Occupational Health Management as Potential Element in Combating Social and Regional Inequalities

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Abstract

Introduction: The epidemiological transition has been going along with demographic aging since the 1980s; its effects are becoming increasingly present. The legislator has addressed this issue with the introduction of the German Act on the Implementation of Measures of Occupational Safety and Health to Encourage Improvements in the Safety and Health Protection of Workers at Work (ArbSchG, 1996), however companies have reacted only hesitantly with the implementation of occupational health management. This impulse, contrarily, has only been a superficially decisive element in the implementation of the Ottawa Charter in the setting of workplaces in Germany. This process, which has been started slowly, was accelerated by projects and the follow-up legislation, not least by the Prevention Act (PrävG, 2015), which prompted a large number of major social partners to take joint action. Methods: The contribution is based on a total of four datasets for the years from 2015 to 2019, which were analysed and interpreted on the basis of the model of social and resulting health inequalities. The datasets include the prevention reports of the statutory health insurance funds, the annual individual reports of the umbrella association of the company health insurance funds and DAK-Gesundheit, the annual reports "Working World in Transition" of the Federal Institute for Occupational Safety and Health (BAUA), as well as the index of the German Trade Union Federation: "DGB-Index Gute Arbeit", which is also published annually. Results: It is assumed that there are clear inequalities in terms of sectors, regions, company size and gender. In addition, the prevention reports and the BAUA reports indicate the low level of epidemiological and practical effects regarding the implementation of the ArbSchG. Discussion: It will be reflected why the measures, taken by the social partners until now, are insufficient to provide decisive support in implementing or even maintaining occupational health management, particularly for micro and small enterprises, as they build the main group of employers. Moreover, it will also be examined, which consequences health inequalities resulting from a deficient occupational health management could have. Conclusion: It seems to be clear that health promotion of insured members cannot be the core task of health insurance companies. Despite the dazzling term of Corporate Social Responsibility, there are also ethical limits to be set for occupational health management. After all, employees can be encouraged as citizens, but cannot be

obliged to behave in a health-promoting manner, as it is the case in some Asian countries. And whether the National Action Plan for the promotion of individual health literacy initiated in 2018 will lead to the urgently indicated behavioural changes at the personal level, remains to be seen.

9.1 Introduction: 1996—Establishment of the German Act on the Implementation of Measures of Occupational Safety and Health to Encourage Improvements in the Safety and Health Protection of Workers at Work (ArbSchG) and Its Consequences

As far as the form is concerned, a distinction should be made between the terms "occupational health management" and "occupational health promotion", because of its relevance for this article. In the first case, the understanding underlying this article assumes that the focus is on management processes which are based on key figures, which corresponds certainly with company management. At the operational level, health has the advantage that it can be connected and integrated with other—established—management systems. Faller (2017) identifies the justifiable danger of expert bias and the resulting top-down processes, which imply little room for participation in the sense of Wright et al. (2010). On the other hand, occupational health promotion in the sense of the WHO-Ottawa Charter for Health Promotion (1986) can be interpreted as enabling employees to actively participate in shaping the workplace environment. The active participation of employees and the associated potential for identification is countered by generally known disadvantages which can be associated with volunteers. In the further course of this contribution, the first mentioned version of occupational health management (OHM) is assumed.

The German ArbSchG, established in Germany in 1996, supplemented the Occupational Safety Law (ASiG), which was 23 years older, by substantial changes. It follows in its recognizable proactivity the credo "Precaution is better than aftercare" and was therefore tantamount to a paradigm shift at that time. In the same year, the law was connected with the implementation of the Federal Institute for Occupational Safety and Health (BAuA), having the following main tasks: "observation and analysis of occupational safety, the health situation, the working conditions and their effects on the health of workers in companies and administrations as well as the development of solutions" (cf. Brüggemann et al., 2015). The work of the BAuA, however, goes further: In addition to observation and analysis, direct and indirect implementation support with regard to the ArbSchG, it is concerned with the further development of primary and tertiary preventive working conditions, primarily on the basis of occupational medicine and epidemiological evidence. It goes without saying that this development (establishment of law and institution), based on a cautious retrospective assessment from a temporary distance of more than 20 years, may have led to clear emotional and social effects of uncertainty in the

established process-based organisations. At the latest, if the timespan since the law was supplemented by the "Risk assessment of mental stress at work" (§ 5 (3) 6 ArbSchG) in 2013 is considered, it is currently clear that this law will be implemented only by about 59% of German companies (Wulf et al., 2017). In their contribution, Wulf et al. note what might have been valid twenty years before: "Despite the high economic relevance of mental health and the legal obligations of the employer to record mental stress in the context of risk assessment, it can be observed that many companies have implementation problems or do not meet their legal obligations" (ibid.).

If even large DAX-listed companies, but above all small and medium-sized enterprises—assuming a sincere effort a priori—have problems with the implementation and updating of the ArbSchG, the question should be investigated: which factors are identified as obstacles, since it is, after all, a matter of the implementation of legal requirements and by no means an optional task. A list of the reasons can be found in Fig. 9.1; although the respective decisive survey was conducted eleven years ago (2009), its timeliness does not seem to have changed (Bechmann et al., 2011).

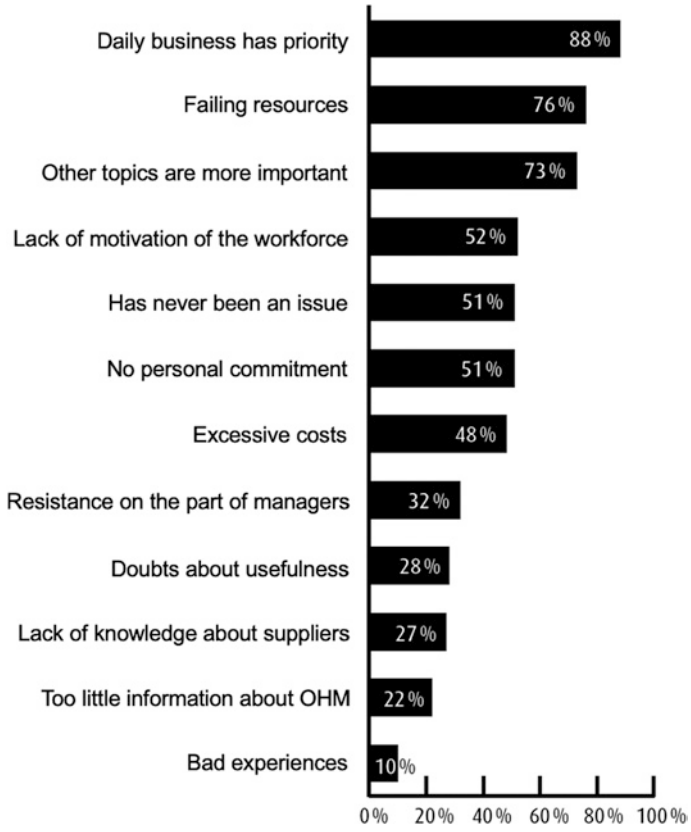

Fig. 9.1 Reasons for not introducing occupational health management (iga, 2011)

A recent study (Arps et al., 2019), in which 284 German and mostly medium-sized companies took part, identified the following additional obstacles (Fig. 9.1).

"- Offers of physical activities dominate OHM
- Digital tools do not yet play a major role in OHM
- Work intensification and poor management are a burden on health
- Mental hazard assessment is still not a compulsory programme
- The connection between digital transformation and OHM is insufficiently recognized
- OHM lacks an overall strategic orientation: activities are still too often "one-day flies".
- Lack of qualified OHM representatives
- And top management still knows too little about the health of the employees".

It is precisely for this reason that various state and public institutions systematically created third-party funding in the form of projects over several years, which were intended to enable a nationwide rollout. Without this important and mutually insightful phase, the high standard of OHM achieved in the medium term would not have been conceivable, despite all the deficits described above.

First of all, the "Cooperation Programme Work and Health" (KOPAG), which is still primarily oriented towards the pathogenic paradigm, should be mentioned, which covered the ratification of the ArbSchG (1996) during a timeframe from 1994 to 1997—the project was funded by the then Federal Ministry of Labour and Social Affairs (BMA). The aim of this basic project was to "develop methods for the health-conscious design of working on the basis of analyses of (work-related) stress and burden and to implement them in models" (DGUV, 1999). To achieve this goal, the Federal Association of Company Health Insurance Funds and the Federation of Institutions for Statutory Accident Insurance and Prevention supplemented the following data: Company personnel data, incapacity-to-work data from the company health insurance funds, accident data from the industrial employers' liability insurance associations, data on occupational illnesses from the industrial employers' liability insurance associations, occupational health data, exposure data from companies and the employers' liability insurance associations, results of the risk assessment, and, if applicable, the results of the company medical basic examination and the results of employee surveys. In order to prove the possible connections, the multiple Poisson regression analysis method was used (see Wollschläger, 2015). In addition to the results, which essentially showed a particularly massive risk exposure for the retail trade, KOPAG (Cooperation Programme Work and Health) was of central importance to the entire development process, because here "for the first time work incapacity data with hazard and stress profiles of homogeneous workplace types" (DGUV, 1999) were statistically combined and subsequently implemented in the form of specific design recommendations. These included both an extended profitability analysis and specific prevention proposals, which can be evaluated as the starting point for current OHM approaches for and in Germany. Based on KOPAG, a follow-up project was realized by the Federal Ministry of Labour and Health in 1999 and 2002 with the "Integration Programme Work and Health" (IPAG), in which the Federal

Association of Company Health Insurance Funds and the German Social Accident Insurance (DGUV) participated again. In addition, the AOK Federal Association, as the largest German health insurance company, the Federal Association of Guild Health Insurance Companies, the Association of Substitute Health Insurance Companies (vdek), and smaller insurance companies also participated. The aim was to develop a model cooperation between the statutory accident insurance and health insurance institutions in order to meet the requirements of the already established ArbSchG. The focus was on small and medium-sized companies, since large companies at that time often developed autonomous structures of occupational health management. For this purpose, IPAG focused on companies in the paint industry as well as inward care facilities (clinics) in order to not only correlate data related to incapacity to work, as was the case at KOPAG. By means of expert surveys, the already mentioned workplace types were classified in a more differentiated way for both sectors (Böhnke, 2005), e.g. for the setting clinic: chief physicians, senior physicians, senior consultants, residents, …, nursing and health care assistants as well as nursing trainees. The very heterogeneous requirements of the wards were also considered in the categorisation:

For example, the special features of palliative care or emergency rooms have been included. The same applies in the figurative sense to the paint industry. At IPAG, primary preventive interventions also made it possible for health insurance companies to offer services based on previously evaluated data and knowledge of workplace types for the first time. In this, and in the context of the period under review, the so-called Reform Act of 2000 (“GKV-Reformgesetz”) regarding the statutory health insurances must be mentioned too. Incorporated in 1989 as § 20 in the fifth of a total of twelve German Social Code Books (SGB V, “Gesetzliche Krankenkassen”), this was amended for the first time. Services of primary prevention generated thereby to binding mandatory offers of the statutory health insurance funds, and occupational health promotion turned to an optional service (see Singer, 2010). The “Leitfaden Prävention” (Prevention Guideline), published by the German National Association of Statutory Health Insurance Funds (GKVS) and the German National Association of Medical Services (MDS), which was developed for the first time to implement this section, was also of great relevance for the further development of occupational health management. In this document, which has been revised for the third time, applicants can find basic information on financial support for their own projects in the context of occupational health promotion. The “Initiative for Health and Work” (iga) and the “Initiative for New Quality of Work” (INQA) subsequently (2002) provided impulses which still exist today. iga, which was initiated by the umbrella organisation of the company health insurance funds, the German Statutory Accident Insurance Fund, the Federal Association of the AOK, and the umbrella organisation of the substitute funds, pursues the goal of further developing prevention and intervention approaches involving providers, with a focus on occupational health and safety and health promotion. The initiative also sees itself as a platform for interdisciplinary cooperation between insurance organisations and companies, institutions, experts, and other bodies. INQA is a network led by the German Federal Ministry

of Labour and Social Affairs in which the social partners (employers 'and employees' representatives), the Federal Employment Agency, the Federal Institute for Occupational Safety and Health and the Central Association of German Trade Unions cooperate. Well-interpreted "aim of the initiators is to find a balance between the interests of the employees in health-promoting working conditions and the economic interests of the companies" (Singer, 2010). In line with this goal, the initiative sees itself as a source of impetus, coach, and mediator in health-related topics of leadership, diversity, health, and competence (see Initiative Neue Qualität der Arbeit, 2020). As a result of the Accident Insurance Modernisation Act (UVMG), the National Occupational Health and Safety Conference was established in 2008. This conference is composed of three representatives each from the Federal Government, the federal states and the accident insurance institutions with voting rights, as well as advisory representatives of top-level organisations of the social partners. The establishment of this institution had to take place on the basis of international, and even more so, European requirements in order to implement the "Joint German Occupational Safety and Health Strategy" (GDA) adopted by the 84th Conference of Labour and Social Ministers of the federal states in the previous year. The following occupational safety and health objectives are currently being focused on in the 3rd GDA period:

- good work design for musculoskeletal strain,
- good work design for mental stress and
- safe handling of carcinogenic hazardous substances.

GDA's website points out with regard to the monitoring of the implementation of the ArbSchG that "the supervisory staff of the executing agencies carry out around 20,000 inspections in predominantly small and medium-sized companies (less than 250 employees) every year" (GDA, 2019). If we subtract from the total of 3,483,961 companies in Germany those having more than 250 employees, only 15,425 remain (Statista, 2020). In order to put the now rather relativising, if not frustrating number of controlled companies into an adequate ratio, the large number of companies with 0 to 9 employees (3,103,896) and those with 10 to 49 employees (still 298,874) is worth mentioning, which may never be inspected, and which therefore make up the majority of the 45% of companies mentioned at the beginning of this article, where the "risk assessment of mental stress" (§ 5, para. 3, sentence 6) regulated in the ArbSchG in 2013 is still not carried out. The German vernacular has a more than succinct answer to this question: "To be self-employed means to work oneself (alone) and constantly". The main reason for the criticism of the implementation of occupational health management in Germany, which is to be manifested here, is to be found in this sub-function of control, which is unfortunately plausible for personnel and thus cost reasons. For the large number of micro and small medium-sized companies, OHM is currently still taking place to a too limited extent or not at all. Even the implementation of legal requirements as a minimum target could not be achieved in 45% of the German companies by means of self-disclosure or maximum randomly

controlled companies since the establishment of the ArbSchG. A small silver lining on the horizon is at best the Prevention Act of 2015, which raise the already mentioned § 20 of the Social Code Book V by a significantly increased network of participating funding organisations beyond the services of the statutory health insurances. Among other things, the Prevention Act aims to alleviate health inequalities, the existence of which is beyond doubt in Germany (Lampert et al., 2018; Mielck, 2005). In the context of the law, the current prevention report 2019, to be submitted annually by the statutory health insurers, can be referred to: the "estimated value" of the number of employees reached in the meantime has risen from 621,913 (2009) to 2,152,547 (2018); this applies to 61% of the above-mentioned company size of up to 249 employees. However, there may not be time to relax—especially since the most risk-exposed company size (1 to 9 employees) has only five percent of subsidized measures (GKV & MDS, 2019).

9.2 Method and Science-Theoretical Embedding: Secondary Data Analysis Based on the Model of Social and Health Inequality

Social epidemiology, as a typically interdisciplinary research discipline, objectifies the socially induced or socialisation-based unequal distribution of diseases (Kawachi and Subramamian, 2018); or "the proof of connections between status markers and health indicators in population studies", as the social physician Siegrist (2005) expressed. On this basis, it is obvious that social epidemiology, from its traditionally transdisciplinary approach, primarily integrates medicine and sociology with each other; medicine because of the epidemiology that decisively constitutes it, sociology because of the traditional demand for ending social and health inequalities. Accordingly, the methodological integration of the social sciences with that of medical epidemiology is also carried out here. While it was developed significantly in the United States at the end of the nineteenth century, it has also been an integral part of the interdisciplinary health sciences established in the German-speaking world since the 1990s, and is an integral part of the efforts to achieve equal health opportunities in accordance with the Ottawa Charter for Health Promotion (1986). Whereas social epidemiology in general often refers back to bio-psycho-social modelling, the following section refers to the model of social and health inequalities (Mielck, 2000). This is based on vertical and horizontal social inequality: The social epidemiologist Mielck (2005) explained that the addition 'vertical' implicitly expresses that the characteristics listed here allow a division of the population into top, middle and bottom. Traditionally, income, occupational status and education are mentioned. The Robert Koch Institute, among others, frequently makes use of this approach of vertical socioeconomic status in its health reporting (RKI, 2015; Lampert et al., 2018). In addition, the following horizontal causes of social inequality are most frequently mentioned: Age, marital status, gender and nationality. On the one hand, the list is not complete, on the other hand, it has never been agreed upon as binding; it is

therefore a more or less accepted construct, but one that is widely used in the social sciences. The fact that this construct has come in for—justified—criticism is to be understood solely on the basis of the following three arguments:

a) Regional differences are not taken into account. In anticipation of the results of this contribution, it should already be pointed out that there are considerable regional differences in Germany with regard to the distribution of wealth and poverty.
b) Occupational inconsistencies in the construct of the vertical socio-economic status: With the approach presented here, neither plumbers who have achieved considerable wealth, nor habilitated philosophers living on the edge of the poverty line, can be explained.
c) It is clear from this that people can ultimately be assigned to several strata in relation to the proposed characteristics and thus cannot be clearly allocated.

Taking these reservations into account, the construct of socio-economic status (SES) can and must be considered here as the basis of the model of social and health inequalities.

Burden such as hard physical and at the same time unergonomic work, the direct confrontation with fumes and toxic substances, shift work and last but not least also those of work aggravation already imply at the keyword level health burden that primarily affects the lower classes. Closely related to this are the coping resources: it is assumed that these are also less distinct in the lower socio-economic status strata. Central to this is the health-psychologically relevant construct of resilience with keywords such as appropriate self-assessment and information processing, the regulation of feelings and emotions, the conviction of being able to cope with demands, the ability to get support, to be able to take charge of oneself and solve conflicts, the ability to realise existing competences in the respective situation, and the general strategies for analysing and dealing with problems (Fröhlich-Gildhoff & Rönnau-Böse, 2011). The third area of social and health inequalities must be distinguished from these two areas: the different use of the healthcare and pension system. This is traditionally favoured in Germany by the worldwide unique differentiation into a box-like statutory health insurance system and a private health insurance system which is better off than the previous one. In addition to the established dichotomy, there are further factors differentiating the system socio-economically. On the one hand, this concerns, for example, recipients of transfer funds (so-called long-term unemployed) or migrants without a clarified residence status, who must receive counter-financing for health services on the basis of Social Code Book II in order to be able to counter-finance the additional financial resources required for the procurement of dental prostheses, spectacle frames or orthoses. On the other hand, above the socio-economically better-off groups of the upper class, there are those in a small elite who, in return for additional private payments, buy exclusive health or additional treatment of their choice. Thus, there are now at least four strata in the German health care system—and not three, as it is assumed in the traditional stratification of the vertical model—in concrete implementation of the inequality model shown in Fig. 9.2. In addition, there are

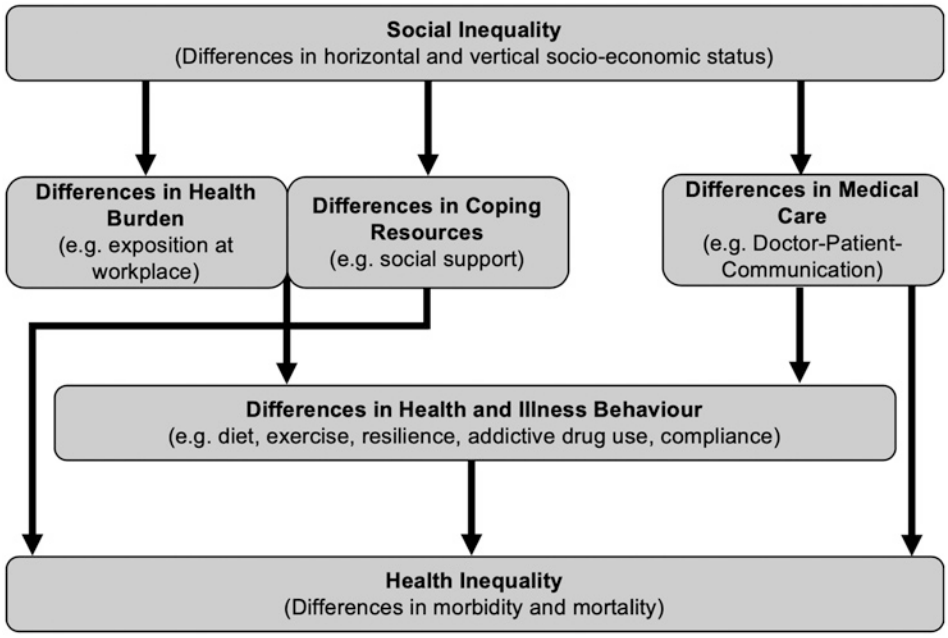

Fig. 9.2 Model to explain health inequalities (Mielck, 2005)

two relevant health-sociological working hypotheses in the present context, which are regarded as quasi fire accelerators on the way into the poverty trap, especially for the lower socio-economic classes:

- the causality hypothesis assuming that unemployment makes people ill, and
- the selection hypothesis implying that illness (chronic diseases, long-term illnesses, disabilities) makes people unemployed.

It is in the tradition of social epidemiological research to confirm established models, such as the model of social and health inequalities underlying this paper, by generating data. For this purpose, the use of routine health care data (Hjollund et al., 2019; Swart et al., 2014), which are available in abundance, is particularly suitable (see Fig. 9.3).

This type of data generation differs from the one established in social sciences, as it is neither based on a scientific question, nor is it hypothesis-based classically operationalized. Rather, as the introduction of the article already showed, in the present case, the core of the efforts was to bring together existing data sets of health insurance and accident insurance companies in order to make them usable afterwards.

Secondary data-oriented analyses offer a number of advantages. According to Zeidler and Braun (2012), the keywords here are cost-effectiveness, supra-regional

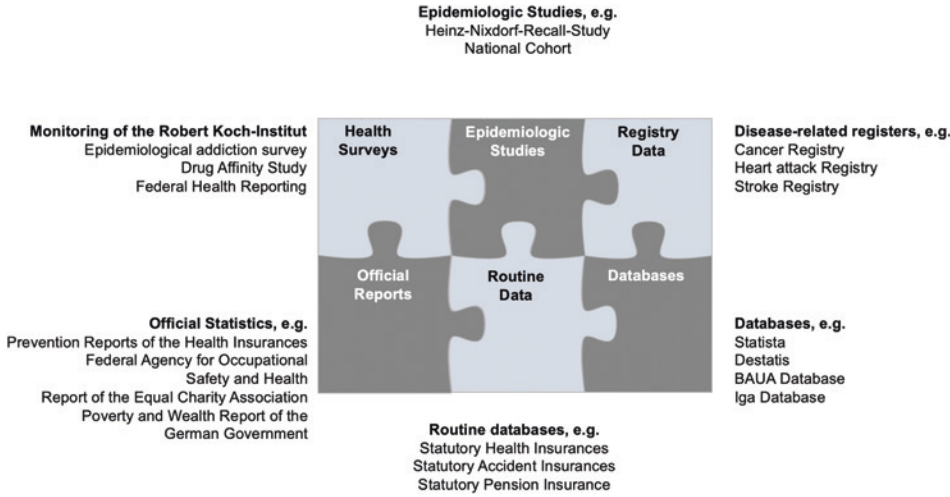

Fig. 9.3 The use of routine data in the field of social epidemiology

study populations and the elimination of study-related biases, which often affect smaller primary data source populations significantly. With regard to the evaluation of secondary data, the eleven guidelines and recommendations "Good Practice Secondary Data Analysis" of the "Working Group on the Collection and Use of Secondary Data (AGENS) of the German Society for Social Medicine and Prevention" (DGSMP) were taken into account. Specifically, the following data sets were subjected to a corresponding review and evaluation under the following question: To what extent does OHM guarantee a reduction of social and regional inequality in Germany In accordance with the model of social and health inequalities, the categories "differences in health burden", "differences in coping resources" and "differences in medical care" were used. The following data sets were subjected to a content analysis in the context of the secondary data analysis:

I. Prevention reports of the statutory health insurance companies: As already reported, the statutory health insurance funds in Germany are required by law (§ 20 of the German Social Security Code) not only to report annually on the health-promoting activities they have carried out as part of the Prevention Act, but also to include occupational health promotion as one of three areas. In addition, the annual document must also report on the expenditure used for this purpose. Currently (06/2020), only data from the reporting years 2015 to 2018 could be evaluated. These data are therefore only able to reflect a first trend. An additional problem for the analysis is the fact that the monetary resources used were increased annually from 2015 to 2018 in accordance with the law. The present guidelines were analysed with regard to the subcategories "company size combined with the number of enterprises reached" and

"distribution of main target groups", which allow an indirect conclusion to the model of social and health inequalities.

II. DAK Health Reports: DAK is traditionally the health insurance company for employees, especially in the retail trade. Currently, (as of 01/03/2020, Euro-Information, 2020), there are 5,600,000 insured persons whose data is collected, documented, and analysed with annual focus topics.

III. BKK health reports: These are the reports of the umbrella organisation of a total of 72 individual company health insurance funds as well as four regional associations, where data on the health and illnesses of a total of 9,000,000 insured persons are available and can be analysed annually. For II and III, the sub-categories "data of incapacity-to-work", "duration of cases", "membership of economic groups" and "regional differences" were analysed and indirectly assigned to the model of this contribution.

IV. "Working World in Transition" by the Federal Institute for Occupational Safety and Health: These are compiled reports with data of different origins: Data from the Federal Statistical Office (Statistisches Bundesamt, 2020) are used to record employment and working hours; those on accidents and occupational diseases are evaluated by the umbrella organisation of the German statutory accident insurance. In 2012 and 2017/18, surveys were commissioned jointly with the Federal Institute for Vocational Education and Training (BiBB) on working conditions in the category of management responsibility; data from the statutory health insurance companies were used to record incapacity-to-work, and data from the German pension insurance funds was used to record pensions. Finally, data from the aforementioned initiative "Joint German Occupational Health and Safety Strategy" was used to record the occupational health and safety situation in Germany.

V. "DGB Index Gute Arbeit": The German Trade Union Confederation represents a total of 5,97 million members (Statistisches Bundesamt, 2020). The index continues the survey conducted by the "Initiative Neue Qualität der Arbeit" (INQA), which was also mentioned above. This is "a scientifically sound instrument for measuring the quality of work from the perspective of employees and represents an independent research achievement of the DGB, which is carried out in cooperation with various partners" (Institut DGB-Index Gute Arbeit, 2020).

In the overall context, the authors of this article initially considered including the so-called "iga.reporte" of the "Initiative Gesundheit und Arbeit" in the analysis because OHM-relevant data is also included in these documents. However, the thematic issues are highly diverse and cannot be related to each other in the context of the data analysis preferred here. Therefore, they were taken into account adequately in available positions, but not in relation to the time period, e.g., within the scope of a sociological qualitative content analysis.

9.3 Results: Current Effects of Occupational Health Management on Social and Regional Inequality in Germany

After almost 25 years of occupational health management in Germany, Fig. 9.4 illustrates the four main components of this business sector, which are bound by the respective legislation—completely independent of company size and economic sector.

However, even a superficial Internet-based comparison of large DAX-listed corporations with larger medium-sized companies reveals a clear difference, which cannot be explicitly discussed here. It is also obvious that correspondingly, the scope of action to small and micro enterprises differs from that of larger medium-sized enterprises in the number of full-time staff working in occupational health management. The next step is to find references from the above-mentioned secondary data sources and literature references to the dimensions mentioned in Fig. 9.4 in order to assign them to the three categories of the model of social and health inequalities in a second step.

9.3.1 Prevention Guideline

It should be noted at the outset that the Prevention Guideline classifies primary prevention and health promotion services together, in contrast to the theoretical construct of primary, secondary and tertiary prevention. In accordance with most recent explanations,

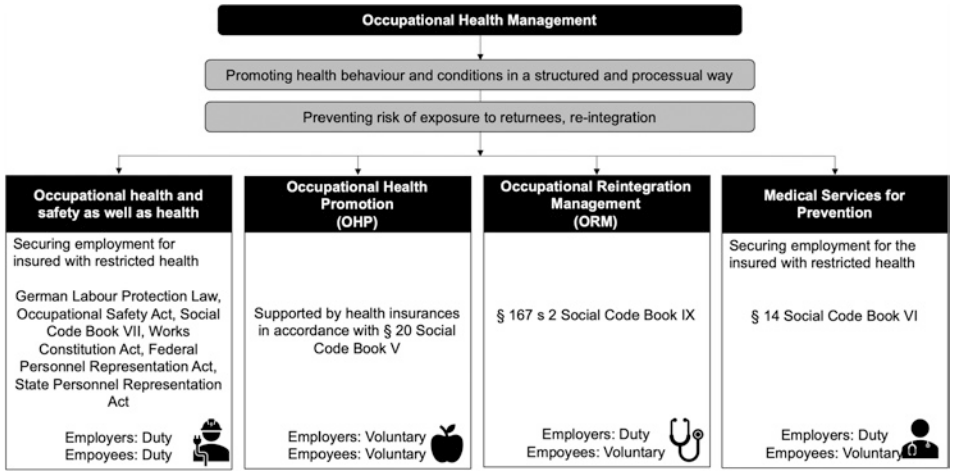

Fig. 9.4 Pillars of Occupational Health Management (following the GKV Spitzenverband / MDS, 2018)

a first tabular view of the company sizes reached with the measures according to § 20 of the Social Code Book V should be made (Table 9.1) possible.

From Table 9.1 it can be seen that, over the entire period, small (10–49) and micro (1–9) enterprises participate the least, although it can be assumed that larger companies (500–1499) and large enterprises have independently implemented an occupational health management system and are implementing it without using subsidies from the statutory health insurance funds.

As far as the sectors are concerned, there is a clear trend towards three areas: The category "Manufacturing industry" received the majority of subsidies, each with clearly more than 30%, followed by "Other services" (economic, other public / personal services, real estate / housing) and "Health and social services", each with approx. 16%. The number of employees reached increased from 1,302,383 to 2,152,547 between 2015 and 2018—this compared to the reference figure of approx. 44,300,000 employees in this period. In the reporting year 2018, the most recent for the time being, only just under 5% of the employees were reached with measures of occupational health promotion or support in the implementation of an OHM.

With regard to the model of social and health inequalities, another important parameter is the target groups of the occupational health promotion measures supported by the statutory health insurance (Table 9.2).

It is noticeable that the strategy shown in Table 9.2 is only directly addressed in the Prevention Guideline Report 2019 (retrospectively evaluating the reporting year 2018) with reference to the iga.report 29 and the multiplier strategy of the statutory health insurance funds (GKV & MDS, 2019). It is also clear, however, that the group of people affected by health inequalities, including employees without management responsibility and trainees, accounted for approximately two thirds of the people directly reached.

Table 9.1 Company sizes (columns) including number of companies reached in the evaluation period (lines). *,**

	1–9	**10–49**	**50–99**	**100–499**	**500–1499**	**≥1500**
2015	236	932	880	**2495**	851	380
2016	394	2101	2101	**5647**	1970	788
2017	707	2828	2651	**7776**	2651	1060
2018	977	3713	3713	**5472**	3713	977

*In the years 2016 (99%, −1) and 2018 (108%,+8), summative, implausible arithmetical errors were published in the report; these were adopted but must not remain unmentioned

**Absolute figures for 2015 were used, percentages from 2016 onwards. In Table 9.1, the absolute values from 2015 have been adopted in order to be able to relate them easier to the 3,483,961 companies in Germany mentioned above.

Table 9.2 Target groups of occupational health promotion (multiple answers possible, in percentage)

	2015	2016	2017	2018
Upper management level	**30%**	**26%**	**23%**	**21%**
Middle management level including master craftsmen / team leader	**34%**	**33%**	**28%**	**28%**
Employees without management responsibility	25%	21%	19%	16%
Trainees	15%	18%	20%	22%
Total groups exposed to health hazards, including…	**28%**	**27%**	**25%**	**24%**
…older workers	7%	7%	9%	9%
…employees with a migration background	2%	2%	4%	3%
… disabled people	not reported	not reported	2%	3%

9.3.2 DAK and BKK Health Reports

Due to its historical development as an employee health insurance fund, DAK-Gesundheit "insures in particular employees in typically female professions (e.g. in health care, trade, office jobs and administration; DAK-Gesundheit, 2019). The three occupational groups primarily insured in the company health insurance funds and thus forming a profile are "Medical health professions", "Non-medical health professions" and "Education, social and domestic professions, theology"; they belong to the economic groups "health care", "homes", and "social services" (BKK, 2015). A comparison leads to the following results (Table 9.3).

Both health insurance companies emphasize that "the extent of the cases of illness is of comparatively little importance for sickness rates due to their short duration" (DAK-Gesundheit, 2019) over the entire period. In addition, both insurance groups have in common that they deal with focus topics on an annual basis, which makes the further consideration of numerical parameters more difficult. For this reason, the focus topics are summarised in terms of the three main categories in the sense of a qualitative content analysis.

Table 9.3 Days / Average case duration in comparison (including rehabilitation and occupational accidents)

	BKK	DAK
2015	16.1	12.1
2016	18.1	12.9
2017	17.7	12.4
2018	18.5	12.6

It can be stated over the entire period, with regard to the DAK health reports, that musculoskeletal diseases (especially back problems according to ICD 10 - M54) dominated, followed by diseases of the respiratory system or infections of the respiratory tract and psychological and behavioural disorders. These are dominated by the ICD 10 diagnosis "Depressive episode" (F32). It is generally known that the diagnosis group of mental and behavioural disorders implies significantly longer absences compared to most other diseases. It is also assumed that women are more affected by the group of the so-called "F-diagnoses" (psychological and behavioural disorders) than men; in men, the diseases of the "musculoskeletal system and connective tissue" (M00-M99) dominate. Economic groups particularly affected by the burden of disease were the following in both insurance companies:

- Collection, treatment and waste disposal / cleaning professions
- Postal, courier, and express services / Transport and logistics professions
- Construction and civil engineering professions
- Nursing staff in care homes and homes for the disabled.

In relation to these particularly vulnerable economic groups, members of IT, information and communication technology professions, and financial services, as well as cross-economic group occupations in business management and organisation, are much less affected. In order to summarise the problem in depth: In addition to the data sets evaluated here, the Federal Health Reporting (2015) shows that the above-mentioned economic groups imply differences in occupational and qualification requirements. For the economic groups mentioned in the list above, (significantly) lower requirements are needed than for the professions in technology and management. With the study "German Health Update" (Gesundheit der Erwachsenen in Deutschland Aktuell-GEDA), the Robert Koch Institute was able to prove that the number of sick days is clearly related to the occupational status, which is one of the three pillars of the socio-economic status: For both women and men, people with low occupational status have a significantly higher number of sick days than those with a medium or higher occupational status. This is confirmed by the feeling of burden: This is felt more strongly by both women and men who have completed an apprenticeship than by those with a university degree (RKI, 2015).

The BKK was also able to prove an increased sickness burden of insured persons in connection with mental disorders and injury/poisoning in the context of temporary employment (BKK, 2019). As far as regional distribution is concerned, it is striking that the total number of occupational accidents in the Eastern federal states and Saarland is at a continuously higher level than in the West, with Baden-Württemberg always showing the lowest values overall; this is similar for health insurance funds, and is thus an important indicator of regional inequalities.

What is striking for both insurance groups during the observation period is that they both deal with the increased importance of mental health and work in the context of the

epidemiological transition (BKK Health Report, 2019; DAK Psychoreport 2015 as a special report). This could reveal (delayed) reactions to the DGB-Index "Gute Arbeit 2015" (Institut DGB-Index Gute Arbeit, 2015), in which the increase in mental illness over the past three decades was addressed on the basis of the phenomenon of the so-called hectic work. It is striking that all the reports evaluated mention the topic of health promotion or support of occupational health management in the context of § 20 SGB V, if at all, then only on the margin.

9.3.3 Reports of the Federal Agency for Occupational Safety and Health "Working World in Transition"

In accordance with the profile of the Federal Agency (BAUA), the analysis of the annual reports focused on the development of risk assessment in the sense of the ArbSchG. In this part of its annual reports, the BAUA referred back to the actual client of the study, the National Occupational Safety and Health Conference. As one of the four pillars of OHM, the field of occupational health and safety is of great relevance. Each year, the BAUA's annual reports include additional focus topics, from which the 2017 report can also draw important conclusions for the OHM and the model of social and health inequalities. For the evaluated period (2015 to 2020), data of the NAK surveys from the years 2011 (for the reporting period 2014) and 2015 (2016 to 2020) serve as a basis. The 2015 survey focused here differed between company surveys (6500 companies; as in 2011) and employee surveys (5000 persons). The data in Table 1 reflect the stratified representative results of the company surveys.

Table 9.4 clearly shows that the tendency to carry out risk assessments increases with the number of employees: the smaller the company, the smaller the legal requirement to carry out risk assessments.

And as the table also shows, this applies particularly to micro and small enterprises, which account for most of the 43 million employees. In addition, there is a further problem, which is shown in Fig. 9.5.

In terms of an overall procedure aimed at continuous further improvements, only 12.9% of the companies implement the procedure stipulated by the ArbSchG. Particular importance is now attached to the risk assessment of mental stress, which still presents certain obstacles to implementation. A study used as an accompanying study in this regard comes to the conclusion that "lack of personnel" (38%), "lack of expertise"

Table 9.4 Realised risk assessment according to company size

1–9 employees	41%
10–49 employees	70%
50–249 employees	90%
250 and more employees	98%
Total	51%

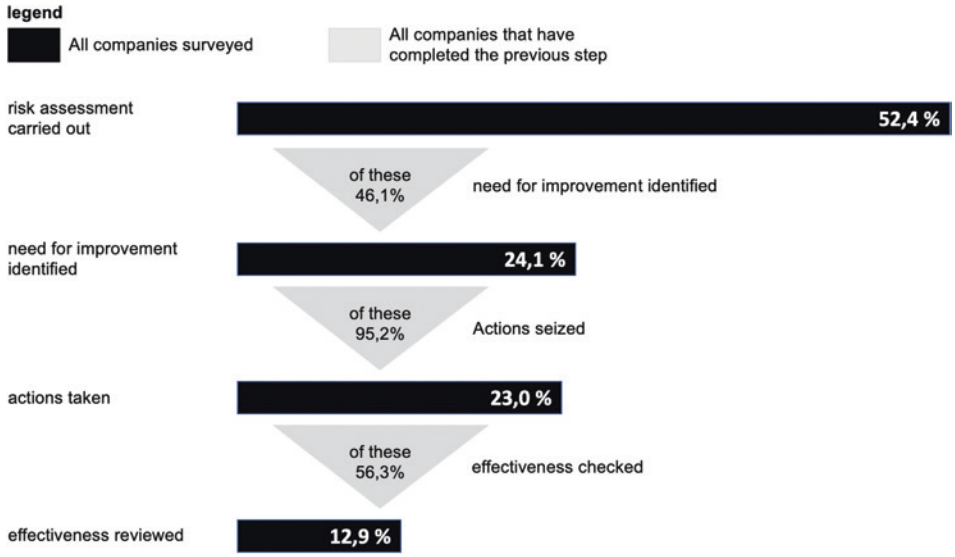

Fig. 9.5 Process steps of risk assessments with actual implementation (in percent)

(33.3%), "lack of information" (29.8%) and, alarmingly, even "lack of necessity" (26.3%) are the most frequently mentioned obstacles (Lenßen, 2015).

The reports "Working World in Transition" point out a social-health connection, particularly with regard to the suspected reports and acknowledgements of occupational diseases: "skin diseases", "noise-induced hearing loss" and "skin cancer due to UV radiation" occur above all in places which are characterised by strong noise or dirty air, and outdoor work. These are particularly jobs in road construction, industrial production and agriculture/forestry, where people with low socio-economic status are employed. These statements can be deepened with a supplementary survey of employees (2018) conducted by the BAUA. According to the report, it is mainly men who complain about working environments characterised by cold, heat, dampness, humidity, draughts and noise. In contrast, microbiological substances dominate the stressful working conditions of women. Social inequality has an impact on health, especially mental health. Accordingly, it is relevant that—similar to what was shown in the health insurance reports—there is a clear educational gradient in the categories "Planning and scheduling one's own work", "Influence on the amount of work" and "Own decision when to take breaks": The higher the last educational qualification, the higher the degrees of freedom in the dimensions mentioned (university degree before master craftsman/technician degree, in-company/school training, and completely unskilled workers without vocational qualification). Similar to the health insurance reports, the BAUA reports also come to the conclusion that "Public and other service providers, education, health", followed by "Manufacturing industry without construction" are the economic sectors with the most incidents of

incapacity-to-work per 100 years of insurance membership. The number of days of incapacity-to-work per sick leave case supports an OHM, which is oriented to the increasing age demography: Whereas this is still six days in the age group of 20–24 years, it rises to 21 days in the age group between 60–64 years.

9.3.4 Focus Reports of the Confederation of German Trade Unions "DGB-Index Good Work"

Based on an employee survey conducted in 2006, the aforementioned "Initiative Neue Qualität der Arbeit" (founded in 2002), defined a construct of "good work", which was oriented to the demands of employees for the first time. The inquiry based on this was continued between 2007 and 2011 as a representative survey among the German workforce. Following an update resp. further development, the DGB-internal Institute DGB-Index Good Work (Institute DGB-Index Gute Arbeit), which was founded in the same year, has been functioning since 2013. The three categories of this construct analysing the quality of work are as follows:

Resources as extensive as possible (4 subcategories),
Minimum possible false loads/burden (4 subcategories) and
Job security and adequate income (3 subcategories).

The survey of dependent employees on the 42 fully standardised items was conducted as a telephone interview (Computer Assisted Telephone Interview, CATI). The number of respondents fluctuated during the survey period between a maximum of 9737 (2016) and a minimum of 4811 (2017). The scoring of the items leads to the creation of the four categories "Good Work" (100–80 points), "Upper Midfield" (79–65 points), "Lower Midfield" (64–50 points) and "Bad Work" (49 points or less). Multivariate, logistic regression analyses were used to verify the correlations (Institute DGB-Index Gute Arbeit, 2019). In addition to the extensive routine data of the prevention reports and the health insurances, the data generated by the DGB Institute have a relatively high general informative value in addition to the BAUA data; this applies both to OHM and the model of social and health inequalities. With the exception of the self-employed, freelancers, students and trainees, the data generated in this study were mainly from income groups, which are suitable for the purposes of corresponding data analysis and interpretation.

As Fig. 9.6 shows, the overall development during the reporting period was very constant. With the exception of 2015 (62 points in the overall score), the years from 2016 to 2019 each scored 63 points, which, according to the classification system, corresponds to the second highest value in the "lower middle field". Despite the great differences between the individual groups surveyed each year, the sub-scaled sub-indexes show a high degree of constancy too.

Unfortunately, only the Index 2019 has socio-demographic data from the total of 6574 respondents, which in turn is related to the overall index and the three sub-categories

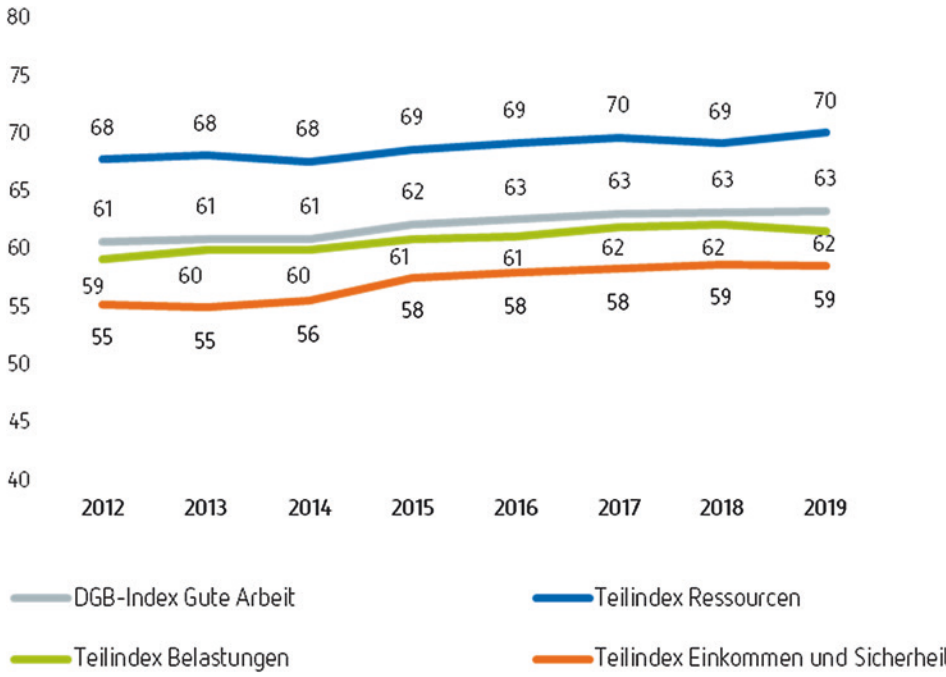

Fig. 9.6 Development of the overall index and its sub-indices between 2012 and 2019

(Table 9.5). In view of the constancy of the overall development, it is assumed in the present context that these values could be applied to the entire evaluation period.

The dimensions "Age Groups" and "Job Requirement Level" stand out particularly in the context of the present results. Overall and individual indices are rated much more positively in the youngest age group than in the age cohort between 56 and 65 years. A slight downward trend can also be observed for the intermediate old cohorts. The tendency that work rises with the increasing requirement level is apparent too. This can be confirmed by the high values in the dimension "leadership function" for those having a leadership position. As far as individual dimensions are concerned, it should also be mentioned that women feel less satisfied in terms of income and security. This reflects the long, sad and never-ending discussion about the equality of women, which is manifested in Article 3 of the Basic Law for the Federal Republic of Germany but is by no means practised nationwide. The DGB-Index confirms the BAUA reports with regard to the economic sectors in some areas. Out of a total of 18 sectors, "Trade", "Transport and storage", "Healthcare" and "Education", each scored 60 and 61 points, respectively, whereas "Information and communication" scored 70 points, placing it in the "Upper midfield" category; followed by "Public administration" and "Defense" with 69 points.

Table 9.5 Sociodemographic evaluation of the DGB-Index Good Work 2019

Index Points	DGB-Index Good Work	Partial Index Resources	Partial Index Burden	Partial Index Income & Safety
Average values	63	70	62	59
Sex				
Men	64	70	61	60
Woman	63	70	62	57
Full-time / Part-time by Sex				
Men in part-time < 35 h	61	68	62	63
Men in part-time in full time	64	71	71	61
Women in part-time < 35 h	62	70	63	55
Women in part-time in full time	63	70	60	59
Age Groups				
15 to 25 years	69	74	70	63
26 to 35 years	64	71	62	59
36 to 45 years	63	70	60	57
46 to 55 years	62	69	60	57
56 to 65 years	63	69	62	59
Job Requirement Level				
Helper / Trainees	62	68	69	51
Technical Restricted employees	62	69	61	57
Complex Trade Gate	64	71	62	60
High Complex Trade Gate	66	74	59	66
Leadership Function				
Leadership Function	65	74	59	62
No Leadership Function	63	68	62	57
Contractual time limitation				
Contractual Time Limitation	64	71	66	56
No Contractual Time Limitation	63	70	61	59
Customer Contact				
Very Often /Often	63	71	59	58
Rarely / Never	65	69	66	59

In addition to the highly comparable data of the routine questionnaire with 42 items, the DGB-Indices 2015 and 2019 should be mentioned in the context of the increase in mental and behavioural disorders, which has already been referred to in this article. In terms of the content, the focus topics “hustle and bustle” (2015) and “work intensity”

revealed risk exposures, which would be easy to manage in the context of situation-based prevention through an adequate corporate culture, characterised by clear process chains and good interface management, among other things. In the DGB-Index 2015, 3195 of a total of 4916 people (65%) stated that they had to deal with too many processes and projects simultaneously. Just behind, 3097 people (63%) found that the personal assessment in their own working environment was too tight. With 61%, still above the 60% mark, 2999 respondents considered the set deadlines or time limits to be too tight, thus encouraging the phenomenon of "work rush". The results were essentially confirmed in the 2019 report. The Index 2016 mentions the effects of digitisation as a central source of the feeling of "work rush", which was proven and has a pathogenic effect during the evaluation period. Among other things, the report comes to the revealing conclusion that 5258 out of 9737 respondents believe that the amount of work has increased as a result of digitisation; this corresponds to 54% and was opposed by 682 persons (7%). This, still optional, connection should be given general importance in the future; this does not concern the GDB-Index only, but also the work epidemiology of every company. The reflection on the 2017 focus topic also revealed that employees in the "social services" sector, followed by "health care", "hotels and restaurants" and "education and training" rate the work-related exhaustion as a difficulty in reconciling work and private life. This could also imply additional references to identify group-specific risk exposures.

9.4 Discussion: Where Further Impulses Must Be Set

9.4.1 Discussion of the Prevention Guideline

First of all, the guidelines on prevention make clear the secret that is well-known in Germany, namely that health promotion / management and primary prevention are of very little importance despite the epidemiological transition. In the sense of the classic, deficit-oriented repair medicine, lifestyle-related illnesses/non-communicable diseases are given more than a clear subordination in the remuneration system of the statutory health insurance funds. This has been criticised particularly by public health circles, which have been academically established in Germany for more than 25 years ago but has had no nationwide consequences so far—apart from the dubious success of the Prevention Act. To make this clear: According to the data published by the "Verband der Ersatzkassen" (vdek, 2020), the statutory health insurances spent a total of 226,200,000,000 EUR on the medical care of their insured members in the last reporting year of 2018. The majority of this expenditure, almost 70%, was distributed to the hospital sector, and with a clear gap to outpatient care, which was almost equivalent to the supply of pharmaceuticals. In the same year, 172,165,808 EUR were invested in health promotion and primary prevention in the sense of § 20 Social Code Book V in the setting "Occupational Health Promotion" according to the prevention report of the statutory health insurance funds, thus not even 0.1%. This argumentation, which is often used

from the perspective of public health and social medicine, is countered by the statutory health insurances saying that the genuine focus of such insurances lies in the nature of the matter, namely the care of sick people in their suffering. This is where the frequently embittered and polarised discussion in Germany often ends. According to the opinion represented here, the prevention reports lack the comparative figures provided in this article to relativise their modest actual investments in comparison to the need for action: The prevention reports of the statutory health insurers reveal much-more namely that, at most and in a figurative sense, regarding OHM only a kind of "emergency care" is being provided. In no way does this network follow a comprehensive prevention strategy that serves to provide adequate care for the above-mentioned risk groups in terms of health inequalities.

As a result of the scarce financial resources, it seems reasonable to invest the financial funds to convince small and micro-enterprises to develop their own OHM system. At the same time, this would mean a withdrawal from the direct occupational health promotion, which should not be in the interests of health insurance companies. After all, occupational health promotion is naturally also used as a popular marketing instrument in the sense of "Do good and talk about it". There is no doubt that the change of strategy would have an effect of "visibility-" or "loss of presence" in the companies, which would be otherwise present at health days or other major events. In the 2019 prevention report, there were 2,152,000 "reached employees" reported, but they could also be identified as potential insurance changers in the health insurance companies' marketing report. Compared to this, there are only 19,544 companies in the same year (2018). Even if the OHM of medium-sized enterprises with several persons appeared at consultation appointments, and the rate of small and micro enterprises receiving advice multiplied, the proportion of reached employees would be significantly smaller, and the advertising effects would be just as significantly reduced. Eventually, this discussion will inspire to consider the current strategy, which is certainly questionable from the point of view of small and micro-enterprises. This is because they are the losers at present, and the medium-sized companies, especially those with 100–249 employees, are the obvious winners of this policy.

9.4.2 Discussion of the DAK and BKK Health Reports

It must be emphasized, on the basis of the evaluated health reports (DAK Gesundheit 2015-2019, BKK Dachverband 2014-2019), that there are significant differences in health burden. This applies to both economic and professional groups. Since it can be demonstrated for the evaluated five-year period, this results in consequences for the OHM, which, if ignored, should lead to negative effects occurring much more quickly, but which, if strategically pursued, should nevertheless lead to moderate health-related consequences. This applies above all to the demographic ageing of companies, which is already noticeable in almost all sectors, with its epidemiologically measurable effects. The results of the reports lead to the conclusion that the OHM

- must be implemented above all in economic groups with low occupational status,
- must offer low-threshold education for people with low or no school qualifications,
- will have to focus on older people with age-adjusted burden of disease,
- must be strengthened in the Eastern federal states and in the Saarland, where greater efforts are required and
- should be focused on especially due to the changed workloads of the group of F-diagnoses.

Beyond that, it is noticeable that with the exception of the BKK Health Report 2018, the evaluated reports imply very similar results to the prevention reports of the German National Association of Statutory Health Insurance Funds discussed in the previous section: If so, then health promotion is mentioned in marginal notes at most. For example, the DAK Health Report 2017 states in the summary of a 192-page document that

> "Explanations for the level of sickness observed among DAK members, however, can also be sought at company level: If there is no increase in sickness levels here, this can be attributed, among other things, to activities of occupational health promotion and the consideration of employee health issues in organisational and personnel development in companies" (DAK Health, 2017).

When health expenditure in relation to the gross domestic product (GDP) is reflected in an EU-wide comparison, clear differences in the use of monetary resources become apparent. This can already be expressed in an exemplary manner by the relative density of doctors and nurses: Only Denmark shows similarly high values, with Germany being quite close to Sweden in terms of physician density, but having considerably more nurses; Denmark shows a higher number of professionals, but has considerably fewer physicians per 1000 inhabitants (OECD, 2019). The report "State of Health in the EU: Germany—Country Health Profile 2019" comes to the following conclusion in relation to the overall context, which is absolutely correct from the position taken here:

> "Resilience: Financial reserves accumulated by the health insurance system offset economic downturns, but future financial sustainability may become challenging as the population ages. There is potential for efficiency gains by centralising hospital activity, containing rising expenditures on pharmaceuticals and making better use of Health" (OECD, 2019).

This conclusion seems to be a noble goal in view of the far too large number of small hospitals distributed throughout the entire country without a "real" raison d'être, the unequal remuneration system of statutory and private health insurance companies, which is unique in the world, and the fact that drugs are considerably too expensive on the domestic reference market. Not to be underestimated in the urgently indicated paradigm shift on the part of the health insurance companies are their co-players, rather probably their opponents: the professional, the hospital representatives as well as often local or regional political prevention policies. If the necessary savings could be achieved successfully and sustainably, the statutory health insurance funds and their actors (statutory pension

insurance, German Statutory Accident Insurance) could give considerable impetus to occupational health management, from which particularly micro and small enterprises could benefit much more than before.

9.4.3 Discussion of the Reports of the Federal Agency for Occupational Safety and Health "Working World in Transition"

Probably the most important findings of these reports are the ones, which reflect according to their own data, that only 52.4% of German companies carry out a risk assessment. Even more troublesome is the information that of these only 12.9% of all German companies actually go through the follow-up process to the proven effects. This raises further questions about the current state of OHM in Germany. This mainly affects micro (1–9 employees), and small enterprises (10–49 employees), which are located in both urban and especially rural areas and dominate these areas as employers. Because of its institutional links as a federal institution, the BAUA can certainly be accused of not being enough—with 20,000 companies visited each year. Therefore, the BAUA would demand more qualified personnel. However, the federal budget sets limits here, which are just as strict as they have been the hallmark of the public health service in Germany for many years. The health authorities are also unable to exercise an additional supervisory duty within the indexed framework. Thus, compliance issues regarding the minimum standards of OHM (only the conduct of risk assessments) should be dealt with by the companies themselves. Even if operation inspections are carried out to a minimal extent only, where missing risk assessments are identified as a malus, the risk of an actual restriction is comparatively low. This applies particularly to the mental health risk assessment. However, non-legally relevant consequences are already clearly visible in this regard. Young people are leaving, even fleeing from rural regions to urban centers, and looking for jobs in large companies using dazzling slogans such as "work-lif- balance" and having ergonomic workplace equipment in a preventive manner. In this context, the large automobile manufacturers should be mentioned, e.g., those introducing ergonomic production lines for the once "assembly line workers" as early as the end of the 1990's and having a proactive approach to the topic of corporate demography with an adequate work intensity and corresponding distribution of tasks. These companies have also had complex OHM institutions in the sense of Fig. 9.4 in order to implement such topics since the end of the last millennium. Thus, the BAUA reports and the surveys of 2011 and 2015, which serve as a basis for them, illustrate the need for action for micro and small companies, and for those which are also subject to the effects of failure to carry out risk assessments, together with further steps to be derived from them. Outstanding to well-qualified young people will simply no longer consider such companies to be lucrative in the future and will follow the mainstream into urban companies with good OHM.

In the canon of the National Occupational Safety and Health Commission (NAK), the Joint German Occupational Safety and Health Strategy (GDA), and the Initiative for Health and Work (iga), the biggest problem of the Federal Institute for Occupational Safety and Health (BAUA) appears to be its lack of public awareness. This is indicated by the high values of not conducted risk assessments (ca. 45–49%). It can also be said that these institutions and initiatives are completely unknown to large parts of the German population, sometimes even to public health experts. If one has hopefully learned about the institutions in the course of their studies, then they often diminish, if the graduates do not work in OHM. The institutions lack (media) presence and, in addition, monetary means to increase awareness. As far as the BAUA as a supervisory authority is concerned, it should not be underestimated that the deficiencies identified by its own staff could lead to restrictions. This makes the work more difficult, because usually only those companies which can afford a larger OHM staff have the knowledge of the network partners mentioned here.

9.4.4 Reflection of the Focus Reports "DGB-Index Good Work"

The survey of permanent employees reveals social inequalities too, and, in this case, only possibly health inequalities. The oldest age cohort (56 to 65 years) rates their job quality as worse than the age cohorts before them. If the level of requirements with its clear results were also considered, a clear need for action and requirements for OHM emerges regarding the DGB-Index: it is the older people without management skills and with low requirement profiles who consider their job quality to be the least good. The Index confirms the previously evaluated reports that there appear to be more sectors of the economy with more burden like "trade", "transport and location", "health" and "education" and sectors with less burden like "information and communication". This facilitates the development of a targeted action strategy by the agitators of a salutogenic and primary prevention-oriented overall strategy, which should lead to a more adequate allocation of resources. This strategic thinking, and above all action, should begin and end with the National Occupational Safety and Health Commission (NAC), the National Prevention Conference and the umbrella organisations of the health insurance companies, the German Pension Insurance and the German Statutory Accident Insurance.

The DGB-Indexes are not the only expression of the German Trade Union Confederation's proactive commitment to the health of their members and all other employees. Health belongs to the genuine core fields of employee representation. The findings evaluated here represent the position of the employees in the context of OHM. Frequently, the representatives of staff and works councils are not only members of the DGB, but also of those who co-decide or even carry out tasks of the OHM themselves. Therefore, the phenomena of work rush and work density, as well as the effects of digitisation will be discussed particularly in the future. The DGB-Indices will have the highest dissemination possibilities, and thus, works councils will have the opportunity to

influence the reduction of social and health inequalities in companies within the framework of OHM.

9.5 Conclusion: The Setting Workplace Has Only Very Limited Chances of Intervention

With the core areas shown in Fig. 9.4
- Occupational health and safety
- Occupational health promotion
- Company integration management and
- Medical services for prevention

OHM has clearly delineated subject areas in terms of structure, which all are suitable for reducing health inequalities. However, it is mainly implemented in the above extent in large companies. Beyond that, the smaller the companies are, the less extensive are the relevant management services provided by the company. The large majority of companies in Germany are those which are worst off in terms of OHM, namely small and micro-enterprises.

Finally, Fig. 9.7 illustrates once again how large a network, which is necessary for a functioning OHM, is. Even for companies assigning only one person in full-time to

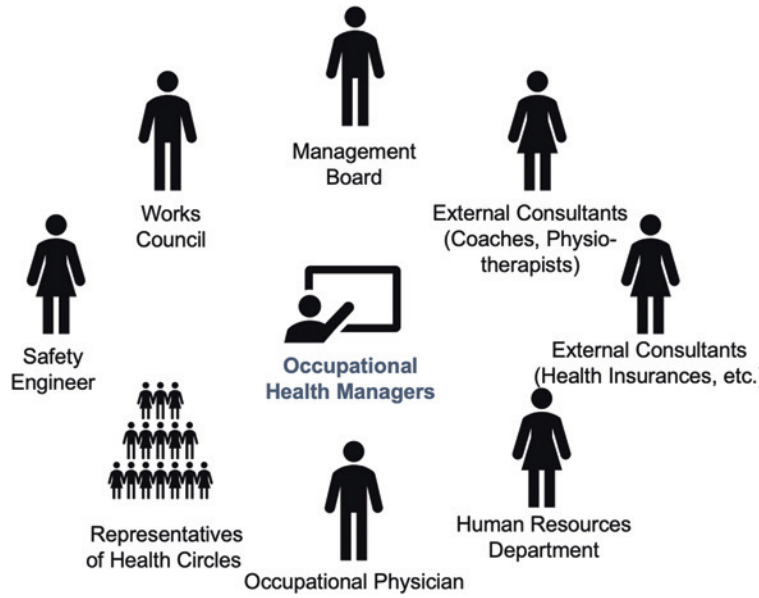

Fig. 9.7 Network of Occupational Health Managers

coordinate the four core tasks mentioned above, it will be impossible to implement all work packages at least in accordance with the legal requirements of the ArbSchG. In such cases, it is more important to obtain the support of the network partners analysed in this article. The main part of the network partners to be named in the context are the German Pension Insurance, the German Social Accident Insurance and the health insurance companies. However, very real limits remain on the whole.

9.5.1 Unfortunately, Health Insurance Remains Health Insurance—for the Time Being

It should not be overlooked that it is the historically grown genuine mission of the statutory and private health insurance companies to primarily finance the treatment of diseases and their consequences; in addition, there is the social security in case of illness, which also historically exists since 1881, and is closely connected to their core mission. The main focus of the statutory accident insurance funds is to prevent work-related accidents, to restore the ability of the insured persons in case of accidents, and to compensate them or their surviving dependents with cash benefits. In the present context, the main task of the pension insurance is and remains to provide monetary benefits in the event of a reduction in earning capacity, if employed persons are unable to work, or partially or completely disabled. This will also be the case on a permanent basis. A complete paradigm shift towards salutogenesis simply cannot be achieved due to these core tasks. However, the aspects developed in the discussion should be taken seriously—and health promotion and prevention services should not primarily be used as a synergetic marketing service. An orientation towards the socially disadvantaged regions and company sizes mentioned in the article should—finally!—be realised. In addition, the untenable differences in the remuneration system of private and statutory health insurance companies could be harmonised and the resulting savings could be invested in health promotion and primary prevention.

9.5.2 The Company and Ethics…

In addition to the general question of feasibility, OHM is ultimately also a responsibility towards employees—and thus towards corporate ethics. As already indicated in the introductory reflection on the term “health management”, it can raise questions about the benefits or “usability”. A provocative question can quickly arise in this context: Does OHM actually serve the employee and his work-life-balance, or is it established in order to achieve primarily profit-oriented goals? Thus, it concerns the ethical justifiability of health offers or, in addition, interventions. This begins far before questions of discharge management in the context of an addiction in terms of obligatory preliminary examinations or the likewise obligatory participation in event offers for movement, nutrition, and

relaxation arise. The German legislation is very liberal in this respect, which in this context actually means that it is employee oriented.

9.5.3 The Patient Should Care: Starting to Take Responsibility for Themselves as Early as Possible

Then, in the end, is it up to the individual person to do something about social and health inequalities? Yes, indeed—at least for the most part and in terms of health promotion. Having a healthy diet, exercising moderately for thirty minutes five times a week, and spending their free time not only in front of the television or the games console; these are, first and foremost, activities over which the company should have no influence; much worse: it would be unimaginable, if it had. Schäffer et al. will be criticized again and again with regard to the random sample of their "Health Literacy Survey Germany" (HLS-GE). Nevertheless, the results, which reflect data of about 2000 people, should be appreciated with care and respect. The results show that 38.4% of Germans have sufficient, 44.6% problematic, and 9.7% inadequate health literacy, compared to only 7.3% having excellent ones. 54.3% of the German population have clear shortcomings in finding health information, then understanding, assessing, and ultimately implementing it. In addition, it should not be forgotten that the term "epidemiological transition" implies a change from the often hygiene- and ratio-related infectious diseases to behavioural lifestyle-related diseases. This is the main reason why the German federal government launched its "National Action Plan Health Literacy" in 2018. The fact that only one recommendation was listed for the setting "workplace" in this framework implies that health literacy, which is the main cause of social and health inequalities, must be dealt with in a much more complex and individualised way. In the overall context and its management possibilities, the setting workplace is only one of many possible approaches to individual health promotion and the epidemiological and demographic transition in German society as a whole. The central starting point remains the human being in their various settings and general behaviour—or also their individual interpretation of everyday life.

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