HEALTH AND SAFETY AUTHORITY

Workplace Health and Well-Being Strategy
Report of Expert Group

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Vision:

A working-age population which values work for its contribution to health and well-being.

A workplace environment and culture which values employee health for its contribution to work.

Published in May 2008 by the Health and Safety Authority, The Metropolitan Building, James Joyce Street, Dublin 1.

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Foreword

The objective of this national Strategy is to raise awareness of the importance of the health and well-being of our working age population and to recommend actions that will improve worker health. The strategy has been developed by an expert group at the invitation of the Health and Safety Authority. The group's approach has been to target long-term benefits right across the spectrum of the Irish labour force by addressing workplace health and well-being in a holistic and proactive manner.

The health and well-being of Irish workers is an important aspect of the remit of the Health and Safety Authority. We are charged with promoting, encouraging and fostering these elements along with preventing accidents. The vast majority of workplaces and workers in Ireland have a general awareness of the importance of safety and the need to prevent accidents at work. Far fewer, however, are aware of the impact of work on health, both positive and negative, and the consequences and benefits that ensue from managing this interaction. The Strategy addresses this lack of awareness and identifies measures which can improve the health and well-being of people of working age through a combination of prevention, promotion and rehabilitation. The workplace is a very important setting for addressing health and well-being at a national and individual level; equally the workplace has much to gain from improved worker health.

The Strategy is supported by recommendations as to how implementation should be progressed. The Health and Safety Authority has an important role in ensuring the particular actions for which it is responsible are successfully completed. The Authority has identified those goals which it will pursue in order to achieve the aims of the Strategy. These are published alongside this report. Other organisations will lead in areas appropriate to their remit. A co-ordinating structure is needed to implement actions, thus moving implementation of the Strategy ahead as an integrated whole.

We believe implementation of this Strategy can improve the health and well-being of our workforce in general and of each individual of working age in particular.

Mary Dorgan
Health and Safety Authority
Chairperson of Expert Group

Executive Summary

1. Health and Work – Setting the Scene

Work can have a positive impact on the health of both the individual in particular and society in general.

At an individual level, it gives a sense of purpose and self-worth, which leads to greater self-esteem. Work is essential to the well-being of the individual and his/her dependents as it enables him/her to meet their many needs, including financial and psychosocial. It provides the means by which the individual can contribute to society and participate in it in a meaningful way.

At a societal level, the more people in employment the better the economic health of the country. This in turn creates an environment and culture that promotes better health – physical, emotional and mental – at an individual level and at a societal level.

While acknowledging the benefits of work, it is equally important to recognise and acknowledge the impact of the working environment on the health and well-being of the individual and the population in general. This impact can be positive when it successfully supports and meets the needs of the individual. However, this impact can also be negative when the workplace is the primary or a contributory cause of ill heath. The challenge, at an individual, enterprise and societal level, is to change the negative impact to a positive one by supporting a healthy workplace.

The primary objective of the national strategy for workplace health and well-being (the Strategy) is to create a workplace culture and environment that will promote health and well-being, prevent ill health and support the rehabilitation to the workplace of those who are out of work through ill health or disability. This will be achieved through the implementation of a set of separate but complementary and pragmatic recommendations that will address the current issues and shortcomings in relation to health and well-being in Irish workplaces. It will be useful if the implementation programme classifies the recommendations as short-, medium- and long-term, especially in relation to the investment required by them.

2. The Changing Workplace and Workforce

The Irish workplace is composed of enterprises that can be broadly classified into two main categories: public sector and private sector. In the case of the latter, the enterprises are of varying sizes, ranging from large multi-nationals through to medium to small and micro enterprises. The small and micro categories account for almost 97% of businesses in Ireland, employing in the region of 840,000 workers. The remaining 1.2m people are employed in a wide range of public sector enterprises and in medium to large sized enterprises in the private sector.

The size and composition of the Irish workforce is undergoing significant change. At present there are in excess of 2m people in employment, with males making up 58% of the workforce and females 42%. The future trend is for an increasing number of females to enter into or return to the workforce. In addition to the gradual change in gender balance, there is also a change in the age profile of the workforce

with an increasing number of older people, particularly women, returning to work. Another notable change in composition is the ever increasing number of non-Irish nationals joining the workforce. Currently they make up in the order of 10% of the total number in employment.

This diversity of composition of the Irish workplace and the Irish workforce, while one of its great strengths, presents particular challenges in creating a culture of health and well-being. To be successful, this Strategy must support the creation of a culture of health and well-being in enterprises of all sizes, both private and public, and support the particular needs of the various groups of workers.

In this regard, particular attention must be paid to the small and micro businesses. Some of these enterprises have successfully responded to the challenge of creating a healthy working environment and promoting the well-being of employees. However, the majority of these enterprises do not have the resources required to address the requirements of employee health and well-being. In addition, the strategies and actions appropriate to large and medium sized enterprises may not be appropriate to small and micro enterprises. This Strategy must take account of the particular challenges facing the small and micro enterprises.

3. The Case for Action

In addition to the positive benefits of a healthy workforce and a healthy workplace, there are compelling reasons for this Strategy and there are clear benefits to be realised by its implementation. These can be summarised as follows:

Cost: The costs of ill health impact at three levels: individuals, enterprises and society. Research would suggest that these costs could be in the order of €3.6 billion annually. In particular, the costs to the state in terms of major benefit payments, some of which are fully or partially related to accidents or illness, are in the order of €2 billion and increasing.

The implementation of this Strategy will reduce this ever increasing cost.

Ageing workforce: The age profile of the Irish population is changing with a gradual increase in the number of people over 65. At present over 65 year olds account for 11% of the population, a figure that will rise to 20% by 2036. This has a wider implication in that there are at present six persons economically active (age group 15–64) to one person over 65. By 2030 this ratio will be 3.5 to 1. This change in age-dependency ratio will present significant challenges. It is imperative that we proactively address this situation, while we have the time and the opportunity. Our objective must be to maintain and improve the working health and safety of our workforce so as to enable those up to 65 years of age to work healthily and those over 65 to continue to work, health permitting, if they so desire. This is consistent with objectives of the Lisbon Agenda and the 2006 National Partnership Agreement, 'Towards 2016'.

The implementation of this Strategy will improve the overall health of the nation, empower individuals to continue working – if they wish, beyond the current retirement age – and ensure that we have a workforce to support our economic growth.

Absenteeism: This is a significant issue in the Irish workplace, with approximately 14m workdays per annum lost at a cost of in the order of €1.5 billion. The costs to both employers and employees are not purely financial as absenteeism impacts negatively on quality, production and customer service, while also placing additional demands on employees who must cope in the absence of their colleagues.

The implementation of this Strategy will reduce the instances of ill health, which are a major cause of absenteeism and should generate significant savings for all concerned.

Challenge of small and micro enterprises: The level and quality of the health services provided in the workplace can vary considerably, depending on the sector and the size of the enterprise. Generally, larger enterprises are better positioned and resourced to provide a comprehensive range of health and well-being related services to their employees. It should be noted that some small and micro enterprises have successfully addressed this issue. However, there are significant inequalities in the current situation as access to these services is not evenly balanced.

The implementation of this Strategy will address the issue of unequal access and so improve the overall health of the workforce.

Case for action – key recommendations

The following recommendations address the specific issues identified in formulating the Case for Action.

Recommendation 1

Develop a service-delivery model that will support small and micro enterprises in implementing workplace ill-health prevention, health promotion and rehabilitation programmes. The UK's Workplace Health Connect support service and the Construction Workers Health Trust (CWHT), which provides health assessment and screening, could provide models for such support.

Recommendation 2

Conduct research to understand the reasons for early exit from the labour force, including the findings from the Irish Longitudinal Study on Ageing, and ensure follow through is implemented as appropriate.

Recommendation 3

Establish structures and supports that facilitate people to stay in the workforce beyond the normal retirement age where appropriate. However, this must take account of existing policies in both the public and private sector, which facilitate people retiring at 65 years of age.

Recommendation 4

Extend the National Employment Action Plan to unemployed people aged 55–64.

4. Core Dimensions of Workplace Health and Well-Being

Workplace health and well-being is most effectively achieved through a combination of policies and programmes that address a range of factors, including the general principles of prevention, hazard identification, risk assessment and health surveillance. Effective workplace health promotion requires a demonstration of leadership and commitment along with policies and procedures on recruitment,

development, training, human resource management, consultation, communication and rehabilitation that shift the emphasis from a healthy workplace to a healthy organisation.

Workplace health and well-being can be achieved through a combination of prevention, promotion and rehabilitation interventions. These separate but complementary intervention categories must be intelligence led, and consequently this is a fourth important dimension. Taken together these four dimensions constitute a working model that can be used to inform the delivery and deployment of the Strategy.

Prevention

The focus of prevention is on identifying and assessing the risks to employees and implementing mitigating actions to reduce or eliminate these risks (e.g. health surveillance, ergonomic design). The Safety, Health and Welfare at Work Act 2005, together with a wide range of supporting legislation, both primary and secondary, provides a regulatory framework for health and safety in the workplace. In general, safety issues, which impact more immediately, are more actively managed than health issues, which are not given the same level of attention.

The level of compliance with existing legislation varies considerably for a variety of reasons – most often the level and complexity of legislation. Enterprises – and especially the small/micro category – are unsure or unaware of their duties and responsibilities. Compliance with existing legislation will have a beneficial impact on the health and well-being of employees in enterprises of all sizes.

Prevention – key recommendations

Recommendation 5

Undertake an awareness campaign for both employers and employees on the role and responsibilities of each in relation to workplace health.

Recommendation 6

Place a greater emphasis on the preventative aspects of workers' ill health, including the provision of health surveillance and ergonomics.

Recommendation 7

Compile a guide for employers on their responsibilities in workplace health.

Recommendation 8

Provide for appropriate infrastructure that will monitor and enforce compliance with workplace health legislation.

Promotion

The concept and practice of workplace health promotion has evolved over the years to the point where it is holistically defined as the combined efforts of employers, employees and society to improve the health and well-being of people at work. A large number of organisations, both voluntary and statutory, have been

actively involved in health promotion, generally operating independently. There are some good examples of collaborative actions with evidence of potential for expansion and greater success in the workplace.

There is clear evidence that the promotion of health in the workplace is effective. In addition to the beneficial impact on the health of individual employees, organisations that have implemented health promotion programmes gain other related benefits, including increased productivity, improved morale, more motivated employees, improved company profile and enhanced ability to attract employees.

In the Irish context there have been a number of national initiatives to address health promotion in the workplace, the most recent of which was The National Health Promotion Strategy (2000) and the subsequent review of 2004. A number of key objectives from the original strategy were explored during this review. This included the need for the various stakeholders to work in partnership to support the implementation and evaluation of current health promotion programmes.

Promotion – key recommendations

Recommendation 9

Find ways for different government departments, agencies and non government organisations to work more in partnership on workplace health promotion at both a national and regional level.

Recommendation 10

Develop a structure that assists and supports organisations in bringing together health promotion initiatives in an integrated model with national agreed objectives.

Recommendation 11

Adopt a more targeted and gender-specific approach to the development of health promotion initiatives in the workplace.

Rehabilitation

The successful rehabilitation of individuals of working age back into employment requires the combined efforts of a number of stakeholders, including the employees themselves, employers, the state and the insurance and medical sectors. The objective of rehabilitation is to restore a person who has been injured or ill to as productive and independent a lifestyle as possible through the deployment of a combination of medical, functional and vocational interventions. The Renaissance Project is an example of a successful programme that facilitated an early return to work of people with back pain.

There are a variety of rehabilitative services in place that address a number of factors, including vocational interventions, financial support programmes and subsidies for the adaptation of the workplace. However, there is undoubtedly scope for improvement and integration of these services. The existing adversarial, legal and insurance systems in place together with the existing social insurance system all combine to militate against the effective positive rehabilitation of the individual. Greater clarity is required on the need, scope and potential for the state, employers, and the medical and insurance professions to work together in support of the rehabilitation process.

The most important element of successful rehabilitation is the successful reintegration of the individual, in so far as possible, back into the workplace. Reintegration strategies require a range of activities, including early intervention and mediation, advocacy, case management, workplace rehabilitation and work adaptations. The relationship between the employer and the employee is one of the main factors influencing the success of these integration strategies.

There is evidence of reluctance on the part of some employers to employ individuals with disabilities mainly because of concerns regarding health and safety, and insurance. The National Disability Strategy makes a number of recommendations in relation to the participation of people with disabilities in developing a comprehensive employment strategy. It emphasises the role that back to work strategies can play in the reintegration and rehabilitation of those suffering from illness and disability.

Rehabilitation – key recommendations

Recommendation 12

Review the scope of the recent Renaissance Project with the aim of extension across other health areas.

Recommendation 13

Develop/devise infrastructures that support and encourage people to return to work, by adopting a multidisciplinary approach, incorporating services such as physiotherapy, occupational therapy etc.

Recommendation 14

Extend the National Employment Action Plan to include disability claimants. This involves modifying the social welfare system to encourage people with illnesses or disabilities to return to employment or undertake education or training.

Recommendation 15

Ensure that all workers in Ireland have access to competent occupational health advice.

Recommendation 16

Develop a model which links primary care to occupational health services.

Recommendation 17

Embark on a collaborative initiative with GPs which builds on the positive aspects of early return to work and the consequent need to modify the management and certification of sickness absence.

Recommendation 18

Develop health and safety guidelines to encourage employers to employ people with disabilities.

Recommendation 19

Develop guidelines to promote safe workplaces and practices in places which employ people with disabilities.

Intelligence

The three main categories of intervention outlined above – prevention, promotion and rehabilitation – must be evidence based and intelligence led. This requires a combination of activities, including the collection of key data at source for each intervention and the undertaking of research on workplace health and well-being. At present there is a clear deficit in both aspects, which must be addressed. To address this effectively a comprehensive data-set with key performance indicators must be defined.

Intelligence – key recommendations

Recommendation 20

Conduct an evaluation of international illness-reporting systems. Identify from best practices, the system which will best meet the needs of the Irish context and apply this with appropriate infrastructure, supports and validation measures.

Recommendation 21

Support and extend The Health and Occupational Reporting Network (THOR) pilot reporting of work-related illness and disease by doctors. Ensure early evaluation and decision on pilot outcome.

Recommendation 22

Implement a system for the recording of occupational illness and disease in line with any future EU requirements to collect such data.

Recommendation 23

Develop health intelligence systems to monitor more closely the health of marginalised groups such as the long-term unemployed, those engaged in transient work and non-voluntary early retirees.

Recommendation 24

Embark on a long term commitment to relevant research and surveys to estimate the cause and extent of health problems in the Irish workforce and contribute to solutions.

5. Key Workplace Health Issues

There are a number of particular illness types that significantly impact individuals in the workplace. These illness types, while not particular to Ireland, must be proactively addressed if the overall health and well-being of the working-age population is to be improved.

Musculoskeletal issues and ergonomics

At present musculoskeletal disorders (MSDs) are the primary cause of ill health in the workplace, with poor manual handling, poor workplace design and poor engineering controls being three of the main reasons for these disorders.

Musculoskeletal issues and ergonomics – key recommendations

Recommendation 25 – Musculoskeletal Issues and Ergonomics

- Promote the benefits of risk assessment in reducing upper limb and manual handling injuries.
- Support the development and implementation of training standards for manual handling.
- Promote the benefits of ergonomically designed workplaces for the health and productivity of the employee, especially when applied at the design stage of new work systems when changes are more easily applied.
- Promote the benefits of ergonomically correct workplace set-up in relation to display-screen equipment for the health and productivity of the employee.
- Increase the level of enforcement of manual handling regulations.

Mental health issues

These types of issues, which include anxiety, depression, major mood disorders, stress, illness resulting from workplace bullying and the psychological aspects of violence, are assuming much greater importance in the workplace. Stress is now the second highest reported work-related health issue in the EU-15 Member States. At any one time there are many thousands of workers in Ireland either out of work or underperforming at work with some form of mental health disorder.

Mental health – key recommendations

Recommendation 26 – Mental Health Issues

- Prepare a Guidance or Code of Practice on managing stress in small and micro enterprises.
- Implement the recommendations of the 2005 Report of the Expert Group on Workplace Bullying.
- Promote awareness among employees and employers of the Health and Safety Authority's revised Code of Practice on the Prevention and Resolution of Bullying at Work.
- Support employers with initiatives that enable a more proactive role in minimising the risk of violence and ensuring a strong message of intolerance of violent behaviour against workers.
- Support initiatives aimed at the reduction of the stigma associated with mental illness.
- Support the development and implementation of psychosocial evaluation techniques with guidance on their application and interpretation.

Other key workplace health issues

There are a number of other key workplace health issues that can be addressed with the following recommendations:

Noise and vibration – key recommendations

Recommendation 27 – Noise and Vibration

- Promote the benefits of risk assessment in relation to noise and vibration.
- Promote the benefits of effective design to minimise noise and vibration in the workplace.
- Implement an awareness campaign for most relevant sectors in relation to their responsibilities for noise and vibration reduction.
- Promote the provision by employers of health surveillance as a prevention measure at pre-employment and during employment in relation to noise and vibration.
- Initiate research on the relationship between vibration and carpal tunnel syndrome.

Dermatitis, asthma, cancer, biological agents – key recommendations

Recommendation 28 – Dermatitis, Asthma, Cancer, Biological Agents

- Promote awareness amongst employers and employees on the merits of reading chemical safety data sheets and labels as a precautionary measure in the prevention of dermatitis and asthma.
- Promote the value of risk assessment within specific sectors where these diseases are prevalent.
- Ensure relevant employers are compliant with the chemical and biological agent's regulations, part of which includes health surveillance and availability of vaccines.
- Develop a national awareness campaign directed at high-risk sectors, such as construction, of the risks of skin cancer and the measures that should be taken to prevent it.

6. Progressing Implementation – Next Steps

The Strategy sets out a wide range of recommendations of varying degrees of complexity. Some can be implemented in the short to medium term while others will require a significantly longer period to implement. The level of funding and the other resources required for implementation will also vary accordingly. Most particularly, it is clear that full implementation will require the combined efforts of a range of organisations – the social partners, relevant government departments and agencies, and voluntary bodies.

The implementation of this Strategy will be challenging. However, the benefits at an individual and a

national level are clear and achievable. What is required are the resources and structures and the combined efforts of all the key organisations to ensure that the challenge is successfully met and the benefits fully realised.

The case for investing in the health and well-being of Ireland's working-age population has already been well made as have the beneficial returns on this investment. The benefits for Ireland and in particular for its working-age population are very evident. What is now required is the investment, resources and efforts of various organisations and agencies to go about the work of improving the health and well-being of Ireland's working-age population.

The Authority has produced an Action Plan indicating the appropriate government department or agency to implement the recommendations and likely completion dates. The Authority is the lead organisation for many of the recommendations and will work with others to ensure implementation of the remaining recommendations.

1. Introduction – The Changing Nature of the Irish Workplace

Ireland continues to undergo rapid social, demographic and economic change. The current population stands at 4.23m. This number is ever increasing and it is predicted to reach 5m by 2015. There is now almost full employment, with a workforce of just over 2m contributing to our social and economic wealth. However, as the number of people claiming unemployment benefit decreases, there is an increasing number of people claiming disability benefits. The needs of all employers and employees of working age, including those at work with full or reduced health and those out of work with full or reduced health, must be addressed.

The nature and composition of our work force is also undergoing significant change as evidenced by the following:

- The increasing number of women in the workplace;
- The greater role and contribution of migrants, who make up 10% of the working population;
- Our ageing workforce, which will see a significant change in the ratio of persons over 65 years to working persons aged 15–64;
- The shift in Ireland's employment landscape from larger to small and micro sized enterprises;
- The move away from the traditional high-employment sectors of agriculture and manufacturing towards construction and services.

The work environment is also changing. There is a drive for more productivity, the pace of work is increasing and deadlines are getting shorter. People are working harder and for longer hours, with implications for both physical and mental health. While traditional physical hazards still dominate in high risk sectors such as construction, psychosocial risks have assumed greater importance in the public and white collar sectors. Placing too much emphasis on results can have harmful impacts on health. The old adage 'your health is your wealth' holds true both for individuals and society.

In summary, the world of work is changing. The work ability of our working- age population must not only be maintained but also improved. Serious consideration must be given to managing their health and well-being. Presently this is not the case as there is a fragmented and piecemeal approach to managing and supporting workplace health and well-being across government departments, agencies and voluntary organisations. The result is increasingly high levels of illness and absence in workplaces with all their associated costs.

The most effective way to address this issue in this ever evolving and dynamic environment is to put in place a national workplace health and well-being strategy (the Strategy). This Strategy will ensure that there is a holistic approach to workplace health and well-being that builds upon and links together the policies and strategies of all stakeholders so as to achieve the common objective of improved health and well-being.
The Strategy is based on the following vision, which acknowledges the positive contribution of work to the health and well-being of each individual:

Vision:

A working-age population which values work for its contribution to health and well-being
A workplace environment and culture which values employee health for its contribution to work

A number of key objectives have been identified to make this vision a reality:

- To promote and create awareness in employers and employees of the benefits of work and of a positive working environment on overall health and well-being;
- To reduce the prevalence and incidence of work-related illness and disease and improve the health and well-being of the working-age population;
- To put in place a series of separate but complementary recommendations designed to enhance the health and well-being of each individual of working age through promotion, prevention and rehabilitation;
- To define the information and data required for monitoring workplace health and well-being, including key indicators, collection methodologies, sources of data and research programmes.

A clear argument will be made for our need of a Strategy. It will become evident who the Strategy is aimed at, what the issues are that need to be addressed and how this will be done. The Strategy is also about making decisions on who and what will not be included as will become evident.

A comprehensive consultation process was undertaken to inform the Strategy. This involved interviews, focus groups and questionnaires (mailed and online) with a variety of stakeholders. A detailed review of the literature, both national and international, was carried out. In addition, other related health strategies, policies and initiatives were reviewed. The consultations, literature review and review of related strategies, policies and initiatives were taken into consideration when identifying the key issues that emerged during the course of preparing the Strategy. They were also considered when putting forward recommendations to address these issues and to improve the health and well-being of all individuals of working age.

Large employers are likely to have greater capacity to provide workplace health promotion activities and occupational health services to their employees than small and micro enterprises. As a result, employees in smaller workplaces may be more reliant on other primary care services. To help address this issue, this Strategy has specific recommendations for small and micro enterprises.

By embracing this Strategy, its vision and its objectives, the benefits for employees, employers and the state will become obvious. The implementation of this Strategy should be seen as an investment in the future of Ireland's workforce.

2. Why We Need a Strategy – The Case for Action

2.1 Introduction

The adoption and implementation of this Strategy will have a positive impact on the world of work in Ireland at an individual, enterprise and societal level. This chapter sets out a strong and compelling case for the Strategy under the following key headings:

- The positive impact of work on health
- Inequalities
- Demographics
- The challenge of small and micro enterprises
- Ageing workforce
- Absenteeism
- Illness and disability
- Costs

2.2 The Positive Impact of Work on Health

Work can be a positive experience, beyond pure monetary gain, giving a sense of meaning and self-worth to the individual. An evidence-based research review (Waddell and Burton, 2006) proposes that work can be good for an individual's health and well-being for the following reasons:

- Work is an important means of obtaining economic resources, essential for the individual's material well-being and participation in society;
- Work has the ability to meet the individual's psychosocial needs;
- Work is viewed as essential to individual identity, social roles and status;
- Employment and socio-economic status can be seen as key contributors to physical and mental health and mortality.

Re-employment of individuals who have been ill and out of work can lead to increased self-esteem, an improvement in general and mental health, and reduced psychological distress. Work has a positive influence on those who are sick or disabled, particularly those suffering from common health problems. These individuals should be supported and encouraged to remain in or to re-enter the workplace as soon as their health permits as it has been shown that work:

- Can be therapeutic and aid in the recovery and rehabilitation process;
- Can minimise the negative physical, mental and social effects associated with long-term sickness absence;
- Can reduce the risk of long-term incapacity.

The adverse effects of not working such as poor physical and mental health can be offset by participation in the workplace, provided that the nature and quality of work does not compromise the individual's health and well-being.

2.3 Inequalities

Overall, the health of employed people is better than that of unemployed people (Mathers and Schofield, 1998). However, amongst those who are employed, the quality of the work environment, both physical and psychological, has important impacts on health. Some workers are more likely to be exposed to unhealthy workplaces, e.g. people in insecure jobs have a higher than normal exposure to both physical and psychosocial work hazards (EFILWC, 1998). Older workers and migrants are particularly vulnerable to the negative health impacts of job insecurity. Intimidation and discrimination in the workplace is also more likely to be experienced by people with disabilities, travellers and migrant workers.

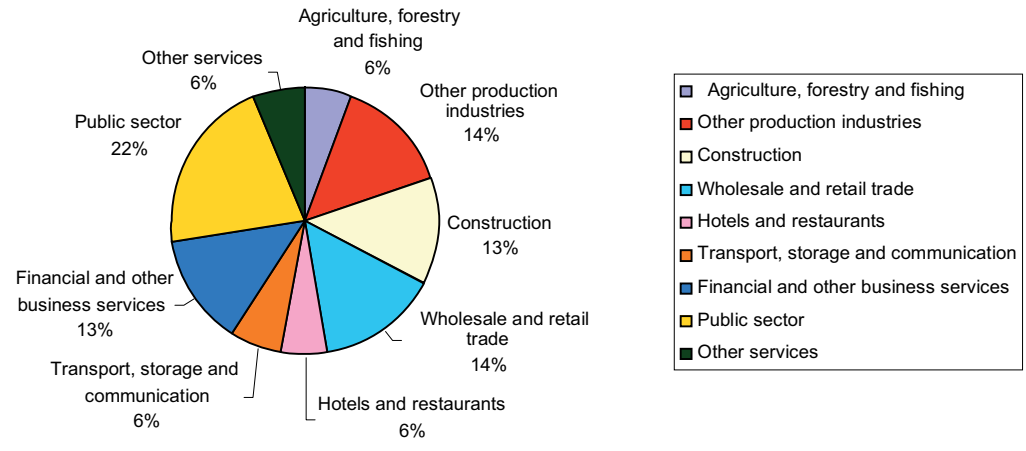
2.4 Demographics

The size and composition of our workforce is changing. The labour force currently stands at just over 2m. Males make up 58% of those in employment with females the remaining 42%. There are increasing levels of women in full- time employment and of married women entering the workforce. Females are mainly employed in the health, retail and financial services sectors, while men dominate in construction, manufacturing and agriculture sectors.

Traditional industries such as agriculture (6% of total employment) are in decline (see Figure 2.1), while there has been an increase in the public sector (22%), financial and business services (13%) and construction (13%). The economy is heavily reliant on the construction industry at present, with an increase of 92% in employment in this sector since 1998.

A sizeable portion (42%) or 840,000 of Irish workers are employed in micro (1 to 9 employees) and small (10 to 49 employees) enterprises. Out of 233,000 businesses in Ireland, 226,000 (97%) are either micro or small. Small enterprises do not have the same infrastructure as bigger companies. There is often a lack of both human and financial resources. Most small and micro businesses do not manage health and safety proactively and there may be no access to training, occupational health services or health and safety competence in the company.

Figure 2.1: Breakdown of employment by sector, 2006



Source: QNHS (2006)

Non-Irish nationals now make up 10% of the Irish workforce. For those who do not speak or understand English, communication can be an issue and may be a contributory cause to a recent number of fatal and non-fatal accidents (HSA, 2006). Likewise, in relation to workplace health and well-being issues there is growing evidence of bullying and neglect of health and safety by employers, especially towards people from the ten new EU accession states (Holmquist, 2006).

2.5 The Challenge of Small and Micro Enterprises

There are a large number of workers (840,000) working in small and micro enterprises. These small organisations, which include the self-employed, pose particular challenges in relation to the adoption of the workplace health and well-being model advocated in Chapter 3. Often these small enterprises do not have dedicated human resource or occupational health and safety personnel. In addition, many do not have the written policies and procedures that larger organisations possess. Therefore, what works for medium and large organisations does not necessarily work in small and micro enterprises. This must be borne in mind when coming up with realistic and workable recommendations. This means that whereas larger employers may be able to afford and manage particular health services, such services may have to be made available to smaller enterprises by others.

Finland is very similar to Ireland in terms of population and the large number of small and micro enterprises. However, unlike Ireland, Finland has a mandatory requirement on all employers to provide occupational health services to their employees. In the case of small employers, these are provided by community health clinics, with the employer paying part of the cost.

In Ireland, many of our bigger employers in both the public and private sectors provide a range of health and well-being related services, including access to occupational nurses and doctors, employee assistance programmes, work-life balance and health promotion activities free of charge to their employees. This

has the effect of preventing illness and promoting and improving health. Arguably, employees who do not have access to such services, particularly in high risk sectors, are at a distinct disadvantage and may suffer from health inequalities. There is a strong argument for making these types of services available to such employees to redress the inequality.

Issue 1

Many small and micro sized enterprises are at a distinct disadvantage in terms of resources and competence if called upon to support and implement programmes in relation to workplace health.

Issue 2

Many employees of small and micro enterprises do not have access to occupational health services.

Recommendation 1 – Small and Micro Enterprise Support

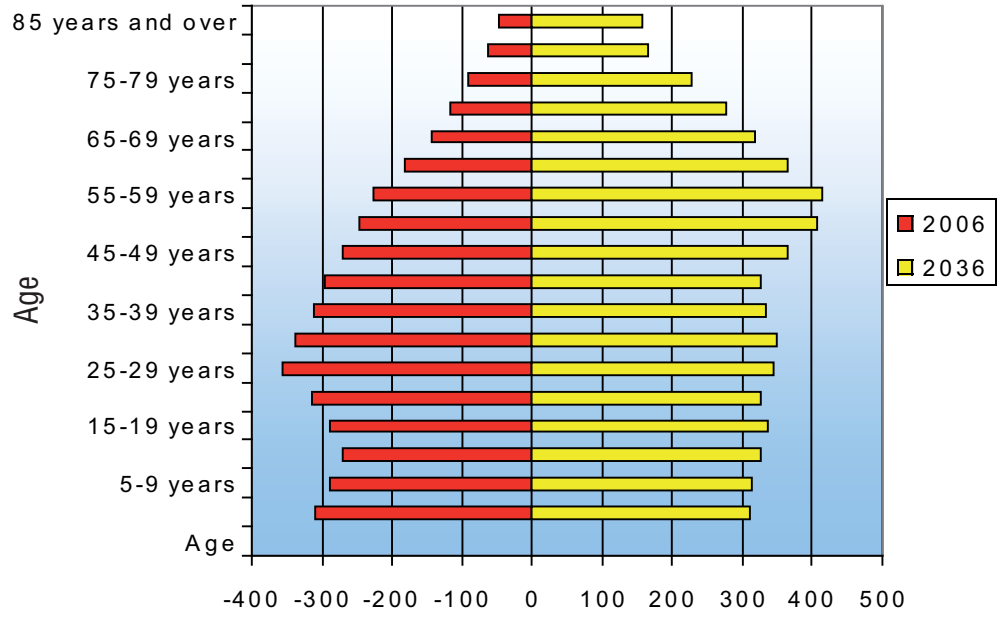
- Develop a service delivery model that will support small and micro enterprises in implementing workplace health prevention, promotion and rehabilitation programmes.
- Develop a support service such as the UK's Workplace Health Connect.
- Establish a structure that facilitates such support.

The model of the Construction Workers Health Trust (CWHT), which provides health assessment and screening, merits extension within the construction and other sectors.

2.6 The Ageing Workforce

People in Ireland are living longer. In 1926, the average life expectancy for males and females was 57.4 and 57.9 years respectively. Today, the life expectancy for men is 76.1 years and 81.1 years for women. By 2036, life expectancy is forecasted to be 82.5 years for males and 86.9 years for females (CSO, 2004). This has significant implications for Ireland's tax, health and social welfare systems.

Figure 2.2: The ageing population



Source: CSO (2004)

While there has been an increase in life expectancy there has been a decline in the fertility rate (average number of children a woman has) from 3.76 in 1960 to 1.88 in 2005. This rate is not expected to increase. The net result of this contrasting shift is that the Irish population is slowly ageing (Figure 2.2). Currently, over 65s account for 11% of the total population. This will reach nearly 15% by 2020 and 20% by 2036 (CSO, 2004). This has direct consequences for the number of persons in the working-age population per person over 65 years. Presently there are six persons economically active (15–64) to one person over 65. This will decrease to 5:1 by 2020, 3.5:1 by 2030 and 2:1 by 2050 (NCB, 2006). There will be a need for people, health permitting, to be able to work healthily up to 65 and beyond in order to address the potentially significant burden of our ageing population.

In July 2006, EU ministers (including Ireland) representing health, social affairs and enterprise, accepted recommendations to extend working life through health promotion activities which are designed to advance the Lisbon Agenda. The overall objective of the Lisbon Agenda is to make the EU the most competitive and dynamic knowledge-driven economy in the world by 2010. One of the key goals in meeting this objective is to increase the labour– market participation of older workers (those aged 55–64).

A number of priority actions are outlined for promoting education and employment opportunities for older people in the new national partnership agreement 'Towards 2016' (DT, 2006). This requires a cultural mindset change by both employers and employees towards encouraging older workers to remain in the labour market. This Strategy will support workers in remaining healthy so that they can avail of the education and employment opportunities as envisaged in the agreement.

An independent evaluation of the National Employment Action Plan undertaken on behalf of the Department of Social and Family Affairs has recommended that the long-term unemployed (unemployed for more than one year) aged between 55 and 64 should be encouraged to return to work or to undertake education or training (Indecon, 2005). Under new measures these individuals will now be required to undertake mandatory FÁS interviews. This is recognition by the state of the importance of this older group in the working-age population and an attempt to address the economic burden of early exit from the workforce.

The Irish Longitudinal Study on Ageing, involving over 10,000 people aged over 55, has just commenced. Those involved in the study will have their health, social and economic circumstances monitored for at least the next ten years. The information gathered from the research will be used to inform policy making in areas such as health, social welfare and pensions.

In comparison to Ireland, Europe is already ageing rapidly. Through the adoption and implementation of this Strategy, Ireland now has the time and opportunity to address this ageing situation. This will be achieved by maintaining and where necessary improving the work ability of the older workforce so that they can:

- Work healthily to full retirement age;
- Work healthily beyond full retirement age if they wish and where appropriate;
- Retire healthily.

However, this must take account of existing policies in both the public and private sectors which facilitate people retiring at 65 years of age.

Issue 3

Ireland is ageing with a consequent increasing age-dependency ratio. The challenge is to encourage people, where appropriate and suitable, to remain in the workforce beyond the normal retirement age.

Issue 4

Older workers (aged 50–64) are exiting the labour market through ill health. The challenge is to reduce this number through prevention of illness and health promotion.

Recommendation 2

Conduct research to understand the reasons for early exit from the labour force, including the findings from the Irish Longitudinal Study on Ageing, and ensure follow through is implemented as appropriate.

Recommendation 3

Establish structures and supports that facilitate people to stay in the workforce beyond the normal retirement age where appropriate. However, this must take account of existing policies in both the public and private sectors which facilitate people retiring at 65 years of age.

Recommendation 3

Establish structures and supports that facilitate people to stay in the workforce beyond

2.7 Absenteeism

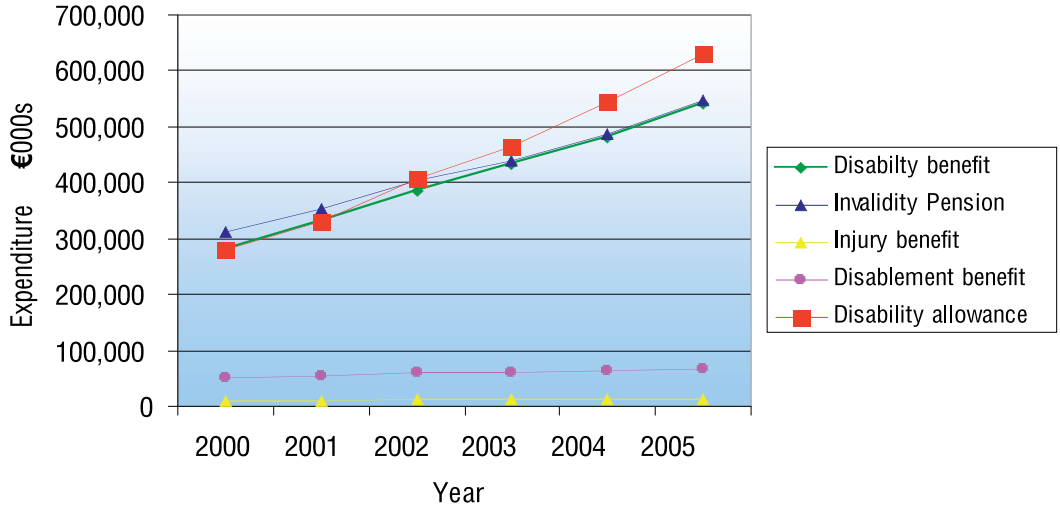
A survey conducted in 2004 found that an average of 14 million workdays per annum was lost because of absence in Ireland and the cost to businesses was almost €1.5 billion (IBEC, 2004). The costs to employers are not just financial in nature: there are also indirect costs associated with the loss of quality and production, and the potential loss of customers. Absenteeism may also put a strain on the absent employee's co-workers, who may be subjected to increased pressure in order to meet deadlines. Short-term absences were due to minor illnesses such as colds, flues and headaches. Recurring health problems such as back problems, cancer, heart disease, etc. were ranked as the main cause of long-term absence. This Strategy is designed to improve individual work ability and consequently reduce the key causes of absenteeism. This should result in significant cost savings to both employers and the state.

Absenteeism can also be the result of psychosocial related illness. A survey conducted by the Small Firms Association in 2006 reports that absenteeism costs small businesses an estimated €692 million per annum. It identifies stress as the main cause of absenteeism from work (SFA, 2006). The survey also highlighted that the highest levels of absenteeism occurred in the electronics industry, which averaged 16 days (7.1%), followed by the metals/engineering sector at 11 days (4.7%) in comparison to the national average of 9 days.

2.8 Illness and Disability

It is estimated that about 85% of working-age people with a disability have acquired their disability over their lives (NDA, 2004) and it is reasonable to assume that some proportion can be attributed to the workplace. In 2004, there were 298,300 persons aged 15–64 in Ireland who reported having a longstanding/chronic health problem (QNHS, 2004) of whom 110,800 were in employment.

Figure 2.3: Expenditure on illness and disability, 2000 to 2005



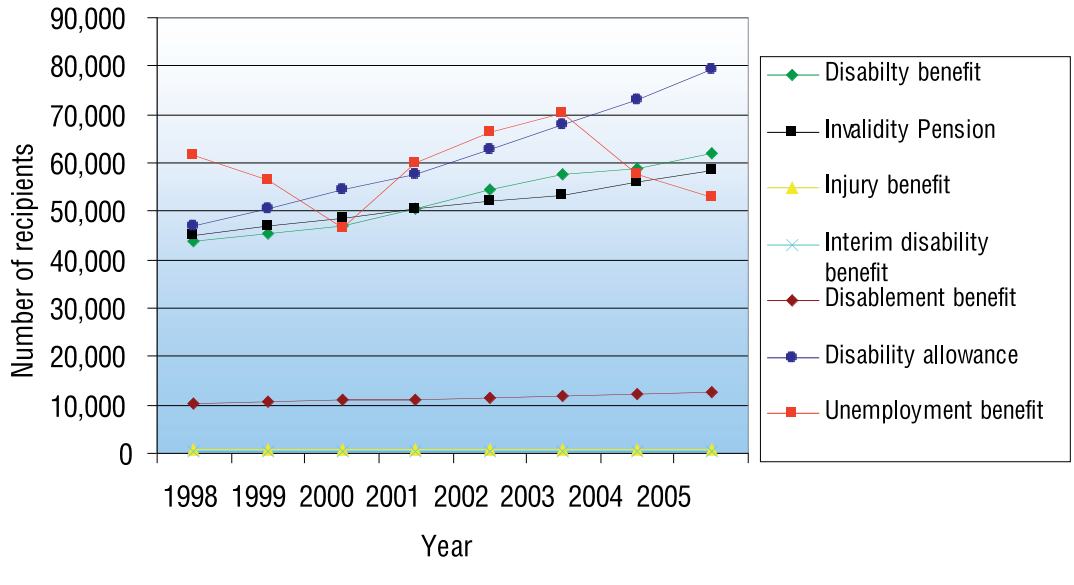
Source: DSFA (2006) Annual Report 2005, Dublin: Department of Social and Family Affairs

In addition to the previous estimated cost of work-related accidents and ill health in Ireland (calculated to be almost €3.6 billion (Indecon, 2006)), the costs to the state are also significant. The four benefit

payment types outlined in Figures 2.3 and 2.4 are fully or partially related to accidents or illness at work affecting a person's health. Figure 2.3 demonstrates a significant increasing level of annual payments by the state to over €2 billion in 2005, representing an increase of over 14% from 2004.

Unlike the decreasing numbers claiming unemployment benefits, there is an upward trend (see Figure 2.4) in the numbers claiming each payment type (just over 200,000 in 2005). While injury benefit and disablement pension are directly related to workplace ill health and accidents, there is also a proportion of disability benefit and invalidity pension payments related to work. Through the implementation of this Strategy, it should be possible to reduce the incidence of work-related illness through promotion, prevention and rehabilitation and consequently reduce this very high level of benefit payments.

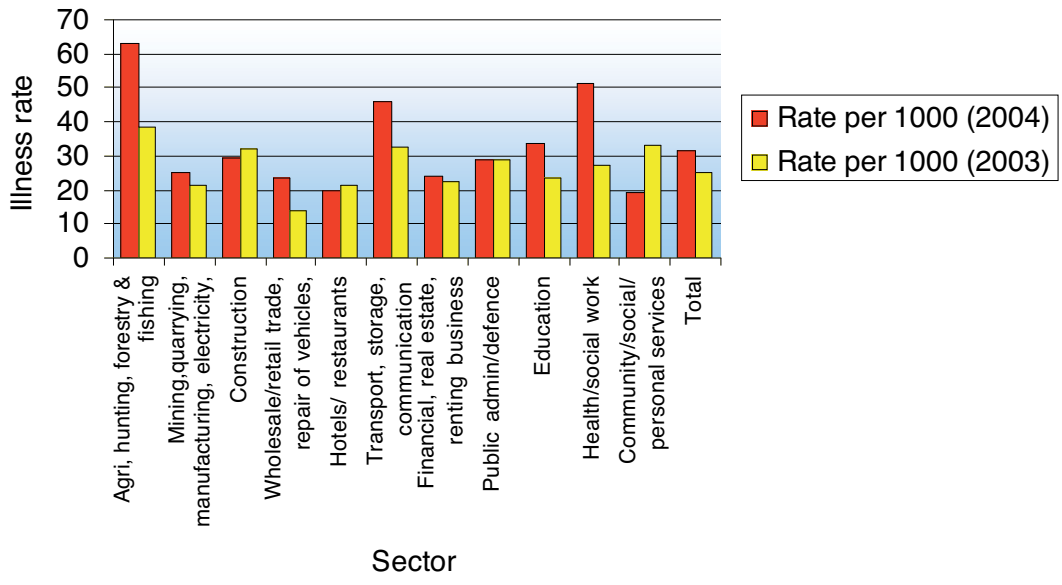
Figure 2.4: Number of recipients of illness, disability and unemployment payments, 1998 to 2005



Source: DSFA (2006) Annual Report 2005, Dublin: Department of Social and Family Affairs.

In 2004, almost 60,000 persons in employment suffered an illness (QNHS, 2004). By far the largest type reported was musculoskeletal disorders such as back, muscle and repetitive strain (50%) followed by mental health issues such as stress (20%). These mirror the major workplace health issues across Europe as evidenced in the Fourth European Workplace Survey (EFILWC, 2005). Manual handling accounts for almost one third of all incidents reported to the Health and Safety Authority. The rate of illness in workplaces is increasing (see Figure 2.5), especially in the agriculture and health and social work sectors (HSA, 2006).

Figure 2.5: Rate of illness by economic sector



Source: HSA (2006)

In similarity to measures encouraging unemployed people aged 55–64 to return to employment, the Department of Social and Family Affairs has recommended that people with disabilities be encouraged to return to work or undertake education or training (Indecon, 2005). Such measures allow people on Disability Allowance and Blind Pension to retain half their benefit for earnings between €120 and €350 a week. Previously, a person lost their allowance or pension on a euro for euro basis for earnings above €120 a week. This change is an acknowledgement of increased life expectancy and the fact that these groups can contribute positively to society. A number of recommendations on illness and disability are made in Chapter 4.

2.9 Costs

The costs of accidents and ill health are incurred at three levels:

- **Individual level:** the costs include loss of earnings, extra expenditure when absent, medical bills, the cost incurred when changing jobs and human costs;
- **Enterprise level:** whilst also incurring the costs of absence and sick pay, the employer is also subject to costs arising from compensation and insurance, company administration, loss of production and quality, damage to property and equipment and recruitment;
- **Society level:** where the overall costs include the loss of output, insurance, administration, human costs and medical treatment.

Recent research (Indecon, 2006) estimates that the annual cost of work-related accidents and ill health in Ireland could be as much as €3.6 billion. The main cost of accidents and ill health to society is the lost

output as a result of temporary and permanent absence in the workplace, prudently estimated to be €1.8 billion, whilst insurance costs are approximately €1.2 billion. Under-reporting of minor accidents and illnesses and the limited availability of relevant and reliable data in Ireland contribute to a likely under-estimation of the true costs of work-related accidents and ill health.

Research has indicated that any spending on workplace health initiatives should be viewed as an investment and not a cost, resulting in increasing productivity and profit in the medium to long-term (Oxenburgh et al., 2004).

2.10 Conclusions

This chapter has made solid human, social and economic arguments for the implementation of the Strategy. Work can be seen as a positive influence on an individual's health. A good work environment is crucial in maintaining and promoting a person's physical and mental health, and well-being.

The benefits of work to the individual and society are clearly evident. The escalating social and financial costs for individuals, enterprises and the state of illness and disability, and the effect absenteeism has on productivity and economic output have been outlined.

Small and micro enterprises and non-Irish nationals pose particular challenges that the Strategy needs to address.

The Strategy can be seen as a necessary vehicle for the advancement of the European agenda of promoting and maintaining the workability of older workers, and preventing the early exit of workers, both young and old, from the labour market through ill health and injury.

References

CSO (2004) *Population and Labour Force Projections 2006–2036*, Dublin: The Stationery Office.

CSO (2006) *Statistical Yearbook of Ireland 2006*, Dublin: Central Statistics Office.

DSFA (2006) *Annual Report 2005*, Dublin: Department of Social and Family Affairs.

DT (2006) *Towards 2016: Ten Year Framework Social Partnership Agreement 2006–2015.* Dublin: Department of the Taoiseach.

EFILWC (1998) *Precarious Employment Conditions in the EU*, European Foundation for the Improvement in Living and Working Conditions.

EFILWC (2005) *Fourth European Working Conditions Survey 2005*, Dublin: European Foundation for the Improvement in Living and Working Conditions.

Holmquist, K. (2006) 'Trying to Shatter a New Glass Ceiling', *Irish Times*, 14th October.

HSA (2006) *Summary of Fatality and Illness Statistics 2004–2005*, Dublin: Health and Safety Authority.

IBEC (2004) *Workplace Absence Survey*, Dublin: Irish Business and Employers Confederation.

Indecon (2005) *An Evaluation of the National Employment Action Plan*, Dublin: Department of Enterprise Trade and Employment.

Indecon (2006) *Report on Economic Impact of the Safety, Health and Welfare at Work Legislation: Final Report*, Dublin: Department of Enterprise, Trade and Employment.

Mathers, D. and Schofield, D. 'The Health Consequences of Unemployment'*, Medical Journal of Australia*, 1998.

NCB (2006) *2020 Vision: Ireland's Demographic Dividend*, Dublin: NCB Stockbrokers.

NDA (2004) *Disability and Work – The Picture we Learn from Official Statistics*, Dublin: National Disability Authority.

Oxenburgh, M., Marlow, P. and Oxenburgh, A. (2004) *Increasing Productivity and Profit through Health and Safety.* 2nd edn, Florida: CRC Press.

QNHS (2004) *Quarterly National Household Survey-Disability Update, Quarter 1 2004*, Dublin: Central Statistics Office.

QNHS (2006) *Quarterly National Household Survey, Quarter 1 2006*, Dublin: Central Statistics Office.

SFA (2006) *6th National Absenteeism Report*, Dublin: Small Firms Association.

Waddell, G. and Burton, K.A. (2006) *Is Work Good for your Health and Well-being?* London: TSO.

3. Workplace Health and Well-Being – A Model for Action

3.1 What is Workplace Health and Well-Being?

To address the issues and realise the benefits identified in the Case for Action, it is necessary to clearly set out what is meant by workplace health and well-being in this Strategy.

Workplace health and well-being is a state of being for each employee and employer which enables each individual to reach their full potential in the workplace by ensuring their ***work ability*** *through the promotion of mental, physical, emotional and psychological health and* ***well-being****. It includes the* ***prevention*** *of all types of illness and disease in these areas, the* ***promotion*** *of workplace health activities and the* ***rehabilitation*** *of individuals who experience such illness and disease so as to facilitate and support their return to employment (see Appendix II for full definitions).*

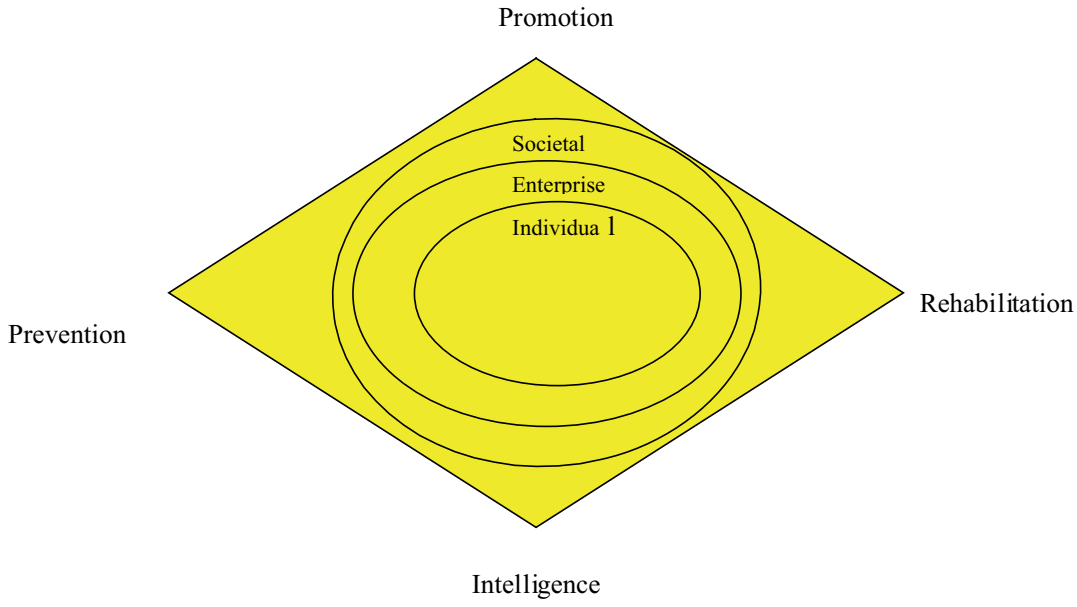
Workplace health and well-being is most effectively achieved through a combination of policies and programmes that address a range of factors, including the general principles of prevention, hazard identification, risk assessment and health surveillance. Effective workplace health promotion requires demonstration of leadership and commitment along with policies and procedures on recruitment, development, training, human resource management, consultation, communication and rehabilitation.

The level of sophistication and support for these policies varies significantly, depending primarily on the size and capacity of the organisation. In large organisations these are typically well addressed as organisations have the requisite capacity, whereas in the small to micro enterprises this is not the case.

Workplace health and well-being can be achieved through a combination of prevention, promotion and rehabilitation interventions. These separate but complementary intervention categories must be intelligence led and consequently this is a fourth important dimension. Taken together, these four dimensions constitute a working model (see Figure 3.1) that can be used to inform the delivery and deployment of the Strategy.

Workplace health and well-being must be addressed at three levels: individual, enterprise and societal. Within these three levels various stakeholders operate in managing workplace health and well-being. On the basis of social partner consultation and consensus, the Government establishes a regulatory framework and develops policies to protect and promote the health of the working-age population. Employers, having a duty of care to their employees, comply with these. In their turn, employees have a responsibility to cooperate with their employer in these matters.

Figure 3.1: A model for workplace health and well-being



Other bodies, such as the voluntary agencies, operate on a number of different levels, e.g. lobbying government and delivering initiatives at the workplace, in influencing improvements in the health of the working-age population. However, regardless of the level or of which dimension is being utilised, the main focus is to improve the health of individuals in the working-age population. For this integrated model to be successful, operation at all levels and utilisation of all dimensions is necessary.

3.2 Prevention

The focus of prevention is on the management of health in the workplace, thereby reducing the risk of employees suffering an illness or injury. The Safety, Health and Welfare at Work Act, 2005, is a framework Act which outlines the general duties of employers and others in managing health at work. This requires employers to prepare a safety statement, undertake a risk assessment and implement preventative measures, including health surveillance, to control the risk to individuals in the particular workplace. Some of the main responsibilities of an employer are: to consult with employees, to provide information and training to employees and to ensure people who are competent in health and safety are available. The provision of specific policies on issues like stress, bullying and intoxicants is also included.

In addition to the 2005 Act, there are particular regulations relating to manual handling, display-screen equipment, noise, vibration, chemicals, carcinogens and biological agents, which, when implemented, will prevent illnesses/injuries such as musculoskeletal disorders, noise induced hearing loss, asthma, dermatitis, cancer and infection.

Compliance by all concerned should result in a workplace in which the physical, physiological and psychosocial hazards are managed and controlled so as to ensure that the health of both employees and employers is not adversely affected.

However, the level of compliance with existing legislation varies considerably, for a variety of reasons, not the least being that there is often confusion and a lack of awareness as to duties and responsibilities under the legislation, primarily among small and micro employers. They do not have the same level of resources available to them as do larger employers for understanding and addressing their legislative responsibilities.

Relatively speaking, safety issues are more actively managed because of their immediate impact while health issues are not given the same level of attention. There is a significant challenge to be faced in making employers (especially small and micro enterprises) aware of their obligations with easy to understand guidance, followed up with enforcement on particular health issues. The general principles of prevention as laid down in the 2005 Act provide a useful reference point and hierarchy of priority for employers on how to manage health and well-being in the workplace.

3.2.1 General principles of prevention

The general principles of prevention are outlined in the Act, with specific emphasis on the responsibilities of the employer. They are:

- The avoidance of risks;
- The evaluation of unavoidable risks;
- The combating of risks at source;
- The adaptation of work to the individual – especially as regards the design of places of work, the choice of work equipment and systems of work – with a view in particular to alleviating monotonous work and work at a predetermined rate and to reducing the effect of this work on health;
- The adaptation of the place of work to technical progress;
- The replacement of dangerous articles, substances or systems of work by safe or less dangerous ones;
- The giving of priority to collective measures over individual protective ones;
- The development of an adequate prevention policy in relation to safety, health and welfare at work, which takes account of technology, organisation of work, working conditions, social factors and the influence of factors related to the working environment;
- The giving of appropriate training and instruction to employees.

Issue 5

There is a significant body of legislation in place. However, there is a need for an improvement in the levels of compliance and enforcement.

Recommendation 5

Undertake a national awareness campaign for both employers and employees on the role and responsibilities of each in relation to workplace health.

Recommendation 6

Place a greater emphasis on the preventative aspects of worker's ill health, including the provision of health surveillance.

Recommendation 7

Compile a guide for employers on their responsibilities for workplace health. Include examples of best practice which will be relevant to all sizes of workplace.

Recommendation 8

Improve the effectiveness of existing infrastructure and provide for appropriate new infrastructure, to ensure that compliance with workplace health legislation is monitored and enforced.

3.3 Promotion

The concept of health promotion in the workplace has developed and expanded over the years from a focus on single risk factors in the 1970s, to wellness programmes in the 1980s, to today's more holistic approach encapsulated in the following definition:

Workplace health promotion is the combined effort of employers, employees, and society to improve the health and well-being of people at work

(Luxembourg Declaration 1997)

A health promoting workplace aims to:

- Improve the work environment and conditions of work for all;
- Focus on the culture and policies within the organisation so that both their development and delivery are health enhancing;
- Deliver interventions that raise awareness about health issues and develop personal skills to motivate personal change.

Workplace health promotion goes beyond what is currently required by health and safety legislation. It is a combined cooperative effort by the employer and employees in implementing and supporting measures that can maintain and improve an individual's health. By having a range of policies and

commitment on issues such as lifestyle, work-life balance, ageing, stress management, health and safety, retention and rehabilitation, a proactive approach to the three strands of prevention, promotion and rehabilitation is ensured.

Many studies on workplace health promotion follow the basic approach of behaviour prevention: i.e. personal health relevant behaviour comes to the fore as the starting point of prevention (Kreis and Bödeker, 2004). Workplace health promotion programmes support individuals in acquiring healthy behaviour patterns, whilst assuming this will lead to an improved state of health (Janer et al, 2002).

The Irish Heart Foundation's Happy Heart at Work Programme is an example of a workplace health promotion initiative which helps employees address healthy eating and physical activity. It encourages employers to create a supportive environment through the provision of catering audits, health checks and various physical activity programmes. Also, the Irish Cancer Society's Healthy for Business Programme aims to create awareness and educate employees on the prevention and early detection of cancer. It encourages and facilitates employees to make the necessary lifestyle behaviour changes to reduce their cancer risk by adopting the recommendations of the European Code Against Cancer.

3.3.1 The case for workplace health promotion

There is evidence that health promotion in the workplace is effective. Organisations that place value on the health of their workforce enjoy advantages such as motivating employees, improving company profile and attracting new employees (De Greef and Van der Broek, 2004). A number of benefits of workplace health promotion are also identified in *An Evaluation of the Happy Heart at Work Programme* (McMahon et al., 2001), including improved employee satisfaction, increased productivity, a healthier workplace and improved workplace morale. A review of evidence-based research (Kreis and Bödeker, 2004) reveals a number of economic and health related benefits in the adoption of workplace health promotion and prevention, which includes a reduction in health risks, medical costs and absenteeism.

3.3.2 Key factors for success in workplace health promotion

The following steps have been identified for successful workplace health promotion initiatives by the Irish National Workplace Health Promotion Officers Group (NWHPOG, 2005):

- Gain support from management;
- Establish a multidisciplinary working group with clear terms of reference;
- Determine health needs with staff;
- Prioritise, plan and implement programmes in response to employee health needs;
- Identify monitoring and evaluation tools to determine effectiveness of programmes;
- Integrate plans and workplace health policies into the organisation's regular management practices;
- Open channels of communication reaching all members of staff.

Two critical factors in developing and implementing a workplace health promotion programme are needs assessment

and evaluation. A needs assessment will guide the appropriateness of an intervention and an evaluation tool will assess its effectiveness.

3.3.3 Workplace health promotion approaches – an Irish context

The policy, *Healthy Bodies Healthy Work* (DHC, 1998) identified that there was a general lack of awareness and low activity levels in Ireland with respect to workplace health promotion. A strong association was also demonstrated between activity levels and company size, with larger companies having higher activity levels. A number of obstacles were found to inhibit the development of workplace health promotion such as:

- A lack of management commitment;
- The special difficulties encountered by small and medium sized enterprises (SMEs);
- An ad-hoc, uncoordinated approach to health promotion;
- Lack of information;
- Lack of expertise.

The Review of the National Health Promotion Strategy (DHC, 2004) identified that the workplace is a growing priority area for the implementation of health promotion policies and programmes. It recognised that there is a high level of activity at regional level but that there needs to be more focus nationally on models of partnership and inter-sectoral working. There is great scope for different state bodies and non-government organisations (NGOs) such as the Irish Cancer Society and Irish Heart Foundation to pool their resources to address workplace health promotion and prevention, especially with initiatives aimed at small and micro enterprises.

3.3.4 Health screening as part of health promotion

The Office of the Chief Medical Officer for the Irish Civil Service (Lavelle and O'Connell, 2006) describes health screening as the encouragement of a person to present for assessment in order to detect disease or a risk factor which is currently not producing symptoms. The aim is to intervene early so that either further progression can be stopped or the eventual outcome can be improved. Health screening can involve blood/laboratory tests and/or lifestyle questionnaires. It is recommended that lifestyle questionnaires should include questions on smoking, diet and exercise. Laboratory tests can be categorised in terms of how beneficial they are (see Table 3.1). It is recommended that all tests in the 'beneficial' category be offered to employees.

Table 3.1: Categorisation of laboratory tests

Beneficial	Possibly beneficial	Not of proven benefit	Best provided by GP
Height Weight Body Mass Index Blood Pressure Glucose Cholesterol	Full blood count Urea and Electrolyte Liver Function Test Lung Function Tests Thyroid Function Test Urinalysis	Electrocardiograph Bone Density Prostate Specific Antigen Food Intolerance Tests	Breast Screening Cervical Screening

Source: Lavelle, B. and O'Connell, T. (2006) *Guide to Health Screening in the Workplace*, Dublin: Office of the Chief Medical Officer for the Civil Service.

The Construction Workers Health Trust (CWHT) aims to protect construction workers' health through lifestyle assessment and health screening on construction sites by nurses. Under this service, workers can also be referred to specialists. This initiative educates and makes construction workers more aware of issues such as smoking, healthy eating, heart disease, diabetes and cancer. This is a very cost effective model funded by workers, which impacts directly on employees in small and micro enterprises and could be expanded to the entire construction/other sectors (see recommendation 1).

Issue 6

Existing approaches to health promotion are fragmented and need to be brought together. There is a need for different departments, agencies and organisations to work in partnership on workplace health promotion, both at a national and regional level. There is a need to create a supporting culture within organisations.

Recommendation 9

Find ways for different government departments, agencies and non government organisations to work more in partnership on workplace health promotion at both a national and regional level.

Recommendation 10

Develop a programme that assists and supports organisations in creating this environment. Ensure that this is co-ordinated under national objectives.

Recommendation 11

Adopt a more targeted and gender-specific approach to the development of health promotion initiatives in the workplace.

3.4 Rehabilitation

Rehabilitation is a combined effort between the employer and the employee to facilitate the return to work.

'Rehabilitation should restore a person who has been injured or suffered an illness to as productive and as independent a lifestyle as possible through the use of medical, functional and vocational interventions.'
(Association of British Insurers and Trades Union Congress, 2002, p. 5)

3.4.1 Rehabilitation in Ireland: policy and activity

The incidence of illness and disability and their subsequent effect on absenteeism levels highlights the importance of rehabilitating workers to make a successful return to some form of employment. Research points to serious failings in the systems and activities followed for rehabilitation. While it must be recognised that Ireland does provide a number of rehabilitative services and activities such as vocational interventions, financial support to facilitate return to work and subsidies for adaptations to the workplace etc., it has been argued (Wynne and McAnaney, 2004) that this system is ineffective for returning people back to the workplace on the basis of eligibility criteria. The focus is on those who are registered as 'disabled', and those who are economically inactive or unemployed owing to illness or injury. There is also a lack of understanding and clarity as to where responsibility lies for rehabilitation and return to work amongst Government, employers, the medical profession and workers.

Research conducted in the UK (Carter and Birrell, 2000; British Society of Rehabilitation Medicine, 2003), highlighted that after six month's absence there is only a 50% likelihood of the employee returning to work. At twelve months this falls to 25%, and few individuals return to any form of work after one to two years absence, regardless of further treatment. The above findings emphasise the importance of beginning the process of rehabilitation as soon as is possible and practicable after the commencement of the period of absence.

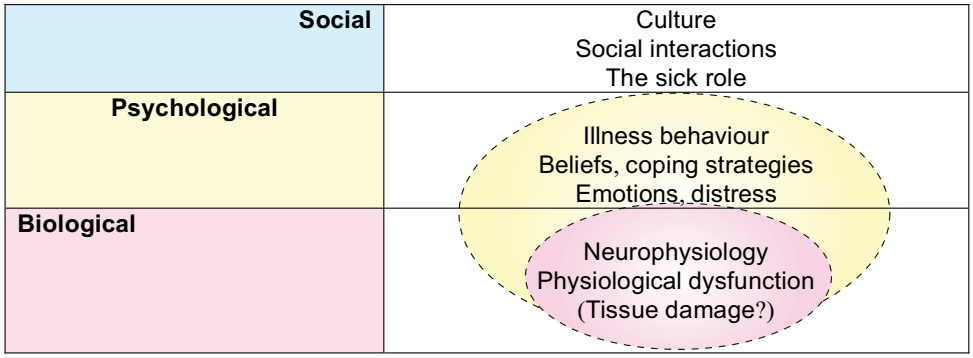
In Ireland, the adversarial legal and insurance system has not encouraged employers and employees to engage with each other after an accident or illness. Absenteeism and rehabilitation have not been considered management's responsibility and it has been regarded as sufficient to ensure that an up-to-date sick certificate is available. The social insurance system has discouraged those on an illness or disability benefit from returning to any sort of work as they would immediately lose some or all of their benefits. General practitioners need to encourage workers to return to work at the earliest opportunity and also revise the practice of issuing sick certificates in cases where work may be the best form of rehabilitation.

3.4.2 The biopsychosocial model of rehabilitation

Traditionally, rehabilitation has been viewed as a separate, second-stage process that takes place after medical treatment, where recovery is still not completed. However, there is now general acceptance that disability, illness and injury are multifaceted events, involving biological, psychological and social

dimensions. The traditional model is no longer considered the most viable or effective method of rehabilitation as it fails to address all of these dimensions (Waddell and Burton, 2004). In a bid to address the shortcomings of the biomedical model (traditional), the biopsychosocial model (see table 3.2) has been developed to take into consideration the psychosocial factors present in common health problems.

Table 3.2: The biopsychosocial model of disability



Source: Waddell, G. and Burton, K. A. (2004) *Concepts of rehabilitation for the management of common health problems*, UK: The Stationery Office.

The biological element of the model refers to the physical or mental condition of the individual. The psychological aspect concerns the personal or psychological elements that impact upon the individual and his or her condition. These include the individual's illness behaviour, beliefs and emotions, and coping strategies. The social perspective of the model addresses an individual's social context and culture, and social interactions.

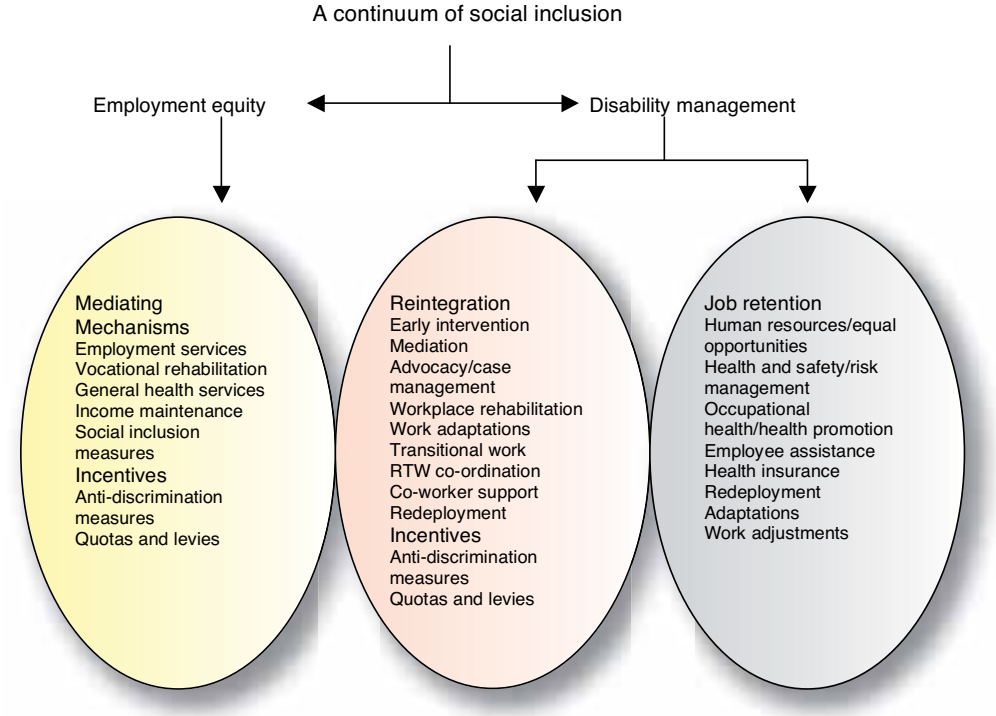
3.4.3 Interventions for rehabilitation and reintegration

The disability management model looks at the various interventions that can be used to prevent absence (retention) and to aid reintegration (see Figure 3.2).

An underlying assumption of the disability management model is the active role the employer plays in the rehabilitation and support of an individual who has sustained a work-related illness or injury. There are two themes in the disability management approach: job retention and reintegration.

Job retention concerns the adoption of various activities (e.g. risk management, health promotion, health insurance, employee assistance and work adjustments) in a bid to 'retain' an ill or injured employee before they choose to exit the workplace and go on long-term absence. The British Occupational Health Research Foundation (2005), in evaluating evidence-based retention at work strategies for individuals with common mental health problems, contends that approaches targeted at the individual rather than the organisation are more effective. These approaches include personal support, individual social skills and coping skills training.

Figure 3.2: A disability management model



Source: EFILWC. Wynne, R. and McAnaney, D. (2004) *Employment and disability: back to work strategies,* European Foundation for the Improvement in Living and Working Conditions, Dublin.

The second theme, reintegration, concerns those individuals who have exited the workplace. Reintegration strategies, as illustrated above, call for a range of activities, including early intervention and mediation, advocacy, case management, workplace rehabilitation and work adaptations. A report by the European Foundation for the Improvement in Living and Working Conditions (Leigh-Doyle and Mulvihill, 2004) contends that 'effective reintegration of an individual with a chronic illness or disability requires commitment in three policy areas: occupational safety and health, human resource management and equality'. Disability management activities are distinct from employment equity measures (vocational rehabilitation, income maintenance) as illustrated in the diagram.

A study conducted by the International Social Security Association found that the success of work reintegration can be dictated by the ability of the employer to adapt the workplace, provide flexible working hours and protect the individual's job. The relationship between the employer and employee is emphasised as vital in the return to work process (ISSA, 2002). It is estimated that just one in eight employers employ people with disabilities (Manpower, 2003). The National Disability Authority, in exploring the reasons for this phenomenon, indicates that a substantial number of employers express concerns regarding the employment of people with disabilities for health, safety and insurance reasons (NDA, 2006). The Authority, in developing a comprehensive employment strategy for people with disabilities (The National Disability Strategy), makes a number of recommendations in relation to the participation of people with disabilities. In particular, it emphasises the role back to work strategies can play in the reintegration and rehabilitation of those suffering from illness and disability (NDA, 2006).

The Renaissance Project, (DSFA, 2004) has made a significant contribution in an Irish context to facilitating an early return to work of people with back pain. A diagnostic triage approach was adopted. Some applicants were advised that returning to work would be the best form of rehabilitation. The outcome of the Renaissance Project is that early intervention is vital in the treatment of lower back pain as it reduces the number of individuals who progress to a chronic disabled stage. The Project also resulted in reduced healthcare costs, a reduction in absenteeism, increased productivity and a savings in long-term illness benefit schemes.

There is a significant amount of work to be done at all levels in Irish society to address the challenge of rehabilitating those who are out of work because of illness or disability. Employers need to be encouraged and educated into changing their prevailing attitudes about those out of the workforce who could be successfully rehabilitated. Health and disability should not be used by employers as a barrier to employing an individual. Work and the workplace can be adapted and this should not cost employers, as the cost will be borne by the state in the form of FÁS job retention grants etc. The social welfare system should encourage those out of work to return without the loss of benefits in the early stages. General Practioners should also encourage individuals to return to work at the earliest stage possible, taking into account the particulars of their condition. This should be reflected in the policy and practice of issuing certificates of sickness. Managers and insurance companies need to take a more proactive role in the management of the absence and return to work of employees.

Issue 7

There are people who are absent from work and others who have never worked because of long-term illness and disability.

Recommendation 12

Extend the Renaissance Project. Review its potential and scope for extension to other health areas.

Recommendation 13

Develop/devise infrastructures that support and encourage people to return to work, by adopting a multidisciplinary approach that incorporates services such as physiotherapy, occupational therapy etc.

Recommendation 14

Extend the National Employment Action Plan to disability claimants. This involves modifying the social welfare system to encourage people with illnesses or disabilities to return to employment or undertake education or training.

Recommendation 15

Ensure that all workers in Ireland have access to competent occupational medical advice.

Recommendation 16

Develop a model which links primary care to occupational health services.

Recommendation 17

Develop a collaborative initiative with GPs which emphasises the positive aspects of early return to work and the consequent need to modify the management and certification of sickness absence.

Issue 8

Some employers are putting up barriers to employing people with disabilities on health and safety grounds.

Recommendation 18

Develop health and safety guidelines to encourage employers to employ people with disabilities.

Recommendation 19

Develop guidelines to promote safe workplaces and practices in places which employ people with disabilities.

3.5 Intelligence

The three primary categories of intervention should be evidence led: i.e. based on and informed by intelligence. This consists of data, performance indicators and research. The collection of data during each type of intervention (prevention, promotion, rehabilitation) is of the utmost importance. In terms of accessing the cost of accidents and work-related ill health, it has been reported that the availability of relevant and accurate data is a key issue. A number of weaknesses in terms of data availability and reporting have been identified in a recent report (Indecon, 2006), including the following:

- Few data sets are concerned with the reporting of occupational diseases or work-related illness. Unlike accidents and dangerous occurrences, there is no requirement of employers in Ireland to report occupational disease/illness;
- With regards to notified accidents, data may be unreliable and it is argued that under-reporting may occur;
- There is often a too narrow focus taken when considering the costs of accidents and work-related ill health, frequently to the detriment of other costs such as work-related stress and musculoskeletal disorders.

With respect to the reporting of occupational diseases, although some progress has been made in this area with the piloting of an online reporting system for occupational asthma and occupational dermatitis in Ireland, there is a need to further expand this pilot on a national level.

The National Centre for Partnership and Performance (NCPP, 2006) has identified the data deficit and fragmentation of data in relation to worker health and well-being. It is envisaged that this Strategy can be the vehicle by which to address this issue.

Carrying out research on workplace health and well-being will help address the data deficit. Internationally there is a lot of evidence as to what has been successful, but it is not always possible to transfer this experience to the Irish context. There is sufficient competence available to have research carried out and to apply the findings and recommendations in Irish workplaces. This Strategy identifies a number of key areas in which much needed research should be undertaken.

Issue 9

There is an incomplete picture of the level of work-related illness as there is no obligation perceived by employers, employees or others, including doctors, to report these illnesses to any particular organisation.

Recommendation 20

Conduct an evaluation of illness reporting systems internationally. Identify from best practices, the system which will best meet the needs of the Irish context and apply this with appropriate infrastructure, supports and validation measures.

Recommendation 21

Support and extend The Health and Occupational Reporting Network (THOR) pilot reporting of work-related illness and disease by doctors.

Recommendation 22

Implement a system for the recording of occupational illness and disease in line with any future EU requirements to collect such data.

Recommendation 23

Develop health intelligence systems to monitor more closely the health of marginalised groups such as the long-term unemployed, those engaged in transient work and non-voluntary early retirees.

Issue 10

There is a lack of evidence-based research in Ireland in relation to all aspects of workplace health and well-being, including occupational illness and disease.

Recommendation 24

Embark on a long-term commitment to relevant research and surveys to estimate the causes and extent of health problems in the Irish workforce and to contribute to solutions.

3.6 Conclusion

This chapter has proposed a model for workplace health and well-being around the key dimensions of prevention, promotion and rehabilitation, based on and informed by intelligence. It is evident there is great scope at all levels to expand and integrate specific activities within these dimensions. This Strategy is the vehicle to co-ordinate and to integrate these activities.

The next chapter will examine the dominant workplace health issues and how they impact on different sectors and sizes of employment. The application of the proposed model will lead to a reduction in the adverse effects of these health issues.

References

Association of British Insurers and Trades Union Congress (2002) *Getting Back to Work: A Rehabilitation Discussion Paper*, London: Association of British Insurers.

British Occupational Health Research Foundation (BOHRF) (2005) *Workplace Interventions for People with Common Mental Health Problems: Evidence Review and Recommendations*, London: BOHRF.

British Society of Rehabilitation Medicine (2003) *Vocational Rehabilitation: The Way Forward.* 2nd edn, London: BSRM.

Carter, J. T. and Birrell, L. N. (2000) *Occupational Health Guidelines for the Management of Low Back Pain at Work – Principal Recommendations*, London: Faculty of Occupational Medicine.

De Greef, M. and Van den Broek, K. (2004) *Making the Case for Workplace Health Promotion – Analysis of the Effects of WHP*, Essen: Prevent.

DHC (1998) *Healthy Bodies Healthy Work,* Dublin: Department of Health and Children.

DHC (1999) *Building Healthier Hearts: Report of the Cardiovascular Health Strategy Group*, Dublin: Department of Health and Children.

DHC (2000) *National Health Promotion Strategy*, Dublin: Department of Health and Children.

DHC (2004) *Review of the National Health Promotion Strategy*, Dublin: Department of Health and Children.

DSFA (2004) *Preventing Chronic Disability from Low Back Pain– Renaissance Project*, Dublin: Department of Social and Family Affairs.

Indecon (2006) *Report on Economic Impact of the Safety, Health and Welfare at Work Legislation: Final Report*, Dublin: Department of Enterprise, Trade and Employment.

ISSA (2002) *Who Returns to Work and Why? Evidence and Policy Implications from a New Disability and Work Reintegration Study: A Summary*, Switzerland: International Social Security Association.

Janer, G., Sala, M. and Kogevinas, M. (2002) 'Health Promotion Trials at Worksites and Risk Factors for Cancer', *Scandinavian Journal Work Environment Health,* Vol 28, No.3, pp.141–157.

Kreis and Bödeker (2004) *Health-related and economic benefits of workplace health promotion and prevention.* 3rd edn, Essen: IGA.

Lavelle, B. and O'Connell, T. (2006) *Guide to Health Screening in the Workplace*, Dublin: Office of the Chief Medical Officer for the Civil Service.

Leigh-Doyle, S. and Mulvihill, R (2004) *Illness and Employment: Retaining the Link to Work-Summary*, [online] Dublin: European Foundation for the Improvement in Living and Working Conditions.

Luxembourg Declaration on Workplace Health Promotion in the European Union (1997) ,, Luxembourg: European Union.

McMahon, A. Kelleher, C. Duffy, E. and Helly, G. (2001) *An Evaluation of the Happy Heart at Work Programme.* Dublin: Irish Heart Foundation.

Manpower SkillsGroup Survey (2003) *Working With Disabilities*, Dublin: Manpower SkillsGroup.

NCPP (2006) *First Report of the High Level Implementation Group on the National Workplace Strategy*, Dublin: National Centre for Partnership and Performance.

NDA (2006) *A Strategy of Engagement: Towards a Comprehensive Employment Strategy for People with Disabilities,* Dublin: National Disability Authority.

NWHPOG (2005) *Developing a Health Promoting Workplace Resource,* Dublin: National Workplace Health Promotion Officers Group.

Safety, Health and Welfare at Work Act, 2005, (S.I. No. 10 of 2005) Dublin: Stationery Office.

Waddell, G. and Burton, K. A. (2004) *Concepts of Rehabilitation for the Management of Common Health Problems*, UK: TSO.

Wynne, R. and McAnaney, D. (2004) *Employment and Disability: Back to Work Strategies,* Dublin: European Foundation for the Improvement in Living and Working Conditions.

4. Health Issues Affecting Workplaces

4.1 Introduction

There are a number of particular workplace health issues that can adversely affect individual health and well-being. These issues are not exclusive to Ireland but are common to most European countries. Table 4.1 identifies some of these key issues.

These issues must be addressed at the three levels of individual, enterprise and society. In addition, it is expected that different approaches, using the dimensions described in the previous chapter, may be required for different sectors and sizes of employment. A particular challenge in the Irish context is how to support the small and micro businesses in addressing these issues.

Table 4.1:Persons in employment who reported they suffered an illness by type of illness and gender

	Male	Rate[1]	Female	Rate[1]	Total	Male and Female 000s Rate[1]
Type of Illness						
Bone, joint or muscle	18.8	1.7	10.8	1.3	29.6	1.6
Breathing, lungs	2.2	0.2	0.5	0.1	2.7	0.1
Skin	0.8	0.1	0.1	0.0	0.9	0.0
Hearing problem	0.7	0.1	*	*	0.7	0.0
Stress etc.	5.3	0.5	6.8	0.8	12.1	0.6
Headache, eyestrain	2.2	0.2	0.9	0.1	3.1	0.2
Heart etc.	1.3	0.1	0.2	0.0	1.5	0.1
Infectious disease	0.9	0.1	2.1	0.3	3.0	0.2
Other	1.8	0.2	3.1	0.4	4.9	0.3
Not applicable	1.0	0.1	0.1	0.0	1.1	0.1
Not stated	0.2	0.0			0.2	0.0
Total	35.2	3.3	24.6	3.0	59.8	3.2

[1]Rates are calculated per hundred in employment

Note: Data may be subject to sampling or other survey errors, which are greater in respect of smaller values or estimates of change.

Source: QNHS, (2004)

4.2 Musculoskeletal Issues and Ergonomics

Musculoskeletal disorders (MSDs), including back pain and upper limb disorders, are by far the largest illness type in Ireland and Europe. In the EU-15, 21% of Europeans report suffering from backache and 19% report suffering from muscular pains in shoulders, upper neck and/or upper and lower limbs (EFILWC, 2005). In Ireland, injuries arising from manual handling account for one third of all reported injuries to the Health and Safety Authority with the back (46%) the most frequently injured body part (HSA, 2006).

Back disorders relate to problems with the spinal vertebrae, intervertebral discs and surrounding soft tissues. Risk factors for manual handling include weight, frequency of lifting and awkward postures, twisting and bending, and poor ergonomic conditions. Low back disorders are common among men and women. Industries and occupations where such disorders are prevalent include agriculture, construction, driving, nursing and nursing assistants (EASHW, 2000). It has been argued that individuals with the highest risk of lower back pain should not be placed in jobs that impose the greatest physical demands. Those with physically or psychologically demanding work report more low back pain symptoms, have more work-related injuries and lose more time off work with lower back pain. There is an inherent weakness in the identification of individuals with a history of lower back pain: regardless of the job they are recruited for, they are likely to suffer from lower back problems. In addition, because a history of lower back pain may be common, it could exclude many people who are medically fit for most work. Pre-placement assessments may also fail to recognise those who may later develop lower back pain.

Upper limb disorders encompass inflammatory, degenerative diseases and disorders affecting tendons, ligaments, muscles and circulation. Risk factors include poor posture, repetitive or forceful movements, fast-paced work, vibration and poor ergonomic conditions. Women are more likely to report work-related upper limb disorders. Industries and occupations where they are common include agriculture, manufacturing, machine operators, craft workers, construction, and work with display-screen equipment (DSE). The sedentary nature of work with DSE and automation, whether in factories or offices, is a contributory factor to both low back and upper limb disorders.

In addition to the physical risks, there are a number of psychosocial risk factors which can lead to musculoskeletal disorders, including excessive job demands, poor working relationships and unsupportive work environments, work-related stress and bullying. By way of illustration, many workers can manifest psychological trauma and stress along with neck and shoulder pains when faced with an unreasonable deadline.

From 1993 there has been specific health and safety regulations and guidance in Ireland relating to manual handling of loads and display-screen equipment. Full compliance with these regulations and guidelines would significantly reduce the incidence of low back pain or upper limb disorders. The main requirements relate to carrying out a risk assessment and providing training to employees to address these risks. Despite the regulations and guidance, a study of manual handling in Ireland in 2001 found that only 17% of employers carried out risk assessments and only 40% provided training, which tended to be of a poor quality (Power, 2001).

The successful management of manual handling requires a wide range of interventions, mainly at the workplace level. These include: improved health promotion; education of designers of workplaces and workstations on good ergonomics and engineering controls; better training; more risk assessment; and greater enforcement. The biopsychosocial model described in the previous chapter is the most appropriate for the rehabilitation of individuals suffering from musculoskeletal disorders back into the workplace.

Issue 11

Employers are over-reliant on training to address manual handling issues. Instead, they should be using risk assessment to reduce manual handling requirements.

Issue 12

The quality of manual handling training is inconsistent and often poor.

Issue 13

Poor workplace design can increase the need for manual handling and consequently reduces productivity.

Issue 14

Poor ergonomic set up of display-screen equipment contributes to musculoskeletal injuries and consequently reduces productivity.

Issue 15

There is insufficient enforcement of the manual handling regulations.

Recommendation Set 25 – Musculoskeletal Issues and Ergonomics

- Promote the benefits of risk assessment in reducing upper limb and manual handling injuries.
- Support the development and implementation of training standards for manual handling.
- Promote the benefits of ergonomically designed workplaces for the health and productivity of the employee.
- Promote the benefits of ergonomically correct workplace set up in relation to display-screen equipment for the health and productivity of the employee.
- Increase the level of enforcement of manual handling regulations.

4.3 Mental Health Issues

Mental health issues are assuming more importance in the workplace. One in four individuals will have a mental health problem at some point in their lives (DHC, 2006). Consequently, at any one time there are many thousands of workers in Ireland both at and out of work with mental health issues. Mental health problems at work include anxiety, depression, major mood disorders, stress, and the effects of bullying and the psychological aspects of violence. In Ireland, there is substantial stigma still attached

to mental health problems: a majority of people experiencing such problems would not want others knowing about it and a majority believe that such people should not be allowed do important jobs (HSE, 2007).After musculoskeletal problems, stress is the second highest reported work-related health issue (20%) in the EU-15 Member States followed by overall fatigue (18%) (EFILWC, 2005). This does not necessarily mean that work is the source of the stress, but it may be a contributing factor and it does impact on an individual's performance and overall work ability.

Mental disorders are ranked second in the global burden of disease and five of the ten leading causes of disability include mental health conditions such as depression (DHC, 2006). It is estimated that the costs of mental health problems are between 3 and 4% of GNP across EU member states (Gabriel and Liimatainen, 2000).

4.3.1 Stress

Stress occurs when the demands of the work environment exceed the employee's ability to cope with or control these demands (Cox et al., 2000). Stress can have emotional, cognitive, behavioural and psychological impacts including depressive disorders. It also has many physiological impacts, including heart disease and gastrointestinal diseases. In addition, stress can also contribute to musculoskeletal disorders. Symptoms include raised blood pressure, chest pain, sleep disruption and irritability. An extensive national survey of employees' attitudes to the changing Irish workplace (O'Connell et al., 2004) found significant levels of work-related stress, with 72% of workers finding their work stressful. Too much stress ultimately has a negative impact both on the health of the employee and the performance of the business.

Sources of stress occur in the context and content of work. In relation to the context of work, role ambiguity and conflict is a common source of stress, while work overload is an example of work content causing stress (see Table 4.2).

Table 4.2: Stressful characteristics of work

Category	Sources of Stress
Context of Work Organisational culture and function	Poor communication, low levels of support for problem solving and personal development, lack of definition of organisational objectives
Role in organisation	Role ambiguity and role conflict, responsibility level
Career development	Career stagnation and uncertainty, under- or -over-promotion, poor pay, job insecurity, low social value of work
Decision latitude/control	Low participation in decision making, lack of control over work (control, particularly in the form of participation is also a wider organisational issue)
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems
Content of Work Work environment and work equipment	Problems regarding the reliability, availability, suitability and maintenance or repair of both equipment and facilities
Task design	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high level of uncertainty
Workload/ work pace	Work overload or under load, lack of control over pacing, high levels of time pressure
Work schedule	Shift working, inflexible work schedules, unpredictable hours, long or unsocial hours

Source: Cox et al. (2000).

Employers should have a written stress policy. In addition, a stress audit can be carried out to identify sources of organisational stress. When they are identified, there is a mix of organisational and individual interventions to address the problem. Managers should have an enlightened attitude to stress in the workplace as good management practices will result in less stress. *Work Positive* (HSA, 2005) is an online organisational assessment tool to identify sources of stress, and it provides guidance on policies and procedures relating to six management standards (demands, control, support, relationships, role and change) to manage work-related stress.

If stress is not managed, it will ultimately result in absenteeism and if the stressors are not removed, it is likely the employee on returning to work will end up on sick leave once more. Stress was identified as the major cause of absence in small and micro enterprises in Ireland in 2006, according to the Small Firms Association (SFA, 2006).

4.3.2 Bullying

Workplace bullying is repeated inappropriate behaviour which undermines the individual's right to dignity at work. The effects of bullying on the individual can be physiological (e.g. loss of appetite, raised blood pressure), psychological (e.g. loss of self-esteem and self-worth, depression, anxiety) and behavioural

(hypersensitive to criticism). Stress levels are likely to be higher in those who are bullied. For the organisation, bullying can result in reduced efficiency and quality of work, creation of an atmosphere of tension and mistrust, low morale, a drop in productivity and high rates of absenteeism.

The instances of bullying in the workplace in Ireland are significant. A survey in 2001 reported that 7% (1 in 14) of respondents reported having been bullied in the previous six months (DETE, 2001). A more recent national survey (ESRI, 2007) conducted by the ESRI for the Department of Enterprise, Trade and Employment showed an increased incidence rate of almost 1 in 13 with higher rates reported for female employees. This would equate to over 150,000 workers, given current levels of employment, which is a very considerable number of people. In addition, the *Fourth European Survey on Working Conditions* reported that 9% of Irish people reported being bullied at work in comparison to the EU-15 average of 5.4% (EFILWC, 2005).

Bullying must be managed in the workplace. Intervention can occur on three levels: prevention, reaction and rehabilitation. The Safety, Health and Welfare at Work Act 2005 requires an employer to manage and conduct work activities to prevent any improper conduct or behaviour at work. This means that where bullying is identified as a hazard, an organisation must have an anti-bullying policy which states that bullying is unacceptable and outlines the procedures, both informal and formal, for dealing with a complaint of bullying. The Report of the Expert Group on Bullying made specific recommendations in relation to improving the procedures to dealing with bullying in the workplace (DETE, 2005). The Health and Safety Authority's recently revised code of practice can assist employers and employees in the prevention and resolution of bullying at work (HSA, 2007). Those who have suffered as a result of bullying may need access to employee assistance programmes or counselling in order to remain in or return to work.

4.3.3 Violence

The effects of violence in the workplace can be both physical and psychological. Violence can result in a physical injury, but as with bullying it can also have physiological, psychological and behavioural effects. Psychological violence has a higher incidence in Irish workplaces than physical violence. People can work in an environment where they feel constantly threatened without experiencing direct physical violence.

Violence is prevalent in the public sector in Ireland in areas such as healthcare (general and psychiatric nurses and doctors), education, social care (social workers and community welfare officers), and law and order (Gardaí and prison officers). In addition, security staff and those who come into contact with the public in the course of their work (e.g. retail, tourism) are also likely to experience either psychological or physical violence at work (HSA, 2001).

The Fourth European Workplace Survey indicated that in Ireland, 8% of the population had received threats of physical violence at work while 9% had experienced physical violence from colleagues and other people in the workplace over the previous12 months (EFILWC, 2005). Experience of physical violence in the Irish workplace has increased since the 2000 survey (5.9%). This suggests that Irish workplaces are becoming more violent. In addition 6% of incidents reported to the Health and Safety

Authority (HSA, 2006) were triggered by 'shock, fright, and violence of others' and these accounted for 25% of all reported incidents in the public administration/ defence sector, almost 21% in financial services and 18% in health/social work sector. The increasing trend is worrying, especially for employees in the public sector, and demands serious attention.

The workplace health and well-being model proposed in the previous chapter is particularly appropriate for violence. Specific interventions on violence around prevention, promotion and rehabilitation are possible. Where workplace violence is an issue, employers must have specific policies and procedures for dealing with the problem. This includes carrying out a risk assessment and implementing all necessary control measures to reduce the risk of violence. In addition, specific needs-based training in de-escalation and the application of physical interventions is required. Employers and employees must work together in a spirit of cooperation to promote the idea that violence in the workplace is unacceptable. The support of colleagues and managers for those threatened or physically injured, and access to counselling services are important in the rehabilitation process (NEHB, 2004).

Issue 16

Current mechanisms to assess and manage stress are not suitable for small and micro enterprises.

Issue 17

Evidence suggests that there are significant levels of workplace bullying in Ireland.

Issue 18

Workplace violence is an increasing cause for concern, particularly in the public sector.

Recommendation Set 26 – Mental Health Issues

- Prepare a Guidance or Code of Practice on managing stress in small and micro enterprises.
- Implement the recommendations of the 2005 Report of the Expert Group on Workplace Bullying.
- Promote awareness in employees and employers of the Health and Safety Authority's 2007 revised Code of Practice on the Prevention and Resolution of Bullying at Work.
- Encourage employers to take a more proactive role in minimising the risk of violence and ensuring a strong message of intolerance. Initiatives will be needed to support employers to achieve this.
- Support initiatives aimed at the reduction of the stigma associated with mental illness.

4.4 Other Workplace Health Issues

Other significant health issues that can affect employees in the workplace are noise, vibration, dusts and chemicals, radiation and biological agents. These can result in occupational diseases such as noise-induced hearing loss, vibration white finger, asthma, dermatitis, cancer, hepatitis and tuberculosis (TB). These are also considered as it is also important to address them with specific recommendations.

4.4.1 Noise

Approximately 20% of EU-27 workers are exposed to loud noise at work and in Ireland 14% of workers report that at least half of the time they have to raise their voice to talk to people (EFILWC, 2005). Exposure to noise is common in the manufacturing, construction and entertainment sectors and is an emerging risk in employments such as call centres.

Noise can cause hearing impairment (including noise-induced hearing loss) and interfere with communication, leading to reduced work and safety performance (WHO, 2001). It can also contribute to work-related stress and cause annoyance (EASHW, 2005). Noise induced hearing loss is irreversible; the damage is permanent even if the worker is removed from the noisy environment or wears personal protective equipment.

In Ireland, there are specific health and safety regulations relating to controlling noise at work (Noise Regulations, 2006). These include carrying out a risk assessment to determine the level of noise and introducing measures to reduce noise exposure, providing information and training, erection of warning signs, wearing of personal protective equipment and provision of health surveillance (hearing checks).

Many employers see the provision of personal protective equipment to employees as fulfilling their requirements under the regulations. However, the correct approach is to apply the general principles of prevention outlined in the previous chapter and set out in the 2005 Act. In addition, there should be health promotion initiatives at an enterprise level to increase employers and employees awareness of noise and its effects. Workers who have suffered noise-induced hearing loss can in most cases continue to work in their jobs.

4.4.2 Vibration

The number of hand held electric and pneumatic tools in such industries as construction, manufacturing, mining and quarrying is the main cause of vibration in Irish workplaces. In 2005, 13% of Irish workers reported that they were exposed to vibration from hand tools and machinery for at least half their working time (EFILWC, 2005).

There are two main types of vibration exposure: hand arm vibration and whole body vibration. Both can lead to muscular/bone structure, neurological and vascular disorders. Vibration white finger (a form of hand arm vibration syndrome) and carpal tunnel syndrome are two well known occupational diseases arising from excessive exposure to vibration in the workplace.

There are specific recent health and safety regulations on vibration in Ireland (Vibration Regulations, 2006). An approach similar to that for noise can be adopted for vibration. There is a significant challenge to be faced in particular sectors in increasing employers and employees awareness of vibration in terms of prevention, promotion and rehabilitation.

Issue 19

There is poor overall compliance by employers and employees in relation to noise and vibration in the workplace.

Recommendation Set 27 – Noise and Vibration

- Promote the benefits of risk assessment in relation to noise and vibration.
- Promote the benefits of effective design to minimise noise and vibration in the workplace.
- Implement an awareness campaign for the relevant sectors in relation to their responsibilities for noise and vibration reduction.
- Promote the provision of health surveillance as a prevention measure by employers at pre-employment and during employment in relation to noise and vibration.
- Initiate research on the relationship between vibration and carpal tunnel syndrome.

4.4.3 Dermatitis

Occupational dermatitis is caused by exposure to substances in the workplace that can either irritate the skin by direct contact or cause a delayed allergic reaction. The irritant form is more prevalent than the allergic type. Almost 7% of Irish people report being exposed to chemical products or substances by handling or being in skin contact at least half the time and 6% say that their work affects their health in the form of skin problems (EFILWC, 2005).

In a recent online pilot reporting-programme by consultant physicians in Ireland, 176 cases of occupational contact dermatitis and 18 cases of occupational asthma were reported for the period 2005 to 2007 (Agius et al, 2008). There were 7 active dermatologists and 4 respiratory physicians reporting over the period. This would indicate that dermatitis is a bigger problem than asthma in the workplace, although there may be other reasons for this difference including lack of recognition and lack of management of undiagnosed occupational lung disease. The differences in numbers should not disguise the fact that undiagnosed or unrecognised asthma is far more likely to prove fatal.

Dermatitis is common in industries where wet work is carried out and is often localised to the hands and forearms (English, 2004). The industries in which dermatitis occurs include hairdressing, food processing, cleaning, healthcare and construction. A participatory health promotion approach by managers and workers at workplace level is seen as the best approach to preventing dermatitis (Held et al., 2002). Recently there was a regulatory initiative taken at EU level whereby cement manufacturers had to cut the amount of Chromium VI in order to reduce dermatitis.

The chemical agent regulations (Chemical Agents Regulations, 2001) and the associated guidance (HSA, 2001) together with the code of practice (HSA, 2007) outline how exposure to chemicals, including those causing dermatitis and asthma, should be controlled in the workplace.

4.4.4 Asthma

In Ireland, 470,000 people have asthma, the fourth highest incidence worldwide. On average, Irish workers are absent 12 days per annum because of asthma. Occupational asthma is a reversible airways obstruction caused by inhalation of a respiratory sensitising agent in the workplace (HSA, 2008).

Work aggravated asthma is a pre-existing condition that is exacerbated by the workplace, while new onset asthma is caused by exposure to workplace sensitisers. Although 9% of Irish workers report being exposed to breathing in dusts, fumes and vapours in their workplace at least half the time, fewer than 2% reported a respiratory problem related to work (EFILWC, 2005).

Respiratory sensitisers and the associated workplace activities are well established (see Table 4.3). Employers should undertake a risk assessment and implement measures to eliminate or reduce exposure (primary prevention). Employers, as part of pre-employment medicals, should be checking for individuals with a pre-existing asthma condition in order to establish a baseline for periodic health surveillance (secondary prevention). Health surveillance of workers exposed should continue on a regular basis.

Table 4.3: Substance groups and common activities

Substance Groups	Common Activities
Isocyanates	Vehicle spray manufacturing, foam manufacture
Flour/grain/hay	Handling grain at docks, milling, malting, baking
Electronic soldering flux	Soldering, electronic assembly, computer manufacture
Latex rubber	Gloves in health care, laboratories
Laboratory animals	Laboratory animal work
Wood dusts	Sawmilling, woodworking, furniture manufacture
Glues/resins	Curing glues and epoxy resins in joinery and construction
Gluteraldehyde	Health care
Hair dyes	Hairdressers
Pencillin's/cephalosporin's	Pharmaceutical
Chromium compounds	Welding stainless steel
Platinum salts	Catalyst manufacture
Cobalt	Hard metal production, diamond polishing
Nickel sulphate	Electroplating
Subtilisin/enzymes	Detergent manufacture

(Source: HSA (2008) *Guidelines on Occupational Asthma.* Health and Safety Authority)

4.4.5 Cancer

Cancer accounts for about 7,500 deaths per year in Ireland, a quarter of all deaths nationally. Lung cancer is the biggest killer, accounting for almost 1,500 or 20% of cancer deaths annually. There are approximately 20,000 new cases of cancer in Ireland every year; the largest percentage by far is non-melanoma skin cancer with over 5,000 cases (DHC, 2006). It is generally accepted that between 2% and 8% of all cancers are attributable to an individual's occupation, with 4% most likely (Doll and Peto, 1981). However, other factors contributing to cancer (e.g. ultra violet radiation and radon) need to be taken into account in trying to determine an accurate figure for work-related deaths owing to cancer.

The main cause of skin cancer is ultra violet radiation from the sun. Outdoor workers have a 60% higher chance of developing non-melanoma skin cancer than indoor workers (Thompson et al., 1993). Non-melanoma skin cancer is generally preventable and treatable if detected early. There is ample scope for health promotion activities in outdoor workplaces to educate employers and employees on the dangers of ultra violet radiation and the simple effective measures to prevent exposure, such as wearing clothing and use of barrier creams.

Exposure to asbestos can result in asbestosis and mesothelioma, both of which are irreversible diseases with a latent period of 20 to 50 years between initial exposure and disease diagnosis. The number of reported deaths owing to mesothelioma from 1993 to 2004 varies from a minimum of 9 to a maximum of 37, averaging 25 cases per year (NCRI, 2006). There are specific health and safety regulations dealing with asbestos (Asbestos Regulations, 2006). Although the manufacture of asbestos is banned in the EU, considerable quantities still exist in buildings and those most at risk include asbestos removal workers, demolition workers, plumbers, fitters and electricians.

4.4.6 Biological agents

Workers may be exposed to biological agents in the form of bacteria, viruses and parasites in a number of industries (e.g. healthcare, waste disposal, agriculture, and veterinary), which can result in infection and disease. Almost 6% of Irish workers report being exposed to infectious materials at work at least half the time (EFILWC, 2005). There is an increasing trend for workers to be exposed to infectious diseases such as tuberculosis (TB) while at work. Both employers and employees need to become more aware of the risks of infectious diseases at work. In addition, different public agencies need to develop more collaborative approaches to tackling the spread of infectious diseases at work. The biological agents' regulations specify the manner in which employers are to control the exposure of their employees to such agents (Biological Agent Regulations, 1998).

Issue 20

In the case of both asthma and dermatitis, employers have a duty to reduce or eliminate the use of the irritants that cause these diseases.

Issue 21

Ultra violet rays are a major cause of skin cancer in Ireland.

Issue 22

There is an increasing risk of contacting infectious diseases at work.

Recommendation Set 28 – Dermatitis; Asthma; Cancer; Biological Agents

- Promote awareness amongst employers and employees on the merits of reading chemical safety data sheets and labels as a precautionary measure to prevent dermatitis and asthma.
- Promote the value of risk assessment for chemicals and biological agents within specific sectors.
- Ensure employers are compliant with the chemical and biological agent's regulations, part of which includes health surveillance, pre-employment screening and availability of vaccines.
- Develop an integrated awareness campaign of the risks of skin cancer and the measures taken to prevent it, directed at high risk sectors such as construction.

4.5 Conclusion

This chapter has described particular health issues in the workplace which can adversely affect workers and has come up with recommendations to prevent them, to promote greater awareness and to assist in rehabilitation based on the model of workplace health and well-being described in the previous chapter.

References

Agius, R., Carder, M., Money, A. and Turner, S. (2008) *The Incidence of Occupational Skin and Respiratory Disease Reported to THOR by Physicians in the Irish Republic Between 2005 and 2007,* Manchester: The University of Manchester.

Cox, T., Griffiths, A. and Rial Gonzalez, E. (2000) *Research on Work-Related Stress*, Bilbao: European Agency for Safety and Health at Work.

DETE (2001) *Report of the Taskforce on the Prevention of Workplace Bullying*, Dublin: Department of Enterprise, Trade and Employment.

DETE (2005) *Report of the Expert Advisory Group on Bullying*, Dublin: The Stationery Office.

DHC (2006) *A Vision for Change, Report of the Expert Group on Mental Health Policy*, Dublin: Department of Health and Children.

DHC (2006) *A Strategy for Cancer Control in Ireland*, Dublin: Department of Health and Children.

Doll, R. and Peto, R. (1981) 'The Causes of Cancer: Quantifiable Estimates of Avoidable risks of Cancer in the United States Today', *Journal of the National Cancer Institute*, Vol. 66(6), pp. 1191–308.

EASHW (2000) *Research on Work Related Low Back Disorders,* Bilbao:
European Agency for Safety and Health at Work.

EASHW (2005) *Reducing the Risks from Occupational Noise,* Bilbao: European Agency for Safety and Health at Work.

EFILWC (2005) *Fourth European Survey on Working Conditions 2005,* Dublin: European Foundation for the Improvement of Living and Working Conditions.

English, J.S.C. (2004) 'Current Concepts of Irritant Contact Dermatitis', *Occupational and Environmental Medicine,* Vol.61, pp.722–726.

ESRI (2007) *Bullying in the Workplace, Survey Reports 2007*, Dublin: Economic and Social Research Institute.

Gabriel, P. and Liimatainen, M.R. (2000) *Mental Health in the Workplace*, Geneva: International Labour Organisation.

Held, E., Mygind, K., Wolff, C., Gyntelberg, F. and Agner, T. (2002) 'Prevention of Work Related Skin Problems: An Intervention Study in Wet Work Employees', *Occupational and Environmental Medicine,* Vol. 58, pp. 556–551.

HSA (2001) *Guidelines to the Safety, Health and Welfare at Work (Chemical Agents) Regulations 2001*, Dublin: Health and Safety Authority.

HSA (2001) *Violence at Work*, Dublin: Health and Safety Authority.

HSA (2005), *Work Positive – Prioritising Organisational Stress Resource Pack*, Dublin: Health and Safety Authority.

HSA (2006), *Summary of Fatality and Illness Statistics. 2004–2005*, Dublin: Health and Safety Authority.

HSA (2007), *Code of Practice for Employers and Employees on the Prevention and Resolution of Bullying at Work*, Dublin: Health and Safety Authority.

HSA (2007) *Code of Practice for the Safety, Health and Welfare at Work (Chemical Agents) Regulations 2001*, Dublin: Health and Safety Authority.

HSA (2008) *Guidelines on Occupational Asthma*, Dublin: Health and Safety Authority.

HSE (2007) *Mental Health Awareness and Attitudes Survey*, Dublin: Health Services Executive, National Office of Suicide Prevention.

NCRI (2006) *Mesothelioma Deaths 1993–2004*, Cork, National Cancer Registry of Ireland

NEHB (2004) *Study of Work-Related Violence*, Kells: North Eastern Health Board.

O'Connell, P.J., Russell, H., Williams, J. and Blackwell, S. (2004) *The Changing Workplace: A Survey of Employees Views and Experiences,* Dublin: National Centre for Partnership and Performance.

Power, F. (2001) *A Report of the Results of the Manual Handling Inspection Programme 2001,* Dublin: Health and Safety Authority.
QNHS (2004) *Quarterly National Household Survey-Disability Update, Quarter 1 2004*, Dublin: Central Statistics Office.
Safety, Health and Welfare at Work Act 2005 (S.I. No. 10 of 2005).
Safety, Health and Welfare at Work (Biological Agents) Regulations 1998 (S.I. No.248 of 1998).
Safety, Health and Welfare at Work (Chemical Agents) Regulations 2001 (S.I. No.619 of 2001).
Safety, Health and Welfare at Work (Control of Vibration at Work) Regulations 2006 (S.I. No.370 of 2006).
Safety, Health and Welfare at Work (Control of Noise at Work) Regulations 2006 (S.I. No.371 of 2006).
Safety, Health and Welfare at Work (Exposure to Asbestos) Regulations 2006 (S.I. No.386 of 2006).
SFA (2006) *SFA 6th National Absenteeism Report*, Dublin: Small Firms Association.
Thompson, S.C., Jolley, D. and Marks, R. (1993) 'Reduction of Solar Keratoses by Regular Sunscreen Use', *New England Journal of Medicine*, Vol. 329, No.16, pp. 1147 –1151.
WHO (2001) *Occupational and Community Noise Factsheet 258*, Geneva: World Health Organisation.

Appendix I

ACKNOWLEDGEMENTS

The Authority acknowledges and sincerely thanks the members of the Expert Group in preparing the Strategy.

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Appendix II

WORKPLACE HEALTH AND WELL-BEING DEFINITIONS

Health

Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity.

Workplace Health and Well-Being

Workplace health and well-being is a state of being for each employee and employer which enables each individual to reach their full potential in the workplace by ensuring their **work ability** through the promotion of mental, physical, emotional and psychological health and **well-being**. It will include the **prevention** of all types of illness and disease in these areas, the **promotion** of workplace health activities and the **rehabilitation** of individuals who experience such illness and disease so as to facilitate and support their return to employment.

Work Ability

Work ability comprises health, physiological and psychological functioning ability, occupational competence, and job motivation. Work ability encompasses workplace activities aimed at promoting and maintaining the ability to work, including all measures that the employer and the employees as well as representative bodies in the workplace make in a united effort to support the ability to work and to enhance the functional capacities of all persons active in working life throughout their working careers.

Workplace Health Promotion

Workplace health promotion is the combined efforts of employers, employees, and society to improve the health and well-being of people at work. This is achieved through a combination of improving the work organisation and the working environment, promoting the active participation of employees in health activities and encouraging personal development.

Well-Being

Maintaining and promoting the health and well-being of workers is an important condition in ensuring quality of work and employment. It concerns physical, mental and social well-being.

Prevention

The employer must carry out risk assessments arising from workplace hazards that could affect employee's health and ensure appropriate controls are in place so that employees are protected and not exposed to health risks at work. Where necessary, **health surveillance** must be made available.

Rehabilitation

Rehabilitation is defined as any method by which people with a condition resulting from sickness or injury which interferes with their ability to work can be returned to work. It is the process of restoration to good health of persons following injury or illness. In the context of this document, rehabilitation aims to restore the person to his/her optimum working capacity.

Health Surveillance

Health surveillance is the periodic review of the health of employees for the purpose of protecting health and preventing occupationally related disease, so that any adverse variations in employees' health that may be related to working conditions are identified as early as possible.

Health Screening

Health screening is described as the encouragement of a person to present for assessment in order to detect disease or a risk factor which is currently not producing symptoms. The aim is to intervene early so that either further progression can be stopped or the eventual outcome can be improved.

Workplace Health and Well-Being Strategy

Report of Expert Group

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