petals in shades of pink, orange, and yellow. There are also several semi-transparent circular shapes in shades of green, orange, and red scattered across the composition.

**Situation Analysis and
Recommendations for
Stewardship on
Workplace Health Promotion
in Poland**

Jorma Rantanen, Rokho Kim

Situation analysis and recommendations for stewardship on workplace health promotion in Poland

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Abstract

This report presents a situation analysis and recommendations on strengthening stewardship of the government for the improvement of workplace health promotion (WHP) within occupational health services (OHS). Information was collected from stakeholders involved in WHP in Poland during a mission by WHO staff and consultant in September 2010. Preliminary analysis and recommendations were reviewed with the stakeholders in April 2011. According to the evidence from research, WHP programmes are more effective and sustainable when they are addressed as an integral part of the OHS system as well as the overall health system. Therefore, the leadership role of the Ministry of Health recognizing occupational health as an area of public health services is critical for improvement of WHP in Poland. The multi-sectoral cooperation and broad-based collaborations between the Ministry of Health and other stakeholders in OHS and WHP (e.g., the Ministry of Labour and Social Policy, National Labour Inspectorate, health sector at large, research institutions, professional associations and the social partners representing employers and workers) are also very important. A reform of Polish OHS system is proposed to move from limited "Occupational Medicine" focusing on health examinations to comprehensive "Occupational Health" focusing on primary prevention and health promotion as well as health protection. For this purpose, it is recommended that the Ministry of Health establish a unit for OHS and WHP, and organize an annual National Conference on Modern OHS with the participation of the stakeholders of OHS and WHP in Poland.

Keywords

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List of Acronyms and Abbreviations

BOHS	Basic Occupational Health Services
CIOP-PIB	Central Institute of Labour Protection-National Research Institute
COPD	Chronic Obstructive Pulmonary Disease
EU	European Union
ENWHP	European Network for Workplace Health Promotion
HRD	Human Resources Development
ICOH	International Commission on Occupational Health
ILO	International Labour Organization
MEs	Micro-enterprises
MoH	Ministry of Health
MoLSP	Ministry of Labour and Social Policy and Social Policy
NCD	Non-communicable disease
NGO	Nongovernmental Organization
NIOH	Nofer Institute of Occupational Health
NLI	National Labour Inspectorate
OHS	Occupational health services
OMP	Occupational medicine practitioner
OSH	Occupational safety and health
PEROSH	Partnership for European Research in Occupational Safety and Health
SMEs	Small and medium-sized enterprises
SWOT	Strengths, Weaknesses, Opportunities, Threats- analysis
UN	United Nations
WHO	World Health Organization
WHO CO	WHO country office
WHO EURO	WHO Regional Office for Europe
WHA	World Health Assembly
WHP	Workplace Health Promotion

Foreword

“If we come together to tackle non-communicable diseases, we can do more than heal individuals — we can safeguard our very future” Ban Ki-Moon, Secretary-General of the UN

Investing in prevention and improved control of noncommunicable diseases (NCDs) will reduce premature death and preventable morbidity and disability, and improve the quality of life and well-being of people and societies. No less than 86% of deaths and 77% of the disease burden in the WHO European Region are caused by this broad group of disorders.

Responding to the regional and global challenges of NCDs, *the Moscow Declaration* was adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow, April 2011, and *the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016* at the Sixty-first Session of the Regional Committee of WHO Regional Office for Europe in Baku, September 2011. In particular, the UN General Assembly adopted the report of the Secretary-General Mr. Ban Ki-Moon, *Prevention and control of noncommunicable diseases* at the in New York City, September 2011 with concrete recommendations to the Member States, the private sector, civil society, and UN agencies and international organizations.

Workers represent half the whole population and are the major contributors to economic and social development of the world. About 400 million European workers work in very diverse conditions having positive and negative consequences to their health and wellbeing. Unfortunately, annually more than 300 000 lives are lost in the Region from various work-related diseases (not including deaths from injury), the majority of which are NCDs. The risk factors for these diseases are involuntary and can be mitigated by the organized efforts of society and enterprises.

Workplaces provide an important entry point for health promotion programmes aiming at NCD prevention and control. Workplace health promotion (WHP), when designed and executed as a comprehensive initiative for healthy workplaces, is effective in reducing NCD risk factors by tackling physical inactivity, unhealthy dietary habits, smoke- and alcohol-free work environments, and psychosocial risk factors, with the participation of workers and managers.

This report presents a situation analysis and recommendations on strengthening stewardship of the government for the improvement of WHP in Poland. It provides evidence-based policy options for the policy-makers and stakeholders to position WHP programmes as an integral part of the overall health system.

We at WHO are thankful to Professor Jorma Rantanen and national experts who contributed to the preparation of this report. We hope that the policy-makers and stakeholders will find the report valuable in the strengthening of WHP and occupational health system in Poland. We believe that the conclusions and recommendations of the report will be also useful in other countries facing similar challenges. WHO will continue encouraging the relevant policy developments and intersectoral collaboration necessary for ensuring effective and efficient health promotion at the workplace for all workers.

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Executive Summary

On the request of the Ministry of Health Poland (MoH), the WHO Regional Office for Europe made a situation analysis and recommendations on strengthening stewardship of the MoH for the improvement of the WHP, WHP according to the biennial collaborate agreement in according to the biennial collaborate agreement (BCA) in 2010-2012. This report is based on the data and information collected at the meetings and interviews with the key representatives of the Polish Stakeholders active in administration, planning and implementation of WHP, during a mission of WHO staff and consultant in September 2010. The report summarizes observations, discussions, SWOT analysis and conclusions of the mission and present recommendations based on relevant literature on WHP in Poland and other European countries. Based on the evidence from research on effectiveness and sustainability of WHP, the report adopted a holistic approach to WHP viewing as an integral part of OHS and national health policy. A draft report was discussed with the stakeholders at a national workshop in April 2011. This report incorporated the comments collected before and after the workshop.

Conclusions

The main conclusions of the consultation on current OHS and WHP developments in Poland are the following:

- Several prerequisites for extension and development of WHP prevail in Poland, but the occupational health approach is not sufficiently recognized in the National Health programme.
- A well organized and widely implemented OHS with WHP can substantially contribute to the general health objectives of the population.
- Poland has high competence and well-developed capacities for WHP in the Nofer Institute of Occupational Health and in the National Institute of Labour Protection
- While competent and widely covering service infrastructure is needed for implementation of sustainable occupational health and WHP activities, the capacities, competence and conditions of operation of Polish occupational health services (OHS) in their current form are less optimal for implementation of nation-wide and comprehensive occupational health programmes.
- The stakeholders recognized urgent need for development of national strategy and programme for OHS, including elements for WHP and need for necessary legal and regulatory actions for further development of the system.
- Research evidence shows that separate WHP activities are not an optimal way for implementation of WHP in practice. The successful cases described in the research reports speak strongly for integration of WHP with the overall strategies of workplaces and for implementation WHP as a part of workplaces “normal” activities with support and contribution by OHS and other workplace level resources.
- Similarly the orientation of WHP only in the individual behavioural aspects of the target groups has not been found effective, while the comprehensive, multidisciplinary approach considering the work, work environment, work organisation and worker-related factors have been reported as successful.
- The project and campaign approaches are likely to be less sustainable than the inclusion of WHP as an integrated part of continuous and in principle, permanent, system for OHS.
- The stakeholders and the occupational medicine specialists identified needs for improving competence, orientation, service provision system, conditions of operation, financing and

service provision models in the Polish OHS system and particularly in the view of extension of coverage of WHP into the Polish workplaces.

- Reform of training curricula for occupational medicine experts (physicians and nurses) and for other multidisciplinary resources was found necessary in order to enable their activities for comprehensive occupational health and WHP. The new orientation in training should be designed for prevention and promotion of occupational health and work ability of workers and for development of work, work environment and other conditions of work more conducive for health.
- The needs for further development of OHS and WHP as an essential part of the overall health policy of Poland requires strengthening of the leadership role of the Ministry of Health in view of OHS and WHP. Such leadership needs close collaborative relations with all the key stakeholders on OHS and WHP in the Country, Ministry of Labour and Social Policy, National Labour Inspectorate, health sector at large, Research Institutions, Professional associations and the social partners, Employers and Workers.

Recommendations

The consultation presents following recommendations for further development of the Polish OHS system and for the activities of WHP:

- The effective and successful WHP activities are recommended to be developed and implemented as an integral part of OHS provision and integral with the other activities of workplace and with the activities of health sector in general.
- According to the lines of the ILO Convention No.161 (which Poland has ratified) drawing up a *National Policy and Strategy for OHS* with appropriate Action Plan is recommended. The plans for development of WHP are recommended to be included in the overall OHS strategy and programme. The policies and strategies for OHS should also be included as essential parts of the National Health Programme.
- For comprehensive situation analysis, production of National OHS Profile, according to a model provided by the WHO Regional Office for Europe, is recommended as an urgent measure for planning national programmes.
- A reform of Polish OHS system is proposed to move from the current limited occupational medicine approach to a comprehensive occupational health approach, including WHP. The reformed OHS is recommended to cover multidisciplinary aspects, including promotion and prevention, surveillance and recognition and health risk assessment for OHS's purposes (different from OSH risk assessment for OSH legislation purposes), occupational health information and education, information and advice on healthy and safe working practices and healthy life styles, health examinations, assessment and promotion of work ability etc.
- New legislation and lower-level regulations are needed as a legal foundation of such new OHS and it is recommended.
- Numerous service provision models for OHS and WHP are available. To meet the needs and opportunities of different sectors of work life, two or several alternative models is recommended for use (e.g. big enterprise model and primary health care model). For extension of the coverage of OHS to the currently underserved groups and sectors, the Basic Occupational Health Services (BOHS) approach is recommended.

- Sufficient numbers of competent occupational health physician and nurse resources and of multidisciplinary experts, psychologists, ergonomists, occupational hygienists should be ensured and adequately trained for modern comprehensive occupational health. A reform of the remuneration system for of OHS personnel, particularly for the occupational health physicians should be developed to enable provision of comprehensive OHS and WHP instead of the present individual health check-based remuneration.
- Adequate training and information on occupational health in general and on OHS in particular should be provided also for employers' and workers' representatives and for the persons responsible for organisation of OHS in the ministries and other relevant institutions.
- Sustainable and sufficient financing should be ensured for OHS and WHP by utilizing appropriate financing channels, public financing, insurance or direct employers' financing or their combinations. The financing should ensure a long-term development and continuity of services for OHS and WHP, including also the financing of research Institutes involved in the development of the OHS system in Poland.
- All the strategies, plans and programmes as well as implementation of OHS and WHP are recommended to be drawn up and implemented in close collaboration with the key stakeholders of occupational health and of WHP, including Ministry of Health, Ministry of Labour and Social Policy, National Labour Inspectorate, Social Partners, Employers' Organizations and Trade Unions, and Research Institutions, Nofer Institute of Occupational Medicine and The Central Institute of Labour Protection, CIOP-PIB and the Network of Workplace Health Promotion.
- The stewardship and leadership role of the Ministry of Health is recommended to be strengthened by establishment of a special Occupational Health Unit in the Ministry. The Unit should work in close collaboration with all the stakeholders relevant for occupational health in Poland.
- Organisation of an annual National Conference on Modern OHS is proposed and for the discussions on the international experiences on development of OHS a European level meeting is recommended in the near future.

1. Introduction

On the request of the Ministry of Health Poland (MoH), the WHO Regional Office for Europe (WHO EURO) and the WHO Country Office for Poland agreed on the task for making an analysis and recommendations on strengthening stewardship of the MoH for the improvement of the workplace health promotion (WHP) in the framework of biennial collaborative agreement (BCA) between WHO and Poland in 2010-2011 (1).

For the implementation of the task, Professor Jorma Rantanen, international consultant and Dr. Rokho Kim, scientist for occupational health, visited Warsaw and Lodz, Poland, 8-11 September 2010, and met the representatives of the Ministry of Health, and interviewed the key stakeholders relevant for WHP. The objectives of the mission included an analysis of the current state and recommendations for the future development of WHP in Poland.

This report is based on the meetings with and interviews of the key representatives of the Polish stakeholders active in administration, planning and implementation of WHP. A questionnaire list was prepared in advance covering questions on stewardship, resource mobilization and generation, service delivery, financing, international and EU dimension of WHP and stakeholders' interest to participate in further development of WHP in Poland. The list was used for relevant parts for each stakeholder as a framework for interviews (2).

In addition to the observations during the mission, the WHO consultant reviewed the relevant documentation and literature on WHP in Poland and Europe to prepare situation analysis and recommendations in this report. A draft report was discussed by the stakeholders at a national workshop organized by the Ministry of Health and the WHO Country Office in Warsaw on 19 April 2011. This report incorporated stakeholders' comments before and after the workshop.

2. Challenges to WHP in the world of work

Virtually all aspects of work life are currently in a dynamic change due to globalization of world economies, growing turbulences and recurring financial crises. Also due to hard competition, productivity demands, and introduction of new technologies, the workers are under constant pressure and changes. New ways to organize work, growing mobility of working people, instability of work contracts, insecure employment coupled with high rates of unemployment, demographic changes including aging of the workforce, fragmentation of workplaces to smaller units, downsizing and outsourcing of production, and new management and business cultures are promoting constant changes. There are global trends for further fragmentation of companies to smaller units, small-scale enterprises, micro-enterprises and workplaces of solitary self-employed (3, 4, 5).

In the Eastern-European transitory countries the big state-owned "kombinats" have been largely reorganized, and their ownerships have been totally or partially privatized. At the same time, the production units were fragmented and the services were outsourced and downsized in many workplaces. Simultaneously, the number of self-employed and micro-enterprises have grown rapidly. Typically such transitions tend to weaken the priority given to occupational health and other programmes for social dimension in the work life.

Research evidence shows that the smaller enterprises are likely to have higher occupational safety and health risks, occupational accidents, and occupational diseases than the larger ones. Ergonomic, physical and chemical hazards are more common in small enterprises. The risks, however, are not well recognized in the smaller enterprises leading to under-reporting of occupational diseases and injuries. The financial capacities of small enterprises for their own OHS and WHP activities are low (4, 5, 6, 7, 8).

In many EU countries, including Poland, the working populations are growing older more rapidly than in Asia and in the Americas. The average age of EU workforce grows with a pace of 2 years in a decade. This brings along chronic morbidity and reduced work ability leading to growing needs for occupational health interventions. The younger age cohorts tend to be smaller and the population growth is zero or negative, which will result in shortage of labour. The EU politicians are concerned about the sustainability of national budgets and social programmes in the future. The reduction of sickness absenteeism, occupational diseases and injuries, and work disability have become a policy issue in many EU countries. Lengthening of work life expectancy is warranted throughout Europe. Such trends call for strengthening of OHS and WHP in order to prevent unnecessary loss of working capacity and to extend productive work life longer beyond the existing retirement ages (9, 10, 11).

Still much needs to be done for prevention and management of traditional occupational safety and health hazards at the European workplaces. Hazardous exposure at the workplace is among the top ten most important risk factors affecting the burden of disease in Europe. Each year about 300 000 people die from occupational diseases and 27 000 from occupational injuries in the Region. Occupational diseases and injuries result in a loss of about 4 to 5% of GDP. The incidence and mortality rates vary significantly between countries, largely owing to differences in the reporting systems. Nevertheless, it is well known that the occupational hazards, risks, disease, and injuries are much higher in the transitory countries than in the old EU member states. Actions are needed to implement World Health Assembly resolution on workers' health (WHA60.26), which highlights opportunities for combining health protection from occupational hazards with health promotion interventions at the workplace (7, 12, 13).

The changes described above affect also prerequisites for occupational health activities and for WHP. The health promotion activities, while they are needed more than before, are challenged to show evidence on their impact on health of workers and productivity of the companies. While the need for WHP is growing, the work life trends described above make implementation of programmes more difficult and demanding. For example, most of the positive results of WHP have been obtained from big companies employing more than 500 workers, while over 90% of enterprises in all countries are smaller than 50 workers (6, 13, 14). Reaching and covering the workplaces, particularly the smallest ones, is a big challenge. Also the interventions for small enterprises inevitably need to be different from the programmes of larger companies. Small enterprises lack certain workplace resources which are important for WHP and its sustainability, such as safety and health committees, human resources development (HRD), staff. The small enterprises even lack the safety representative of the workers. The turnover of workers and employers is higher in small companies affecting the sustainability of WHP programmes, if any.

The small enterprises, self-employment and informal sectors need inevitably external resources supported by public financing. Internationally some of the ILO "WISE" and "WIND" action models have shown positive results by using sector- or area-wide group interventions towards small enterprises (15, 16).

3. Theoretical notes

There is a bulk of scientific and professional literature on WHP theories which cannot be reviewed exhaustively in this report. Instead, this report refers to key internationally available material for further information. Some of the commonly utilized theories are listed in Table 1 without describing them in detail.

Table 1. Examples of theory approaches in health promotion (17, 18, 19, 20, 21)

Theory	Examples
Individual-level theories	The health belief model Self-esteem enhancement theory Conservation of resources theory Self-determination theory Reasoned action and planned behaviour The trans-theoretical (stages of change) model
Group-level theories	Social Cognitive Theory
Community level theories	Community organisation theory Developing community capacity
Communication theories	Diffusion of innovation theory Health Literacy theory Communication-behaviour change model Social marketing theory
Organisational theories	Theories of organisational change Models of inter-sectoral action
Ecological approach	Social action theory Gender and power Interactive domain theory
Social determinants theories	Social determinants of health approach Settings approach

Source: Green, J. (2000); Nutbeam, D. and Harris, E. (1998); US National Cancer Institute (2005). US National Institute for Occupational Safety and Health, NIOSH (2008); and Terris M (1992)

Health promotion activities originally started from individual behaviour-oriented activities assuming that the health behaviour is a voluntary choice of the individual dependent on interests, knowledge and value of health for the individual. In WHO policies, the health promotion philosophy and approaches have been developed to a more comprehensive direction taking into consideration not only individual's behaviour, but also environmental, workplace and working conditions, social conditions and social determinants of health. The determinants originate from a wide range of sources starting from macro-level global politics and economics to worksite level structural, cultural, managerial and organisational aspects. The use and feasibility of WHP theories and models is dependent on the nature of the programme and level at which it is implemented. The evaluation studies and meta-analyses showed the effective and sustainable implementation of WHP at the individual workplaces are more likely when the individual, group, organisational and ecological approaches are combined, the special characteristics and needs of workplaces are considered, and WHP programmes are considered an integral part of OHS in general (22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32). In the programmes at the level of policy, systems and community, the recent trends of WHP in Europe emphasize the comprehensive model with "determinants" and "settings" approaches.

4. WHO health promotion policies

The development of concept of health promotion was led by the WHO and WHO Regional Office for Europe in particular. The development of WHO policy on health promotion was started in mid-1980 by the WHO Regional Office for Europe. It was globally accepted through the First Global Conference on Health Promotion held in Ottawa, Canada, in 1986. Since then seven Global Conferences have been organized by WHO in collaboration with several interested partners, the latest one in 2009 in Nairobi, Kenya. The next one is scheduled for 10-16 June 2013 in Helsinki, Finland. The Global Conferences evaluated the implementation and effects of the recommendations by the previous Conferences and guided the future developments in the health promotion activities. The attendance by over 100 Member Countries and hundreds of participants from expert communities and NGOs witness the importance of health promotion in modern health policies (33, 34).

The themes of the seven Global Conferences and their charters and recommendations reflect a very comprehensive view of health promotion, accommodating most of the theoretical approaches listed above, analysing the experiences and practices, their effects and impacts, and thus representing one of the key health promotion principles: collective learning at global level.

A special feature of the WHO Regional Office for Europe in health promotion policy has been the focus on WHP, introduction of good practices, and working in close collaboration with the EU and the European Network for WHP, ENWHP, which has also been strongly supported by the EU. Another feature has been the development of evaluations of WHP, which has resulted in production of a comprehensive over 500-page book on evaluation of WHP (26). A third feature is the extension of WHP activities from the “old EU area” to “new Europe” i.e. countries which have recently passed a socio-economic transition and undergone deep-going reforms of the work life and health systems. Poland has played an instrumental role in such extension programmes (35, 36).

In the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable diseases (NCDs) 2012–2016, adopted at the WHO EURO Regional Committee in 2011, workplaces are recognized as an important entry point for NCD prevention and health promotion programmes. Rationale is stated, “WHP, when designed and executed as a comprehensive initiative for healthy workplaces, is effective in reducing NCD risk factors by tackling physical inactivity, unhealthy dietary habits, smoke- and alcohol-free work environments, and psychosocial risk factors, with the participation of workers and managers.” Actions related to WHP are recommended to “develop policy, legislation and governance tools targeting occupational and work-related NCDs at the national, local, and workplace settings in line with WHO guidance, and ensure employers’ compliance with relevant rules and regulations.”

5. European Network for WHP, ENWHP

The European Network for WHP is an informal network of national occupational health and safety institutes, public health institutes, health promotion and statutory social insurance institutions. ENWHP was established in 1996 by a number of leading European institutions in health promotion, institutes of occupational health, and occupational safety and health. The Network promotes good practices in WHP and advocates the adoption of such practices in all European workplaces. The network has launched so far eight joint initiatives for specific aspects of WHP, such as quality criteria, small enterprises, public sector, Latin and South European countries, infrastructures,

ageing, moving Europe (physical activity), work and tune in life (mental health). A special initiative for enlarging Europe covered the countries in transition in which WHP is a new concept. The ENWHP has developed several good practice guidelines for different target groups or sectors and helped in the establishment of network focal points and infrastructures for WHP in European Countries, including establishment of national WHP networks (14).

The ENWHP has produced five Policy Declarations from the meetings of the Network. The declarations spell out the Network's basic consensus on the common goals, vision and mission (37):

- Edinburgh Declaration on the Promotion of Workplace Mental Health and Well-being
- Luxembourg Declaration on WHP in the European Union
- Lisbon Statement on Workplace Health in Small and Medium-Sized Enterprises (SMEs)
- Cardiff Memorandum on WHP in SMEs
- Barcelona Declaration on Developing Good Workplace Health Practice in Europe.

Together with the WHO policy lines and the Charters of the Global Health Promotion Conferences these documents constitute the key international guidance for development of health promotion and the ENWHP Declarations have a special value in addressing on WHP, which is less addressed by the other international health promotion policy documents.

Fig 1. The ENWHP paradigm for WHP (38)



Source: Breucker G (2004)

The theoretical approach of ENWHP is a comprehensive one covering all the critical prerequisites mentioned in the next section (Fig. 1). The model has been tested in practice in numerous programmes and projects and deemed feasible. In addition to traditional individual and behavioural aspects of health, the model comprises of policy, social, cultural, managerial, structural (workplace)

and services aspects. In this respect the European model differs from several other international models, which in majority of cases are individual life-style oriented. The European model considers the determinants of health and work ability, and focuses on workplace-specific issues (37, 38).

6. Key prerequisites for effective WHP practices

A large number of WHP research and evaluation reports, guidelines and case descriptions have documented lessons on critical prerequisites which need to be met in the WHP programmes in order to be effective and sustainable (18, 20, 29, 30, 31, 32, 39). Out of the high numbers of studies and reports, the following key prerequisites are listed as the most important ones.

Programme planning

- Defining and declaring clearly the objectives and key steps in the implementation of the programme
- Using a comprehensive paradigm considering individuals, groups, work environment and work organisation
- Ensuring adequate resources and realistic time schedules
- Considering determinants, work environment hazards and health behaviour
- Addressing specific characteristics of the workplace and adjusting the programme according to specific needs of the workplace
- Planning and preparing evaluation of programme by establishing measurements, indicators and criteria

Organisational level

- Ensuring support from secondary and tertiary levels
- Involvement of partners of the workplace, employers and workers and middle level management
- Adjusting to the workplace culture and working methods, e.g. shift work
- Establishing regular meeting and information practices with all involved

Implementation

- Mobilizing workplace's own resources and ascertaining their ability to contribute and utilising multidisciplinary competences
- Sharing and delegating responsibilities and tasks
- Establishing contacts and reporting practices to stakeholders
- Using validated, appropriate and feasible methods
- Ensuring sustainability of the programme on the long-term basis

Numerous factors facilitating the effective implementation of WHP programmes have been recognized in Europe and elsewhere. Also several obstacles have been identified which may affect or even prevent the effective implementation of the projects.

Facilitators

- WHP is a widely researched topic with an overwhelming number of theoretical and practical reports and guidelines.
- WHP has been considered as an important tool for overall health policies of numerous international bodies (particularly WHO and EU).

- In addition to traditional risk-oriented occupational safety approach (in form of prevention of occupational accidents and diseases), which is still important and valid, the demographic changes and developments in work life call upon promotion activities and for prevention and management of work-related diseases, workplace stress, problems of work ability, premature pensions and sickness absenteeism.
- Although high in numbers, the majority of WHP projects and interventions have been found in evaluations methodologically weak or in other ways less appropriate. A growing body of evidence obtained from a few evaluation research and meta-analyses show positive impacts of well-designed WHP programmes.
- The economic appraisal studies have shown a positive economic impact with great variation of the return of investment, convincing the management on the value of WHP investments.

Obstacles

The vast amount of theoretical literature on health promotion has not guaranteed successful implementation in practice. There is an implementation gap recognized among others by the Global Conferences on Health Promotion (33, 34). WHP is not an exception. There are several reasons for the gap in the WHP.

- Insufficient knowledge of planners of programmes pertaining to prevailing cultures and realistic conditions of operation in the work life. That may affect the access to workplaces and trust between the partners.
- Insufficient knowledge and competence on occupational health and safety hazards and problems which are in the prime interest of the workplace partners
- High variation of methods, approaches and models without sufficient standardization and validation
- External WHP actors without long-term anchoring to the everyday realities of the workplace are found ineffective and unsustainable
- Taking only individual-oriented behavioural models into use and forgetting the working conditions and work environment
- Use of health sector language in the workplace environments which may not be common and may use their own language
- Paying less attention to the participation principle which is the rule in all activities for development of the workplace. Participation interest of workplace parties may be originally low or vanish during the course of the programme.
- Implementing short-term projects instead of integrating WHP into the existing structures and activities of the workplace, which would ensure long-term sustainability.
- The demonstration of effectiveness and impact of projects and programmes is difficult, otherwise than in the clinical settings, as the workplace interventions are made as “natural experiments” in which a methodologically ideal study designs may be impossible.
- A modern obstacle is the rapid change of work life, working methods, work organisations and short-term employment contracts and high turnover of both workers and companies.

It is important to be aware of these factors, which may facilitate or hinder the effective implementation, and to take them into consideration in planning of WHP programmes.

7. Approaches to WHP: separate or integrated?

In the recent years, WHP has gained more attention from policy-makers of public health. The government's stewardship function in this area has not been very clear about to improve the effectiveness and sustainability of WHP programmes at the workplace. WHP programmes were introduced to the workplace as a brand new stand-alone programme without linkage with the conventional OHS. However, evidence accumulated from the evaluation studies show that WHP programmes at the workplace are more effective and sustainable when they are coordinated with or integrated into the general health and safety policies.

WHP as a health promotion campaign at the workplace

The populations' health has shown adverse trends in the industrialized world due to several life-style factors increasing the risk of NCDs, such as diabetes II, cardiovascular disorders, cancers, musculoskeletal disorders, stress-related disorders such as depression, respiratory disorders such as chronic obstructive pulmonary disease, COPD, and alcohol and psychotropic drug-related health disorders. The life-style factors affecting the risk of these disorders are many; for example, excess and unhealthy nutrition, tobacco smoking, alcohol consumption, sedentary life-styles, unhealthy sleeping habits and other adverse trends in health behaviour.

Workplace has been found important for health promotion as it constitutes a key arena for reaching adult working age populations and to make group-, workplace- and company-level WHP interventions and campaigns.

If effective and successful, the "WHP as a health promotion campaign at the workplace" has a potential to make a positive impact on adult population's health and contribute to prevention of the risk factors which are associated with the morbidity from the most prevalent NCDs.

The public health interventions for WHP are usually implemented by government bodies, public health organisations, community health units, several NGOs active in health promotion, and university research groups. The substantive content of programmes is dominantly health educational and relies often on health experts' input coming from outside the workplace. The strength of the public health approach is the experience and competence of public health organisations in health interventions and their good competence in health education and health information (22, 23, 29 40). Their weakness is the external nature of the interventions, limiting them often to health education and individual-oriented intervention methods only, poor knowledge of works and less experience on operation in the realities of workplaces, often ignorance of occupational health and safety hazards at work and not knowing the way working organisations and their actors are functioning. A majority of projects are time-limited and oriented to individuals or group of workers instead of taking the whole workplace, working conditions, work environment and work organisation into consideration (20, 22, 24, 29, 32). Projects are often agreed upon with the management of the companies without involvement of workers and their representatives, which affects their interest to participate. Some reports indicate lack of trust within the workplaces toward the external public health experts or other WHP actors who do not speak the language of the workplaces. The trend in recent WHP programmes following public health approach has successfully combined the traditional individual-oriented methods with the wider group- and enterprise-oriented approach and included more participatory principles in the programmes. The problems in participation have raised questions on the commonly used doctrine on reaching the working populations with public health programmes through workplace setting (22, 23, 29).

WHP as an element of comprehensive OHS

The occupational health approach starts from work life realities and occupational health aspects by considering the special conditions of the workplace, branch of economy (e.g. manufacturing vs. service occupations) and the company setting, such as size and organisation of the company, the type of work and work environment and the differences in the employment patterns, e.g. employee versus self-employed or informal sector workers and permanent versus precarious workers. The key operators in occupational health approach are the workplace's own resources supported by the OHS personnel and often with the back-up by the Institutes of Occupational Health. The arguments for inclusion of WHP in the occupational health programmes are related to several new trends in the work life and workers' health.

- Due to demographic trends, the working populations in the industrialized world are ageing rapidly and this trend is particularly strong in Europe. The ageing of workers brings along growing risk of NCDs, which at least in part are preventable with occupational health measures.
- The trends of declining work ability with age, short or long-term work disability and early retirement and sickness absenteeism reduce the total work input of nations, which also for demographic reasons suffer shortages of labour and this trend is growing in the future. The countries feel pressures concerning sustainability of the pension and other social security programmes because of constricting numbers of contributors and growing numbers of beneficiaries.
- There is a growing body of evidence on work-relatedness of the most important population's diseases affecting work ability, such as cardiovascular disorders, musculoskeletal disorders, respiratory disorders, diabetes II, depression, skin disorders and a number of infectious disorders (41, 42, 43, 44, 45). As they have full or partial origin in the working conditions or they substantially affect work ability, preventive potential by managing causative factors at work can substantially open new possibilities for improvement of health and contribute to prevention of this morbidity.
- As mentioned above, a part of WHP programmes has been shown economically beneficial with a positive benefit/cost ratio that has improved both the loss control of the companies and improved productivity with a positive overall impact on company's economy (27).
- By reducing the loss of productive working years through prevention of sickness absenteeism, loss of work ability and disability and premature pensions the WHP contributes positively by lengthening the work life expectancy and to economic sustainability of enterprises, of social security programmes and of social insurance.

British and Canadian critical evaluations of effectiveness of WHP studies using good practice guidelines as references give less convincing results on the effectiveness of the WHP programmes in general and the "health promotion campaign approach" in particular (22, 23). Approximately a quarter of evaluated interventions were implemented in response to the explicit needs of the employees. Only a few were given the opportunity to genuine partnership. Most of the programmes targeted individual behaviour of workers.

The interventions toward work, work environment and working conditions and in work organisation were limited. The majority of the outcome evaluations were not fully appropriate for WHP and even less to improvement of conditions of work. However, some predictors of success were identified. A wide disparity exists between what counts as 'good practice' within WHP and what is reported in the evaluation of effectiveness literature. Also the evaluation methods, if evaluation is exercised at all, are not always appropriate leaving the workplace indicators out from the analysis. Due to lack of participatory principles the participation of workers is not always satisfactory. Participation in WHP

is more likely to happen if workers see simultaneous improvements in the work environment for prevention and management of occupational hazards.

These analysts conclude that participation in WHP may be increased if interventions also take into account health risks arising from work activities i.e. the genuine occupational health approach is utilized. The following recommendations are made for improvement of the effectiveness of WHP and employee partnerships.

- there should be visible and enthusiastic support for, and involvement in, the intervention from top management;
- there should be involvement of employees at all organisational levels in the planning, implementation and activities of the intervention;
- a focus on a definable and modifiable risk factors in work and work environment, which constitutes a priority for the specific worker group, can make an intervention more acceptable to that group of workers and increase their participation and
- interventions should be tailor-made to the characteristics and needs of the recipients.

The comprehensive evaluation studies speak strongly for occupational health approach. The occupational health approach means strong integration of WHP programmes with the workplace cultures, management and participatory systems, health and safety and occupational health activities and often with the company development and HRD programmes. The workers and management participate on equal footing according to the bipartite principles of modern work life. The workplace actors, occupational safety and health committees, employer's occupational safety and health officers or specially assigned WHP representatives and occupational health and safety representatives of workers constitute the key resources for WHP with support of occupational health experts, OHS or respective resources. The WHP is adjusted to the key activities and key needs of the workplace, which vary widely depending on the type of workplace and type of production.

The weaknesses of the occupational health approach is the lower experience of occupational health experts on public health type interventions, often weaker competence in health education and WHP theories and as a relative obstacle the inhibitory factors from being virtually a part of the staff or knowing "too well" the workplace and possible frozen attitudes in the workplace culture (46, 47) For a part of workplaces, particularly the small enterprises, the WHP activities and even OHS is external or the whole OHS setting of the country may be organized on external service providers (23). In some countries the whole OHS system is based on external services provided by individually contracted physicians. This seems to lead to individual health examination and curatively oriented activities with less or non-existent contacts with the workplace. Such a setting brings along challenges which resemble those faced by the health promotion campaign approach.

In summary the practices have been divided between the two distinguishing approaches to WHP, trusting on one hand the external public health actors and on the other occupational health and workplace actors. The most recent trend is suggesting a combination of the two by using the external multidisciplinary resources and workplace actors for implementation of the WHP programmes innovatively. According to the WHO Global Plan of Action on Workers' Health, it is recommended that the ministries of health take a leading role to include WHP and promotion and maintenance of work ability in the legitimate content and activities of overall OHS. This approach would provide a permanent infrastructure and wide coverage and sustainability for WHP as an element of comprehensive OHS in comparison to the time-limited "project-type" or "campaign-type" activities (48).

8. Polish profile of the employment

Polish economy is characterized by a relatively large proportion of agriculture and industry when compared to the EU 15. Employments in public sector and big industries are relatively big (Table 2). The proportion of small and medium-sized enterprises is lower than in other EU countries, but it is growing fast. Employment in high-risk sectors is still comparatively high. Risks of occupational injuries and diseases are higher than in the EU 15, although they are underreported. All these features in the Polish work life emphasize the importance of effective and comprehensive OHS.

Table 2. Statistics of Polish Work life 2010 (49)

Parameter	Number	% or rate
Total population (n x 1000)	38 200	
Population aged 15 and + (n x 1000)	31 461	
Life expectancy (cf. EU-15 average 80.0 yr)	76.0 yr	
Economically active population (n x 1000, % of population 15 and +)	17 660	56.1
Employed population (n x 1000, % of population 15 and +)	15 961	50.7
Agriculture, forestry and fishery (% of employed)		15.18
Industry and construction (% of employed)		27.4
Services (% of employed)		57.4
Public sector (% of employed)		25.5
Private sector (% of employed)		74.5
Unemployment (n x 1000, % of economically active population)	1699	9.6
Working in hazardous conditions (n x 1000, % of paid employees)	1123.8	9.79
Non-fatal occupational accidents ^{a)} (Registered by the NLI, 2010)	94 207	8.12/1000
Fatal occupational accidents ^{a)} (Registered by the NLI, 2010)	444	0.04/1000
Occupational diseases ^{a)} (Registered by the NLI, 2009)	3100	0.3/1000

a) Excluding private farms in agriculture

Source: Central Statistical Office, Poland. Concise Statistical Yearbook of Poland, 2011.

The economic structures of Poland are still in transition with a comparably high proportion of employment in primary production and relatively low percentage in services differing substantially from the EU 15 economic structures (Table 2). This affects the nature of work done by the workers, which likely exposes more to the traditional occupational health and safety hazards. As Poland is rapidly growing in “new economies” it means a double burden of occupational health problems, both traditional (such as occupational accidents and occupational diseases) and modern (stress-related disorders and problems from new technologies). Accordingly, the methods and contents of OHS and WHP need to be adjusted to these needs. In practice this implies consideration of health hazards in physical, chemical, ergonomic and psychosocial working environment as important determinants of workers health and as targets for preventive interventions.

Table 3. Size of Polish enterprises in 2004-2005 (50)

Size of enterprise	Number of enterprises	%	Number of employees	%
Micro (1-10 workers)	1.349.882	95.9	2.967.909	39.2
Small (11-50)	41.296	2.9	906.172	12.0

Medium-sized (51-250)	13.491	1.0	1.415.292	18.7
All SMEs	1.404.669	99.8	5.289.373	69.8
Large (250+)	2680	0.2	2.286.551	30.2

Source: European Commission Enterprise and industry SBS Fact sheet. Poland. 2009.

The majority, almost 70% of Polish employees are working in companies with less than 250 workers and half in companies with fewer than 50 workers (Table 3). The trend towards even smaller average size of enterprises continues constantly. The small enterprises (11-50 workers) employ 12% of Polish workforce and the micro-enterprises (<10 workers) employ almost 40%. About 1.3 million, (10% of total workforce) are self-employed or entrepreneurs. Agriculture, forestry and fishery which are typically fragmented to single family farms, employ 2.13 million people (15.2% of total). Thus the health promotion activities for such high numbers of companies and workplaces with severe risks, which have often a scattered location, constitute a great challenge for both occupational health services and for health promotion.

9. Occupational health situation

The Fourth European Survey on Working Conditions in the EU reports on numerous key parameters on conditions of work on the basis of national surveys made for representative samples of workers in all Member states, including Poland (51). Here only a brief summary of situation of Polish working conditions in comparison with the EU Countries is given in Table 4. The statistics in Table 2 and findings of the survey reflect the transitory stage of the Polish work life characterized by the traditional hazards of manufacturing industries and primary production rather than by the “new work life” hazards, such as high pace of work and low autonomy at work. The work intensity index as well as the reports on stress in Poland is one of the lowest among the surveyed countries. Similarly the position of Poland in the map of job demand/control according to the Karasek model shows passive, low intensity, low strain profile of work (Fig. 2). The survey results may have an impact on recognition of need for WHP to be integrated with comprehensive OHS. The overall profile of Polish work life is passive, and actions from workplace level cannot necessarily be expected, but external public and professional actions are likely needed. The passive workplace culture is conducive neither for improvement of conditions of work nor for good individual health behaviour.

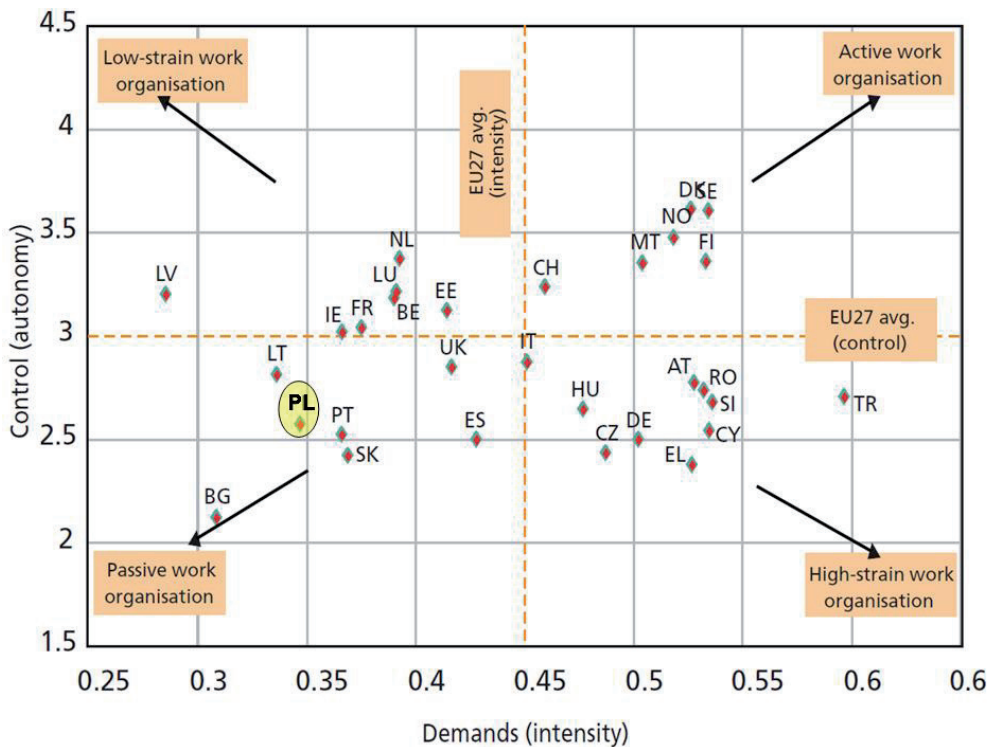
Table 4. Some indicators of working conditions in Poland as compared with the most favourable and most adverse conditions in the EU27 Countries (52)

Parameter	% Poland	% Most favourable whole survey	% Most adverse whole survey
Satisfied with work	78.8	92.5	56.1
Finding health at risk in work	49.0	23.0	54.0
Ergonomic problems at work	25.5	13.0	40.9
Having been absent from work during the past 12 months	17.5	11.6	47.3
Exposed to ambient hazards at work at least 50% of time	13.8	6.3	26.7
Exposed to chemicals at least 50% of time	6.4	3.1	11.4
High pace of work (over 50% of time)	13.8	13.8	31.5
Pace of work determined by other factors than the worker self	34.4	34.4	44.5

Source: Peña-Casas R, Pochet P (2009)

According to the survey on working conditions, the work ability and occupational health situation of the Polish workforce is likely to be below than the EU average. The retirement ages are comparably low and the actual premature retirement is high. This calls for special actions for OHS, for promotion and maintenance of work ability and for WHP. The country faces a problem of premature retirement from work life due to disability pensions (average retirement age (57 yr) that leads to short work life expectancy. This is partly due to poor work ability per se, but partly also to the practices for assessment of work ability and disability. There are also numerous regulations allowing lowered retirement age for special groups of workers. This threatens the productivity of national economy and sustainability of the pension system. There is a need to define more clearly the concept of disability and fine-tune the work ability assessment practices in the health care system.

Fig. 2. Job demands (work intensity) and job control (worker's autonomy) by country (Karasek model)(51)



Source: Parent-Thirion A, Fernández M E, Hurley J, Vermeylen G (2007)

The data on workers' experiences of occupational health situation in the Polish workplaces indicates a wide implementation gap of existing legislation in OHS and WHP (53, 54). In general their findings are well in accordance with the findings of the European Survey.

- In 44% of enterprises only safety and hygiene regulations are followed, nothing beyond
- 15% of firms do not care about employees' health at all

- 54% are convinced that they can not diminish or control the harmful influence of work condition on their health (Karasek imbalance)
- 90% of workers expect health promotion should be carried out in their workplaces

If the experiences of micro-enterprises, self-employed and informal sector were monitored, the situation would be even worse that the above figures.

10. Institutional capacity for WHP

Poland under the leadership of the Ministry of Health has participated actively in the international (WHO) and EU collaboration on WHP. Simultaneously Poland has played a leadership role in the development of health promotion in the “New Europe”, the Members who joined in 2004 and the candidate and potential candidate countries of EU. Two principal Institutes are most active in the WHP.

The Nofer Institute of Occupational Medicine, NIOH

The Health Promotion Centre of the Nofer Institute of Occupational Medicine (NIOH) has been active in the European Network for WHP, ENWHP. Among others the Center has played a coordinating role in the ENWHP Enlargement initiative. A separate Programme for health promotion and prevention was set up in 1996 for the National Network for WHP. In the National Health Programme for the years 2007-2015 health promotion is declared as a priority (55). The Programme is coordinated by the National Centre for WHP of the Nofer Institute and it also coordinates the National Network for Workplace Health (53, 56). The Centre carries out three activities related to WHP.

1) Research

Health promotion research and research of work ability and human capital development belong to the research agenda of the Institute. The Centre carries out research programme with following projects.

- Exploration of social awareness, behaviours and lifestyles related to health of various groups of society
- Systematic monitoring of the state of health promotion activities in enterprises
- Systematic analysis of the key stakeholders’ attitudes on WHP (occupational medicine professionals, managers, employers, employees).
- Analysis of both national and international system conditions for WHP
- Assessment of the quality and effectiveness of WHP
- Development of methodology for preparation and evaluation projects of WHP activities

2) Consultations

The Centre provides consultation projects for enterprises, trains professionals for WHP activities in practice and coordinates the activities of the Polish Network of WHP.

3) Human capital operational programme

The Nofer Institute also participates and supports employees’ health and WHP by focusing on the most prevalent problems affecting work ability. Following ten preventive projects are ongoing for the ten most common occupational diseases in Poland.

- Hearing loss
- Skin diseases
- Allergic diseases
- Infectious diseases
- Musculoskeletal disorders
- Cardiovascular diseases
- Psychosocial factors
- Vocal disorders
- Pneumoconioses
- Allergic diseases

The human capital activities are model projects for the top ten occupational diseases or work-related diseases in Poland.

The record of the National Centre for WHP is impressive (35). Dozens of WHP seminars have been organized, the National WHP Network has been established, and a WHP web-site portal has been opened. Dozens of intervention projects have been or are currently implemented, disease-specific interventions are piloted and national and local alliances for WHP have been founded with active projects in the companies. High numbers of information and education materials have been produced and good practice guidelines produced, including a quality assurance guideline for WHP. About 200 persons have been recruited and trained as WHP Leaders and about 500 persons in over 100 companies have been trained and introduced to make interventions in their workplaces.

The National Center for WHP is an active and respected member of ENWHP. A special activity of the Polish Centre is the "Dragon Fly" Project which develops structures for dissemination of "Good Practice" in the field of WHP in New EU Member States and Countries in process of accession to EU. Carried out under the leadership of the Nofer Institute, the projects seek to develop a framework for cooperation between relevant stakeholders of the applicant countries and the current Member States. After having established national contact offices in Cyprus, Estonia, Malta, Lithuania, Latvia, Slovenia, Slovak Republic, the Network analyses the current situation with regards to strategies, policies and practices for promoting workplace health. The Polish Centre also has produced a milestone book on WHP in Enlarging Europe (35).

The Polish Network for WHP supports and utilizes the support of the National Centre for WHP and participates in dissemination of information, training, research and implementation of WHP implementation of WHP activities. The Network is organized at four levels (53, 56).

- The National Centre for WHP - coordinator
- Local centres and local WHP leaders
- Supporting centres
- Companies implementing WHP and company leaders.

The Network aims at development in all Regional Occupational Medicine Stations (WOMP) and biggest Sanitary Inspection Stations posts or departments responsible for WHP activities, prepares staff for WHP implementation, disseminates WHP concept and expected benefits from WHP for employers, management of companies and for trade unions. The current priorities in the Network Strategy are the following.

- Creation of strong market for WHP services among company managers
- Development of regional strategies for WHP

- Advocating WHP at national level
- Involvement in ENWHP initiatives
- Improvement of marketing of WHP

The Central Institute of Labour Protection – National Research Institute, CIOP-PIB

The CIOP-PIB has a strong and active research programme on WHP focusing particularly to the promotion of health of working populations at large, including promotion and maintenance of work ability of ageing workers and preventing the hazardous factors in work., work environment and work life in general, which affect ability to work, cause work disability, absenteeism and premature pensions. CIOP profile gives important added value for WHP by providing in addition to health promotion and particularly occupational health promotion like the work ability activities also work environment and safety competence into the use of WHP projects. The research programme of CIOP in topics relevant for WHP and occupational health are of high standard and highly productive with strong international and European dimension. The CIOP also organises different range of actions - campaigns, competitions and specialised conferences and seminars. The information and training material production of CIOP is in WHP as occupational health and safety in general is of high quality and well received by the workplaces. The workplace promotion materials have been granted with Polish and international awards. The CIOP website is well developed and actively visited by the workplace actors and it contains abundant materials relevant for WHP . The CIOP provides over 5 million people in the Polish work life with vast amounts of information on safety, health, OSH and WHP.

The CIOP is a key actor in several national networks in OSH and work life in general, such as Network of OSH Experts, Network of Regional Centres of OSH and Work Safety Leaders Forum. The duties of these structures include promoting healthy and safe work style and life style and emphasising the role of prevention.

Permanent initiatives are worth to be marked, for example health promotion at the workplace led by CIOP Centre for Scientific Information and Documentation in collaboration with European Agency for Safety and Health at Work (for which CIOP is Poland's Focal Point). CIOP is also a member of several others European collaborative programmes, among others the network of European Institutes for Occupational Safety and Health, PEROSH and numerous activities of the International Labour Organisation, ILO, including national CIS Centre and focal point for ILO Global Information Network.

CIOP wants to emphasize a comprehensive approach in the WHP, combining health, OSH and economic aspects and ensuring participation at all levels of social partners, employers and workers and their organisations. CIOP also supports the idea of closer collaboration between the institutions active in WHP in Poland.

The WHP situation in Poland is simultaneously positive and challenging. Thanks to the activities of the National Centre for WHP and the numerous activities under its coordination, and the WHP and promotion of work ability programmes of CIOP, the basic information, knowledge, training material, good practice guidelines, trained human resources and results from model interventions constitute a strong and healthy basis for WHP. The weaknesses are the missing nation-wide infrastructure, lack of training of occupational medicine physicians in WHP and strict separation of OHS of health sector and of OSH activities of labour sector at all levels. The potential for overcoming the existing obstacles constitute a policy challenge which can be at least in part met by strengthening the leadership of the Ministry of Health in the field of WHP and by drawing up the National Strategy for OHS covering WHP. Better inter-ministerial and inter-sectoral collaboration particularly with National Labour Inspectorate, Ministry of Labour and Social Policy as well as

stronger involvement of the Social Partners, organisations of Employers and Trade Unions would also strengthen the Polish WHP.

11. Integration of WHP and OHS

OHS are legally regulated in great detail in Poland. They cover the formal workforce and well organized companies, but the coverage of smaller, fragmented workplaces and workers without working contract are likely to remain uncovered. The formal activities are called “occupational medicine” which, according to the internationally accepted concept, is a part of comprehensive occupational health in the view of ILO Convention No. 161 (57) on Occupational Health Services and the WHO definitions. Without underestimating the value of pure occupational medicine services aiming at clinical services and health examinations, they are monodisciplinary and have less impact to health at workers’ population level. Poland has ratified the ILO Convention No. 161, but the implementation still needs efforts. One of the first actions required by the Convention 161 is the drawing up a National Policy and Programme for OHS. The ILO Convention No. 161 and related Recommendation No. 171 (57, 58) specify in great details the policy principles, coverage, obligations to government, employers and workers, content and activities of services, model for multidisciplinary OHS staff, options for service provision models and conditions of operation, collaboration between employers and workers and financing of services. For producing the National Occupational Health Policy and Programme, a National Occupational Health Profile would be very helpful tool by identifying strengths, weaknesses, challenges and gaps in the national OHS system and providing systematically presented information equally to all stakeholders. The WHO Regional Office for Europe is in the process of producing such profiles from several countries, which could provide a format for profile-making.

In Poland the activities of occupational medicine are carried out either by physicians hired by companies or in the majority of cases by external individual occupational medicine practitioners (OMP’s). In most cases the services are provided from outside the companies and most of the activity is to carrying out pre-employment and periodic health examinations which are stipulated by law. According to the Polish Association of Occupational Medicine, typical activities of the occupational medicine doctors are listed as follows (59, 60).

- Pre-employment health examinations
- Periodical health examinations
- Health Surveillance
- Ergonomic analysis of workplace
- Drug & Alcohol Testing
- Workplace health risk assessment for new and expectant mothers

Health examinations are also done periodically during the employment in order to assess an individual’s fitness to work.

The law stipulates that before the employer can recruit a worker the pre-employment health examination shall be done for each employee for assessment of his/her physical and psychological fitness to work.

The human resources for occupational medicine services in Poland are remarkable. There are 8000 physicians authorized for making health examinations for employees. About half of them are

specialists in occupational medicine. If calculated as full-time resources the density of OMPs is good, about one OMP/1700 workers and an average of about 1/3400 occupational medicine specialists, which both are comparably good figures. The survey on recognition of various competences among the occupational health physicians showed that they rank the occupational hazards, health promotion and work ability assessments as the most important competence areas in their professional profiles (61). On the other hand regional surveys studied the fulfilment of legislation-stipulated tasks and particularly health examination practices by occupational health physicians and found substantial quality differences between occupational medicine specialists and non-specialists and in the inclusion of different stipulated tasks into the service programme. Enhanced efforts for training were proposed (62, 63, 64, 65).

A questionnaire survey among a sample of Polish OMPs showed that more than 90% of OMPs are interested in participating in WHP Programmes and thought it is their task (46). They recognized several benefits for OHS from WHP, such as increased possibility of influencing the state of patients' health, greater work satisfaction, keeping abreast with progress in occupational medicine and public health, gaining a greater respect by occupational medicine physicians among the managers of companies and gaining a greater respect by occupational medicine physicians among patients. They also identified numerous obstacles in carrying out such service, the most prominent ones being lack of interest and support by employers, their own readiness to WHP activities and lack of training and also lack of interest among workers. The survey concluded that in spite of high interest, the Polish OMPs are not fully prepared to become active members or managers of multidisciplinary OHS teams operating at company level as a part of the comprehensive OHS system that integrates medical, technical, hygiene and psychosocial approaches into a comprehensive expert advisory service for companies and work life. Similarly the survey among occupational health nurses showed a great interest toward practical activities for WHP (61).

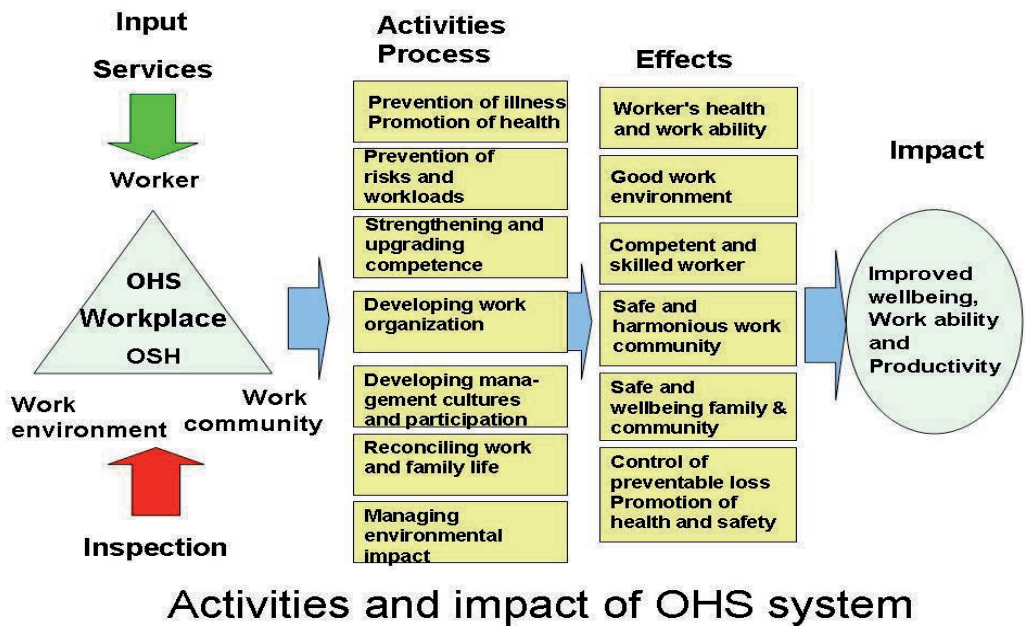
The professional potential and interest of Polish OHS for WHP is high, but the current practical prerequisites are not fully met. Without underestimating the great value of the existing OHS in Poland, following obstacles were recognized on the basis of the available documents and the interviews in 2010-2011:

- Outdated structures and monodisciplinary functions of OHS and low level of activities towards work environment, work organisation and work community.
- Low readiness of OMPs to adopt WHP tasks and even lower to take a leadership role in WHP
- Lack of training of OMPs in WHP
- Lack of tradition in multidisciplinary work at the workplace together with other experts
- Strict separation of OHS and OSH activities
- Low level of awareness of employers and workers on WHP.
- Lack of national OHS strategy. Suboptimal leadership of the Government on OHS in general and need to clarify the leadership roles concerning the strategic development of OHS.

OHS carry out health examinations, produce fit-notes but do less activity directed for improvement of health conditions at the workplace. The occupational medicine specialists are paid on capitation basis and for health examinations, which directs the activities to that direction. The surveys among occupational health professionals interest for expansion of their role from the current occupational medicine profile to broader occupational health profile. The replies for the questionnaire studies indicate a thrust for better professional status, more meaningful work and for possibility to develop along with the rapidly changing work life (61).

More comprehensive OHS orientation and integration of WHP Programme with OHS are needed to improve the health of Polish working population and to support the objectives for longer working careers. The modernization of OHS is likely in need of substantial reform of OHS legislation, critical review of current organisation of services, including service provision models, and the content and methods used in services. Active participation of all relevant stakeholders, employers, workers and authorities in the development of future OHS and WHP for Poland should be ensured. The service provision models and organisation of the delivery of services should be thoroughly reviewed. Models for comprehensive OHS are internationally available and the guidance from international Organisations. ILO and WHO, provides support for the development of such services. As a good practice example of the comprehensive OHS, the logical scheme and activity profile of Finnish OHS are illustrated in Fig. 3 and Fig. 4, respectively. The Promotion and Maintenance of Work Ability (PMWA) constitutes the most central component of the integrated OHS in Finland (48, 62).

Fig. 3. Logic scheme of Finnish OHS (66)



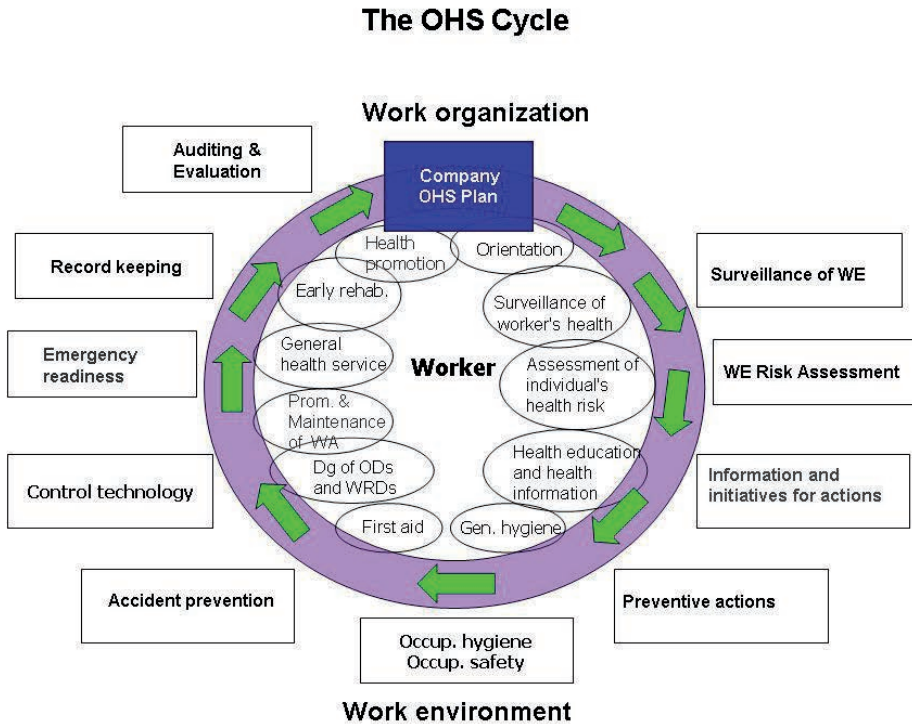
Source: Rantanen J (2009)

While several big OHS providers in Finland are able to hire multidisciplinary experts, many of the smaller OHS units are not able to provide such a comprehensive service without external support. Such support is provided by the Finnish Institute of Occupational Health Regional Units and, if needed, several other external services, including among others the psychologists of the municipal health centres (primary health care units). The BOHS approach as recommended by WHO, ILO, and ICOH was used in Finland and several other countries to fill the gap in the coverage of the underserved groups and sectors and the sectors without any OHS (67).

A great challenge for the Polish OHS is how to widen the coverage of services to more workers. Although there is no information on access to OHS among the self-employed, micro-enterprises and informal sector, a conservative estimate of uncovered working population amounts to a minimum of 3 million workers in agriculture, smallest enterprises and among self-employed. The coverage of

these highly fragmented, scattered and less organized workplaces inevitably can be possible by public intervention through public funds. Providing OHS for underserved groups requires structural changes in the service provision models and utilization of primary health care approach in the delivery of OHS following the BOHS approach (see above).

Fig. 4. Activities and activity cycle of Finnish comprehensive OHS (66)



Source: Rantanen J (2009)

The available survey documentation and discussions with the stakeholders lead to the conclusion that the Polish occupational medicine services, occupational medicine physicians and nurses, are currently not able to carry out WHP to all workplaces, but the experts are interested and can be trained and introduced to do so. To ensure sustainable, accessible and well-integrated WHP activities at the workplaces, inclusion of WHP as a legitimate part of OHS activity is the most realistic solution. External WHP activities separated from OHS have been found neither effective nor sustainable. In order to enable effective contribution of OHS to such a goal, changes are needed in the orientation and content of Polish occupational medicine curricula and service delivery system. The competence and activities should be directed to more prevention- and promotion-oriented, comprehensive occupational health approach with more versatile and multidisciplinary activities than the traditional health examinations and fitness checks. This requires also an extensive training and re-training programmes for the OHS personnel. In addition, structural changes in the service delivery models and the overall organisation of OHS are needed. Such development is seen inevitable, not only in the view of WHP, but also in the view of responding to the health, safety and work ability challenges of the current and future working populations and work life in general. To achieve this, a strong leadership and new policies and strategies by the Ministry of Health are warranted.

12. National Health Programme 2007-2015

The Draft National Health Programme for the years 2007-2017 (55) has been drawn up for the Ministry of Health by a special Expert Group and approved by the Government. The Programme contains one strategic objective and five operational objectives referring to health promotion. In particular, the Operational Objective No. 15 is important: "Increase and optimize the use of the health system and infrastructure of local governments for health promotion and health education." Any objectives do not specially address WHP, however. When the National Plan for Health Promotion is drafted, the workplace should be considered as one of the key arenas of OHS for health development of adult working-age population.

As the working population constitutes a major part of the total adult population, it is important that occupational health and work ability of working population would be better considered in the next revision of the National Health Programme. Inclusion of aspects of occupational health would substantially support the achievement of overall objectives of the Programme as a whole. Indeed, the Programme objectives can realistically be achievable only with the help of occupational health approach (e.g. tobacco control, cancer, COPD, mental health, and the large entity of work-related diseases such as musculoskeletal disorders, cardiovascular disorders, several respiratory disorders and allergies and work-related depression). Modern preventive occupational health approach would also strengthen the preventive and public health approach of the Programme in general, which according to our assessment should be substantially strengthened in the whole Programme.

Therefore the Draft Programme should be completed by adding the relevant elements of occupational health including WHP into the Programme. Without prejudicing the value of disease-oriented curative medicine, the primarily preventive and public health approach in the whole programme is recommended to be strengthened in order to ensure its long-term impact on the health of the population and effective management of the major health challenges in Poland. The National Health Programme has been approved by the Prime Minister and its coordination belongs to Ministry of Health. In practice the coordination has been in the hands of the National Institute of Public Health, but the Ministry has recently appointed a special officer for the Ministry's coordination of the Programme. Some funding for implementation has been provided by the Ministry, but it has been relatively limited due to the financial crisis. The implementation is a challenge also because all the relevant operators are heavily overloaded due to still continuing transition of the health sector in Poland.

The National Health Programme was prepared to emphasize prevention as an important strategy for improvement of health of the population, but in practice the emphasis is still heavily on curative activities and prevention remains a secondary priority. This is true for all sectors of the health system. The institutional curative health care, however, dominates and the primary health care services do not get sufficient priority or resources in the Programme. Several specific programmes have been implemented, such as Tobacco control, NCDs, Cardiovascular diseases, Disaster preparedness, Social determinants of health, Human capital, etc. The public financing of health services has been based on National Health Insurance Fund that collects contributions of about 9% of employees' salaries. The Government budget finances special programmes like tobacco programme, cardiovascular disorders, etc. OHS are financed by the employers. However, a great proportion of workforce works without employment contract and is not covered by such service.

13. Conclusions: Situation of WHP and OHS

- 1) There are prerequisites for extension and development of WHP in Poland. Health promotion is included as an element in the National Health Programme 2007 – 2015. However, the OHS and WHP objectives are not substantial in the National Programme. Consideration of OHS and WHP would be very important particularly in the view of burdens of occupational diseases and accidents as well as the problems of ageing workforce, work-related morbidity, work ability, growing job demands from competitive work life and the work stress epidemic typical for the modern work life.
- 2) In addition to prevention and management of occupational diseases and accidents, well-organized OHS can substantially contribute to the general average health of the population by dealing with the largest subpopulation in the country. The working population is half of the whole population, and they are the key contributors to the overall socioeconomic development and the only producer of the GDP. The promotion and maintenance of work ability of workers is, however, not only an issue of health, but also critical to the sustainability of the national economies, productivity of work and sustainability of social policy (69).
- 3) The competence and knowledge on OHS in general including WHP is well available in the Polish National Centre for WHP, which is located in the Nofer Institute of Occupational Medicine. The Nofer Institute, in collaboration with the key stakeholders and other relevant national and regional institutions, is well prepared for the development of a Nation-wide Programme for OHS and for WHP. Many of the basic requirements for such a nation-wide WHP programme are in place in Poland.
- 4) Substantial capacity, research and practical activities, competence and interest for development of occupational health and WHP are also found in the Central Institute of Labour Protection, CIOP-PIB, with good capacities and contacts to workplaces and to social partners, employers and trade unions. Close collaboration between NIOH and the CIOP as well as between OSH and OHS in general, including WHP, is warranted.
- 5) The conditions of practical operation for the OHS and for WHP in Poland are limited. The scope of OHS is limited widely to only health examinations and fitness checks. The current WHP in Poland activities comprise individual projects and targets instead of systems-wide activities. The individual worker-oriented approach is working well, but the orientation to working conditions and work environment is weak. It is reasonable to conclude that the methodology and competence for more comprehensive OHS and WHP is available, but that there is a shortage of wide-scale implementation of in Poland. Such wider implementation would need an infrastructure with ability to reach all workplaces and all workers in their work environments. The Polish Network for WHP has demonstrated impressive results. For development of wider coverage of OHS a modern national strategy for OHS and WHP is needed. The well-working and widely covering OHS system would provide the best infrastructure for all occupational health activities, including WHP.
- 6) If the necessary policy, legal and training actions are instituted appropriately, OHS could provide a real opportunity for the implementation of WHP in a system-wide scale. Virtually all stakeholders interviewed by the WHO Mission recognized the need for development of a national system for comprehensive OHS. It will be difficult to ensure integration of workplace level WHP activities and its wide-scale implementation without having such an infrastructure for practical work at grassroots level. Therefore, a national strategy and programme for development of comprehensive OHS system is a precondition for effective WHP. If WHP programmes are developed as a national system separated from OHS, many activities of WHP and OHS will overlap and become less effective than the integrated approach to comprehensive occupational health (see below).

7) All the stakeholders relevant to occupational health and WHP (2) in Poland found it most valuable to draw of a National Strategy for OHS, including Programme for WHP. The strategy would be drawn on the basis of situation analysis and analysis of trends in the work-life development, development of health, safety and work ability of Polish workforce, identification of risks, challenges and opportunities, defining strategic objectives and proposing an Action Plan for implementation.

8) Evidence shows that a separate WHP activity is not an optimal way for implementation. Instead, it would benefit from being an integrated part of a modern OHS activity in which WHP is carried out as a legitimate part of OHS and integrated also closely into the general health services. This view corresponds also to the wide international experience. The condition for such integration is, however, a well-working and widely covering OHS system and infrastructure able to carry out modern comprehensive OHS at workplace level.

9) Evidence shows that WHP activity focusing on individual workers and their life-styles only is not effective in improving the health outcomes in the long run. On the contrary, there is abundant evidence confirming the effectiveness of comprehensive WHP programmes integrated with OHS and general health services targeting workers' health, working environment, work organisation, social determinants of health, and work-life balance.

10) According to Polish stakeholders, the ability of the current OHS in Poland has weak points in prevention of hazards at the workplace, promoting and maintaining work ability of workers, and promoting of occupational health and decent working conditions in general. Reorientation and competence building of the actors in OHS and WHP is necessary for improvement of performance at the workplace.

11) Reform of training curricula for occupational medicine and OHS experts and development of more multidisciplinary competences for OHS are needed, as well as orientation of occupational medicine /occupational health in view of the needs of modern work life, i.e. to prevention and promotion.

12) While numerous potentials do exist and several prerequisites are met, the challenges to OHS and WHP in Poland cannot be effectively met through a WHP Programme alone, but a reform of Polish OHS is needed to integrate WHP into comprehensive OHS and to improve the collaboration at all levels between OHS, WHP, general health service and OSH. This all can be achieved through the determined leadership of policy-makers in the Ministry of Health and the Ministry of Labour and Social Policy, supported by the Nofer Institute of Occupational Health, the Central Institute for Labour Protection, CIOP-PIB, the National Labour Inspectorate, in collaboration with social partners and other stakeholders.

We summarize in Table 5 the strengths, weaknesses, opportunities and threats of the WHP and OHS situation in Poland.

Table 5. SWOT analysis of occupational health situation

<p>STRENGTHS</p> <ul style="list-style-type: none"> • Health promotion element included in the National Health Programme 2007-2015 • Strong tradition in the occupational medicine before transition to market economy in 1990s • About 8000 physicians involved in occupational medicine service • Capacity for OHS and OSH in the Nofer Institute (NIOH) and CIOP-PIB • National WHP Centre in the NIOH and the National WHP Network • Active participation of the Nofer Institute and CIOP in the European-wide and international (WHO, ILO, EU) collaboration projects • Willingness of key stakeholders, including NIOH and health sector, OSH sector (NLI and CIOP) and Employers and Trade Unions • Availability of good practice models and examples for OHS and WHP with evidence on effectiveness 	<p>WEAKNESSES</p> <ul style="list-style-type: none"> • Lack of laws and regulations supporting comprehensive OHS • Weak collaboration between MoH and MoLSP, and social partners • Lack of systematic policies and programmes for development of WHP as a part of OHS activities • Outdated orientation of occupational medicine to health examinations without preventive services at the workplace • Lack of coverage of OHS in SMEs, MEs and the self-employed • Poor understanding of potential of workplace setting approach and OHS as an instrument for achieving the objectives of the National Health Programme • Inequity of health protection of the workers in high-risk sectors • Lack of social dialogue focusing on health and safety at work among the representatives of employers and workers
<p>OPPORTUNITIES</p> <ul style="list-style-type: none"> • Inclusion of OHS and WHP in the National Health Programme • Expansion of coverage and enhancement of competence of OHS • Reorientation of OHS with adequate training • Much collaboration opportunities within health sector and between health and labour sectors and their institutions • Improvement of population's work ability through modern OHS approach and thus strengthening work ability, productivity and competitiveness of the Nation • Utilizing guidance from WHO and ILO and good examples from other European countries • Drawing up new national strategy and programmes for OHS and WHP in combination. 	<p>THREATS</p> <ul style="list-style-type: none"> • Fragmentation of important national and system-wide activities into isolated individual projects without coordination and systematization • Not including the working population in the priority target groups of national health policies, and thus, losing the opportunity for improvement of population's health and work ability • Growing problems of exclusion from work due to work-related disability and unemployment • Delaying to reform OHS to respond to the needs of modern work life • Threatened sustainability of social programmes and national productivity due to premature retirement and low participation rates in the labour market

14. Recommendations: Integrated development of OHS and WHP

On the basis of studies of relevant national and international research, survey and policy documents, analysis of several aspects of Polish work life, occupational health and WHP activities and drawing from the results of interviews of most representative stakeholders by the WHO mission in Poland, following recommendations are presented for further development of OHS and WHP in Poland.

1) According to the international experience and scientific evidence, isolated and individual-oriented WHP programmes without close connection with OHS and other actors of the workplace are less effective than the comprehensive and integrated approach. This is due to the need to modify and manage multiple factors and determinants of health at work and in the working environment not limiting only to the individual worker's behaviour and life-style. Therefore, it is recommended that the WHP programmes are developed as *an integral part of OHS* constituting the national health system.

2) It is recommended that the OHS system in Poland be reformed according to the Guidance by the ILO Convention No.161 and Recommendation No. 171 and the guidance provided by the WHO Global Plan of Action for Workers' Health. As the first step of reform, a *National Policy and Strategy for OHS with an appropriate Action Plan* is recommended to be drawn up in collaboration with all key stakeholders, including the relevant Ministries (MoH, MoLSP), social partners, research institutions and professional associations. In many countries drafting task is given to a National Committee or Task force consisted of all the key stakeholders and relevant competences in the field of occupational health.

3) Drawing up a *National Occupational Health Profile* is recommended. The Profile should provide information on all the legal and other prerequisites for occupational health, national programmes, material and human resources, key institutions, social partners, key challenges and problems, strengths and opportunities, and on occupational health and safety outcomes such as occupational diseases and injuries, loss of effective working years through sickness absenteeism and work disability, etc.

4) A reform of Polish OHS system is proposed to move from limited "Occupational Medicine" focusing on health examinations to comprehensive "*Occupational Health*" focusing on primary prevention and health promotion as well as health protection as defined jointly by WHO and ILO. For more comprehensive content of OHS see Figures 3 and 4. The reformed system should include the following key activities of modern comprehensive occupational health.

- *Prevention of workplace hazards* as the major part of OHS activities, targeting working environment and work organization rather than health examination of workers
- *Promotion of health and work ability* of workers paying special attention to occupational determinants of health, psychosocial risks, work-life balance and individual life-style factors influenced by work
- *Surveillance, recognition, prevention, assessment and management* of hazards causing occupational diseases and work-related diseases and injuries, and instituting management and preventive actions at workplace level
- *Health information, health education, guidance and expert advisory support* for employers and workers in the development of safe, healthy and decent working conditions

- *Health education and advice* on safe and healthy working practices, healthy life-styles, and development of work organisations conducive to health and safety
- *Pre-employment and periodical health examinations*, as a part but not as the main activity of OHS because they are secondary to the primary prevention- and work environment-oriented activities.

5) The modern comprehensive OHS should be based on modern legislation and be integrated with and take support from the other parts of the health sector and labour sector. Consequently, the development of OHS should be done as **a part of health system, included in the National Health Programme** and other relevant programmes of the health sector (stewardship). Where special disease-oriented or other relevant national programmes are launched, the participation of occupational health actors should be duly considered to reach out the workers in the workplace setting. OHS should also **collaborate with OSH activities of the labour sector** such as OSH inspection following the relevant ILO guidance.

6) **Different OHS delivery models** are recommended for provision of OHS to all workers (service delivery), depending on different needs of different types of workplaces and workers. Big enterprises are encouraged to employ their own in-company OHS, while SMEs and the self-employed are allowed to organize external services either from special occupational health units or from primary health care providers who are trained for provision of OHS and particularly basic occupational health services, BOHS. To achieve the coverage of OHS to the underserved workers and sectors, the BOHS approach based on public health system is recommended.

7) **Sufficient numbers of competent occupational health experts** are needed (resources generation). Occupational health physicians, nurses, occupational psychologists, occupational hygienists and ergonomists, should be ensured for OHS and for WHP. This requires organisation of appropriate national training programmes for occupational health personnel on modern contents of comprehensive occupational health. Where it is not possible to organize a multi-disciplinary OHS teams other than occupational health physician and nurses, the special services of experts (e.g., ergonomists, occupational hygienists, psychologists) should be provided as support services at secondary and tertiary levels. Special training programmes should be arranged to elevate OMP's competence in comprehensive OHS and WHP.

8) The remuneration model for OHS providers based on limited activities such as health examinations and certificates leads to inefficient use of the competence of OMPs and limits the scope of OHS to occupational medicine services. This is not conducive for development of comprehensive preventive and workplace-oriented OHS and for WHP. The OHS reform should also comprise **an amendment of the financing and remuneration system** for OHS.

9) **Adequate level of training and information** on occupational health in general and on OHS in particular should be provided to employers' and workers' representatives and to the persons responsible for organisation of OHS in the Ministries and other relevant institutions, including institutes of occupational health. This would require a national training programme on modern OHS. Establishment of a special national information centre for occupational health and occupational health services is also recommended. .

10) For special enhancement of OHS and WHP an appropriate **National Programme for Promotion and Maintenance of Work Ability of Polish Workers** is recommended as a part of *National Policy and Strategy for OHS* proposed above. An expansion of the current WHP model is recommended to include a comprehensive promotion and maintenance of work ability model focusing on strengthening of work ability, prevention of work disability, support for continuation at work for older age, and focusing intensively to improvement of working environment and work organisation

conducive to the attainment of work ability. The whole activity should be supported by multi-disciplinary expert competences. Participation of employers, workers representatives and adequate expert communities is recommended for both drawing up of the Programme and for its implementation. Such programme should be implemented with the help of the reformed OHS and with strong input by the OHS personnel, the relevant support services and other experts and partners of the work life, particularly employers' and workers' organisations.

11) **Sufficient and sustainable financing** should be ensured for OHS and for the WHP within it. In the reform of financing system different situations of different target groups of OHS should be taken into account. For instance, different capacities for contributions among big enterprises, micro-enterprises, self-employed and informal sector should be taken into account. Possibility for allocating public financing for the services of currently underserved sectors should be examined. Another possibility is the inclusion of solidarity principle in the insurance models (see Recommendation 12).

12) The **financing model of both the OHS and WHP** is to be developed considering the country's overall model for health financing. In most new EU member countries the insurance model has been chosen. If such insurance model will be chosen, the primary responsibility of employer as financer of OHS and WHP should be considered according to the ILO principles. In some countries the costs of OHS are allocated from a certain proportion of the occupational accidents insurance premiums collected from the employers. The services for un-covered and underserved sectors and groups of workers (e.g. agriculture, self-employed and informal sector) need to be financed from public funds.

13) **Research support** for development of OHS and WHP from the relevant research institutions, such as NIOH, NIPH and CIOP-PIB should be organized on a permanent and sustainable basis. Establishment of a joint collaborative forum between these institutions is recommended.

14) **The stewardship and leadership of the Ministry of Health** should be strengthened by establishment of a special unit in the Ministry for OHS. Such unit should work in close collaboration with all the relevant stakeholders of occupational health in Poland. Full participation should be ensured and roles and responsibilities be defined for the Ministry of Health, Ministry of Labour and Social Policy and Social Policy, for the Nofer Institute of Occupational Health, NIOH and the Central Institute for Labour Protection, CIOP-PIB in the development of OHS and their practical implementation. The resources of public institutions for such activity are recommended to be guaranteed on a sustainable basis. Similarly, the participation of social partners, employers and workers should be ensured.

15) For enhancement of systems-wide activities for renewal of policies, governance and practices for the development of OHS in Poland (including WHP) a proposal is made for organisation of **National Conference on Modern OHS** with possible international input such as Baltic Sea Network for Occupational Health and Safety. The tradition of such Conference could be continued in the future as an annual *National Forum for OHS*. WHP should be one of the key items on the agenda of such forum.

16) **International experiences and good practice models** should be taken into account for development of comprehensive OHS, incorporating activities on promotion and maintenance of work ability as well as of workers' health. For sharing such experiences, organisation of a European-level expert meeting on strategies for OHS and WHP is recommended. Outcomes of such meeting should be used for the benefit of planning the national-level activities and drafting strategies for future development of OHS and WHP.

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Situation analysis and recommendations for stewardship on workplace health promotion in Poland

This report presents a situation analysis and recommendations on strengthening stewardship of the government for the improvement of workplace health promotion (WHP) within occupational health services (OHS). Information was collected from stakeholders involved in WHP in Poland during a mission by WHO staff and consultant in September 2010. Preliminary analysis and recommendations were reviewed with the stakeholders in April 2011. According to the evidence from research, WHP programmes are more effective and sustainable when they are addressed as an integral part of the OHS system as well as the overall health system. Therefore, the leadership role of the Ministry of Health recognizing occupational health as an area of public health services is critical for improvement of WHP in Poland. The multi-sectoral cooperation and broad-based collaborations between the Ministry of Health and other stakeholders in OHS and WHP (e.g., the Ministry of Labour and Social Policy, National Labour Inspectorate, health sector at large, research institutions, professional associations and the social partners representing employers and workers) are also very important. A reform of Polish OHS system is proposed to move from limited "Occupational Medicine" focusing on health examinations to comprehensive "Occupational Health" focusing on primary prevention and health promotion as well as health protection. For this purpose, it is recommended that the Ministry of Health establish a unit for OHS and WHP, and organize an annual National Conference on Modern OHS with the participation of the stakeholders of OHS and WHP in Poland.

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