



Initiative
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IGA-Report 8e



The Initiative Gesundheit und Arbeit (IGA – Initiative for Health and Work) is a collaborative project between the Federal Association of Company Health Insurance Funds (BKK), the Federation of Institutions for Statutory Accident Insurance and Prevention (HVBG) and the Federal Association of Local Health Insurance Funds (AOK). The aim of the common initiative is to generate new approaches to prevention and intervention in health in the workplace and to further develop existing ways and methods. Being project based, the initiative makes a valuable contribution to research, training and consultancy. It does not do so in isolation, though: the partners in this collaborative project actively seek to enter into a dialogue with interested parties in business, politics, social insurance, employers' and employees' organisations and many other institutions.

This publication aims to contribute to the development of suitable approaches to prevention and intervention.

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Developing Aims and Objectives for Health Prevention in the Work Environment

Fritz Bindzius, Wolfgang Bödeker, Gudrun Eberle, Frauke Jahn, Julia Kreis, Annekatriin Wetzstein, Jürgen Wolters



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1 Introduction

There is a growing consensus in Germany that prevention aims and objectives should be agreed upon. By directing measures and services in primary prevention and health promotion in a coordinated manner and towards defined objectives, outcomes of prevention are to be made more successful. In view of limited and often increasingly scarce resources, prevention activities can thus be applied in a more target-oriented, more concentrated and more concerted way. Also, defining prevention objectives allows for a better evaluation of the success or failure of preventative action. After all, this increases the sustainability of successes in prevention. The present discussion of a Bill of Prevention shows the broad acceptance of target-oriented action. Despite the controversial discussion on the regulatory contents of the draft Bill, the fact that all stakeholders focussed their efforts on commonly agreed prevention aims and objectives has met with general approval. Today, the approach of establishing aims and objectives in prevention is securely in place in Germany.

In the framework of the Initiative Gesundheit und Arbeit (IGA – Initiative for Health and Work) the partners¹ agreed on devising a methodology enabling them to define aims and objectives for workplace health prevention. This seemed mandatory because, although there was a body of experience in developing general health objectives (cf. www.gesundheitsziele.de), the area of health in the work environment had so far been largely excluded from these efforts.

This methodological approach makes good sense and is especially useful in the cooperation between statutory accident insurers and statutory health insurers in the field of prevention and occupational health promotion since their adoption of common objectives can serve to make the cooperation even more efficient and fruitful.

The three partners in the initiative agree that despite the adoption of common aims and objectives they must each retain their ability to act according to the needs of individual companies or sectors of the economy, even in cases where fulfilling these needs means deviating from the commonly agreed objectives. After all, the partners each have a strong service commitment. There is also agreement that work-related health objectives are a subset of national prevention aims yet to be developed. Of course certain work-related health objec-

¹ Federal Association of Company Health Insurance Funds (BKK), Federation of Institutions for Statutory Accident Insurance and Prevention (HVBG) and Federal Association of Local Health Insurance Funds (AOK)

tives, for example the prevention of skin diseases or lowering the number of cases of circulatory illness, can also be applied in other areas of life such as schools and kindergartens. And finally, as stipulated by law for each statutory body concerned, accident insurers and health insurers both have to follow their respective priorities when defining common objectives of prevention.

In the beginning, the partners of the IGA project “Developing Aims and Objectives for Work-related Health Prevention” defined a framework for the development of objectives. After working through a number of existing national and international objectives systems, they agreed upon a set of approaches for the development of objectives for primary prevention and health promotion. The fact that the approaches for action in primary prevention on the one hand and health promotion on the other hand are basically different is mirrored in the suggested approaches for defining objectives.

Core elements of the proposed staged approach in the development of objectives of *primary prevention* are, firstly, a ranking process on the basis of empirical data on the burden of a particular disease and, secondly, exchanges among experts. The latter are used for assessing diseases which have been taken into closer consideration for defining health objectives according to the criteria “preventability”, “work-relatedness” and “operability”. Due to the sophisticated ranking process, the description of the method of defining objectives in primary prevention takes up a relatively large part of this report.

By comparison, the development of objectives in *health promotion* takes place on the basis of generally accepted concepts and values of health promotion. Policy documents of the WHO and the European Network for Workplace Health Promotion provided a valuable starting point.

By presenting the results of this project, the partners of the Initiative Gesundheit und Arbeit want to reach out towards all federal organisations in statutory accident and health insurance with the aim of initiating a fruitful discussion on the adoption of common objectives in our fields of work.

2 Framework for the Development of Aims and Objectives: Primary Prevention and Health Promotion

2.1 Main Issues

Many stakeholders are active in health promotion. Health promotion in the work environment is the main concern of this report. This takes in measures of health promotion in the workplace, of occupational health promotion and of safety at work. Although no agreed definition of these terms exists, it is mandatory to differentiate between them in order to make it clear that objectives for health promotion in the workplace have to be derived from the individual perspectives of a range of disciplines.

Health promotion in the workplace means that established measures for preventative and health promoting behaviour such as training seminars, information dispersal, programmes on nutrition, giving up smoking and physical exercise are being carried out in companies. Although such measures can also be successfully implemented outside the workplace, they are seen to be especially efficient in a work context since, for example, the flow of information within a company, the team spirit or the binding character of such programmes all act in a positive way.

By contrast, *occupational health promotion* goes beyond behaviour-oriented prevention. It encompasses also measures aimed at creating health promoting conditions e.g. in the way work is organised and the whole company is structured. In this way there is a direct interface with safety at work which aims to prevent work-related health risks beyond the classic sphere of the prevention of accidents and work-related diseases.

These different perspectives show that health promotion in the work environment is primarily directed at reducing risk factors in the workplace as well as strengthening individual and institutional health resources. Thus, the development of priorities in prevention objectives should focus both on primary prevention and on health promotion.

As *primary prevention* aims at preventing illness, it always specifically relates, be it explicitly or implicitly, to illness. Thus, a suitable guiding question for developing aims and objectives for work-related primary prevention is as follows:

Which diseases are particularly important, which (especially work-related) ways of behaviour and sets of circumstances, and also which groups of people have to be given special consideration?

The target parameter is by how much sickness rates can be brought down through reducing risk factors.

According to the Ottawa Charter of the World Health Organisation (WHO), the promotion of health resources and of health promoting structures is at the centre of all *health promotion*.

Thus, developing objectives for specific diseases does not seem appropriate. Instead, a suitable guiding question for developing aims and objectives in health promotion is the following:

Which strategies of health promotion can be regarded as especially effective, and which strategies can be successfully implemented in the workplace?

The target parameter is by how much individuals or groups of people can be enabled to attain a higher degree of autonomy regarding their health, and how far the salutogenic potential of the work environment can be utilised.

There is no standardised process for the development of prevention objectives. Basically one can distinguish between, on the one hand, processes based on taking in as much scientific expertise as possible and, on the other hand, processes which seek actively to involve participants in arriving at a consensus on health objectives. Within the framework of a scientific approach such as has been used, for example, in developing health objectives for the German city state of Berlin, the choosing of health objectives and their ranking is based on epidemiological data and criteria. By comparison, in a participatory process the political protagonists determine the relevant criteria for developing health objectives based on decisions on values and on reaching a consensus.

The pragmatic way is to integrate both approaches. This way, scientific expertise as well as participatory elements and consensus finding processes are utilised. Examples of health objectives programmes developed in such a way are to be found in, among other places, the UK, Australia and North Rhine-Westphalia (www.gesundheitsziele.de, 2002).²

² The different approaches used so far internationally and on a regional level for developing health or prevention objectives have been extensively documented in the report "www.gesundheitsziele.de: Health objectives for Germany – Development, Orientation, Concepts. GKV-Schriftenreihe vol. 37".

Having said this, what needs defining first and foremost in any process of developing health objectives is the underlying system which lays down the interrelationships between the various objectives. A system of objectives can be structured in a hierarchical way, or it can define objectives for different prevention areas as largely independent from each other.

This latter approach was chosen for the framework of www.gesundheitsziele.de: objectives relating to specific illnesses, to citizen and patient issues, to prevention areas and to population groups all ranked on an equal level.

As shown above, there are different guiding questions for the development of objectives in primary prevention and in health promotion. According to this different orientation, we propose different systems of objectives for both areas.

2.2 System of Aims and Objectives for Primary Prevention

After evaluating different systems of aims and objectives which are in use nationally and internationally, we propose for the development of work-related objectives in primary prevention a morbidity-based hierarchic system of only a few (≤ 5) top aims directly relating to diseases, e.g. lowering sickness or mortality rates for circulatory or musculoskeletal diseases. Based on these aims, a set of objectives for relevant prevention issues is defined. These are directed at individual behaviour, at sets of circumstances and at population groups. For example, the aim of “Reducing illness due to musculoskeletal disorders” might have objectives relating to “Lifting loads the right way” or “How to make people more physically active”. With regard to “Sets of circumstances”, these objectives could be “Less lifting of loads in the workplace”, “Preventing unnatural postures in the workplace” or “Lessening the strain of having to perform well at work”. With regard to “Population groups”, we could take a special look at groups of people with an above average risk of illness such as building workers or nursing staff. This example is shown in fig.1.

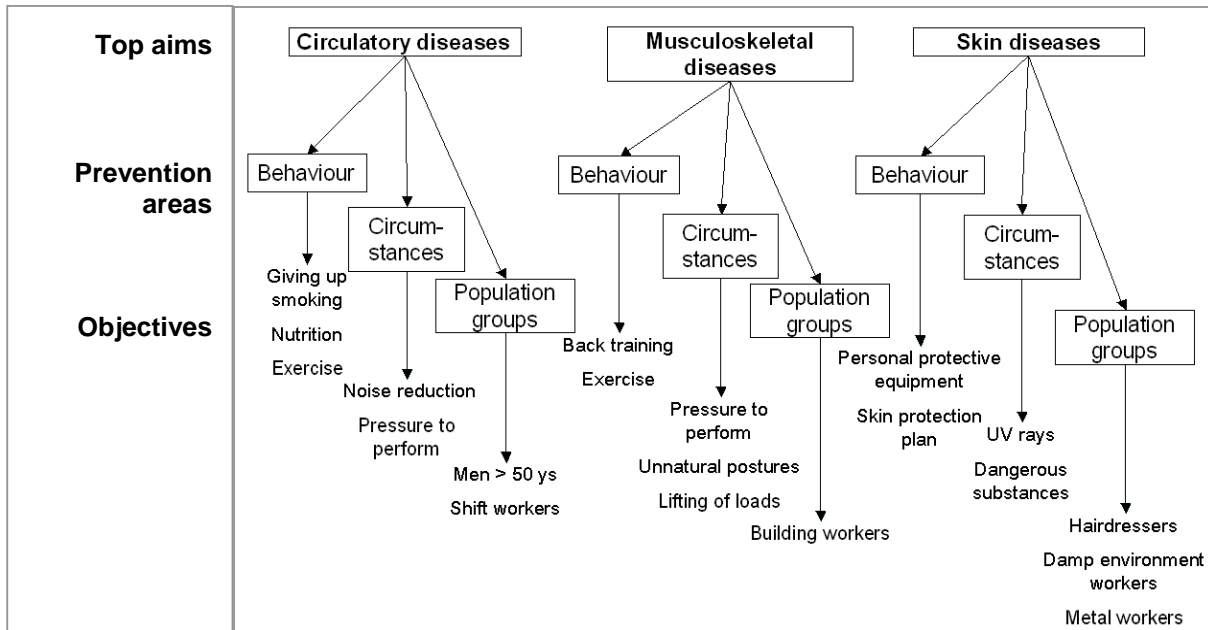


Fig. 1: Hierarchic system of aims and objectives

The decision in favour of a hierarchic system giving top priority to morbidity-oriented objectives comes more naturally to institutions like health and accident insurance funds since understandably they have a strong interest in lowering morbidity and the costs that go with it. Also, focussing objectives on a limited number of aims has the advantage of pooling resources. This in turn increases the probability of actually achieving these objectives. At the same time, the concept offers a comparatively high degree of flexibility as there is no limitation on the number of objectives on the lower level. Since the morbidity-based approach is highly plausible, this concept of objectives can be communicated well and is willingly accepted by the relevant stakeholders.

2.3 System of Aims and Objectives for Health Promotion

For the area of health promotion, though, we propose a different system of objectives. The usual distinguishing mark of health promotion measures is that they follow a set of objectives aimed at strengthening individual and collective resources (cf. Rosenbrock, 2004). For this reason a hierarchic system of objectives with a number of high priority aims at the top does not seem appropriate in this area. We therefore propose to do without a hierarchy of aims for health promotion and rather to define objectives which all have the same ranking.

3 The Process of Developing Aims and Objectives

In the course of the project we developed an approach which describes how objectives for primary prevention and health promotion can be developed. The proposed plan of action integrates elements which allow for a maximum degree of objectivity on the one hand with elements of user participation on the other hand. Some steps are carried out separately for the aims of primary prevention and those of health promotion, others are applied in the same way to both areas. The individual elements of the process used in this approach are shown in fig.2. Thus, this approach combines a scientific angle with a participatory perspective which ultimately leads to a pragmatic process.

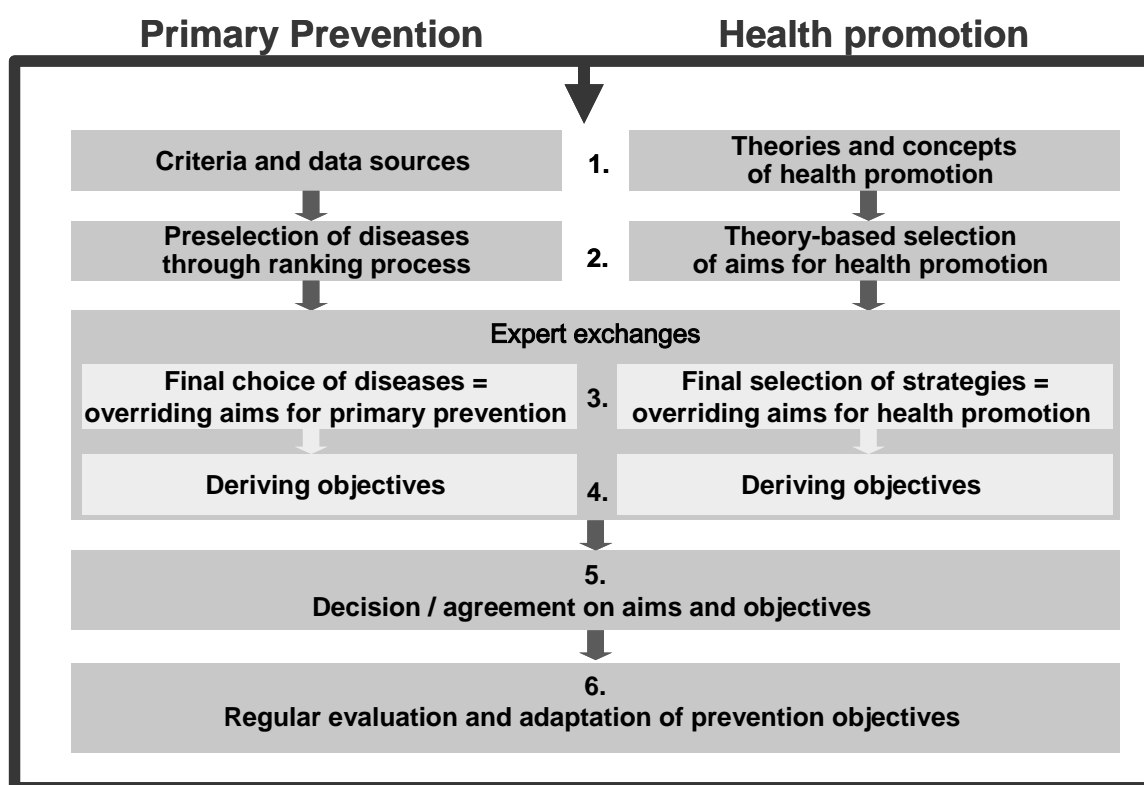


Fig. 2: The process of developing aims and objectives

As a first step in the process the basic principles for deriving objectives from aims are laid down: in the area of primary prevention for which a hierarchic, morbidity-oriented system of objectives is to be developed, the first step is to define the criteria for the process of ranking diseases in the most objective manner possible (1). In order to ensure the highest possible degree of objectivity, at this stage only criteria are chosen for which robust data are available. These criteria are to reflect the various facets of a given disease's importance. As a

second step in the development of primary prevention objectives, diseases are put into a ranking order based on an evaluation of data for the previously defined criteria (2). The result is a ranking order showing which diseases can be regarded as the most important ones across the range of the various criteria. This prioritisation procedure thus fulfils the demands of a scientific process committed to objectivity.

By contrast to this data-based approach we suggest a wholly different one when defining objectives in the area of health promotion. Since values arrived at by consensus traditionally play an important role in health promotion, they should also play a prominent role when developing objectives in this field. Therefore there has to be agreement from the outset on which health promotion concepts are deemed relevant (1). As a second step, on this basis the currently most important values and strategies for the work environment are chosen (2).

After these two first steps which are based on a scientific approach the following steps show that the final agreement on aims, objectives and targets cannot be reached exclusively according to objective criteria. There are other criteria, too, which should be taken into account when selecting general aims but for which there are no extensive data. Instead expert assessments have to be relied upon. Moreover, international initiatives have shown, too, that efforts to define priorities in health aims which rely solely on formal, rational, science-based processes do not produce generally accepted decisions (WWW.GESUNDHEITSZIELE.DE).

Therefore step 3 and 4 in the process are carried out through expert exchanges: having made a preliminary selection of diseases, concepts and priority values in health promotion in step 2 and after taking additional criteria into account, in step 3 the top aims are defined. Finally, in step 4 experts derive targets from these aims and objectives. For primary prevention targets are worked out for modes of behaviour, sets of circumstances and population groups (4). Before this can be done, though, the expert exchanges have to be well prepared. In step 5 final decisions are made by a political panel yet to be appointed. Its members agree upon the common aims, objectives and targets for prevention in the workplace both for statutory health and accident insurance funds (5).

The reaching of objectives and targets should be continually monitored. In time intervals yet to be laid down it should be regularly examined by way of a feedback loop if the objectives and targets are still adequate or whether they need readjusting (6).

4 Developing Aims and Objectives in Primary Prevention

4.1 Ranking Process

The decision on which disease is the most important one and should thus be given special consideration in the development of prevention objectives depends on the standpoint of the person who is to make that decision. While for patients their suffering is surely the most important factor in itself – although at the same time the most difficult to ascertain objectively –, insurance agencies and employers (to name but two institutions) take an economic and health political viewpoint. It follows that the burden of disease for a country's economy, measured for example in terms of mortality or costs, but also the disease's effects on the work environment, measured in sickness rates or early retirement rates due to disability, could be used as criteria for assessing the importance of a given disease.

In other words, if the process of prioritising diseases is to be carried out irrespective of individuals' viewpoints, it is necessary to adopt an integrated approach such as can be realised by a ranking process. If one transfers this approach to diseases, a ranking process using various criteria puts diseases or groups of diseases in a ranking order. The disease with the highest mortality rate receives the highest rank, the one with the second highest mortality rate is put in second place and so on. The same procedure is followed for other criteria such as sickness rates, early retirement due to disability and others. Finally all attributed ranks for a given disease are added together. The disease with the highest aggregate rank has the highest importance.

The advantage of such a ranking process is the integrating prioritisation. It means that on the one hand a given disease can theoretically be classed as important although it assumes only a medium rank according to several criteria. On the other hand a disease may have been accorded first rank in one area; but if it has only a low score in other areas it may be deemed of lesser importance overall. Generally, though, only those diseases are classed as especially important which are given a high rank in several different areas. In the ranking process described above all criteria are weighted equally when computing the aggregate score. Thus, a given rank in, for example, "frequency of absence through sickness" counts as much as the same rank in "mortality". In principle this order can be influenced by adopting a different weighting of criteria. In such a case, however, the process would lose some of its objectivity since the experts would have to agree on a weighting of criteria which was not supported by data.

Ranking processes have to be founded on a basis of robust systematic data. The process should be carried out in such a way that any missing data for one particular criterion do not lead to an unintended effect on the weighting of this criterion and thus to a false representation of the ranking order. To assure this, so-called fractional ranks can be used. In order to arrive at a disease's aggregate rank one does not rely on the absolute rank but on a quotient of this rank's numerical value divided by the total number of ranks to be accorded. Thus, the highest *fractional rank* that can be achieved is 1. The highest potential *aggregate rank* for a disease corresponds to the number of criteria taken into account. When ranks are tied the average rank can be taken. The integrating prioritisation of diseases by way of a ranking process constitutes the first step in the derivation of prevention objectives as we propose it. This step is regarded as largely objective since it is first carried out without any bias and weighting by the participants. Thus, only data sources should be used which permit a representation of health political and economic criteria with a comparable aggregation of diagnoses. The criteria to be taken into account should be selected in such a way that they contain as much complementary information as possible.

The following chapter presents an example application of the ranking process which allows for an estimate of the process's feasibility and the amount of work it entails. The ranking process for diseases listed in the ICD-10 and for work-related diseases has to be carried out separately since both classifications are not congruent. Nonetheless, common aims and objectives of prevention are derived for both branches of the social insurance system.

4.1.1 Ranking Process for Diseases according to ICD-10

The health monitoring carried out by the Federal Ministry of Health and the federal organisations of the German statutory health and pension insurance funds provides a routine survey of mortality and morbidity on the aggregation level of the ICD-10. Relying on these statistical data, seven criteria for a ranking process were selected. Mortality and years of life lost are two standard criteria of health monitoring. Morbidity becomes a workable concept with the help of statistical figures for absence through sickness and for numbers of workers receiving a partial disability pension for the first time. The economic importance of diseases is estimated on the basis of the relevant cost-of-illness calculation by the Federal Statistical Office.

All members of the working population of 15 to 64 years of age are taken account of in the ranking process. This includes presently unemployed people. The individual criteria are described hereafter.

Mortality

This criterion gives the number of deaths from the relevant statistics on causes of death. It encompasses all persons who died in the reporting year except for stillbirths, subsequently declared war deaths and deaths certified by coroner's inquest. The statistics are based on death certificates issued by doctors and on record cards for deaths issued by the registrar's offices. Causes of death are coded according to the ICD-10 on the basis of the dead person's primary illness.

Source: Statistics on causes of death, Federal Statistical Office, 2005

Years of working life lost

The calculation of "years of working life lost" is an extension of that for "years of life lost". The latter is calculated as the difference between a person's actual age at death and the average remaining life expectancy of men and women at that age. On top of this, calculating the number of years of working life lost takes into account the proportion of people in work at that age.

Source: German Health Monitoring System, Cost-of-Illness calculation, Federal Statistical Office, 2004

Number of cases and days of sick leave per 100 insured members

The impact of a disease on the work environment is to be measured through the number of cases of illness and of sick days per 100 insured members ascribable to this disease. The diagnosis data are collected on the basis of the ICD-10 by using the main diagnosis entered for each case. Diagnosis-related data on absence through sickness can be found both in the statistics of the Federal Ministry of Health and the Federal Statistical Office as well as from individual health insurance funds such as AOK, BKK, DAK, GEK, IKK. The robustness of the figures on absence through illness with regard to the ranking process has been tested against the data provided by AOK and BKK. Thus, when the ranking process was tested with AOK figures for absence through illness for 2003, the ranking order of groups of diseases was found to be comparable to that based on the BKK data. Both criteria are shown in table 1 on the basis of the Federal Association of BKK data.

Source: BKK Health Report, Federal Association of BKK, 2005

New pensions due to reduced earning capacity

This criterion takes in the number of persons drawing disability pension due to reduced earning capacity as defined in Social Insurance Code Section VI. This takes in partial or total disability to work. The statistics used exclude miners drawing a pension on account of reaching 50 years of age. The diagnoses are recorded according to the ICD-10 on the basis of the person's primary illness.

Source: German Federation of Pension Insurances, 2005

Direct costs

The present cost-of-illness calculation by the Federal Statistical Office uses the term "direct costs" in an expenditure-oriented way. Figures are computed by taking in costs for medical treatment, the resources spent on prevention, rehabilitation or nursing care as well as administrative costs of service providers and other institutions financing health services. The costs are attributed to ICD-10 chapters, ICD-10 blocks and ICD-10 (sub)categories.

Source: Federal Health Monitoring System, Cost-of-Illness Calculation, Federal Statistical Office Germany, 2004

Costs per case

When calculating the costs per case, the directly attributable expenditure is related to the number of cases treated. Thus, this criterion can show the economic importance even of rare (but expensive) diseases.

Source: Federal Health Monitoring System, Cost-of-Illness Calculation, Federal Statistical Office Germany, 2004

Data is available from freely accessible routine statistics. The depth of evaluation and thus the potential for evaluation according to occupation, age, sex or individual diagnoses varies. The following table shows the results of a ranking process. Both data drawn upon as well as ranks accorded to each individual criterion are shown. Furthermore, the two leftmost columns contain the aggregate sum of all ranks as well as the rank given to each disease according to the aggregate rank sum. Diseases are shown in decreasing order of rank.

Table 1: Ranking process for diseases according to ICD-10

Groups of diseases (excluding pregnancies) according to ICD-10			Criteria (15 to 64 years of age)													
			Mortality		Working Years of Life Lost		Absence through illness				New pensions due to partial disability		Direct costs ¹		Costs per case ²	
							Days per 100		Cases per 100							
Rank		Aggregate Rank	Rank		Rank		Rank		Rank		Rank		Rank		Rank	
			2002		2002		2003		2003		2002		2002		2002	
			Number		Per 1,000 years		Per 100 members		Per 100 members		Number		€n		in € per habitant	
Diseases of the musculoskeletal system	1	5,92	318	0,25	794	0,95	358,7	1,00	19,41	0,94	38.868	0,94	13.792	0,95	310	0,89
Diseases of the circulatory system	2	5,71	38.808	0,94	406	0,79	65	0,69	3,38	0,56	21.844	0,83	11.739	0,89	430	1,00
Mental and behavioural disorders	3	5,64	4.365	0,63	737	0,89	102,2	0,81	3,55	0,63	49.820	1,00	11.664	0,84	270	0,84
Diseases of the digestive system	4	5,62	13.803	0,81	235	0,68	90,3	0,75	14,55	0,88	3.856	0,56	22.163	1,00	380	0,95
Diseases of the respiratory system	5	5,45	5.707	0,69	355	0,74	229,5	0,94	33,95	1,00	4.685	0,72	6.297	0,68	150	0,68
Injury and poisoning	6	5,33	18.591	0,88	1.260	1,00	205,7	0,88	11,47	0,81	4.334	0,67	5.083	0,53	130	0,58
Neoplasms	7	5,06	60.080	1,00	478	0,84	39,2	0,50	1,25	0,25	24.091	0,89	7.119	0,79	180	0,79
Symptoms and abnormal findings	8	4,24	6.223	0,75	158	0,58	55,3	0,56	5,57	0,69	2.045	0,50	4.280	0,47	150	0,68
Diseases of the nervous system	9	3,94	3.393	0,56	190	0,63	30,5	0,38	2,18	0,44	9.781	0,78	5.113	0,58	130	0,58
Certain infectious and parasitic diseases	10	3,3	2.576	0,44	111	0,53	56,9	0,63	9,66	0,75	1.234	0,33	2.102	0,32	50	0,32
Diseases of the genitourinary system	11	3,28	1.030	0,38	77	0,47	31,1	0,44	2,92	0,50	1.630	0,39	5.602	0,63	110	0,47
Endocrine, nutritional and metabolic diseases	12	3,19	3.248	0,50	71	0,42	10	0,13	0,5	0,06	4.173	0,61	6.375	0,74	160	0,74
Diseases of the skin and subcutaneous tissue	13	1,98	53	0,13	39	0,26	21,2	0,31	1,84	0,38	697	0,22	2.420	0,37	50	0,32
Diseases of the eye and adnexa	14	1,59			29	0,21	8	0,06	1,07	0,19	1.683	0,44	1.826	0,26	60	0,42
Factors influencing health status	15	1,32			16	0,11	14	0,25	1,03	0,13			3.289	0,42	60	0,42
Diseases of the ear and mastoid process	16	1,25			25	0,16	12,9	0,19	1,34	0,31	656	0,17	1.196	0,21	30	0,21
Congenital malformations, deformations	17	1,22	415	0,31	55	0,37					726	0,28	584	0,11	20	0,16
Diseases of the blood and blood-forming organs	18	0,61	312	0,19	10	0,05					358	0,11	602	0,16	10	0,11
Conditions originating in the perinatal period	19	0,59	9	0,06	54	0,32					177	0,11	61	0,16	10	0,11

¹ including dental treatment² in relation to the total population

Table 1 shows that diseases of the musculoskeletal system have the highest aggregate rank and thus assume first position. This group of diseases has a high importance according to all criteria except for mortality. In comparison to the diseases of the circulatory system in second place the integrating effect of the ranking process becomes apparent: diseases of the circulatory system nearly attain the same aggregate rank as those of the musculoskeletal system. In the former, though, the rank results from the relative importance of the criteria of mortality and costs per case whereas mortality plays a secondary role for diseases of the musculoskeletal system.

In conclusion it can be said that the ranking process for diseases according to ICD-10 is easy to handle and that it provides a good empirical basis for deciding on which diseases to give high priority to. It shows which diseases are important overall and should thus be given special consideration when developing prevention aims and objectives. The process as such is independent of an individual's viewpoint since it relies on objective criteria.

4.1.2 Ranking Process for Occupational Diseases

The central area of concern in statutory accident insurance apart from the prevention of work-related health risks is the prevention of occupational diseases and accidents at work. While statutory health insurance funds focus their services primarily on diseases, the statutory accident insurers are concerned with events which have a direct bearing on the work environment but which occur less frequently. When developing a common approach, the process for the derivation of work-related prevention aims and objectives has to take this into account. Otherwise, occupational diseases would hardly score high in the ranking process. Also, since occupational diseases cannot be transferred to the ICD-10 system without difficulty, their ranking should be carried out separately. The common prevention aims and objectives should then relate to the most serious diseases in both ranking orders.

By way of example, the following ranking process takes in occupational diseases according to the List of Occupational Diseases 2002 (cf. *Berufskrankheiten-Verordnung [BKV]* = German Ordinance on Occupational Diseases of 5th September 2002 with the appendix listing all occupational diseases). For the meaning of the term "occupational disease" see Chapter 9 Para 1 of the Social Insurance Code Section VII.

The following criteria were selected for carrying out the ranking of occupational diseases:

- Latency period
- Confirmed cases of occupational diseases (excluding new pensions)
- Age at confirmation of occupational disease
- New pensions
- Reduction of ability to work of new pensioners (excluding cases of death)
- Cases of occupational and social rehabilitation
- Total costs of cases compensated (medical, occupational and social rehabilitation as well as pension)
- Mortality

All data sources for these criteria are to be found in the statistics of the Federation of Institutions for Statutory Accident Insurance and Prevention. The ranks have been transformed into fractional ranks as in the ranking process for diseases according to ICD-10. In case of tied ranks the average rank is accorded.

Latency period

The latency period is the time elapsed between the first exposure and the outbreak of the disease (date of event insured). With regard to a continuous review of aims and objectives and a quicker achievement of prevention successes, the occupational disease with the shortest latency period is accorded the highest rank.

Confirmed cases of occupational disease (excluding new pensions)

These are persons for whom the suspicion of an occupational disease has been confirmed, in other words who have contracted an occupational disease. This criterion, through, is not identical to having what in Germany is called an *officially recognised* occupational disease. The reason is that for an occupational disease to be officially recognised special preconditions in insurance terms have to be met, for example the cessation of any activity causal or potentially causal of the development, the worsening or the resurgence of the disease. Only if these preconditions are met can the occupational disease be recognised.

So, as an occupational disease can only be officially recognised if and when certain conditions are fulfilled, a group of cases was created for which the suspicion of the existence of an occupational disease could be confirmed. Thus, the recognised occupational diseases are a sub-set of all confirmed cases of occupational disease. In questions of prevention a lot of importance is attached to this group.

Age at confirmation

For all confirmed cases of occupational disease the average age of all persons contracting this disease is used. In the ranking process the occupational disease with the lowest average age receives the highest rank.

New pensions

In cases where an occupational disease is recognised and the partial disability for work leads to the worker receiving a pension or if the afflicted has died from the occupational disease, then this usually serious occupational disease is called a “new pension”. So, new pensions are a sub-set of all recognised occupational diseases and another important criterion.

Partial disability in new pensions (excluding deaths)

The granting of partial disability status depends on how much the diminishing of a person’s physical and intellectual capacity is found to limit his earning capacity. The degree of disability is measured as the difference between a person’s lifelong earning capacity before and after the event insured.

If the earning capacity is diminished due to several events insured, the degree of disability is calculated separately for each of them, and the insured will receive several pensions. The degree of disability is stated in per cent.

Cases with occupational and social rehabilitation

After the occurrence of an event insured (occupational accident, commuting accident or occupational disease), an insured person, despite the best possible medical treatment having been carried out, may not or not without problems be able to take up his former occupation again. Thus, the German Institutions for Statutory Accident Insurance and Prevention are obliged by the Social Insurance Code Section VII to ensure, as soon as possible and by all suitable means, the permanent occupational rehabilitation of the insured person taking into account his suitability, inclination and former activity. The following services in particular are available:

- help in keeping a job or finding a new job
- schemes preparing for employment
- initiation courses, further training, initial training and retraining schemes
- help in getting an adequate education
- services to employers
- mobility assistance
- help with adequate housing.

Total costs of (a) medical, occupational and social rehabilitation and (b) of pensions for occupational disease

a) *Medical, occupational and social rehabilitation*: The total costs take in all expenditure for medical treatment (medical rehabilitation) and for reintegration into the labour market (occupational rehabilitation) as well as the social environment (social rehabilitation).

In order to guarantee a basic standard of living during the period of rehabilitation, injury benefits or temporary allowances are granted by the institutions for statutory accident insurance and prevention. Costs for medical treatment take in all expenditure for first-line emergency treatment, ambulatory treatment by a qualified accident and emergency doctor or, if and when needed, hospital treatment. Home nursing services, dental treatment, provision of medicaments and surgical dressings, physiotherapy and medical aids are also covered.

b) *Pension*: In case of total disability the worker receives a full pension amounting to two thirds of his annual income before the accident at work or the occupational disease occurred. In case of partial disability a pro rata pension is paid, e.g. one third of his annual income in case of 50 per cent disability. The amount of the pro rata pension depends on the degree of disability and the annual income. A pension will only be paid in case of 20 per cent impairment and over.

Mortality

The criterion expresses the number of deaths as a consequence of occupational disease.

The result of the ranking process for occupational diseases can be seen in table 2 which is based on 2004 statistics.

Table 2 shows obstructive respiratory diseases in first place followed by diseases due to inorganic dust with skin diseases in third place.

In the course of the ranking process occupational diseases are looked at in groups. If a group with a number of distinct occupational diseases has been identified in the ranking process as having priority, it can be helpful when preparing expert exchanges to look at how the single diseases score in respect of the relevant criteria, too. For the definition of health targets a closer scrutiny of single occupational diseases also makes sense.

4.2 Expert Exchanges

As shown above, ranking processes make it possible to prioritize diseases listed in the ICD-10 as well as occupational diseases. The result, though, is a ranking order, not a selection. There is no rule imminent to the process that says from which rank on a disease becomes unimportant. The decision on how many diseases shall enter the process of defining health objectives has to be made outside the process. The chosen criteria have entered the ranking process on an equal footing. As far as prevention policy is concerned it may be sensible to take in further criteria including ones regarding quality. In a second step, these criteria are to enter into the prioritization process by way of expert assessment. From a multitude of potential criteria the three most important ones and the ones for which research can be carried out most easily for the expert exchanges have been chosen. These three are:-

- preventability
- work-relatedness and
- operability.

These criteria are deemed to be suitable for choosing the most important diseases in an expert assessment. At the same time it becomes apparent that due to the high complexity of criteria, an approach based on purely scientific objectivity increasingly has to take second place to participatory decisions. This is also true for example in regard to the relative importance and the weighting of the various criteria.

In the expert exchanges representatives of accident and health insurance funds, the Initiative for Work and Health, the relevant ministries as well as experts engaged in research and practice (e.g. experts in occupational medicine) should get together. Assisted by a moderator and on the basis of the three criteria above, the experts discuss the diseases which have

been accorded top priority in the ranking process, i.e. the ones in the first three places². The expert exchanges have to be prepared professionally: the three ICD-10 diseases and the three occupational diseases that have emerged from the ranking process with the highest priority (in other words, six in all) must be examined in regard to the three criteria with the help of a thorough research in expert literature. On this basis the diseases for which prevention aims and objectives are to be worked out can now be chosen and prioritised. At the end of the expert exchanges aims, objectives and targets in primary prevention are derived for two top priority diseases.

The term “aims” refers to non-quantifiable goals, e.g. “reduction of musculoskeletal diseases”. The definition of targets, though, entails quantification, e.g. “the proportion of the population taking sufficient exercise (twice weekly) is x % or rises by x %”.

The *decision/agreement* on aims, objectives and targets is reached after conclusion of the expert exchanges in the responsible decision-making bodies of the statutory health and accident insurance funds.

4.2.1 Preventability

The criterion of preventability³ is meant to express if there is a possibility of influencing a disease or a risk of contracting a disease by means of prevention or health promotion. The answer can be of a quantitative or qualitative nature. In order to ascertain a disease’s preventability it is checked whether any prevention programmes for the disease in question exist in the first place and which details there are to be found on the programmes’ effectiveness.

Based on the examples of circulatory diseases and skin diseases, tables 3 and 4 show how preventability is assessed in studies.

² In the exchanges, though, the entire ranking process is made available to the experts. It follows that in cases where this is justified the experts may want to discuss a disease on the basis of the three criteria even though this disease has not been given top priority.

³ The term “preventability” is mentioned in the Prevention Bill of 2005. There are similar terms to be found in the scientific literature. For example, the statutory health insurance fund KKH in a report in 2004 mentions “prevention potential”. The official report by the National Experts Panel for Concerted Action in the Health System in 2001 contains the wording “preventative potential or prevention potential”. Lenhardt uses the term “preventionability” (2001).

Table 3: Reduction of incidence, mortality or risk of contracting heart and circulatory diseases through selected prevention measures

Kind of disease and risk factors	Modification achieved	Reduction of		Relative attributable risk	Risk reduction	Source
		Incidence	Mortality			
Myocardial infarction:						
Cholesterol	-10%		24-27%			National Experts Panel on Health, 2001
Stress management			22%			"
Cholesterol, smoking, weight control, exercise, blood pressure		25%				"
Ischemic heart diseases:						
Cholesterol	-10% -5,5 mm Hg syst. -3 mm Hg diast.		15%			"
Blood pressure	5-6 mm Hg diast.		20-25%			"
Blood pressure						"
Stroke:						
Hypertension				40%		"
Smoking				15%		"
Diabetes				10-20%		"
Obesity				20%		"
Coronary heart disease:						
Little physical exercise (men)	≥4,200 KJ per week				20%	Health insurance fund KKH, 2004
Nutrition, physical activity, overweight, smoking, alcohol consumption (women)					82%	"
Nutrition (consumption of fruit and vegetables)					20-30%	"
Cholesterol, blood pressure, smoking			55% men 68% women			"

Circulatory diseases are a good example for illustrating a number of problems attached to the criterion of preventability (table 3). The types of intervention are very heterogeneous. Among other factors, nutrition, exercise, stress management, smoking habits and alcohol consumption are being tackled. Also, different criteria are being looked at, for example a reduction of incidence, mortality or risk. And finally, the conclusions refer both to groups of diseases as well as to individual diseases.

Table 4 gives an assessment of the criterion "preventability" for skin diseases. There exist a number of preventative measures or programmes for tackling this health issue, among them information material, posters, DVDs, check lists, pamphlets, a specific risk assessment, skin protection plans, skin protection campaigns, seminars, counselling procedures, assessments and the use of protective gloves. Table 4 shows various studies in which, helped by professional participants, prevention programmes were carried out for occupational groups at risk of contracting skin disease. The table also shows which effects could be achieved by this.

Table 4: Changes achieved in skin diseases through prevention measures

Occupational group	Disease	Professional participants	Programme	Effect	Source
Baking, hotel and catering trade	Skin disease	Institutions for Statutory Accident Insurance and Prevention; Clinic for Dermatology and Dermatological Allergies, Friedrich Schiller University, Jena; Centre for Occupational Prevention at the Research Institution for Applied System Safety and Occupational Medicine (FSA mbH), Erfurt	Interdisciplinary prevention programme on skin for the baking, hotel and catering trade in Thuringia and Saxony (detailed exposure analysis, occupational dermatological examination, individual skin protection, cleansing and care programme, practical exercises in skin protection for a maximum of two years, skin protection seminars and follow-up examinations)	Superiority of the programme when used for repeated i.e. long-term support and intensive training 79% success rate in intervention group vs. 36% in control group	Stadeler, Kelterer & Bauer, 2003
Hairdresser apprentices	Work-related hand eczema	No details	Teaching programmes, health education for patients, advice given to businesses	Significant reduction of cases of disease when comparing intervention and control group Significant difference in rate of workers staying on in their occupation between intervention and control group (79.5% vs. 60%)	Wulforth & Schwanitz, 2003
Damp environment workers	–	No details	Evidence based skin protection programmes (five months) as part of a safety at work management system (incl. educational measures, information, skin protection plan)	Better information on skin protection, significant alteration in behaviour	Held, 2002
Nurses	Skin disease	No details	Educational programme and practical training	Significantly less use of disinfectant in intervention group, significantly less worsening of condition; dehydration of skin more severe in control group	Held, 2001
Metal processing	Skin disease	Factory department of health protection – exchange of data with company health insurance funds? (BKK) and institutions? for statutory accident insurance and prevention (BG)	Prevention measures	Fewer cases of moving workers to different workplace due to skin problems, reduction in the number of occupational diseases reported, reduction of working days lost to sickness through contact eczema	Nöring, 1995
Metal works	Skin disease	Southern German Metalworkers Institution for Statutory Accident Insurance and Prevention (BGMS, Mainz) / discussion group for occupational diseases; advisory doctor for skin problems; occupational disease and prevention service	Special "Skin Procedure"	More than 90 % of insureds with reduction of skin problems, reduction of costs, improvement by 4.500 employees	Adam & Rose, 2005
Hairdressing trade	Skin disease	Institution for Statutory Accident Insurance and Prevention in Health and Welfare Services (BGW, Hamburg)	Various activities (recommendations, procedures and products used at work, improved products, operating directives, skin protection plan, seminars)	~ 75% reduction of suspension advices of skin diseases, reduction of compensation paid, reduction of contributions for statutory accident insurance and prevention	Liese, 2004

In their exchanges, the experts have to come to a quantitative and qualitative assessment of preventability by taking into account the problems outlined above as well as the most recent research findings and their own professional knowledge. For diseases for which as yet there is no information on their preventability to be found in literature, reviews or similar material would have to be generated.

4.2.2 Work-relatedness

For the development of prevention aims for the work environment it is a good idea to include work-relatedness as a further criterion in the selection of diseases. This is based on the expectation that the more strongly the development of a disease is influenced by the work situation, the more successful prevention in the workplace can be.

The criterion “work-relatedness” needs only be taken into account for diseases prioritised according to ICD-10 since in the case of occupational diseases it has already been established. An occupational disease is only confirmed if and when it has been caused to a considerable degree by the activity carried out at work.

There is no unanimous definition of the concept of “work-relatedness” of diseases over and above that of occupational diseases (Batawi, 1984). However, there is growing consensus on taking on board disease-exposure relationships beyond the strict requirements to show causal relationships as contained in the German occupational diseases legal provisions. Heuchert, Horst and Kuhn in 2001 give the following definition, “Work-related diseases are health disorders which are wholly or partially caused by conditions at work or whose development can be influenced unfavourably by these conditions.” According to this concept “work-relatedness” relates not only to specific diseases. In principle *all* diseases can be partly caused by conditions at work. This concept of work-related diseases has already formed the basis of the German safety-at-work legislation. It can also be found in health monitoring for the work environment (WHO, 2002, cf. Kreis & Bödeker, 2004).

On the basis of this concept of work-relatedness, the following steps are taken to quantify the degree to which a disease is work-related:

1. calculation of attributable risks
2. interviews with experts for safety at work and with employees

Attributable risks for stresses in the work environment

The portion of a disease that is caused by particular factors can be calculated by using a parameter well established in epidemiology, namely “attributable risk”. An attributable risk, when applied to the work environment, shows what proportion of a disease could be prevented if, for example, a stress factor in the work environment were to be removed or reduced by preventative measures. When calculating an attributable risk it is necessary first to work out how strongly the occurrence of a stress factor and the disease are associated. This is called “relative risk”. Provided that it is also known what proportion of the working population is subjected to the stress factor (“prevalence”), the size of the attributable risk can be worked out by a mathematical calculation involving the two figures.

From the calculation basis for attributable risks outlined above it may already be gathered that in the existing literature a whole range of different figures has been published since attributable risks are always calculated for concrete disease-exposure constellations. There are, however, also risks associated with the factor “work” in general although the work environment was operationalised in different ways. Table 5 is an example of a compilation of various work-related disease rates. It shows a spread between 2% for leukaemia and 40% for coxarthrosis. The variability shows itself both in regard to the diseases in question and the risk factors.

Table 5: Example compilation of attributable risks for stress factors in the work environment.

Outcome	Factor	Attributable risks	Source
Lung cancer	Occupations with exposure to dangerous substances	22-35	Gail & Benichou
Lung cancer	Dangerous substances	10	WHO, 2004
Leukaemia	Dangerous substances	2,4	WHO, 2004
Coxarthrosis	“Physical work load”	40	WHO, 2004
Multiple sclerosis	Solvents	10	WHO, 2004
Myocardial infarction	Job strain	7-13	Theorell, 1999
Asthma	Dangerous substances	5-18	WHO, 2004
Asthma	“occupation”	26-27	Arif et al, 2003
Back pain	“occupational risk factors”	37	Arif et al, 2003
Hearing loss	Noise at work	16	Arif et al, 2003
DALYs (Disability Adjusted Life Years)	Occupation	3-5	Murray & Lopez

Table 6, dealing with mortality, is an example of attributable risks that have been formulated for the work environment in general. According to this, 7% of mortality is attributable to “work”. The highest work-related portion at 24% is reported for lung cancer.

Table 6: Mortality risks attributable to “work environment”

Mortality	Attributable risk in %
Work-related mortality	7
Circulatory diseases	12
Malignant neoplasms	8
Respiratory diseases	4
Psychiatric disorders	4
Diseases of the nervous system	3
Accidents	3
Lung cancer	24
Ischemic heart diseases	17
Chronic obstructive lung diseases	12
Stroke	11

Source: Nurminen & Karjalainen, 2001

The comparability of attributable risk statistics to be found in literature is made more difficult by the fact that to a certain extent there are no exact names for diseases. In contrast, there are systematic data for the so-called ICD chapters such as those furnished by the already classic study of the Nordic Council (Hansen, 1993) and by a more recent study by the BKK Team for Health (Bödeker et al, 2002). The results juxtaposed in figure 3 show that the results for the majority of groups of diseases agree well although the studies looked at different outcomes.

Work-related portion of given diseases

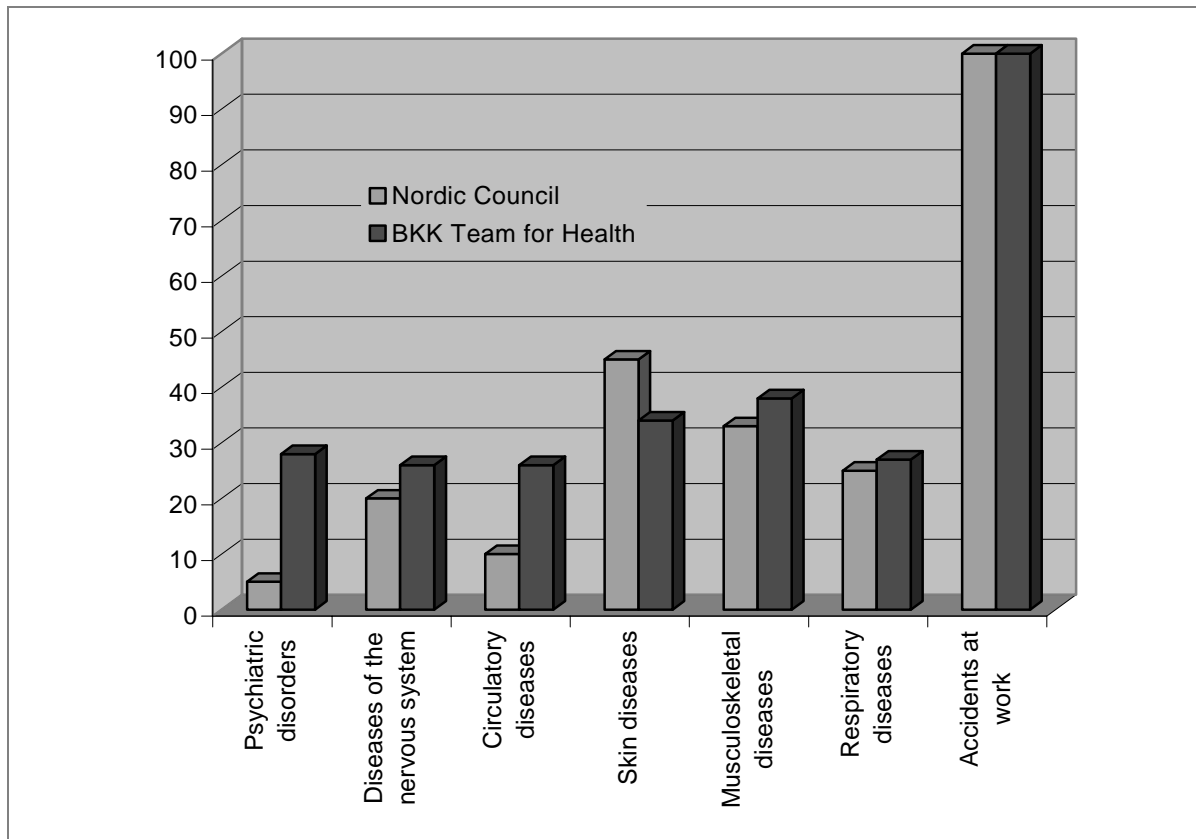


Fig. 3: Estimates of work-related morbidity for given diseases in two studies

Interviews with experts for safety at work and with employees

Another possibility for quantifying work-related morbidity is to conduct interview with employees and experts for safety at work for which by now a number of national and international survey results are available. By way of example, table 7 shows the results for the German population of the European Survey on Working Conditions 2000. The interviewees reported the highest work-related portion (35%) for back problems. This shows a high level of agreement with the attributable risks mentioned above. In the opinion of experts for safety at work, the assessment of work-related portions for stress and exhaustion could well turn out to be higher. For example, Paridon et al in 2004 report expert assessments which attribute 39% of psychological strains to the work environment.

Table 7: Employees' estimates of the work-relatedness of diseases

Complaints	Work-relatedness in %
Back	35
Exhaustion	16
Stress	25
Headache	13
Lower limbs	7
Upper limbs	9
Neck and shoulders	32

Source: Accident Prevention Report 2002

Conclusion

For the development of work environment related prevention aims and objectives the criterion “work-relatedness” can be drawn upon for the further prioritisation of diseases since by these means specific areas for the realisation of prevention potential can be identified. Figures on the extent to which mortality and morbidity are work-related have been published and can now be collated in a systematic manner. However, often the work-related portions have only been calculated for specific disease-exposure constellations making it hard to arrive at a consistent representation.

4.2.3 Operability

The criterion “operability” addresses the question in how far effective prevention programmes are not only theoretically possible but can also be put into practical operation and on top of this meet with acceptance. Thus the criterion “operability” looks at the actors, the contribution by the people for whom the intervention is carried out, the cost-effectiveness, the amount of time spent and the approaches of prevention for the chosen area of attack. The following questions have to be addressed when preparing the expert exchanges (table 8).

Table 8: Questions and starting points for “operability”

<i>Professional participants</i>	Are there qualified actors available to initiate and, if need be, carry out the prevention programme? If applicable, what supplementary training has to be undertaken?
<i>People concerned</i>	Can those affected (employees and employers) actively contribute to the programme’s implementation?
<i>Ways of and scope for financing</i>	Who can be brought to contribute to the financing of a prevention programme, what preconditions must be fulfilled for the
<i>Time resources</i>	How quickly can a prevention programme be carried out?
<i>Approaches</i>	How easy is it to win over those concerned?

Looking again at the example of skin diseases, one can already glean from table 4 some information on professional participants, people concerned (in this instance: various occupational groups), time resources and approaches. There are some prevention programmes for which not all information is available. The programmes were financed by institutions for statutory accident insurance and prevention, statutory health insurance funds and companies.

The example of heart and circulatory diseases, too, shows how the operability of prevention programmes is an important criterion for the development of prevention aims and objectives. Especially the German Heart and Circulation Prevention Study (Kreuter et al, 1995) has provided ample experience on all aspects contained in the table above.

5 Developing Aims and Objectives in Health Promotion

For the area of primary prevention, aims and objectives can be derived empirically with the help of prioritisation processes. In contrast, because of the different approaches it does not seem sensible to undertake a similar derivation for the area of health promotion, too (Brößkamp-Stone, 2003). According to scientific definition primary prevention includes all specific activities for the avoidance of exogenous damage as well as the prevention or reduction of personal risk with the aim of lowering the incidence for a disease in a given population (Walter & Schwartz, 2003). Health promotion, though, aims at a “process of enabling people to increase control over, and to improve, their health” (Ottawa Charter for Health Promotion, 1986). Against this background it makes sense to formulate aims and objectives for health promotion complementary to those for primary prevention, too. While empirical data, e.g. on morbidity, are always central to the derivation of objectives for primary prevention within the prioritisation process, the objectives for health promotion are formulated rather in a conceptual than in an empirical way.

Therefore we propose, with reference to the pillars of health promotion – the Ottawa Charter and the salutogenic approach – to define the following aims:

1. to enable individuals or groups of people to increase control over their health and
2. to utilise fully the salutogenic potential of the work environment.

In the spirit of the Ottawa Charter three strategies for reaching these aims can be applied: a) advocate, b) enable, c) mediate.

The aims and strategies mentioned above do not run parallel to but rather complement the aims and objectives of primary prevention (see fig. 4).

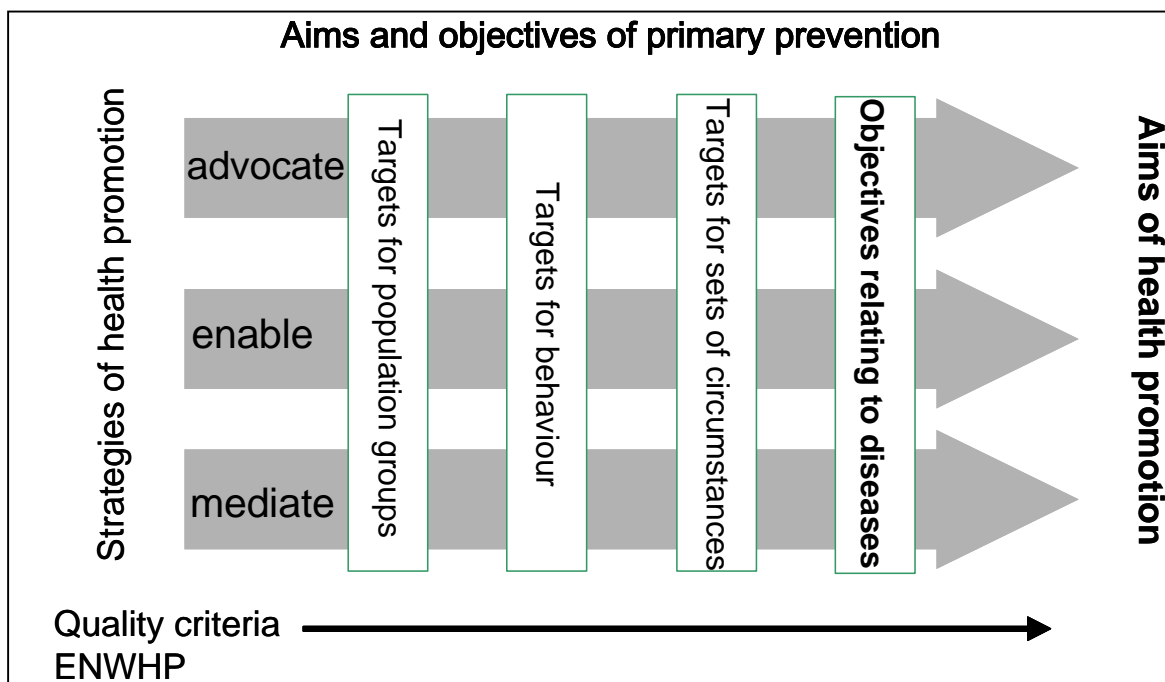


Fig. 4: Relationship between objectives of primary prevention and objectives of health promotion

This process does not result in cells such as in the case of a matrix. Rather the strategies of health promotion should permeate all aims and objectives of primary prevention. This means that the following strategies are being pursued at the same time:

- a) by championing the aims and objectives of primary prevention to exert a positive influence on the political, economic, social, cultural, biological, environmental and behaviour factors affecting health and to render them conducive towards health;
- b) to create the right conditions enabling people to realise to the fullest extent their health potential (this encompasses safety and security, being at home in a supportive social environment, access to all relevant information, the development of practical abilities as well as the chance to make decisions regarding one's personal health and
- c) a co-ordinated effort of all responsible parties in government, health, welfare, the economy, in non-state and self-administered associations and initiatives as well as in local institutions, in industry and in the media (cf. WHO, 1986).

Criteria for the implementation of strategies in health promotion in the work environment have already been formulated by the European Network for Workplace Health Promotion (ENWHP, 1998). These 27 quality criteria describe the activities in the context of a comprehensive occupational health management which a company has to demonstrate in order to be labelled "health promoting". There is a broad consensus among statutory health insurance funds in Germany on these criteria. This is evident through the fact that these criteria have been made part of their common guide on the implementation of chapter 20 of the Social Insurance Code

Section V (Common Working Group of the Federal Associations of Statutory Health Insurance Funds, 2003).

On this basis the umbrella institutions of the German social insurance system have devised the following targets:-

1. to promote and to disseminate the concept of workplace health management and
2. in the context of their consultancy work and support activities to see to it that the measures of occupational health management adhere to the quality criteria outlined above.

The above targets, too, can be quantified. The terminology for aims, objectives and targets is the same as that for primary prevention as described on page xx.

The aims and objectives of health promotion pose demands which are for individual businesses to strive to fulfil. In this the businesses are supported by the statutory funds for accident and health insurance. The ENWHP criteria constitute a model which can be adapted to different sets of circumstances such as the size of the business or the sector of industry.

6 How to Go on from Here

The aim of the IGA project was to develop an approach for identifying aims and objectives for health prevention in the work environment, but not yet for deriving and selecting the resultant prevention aims. As a next step, the approach that has been developed is to be discussed with the associations of the statutory accident and health insurance funds and with other experts. Once the two branches of the social system (accident and health insurance funds) have agreed on which approach to use, the first process for developing aims and objectives will be started. The Initiative Gesundheit und Arbeit (Initiative for Health and Work) offers its assistance in this process by undertaking a special project. The task of agreeing and deciding on which are the most important prevention aims and objectives for the work environment lies with the responsible bodies of the statutory accident and health insurance funds. The prevention aims and objectives that have been decided upon should be made part of the guidelines for the collaboration between the institutions for statutory accident insurance and prevention and the statutory health insurance funds on the prevention of work-related health risks. They should also enter into the outline agreement of the federal organisations of the statutory health insurance funds and those of the statutory accident insurance funds for their collaboration in the prevention of work-related health risks.

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