BKK Bundesverband GbR

PHPRO

Addition to Country Report Germany:

2 Practical Examples

First preliminary draft

INSTITUT FÜR PRÄVENTION UND GESUNDHEITSFÖRDERUNG
AN DER UNIVERSITÄT DUISBURG-ESSEN

Index of contents

1. Introduction

1.1 Two examples of PHP in Germany

The two examples for public health policies (PHP) in Germany described below are (1.) Workplace Health Promotion (WHP) in general and (2.) a project on health promotion for unemployed. Both examples are based on the § 20 of Social Code Book No. V (SGB V)[1] (in detail cf. Prüßmann & Schröer 2010).

1.1.1 Example 1: Workplace Health Promotion

For health insurance funds and business enterprises, company health promotion activities offer a possibility for reducing the costs of sickness. This is – alongside others, such as providing an effective marketing strategy tool for the health insurance funds or an opportunity for companies to present themselves positively both internally and externally, etc. – one of the main benefits of company health promotion measures from the point of view of the business enterprises and the health insurance funds. This financial focus also finds its expression in the primary goal of company health promotion measures, namely to help in reducing the level of employee absence through sickness by the application of appropriate intervention measures. Implementation of the measures is generally guided by need, i.e. they are implemented in the areas of a business where sickness levels are highest and the health status of the employees is lowest. This strategy of orientation to need, adopted out of economic considerations, means in practice that health promotion measures tend to be carried out most frequently in those areas of the business where the employees tend to be disadvantaged both socially and in terms of their health. These are usually the areas where the working conditions are also most detrimental to health.

Pursuant to § 20a and § 20b SGB V, health insurance funds can offer in-company health promotion measures to supplement occupational safety measures. Reducing the socially conditioned inequality of health opportunities and discussing or dealing with the social determinants of health was initially neither intended nor even thought of in the relevant section of § 20 SGB V nor by the health insurance funds within the context of their company health promotion activities.

Within the framework of company health promotion activities, a whole catalogue of measures has meanwhile become established which, taken together, can be used as an integrated concept of health management and health policy by and in business enterprises. The key elements of company health promotion in Germany are health reports, health circles and employee surveys; though a whole range of other tools exists besides.

Health reports (cf. Sochert 2000, 1998) present the results of work disability analyses produced from health insurance fund data. The analysis covers all cases of unfitness for work of compulsorily or voluntarily insured members, which ended during the period under review. In preparation of the report, strict standards are applied with regard to data privacy. All data provided by a business enterprise is coded in such a way as to render the identification of individual persons impossible. Units with fewer than 50 members are evaluated only in strictest compliance with data privacy or are combined with others to form larger units. Types of illness with fewer than five cases are obliterated on data protection grounds.

The health report provides a general overview of sickness levels within a company and analyses any particularly conspicuous areas, those with above-average numbers. The results of all evaluations are docu-

[1] The Social Code Book No. V regulates all concerns of statutory health insurance in Germany. The § 20 of Social Code Book No. V regulates the fields of primary prevention, (workplace) health promotion and self-help.

mented in detail for each investigated unit. The report is intended in particular for the experts within a company at local level, for instance company doctors, works council members, occupational health and safety officers or technical monitoring personnel of the employer's occupational accident insurance society, and offers the possibility to use the documented data material for further interpretations.

The analysis is performed in several steps. The health report starts with a description of the structure of the members and a brief presentation of any conspicuous features in the levels or duration of work disability. This provides an initial overview of any sickness hotspots within the company.

This is followed by a review of whether the work disability figures show any abnormalities as compared to other similar groups. To this end, the number of cases of work disability and the length of the disability in days is compared both with other areas within the business enterprise as well as with figures at national level and statistics for the economic group. The cases of work disability are then analysed according to age, sex and incidence, and broken down by long-term and short-term disability. A comparison of sickness groups in the most conspicuous areas is also carried out. This evaluation provides an overview of what abnormalities there are in which sickness groups within the units investigated.

Besides personal lifestyle behaviour, the causes of high sickness levels frequently are laying in avoidable deficiencies in technical and organisational processes, in the motivation and satisfaction of the employees, and in the workplace climate. *Health circles* present a tool that enable hitherto disregarded or hidden work demands, especially of a psychosocial nature, to be considered and proposals for solutions to be made. Health circles are participative, communicative and practically orientated tools that allow problems such as sickness, work disability and work dissatisfaction to be addressed from the point of view of the people directly affected (cf. Schröer & Sochert 2000, 1997).

Under the chairmanship of an experienced moderator, discussions are held between the employees of a company area, work safety experts, works doctors, the works council and members of the management at which stresses and strains of the workplace are explored and proposals for improving the daily work situation developed. In these circles, it is the employees who are the real experts. The circles offer a forum at which the frequently under-utilised creative potential of the employees and their knowledge of the wide diversity of factors at the workplace can be combined with the know-how of the other experts.

The task of the health circles is to identify working conditions that cause strain and stress and to consider a possible link between these conditions and particularly frequent physical or mental complaints or illnesses. They also jointly develop practicable suggestions for improving technical, organisational or personnel-related working conditions. A further task of health circles is to put technical, organisational and personnel-related measures into practice at the workplace.

The health circle goals are to increase employee satisfaction, optimise the work processes and productivity, enhance the well-being of the employees, reduce the levels of sickness-related absence, and improve professional communication.

A health circle consists of three phases: an initial phase, a project phase and an evaluation. The initial phase has the purpose of informing the management circle and undertaking the joint organisational planning, informing the employees in the intervention area concerned, conducting an employee survey on key causes of stress and strain, grievances and needs, and also a work system analysis.

The project phase comprises the organisation and moderation of 5-7 health circle sessions (of approx. 90 minutes duration each). Information is regularly issued to the employees about the progress and results of the health circle.

Evaluation of the health circle takes place with a concluding workshop about 6 months later. An assessment of the catalogue of measures undertaken is carried out, and a survey conducted of the handling and

outcome of the health circle, and also a survey relating to changes in the stresses and strains and causes of grievance.

An *employee survey* is a modern method of personnel and organisational development using (partially) standardised questionnaire forms. The result is a comprehensive description of the actual state of an organisation as seen by the employees. The particular value of an employee survey is that it takes equal account of the interests of the various groups within a business enterprise. It gives the employees the opportunity to anonymously express their opinions, draw attention to existing grievances and health problems and put forward improvement suggestions, and in this way to indirectly influence management decisions. It gives managers statistically supported feedback about their leadership behaviour, the level of satisfaction of the employees and the quality of cooperation within the departments. The top management is provided with information about the general satisfaction of the workforce, the strengths and weaknesses of the individual departments, and the familiarity with and acceptance and implementation of corporate and management principles and guidelines. Employee surveys therefore provide an opportunity both to accommodate the need for participation and also to activate unutilised cooperation and performance potential. They are an important element in modern corporate management.

In the beginnings of company health promotion, the measures were usually initiated by the health insurance funds, who used either their own employees who had undergone training in the field of company health promotion, or else external personnel. Today, however, more and more business enterprises are initiating company health promotion schemes themselves with the aid of external personnel. To some extent, therefore, funding of the measures has also changed accordingly: Originally, the statutory health insurance funds financed the measures out of members' contributions in accordance with § 20 Subsection 2 SGB V. Now, some business enterprises bear the costs themselves insofar as they are the initiators of the measures.

Generally the different methods of workplace health promotion are combined in practice. The method of health circles has been evaluated by Sochert (2000). In practice, evaluation of health circles is in addition done by health reports and employee surveys – and in most cases this will also be an evaluation of reducing health inequities at the workplace.

1.1.2 Example 2: Health Promotion for unemployed people

In the field of health promotion and primary prevention for unemployed people for e.g. a new approach has been developed and new methods have been used in the way of implementing it and the way of funding: Because unemployed people in most cases do not share a setting in common the projects *JobFit Regional* and *JobFit NRW* chose the job agencies where unemployed are seeking new jobs and also are trained for new employment as setting for their approach. The Ministry for Employment, Health and Social Affairs of North Rhine Westphalia - which is a big county of Germany - was brought in those projects. This enabled that the consultants of employment or job agencies, who normally only consult their clients regarding the field of job seeking and training, could have been trained in a special methods of health consultation and the field of primary prevention and health promotion. In their conversations with their clients the health status and the importance of good health for finding a new job have been systematically discussed and services and courses of health promotion and primary prevention had been offered if clients wanted and needed them.

As statistics of the labor market in Germany are showing, a weak health status is one of the major barriers for reintegration into employment (cf. e.g. IAB 2002). It is necessary to mention that talking on health

items in Germany is culturally very normal and common and not like in many other countries a taboo subject. Participants are for e.g. asked which health problems *they* like to change if they could and which health problems are making it difficult for *them* to work in the job they like. If needed the participants are motivated to work on those health problems, including all the life circumstances in the analysis of the problems and possible opportunities to change them. The participation of further health services is voluntary and is orienting at the needs of the clients.

The training on health counselling is organized by the Health Insurance Organization. The health counselling practice is financed by the employment organizations and the further services of health promotion and primary prevention are funded by the health insurance organizations in the financing frame of § 20 SGB V. For funding the further health promotion and primary prevention services and courses there has been a new model implemented. The organizations of statutory health insurance in Germany contracted, that they will fund the health services of their insured individuals participating in these projects even if these health services are provided by another health insurance organization. Facing the special economic situation of unemployed people, the costs for those health services will be paid at the start of those courses and services which is not the general way: In general insured individuals have to finance those services and courses first and then get the money back from the health insurance organization.

These projects have been evaluated by external experts and significant results have shown an increase in mental health status, an increase in employability and also a tendency towards a better physical health status (cf. e.g. Kirschner 2007; Wewel & Lenz 2007).

1.2 The role of the Statutory Health Insurance regarding the examples

Both of the examples are according to § 20 Social Code Book No. V and relevant subsections of it. This law is a national law and was passed by the German parliament. To fulfil the law, the head organizations of HI (on national level) developed a guideline for implementing and providing measures according to § 20 Social Code Book No. V as well as for quality assurance of such services. This guideline has been developed in cooperation with external (scientific) experts. The development of such services has also be done by the single head organizations of HI on national level. The implementation and financing of those services is performed in cooperation of head organizations and single health insurance funds (on national/regional/local level) (in detail cf. Prüßmann & Schröer 2010).

1.2.1 The role of the Statutory Health Insurance regarding WHP

As mentioned above, the statutory health insurance (HI) may offer WHP according to §20a and §20b of Social Code Book No. V. To a big amount, measures of WHP have been developed by parts of the HI. HI in Germany is also planning, implementing and financing WHP. In some cases HI itself does those WHP-services; in most cases external providers offer those services[2].

[2] HI operates some of those external providers.

1.2.2 The role of the Statutory Health Insurance regarding Health Promotion for unemployed people

HI is requested by § 20 Social Code Book No. 5 to offer primary prevention and health promotion measures targeting the reduction of social caused health inequalities (in detail cf. Prüßmann & Schröer 2010). HI has developed, planned, implemented[3] and financed such measures. Example 2 is one of these.

1.3 Stages of PHP development that HI has been involved

As mentioned in 1.2, a guidance for implementing, providing, financing and quality assurance of actions regarding to § 20 Social Code Book No. V has been developed on national level by the head organizations of HI in cooperation with external experts. Furthermore, the single head organizations of HI have developed strategies, actions and services on national (and sometimes also on regional level).

1.3.1 Example 1: Stages of development in the field of WHP that HI has been involved

WHP-services have been developed on national level by internal experts of the head organizations of HI in cooperation with external experts/scientists. Single actions like *health reports*, *health circles* and *employees surveys* have been transferred into integrated concepts of WHP.

1.3.2 Example 2: Stages of development in the field of Health Promotion for unemployed people that HI has been involved

With the reform of the health system in 2000 again services of primary prevention and health promotion became part of the funded basket of services of health insurance organizations. This was regulated by article 20 of the 5th Social Code Book (§ 20 SGB V). Article 20 was also widened up by a formulation regarding health inequalities: *Health insurance should provide services of primary prevention and health promotion to increase the health status of the overall population, and in particular to reduce social caused inequality of health opportunities*. The item of reducing social caused inequality of health opportunities was brought into the discussion by Prof. Rolf Rosenbrock[4] during an open hearing to the draft of § 20 SGB V (Steindor 2005).

To enable health insurance organizations providing such services, the head organizations of the health insurance organizations are asked by § 20 SGB V to engage extern expertise to support the development of a guidance of how to translate the law into practice by the single health insurance organizations. This guidance also had to provide quality standards for services of health promotion, primary prevention and action in the field of reducing health inequalities. The development of the guidance was the first step done by the head-organizations of the health insurance in Germany regarding the new version of § 20 SGB V. Especially for reducing health inequalities by primary prevention and health promotion services a setting approach was recommended (Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen 2008).

There have been two major difficulties to bring § 20 SGB V into action: (1.) There was not much experience existing how to reduce health inequalities at the health insurance level. (2.) The staff which was specialized in health promotion and primary prevention was not available, because many of them had been dismissed in 1996 and the following years.

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[3] Development, planning and implementation have been done in cooperation with external experts and providers.
[4] Prof. Rosenbrock is also member of the consulting expert group in the field of health for the German parliament.

For these reasons – and facing the fact that the development of the guidance as basis for any further action took time – first projects aiming the reduction of health inequalities started in 2002. The overall approach of those projects and programs was to offer services of health promotion and primary prevention to targeted disadvantaged groups like e.g. unemployed people, migrants, poor children and young persons, etc.

Needing more experiences how to start action on the reduction of health inequalities; for e.g. the Federal Office of Company related Health Insurance Funds (BKK BV) asked several extern experts to do experts′ reports on how to reduce health inequalities in general and how to promote specific disadvantaged target groups. Rosenbrock (2004, 2005) prepared an extensive expertise on primary prevention as method to reduce social caused inequality of health opportunities with political suggestions for the statutory health insurance putting § 20 SGB V into practice.

External experts were also asked to develop new instruments for health promotion and primary prevention services which fit to the needs of disadvantaged target groups. Those new instruments and methods have been implemented in several model projects and evaluated.

As first results of the projects evaluation showed, in many cases there had been difficulties to reach the targeted groups and to motivate them to participate. They showed that new models were needed, especially to bring in other actors who where needed to put the setting approach into practice and also regarding funding to enable that model projects could be widened up to bigger population groups.

For e.g. in model projects for unemployed people, which offered health promotion, primary prevention services and consultations the target group was hardly to be motivated for participation. A Health Insurance Organization wrote to all their unemployed individuals and advised of their services and courses to be held, but in the end only a few people were turning up.

One other difficulty concerned the way of funding services: If Health Insurance Organizations wanted to offer special services for target groups by using a setting approach, the choice had to be made if individuals of the target group who are not insured by this Health Insurance Organization will have the chance to participate and who will pay for this participation. Because there were no contracts between different Health Insurance Organizations regarding the fund sharing of such services existing, the participation of individuals insured by another Health insurance Organization only could be refused or costs for the participation had to be funded by that Health Insurance Organization which was offering the services or courses.

As solution for these problems, new models of implementation, funding and co-funding have been developed and other actors outside the health sector have been brought in several projects like example 2 (Health Promotion for unemployed people).

First external experts and the head organization of BKK developed the idea for the project. A control board has been implemented, participating the Ministry for Employment, Health and Social Affairs of North Rhine Westphalia. This control board developed the way of implementation and brought all participating parties together. The further practical implementation of the project, trainings and counselling, etc. have been put into practice by external providers and the job agencies. The control board has supervised the project.

1.4 Differences between PHP at national and regional level

First of all, there are not a lot of activities regarding PHP at regional level in Germany as far as it concerns the HI. This is valid for both types of examples. If there are such activities at regional level, the main or only difference is that activities of the regional HI level are restricted to the region while activities of the national level can apply to the whole country.

1.5 What?

1.5.1 Is it a regulation or a program?

For both examples a regulation (§ 20 Social Code Book No. V) is the basis. The regulation has been translated into programmes by the head organizations of HI.

1.5.2 Is it a legal requirement (to develop the PHP) or an initiative?

It is more or less a legal requirement: The formulation for example 1 (WHP) in § 20 Social Code Book No. V is "HI can provide services"; the formulation for projects as type of example 2 (Health promotion for unemployed people) is "HI should provide".

1.5.3 Is it correlated with other public policies and with which?

Example 1 (WHP) is correlated with actions on occupational safety, which are carried on by the Statutory Accident Insurance in Germany. Example 2 (health promotion for unemployed people) is somehow correlated with actions of the National Ministry of Labour to re-integrate unemployed into to the labour market.

2. Processes

2.1 The decision to make the new PHP

2.1.1 Who is deciding to make a new PHP?

2.1.1.1 Example 1: Who decides upon the development of the PHP?

In the case of WHP the head organization of BKK decided to develop instruments for WHP and to implement a WHP policy. The general decision to allow HI to provide services of WHP was taken by the German parliament by implementing § 20 Social Code Book No. V.

2.1.1.2 Example 2: Who decides upon the development of the PHP?

In the case of health promotion for unemployed people the BKK head organization decided to develop services for promoting health of vulnerable and disprivileged people. The general decision of having such a PHP was taken by the German parliament by implementing § 20 Social Code Book No. V.

2.1.1.3 Example 1: Who are the stakeholders in the process?

Head organization of BKK (main development, big campaigns, public relations, international engagement in this field, etc.) and to a much smaller amount: single BKKs (financing, providing data on health for health reports, etc.), companies, employees board, providers of WHP, employees, company doctors, etc.

2.1.1.4 Example 2: Who are the stakeholders in the process?

Head organization of BKK (development, council board, financing), Ministry for Employment, Health and Social Affairs of North Rhine Westphalia (council board), Institute for innovative employment (which is driven by the Ministry), Institute for Prevention and Health Promotion at the University of Duisburg-Essen (theoretical development, practical implementation, etc.).

2.1.2 How has the decision to make a new PHP been made?

2.1.2.1 Example 1: Which are the reasons for deciding to develop the PHP?

WHP is also seen as a marketing instrument in the field of competition with other HI. Other reasons are cost reduction and need of instruments to promote occupational health.

2.1.2.2 Example 2: Which are the reasons for deciding to develop the PHP?

To fulfil the demands of § 20 Social Code Book No. V, need to have instruments for promoting the health of unemployed (there are more likely ill), cost reduction (prevent illness, get contributions if unemployed are back in a job).

2.1.2.3 Example 1: What kind of data is used to justify actions/decisions?

Health reports, data on job related diseases.

2.1.2.4 Example 2: What kind of data is used to justify actions/decisions?

National Health Surveys, other scientific surveys in this field, analysis of HI-data.

2.1.2.5 Example 1: Are there any rules you have to consider while developing a PHP?

Guidance of HI regarding services corresponding to § 20 Social Code Book No. V.

2.1.2.6 Example 2: Are there any rules you have to consider while developing a PHP?

Guidance of HI regarding services corresponding to § 20 Social Code Book No. V.

2.2 The development of the PHP

2.2.1 Who is developing the new PHP?

2.2.1.1 Example 1: Who develops the PHP?

Internal experts of BKK head organization and external experts (scientists).

2.2.1.2 Example 2: Who develops the PHP?

External experts (scientists).

2.2.1.3 Example 1: Who are the stakeholders in this process?

Internal experts of BKK head organization and external experts (scientists).

2.2.1.4 Example 2: Who are the stakeholders in this process?

Internal experts of BKK head organization and external experts (scientists).

2.2.1.5 Example 1: Who works in developing the PHP?

Internal experts of BKK head organization and contracted external experts (scientists).

2.2.1.6 Example 2: Who works in developing the PHP?

Internal experts of BKK head organization and contracted external experts (scientists) .

2.2.2 How is the new PHP developed?

2.2.2.1 Example 1: Which are the resources necessary for developing the PHP?

Money, knowledge, infrastructure, staff.

2.2.2.2 Example 2: Which are the resources necessary for developing the PHP?

Money, knowledge, infrastructure, staff.

2.2.2.3 Example 1: What kind of data is used to justify actions/decisions?

Health reports, data on job related diseases.

2.2.2.4 Example 2: What kind of data is used to justify actions/decisions?

National Health Surveys, other scientific surveys in this field, analysis of HI-data.

2.2.2.5 Example 1: What are the instruments used to develop the PHP?

Scientific methods: Literature analysis, data analysis, etc.

2.2.2.6 Example 2: What are the instruments used to develop the PHP?

Scientific methods: Literature analysis, data analysis, etc.

2.2.2.7 Example 1: Who are the people selected to work in developing the PHP?

Scientific expertise in this field or similar fields.

2.2.2.8 Example 2: Who are the people selected to work in developing the PHP?

Scientific expertise in this field or similar fields.

2.3 The approval of the PHP

2.3.1 Who approves the new PHP?

2.3.1.1 Example 1: Who approves the PHP?

BKK head organization, single BKKs, companies, employee boards.

2.3.1.2 Example 2: Who approves the PHP?

BKK head organization, Ministry for Employment, Health and Social Affairs of North Rhine Westphalia, single job agencies.

2.3.1.3 Example 1: Who are the stakeholders in this process?

BKK head organization, single BKKs, companies, employee boards.

2.3.1.4 Example 2: Who are the stakeholders in this process?

BKK head organization, Ministry for Employment, Health and Social Affairs of North Rhine Westphalia, single job agencies.

2.3.2 How is the PHP approved?

2.3.2.1 Example 1: How is the PHP approved?

By contract and/or declarations of cooperation.

2.3.2.2 Example 2: How is the PHP approved?

By contract and declarations of cooperation.

2.3.2.3 Example 1: Are there specific rules you have to consider while approving a PHP?

There are no specific rules despite the law on data protection (health reports and employees surveys) and the law on worker's participation. Furthermore the services/actions have to match the guidance of HI for actions corresponding to § 20 Social Code Book No. V.

2.3.2.4 Example 2: Are there specific rules you have to consider while approving a PHP?

There are no specific rules. Of course the services/actions have to match the guidance of HI for actions corresponding to § 20 Social Code Book No. V.

2.4 The implementation of the PHP

2.4.1 Who implements the new PHP?

2.4.1.1 Example 1: Who implements the PHP?

In the past WHP activities have been initiated and implemented by the BKK headquarter and single BKKs. Normally WHP are now implemented by a service provider (like Team Gesundheit GmbH), single BKKs and the companies.

2.4.1.2 Example 2: Who implements the PHP?

The PHP is implemented by the BKK headquarter, a service provider and job agencies.

2.4.1.3 Example 1: Who are the stakeholders in the process?

Single BKKs, service provider, companies and employee board.

2.4.1.4 Example 2: Who are the stakeholders in the process?

BKK headquarter, service provider and job agencies.

2.4.1.5 Example 1: Who provides resources required for the PHP implementation?

Resources are provided by the single BKK involved and/or the company.

2.4.1.6 Example 2: Who provides resources required for the PHP implementation?

First the resources are provided by the BKK headquarter and other HI. The job agencies provide resource in that form that their staffs are trained in the working time. Further activities of primary prevention and health promotion resulting of the cousellings are financed by that single health insurance of the unemployed person.

2.4.1.7 Example 1: Who applies the PHP?

There is no need to apply the PHP, because WHP is funded by the organization, which is ordering it (single BKK or company).

2.4.1.8 Example 2: Who applies the PHP?

There is also no need to apply the PHP because the initiative and the biggest part of funding is by the BKK headquarter.

2.4.1.9 Example 1: Who controls the implementation?

The implementation of WHP activities is controlled by the involved BKK, the service provider and the company.

2.4.1.10 Example 2: Who controls the implementation?

The implementation of the PHP is controled by the steering/council board.

2.4.2 How is the new PHP implemented?

2.4.2.1 Example 1: How is the PHP implemented?

The single BKK or the company is hiring a service provider for putting WHP into practice. The service provider will implement a steering board in which all stakeholders are involved. This steering board will decide how to implement the WHP activities. The service provider does the practical implementation.

2.4.2.2 Example 2: How is the PHP implemented?

The job agencies have been informed about the project. They got in contact to the service provider. The staff had been trained to enable health oriented counselling by the job agencies. Then the job agencies counsel unemployed persons not only regarding new job perspectives or new qualification/education, but also regarding health needs.

2.4.2.3 Example 1: Are there any rules you have to consider while implementing a PHP?

No. The only thing which have to be considered is that the activities match the guidance of the head organizations of HI regarding § 20 Social Code Book No. V.

2.4.2.4 Example 2: Are there any rules you have to consider while implementing a PHP?

No. The only thing which have to be considered is that the activities match the guidance of the head organizations of HI regarding § 20 Social Code Book No. V.

2.5 The monitoring of the PHP outcomes/effects

2.5.1 Who monitors the PHP outcomes/effects?

2.5.1.1 Example 1: Who monitors the PHP?

The steering board monitors activities of WHP.

2.5.1.2 Example 2: Who monitors the PHP?

The steering board and especially the BKK headquarter is monitoring the PHP.

2.5.1.3 Example 1: Who are the stakeholders in the process?

The steering board (single BKK, company, service provider and employees council).

2.5.1.4 Example 2: Who are the stakeholders in the process?

The steering board (BKK headquarter, Ministry, service provider and G.I.B.).

2.5.1.5 Example 1: Who works in monitoring the PHP (conditions they have to comply with)?

Usually people with a scientific education and experience in quality assurance/quality management.

2.5.1.6 Example 2: Who works in monitoring the PHP (conditions they have to comply with)?

Usually people with a scientific education and experience in quality assurance/quality management.

2.5.2 How are the PHP outcomes/effects monitored?

2.5.2.1 Example 1: What are the formal instruments (mechanisms) used to monitor the PHP?

Usually methods of process evaluation.

2.5.2.2 Example 2: What are the formal instruments (mechanisms) used to monitor the PHP?

Methods of process evaluation. Beneath an outcome (overall) evaluation a process evaluation has been done.

2.5.2.3 Example 1: What kind of data/indicators is/are used in monitoring the PHP?

Tools of project management and quality assurance are used, like agreed steps and milestones, outcomes. Usually the WHP activities are documented.

2.5.2.4 Example 2: What kind of data/indicators is/are used in monitoring the PHP?

Tools of project management and quality assurance are used, like agreed steps and milestones. The counselling activities are documented.

2.5.2.5 Example 1: How are people selected to work in monitoring the PHP?

Those people usually have a scientific education and experience in project management and quality assurance.

2.5.2.6 Example 2: How are people selected to work in monitoring the PHP?

Those people usually have a scientific education and experience in project management and quality assurance.

2.5.2.7 Example 1: Are there any rules you have to consider while monitoring the PHP?

In the guidance of the statutory HI on activities regarding to § 20 Social Code Book No. V are hints on quality assurance. In the past beneath this guidance there has been a separate document on quality assurance of such activities. There are also documents available by the BZgA on quality assurance of such initiatives.

2.5.2.8 Example 2: Are there any rules you have to consider while monitoring the PHP?

In the guidance of the statutory HI on activities regarding to § 20 Social Code Book No. V are hints on quality assurance. In the past beneath this guidance there has been a separate document on quality assurance of such activities. There are also documents available by the BZgA on quality assurance of such initiatives.

2.6 The evaluation of the PHP

2.6.1 Who evaluates the PHP?

2.6.1.1 Example 1: Who evaluates the PHP?

Regarding the outcomes the WHP the service provider evaluates activities. WHP activities often are integrated in a concept for Workplace Health Management and are combined. A new series of health reports and employee surveys can be used to evaluate other activities of WHP.

Regarding the overall activities in the field of WHP the Medical Service of the HI Head Organizations (Medizinischer Dienst der Spitzenverbände der Krankenkassen) does annually a documentation/evaluation.

2.6.1.2 Example 2: Who evaluates the PHP?

An extern evaluator evaluates the project. Regarding the overall activities in this field of PHP to reduce socially caused inequality of health opportunities the Medical Service of the HI Head Organizations (Medizinischer Dienst der Spitzenverbände der Krankenkassen) does annually a documentation/evaluation.

2.6.1.3 Example 1: Who are the stakeholders in the process?

The service provider as evaluator and in the case of employees survey the employees answering the questionnaires. In the case of health reports, the single BKK and the company are delivering data for the analysis.

2.6.1.4 Example 2: Who are the stakeholders in the process?

The extern evaluator, the job agencies and the unemployed people counselled. Those people have to answer questionnaires.

2.6.2 How is the PHP evaluated?

2.6.2.1 Example 1: What are the instruments and the methodology used to evaluate the PHP?

Usually health reports and employees surveys are used for evaluation of other WHP activities. But also health circles can be a method to evaluate a WHP process.

2.6.2.2 Example 2: What are the instruments and the methodology used to evaluate the PHP?

a) Process evaluation: using methods of project management and quality assurance; review of project documentations.
b) Outcome evaluation: Panel designed survey with items on health.

2.6.2.3 Example 1: What kind of data (indicators) is for evaluation (impact assessment)?

a) Health reports: sickness rates (cases and days as well), diagnoses, etc.
b) Employee surveys: strains, satisfaction with different areas of working conditions, etc.
c) Health circles: strains, satisfaction with different areas of working conditions, etc.

2.6.2.4 Example 2: What kind of data (indicators) is for evaluation (impact assessment)?

Survey: Health variables, satisfaction with the intervention

2.6.2.5 Example 1: How are people selected to work in the evaluation of the PHP (skills and credentials)?

Those people working in the evaluation of WHP activities have a scientific education, are experienced in WHP methods and in evaluation.

2.6.2.6 Example 2: How are people selected to work in the evaluation of the PHP (skills and credentials)?

The extern evaluator has a scientific background and is very experienced especially in the field of evaluation.

2.6.2.7 Example 1: Are there any rules you have to consider while evaluating the PHP?

Beneath the scientific rules and standards for evaluation: Data protection law, guidance on activities regarding § 20 Social Code Book No. V of the head organizations of HI.

2.6.2.8 Example 2: Are there any rules you have to consider while evaluating the PHP?

Beneath the scientific rules and standards for evaluation: Data protection law, guidance on activities regarding § 20 Social Code Book No. V of the head organizations of HI.

2.6.2.9 Example 1: Does the evaluation become public?

The results are available only for the single BKK, the company, the employee´s board and the employees.

2.6.2.10 Example 2: Does the evaluation become public?

The results are published in scientific articles and books.

3. Final questions

3.1 Final questions

3.1.1 Example 1: Can you mention what do you consider the strengths of the process?

a) Participation of all stakeholders, especially the employees (who also might be the subjects of WHP);
b) An integrated concept of WHP starts with an analysis followed by intervention and evaluated with an analysis, too. If the results of the evaluation are showing need for correction, this can be done with new interventions and so on. WHP in this sense is a circle of continuous analysis, learning and intervention.

3.1.2 Example 2: Can you mention what do you consider the strengths of the process?

Unemployed people can be reached by activities of PH and primary prevention. Job counselling and health counselling are combined, which is important because a bad health status is the biggest barrier to be re-integrated into the first labour market in Germany.

3.1.3 Example 1: What are the weaknesses of these processes, in your opinion?

The participation of all stakeholders in these processes requires a lot of work on coordination.

3.1.4 Example 2: What are the weaknesses of these processes, in your opinion?

There has to be done a lot of work on coordinating all stakeholders and their needs, wishes, etc.

3.1.5 Example 1: What are the pitfalls to be avoided in implementing the PHP?

Not to participate all the stakeholders from the very beginning.

3.1.6 Example 2: What are the pitfalls to be avoided in implementing the PHP?

Not to have a binding declaration of cooperation of all stakeholders in the very beginning.

3.1.7 Example 1: What are your recommendations for a successful agency in charge of PHP development?

a) Have a staff of mixed professions/scientific educations.
b) Develop a binding guidance for setting standards, targets and target groups, ways to reach the target and for quality assurance.

3.1.8 Example 2: What are your recommendations for a successful agency in charge of PHP development?

a) Have a staff of mixed professions/scientific educations.
b) Develop a binding guidance for setting standards, targets and target groups, ways to reach the target and for quality assurance.

Literature

Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen (Hg.) [2008]; Leitfaden Prävention. Gemeinsame und einheitliche Handlungsfelder und Kriterien der Spitzenverbände der Krankenkassen zur Umsetzung von § 20 Abs. 1 und 2 SGB V vom 21. Juni 2000 in der Fassung vom 2. Juni 2008; o.O.

Auslander, G.K.; Litwin, H. [1991]; Social networks, social support, and self-ratings of health among the elderly. In: *Journal of Aging and Health*, Vol. 3, No. 4: 493-510.

Brede, F. [2006]; Gesundheitspolitik und Politikberatung. Eine vergleichende Analyse deutscher und kanadischer Erfahrungen. Deutscher Universitäts-Verlag, Wiesbaden.

Busse, R.; Riesberg, A. [2004]; *Health care systems in transition: Germany*. Copenhagen, WHO Regional Office on behalf of the European Observatory on Health Systems and Policies.

Crooks, V.C.; Lubben, J.; Petitti, D.B.; Little, D.; Chiu, V. [2008]; Social network, cognitive function and dementia incidence among elderly women. In: *American Journal of Public Health*, Vol. 98, No. 7: 1221-1227.

Drupp, M. [2002]; Gesundheitsförderung durch Krankenkassen. Vom "Gesundheitskurs" zum "Gesundheitscoaching". In: Walter, U.; Drupp, M.; Schwartz, F.W. (Eds.); Prävention durch Krankenkassen. Zielgruppen, Zugangswege, Wirksamkeit und Wirtschaftlichkeit. Juventa Verlag, Weinheim und München [2002]; P.24-39.

Hanson, B.S.; Isacsson, S.-O. [1992] ; Social network, social support and regular leisure-time. Physical activity in elderly men. A population study of men born in 1914, Malmö, Sweden. In: *The European Journal of Public Health* 1992 2(1):16-23.

Institut für Arbeitsmarkt- und Berufsforschung der Bundesanstalt für Arbeit (IAB) (Ed.) [2002]; Arbeitslosenuntersuchung – Teil 1. Was beeinflusst den Übergang von der Arbeitslosigkeit in die Erwerbstätigkeit? In: IAB Kurzbericht; Ausgabe Nr.1 / 21.01.2002; Institut für Arbeitsmarkt- und Berufsforschung, Nürnberg.

Kirschner, W. [2007]; Ergebnisse der Teilnehmerbefragung. In: Bellwinkel, M. (Ed.); JobFit Regional. Ein Modellprojekt zur Verbesserung der Beschäftigungsfähigkeit von Arbeitslosen durch Gesundheitsförderung. Wirtschaftsverlag NW, Bremerhaven [2007]; P. 61-94.

MDS (Medizinischer Dienst der Spitzenverbände der Krankenkassen e.V.) [2008]; Präventionsbericht 2007. Dokumentation von Leistungen der gesetzlichen Krankenversicherung in der Primärprävention und betrieblichen Gesundheitsförderung - Berichtsjahr 2006. Essen.

Mosebach, K.; Schwartz, F.W.; Walter, U. [2004]; Gesundheitspolitische Umsetzung von Prävention und Gesundheitsförderung. In: Hurrelmann, K.; Klotz, T.; Haisch, J. (Eds.); Lehrbuch Prävention und Gesundheitsförderung. Verlag Hans Huber, Bern [2004]; P. 341-353.

Plamper, E.; Stock, S.; Lauterbach, K. [2004]; Kosten und Finanzierung von Prävention und Gesundheitsförderung. In: Hurrelmann, K.; Klotz, T.; Haisch, J. (Eds.); Lehrbuch Prävention und Gesundheitsförderung. Verlag Hans Huber, Bern [2004]; P. 367-377.

Prüßmann, J.; Schröer, A. [2010]; Promoting health and reducing socially caused inequalities in health opportunities: Health insurance sector in Germany. BKK Federal Association, Essen. Available at: http://www.bkk.de/fileadmin/user_upload/PDF/Arbeitgeber/Betriebliche_Gesundheitsfoerderung/Zielgruppen/Soziale_Ungleichheit/German_law_20__2_.pdf.

Röhrle, B. [1994]; Soziale Netzwerke und soziale Unterstützung. Beltz Psychologie Verlags Union, Weinheim.

Rosenbrock; R. [2005]; Primärprävention für sozial Benachteiligte. In: Geene, R.; Steinkühler, J. (Eds.); Strategien und Erfahrungen. Mehr Gesundheit für alle. Die BKK-Initiative als ein Modell für soziallagenbezogene Gesundheitsförderung. Gesundheitsförderung und Selbsthilfe Band Nr. 14.; Wirtschaftverlag NW, Bremerhaven; pp. 25-42.

Rosenbrock, R. [2004]; Primäre Prävention zur Verminderung sozial bedingter Ungleichheit von Gesundheitschancen - Problemskizze und ein Politikvorschlag zur Umsetzung des § 20 Abs. 1 SGB V durch die GKV. In: Rosenbrock, R.; Bellwinkel, M.; Schröer, A. (Eds.); Primärprävention im Kontext sozialer Ungleichheit. Wissenschaftliche Gutachten zum BKK-Programm ‚Mehr Gesundheit für alle'. Gesundheitsförderung und Selbsthilfe Band Nr.8; Wirtschaftverlag NW, Bremerhaven; pp. 7-149.

Rosenbrock, R. [2002]; Krankenkassen und Primärprävention – Anforderungen und Erwartungen an die Qualität. In: Walter, U.; Drupp, M.; Schwartz, F.W. (Eds.); Prävention durch Krankenkassen. Zielgruppen, Zugangswege, Wirksamkeit und Wirtschaftlichkeit. Juventa Verlag, Weinheim und München [2002]; P.40-57.

Schröer, Alfons; Sochert, Reinhold [1997]; Gesundheitszirkel im Betrieb. Modelle und praktische Durchführung. Universum Verlagsanstalt, Wiesbaden.

Schröer, Alfons; Sochert, Reinhold [2000]; Health Promotion Circles at the Workplace. A new approach to workplace health promotion. Models and practical implementations. Wirtschaftsverlag NW, Bremerhaven.

Sochert, Reinhold [2000]; Gesundheitszirkel. Evaluation eines integrierten Konzepts betrieblicher Gesundheitsförderung. In: Alfons Schröer; Betriebliches Gesundheitsmanagement. Strategische Investitionen in die Gesundheit des Unternehmens und der Mitarbeiter. Betriebliches Gesundheitsmanagement und Prävention arbeitsbedingter Gesundheitsgefahren Band 17; BKK Bundesverband Essen (Eds.); Wirtschaftsverlag NW, Bremerhaven 2000, S. 79-94.

Sochert, Reinhold [1998]; Gesundheitsbericht und Gesundheitszirkel. Evaluation eines integrierten Konzepts betrieblicher Gesundheitsförderung. Betriebliches Gesundheitsmanagement und Prävention arbeitsbedingter Gesundheitsgefahren Band 3; BKK Bundesverband Essen (Eds.); Wirtschaftsverlag NW, Bremerhaven.

Steindor, M. [2005]; Gerechte Gesundheitschancen – ein halbherziges Thema über 200 Jahre deutscher Gesundheitspolitik. In: Corste, M.; Rosa, H.; Schrader, R. (Eds.); Die Gerechtigkeit der Gesellschaft. VS Verlag für Sozialwissenschaften, Wiesbaden [2005]; P. 171-228.

Walter, U.; Schwartz, F.W. [2002]; Prävention durch Krankenkassen – Auf dem Weg zu mehr Zielorientierung und Qualität. In: Walter, U.; Drupp, M.; Schwartz, F.W. (Eds.); Prävention durch Krankenkassen. Zielgruppen, Zugangswege, Wirksamkeit und Wirtschaftlichkeit. Juventa Verlag, Weinheim und München [2002]; P.15-23.

Wewel, M.; Lenz, S. [2007]; Ergebnisse der Projektbefragung. In: Bellwinkel, M. (Ed.); JobFit Regional. Ein Modellprojekt zur Verbesserung der Beschäftigungsfähigkeit von Arbeitslosen durch Gesundheitsförderung. Wirtschaftsverlag NW, Bremerhaven [2007]; P. 39-59.

Wilson, R.S. [2009]; Aetiology – Elderly women with larger social networks are less likely to develop dementia. In: *Evidence-Based Mental Health*, Vol. 12: 22.