4 Government policies to promote health and well-being at work: An analysis of ten OECD countries

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This chapter examines policy levers that governments can use to promote health and well-being through the workplace in ten OECD countries, including the Group of 7 (G7) (Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States) and the OECD countries in the Asia and Pacific region (Australia, Korea and New Zealand). After setting out the legal and policy context, it provides a comparative analysis of workplace regulations, return-to-work legislation, financial incentives, and other measures that governments can and are taking at both the national and sub-national level.

Key findings

As the impacts of ill-health and poor well-being in the workplace have a broader economic impact that can be accounted for by employers, policies – at both the national and sub-national level – play an important role in facilitating employers in promoting health and well-being in the workplace. The differing delineation of responsibilities between government, employers and insurance institutions across the ten countries studied in this chapter shapes the policy levers available to government. The ten countries studied are the G7 countries (Canada, France, Germany, Italy, Japan, the United Kingdom and the United States) and three OECD countries in the Asia and Pacific region (Australia, Korea and New Zealand).

Workplace regulations set minimum standards in terms of health, safety and well-being in the workplace, and are an important foundation for health and well-being promotion:

- Working hour regulations specify a maximum number of hours that employees can work in six of the ten countries. Such regulation, when enforced and complemented with supporting measures, can protect employees from working excessively long hours, which is a psychosocial risk factor.
- Employee health checks or screenings are only a requirement in three of the ten countries (France, Japan and Korea), although sector- and industry-specific requirements are common. This reflects differences in policy contexts, considerations over potential drawbacks of testing and worker rights to privacy for sensitive information.
- Smoking in the workplace is regulated in all ten countries as a public health measure, but only three of the countries have comprehensive smoking bans in enclosed workplaces (Australia, New Zealand, and the United Kingdom). Comprehensive smoking bans can be effective in reducing exposure to second-hand smoke. There is significant variation across the ten countries in their approach to e-cigarette use in the workplace.
- Only two countries (France and Italy) regulate consumption of alcohol at work across all jobs and all tasks. Alcohol consumption regulation is typically limited to safety-sensitive industries in the other countries.

Sick leave and return-to-work legislation and policies hold the key to preventing avoidable sickness absence and facilitating timely return-to-work.

- Employer-paid sick leave legislation, which is only available at the national level in six of the ten countries, can create financial incentives for employers to prevent absence from work and promote timely rehabilitation if the duration of employer responsibilities is sufficiently long.
- The COVID-19 crisis has triggered a number of governments – at the national and sub-national level – to consider redesigning or strengthening their legislation relating to sick leave, especially as allowing workers to stay away from work can slow down the outbreak of infectious diseases.
- Requirements to promote timely return-to-work and make accommodations for workers with health conditions are commonplace, although requirements to make accommodations are too often limited to employees with disabilities and does not refer to those with health conditions.
- Gradual return-to-work mechanisms, identified in two countries, aim for return to work through the initial provision of reduced working hours and lighter working duties, with a view to a phased return to regular duties.

Financial incentives are an important lever for governments to encourage and facilitate employers to go beyond basic accident prevention and safety, and to comprehensively promote health and well-being in the workplace.

- Lower insurance premiums from accident insurance systems are granted to employers with a better record of ensuring worker safety in all ten countries. Many insurance institutions – both health insurance and accident insurance – also provide further benefits and advantages for employers who engaged in additional action to promote workplace health and well-being.
- Tax credits, in the form of exemptions from corporate tax for expenditure related to workplace health and well-being, are available in at least four of the ten countries at the national level (France, Germany, Italy and the United Kingdom). Tax credits specific to promoting active commuting to work are available in two countries (France and the United Kingdom).
- Subsidies for employers to promote health and well-being in the workplace are less widely available and often specifically for small and medium-sized enterprises (SMEs), given the specific challenges they face. Subsidies are often only available to a very limited number of employers and thus do not affect the decisions of most employers with regard to health and well-being promotion.

Disseminating information, tools and guidance to promote health and well-being in the workplace is a low-cost way for governments to increase awareness and facilitate employer action.

- The involvement of non-governmental stakeholders – including charities, trade unions and employer associations – helps ensuring widespread outreach to employers and when developing health and well-being promotion tools and guidelines for them.
- Self-assessment tools, which allow employers to diagnose the extent to which they are effectively promoting health and well-being among employees, are available in at least four of the ten countries (France, Germany, the United Kingdom and the United States).
- Provision of guidance on health issues that remain stigmatised such as mental health (e.g. depression or anxiety) can be particularly important to ensure employers and line managers develop an understanding of what appropriate steps they could take to support workers.
- Information and guidance on the COVID-19 crisis has been widely disseminated. Guidance covers issues relating to slowing the spread of the coronavirus such as ventilation, teleworking and sanitary measures, but also other impacts of the pandemic such as ensuring employee well-being, managing stress and supporting workers experiencing long COVID.

Certification and award schemes can reward employers that promote health and well-being among their employees.

- Certification and award schemes have been increasingly developed both by governments and the non-governmental sector, and can provide reputational benefits by certifying that employers meet certain standards relating to health and well-being promotion at work. The Health and Productivity Management Programme (H&PM) in Japan is a particularly large-scale scheme, with around 7.7 million employees working for certified companies.
- These schemes often go hand-in-hand with the disclosure of information on company-led programmes and health and well-being in the workplace, which can be used to inform both policy and employer interventions, although collection of such data can raise concerns about data protection and privacy in some countries.

The public sector, which accounts for one in seven workers (14%) on average in the ten countries studied, has an important role to play in promoting health and well-being at work. It is a leading employer that can showcase good workplace health and well-being promotion practices for the private and other non-governmental sectors to follow.

4.1. Introduction

Governments play an important role in steering employers to promote the health and well-being of their employees in the workplace through a mix of regulations, incentives and the dissemination of information. In many circumstances, self-interested employers will see the promotion of health and well-being of their employees as a priority as discussed in Chapter 3, but this may not always be the case. Moreover, the costs of a lack of action to promote health and well-being that falls directly on employers accounts for only a fraction of the total economic cost, which includes reduced employment, pressures on the social security system and increased costs for health systems as discussed in Chapter 2.

The responsibility for employers to protect the health and safety of their employees is well-established both in international and legal policy contexts, but this is often narrow and limited to preventing accidents, injuries and deaths related to work, and misses the opportunities that the workplace presents as an ideal location for intervention and early action to prevent ill-health. This chapter, in line with the report-at-large, looks primarily at how policy levers can encourage employers to use the workplace as an arena for the promotion of healthy lifestyles and practices that are conducive to good health and well-being.

This chapter covers policies in ten countries consisting of the G7 countries and three additional OECD countries in the Asia and Pacific Region (Australia, Canada, France, Germany, Italy, Japan, Korea, New Zealand, the United Kingdom, and the United States). This allows for comparison across countries that have differing legal and policy contexts, but nonetheless share a commitment to promoting health and well-being at the workplace. This review does not aim to be exhaustive, and similar initiatives aimed at promoting health and well-being also exist in many other OECD countries such as the examples described in Box 4.1. This chapter reviews the levers used by the government of the ten countries to support companies to implement health and well-being programme for their employees, beginning by setting out differences in legal and policy contexts (Section 4.2). It then looks at (4.3) regulatory measures related to health and well-being at work, (4.4) paid sick leave and return to work policies, (4.5) financial incentives for employers to implement health and well-being programmes, (4.6) dissemination of information, (4.7) certification and award programmes, and (4.8) the potential of public employment to lead by example.

Box 4.1. Health promotion and well-being at work in other OECD countries

The review presented in this chapter focuses on 10 OECD countries, including countries part of the Group of 7 and OECD countries in the Asia-Pacific region. However, similar initiatives aimed at promoting health and well-being also exist in many other OECD countries such as in Costa Rica, Ireland, Poland and Portugal.

Costa Rica

The Occupational Health Council (OHC), as a technical body attached to the Ministry of Labour and Social Security (MTSS), has a mandatory leading role to execute prevention actions and co-ordination among the State, employers and workers representatives, to encourage a decent, safe and inclusive working culture and environment. OHC has supported the regulation to promote and strengthen well-being in the workplace, especially the Executive Decree 4135-MTSS-MCJ-MEP-MIDEPOR “Development of Intersectoral Community and Labor Well-being Promoting Interventions”, and the Executive Order No.-027-S-MTSS on the Promotion of Well-being through the Adoption of Healthy Eating Habits, Physical and Mental Health, Physical activity and Work Recreation and Free Tobacco Smoke Spaces. OHC has also a key role in dissemination of information on promoting health through work. Specifically, OHC co-ordinates activities and public efforts that aim to improve health and safety conditions at work in all work centres, and encourages healthy practices in work environments and centres. Costa Rica commemorates the Well-being Week every year in September, an event established and promoted by PAHO/WHO, that aims to mobilise stakeholders to raise awareness and

encourage change towards healthy lifestyles, environments, and policies. As part of the local activities, recognition is expected to be granted to community and labour initiatives that show achievements in promoting healthy lifestyles, in accordance with the criteria established in the Ecological Blue Flag Program (national award scheme) in the category of community health.

Ireland

In Ireland, the Healthy Workplace Framework 2021-25 aims to support the growth of effective approaches to enhance health and well-being in the workplace. It recognises that workplaces have the potential to impact on the lives of a significant proportion of the population, with over 2 million people in employment in Ireland. The Framework has seven key objectives: 1. Build implementation structures, 2. Raise awareness, 3. Drive engagement, 4. Transform culture, 5. Provide supports, 6. Share good practice, and 7. Drive quality improvement and ensure sustainability. The Framework is underpinned by robust evidence and public consultation as well as ongoing engagement with key stakeholders including the Health Service Executive (HSE), health and safety, human resources, occupational health, and academia. The Department of Health and the Department of Business, Enterprise, and Innovation oversaw the development of this Framework. While many workplaces in Ireland have already embraced the health and well-being agenda, the development of this new Framework creates an opportunity to ensure it becomes embedded in the culture of all workplaces.

Poland

The Ministry of Health of Poland and Nofer Institute of Occupational Medicine in Lodz (NIOM) have been undertaking for years numerous initiatives to promote healthy lifestyles in the work environment, as part of the National Health Programmes for 2016-20 and 2021-25. A first example is the project on promoting physical activity and healthy diet in the world of work**,** run over 2016-20 by the National Centre for Workplace Health Promotion (NCWHP) located in NIOM, with the objective to improve competencies of employers and health managers about programmes promoting healthy eating and physical activities to tackle obesity and overweight. A second project was about promoting healthy and active ageing in employees, co-ordinated by NCWHP under the 2016-20 national programme, with the objective to educate employers, managers, human resource and occupational health specialists about creation and implementation of worksite programmes aimed at managing the health of ageing employees**.** A third example is a project in continuation of the two aforementioned, carried out over 2021-25 by NIOM. In particular, it relies on consultation centres that propose free consultations for employers and workplace health management professionals – by multidisciplinary team of NIOM experts – on environmental (including lifestyle-related factors) and occupational health determinants, planning, developing and implementing strategies to promote the health of ageing employees. Additional activities include development and implementation of educational materials, tools and campaigns for employees, employers, and occupational health professionals.

Portugal

In Portugal, the "Legal Regime for the Promotion of Safety and Health at Work" is specific to work legislation since 2009, which includes the development of health promotion activities among the main activities under the responsibility of the occupational safety and health services. By law, smoking is not allowed in enclosed workplaces. However, smoking may be permitted in designated areas expressly provided for this purpose as long as they comply with specific legal requirements. Detection of alcohol and illicit substance use may be carried out through toxicological tests in a limited number of professions linked to high levels of safety and performance, and according to well-defined parameters approved by the organisation/enterprise. Tests are undertaken only at the request and/or responsibility of the occupational health doctor. There is no comprehensive national law limiting or prohibiting alcohol and illicit drugs consumption at the workplace, but several regulations apply at the local administration level, such as city halls.

Source: For Ireland: www.gov.ie/en/publication/445a4a-healthy-workplace-framework/; for Poland: https://www.imp.lodz.pl/, https://promocjazdrowiawpracy.pl/, https://www.pracanazdrowie.pl.

4.2. Labour and workplace legislation and health system characteristics set the foundation for the range of policy levers available to governments to promote health at work

Standards and legislation relating to health and safety at work have existed for decades at the international, national and sub-national level, which underpin and shape the promotion of health, safety and well-being in workplaces. In many cases, such standards place a focus on traditional occupational safety and health approaches and are thus concerned with the prevention of work-related accidents, injuries and fatalities. At the international level, these include the 1981 Occupational Safety and Health Convention of the International Labour Organization, and the 1989 EU Framework Directive on Safety and Health at Work for three member countries of the EU. Specifically, in the European Union, Occupational Safety and Health (OSH) is regulated by the Framework Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work, and other related EU OSH directives, which are transposed by the EU Member States into their national laws, regulations and administrative provisions. Member States can adopt more stringent measures, going beyond the minimum requirements provided for in the abovementioned Directives. In countries with decentralised governments, OSH regulation and enforcement may be under the responsibility of sub-national authorities, which is recognised in this chapter. For instance, in Australia, state and territory governments regulate and enforce the work health and safety laws in their jurisdiction. In Canada, each provincial department is responsible for the administration and enforcement of OSH act and regulations.

In all ten countries, employers play a primary role in financing and organising measures relating to health and safety at the workplace, and this is typically enshrined in national legislation. In many countries, such as France, Germany, Italy and Japan, employers are specifically required to provide occupational health services to employees. In Japan, this requirement only applies to employers with more than 50 employees as small and medium-sized enterprises (SMEs) can access regional occupational health centres that are funded by government and can provide advice and guidance for both employers and employees. While such services have traditionally focused on preventing work-related accidents, injuries and fatalities, they have broadened their scope in some cases to also include health promotion.

The shift to focusing on health promotion and well-being and going beyond traditional occupational safety and health is more visible when looking at action plans and programmes that set out priority areas and are shown in more detail in Table 4.1. Workplace health and well-being considerations may be included in occupational health and safety strategies such as in Germany, or within broader health promotion strategies such as in Japan. In Germany, the Occupational Safety and Health Strategy includes traditional issues such as safe handling of carcinogenic materials in its objectives for 2019-24, but also broader issues such as the prevention of psychosocial strain and musculoskeletal disorders. In Japan, while the Occupational Safety and Health Strategy is relatively narrow, the National Health Promotion Movement in the 21st Century action plan includes measures to eliminate passive smoking in the workplace and address long working hours. In Italy, strategies on health at the workplace are included in the broad National Prevention Plan, but there are also three condition-specific national strategies, which are on the prevention of musculoskeletal disorders at work, work-related stress and occupational carcinogens/cancers.

Table 4.1. Description of national strategies relating to health and well-being in the workplace

Country	Name of relevant strategies	Description of strategies
Australia	Australian Work and Safety Strategy 2012-22	The strategy seeks to promote "healthy, safe and productive working lives" for all workers and across all sectors. There are three targets to be achieved by 2022 which are to reduce (1) worker fatalities due to injury by at least 20%, (2) incidence rate of claims resulting in one or more weeks off by at least 30%, and (3) incidence rate of claims for musculoskeletal disorders resulting in one or more weeks off work by at least 30%. The National Preventive Health Strategy for 2021-30 also includes workplace objectives including to promote physical activity and elimination of exceptions to the prohibition of smoking in workplaces.
Canada	Not applicable	Strategies are developed at the provincial and territorial level. For example, Ontario has a five-year Prevention Works Strategy for 2021-26, which includes a specific focus on eliminating barriers for SMEs to ensure health and safe workplaces. Quebec also updated its OSH legislation in 2022, which will among other changes, mean that employers have to provide prevention programmes and psychological health is fully embedded in OSH.
France	4th Occupational Health Plan 2021-25 (*Plan santé au Travail)*	The plan focuses on prevention and sets up ten operational objectives across one cross-cutting axis – tackle deadly and serious work accidents – and four strategic axes cantered on addressing emerging occupational health issues such as gender-related violence. The plan was developed jointly by the government, public health agencies and social partners.
Germany	Joint German Occupational Safety and Health Strategy 2019-24 (Gemeinsame Deutsche Arbeitsschutzstrategie)	The objectives of the plan are to ensure safe handling of carcinogens and good work organisation to prevent psychosocial strain and musculoskeletal workload. The plan was jointly developed by the national government, the 16 states and accident insurance institutions.
Italy	National Prevention Plan 2020-25 (Piano Nazionale della Prevenzione)	There is an objective relating to workplace health in the National Health Plan. There are elements relating to accident and injury prevention, but also references to health promotion in the workplace in a changing world of work. The plan also mentions standards such as the *Total Worker Health*® approach in the United States and the Healthy Workplace Model of the World Health Organization. There are also two condition-specific national strategies, which are on the prevention of musculoskeletal disorders at work and work-related stress.
Japan	National Health Promotion Movement in the 21st Century (Healthy Japan 21) 13th Occupational Safety & Health Program 2018-22	Japan has both a health promotion plan (Healthy Japan 21) with a workplace element and a specific OSH strategy. Healthy Japan 21 includes targets specific to coverage of mental health supports in workplace settings, incidence of long working hours, and exposure to second-hand smoke at the workplace that will apply through to end-2023. The OSH strategy focuses primarily on accident prevention (e.g. hazardous materials), although with specific health considerations such as occupational back pain and job-related anxiety.
Korea	4th Labor Welfare Promotion Plan 2017-21 National Safety Control Plan 2020-24	The Labour Welfare Promotion plan supports the creation of safe workplace and the improvement of workers' health. To this end, the government strives to improve working environment (harmful and hazardous facilities) and provides mental health and psychological therapeutic services to emotional workers. Priorities include a) to create a safe workplace through intensive industry-specific management of risk factors, b) to reduce the maximum working hours to a 52 hours per week, c) to build a supportive environment to enhance equity in workers' health management, and d) to prevent suicide by providing mental health services. Korea also has a National Safety Control Plan that provides direction on measures to prevent industrial accidents.
New Zealand	Health and Safety at Work Strategy 2018 – 2028	This strategy places the emphasis on the importance of ensuring health as much as safety of workers. The strategy outlines health risks primarily related to workplace accidents and injuries, but also includes a specific reference to work-related stress.
United Kingdom	Shaping Future Support: The Health and Disability Green Paper 2021	This strategy has an emphasis on helping prevent workers with a health condition or disability from falling out of work and supporting them in their return-to-work. The government's strategy to prevent ill-health related job loss is also due to be published in 2022 as a response to a consultation on how employers can support people at work with health conditions. These two strategies, when combined, covers the areas included in the previous 2017 strategy, Improving Lives: The Work, Health and Disability Green Paper.
United States	National Institute for Occupational Safety and Health (NIOSH) Strategic Plan 2019-24	The plan includes seven strategic goals including the reduction of occupational diseases such as chronic diseases (cancer, cardiovascular diseases, adverse reproductive outcomes), hearing loss, immune, infectious, & dermal disease, musculoskeletal disorders, respiratory disease, traumatic injuries, and the promotion of safe and healthy work design and well-being. Along with the Healthy Work Design and Well-Being Program, NIOSH also has a *Total Worker Health*®[1] Agenda which includes programmes and measures to promote worker well-being by creating safer and healthier work environments.

Source: International Comparison of Occupational Health Systems and Provisions: A Comparative Case Study Review, Department of Work and Pensions (2021[1]); national legislation.

As the range of strategies presented in Table 4.1 shows, the delineation of responsibilities for promoting health and well-being at work varies widely across the ten countries studied. Responsibility for health and well-being at work can fall under the responsibility of either the health agency, the labour agency or a mix of both. In the United States, the National Institute for Occupational Safety and Health (NIOSH) is part of the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services. By contrast, in Korea and New Zealand, the Korea Occupational Safety and health Agency (KOSHA) and WorkSafe operate under the direction of the Ministry of Employment and Labour and the Ministry of Business, Innovation and Employment respectively. In many cases, it is unclear where the responsibility for the promotion of health and well-being at work lies, which can result in a lack of co-ordination and attention across government (OECD, 2021[2]). To address this issue, the United Kingdom, for example, launched a Work and Health Unit (WHU) in 2015 as a joint unit of the Department of Work and Pensions and the Department of Health and Social Care, with the aim of promoting cross-sectional collaboration on health and work. The WHU has subsequently led a number of reviews and analyses on the promotion of health and well-being at the workplace to inform policy making.

In addition to governments and policy makers, other stakeholders play an important role in shaping health promotion at work; these includes insurance institutions, employers, employees, trade unions and social partners. For instance, trade unions play an important role in ensuring good working conditions and guaranteeing employee health and safety through promoting collective bargaining. The difference in the proportion of employees who are members of trade unions, despite a crude measure, gives some indication as variability across countries in trade union arrangements. While trade union density lies on average at around 18% among the ten countries studied, it is lowest at 10.3% in France and highest at 32.5% in Italy (OECD and AIAS, 2021[3]).

Collective bargaining plays an important role not only in wage-setting, but also in setting other conditions of employment such as job security, working time and occupational safety and health, all of which are issues that are closely related to health and well-being (OECD, 2019[4]). The role of trade unions in working hour regulation, for example, are described in detail in Section 4.3.1. Trade unions are also involved in international level discussions on workplace health promotion. For instance, the European Trade Union Confederation has contributed to the EU Strategic Framework on Health and Safety at Work 2021-27. Trade unions and their networks may also run their own programmes and research, building on their role of strengthening employee-employer relations. A notable example is the Health Workplaces Project launched in 2013 by the Trades Union Congress, a national trade union centre in England and Wales. The TUC has since increased the involvement of employees in health promotion initiatives working together with the National Health Service and other major employers. As a result of participating in the project, 40% employers reported a fall in sickness absence while more than 70% of employers and 90% of employees reported the workplace was a better place to work (TUC, 2013[5]).

The institutional arrangements of health systems results in significant differences in the role of employers in promoting the health and well-being of employees across the ten countries. For example, workplaces may play a larger role in Korea and Japan where primary care services are less prominent features of the health system as this can result in the decentralisation of the health system (OECD, 2019[6]). In other countries, general practitioners or primary care physicians deliver interventions that might otherwise be well-suited for implementation in workplaces, and typically act as gatekeepers to specialist care. In five of the countries, there are requirements to receive a referral to a specialist (Australia, Canada, Italy, New Zealand and the United Kingdom). In the remaining three countries, there are incentives to register with a primary health care physician (Germany), incentives to receive a referral to a specialist from a primary care physician (the United States) or incentives for both (France) (OECD, 2020[7]).

Health system characteristics also influence the role of the employer in financing health care as shown in Table 4.2. Five of the ten countries operate a national health system that entitle individuals to health care based on residency (Australia, Canada, Italy, New Zealand and the United Kingdom). In these countries, health care services is mostly financed by government schemes and thus employers tend to play a minimal

role. Employers may also provide private health insurance as an employee benefit and this is common especially in Canada. By comparison, France, Germany and Japan have multi-payer health insurance systems where employers and employees together pay contributions for health insurance. The United States is an exception as it has no universal health coverage. Despite employers being required to provide health insurance coverage for employees as part of the Affordable Care Act, only around 55% of the US population receive employment-sponsored health insurance. Employers also purchase health care directly for employees, although this accounts for a very small proportion of health care expenditure and no more than 1.2% of expenditure across any of the ten countries studied. The role of accident and workers' compensation insurance is discussed in Section 4.5.1 on insurance-based incentives, as these all interact directly with employers across the ten countries studied.

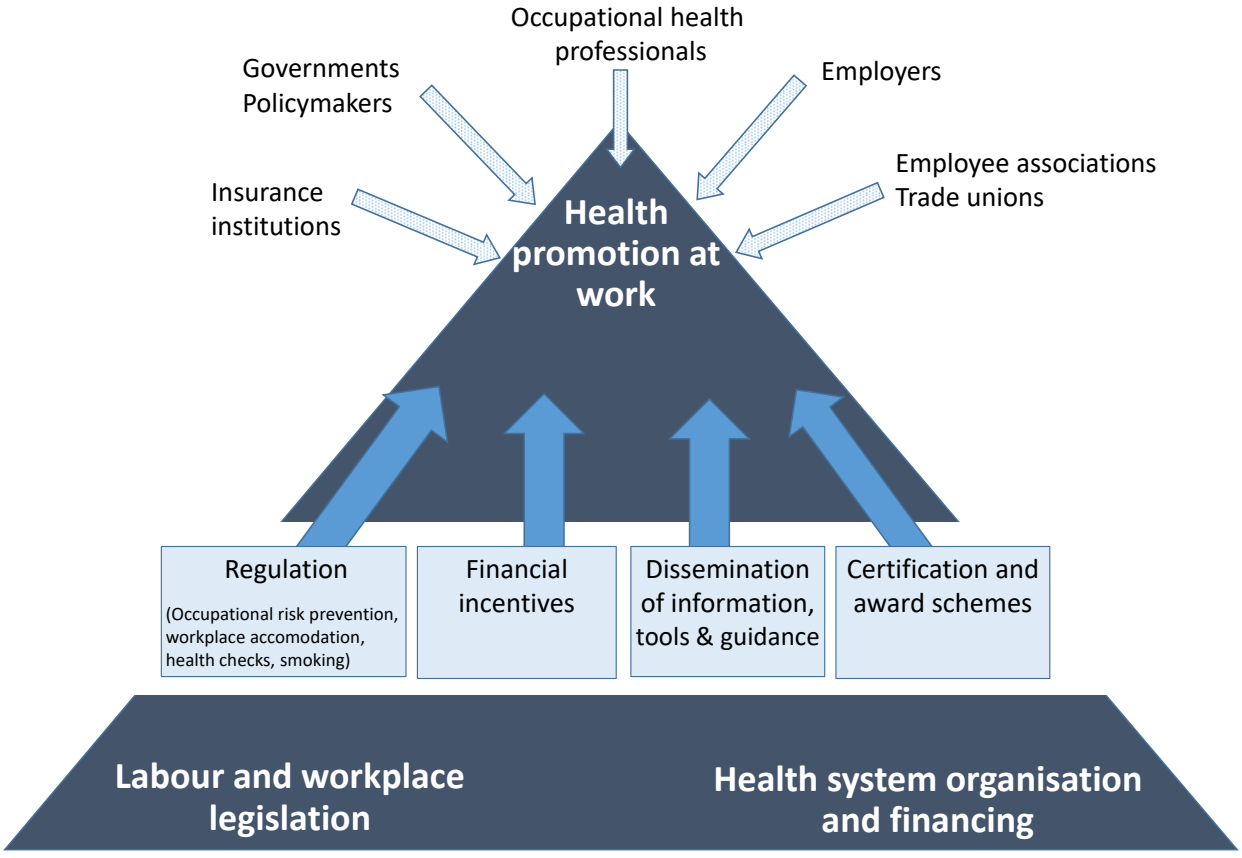
Table 4.2. Health system characteristics influence the role of the employer in financing health care

	Health system type	Role of employer
Australia	Universal national health system.	Voluntary private insurance is purchased by individuals. Complementary private insurance is held by 46% of the population.
Canada	Universal national health system covering medically necessary hospital and physician services.	Employment-sponsored insurance is common to provide complementary coverage to the universal health system. Complementary private insurance held by 67% of the population
France	Multi-payer insurance model.	Employer and employee both pay public health insurance contributions. Employers are also required to make voluntary private insurance available to all employees.
Germany	Multi-payer insurance model. Most are covered by public health insurance (88%), with the rest covered by substitutive private health insurance.	Employers pay half of the public health insurance contributions for most employees.
Italy	Universal national health system.	Voluntary private insurance may be provided by employers.
Japan	Multi-payer insurance model. Combination of employment-sponsored insurance and residence-based insurance. There is also a non-contributory public assistance system for those who face financial challenges.	Employment-sponsored health insurance held by 59% of the population. Voluntary private insurance is rarely offered by employers.
Korea	Single-payer insurance model.	Employer and employee both pay health insurance contributions. Most households hold some form of complementary health insurance.
New Zealand	Universal national health system.	Complementary private insurance held by 33% of the population. It is usually purchased by individuals.
United Kingdom	Universal national health system.	Complementary private insurance held by 10.5% of the population. Private insurance may be provided as an employee benefit.
United States	No universal health coverage. Around 92% of the population estimated to be covered by health insurance.	Private health insurance held by 67% of the population. Employment-sponsored health insurance held by 55% of the population.

Source: Health Systems Characteristics Survey; OECD, (2020[8]); Country Health Profiles, OECD, (2021[9]); International Health Care System Profiles; The Commonwealth Fund (2020[10]); Health Systems Institutional Characteristics: A Survey of 29 OECD Countries; Paris, Devaux and Wei (2010[11]).

Figure 1.6 shows the role that labour and workplace legislation and health systems play in setting the foundation for health and well-being at work and shaping the range of policy levers available to governments to promote health at work. These policy levers, which are described in the rest of this chapter, include (i) regulation, (ii) financial incentives, (iii) dissemination of information, and (iv) certification and award schemes. Figure 1.6 also highlights the role of stakeholders including occupational health professionals – who play an important role to diagnose risks and health problems in companies, identify needs and solutions – governments and policy makers, insurance institutions, employers, employees, trade unions and social partners.

Figure 4.1. Determinants of health and well-being promotion through work



4.3. Workplace regulations set minimum standards on employers' responsibilities to ensure health and safety in the workplace

Laws and regulations, when clear and well-designed, play an important role in setting legal standards relating to health in the workplace. General principles around employer responsibilities for employee health have already been discussed within the framework of occupational safety and health laws in Section 4.2, and thus this section looks at more issue-specific regulations that require employers to take actions relating to employee health and well-being in four areas. These are working hours (4.3.1), health check-ups (4.3.2), smoking at work (4.3.3), and alcohol consumption at work (4.3.4). Regulations relating to sick leave, return-to-work and reasonable accommodations for workers with health conditions is covered in Section 4.4.

While regulations can also only play a partial role in promoting health and well-being, it is primarily geared towards preventing accidents and work-related injuries. This is because regulation only sets out a minimum standard that employers are required to meet, which usually relate to workplace hazards, and there is no incentive to take further steps beyond this minimum standard. A combination of the threat of fines and the possibility for labour inspections play an important role in deterring employers from violating these regulations. Many governments also provide information and guidance to employers on how to ensure they are compliant with regulations as discussed in the sections below.

4.3.1. Working hour regulations to prevent excessively long working hours that can be detrimental to health are widespread

As discussed in Chapter 2, the health risks of excessively long working hours are well-established. A joint WHO/ILO analysis has shown that the disease burden that can be attributed to exposure to long working hours is higher than that of any other occupational risk factors. Most of the ten countries studied therefore have some form of regulation combined with supporting measures to minimise incidence of employees working excessively long working hours as shown in Table 4.3. Most countries set regulation on statutory normal working hours, which is supplemented by a statutory limit on maximum working hours including overtime (OECD, 2021[12]). **From a public health perspective, the priority is to prevent excessively long working hours as opposed to reducing median weekly hours, and thus the focus is placed on maximum working hour regulation.**

Table 4.3. Regulation on weekly working hours and compliance

Country	Normal weekly working hours	Maximum weekly working hours (including overtime)	Measures to enforce compliance
Australia	38 hours	No statutory limit	Employers are required to record working hours.
Canada	40 hours	48 hours	Employers are required to record working hours. The labour inspectorate can implement escalating compliance and enforcement actions including fines of up to CAD 250 000 (USD 200 00) for recurring offences.
France	35 hours[a]	48 hours	Employers are required to record working hours. Breach of working time regulation can result in fines ranging from EUR 45 000 to EUR 225 000 (USD 53 000 to 266 000) and potential imprisonment for individuals responsible.
Germany	No legal limit[a]	48 hours	Employers are required to record working hours. Breach of working time regulation can result in fines up to EUR 15 000 (USD 18 000) and potential imprisonment for individuals responsible.
Italy	40 hours[a]	48 hours	Employers are required to record working hours. Violations can result in administrative fines of up to EUR 10 000 (USD 12 000) depending on the number of breaches and the amount of extra time
Japan	40 hours[a]	51.25 hours[b]	Employers are required to record working hours. The Labour Standards Inspection Office carries out targeted inspections. Violations can result in an imprisonment of up to six months for individuals responsible or a fine up to JPY 300 000 (USD 2 700). Subsidies available.
Korea	40 hours	52 hours	Breach of working time regulation can result in fines and potential imprisonment for individuals responsible. Subsidies available.
New Zealand	40 hours	No statutory limit	Employers are required to record working hours.
United Kingdom	No legal limit	No statutory limit[c]	Targeted labour inspections including by specifically trained working-time officers. Improvement notices can be escalated to fines and imprisonment for individuals responsible.
United States	40 hours	No statutory limit	Employers are required to record working hours.

Note: Regulation on weekly hours is usually applied based on average hours over a certain number of weeks. The regulation shown above relates to statutory rules on working hours.

[a]In these countries, the OECD Policy Questionnaire was also able to find the most frequent or the average clause in terms of working hours among all workers covered by collective bargaining, which differ slightly from the statutory working hours.

[b]In Japan, statutory working hours are 40 hours per week, and the overtime limit is set at 45 hours per month and 360 hours per year in principle. Therefore, 51.25 hours per week is just a rough standard.

[c]There is a statutory limit on weekly working hours in the United Kingdom but individuals can opt out, and most contracts include such provisions.

Source: OECD Policy Questionnaire on Working Time Regulation, 2020.

As shown in Table 4.3, the most common limit on maximum weekly working hours is 48 hours (Canada, France, Germany and Italy). This is aligned with the EU's Working Time Directive, which requires that average weekly working hours must not exceed 48 hours including overtime. The United Kingdom also has a statutory limit of 48 hours per week, but most contracts include provisions where employees opt out of this limit, and hence, it is shown as having no statutory limit. Korea has a slightly higher limits at 52 hours, and the country has implemented reforms to reduce incidence of excessively long working hours in recent years. The impact of Korea's reform to phase in a reduction in maximum weekly hours from 68 to 52 hours is discussed in more detail in Box 4.2.

Box 4.2. Korea's working time reform to reduce maximum weekly working hours from 68 to 52

While the incidence of long working hours has declined significantly in recent decades, in 2019, almost one in five workers (18%) in Korea still reported working more than 55 hours per week, significantly above the OECD average of 10%. Long working hours affect health, productivity and well-being, and could also be linked to the high rates of fatal accidents and injuries at work in Korea. It also hinders work-life balance. For example, it can create obstacles to working for women who are pregnant or workers with caring responsibilities. The government thus subsequently launched a working time reform to reduce the incidence of long working hours through reducing the maximum statutory weekly working hours from 68 to 52 hours per week, which was implemented between 2018 and 2022. This brings the regulation on maximum weekly working hours in Korea more closely in line with the ten countries studied.

The reform consisted of a reduction of the maximum weekly overtime hours from 28 to 12, while the normal weekly working hours were kept at 40 hours per week. Recognising that fulfilling this requirement would be more challenging for SMEs, the reform was implemented in a gradual manner, with larger employers subject to the regulation first. Since July 2018, all firms, state and local governments, and public institutions with at least 300 regular employees were required to comply with the new working hour regulation, with active enforcement taking place in July 2019. This reform was extended to workplaces with 50 to 299 regular employees in January 2020, then to workplaces with 5 to 49 regular employees in July 2021. The government also put in place support measures to promote compliance including subsidies. Firms that fulfilled the requirements, could receive grants up to KRW 800 000 (Korean won) (USD 700) per month (up to two years) as compensation for the indirect cost, and a further KRW 400 000 (USD 350) per month (up to 80% of the employer's payment and up to two years) to compensate employees for a reduction in their wages. These subsidies were boosted if firms achieved compliance with the new weekly limit before it was legally required.

While a full picture is yet to emerge, preliminary evidence suggests that the reform may be effective and receives public backing. For example, the percentage of workers who worked more than 52 hours a week decreased gradually from 15.1% in 2017 to 6.8% in 2021. In a survey in 2021 by the Ministry of Employment and Labour, three in four respondents (78%) considered the reform to be a "good thing", and an overwhelming majority (88%) reported that their workplace was either "strictly complying" or "complying in some degree" with the new regulation (2022[13]). Challenges nonetheless remain in ensuring the successful implementation of the regulation, including ensuring that coverage of the new regulation applies to a sufficient number of workers. In 2021, around two in five workers were still not covered by the regulation due to exemptions. The incidence of long working hours within this group of exempt workers is also high compared to sectors where the new regulation applies (2020[14]).

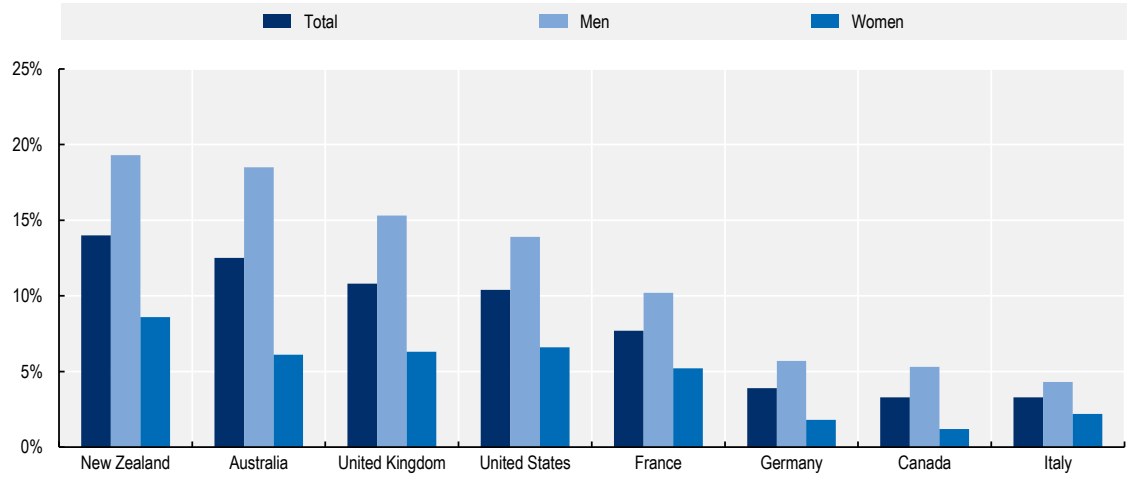
Source: Hijzen and Thewissen (2020[14]), The 2018-21 working time reform in Korea: A preliminary assessment; Ministry of Employment and Labor of Korea (2021[15]; 2022[13]), "52-Hour Work Week Receives "Thumbs Up" among 77.8% of Korean Workers", https://www.moel.go.kr/english/news/moelNewsDetail.do?idx=3062, and "The Work Hours Reduction System will Extend its Reach from Next Year", https://www.moel.go.kr/english/news/moelNewsDetail.do?idx=3061.

It is important to note, however, that while Table 4.3 presents statutory working hours, **working time is an area where rules negotiated through collective bargaining are particularly important, as this results in significant variation in practices depending on local and sector-specific needs** (OECD, 2019[4]). While the upper limit on maximum hours is bound either by the statutory or collectively agreed level at the central level in Germany and Korea, there is a possibility to exceed the upper limit on maximum hours based on collective agreements at the sub-national level or in individual contracts in the other eight countries (OECD, 2021[12]). For instance, in Germany, collective agreements signed in 2018 pointed to a shift towards unions representing metal workers calling for greater individual choice over working hours rather than a reduction in working hours that apply across all workers in the sector (OECD, 2019[4]).

Despite regulation, excessively long working hours nonetheless remain relatively widespread across the countries studied as shown in Figure 4.2, and is higher among men than women among all countries studied.[2] Although in countries with no statutory limits on maximum weekly working hours (Australia, New Zealand, United Kingdom and the United States), the proportion of employees working more than 50 hours per week exceeds 10%, there is still a sizeable proportion of employees reported to be working more than 50 hours in other countries with a 48 hour weekly limit. While there is no comparable data from Japan and Korea, it is well-established in both countries that excessively long working hours is considered an issue with significant health costs that requires policy attention (Hijzen and Thewissen, 2020[14]; OECD, 2018[16]).

Figure 4.2. Employees working excessively long hours remains widespread

Proportion of employees reporting working more than 50 hours per week by gender



Note: Data refer to 2020 except for Australia (2018).
Source: OECD Better Life Index, 2020, stats.oecd.org.

StatLink https://stat.link/512ztr

Governments face an uphill challenge in enforcing compliance with working time regulations. Employers are typically required to record working hours, and compliance is enforced through a mix of targeted inspections and the threat of potential fines and imprisonment for the individuals responsible. In a recent assessment by the ILO on the implementation of international instruments on working time arrangements, trade unions across many countries reported that the lack of clear delineation of responsibilities hampered inspection efforts, and that in many cases, there has been insufficient resources dedicated to tackle violations of working time regulation (ILO, 2018[17]). Where inspections are held, violations of working hour regulation may still occur regularly. For example, of the 24 042 workplaces that

the Labour Standards Inspection Offices in Japan visited in April 2020 to March 2021, more than one in three (37.0% or 8 904 workplaces) were found to have illegal overtime work. Of those found to have illegal overtime work, around one in three (33.5% of those will illegal overtime work or 2 982 workplaces) were found to have employees working in excess of 80 hours of overtime per month (MHLW, 2021[18]).

Governments also provide softer supporting measures to facilitate a reduction in incidence of long working hours. Among the countries studied, Japan and Korea are the only countries that have recently provided grants and subsidies for employers seeking to reduce excessively long working hours. In Japan, there is a subsidy for SMEs to implement work style reforms to reduce overtime work and promote take-up of annual leave. In Korea, as discussed in Box 4.2, the government supported the firms that reduced working hours to 52 hours per week in accordance with the working hour reform. Information is also widely disseminated in some countries to encourage compliance. In Korea, SMEs are able to receive free counselling support from labour experts on how to reform their workplace policies, while in the United States, the Department of Labor has developed a dedicated mobile timesheet app that employers and employees can use to keep track of working hours.

4.3.2. Countries rarely place requirements for health check-ups of employees due to employee privacy concerns

While health check-ups and examinations at the workplace can promote early identification of ill-health and thus facilitate intervention and treatment, this is rarely reflected in national policies. This may reflect drawbacks of health checks, differences in legal and policy contexts and concerns over employee privacy. Among the ten countries studied, while many have sectoral regulation requiring examinations of workers in hazardous circumstances, only three (France, Japan and Korea) require the provision of health check-ups to employees across sectors on a regular basis.

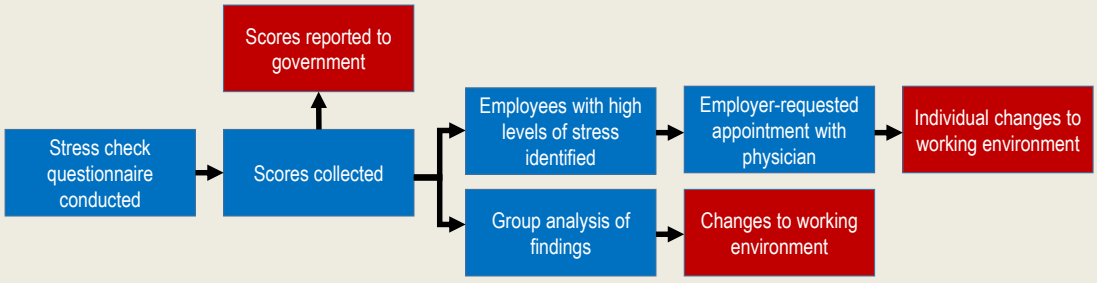
Japan has the strictest requirements, with employers obliged to offer a core health check-up (*ippan kenshin)* to all employees upon hiring and on an annual basis thereafter. These check-ups must include at least a standardised set of items that cover employee-reported items such as medical history, but also weight, vision, hearing, blood pressure, urinary sugar and uric protein tests (OECD, 2019[6]). All employers with more than 50 employees are required to report this information, and any employer failing to provide a core health check-up to their employees is subject to a fine of up to JPY 500 000 (Japanese Yen) (USD 4 600). SMEs can also apply for subsidies to finance the implementation of the health check-ups. Since 2015, all employers in Japan with more than 50 employees are also required to offer a stress check to their employees. The stress check consists of a questionnaire, which when filled by employees, provides insights for employees themselves, employers and policy makers as shown in the flow chart presented in Box 4.3. Employees receive individual scores, based on which they can alter their behaviours, and employers can make adjustments at both the individual and organisation-level based on the results. Employers then send their anonymised data to the government, which provides evidence on the uptake and usefulness of the stress check.

Box 4.3. Employers in Japan are required to conduct annual stress checks of their employees

All employers with more than 50 employees in Japan are required to evaluate the stress levels of their employees since December 2015. In 2020, 84.9% of employers offered the stress check, varying from 79.6% among employers with 50-99 employees to 97.3% for employers with more than 1 000 employees (2020[19]). The stress check aims to increase awareness of stress among employees such that they can take measures to prevent a deterioration of their mental health at the individual level, while also providing data for employers to assess how they can address psychosocial risk factors at work.

As shown in Figure 4.3, all employees are asked to fill the stress check questionnaire, and the results are used to make changes to the working environment at both the individual and company-wide level. The Ministry of Health, Labour and Welfare recommends that employers use a 57-item questionnaire with a four-point Likert-type scale, which is based on a questionnaire designed by the National Institute for Occupational Safety and Health in the United States. The recommended questionnaire captures a range of factors including work-related issues, individual factors and relationships with work colleagues.

Figure 4.3. Simplified process of stress check implementation for employers



Source: Based on information from Kawakami and Tsutsumi (2016[20]), The Stress Check Program: a new national policy for monitoring and screening psychosocial stress in the workplace in Japan, https://doi.org/10.1539/joh.15-0001-ER.

Individuals identified as having high levels of stress can request an interview with a physician. If requested, the employer is then required to arrange an appointment and make changes to the individual's working conditions as recommended by the physician. In 2017, 0.6% of employees receiving the stress check requested such an appointment. This low proportion may be indicative of continued stigma surrounding stress, especially as more than 10% of employees are identified as having high levels of stress in surveys (2020[21]). Measures are also in place to support the implementation of the stress check. Subsidies are available to SMEs to help them implement the stress check, and additional funds available in cases where a high-risk employee requests an appointment with a physician. A dedicated website for employers provides software to support implementation of the stress check and interpret results. Information on the value of the stress check and how to promote mental health at work is also available in the *Kokoro no Mimi* (Ears of the Mind) online portal.

The effectiveness of the stress check is also contingent on employers conducting data analysis of their findings and to using this to make changes to the working environment. The government has thus funded guides targeted at employers on how to make effective adjustments to the working environment, including through the involvement of employees. SMEs can also apply for subsidies to improve the working environment or to implement mental health promotion plans in the workplace. The proportion of employers reporting analysing the data from the stress check to make adjustments to the working environment has increased over time from 37% in 2016 to 67% in 2020 (2020[19]).

Source: Data reported from Inoue (2020[21]), Improvements in the working environment: information based on group analysis of stress checks, https://www.mhlw.go.jp/content/000715404.pdf; Ministry of Health, Labor and Welfare (2020), Implementation of stress check System [*Stress check seido no jisshi joukyou*], https://www.mhlw.go.jp/content/11303000/000805299.pdf.

In France, there is a requirement for a visit for information and prevention of ill-health with an occupational physician within three months of employment, and every five years thereafter. However, there is no obligation to go beyond by asking employees about their health status or by providing them with information and guidance during such visits. While such an arrangement may be non-intrusive and lower cost, this also means that the measures that can be recommended by the occupational physician are almost entirely dependent on the self-reporting of health by employees. In Korea, employers have an obligation to ensure their employees receive a general health check-up at least once every one or two years, although, in practice, employees receive their check-up through the National Health Insurance Service and not at the expense of the employer.[3]

Health check-ups at the workplace can only be effective if there is a pathway that begins with identifying signs of ill-health and includes follow-up support and interventions. This means that any workplace health check-up scheme needs to be linked to the health system, and account for the potential increase in access to health services that may result from such a measure (WHO Regional Office for Europe, 2020[22]). For example, a standalone workplace health check-up scheme may result in cases where employees identified as at-risk face long waiting lists or have to rely on out-of-pocket payments. In Japan, employees who are identified as being at risk of cardiovascular and cerebrovascular diseases in the core health check-up can request a free secondary-check up and health guidance from a physician on nutrition, physical activity and day-to-day life. As discussed in Box 4.3, follow-up mechanisms similarly exist for individuals identified as having high levels of stress through the annual stress check.

Differences in the role of the primary care sector across the ten countries may partially explain why some countries require workplace health check-ups but others do not. As discussed in Section 4.2, the delivery of public health interventions in the workplace may be more common in Japan and Korea, where primary care does not function as the sole gatekeeper to secondary and specialist care. For instance, in Japan, patients are not required to register with a single general practitioner (GP). This may also partially explain why employers are required to ensure their employees receive a regular health check, whereas conducting such checks in other countries may result in duplication of services offered by primary care physicians. It should be kept in mind when introducing workplace health checks that screening programmes can have both public health benefits as well as potential drawbacks such as over-diagnosis (where a condition or risk factor is identified that would not cause any harm) and overtreatment (where individuals receive more extensive or invasive treatment than is required) (WHO Regional Office for Europe, 2020[22]).

The lack of compulsory workplace health checks is also likely due to concerns over privacy and discrimination based on health or disability status. In many countries, employers are advised to collect the minimum possible data on the health of their employees to conduct their core functions and responsibilities as an employer such as to protect their health and safety. In the United States, employers are only permitted to ask employees to take health examinations and collect information on the findings if this need is directly related to the employee's responsibilities or the duties of the employer. In the European Union (and hence in France, Germany and Italy), the General Data Protection Regulation recognises data concerning health as a special category of data (European Union, 2016[23]). This places strict limitations on collection of information on employee health by employers, with specific limitations such as cases where collection of health data is necessary for carrying out contractual obligations (e.g. the provision of sick leave) or for public health and safety purposes.

In all the countries studied, there are nonetheless specific regulations requiring the surveillance and monitoring of the health of employees (health monitoring) and exposure to potential health risks (exposure monitoring) in workplaces where toxic or hazardous substances are handled. In Australia, for example, there are specific monitoring requirements if there is a significant risk of exposure to lead, asbestos or any other hazardous chemical. In the United States, most states also participate in a programme operated at the federal level by the CDC through which they provide data on blood lead levels. The data provided from states are then used to determine reporting requirements and regulation on lead exposure.

The issue of what information employers can collect on employee health has also been subject to attention during the COVID-19 crisis, as **information not usually collected previously such as previous and current infection status; vaccination status for COVID-19 and temperature checks became valuable for employers seeking to minimise infection risk** among their on-site employees. Employers in both the United Kingdom and the United States have been able to ask employees about their COVID-19 vaccination status on the condition that this is to protect the health and safety of other employees (Information Commissioner's Office, 2022[24]; U.S. Department of Health & Human Services, 2022[25]).

4.3.3. All countries consider the regulation of smoking in workplaces to be an important public health measure

Regulations to prohibit smoking at the workplace can improve public health outcomes, primarily by lowering exposure to second-hand smoke, and to some extent, by creating a supportive environment to reduce or quit smoking for existing users. A meta-analysis of 21 countries has found consistent evidence across countries that general smoking bans improve cardiovascular health outcomes and lower deaths from smoking-related illnesses and health conditions (Frazer et al., 2016[26]). It is important that comprehensive smoking bans are implemented guarantee as evidence show that these are more effective at reducing second-hand smoke exposure than partial bans. For instance, a review of seven European countries finds that PM2.5 levels,[4] which are often used as measure of second-hand smoke, reduced more in hospitality workplace settings in countries that introduced comprehensive bans (e.g. Ireland and Scotland) than other countries (Ward et al., 2013[27]). Workplace smoking bans may also incentivise existing smokers to quit or reduce their use as discussed in Chapter 3.

Smoking in enclosed workplaces is regulated in all ten countries, but most do not prohibit smoking entirely as shown in Table 4.4. **The most common policy among the ten countries studied is to prohibit smoking in enclosed workplaces except in designated smoking rooms** (France, Italy, Japan and Korea). While this is preferable to no limitations on smoking, it can only partially eliminate exposure to second-hand smoke (Cains et al., 2004[28]; Yamato et al., 2000[29]). By comparison, Australia, New Zealand and the United Kingdom are the three countries that prohibit smoking entirely in all enclosed workplaces, while in Canada, comprehensive workplace smoking bans are in place in most jurisdictions that together cover 95% of the population. In the United States, smoking in enclosed workplaces is also prohibited in a majority of states. Germany differs from all other countries in that smoking is not prohibited within enclosed workplaces and there is only a right for non-smokers to be protected from exposure to second-hand smoke.

Table 4.4. Regulation on smoking in enclosed workplaces

Country	Is smoking prohibited in all enclosed workplaces?	Do the measures cover vaping and e-cigarettes?
Australia	Yes	Separate regulation. Since 2021, e-cigarettes containing nicotine may only be accessed legally with a prescription.
Canada	Regulation at sub-national level. Prohibited entirely in 7 out of 13 jurisdictions, which account for 95% of the population.	In many jurisdictions, smoking regulation also applies to vaping and use of e-cigarettes..
France	Partially. Smoking is only permitted in designated smoking rooms.	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes.
Germany	No. Employers have a duty to protect non-smoking employees from exposure to tobacco, but there is no explicit prohibition.	N/A. There is no explicit prohibition of tobacco.
Italy	Partially. Smoking is only permitted in designated smoking rooms.	No. E-cigarette use and vaping is considered outside the scope of existing regulation.
Japan	Partially. Smoking is only permitted in designated smoking rooms.	Designated e-cigarette rooms can be established in addition to designated smoking rooms. E-cigarette rooms differ in that consumption of food and drinks is permitted.

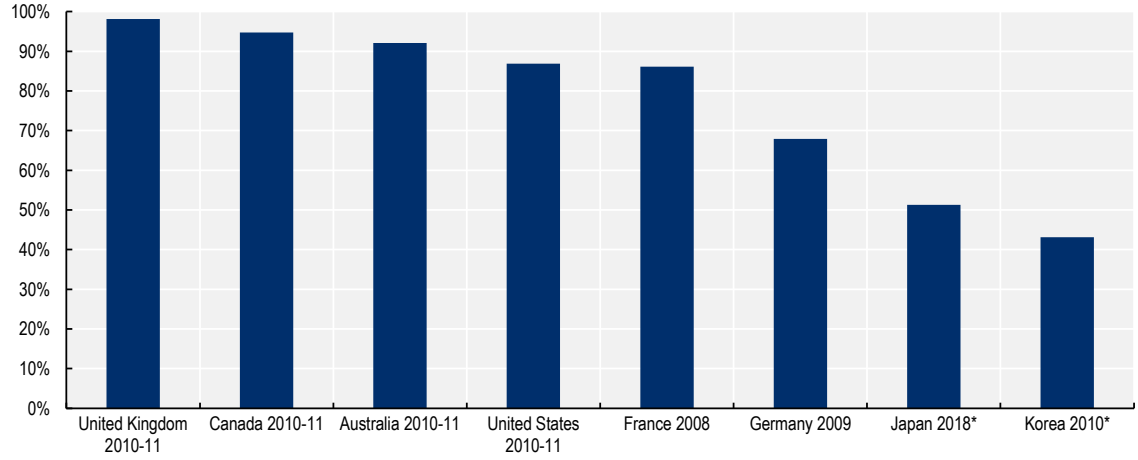
Country	Is smoking prohibited in all enclosed workplaces?	Do the measures cover vaping and e-cigarettes?
Korea	Partially. Smoking is permitted in designated smoking rooms. It is otherwise prohibited in all workplaces within buildings that have a floor area exceeding 1 000 square metres.	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes
New Zealand	Yes	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes
United Kingdom	Yes	Yes. Regulation on smoking in enclosed workplaces also applies to vaping and use of e-cigarettes.
United States	Regulation at sub-national level. Prohibited entirely in a majority of states.	In many states, smoking regulation also applies to vaping and use of e-cigarettes.

Source: The Global Health Observatory, World Health Organization (2020[30]); national sources.

In countries where workplace smoking is not fully prohibited, employers nonetheless retain the right to prohibit smoking within their own workplaces. This explains the significant variation in the implementation of smoking bans in enclosed workplaces. Data from the International Tobacco Control Policy Evaluation Project (ITC) shows that workplace smoking bans are reported by almost all smokers and ex-smokers in countries with comprehensive bans (Australia, New Zealand, and the United Kingdom) (Figure 4.4). By comparison, there is significant variation in prevalence of reported workplace smoking bans in other countries, ranging from a high of 86.9% in the United States to around 50% or less in Japan and Korea. Both Japan (2020) and Korea (2012) introduced measures to prohibit smoking at the workplace except in designated smoking rooms after the surveys were conducted.

Figure 4.4. Coverage of smoking bans at the workplace vary significantly

Proportion of current and ex-smokers who reporting that their workplace has a comprehensive smoking ban



Note: *Legislation was introduced in both Japan (2020) and Korea (2012) after the surveys, which prohibited smoking in the workplace except in designated smoking rooms as explained in Table 4.4. Data from Korea are from male respondents only.
Source: Smoke-Free Policies: ITC Cross-Country Comparison Report (2012); Use of Heated Tobacco Products within Indoor Spaces: Findings from the 2018 ITC Japan Survey (2019[31])

StatLink https://stat.link/yh9jpa

Most countries also put in place supporting measures to ensure compliance, including fines to enforce implementation and requirements to signpost restrictions on smoking. For example, in the United Kingdom, all workplaces must display the "no smoking" sign and employers have a duty to stop

people found to be smoking in the workplace. Employers that do not display the sign can be fined up to GBP 1 000 (British pounds) and employers who do not stop people smoking in the workplace can be fined up to GBP 2500. Japan is the only country among those studied that provides subsidies to ensure compliance, in this case specifically for SMEs up to JPY 1 million (USD 9 100) to adapt their practices to meet changes in regulation, including by establishing designated smoking rooms. There are also a wide range of other measures taken by governments to support employers in reducing smoking at work such as financial incentives for smoking cessation programmes and dissemination of best practices. As these measures are not directly related to the implementation of regulations on workplace smoking, they are discussed in further detail in the sections on financial incentives (4.4) and dissemination of guidelines (4.6).

A contentious issue among the ten countries studied is how vaping and the use of e-cigarettes in the workplace should be regulated. The WHO advocates for the strict regulation of e-cigarettes, noting that their use in areas where smoking is otherwise forbidden could contribute to the renormalisation of smoking in public, and that the use of e-cigarettes is increasingly shown to have harmful effects, in particular, for cardiovascular health (2021[32]). France and Korea extend most or all of their regulation on workplace smoking to include vaping, while Australia forbids the sale of e-cigarettes containing nicotine without a prescription. In contrast, Italy, Japan and the United Kingdom have more lenient approaches to workplace vaping to varying extents as shown in Table 4.4. The difference in approaches between smoking and vaping is particularly stark in the United Kingdom, where policy makers have so far decided that e-cigarettes should not be covered by smoke-free legislation. In the United Kingdom, since 2017, Public Health England (PHE) – since replaced by the UK Health Security Agency (UKHSA) – has regularly collected updated evidence on the health effects of e-cigarette consumption. The UKHSA advises that the e-cigarette consumption is not risk free and non-smokers should not start vaping but, if properly regulated, e-cigarettes are far less harmful than smoking (2020[33]). The latest evidence review from the UKHSA also finds that e-cigarettes can be an effective tool to facilitate smoking cessation (McNeill et al., 2021[34]).

4.3.4. Countries tend to leave decisions on consumption of alcohol to employers except in specific high-risk sectors

The consumption of alcohol is less heavily regulated among the countries studied compared to smoking. This may be as alcohol consumption at work may have less visible harmful impacts on bystanders in most jobs and industries. It may also reflect the tolerance and/or normalisation of consumption of alcohol both at work and work-related events (OECD, 2020[35]), and thus a view that strict regulation would result in excessive intrusion into private lives and lifestyle choices.

In all ten countries studied, consumption of alcohol in the workplace is not explicitly prohibited across all jobs and tasks. As shown in Table 4.5, in most countries, there is only a duty for workers and employers alike to manage health and safety at work, with decision around the provision and consumption of alcohol left to employers or in some cases to collective bargaining agreements. The exceptions are for tasks and jobs where working while under the influence of alcohol entails a high risk of injuries and accidents (e.g. construction workers at risk of falls), and jobs or tasks where impairment due to alcohol consumption can threaten public safety and endanger lives (e.g. bus or train driver).

France and Italy stand in contrast to other countries as they provide more explicit regulation designed to restrict harmful alcohol consumption in the workplace that applies to all jobs and sectors. In France, consumption of all alcoholic beverages other than wine, beer, cider and perry (*poiré*) is forbidden in the workplace. In Italy, while the law does not explicitly rule out consumption for all jobs and during all tasks, the provision of alcohol in the workplace is limited to the canteen, where only wine and beer may be served.

Table 4.5. What does legislation say about alcohol consumption at the workplace?

Country	What does legislation say about consumption of alcohol at the workplace?
Australia	No explicit prohibition of alcohol consumption at work that applies across all jobs and during all tasks. There is a legal limit on blood alcohol levels in jobs with high risk of accidents (e.g. heavy industry) or where others' health and safety can be jeopardised (e.g. public transport).All workers have a duty to manage their own health and all employers have a duty to manage health and safety risks for workers, which may include excess alcohol consumption.
Canada	No explicit prohibition of alcohol consumption at work that applies across all jobs and during all tasks. Employers may conduct testing for alcohol use in safety-sensitive positions (positions in which "incapacity due to impairment could result in direct and significant risk of injury to the employee, others or the environment) in limited circumstances.
France	No alcoholic beverage other than wine, beer, cider and perry/poiré. Employers may also limit or prohibit consumption of alcohol to protect the health and safety of workers, provided the measure is proportionate to the aim sought. Workers intoxicated with alcohol are also not allowed to enter workplaces.
Germany	Alcohol consumption at work is considered an internal issue that is regulated by employers together with trade unions and work councils. There is a limit on blood alcohol levels in jobs where others' safety is at risk (e.g. public transport).
Italy	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. It is strictly forbidden to take or provide alcohol during working activities where the work entails a high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. transport). A zero tolerance rule on blood alcohol levels applies for professional drivers. Serving of alcoholic beverages is prohibited at work, with the exception of canteens, where only wine and beer may be served.
Japan	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. There is a limit on blood alcohol levels in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).
Korea	No explicit prohibition of alcohol consumption at work that applies across all jobs and all tasks. There is a limit on blood alcohol in jobs where others' safety is at risk (e.g. public transport).
New Zealand	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. There is a limit on blood alcohol in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).Workers have a duty to manage their own health and employers have a duty to address worker health hazards, which may include excess alcohol consumption.
United Kingdom	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. There is a limit on blood alcohol in jobs with high accident risk (e.g. heavy industry) or where others' safety is at risk (e.g. public transport).Workers have a duty to manage their own health and employers have a duty to prevent worker health/safety risks, which may include excess alcohol consumption.
United States	No explicit prohibition of alcohol consumption at work across all jobs and all tasks. Employers in safety- and security-sensitive industries such as public transport and defence are required to conduct drug-testing, including for alcohol. Employers in public transportation are required to also run awareness-raising sessions on alcohol consumption. .

Source: Review of national regulation on alcohol consumption at work.

Alcohol testing at work is not widely implemented across the analysed countries. To some extent, and similarly to other forms of health checks as discussed in Section 4.3.2, concerns over intrusion into employee privacy may be among the reasons underlying a reduced use of alcohol testing at work. The use of alcohol testing – much like requirements to prohibit alcohol – is therefore usually limited to industries where working under the influence of alcohol can pose a threat to public safety. In the United States, for example, while there is no general provision that allows for alcohol testing at work, an estimated 12.1 million transportation employees categorised as performing safety-sensitive functions are subject to some form of alcohol and drug testing (US Department of Transportation, 2022[36]).

4.4. Paid sick leave and return-to-work regulation play an indispensable role in preventing ill-health and health promotion at the workplace

Preventing avoidable sickness absence from work due to ill-health is key to promoting health and well-being at the workplace. This applies both to preventing occurrence/recurrence of sickness absence and the promotion of timely return-to-work. While taking sickness absence, where required, should be facilitated, avoidable long-term absence from work due to sickness can have long lasting effects on labour market outcomes. Evidence from a number of OECD countries – including Belgium, the Netherlands, the

United Kingdom – shows that return-to-work becomes increasingly difficult as the duration of absence extends and especially so after three months of absence which in turn, increases the likelihood of labour market exit (OECD, 2015[37]). For example, in the United Kingdom, while 5.6% of workers on long-term sickness absence for four weeks leave work, this more than doubles to 12.2% for workers on absence for three to six months (UK Government, 2019[38]). For some workers, such as those with mental health conditions, prolonged absence from work can also be detrimental and contribute to exacerbation of health issues. There are a range of policy levers that can be used to prevent avoidable sickness absence and promote early return-to-work through employer involvement, including the provision of employer-paid sick leave and regulation to facilitate return-to-work.

4.4.1. Requirements for employers to provide paid sick leave could be strengthened to create stronger incentives for employers to prevent ill-health among their employees

Paid sick leave – which usually consists of a combination of a period of employer-paid sick leave and thereafter a period of government- or tax-funded sickness benefit as shown in Table 4.6 – can promote better health outcomes at the individual level by allowing sick workers to recover at home and ensuring they can access medical support. In the absence of paid sick leave, workers are often left with a choice of either forgoing income for the benefit of their health, or continuing to receive income yet at the risk of further deterioration of health. In Korea, for example, nine days of unpaid sickness absence can result in income loss equivalent to the monthly rent or mortgage payment (Gould and Schieder, 2017[39]; OECD, forthcoming[40]).

Table 4.6. Comparison of paid sick leave systems across OECD countries

Country	Minimum number of days of employer-paid sick leave	Number of days of sickness benefit financed by tax or government expenditure	Minimum proportion of previous salary paid by employer
Australia	10	182	100%
Canada	Provincial	105	-
France	60[a]	364	40%[b]
Germany	42	546	100%
Italy	3	180	100%
Japan	-	546	-
Korea	-	-	-
New Zealand	10	No limit	100%
United Kingdom	196	-	Statutory Sick Pay
United States	State	State	-

Note: "-" means no minimum entitlement. [a]: duration depends on tenure, [b]: employer-paid sick leave tops up sickness benefits, which already covers half of the previous salary.
Source: Towards equitable and adequate paid sick leave (OECD, forthcoming[40]), national sources.

Paid sick leave also has a broader impact on public health beyond the individual as it can mitigate the spread of infectious diseases. Individuals without access to paid sick leave are more likely to continue to attend work while sick (DeRigne, Stoddard-Dare and Quinn, 2016[41]), which in turn, can result in sick workers passing on infectious diseases in the workplace. Estimates during the H1N1 pandemic in 2009-10, there were around 5-7 million additional individuals infected with H1N1 in the United States due to employees who had not fully recovered from influenza-like illness going to work (Kumar et al., 2012[42]). There is also emerging evidence from the COVID-19 pandemic, which shows that access to paid sick leave has played an important role to allow workers who are suspected to – or who have – contracted SARS-CoV-2 to quarantine or self-isolate to minimise infection risk (OECD, 2022[43]).

As shown in Table 4.6, most of the countries studied have a combination of employer-paid sick leave and sickness benefit for workers on sickness absence. The **period of employer-paid sick leave is of particular relevance for this chapter, as it creates a financial incentive for employers to promote better health among their employees.** This operates through two channels. First, it creates incentives for employers to promote health and well-being at work and prevent sickness absence, regardless of whether this is exacerbated directly by the working environment or not. Second, it can – if the duration is sufficiently long – create incentives for employers to promote the timely return-to-work of employees on sickness absence.

Across the ten countries studied, as shown in Table 4.6, while most countries provide some form of paid sick leave, **the maximum entitled employer-paid sick leave at the national level for private sector employees tends to be very short and thus insufficient to create strong financial incentives to reduce or prevent sickness absence**. Canada, Korea, Japan and the United States are the only countries with no minimum entitled employer-paid sick leave at the national level, and account for around half of the OECD countries that have no such arrangement (OECD, forthcoming[40]). In Canada and the United States, however, employers must provide paid sick leave in certain regions, provinces and states. In Canada, employer-paid sick leave is available in three provinces and territories (British Columbia, Quebec and Prince Edward Island), while in the United States, 14 states and the District of Columbia have legislation on employer-paid sick leave. It is worth noting that workers in the public sector in Korea are covered by a paid sick leave scheme that provides full salary replacement for up to 60 days of sick leave per year and partial salary replacement for up to two years of sick leave (OECD, forthcoming[40]).

Even in the countries studied where employers have to provide sick pay for a longer duration, the financial incentive mechanism is dampened as employers are only responsible for covering a limited proportion of previous salaries. In the United Kingdom, sick workers are paid for 28 weeks from their employers, although employers are only required to pay the Statutory Sick Pay, as opposed to replacing a proportion of the previous salary. In France, meanwhile, minimum employer contributions depend on employee tenure, but typically continue for around two months, and are provided in combination with contributions from social security. Evidence from Switzerland and the Netherlands, two countries with a long duration of employer-paid sick leave, stronger employer contributions to pay, when implemented with supporting measures, can stimulate engagement from both employers and insurers to prevent ill-health and support rehabilitation and return-to-work. For example, in the Netherlands, since reforms to increase employer obligations to pay at least 2 years of sick leave at 70% of the salary[5] in the 1990s, both labour market exit rates and sickness incidence have decreased significantly (Hemmings and Prinz, 2020[44]).

The duration of employer-paid sick leave also differs across occupations and employment status with temporary workers often not covered in such schemes across OECD countries (OECD, forthcoming[40]), whereas many have mandated longer periods of employer-paid sick leave in the public sector. As discussed in further detail in Box 4.4, paid sick leave has played a particularly important role in protecting jobs, incomes and the health of workers who have fallen ill during the COVID-19 pandemic, and this has contributed to long-term policy changes in a few countries.

Box 4.4. COVID-19 is reshaping policies on sick leave and could help increase the role of employers in promoting employee health and well-being

In response to COVID-19, many OECD countries strengthened arrangements to provide paid sick leave, and this played a key role in protecting incomes, health and jobs amidst the pandemic and its broader impacts (OECD, 2020[45]). Many countries, especially those with less extensive sick leave legislation, put in place emergency measures to extend sickness benefits in case of absence due to contracting the coronavirus or self-isolation and quarantining requirements. In a few countries, measures went yet further by applying to indirect impacts of the pandemic on health and availability for work such as absence arising from mental health issues or disruptions to care and schooling. In most cases, however, the primary burden of increased paid sick leave lay on governments themselves as opposed to on employers.

This spotlight placed by the COVID-19 crisis on access to paid sick leave is also driving structural and long-term changes, with a number of countries seeking to place stronger incentives for employers to prevent sick leave. In New Zealand, employer-paid sick leave was extended from 5 to 10 days in July 2021, in part due to the recognition of the importance of sick pay amidst the COVID-19 crisis. In British Columbia (Canada), the regional government introduced 5 days of employer-paid sick leave in January 2022 to cover both full and part-time employees. These are encouraging developments that point to an increased recognition of the value of employer-paid sick leave in promoting the health and well-being of employees.

4.4.2. Regulations often place obligations on employers to promote timely return-to-work including to make accommodations and develop return-to-work plans

Regulations can also play a prominent role in promoting rehabilitation of workers absent from work due to ill-health, including by requiring employers to make accommodations for workers with health conditions and implement measures to promote a timely return-to-work. Such measures are particularly important in the ten countries studied, since as shown in Table 4.7, in most of these countries, employer-paid sick leave either does not exist or is very limited in duration, and thus reinforcing measures can help to facilitate timely return-to-work.

Table 4.7. Variations in reasonable workplace accommodation regulation across countries

Country	Which employees must employers make reasonable accommodations for?
Australia	Employees with a health impairment or disability.
Canada	Employees with a health impairment or disability.
France	Employees with an impairment or disability.
Germany	Employees with disabilities or with a long-term illness.
Italy	Employees with disabilities and impairments, but not workers with health conditions.
Japan	Employees with disabilities or with a long-term illness.
Korea	Employees with disabilities and impairments, but not workers with health conditions.
New Zealand	Employees with disabilities and health conditions. Broadly defined.
United Kingdom	Employers with disabilities, but not workers with health conditions.
United States	Employees with disabilities and impairments, but not workers with health conditions.

Source: International Comparison of Occupational Health Systems and Provisions: A Comparative Case Study Review, Department of Work and Pensions (Department for Work and Pensions, 2021[1]); national sources.

Workplace accommodations, which can involve changes in the workplace such as responsibility modifications, working time arrangements or changes to the broader working environment, play an important role in return-to-work and are often requirements placed on employers. As shown in Table 4.7, in all of the ten countries examined, employers are obligated to make adjustments or accommodations to workers with disabilities. However, this does not usually extend to workers with health conditions or workers experiencing sickness, illness or injury in most countries. Expanding eligibility of workplace adjustments to workers with health conditions is important, as many such workers would benefit from targeted support, even if they would not be classified as having a disability. Evidence also suggests that accommodation costs are often minimal, as accommodation typically involves an increase in flexibility provided to employees rather than an increase in expenditure (OECD, 2021[46]).

Gradual return-to-work mechanisms aim to facilitate employees who have been absent from work, often due to ill-health or illness, to return to work through the initial provision of reduced working hours and lighter (or different) working duties, with a view to a phased return to regular duties. For instance, adapting working hours, work tasks, equipment or job roles, that are often low cost measures, was found to help people suffering from chronic conditions, such as musculoskeletal disorders (MSDs), to stay at work (Davis et al., 2020[47]; EU-OSHA, 2021[48]). Many European OECD countries facilitate gradual return-to-work through regulation that ensures workers can continue to receive a proportion of paid sick leave (OECD, forthcoming[40]). Among the ten countries studied, only Germany and the United Kingdom have such regulation. In both countries, employees that return to work with reduced working hours, continue to be eligible for employer-paid sick pay for those hours they are not working as a result of ill-health.

The increased implementation of gradual return-to-work mechanisms reflects the growing evidence that such mechanisms go hand-in-hand with recovery from a range of health conditions, including mental health conditions and musculoskeletal disorders. Evidence from Germany suggests that the use of gradual return-to-work reduces the duration of sickness absence, especially for employees on long-term sickness absence and workers with mental health conditions (Schneider, Linder and Verheyen, 2016[49]). In Norway, where gradual return-to-work is compulsory for employees after eight weeks of sickness absence, these schemes are estimated to reduce lost working hours due to sickness absence by 12% to more than 50% with differences across studies (OECD, forthcoming[40]).

Most of the ten countries studied also place other obligations on employers to take measures to facilitate return-to-work. **One common measure across OECD countries is to require the development of return-to-work plans.** In Germany, employers are required to invite all employees who have been absent for more than six weeks during a 12-month period to a meeting to discuss and develop return-to-work plans. In Australia, employers are required to implement return-to-work plans in most states and territories, and in South Australia, the employer is required to appoint a Return to Work Co-ordinator if they have more than 30 employees. This does not in practice translate to return-to-work plans being in place for all employees who are absent from work. In the National Return to Work Survey in Australia in 2018, less than two-thirds (65%) reported that they had a return-to-work plan (Social Research Centre, 2018[50]). In France and Japan, meanwhile, employers are required to take measures to make reasonable accommodations based on guidance from an occupational physician.

A few countries also provide financial incentives that **reward and incentivise employers specifically to facilitate return-to-work**. In the United Kingdom, employers can apply for tax relief for medical treatments up to GBP 500 per employee that are recommended by a health care professional to facilitate return-to-work. To be eligible, the employee must be assessed by a heath professional to be unfit for work for at least four weeks without medical treatment or have already been absent from work due to injury or illness for four weeks. As discussed in Box 4.6, a limited number of subsidies are also available in Tasmania (Australia) for employers specifically seeking to improve return-to-work outcomes. Broader financial incentives discussed in Section 4.4 relating to health and well-being promotion such as in Germany, Japan and Italy could also be used to facilitate return-to-work.

4.5. Financial incentives can encourage employers to go beyond minimum standards by actively promoting health and well-being

Financial incentives go beyond stipulating the minimum standards for employers and thus can encourage employers to proactively promote health and well-being at work. Such incentives are particularly important for micro, small and medium-sized enterprises. For example, governments may not wish to require employers to put in place accommodations for employees to cycle to work, but they may wish to provide grants, tax breaks or other financial incentives to facilitate cycling to work. When looking at measures that promote health and well-being and go beyond preventing accidents and work-related injuries, financial incentives play a more significant role.

The use of financial incentives remains relatively limited in the studied countries with the notable exception of insurance-based incentives (4.5.1), which is consistent with findings from a prior review by the European Agency on Health and Safety at Work on existing economic incentives to improve occupational health and safety (EU-OSHA, 2010[51]). The other tools available, including tax credits (4.5.2) and subsidies (4.5.3) are then discussed in detail. Financial incentives to facilitate or ensure fulfilment of regulation are not covered in this section but in Section 4.3 on workplace regulations. Incentives relating exclusively to return-to-work, rehabilitation and sick leave are discussed in Section 4.4.

4.5.1. Insurance-based incentives vary in scope and form depending on legal and policy contexts

Insurance institutions, typically in the form of workers' compensation insurance boards and accident insurance systems, play an important role in creating incentives for preventing work-related accidents. **The responsibility of such institutions and the rules under which they operate are determined by government legislation, and especially in countries where insurance institutions are public agencies** (as shown in Table 4.8)**.** Accident insurance institutions reward companies that have a better record of preventing accidents and ill-health by offering lower insurance premiums. In a number of countries, the responsibility of insurance institutions extends further to facilitating timely return-to-work and workplace health promotion, and boards may even offer subsidies for implementing programmes related to health promotion and the prevention of ill-health.

Table 4.8. Institutional setup of workers' compensation boards and accident insurance systems

	Provider of insurance	Does government permit premium differentiation based on occupational health and safety outcomes?
Australia[a]	Public/Private	Yes, depends on insurance provider
Canada	Public	Yes, based on claims history
France	Public	Yes, based on claims history but only for firms with 200+ employees
Germany	Public	Yes, based on claims history and differs widely across industries/sectors
Italy	Public	Yes, based on claims history
Japan	Public	Yes, based on claims history
Korea	Public	Yes, based on claims history
New Zealand	Public	Yes, based on claims history
United Kingdom	Private	Yes, depends on insurance provider
United States[b]	Public/Private	Yes, based on claims history for public funds

Note: [a] workers' compensation boards are regulated at the secondary level of government (states and territories). Some states/territories have public/monopolistic schemes, while others have private/competitive schemes. [b] There are workers' compensation funds in each state, but some give the option for employers to purchase coverage from a private insurance provider.
Source: EU-OSHA, 2018, Economic incentives to improve occupational safety and health: a review from the European perspective; national sources.

As shown in Table 4.8 (column 2), all ten countries have schemes to differentiate insurance premiums between employers based on occupational health and safety outcomes, most notably, the frequency of work-related injuries and ill-health. These are often referred to as "experience-rating" approaches as they rely on the performance of employers in previous time periods. Such mechanisms can create financial incentives to promote employee health as employers with stronger outcomes are rewarded with lower insurance premiums, and those with poorer outcomes will face additional costs. For example, in the United States, insurance premiums are calculated at the state level, and are most often based on a combination of occupation and an "experience modification factor" which can increase or decrease the premium based on the history of previous workers' compensation claims compared to the average in the industry or claims category.

Insurance premiums may also be differentiated based on ongoing initiatives or future performance. In Italy, the National Institute for Insurance against Accidents at Work (INAIL) is running a "Swing for Prevention" (*Oscillazione per prevenzione*) campaign, under which employers carrying out interventions related to health promotion in the workplace are eligible to receive an insurance premium reduction. These measures can be wide-ranging, ranging from programmes for healthy diets and canteen use to campaigns to prevent smoking and harmful consumption of alcohol and drugs (2022[52]). In Alberta (Canada), SAFE Work certification is available in a number of industries, in which if employers are able to receive a certain standard in ensuring a safe and healthy workplace, they are eligible for a rebate of either 15 percent of the premium paid to the workers' compensation board or up to CAD 3 000 (Canadian dollars) (USD 2 400) for smaller employers.

Workers' compensation boards and accident insurance institutions also go beyond insurance premium variation and provide occupational health services or subsidies for employers to prevent work-related injuries. In Italy, in addition to insurance premium variation, from 2010 to 2022, INAIL issued 14 calls to encourage the implementation of interventions in the field of health and safety at work, and allocated over EUR 2.7 billion (euro) (USD 3.2 billion) in funding to such projects over this period, reaching almost 190 000 companies through the scheme. In Germany, prevention of work-related accidents and health hazards is embedded as the key objective of accident insurance institutions by government regulation, and thus these insurance institutions typically offer prizes, awards and recognition of high-performing companies, as well as services – such as counselling and training – and even subsidies for employers implementing prevention measures to fulfil their obligations. In France, the public accident insurance has subsidies for SMEs with less than 50 employees that are investing in equipment or actions to avoid work-related accidents. SMEs with less than 200 employees in France can also apply for a prevention contract, an agreement under which employers are able to receive an advance on expenditure relating to preventing accidents and ill-health, which is then converted into a grant if employers are able to meet the objectives agreed.

Health insurance institutions can also play a sizable role in incentivising employers to promote the health and well-being of employees in countries where health insurance is typically provided by the employer (e.g. Germany, United States) as discussed in Section 4.2. The 2015 Prevention Act in Germany requires health insurance funds have been required to spend EUR 7 (USD 8.28) per insured person on prevention measures, of which at least EUR 2 (USD 2.37) have to be spent on workplace measures. The introduction of this act coincided with a more than three-fold increase in expenditure per insured person on workplace health promotion between 2015 and 2019 by health insurance funds (Gerlinger, 2021[53]). The role of private health insurance companies is also discussed in Chapter 3.

4.5.2. Tax credits are used in a select number of countries

Tax credits, which usually take the form of reductions or exemptions from corporate tax, provide governments with a means to incentivise employers to invest in workplace health and well-being. Compared to subsidies, tax credits are often easier to implement as they can be included within existing

mechanisms relating to tax reporting mechanisms. Four of the ten countries studied (France, Germany, Italy and the United Kingdom) provide tax credits at the national level related to health and well-being and such credits are also available at the sub-national level in several states in the United States. In most cases, these measures have been introduced over the past decade (with the exception of Germany), suggesting that there is a growing emphasis on using such measures to incentivise employers to invest in employee health and well-being.

In Germany, a tax exemption introduced in 2008 provides employers with an exemption for health and well-being expenditures up to EUR 600 (USD 710) per employee per year (Federal Ministry of Health, 2022[54]). These measures can be wide-ranging and go beyond the provision of medical treatments, and thus can be used for expenditures related to the implementation of programmes to facilitate physical activity, healthy diets, addiction treatments and stress management. In Italy, a series of laws passed from 2016 onwards have expanded the scope of tax reductions for employers to include issues related to corporate welfare and employee health. In the United Kingdom, a corporate tax exemption of up to GBP 500 per year per employee was introduced in 2015 for medical treatments to support employees return-to-work as discussed in more detail in Section 4.4.

Tax credits have also been increasingly seen as a means to incentivise employers to invest in wellness programmes in the United States among lawmakers, although there has not been agreement to their implementation at the federal level or in most states. In 2009, a bill with bipartisan support called the Healthy Workforce Act was introduced but not passed. It would have provided a tax credit to employers for the costs of implementing workplace wellness programmes across the United States.[6] At the state level, a review of legislation found that 34 bills had been introduced for tax credits for employers to implement workplace wellness activities in 2001 to 2006, but that none had been passed (Lankford, Kruger and Bauer, 2009[55]). These examples show that while there is an appetite among some lawmakers for tax credits to employers implementing workplace wellness programmes, barriers remain, most notably in relation to cost. A more recent review of state legislation as of 2014 found that only four states (Georgia, Indiana, Maine and Massachusetts) have tax credits for employers promoting workplace wellness programmes (Pomeranz et al., 2016[56]).

France and the United Kingdom have exemptions designed specifically to facilitate cycling to work at the national level. In France, employers are able to pay employees up to EUR 500 (USD 592) per year for commuting by bicycle or car-sharing schemes as part of the Sustainability Mobility Package (Forfait Mobilité Durable).[7] This tax credit was introduced exclusively for commuting by bicycle in 2015 with a limit of EUR 200 (USD 237) per year as a public health measure, but was extended in 2020 to have broader sustainability objectives. An assessment of a trial of the tax exemption found that it resulted in a 125% increase in the share of commuting by bicycle after one year (ADEME - Agence de la Transition Écologique, 2016[57]). Employers providing bicycles to their employees for free are also able to receive a tax exemption for 25% of the cost of purchasing a fleet of bicycles for employees. In the United Kingdom, through the Cycle to Work Scheme, since 1999, employers can hire bicycles and safety equipment on behalf of an employee as a tax-free benefit. If the employer wishes to recoup the costs of hiring a bicycle, deductions can be made from the employee's gross salary, resulting in an exemption from the employee's income tax and contributions to National Insurance. Although employers can also apply for a tax exemption for payments to cover employee commutes in Germany and Japan, these are not explicitly or exclusively for commuting by bicycle or other methods that promote physical activity.

4.5.3. Subsidies are used in a targeted manner and often to support SMEs

While governments provide subsidies and grants to employers in all ten countries, they are typically targeted towards SMEs and often implemented at the sub-national level**.** As SMEs face barriers to implement workplace health and well-being programmes, dedicated subsidies are one of the facilitators to help them invest in these programmes (Box 1.3). **One main point of difference between subsidies and**

tax credits is that the former is often only available to a limited number of recipients and is thus more exclusive and limited in scope. Of the ten countries studied, only two (Japan and Korea) provide subsidies to employers to promote employee health and well-being at the national level, although many are related to accident injury and prevention and limited in scale. There are also many initiatives at the sub-national level and a select number of initiatives relating to health promotion are discussed below.

Box 4.5. Barriers and facilitators for small-medium enterprises (SMEs) to implement workplace health and well-being programme

In general, SMEs are less likely than large companies to implement health and well-being programmes for their employees, because of a number of barriers, such as the cost of the programmes, insufficient human resources and lack of programme knowledge (Chapter 3).

A number of facilitators, especially directed at SMEs, can help the adoption of workplace health and well-being programmes. These include strengthening occupational health services, offering subsidies for SMEs (such as subsidies described in Section 4.5.3 or subsidies to implement reforms to reduce overtime work (Section 4.3.1)), creating certification and award programmes for employers dedicated to SMEs (Section 4.8), developing national accreditation for health and well-being providers (Saint-Martin, Inanc and Prinz, 2018[58]), and integrating occupational health planning in supply chain arrangements (EU-OSHA, 2018[59]).

In Japan and Korea, subsidies are primarily designed to support implementation of good practices and facilitate compliance with regulation. In Japan, there are at least two subsidies that go beyond accident prevention and seek to facilitate workplace health promotion. SMEs implementing a Mental Health Promotion Plan can apply for a subsidy of up to JPY 100 000 (USD 911), and employers implementing measures to ensure employees with health conditions can balance their work with accessing medical treatments and supports are also eligible for a subsidy of up to JPY 200 000 (USD 1 821) (Japan Organisation of Occupational Health and Safety, 2021[60]). There are also subsidies in Japan to facilitate implementation of the stress check and health check-ups as discussed in 4.3.2, and subsidies for the recruitment of occupational physicians or nurses in the workplaces as required by occupational safety and health regulation. In Korea, there are also a range of subsidies to support good practices, although these are primarily centred on preventing accidents and injuries. For example, the Health Stepping Stone project is primarily for the implementation of exposure screening and health screening, while the Clean Workplace Project provides subsidies to prevent industrial accidents such as deaths and fatal accidents. Korea also provides subsidies for workplaces that are implementing measures to ensure compliance with the working time reform initiated in 2018 (Box 4.2).

Subsidies at the sub-national level that incentivise employers to promote health and well-being also play a role in Australia and the United States. These subsidies are typically not to support employers in meeting their obligations as employers, but rather to **implement innovative or new practices to promote health and well-being in the workplace**. In Australia, the two grant programmes identified that go beyond accident and hazard prevention focus on mental health, musculoskeletal disorders and return-to-work, which are discussed in more detail in Box 4.6, with a focus on subsidising innovative programmes. In Western Australia, grants are available for employers seeking to address work-related psychological hazards and promote mental well-being in the working environment. In Tasmania, the grant programme is specifically for the prevention of musculoskeletal disorders and the improvement of return-to-work outcomes, with grants capped at AUD 50 000 (Australian dollar) (USD 37 600) per organisation. In Indiana (United States), the local government provides grants of up to USD 10 000 for employer initiatives to promote wellness with a broader focus on initiatives relating to healthy lifestyle choices, increased physical activity, facilitation of breastfeeding and stress reduction.

Box 4.6. Australia's two sub-national subsidies for employers implementing innovative measures to promote health and well-being at work

In Australia, two grant programmes, implemented at the sub-national level, support employers to implement innovative or new practices to promote health and well-being in the workplace, the first being related to mental health, and the second to musculoskeletal disorders and return-to-work.

2021-25 Mentally Healthy Workplaces Grant, Western Australia

This grant programme launched in 2021 provides funding to a limited number of organisations for up to four years in Western Australia that implement initiatives to manage psychosocial hazards at work and promote good practices to support mental health and well-being at work. Some of the outcomes sought include reduced rates of bullying and prevention of workplace stressors, increased mental health literacy and a commitment to improving workplace culture from leadership of the organisation. Criteria for assessment are clearly set out in guidelines for the grant programme, and include a demonstration of an innovative or original approach to promoting mental health in the workplace.

The initiative is led by the Department of Mines, Industry Regulation and Safety, although funding can be given to organisations across all sector. *Mates in Construction* – a charity promoting suicide prevention in the construction sector – and to *Steering Health Minds* – a collaboration in the transport industry to promote mental health have each received AUD 250 000 (USD 190 000) in funding already as part of an election commitment. A further AUD 500 000 (USD 376 000) has been allocated for those applying for the grant. Successful applicants receive guaranteed funding of up to AUD 175 000 (USD 131 000) for year one. Funding for years two to four is subject to evaluation and dependent on meeting criteria agreed to in the grant agreement.

2022 Healthier Safer and Productive Workplaces Grants, Tasmania

This grant programmes provides funding to workplaces and researchers in Tasmania developing and implementing innovative solutions to prevent MSDs and/or to improve return-to-work outcomes for injured workers. All applicants have to specify in what way they perceive their solution to be innovative, and some measures cited include solutions to increase employer participation in the return-to-work process, reduce stigma associated with work-related injuries, and to tackle cultural restraints or language barriers that can hinder return-to-work. The guidelines explicitly mention that measures designed to ensure compliance with legal obligations or that do not differ from current practices will automatically be excluded. Organisations – including employers – can receive up to AUD 50 000 (USD 37 600) in funding, and researchers can receive up to AUD 100 000 (USD 75 100).

Source: Mentally Healthy Workplaces Grant Program (Government of Western Australia, 2022), https://www.dmirs.wa.gov.au/dmirs/mentally-healthy-workplaces-grant-program; 2022 Healthier Safer and Productive Workplaces Grants Program (WorkSafe Tasmania, 2022), https://worksafe.tas.gov.au/topics/services-and-events/2022-healthier-safer-and-productive-workplaces-grants-program.

Subsidies may also be provided to employer organisations, research institutions, and even employees themselves to implement good practices. In the United States, the Susan Harwood Workplace Safety and Health Grants provides annual grants to non-profit organisations that provide training to employers and workers on health at the workplace, with a thematic focus on preventing infectious diseases including COVID-19 for 2022. Successful applicants can receive grants of up to USD 160 000 and the total grants available each year are worth around USD 3 million in total. In Québec (Canada), there are grants available for unions and employer associations seeking to provide training or educational activities relating to workplace health and safety. Organisations that provide research or training are also eligible for the

aforementioned grants in Australia for mentally healthy workplaces (Western Australia) and for healthy workplaces (Tasmania) which are discussed in Box 4.6.

A major limitation in existing subsidies and financial incentives directed at employees is that they may only be accessible to individuals with a disability. Broadening eligibility for subsidies to also include individuals with a health condition could be valuable, as many workers with a health condition would benefit from targeted support. This distinction can be seen when comparing Australia and the United Kingdom's approach to financial supports for employees looking to stay in work. Whereas the Employee Assistance Funds in Australia provides financial support exclusively to workers classified as living with a disability (OECD, 2015[61]), the Access to Work grant in the United Kingdom provides financial assistance both for workers with a health condition and for those living with a disability. The importance of including workers with health conditions in accommodation measures is also discussed in Section 4.4.2.

4.6. Governments play an important role in facilitating best practices by disseminating information, tools and guidelines working with other stakeholders

Governments can also facilitate employers in implementing workplace health and well-being programmes through dissemination of information on the benefits for employers to invest in health of their employees and through providing guidelines and other tools that can support the implementation of good practices by employers. While uptake of guidelines is voluntary, this also allows for the inclusion of measures that promote health and well-being in the workplace and go beyond legal requirements that are usually set out in occupational safety and health regulations. Such guidance and tools may also be used for certification and award programmes as discussed in further detail in Section 4.7.

All ten countries provide information at the national level on health, safety and well-being in the workplace, typically through their agencies dedicated to occupational safety and health, and most provide specific tools such as self-assessment tools and guidelines for employers at either or both the national or sub-national level. Some countries also have dedicated agencies for researching and disseminating information on health in the workplace with an increasing focus on health promotion and early intervention. At the international level, the European Agency for Safety and Health at Work (EU-OSHA), plays a large role in both researching on the effectiveness of interventions to promote health at work and in disseminating this information to relevant stakeholders including employers.

At least four countries (France, Germany, the United Kingdom and the United States) provide tools for employers to assess the extent to which they are promoting health and well-being of employees. In France, the National Research and Safety Institute (IRS), which is responsible for researching on occupational health and safety, has developed a self-assessment questionnaire, which medium- and large-sized enterprises can use to diagnose gaps in workplace health promotion. The questionnaire includes questions for employees relating to self-reported health, work demands and the broader working environment. In the United States, the CDC developed a Worksite Health ScoreCard, which allow employers to assess the extent to which they have implemented evidence-based measures to promote the health and well-being of employees by filling out a questionnaire. The ScoreCard includes questions related to many areas, including weight management, physical activity, high blood pressure, tobacco use, musculoskeletal disorders, stress, sleep and maternal health (Centers for Disease Control and Prevention, 2022[62]). Participating employers in Japan's Health and Productivity Management programme (see Box 4.9) also receive a scorecard diagnosing areas of improvement based on their responses to a questionnaire.

Guidelines on how employers can promote health and well-being in the workplace are provided by governments at both the national and sub-national level. In Germany, the Businesses do Health (*Unternehmen unternehmen Gesundheit*) brochure developed by the Federal Ministry of Health outlines the responsibilities of employers, financial supports available to employers, intervention options and examples of good practices in workplaces (Federal Ministry of Health, 2022[63]). In the United Kingdom,

beyond guidelines provided by the Health and Safety Executive, there is also a National Institute for Health and Care Excellence (England), a public body dedicated to developing guidelines relating to health and clinical practices. In Australia, at least five states and one territory (Queensland, South Australia, Tasmania, Victoria, Western Australia and the Australian Capital Territory) provide guidelines for employers on how to promote health and well-being in the workplace. In the United States, the National Institute for Occupational Safety and Health (NIOSH) makes available several resources that employers and employees can use to promote a safe and healthy work environment, including Fundamentals of *Total Worker Health*®, Promising Practices, Let's Get Started with *Total Worker Health*® Approaches, and the NIOSH Worker Well-Being Questionnaire (WellBQ).

The involvement of non-governmental actors such as charities, trade unions and business associations in both the development and dissemination of guidelines is common across all countries studied, and is key to ensuring uptake and use of guidelines by employers, given the close associations and connections that these organisations may have with employers. For example, in the United Kingdom, the Prime Minister commissioned a report in 2017 on promoting mental health in the workplace (Thriving at Work), which was conducted by a mental health campaigner and business leader together with the CEO of Mind, the mental health charity (Stevenson and Farmer, 2017[64]). All recommendations were subsequently accepted by the government, and Mind subsequently developed a guide for employers on how to meet and implement the six core standards for mental health in the workplace. Guidelines and tools are also developed independently by non-governmental actors and independently of government. In Australia, the National Workplace Initiative illustrates the collaboration across sectors. The National Workplace Initiative is led by the National Mental Health Commission in collaboration with the Mentally Healthy Workplace Alliance made up of national organisations from business, union, government, workplace health and mental health sectors. The National Workplace Initiative is an AUD 11.5 million investment (USD 8.6 million) by the Australian Government to create a nationally consistent approach to mentally healthy workplaces.

Guidelines and tools are often targeted at specific health issues including MSDs and mental health conditions. As discussed in Chapter 2, MSDs and mental health conditions are among the leading causes of work-related health issues. At the international level, EU-OSHA is running a campaign on MSDs at work called Healthy Workplaces Lighten the Load for 2020-22 and has disseminated information and guidance to employers. At the national level, the Health and Safety Executive in the United Kingdom has developed a digital assessment tool that combines a range of questions to assess the risks for musculoskeletal health of specific tasks. Employers seeking detailed findings can purchase a premium version of the tool. At the sub-national level in Canada, guidance is available in the provinces of British Columbia and Ontario. Guidance in British Columbia released in 2010 by the Workers' Compensation Board provides information to support employers to identify risk factors, develop appropriate measures to reduce risk, and respond to injuries and symptoms of MSDs among employees. In Ontario, an MSD Prevention Guideline was established in 2007 and has been updated since. An online portal for guidance is now available, which industry- and occupation-specific guidelines and a range of tools available to employers (Centre of Research Expertise for the Prevention of Musculoskeletal Disorders, 2022[65]).

Mental health also features prominently in government guidance on health at work before the COVID-19 pandemic and this trend has continued since. In Germany, as part of the New Quality of Work Initiative (INQA) funded by the Federal Ministry of Labour and Social Affairs, the federal government runs psyGA, a portal targeted to SMEs on measures to promote mental health at the workplace (2022[66]). The tools offered as part of psyGA include a campaign toolbox based on an award-winning initiative at Siemens released in 2022, and a benchmarking tool that allows employers to assess their performance on workplace mental health and identify areas for improvement (Federal Ministry of Labour and Social Affairs, 2022[67]). Meanwhile, Canada's National Standard for Psychological Health and Safety in the Workplace were the first national guidelines on mental health in the workplace released in 2013, and since being introduced, the government has developed tools to guide implementation such as videos and sharing of promising practices (OECD, 2021[2]). An Ipsos poll in 2017 found that employees working for organisations

that implement the Standard are far less likely to say their workplace is psychologically unhealthy or unsafe (5%) compared to organisations not implementing the Standard (13%). The poll also found that implementation of the Standard also results in a decrease in absence from work among employees who report experiencing depression (Ipsos Public Affairs, 2017[68]).

The dissemination of information and guidance has also played an important role in preventing and reducing transmission of the SARS-CoV-2 virus among employees in all ten countries studied. Guidance has typically related to sanitary measures; facilitation of teleworking (Box 4.7); facilitation of sick leave and self-isolation (Box 4.4); encouraging vaccine uptake and air quality and ventilation. While such guidance has typically been designed to slow transmission of SARS-CoV-2, they also apply to other infectious diseases. For example, in the United States, the Clean Air in Buildings Challenge introduced in March 2022 is encouraging employers to follow guiding principles to reduce risk of transmission of viruses and other contaminants indoors through creating an indoor air action plan, ensuring fresh air ventilation, strengthening air filtration and cleaning, and communicating to the broader community. Another example is the Australian National Workplace Initiative that provides organisations with detailed guidance to address emerging issues surrounding COVID-19 and workplace mental health. Examples of topics covered include, among others, setting up sustainable hybrid work environments, and resources for people in high-pressure executive roles, and bespoke guides for SMEs.

Box 4.7. Ensuring that teleworking contributes to health and well-being through measures such as "the right to disconnect"

The onset of the COVID-19 crisis saw a sudden rise in teleworking to limit the spread of the novel coronavirus, which required policies and legislation to facilitate this shift. In many cases, employers were required to implement teleworking arrangements for their employees to the extent possible. For instance, in France, requirements for employers to enforce teleworking where possible were in place for many periods of the pandemic, with these restrictions amended depending on the epidemiological situation, and social partners played a key role in clarifying the interpretation of rules around teleworking (International Organisation of Employers, 2021[69]). In Australia, France and the United Kingdom, nearly half (47%) of workers reported teleworking during periods of lockdown in 2020, although the increase seen was less sharp in countries such as Japan which did not institute a national lockdown (OECD, 2021[70]). Governments across all ten countries studied in this chapter facilitated this shift including through guidance and informational campaigns, the establishment of a right to telework, and adaptations to legislation, and promoting the use of digital technology (OECD, 2021[71]).

While most countries have scaled back efforts to facilitate or require teleworking as epidemiological circumstances have improved, it is likely to persist in some form as workers seek greater flexibility such as through hybrid working in the world of work. For instance, based on a survey conducted by the Eurofound, around 60% of the workforce in the European Union are estimated to want to work from home (either daily or several times a week) after the pandemic (Eurofound, 2022[72]). It should be kept in mind nonetheless that not all jobs can be done remotely, and it is estimated that only around one-third of jobs across OECD countries can be done fully remotely (OECD, 2020[73]).

As teleworking is set to stay in some capacity, whether full-time or more often as part of a hybrid working arrangement, the focus is increasingly shifting towards ensuring that such work remains conducive to good health and well-being in the workplace. This is because while teleworking brings opportunities for working arrangements, it also comes with new complications for both physical and mental health. Teleworking can increase risk of blurring of boundaries between work and the home and detachment from work, both of which are risk factors for poor mental health (OECD, 2021[2]), raise the risk of musculoskeletal strain resulting from unsuitable home work environments (EU-OSHA, 2022[74]), and even increase the likelihood of physical inactivity.

One common measure, which has picked up momentum during and in the aftermath of the COVID-19 crisis, is the introduction of a "**right to disconnect**", the idea of which is to enshrine the right for workers to disconnect outside their working hours without any repercussions. Of the ten countries studied, France and Italy already had a right to disconnect in place prior to the COVID-19 pandemic (OECD, 2021[2]), while Ontario (Canada) introduced such legislation in December 2021. In December 2020, the European Parliament also called for the European Commission to propose legislation to introduce the right to disconnect, with mental health considerations a key driver. Legislation alone, however, is likely to be insufficient, and supporting measures to translate the right to disconnect from an ambition to a reality will be necessary. In one national survey of employees by a trade union in France in 2021, a majority of employers (60%) did not have a system to ensure the right to disconnect, even though France was the first country to introduce such legislation in the world (General Confederation of Labour - CGT, 2021[75]).

An emerging area where governments have been providing guidance to employers in the wake of the COVID-19 crisis is on how to support workers experiencing long-lasting health impacts from SARS-Cov-2 that lasts beyond the period of initial illness. As discussed in Chapter 2, long COVID is estimated to affect around 10% of individuals infected, and in the United Kingdom, is estimated to affect as much as 2% of the general population (Office for National Statistics, 2022[76]). **At least three countries (Japan, the United Kingdom, and the United States) and the European Agency for Safety and Health at Work provide guidance to employers on supporting workers experiencing long COVID.** Such guidance usually includes a mix of information on long COVID and the wide-ranging potential symptoms; recommendations to conduct an occupational health assessment; and guidance on how to support return-to-work. Paid sick leave systems can also play an important role in ensuring workers are able to work while recovering from long COVID as discussed in Section 4.4. The development of guidelines and reforms to support workers with long COVID could also have spill-over benefits, as this can create an environment where workers with other chronic health conditions can remain in work with the support of their employers.

Awareness-raising tools are useful for certain health issues that are surrounded by stigma in the workplace such as mental health and sexual health. If there is stigma associated with a health condition, employees are less likely to seek the support they need for fear of discrimination and judgment, and managers are less likely to know how to raise the issue with employees if they identify potential symptoms. There is clear evidence from across countries on the stigma surrounding mental health. In a 2019 survey by Ipsos MORI and King's College London, among the nine of the ten countries studied where data was collected,[8] less than two-thirds (62%) of respondents stated that mental illness is an illness like any other (2019[77]). This stigma extends to the workplace. For example, more than a third of respondents to a survey in Australia in 2013 reported that they would never disclose talking about mental health at work, even if it would be appropriate to do so (Mental Health Australia, 2013[78]). Another issue surrounded by stigma is menopause. Reducing stigma and increasing support for women experiencing menopause in the workplace can support workforce participation and have positive impact on women's overall health and well-being. In Australia, the National Women's Health Strategy 2020-30 recommends actions to improve awareness and encourage further research and support services for menopause, including examining the overall impact of menopause on work. The example of workplace policies to accommodate the needs of workers who experience menopausal symptoms in the United Kingdom is discussed in more detail in Box 4.8.

It is also important for guidelines and tools to emphasise line management in health promotion. Previous OECD work on mental health has shown line management to be particularly important in promoting employee health as called for in the Recommendation on Integrated Mental Health, Skills and Work Policy (OECD, 2021[2]). Evidence from the Netherlands and the United States also shows that line manager involvement can reduce sickness absence and improve the well-being of employees (Quigley et al., 2022[79]; Hendriksen et al., 2016[80]), while workplace conflicts – often the result of poor management – are a major risk factor for mental ill-health (OECD, 2015[37]). Although senior executives and directors play an important role in creating a culture of health, there is no guarantee that this will trickle down and reach

employees if line managers are not adequately aware or lack an understanding of health issues. Line managers need to not only show an understanding of health issues, but also understand their crucial role in designing work in a way that is conducive to good employee health and well-being (OECD, 2021[2]).

Box 4.8. Supporting workers experiencing menopausal symptoms in the workplace in the United Kingdom

Supporting women and other workers experiencing menopausal symptoms in the workplace has been the subject of growing attention among all stakeholders in the workplace – employers, trade unions, policy makers, charities and the public sector – in the United Kingdom. In 2019, a survey by Bupa, an international health insurance company based in the United Kingdom, found that almost 1 million women had already left the workforce early because of a lack of support for menopausal symptoms. A survey of employers in 2021 by the Chartered Institute of Personnel Development, a human resources association, also found that less than only a quarter (24%) of employers among their membership reported having a framework, policy or guidance to support workers experiencing menopause.

As women across the ten countries studied work longer than before, the importance of supporting workers through menopause has become increasingly important as many more women experience menopause at work. In the United Kingdom alone, there are more than 4.3 million women aged 50 and above in employment, and this age group has accounted for more than two-thirds of women's employment between 1994-2014. Menopause, which is a natural stage for women when their oestrogen levels decline and after which no periods occur, typically starts between the ages of 45 and 55, and can be accompanied by mild to severe symptoms such as lowered concentration, poor memory, tiredness and feelings of depression, all of which can have an impact on individual's working lives. In a survey by the Women and Equalities Committee in September 2021, a vast majority of workers experiencing menopause stated that menopause had not affected their ability to work and almost one-third had taken time off work due to symptoms.

Existing legislation – most notably the Equality Act 2010 and the Health and Safety at Work Act 1974 – largely forbids discrimination against workers experiencing menopause, but there have also been calls to develop specific legislation requiring employers to have a menopause policy to prevent discrimination against workers experiencing menopause. Acas, a publicly funded organisation that seeks to improve work through better employment relations, provides guidance for employers on supporting workers going through menopause. Both the Chartered Institute for Personnel Development and Bupa, the health insurance company, provide guidelines for employers and line managers on how to support workers experiencing menopause.

The public sector has also begun to implement menopause support and accommodation measures in recent months. In March 2022, the Mayor of London announced that menopause support would be made available to all workers in City Hall, the headquarters of the regional government for Greater London, through a policy, which was developed together with UNISON, the UK's largest union. Measures to be implemented include the provision of temperature-controlled areas, flexibility to allow for breaks during times where symptoms become severe, and the right to time off from work to attend medical appointments. In Northern Ireland, the Civil Service also announced a Menopause Policy in March 2022, to follow up on its awareness-raising event on "Making the Menopause Mainstream".

As awareness and understanding of the impact on menopause on the workplace has grown, the UK Government has committed to reviewing existing legislation and policy on this issues. In July 2021, the Women and Equalities Committee opened an inquiry regarding menopause and the workplace in the United Kingdom, and this was followed by the launching of a Menopause Taskforce in February 2022.

Source: UK Parliament (2022), Menopause and the workplace: inquiry, https://committees.parliament.uk/work/1416/menopause-and-the-workplace/.

4.7. Certification and award schemes can recognise employers prioritising health and well-being

Governments can recognise employers that put in place best practices by providing them with certification and award. A variety of schemes are introduced (4.7.1), ranging from large-scale national schemes such as Health and Productivity Management (H&PM) in Japan to smaller schemes such as the Corporate Health Standard in Wales (United Kingdom).

4.7.1. Well-implemented certification and award schemes can help to create reputational incentives for employers to promote employee health and well-being

The purpose of certification and award schemes is to create reputational benefits for employers promoting health and well-being in the workplace. There are at least three important criteria to ensure the credibility and usefulness of such schemes. Schemes must be (1) sustainable in the long-run and sufficiently long-lasting; (2) visible and disseminated to relevant stakeholders; and (3) they must be based on sound evidence that can effectively differentiate higher-performing employers implementing good practices compared to employers simply meeting legal obligations. Certification and award schemes are however exclusive as they are mainly accessible to higher-performing employers, and may offer little incentive for health promotion in workplaces where it is not considered a priority. This is especially the case for competition-style awards, whereas certification is usually contingent on meeting a certain standard of health and well-being promotion at work. Award and certification schemes are often classified as non-financial incentives as they incur no direct cost on governments themselves beyond those related to administration, although some may come with small monetary awards.

Japan has the most extensive range of government-led certification and awards including at both the national and sub-national level. The most prominent of these is the Health and Productivity Management programme (H&PM) launched in 2014 by the Ministry of Economy, Trade and Industry (METI), which is the largest-scale award and certification system across the ten countries studied. As discussed in Box 4.9, this programme provides certification for employers meeting a minimum standard in promoting health and well-being at work, and the top 500 SMEs (“Bright 500”) and top 500 large enterprises (“White 500”) are then provided with particular award. Japan also has similar recognition schemes to promote physical activity and bicycle commuting. The Sports Yell Company programme launched in 2017 by the Japan Sports Agency provides certification for employers that promote sports. Measures recognised as good practices in the Japan Sport Agency’s guidelines include the organisation of employee walking campaigns, corporate stretching and yoga programmes and health promotion seminars. The Ministry of Land, Infrastructure, Transport and Tourism (MLIT) also introduced a scheme with a similar recognition mechanism in 2020 to certify employers that support employees to use their bicycles to commute as Bicycle Commuting Promotion Companies. According to METI, there were also close to 100 programmes to reward companies for promoting health in the workplace at the sub-national level of government throughout Japan in 2021.

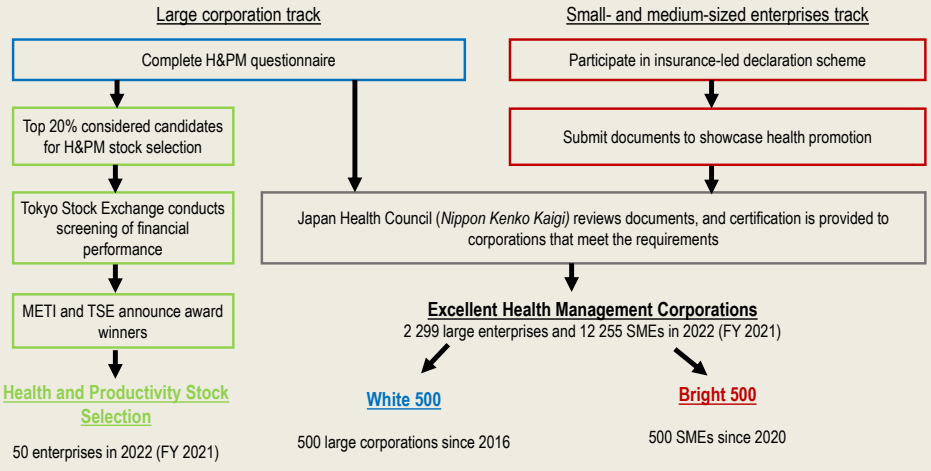
Box 4.9. Health and Productivity Management Programme (H&PM) in Japan

In 2014, the Ministry of Economy, Trade and Industry (METI) launched the Health and Productivity Management Programme (H&PM). The programme provides both certification and awards for employer who take measures to promote health and well-being at the workplace, and also aims to incentivise investment in such health-promoting corporations. As shown in the flow chart below, employers that meet a certain standard are certified as Excellent Health Management Corporations. Whereas large corporations are required to fill a dedicated H&PM questionnaire, SMEs only need to submit written evidence for assessment, given that the questionnaire requires detailed information that may not be collected regularly by smaller companies. The top 500 SMEs are then awarded the "Bright 500" status and the top 500 large corporations are awarded the "White 500 Corporation" status. A selection of companies are also chosen for stock selection, a mechanism designed to facilitate investment in these companies, as described in more detail in Box 5.4 of Chapter 5.

Since being implemented, participation in H&PM has increased significantly both among SMEs and large corporations. In 2016, the first year in which certification was issued, only 318 SMEs and 235 large corporations received Excellent Health Management certification, but this had increased to 12 255 SMEs and 2 299 large corporations by financial year 2021. Around 7.7 million workers or 13% of Japanese employees thus work for H&PM certified companies.

Figure 4.5 shows the process through which employers are certified or awarded. Employers applying for certification and awards are assessed primarily based on descriptions of programmes they implement to promote health among employees. This includes but is not limited to measures to increase health literacy, promote physical activity, support smoking cessation and support balancing of work with medical treatments. In addition to quantitative indicators such as stress check and health check-up completion rates and the prevalence of smoking and exercise habits, indicators for presenteeism and absenteeism have been added to recent H&PM surveys for large corporations. By comparison, the disclosure mechanism for SMEs is less burdensome and relies on applying SMEs declaring what measures they are taking to promote health and well-being in the workplace.

Figure 4.5. Process for employer recognition (awards and certification) in the Health & Productivity Management Programme



Source: Ministry of Economy, Trade and Industry of Japan (2021[81]) , *Enhancing Health and Productivity Management Programme* [Kenkō keiei no suishin ni tsuite], https://www.meti.go.jp/policy/mono_info_service/healthcare/downloadfiles/211006_kenkokeiei_gaiyo.pdf.

Information on the implementation of H&PM provides useful insights for employers, policy makers and experts on the promotion of health and well-being in the workplace. Aggregated information from H&PM provides data on the impact of H&PM implementation on health and labour market outcomes, as well as employer motivations and mechanisms to promote health and well-being (see Chapter 3). For example, high-performing companies based on survey results have lower rates of smoking, hypertension (high blood pressure) and hyperglycaemia (high blood pressure) among other outcomes. There also seem to be significant monetary benefits for employers. Employer medical expenditure for employee health is considerably lower in higher-performing companies, and turnover rates in Excellent Health Management Corporations (5.4%) were about half of the turnover rates in companies across Japan (11.4%), suggesting that H&PM implementation enhances employee retention and loyalty. Large corporations also receive an individualised feedback sheet based on their responses to the H&PM survey that helps them to diagnose areas for improvement.

Source: Ministry of Economy, Trade and Industry of Japan (2021), Enhancing Health and Productivity Management Programme [Kenkō keiei no suishin ni tsuite], https://www.meti.go.jp/policy/mono_info_service/healthcare/downloadfiles/211006_kenkokeiei_gaiyo.pdf.

Recognition schemes in other countries at the national level tend to be much smaller in scale and often take the form of **award schemes with a competition-style model in which only a small number of organisations receive recognition**. While such schemes may only incentivise a select number of firms already invested in promoting heath at the workplace, they may foster innovative practices. In Germany, the Federal Ministry of Labor and Social Affairs, the State Committee for Occupational Safety and Safety Technology and the German Statutory Accident Insurance have recognised exemplary commitment to health promotion at work through the German Occupational Safety and Health Awards. The competition has been held every two years since 2009, and the focus is aligned with goals agreed to in the national Joint Occupational Health and Safety Strategy, which currently include designing workplaces to reduce musculoskeletal loads, promote mental health and ensuring safe handling of carcinogenic and hazardous substances. New Zealand has also had a Health and Safety Award since 2005, although the award is only available to a small number of organisations each year. In 2022, for example, there are only nine categories of awards for organisations. In the United States, while most schemes are run at the state level or by non-profits, the federal government operates a Safe-in-Sound Excellence in Hearing Loss Prevention Award for employers that have demonstrated significant achievements towards reducing noise exposure and preventing hearing loss among employees.

Certification and award schemes are also provided at the sub-national level in countries including Australia, the United Kingdom and the United States. Two schemes in Wales (United Kingdom) and Canberra (Australia) are worth noting as they follow a certification model and could have a significant impact if scaled up. In Wales (United Kingdom), employers following the Corporate Health Standard can be given five different levels of awards based on their performance. This programme has since been paused, in part due to challenges posed by the COVID-19 crisis, and it is currently under review with a view towards a relaunch. The Healthier Workplace Recognition Scheme in Canberra (Australia) operates similarly with five different levels of recognition, although unlike the Welsh scheme, moving up levels of recognition is reliant on a proven long-term commitment and continued participation in the scheme over consecutive years. Awards are also available in other states and territories of Australia including New South Wales and Victoria, although these take the form of competitive awards that are only available to a small number of organisations.

A wide range of awards and certifications have also been developed by non-governmental stakeholders including private sector actors and non-profit organisations. In France, *Harmonie Mututelle,* a private insurance firm, holds an annual prize for health-promoting companies. In 2020, 30 initiatives were rewarded with a small monetary prize. In Germany, the Corporate Health Award, which is operated by a private company, has provided awards to companies showcasing excellence in health management in the

workplace since 2009. Mind, the UK-based mental health charity, runs a Workplace Well-being Index, which employers can participate in to increase their understanding of employee perceptions of mental health programmes in the workplace, learn from a network of employers, and gain public recognition of commitment to well-being in the workplace. The Workplace Well-being Index showcases the potential for governments to work closely with non-governmental stakeholders. While operated by a charity, its roots lay in a report commissioned in 2017 by the Prime Minister on how to better promote mental health for all in the workplace. The six core standards for employers that were established in the report are the criteria used in the Workplace Well-being Index.

4.7.2. Certification and award schemes can be associated with the disclosure of information on company-led programmes and health and well-being in the workplace

Certification and award schemes also go hand-in-hand with collection of more granular information on health and well-being in the workplace, which can be used to widen the evidence base to inform both policy and employer interventions. This is because recognition schemes are typically based on information shared by employers on the health and well-being outcomes of employees and the specific measures and programmes they implement. The H&PM programme, which is described in detail in Box 4.9, provides a wealth of information relating to employer motivations and the relationship between health interventions at the workplace and health outcomes, given the scale of the programme. Even with smaller scale programmes such as Mind's Workplace Well-being Awards, there are opportunities to identify good and innovative practices that could be disseminated to other employers seeking inspiration. While ensuring that employee privacy rights are protected may be a challenge, the release of such information may also be able to increase transparency and facilitate investment in health promoting companies as discussed in Chapter 5.

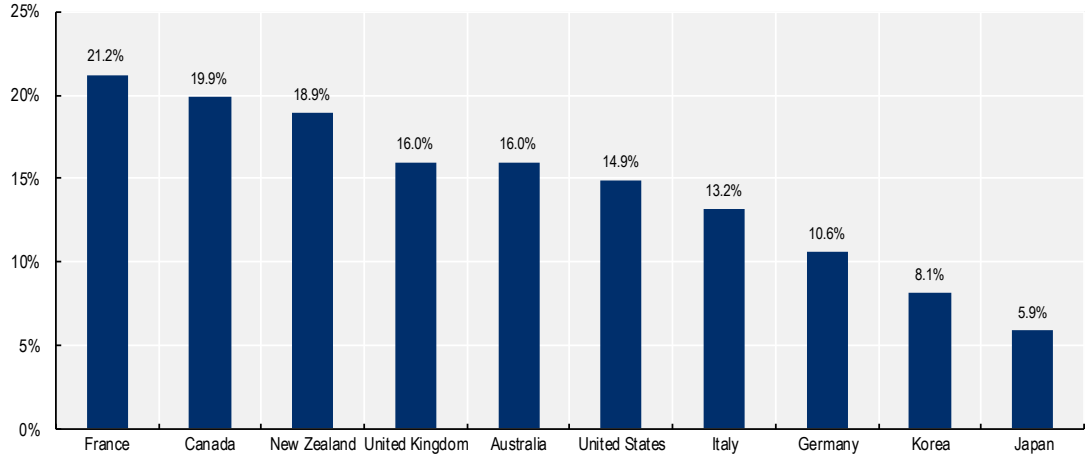
4.8. The public sector can lead by example by being an exemplary employer and promoting health and well-being in the workplace

The public sector has an important role to play in promoting health and well-being at work as it accounts for a large proportion of total employment, and as the government – through its greater influence on the public sector – can set a standard for other employers in non-governmental sectors to follow. This section begins by considering the importance of promoting health and well-being in the public sector, and then looks at both strategies and programmes designed to promote health and well-being in the public sector.

Promoting health and well-being among employees in the public sector is necessary because of the large contribution of the public sector to total employment. As shown in Figure 4.6, government employees accounted for around one in seven employees across the ten countries studied, ranging from as high as 21.2% in France to 5.9% in Japan as of 2019 (OECD, 2021[82]). In many of these countries, specific public agencies are also the largest employers, giving them a significant role in promoting health and well-being at work. The Department of the Defense in the United States employs around 3 million people (2021[83]), making it the largest employer in the world. Meanwhile, the National Health Service, which provides universal health care in the United Kingdom, employs around 1.4 million people, making it the largest employer in Europe (2022[84]).

Figure 4.6. The public sector accounts for around one-seventh of total employment across the ten countries studied

Employment in general government as a proportion of total employment, 2019



Note: Data for Japan are from 2017. Data for Australia are calculated based on data from the Australian Bureau of Statistics for 2021. Data for New Zealand are from Te Ratonga Tūmatanui | The Public Service for 2021.
Source: Government at a Glance, OECD (2021[82]). National sources for Australia and New Zealand.

StatLink https://stat.link/fbg21h

At least two countries (France and Korea) have strategies specific to the promotion of health and well-being among government employees at the national level. In France, the inaugural Occupational Health Plan for the Public Service (*Plan Santé au travail dans la Fonction publique)* sets out 30 actions to be taken between 2022 and 2026 across five separate areas with a focus on prevention. It integrates lessons learnt from the COVID-19 crisis, and thus includes commitments to strengthen psychosocial risk prevention through the roll-out of mental health first aid, strengthening of data on occupational health, and the development of preventative medicines (Minister of Transformation and Public Service, 2022[85]). In Korea, efforts to promote health in the workplace are based on the Guidelines for Public Officials' Health Management, a document released in 2009 by the Ministry of Interior and Safety. The guidelines call for the expansion of health care support facilities in public agencies, including fitness centres and gyms, refresh zones and counselling centres, and the organisation of campaigns to improve awareness and understanding of health in the workplace.

Strategies to promote health and well-being in the public sector at the sub-national level also exist in Australia and the United States. The regional Government of Western Australia (Australia) sets out a vision for ensuring public sector health and safety to ensure compliance with the principles set out in the Australian Work Health and Safety Strategy 2012-22. North Carolina (United States) also has a Worksite Wellness framework that introduces measures related to smoking cessation, improving nutrition, encouraging physical activity that state government agencies are expected to consider. There are also leading examples within state agency. For instance, the U.S. CDC/NIOSH provides its own workforce with programmes, practices, and policies that prevent injury and illness while promoting health and well-being, under the Healthiest NIOSH programme (NIOSH, 2022[86]).

4.9. Conclusion

Governments – at both the national and sub-national level – play a significant role in facilitating, incentivising and supporting employers to promote the health and well-being of employees, working closely with other stakeholders. At the bare minimum, governments must continue to ensure employers are meeting minimum standards of health and safety regulation and addressing work-related health issues. Yet governments can also go further to support employers to promote the health and well-being of employees. Governments can use a range of reinforcing and complementary measures to support employers. These include regulations relating to working hours and smoking; financial and non-financial incentives to facilitate investment of employers in employee health and well-being; dissemination of information, tools and best practices to guide employers; recognition of high-performing employers; and the reform of sick leave and return-to-work systems. Governments can also showcase good practices in promoting health and well-being of employees in the public sector by acting as an exemplary employer, and set an example for employers in the private sector to follow.

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Notes

[1] *Total Worker Health*® is a registered trademark of the U.S. Department of Health and Human Services.

[2] This may mean that men are more at risk of health issues related to excessively long hours of paid work, but women are significantly more likely to work more hours of unpaid work than men in all countries studied. When both paid and unpaid work are accounted for, it is estimated that women work longer each day than men in all of the ten countries studied with the exception of New Zealand.

[3] In Korea, employers are required to ensure their employees receive a general health check-up once every one or two years, but this may not be at the expense of the employer. While the Occupational Health and Safety Act stipulates that a workers' general health check-up is compulsory, it also states that it may be substituted by a health check-up offered under the National Health Insurance Service, which is not provided at the expense of the employer.

[4] $PM_{2.5}$ refers to particulates, whose diameter is 2.5 μm or smaller. Smoking is a major generator of $PM_{2.5}$, and $PM_{2.5}$ levels are therefore used as a reliable measure of the extent of exposure to tobacco smoke.

[5] In the Netherlands, employers have an obligation to pay at least two years of sick pay at 70% of the previous salary. The duration can be longer and the rate of replacement of previous salary can be higher under certain circumstances.

[6] Slightly different versions of the bill – but with the core principle of tax credits for workplace wellness programmes – were later introduced, but these were also not passed.

[7] When first introduced, the ceiling for tax exemption for commuting to work by bicycle was EUR 400 per year. This was subsequently increased to EUR 500 per year in January 2021.

[8] All of the ten countries other than New Zealand were included as this was a report to inform policy at the G20 level. The average presented is thus of the remaining nine countries.