Workplace health improvement: perspectives of environmental health officers

J. Reynolds¹ and J. Wills²

¹Department of Global Health and Development, London School of Hygiene & Tropical Medicine, London, UK, ²Institute of Primary Care and Public Health, Faculty of Health and Social Care, London South Bank University, London, UK.

Correspondence to: J. Reynolds, Department of Global Health and Development, London School of Hygiene & Tropical Medicine, 15–17 Tavistock Place, London WC1H 9SH, UK. Tel: +44 (0)20 7927 2768; fax: +44 (0)20 7637 5391; e-mail: Joanna.reynolds@lshtm.ac.uk

Introduction

Environmental health practice concerns protecting human health from physical, social, chemical or biological aspects of the environment and practitioners include environmental health officers (EHOs). In the UK, EHOs are principally employed by local government and may specialize in food safety, noise or health and safety (H&S), including health in the workplace [1]. Traditionally, EHOs have concentrated on the physical hazards to health in the workplace, seeking to prevent injury and occupational diseases [2,3]. As part of this protective approach is the enforcement function of EHOs in the UK: the duty to inspect businesses and ensure compliance with H&S legislation [2,4].

More recent conceptualizations of environmental health have sought to extend practice beyond this traditional enforcement role. "Environmental healthness" denotes environmental health practitioners’ ability to look at problems and generate solutions that reflect the ‘holistic public health position’ [5, p. 255]. This approach corresponds with the recent emphasis by the UK’s Chartered Institute of Environmental Health (CIEH) on practitioners’ responsibilities to contribute to ‘the . . . improvement of public health and improving quality of life and wellbeing’ [6, p. 1]. Calls for development of ‘environmental health promotion’ reflect a broadening of the definition of environmental health practice towards an ecological approach addressing wider determinants of health [7,8]. The profession’s potential contribution to health promotion strategies that enable people ‘to increase control over, and to improve, their health’ [9, p. 1], has been acknowledged.

However, other literature suggests that EHOs’ health improvement role is not always fully realized in practice.

Background

Environmental health practice in the field of occupational health and safety is traditionally concerned with protecting health relating to the workplace. However, little is currently known about environmental health officers’ (EHOs) perceptions of their role in workplace health improvement, a pertinent topic in light of the recent government agenda for improving the health of the workforce in the UK.

Aims

To explore how EHOs perceive workplace health improvement and its relevance to their professional role.

Methods

A qualitative methodology was employed, using a case-study design with thematic analysis of 15 transcripts of in-depth telephone interviews with EHOs working in London, UK.

Results

EHOs view themselves primarily as enforcement officers, with legislation guiding their understandings of workplace health. Many interpret work-related ill health in terms of safety and physical injury and do not feel competent in assessing broader psychosocial elements of ill health. However, a few EHOs welcomed the opportunity to promote health in the workplace, recognizing the importance of prevention.

Conclusions

This study indicates a gap between the contemporary EHO role framed by professional bodies as holistic and contributing to public health goals and the role perceived by EHOs ‘on the ground’. A more traditional, protective and enforcement-based approach persists among EHOs in this sample, and few feel they have skills to address determinants beyond physical hazards to health. Yet, a minority of EHOs adopted a more health-promoting approach, suggesting that the potential contribution of EHOs to the workplace health improvement agenda should be explored further.

Key words

Environmental health officer; health promotion; professional role; workplace health.
According to LaFollete et al. [10], a prevailing focus on enforcement activities has led to an entrenched ‘regulatory paradigm’ within the profession, characterizing a reactive, problem-solving approach to EHO work. In the mid-2000s, advocates of ‘environmental health promotion’ acknowledged the tensions faced in incorporating health promotion into the profession, suggesting that EHOs trained in natural science disciplines lacked the necessary conceptual frameworks to adopt an ecological model of health that recognized its determinants [7].

Environmental health practice in the workplace illustrates this tension. The need to protect and improve the health of the workforce has been acknowledged internationally, in the WHO’s Healthy Workplace Framework [11] and in UK government health policy. However, it is only recently that an explicit strategy to address the health of the workforce has emerged in the UK [12]. Dame Carol Black’s 2008 report to the British Government highlighted the extent of absenteeism due to ill health, its implications for health and social inequalities and its impact on economic productivity [13]. It also reported evidence that working in the right conditions can be beneficial for health [14]. The government’s strategy in response to the Black Report attempts to break the links between ill health and ‘worklessness’ by focusing on minimizing sickness absence and facilitating return to work following sick leave [12].

The psychosocial factors affecting health at work including issues such as shift work, low pay, job insecurity and supervisory relationships have received more attention in recent years, particularly in relation to management of stress for which guidance has been developed by the Health & Safety Executive (HSE) in the UK [15]. The 2010 Marmot review inquiry into health inequalities identified work and the workplace as key elements of the social determinants of health [16]. The review stressed that the complex relationship between work and health should be understood and responded to by all practitioners with a central role to play in the design and delivery of services that promote health and well-being [17].

Yet the reality of addressing the broad determinants of workplace health for its improvement remains problematic; for example, currently only a small proportion of the UK working population has access to occupational health services [18,19]. The workplace has long been identified as an ideal context for health promotion, reflecting the ‘settings approach’ of creating supportive environments in which health can be improved [9,20]. However, many workplace health promotion interventions have been criticized for targeting individual behaviour, failing to address determinants at the organizational level [21]. Could the environmental health profession, with its existing commitment to H&S protection in the workplace, offer an alternative approach to improving workplace health?

The CIEH recognizes the profession’s responsibility towards addressing the impact of stressors, including the physical, social and psychosocial, using skills including inspection, enforcement, advocacy and research [6]. However, there remains a paucity of literature on how EHOs themselves conceptualize their role in improving workplace health beyond enforcement. One study explored EHOs’ perceptions of mental illness in the workplace and their role in improving workplace mental health and concluded that EHOs displayed a protective approach to mental health, rather than a health enhancing one [22]. Beyond this, there remains a gap in the literature around EHOs’ perceptions of promoting health in the workplace.

This study aimed to explore EHOs’ perceptions of workplace health and of their role in improving workplace health.

### Methods

The study assessed the perceptions among EHOs of workplace health improvement and its relevance to their role through a qualitative methodology using a case-study design. The qualitative approach was suitable as it facilitated a reflexive account of participants’ understanding of their position and practice.

This case-study was based on a team of EHOs in the commercial premises management department of one borough in London, UK, who had been involved in promoting a pilot workplace health improvement scheme—the ‘Well at Work’ scheme (WaW)—across the borough between 2009 and 2010. The scheme offered access to free healthy business advice and occupational health services for small and medium-sized enterprises (SMEs) between 2008 and 2010. EHOs were requested to promote the scheme to eligible SMEs as part of their routine inspection work and to identify suitable SMEs for referral to the scheme. See Figure 1 for a summary of the WaW scheme.

As part of a service evaluation of the scheme, 18 EHOs participated in telephone interviews between December 2009 and February 2010. This represented a convenience sample, based on willingness to participate, recruited from a team of 29 EHOs who had helped promote the

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**The Well at Work Scheme**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Clinical management (individuals)</th>
<th>Risk assessment (individuals &amp; organisations)</th>
<th>Healthy workplace advice (organisations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>Occupational health nurses</td>
<td>Environmental health officers</td>
<td>Healthy business advisors</td>
</tr>
<tr>
<td>Example Activities</td>
<td>Offering OH advice and treatment referrals for physiological and psychological conditions</td>
<td>Identifying SMEs for inclusion in the scheme</td>
<td>Offering advice on sickness absence monitoring, policies for night work, return-to-work policies, debt advice</td>
</tr>
</tbody>
</table>

Figure 1. Outline of the Well at Work scheme.
scheme. Of these, 15 EHOs consented to the analysis of their interviews for this case-study exploring perceptions of their role in workplace health improvement. The interviews conducted with these EHOs were semi-structured, lasting an average 27 min, and were transcribed fully verbatim before analysis.

The sample included 10 members of the H&S team and 5 from the food team (FT). Although the latter group had a primary responsibility for ensuring compliance with food safety legislation, ~30% of their inspection duties focused on the H&S of food premises.

Thematic content analysis was used to analyse the 15 interview transcripts, in order to identify common and disparate themes relevant to the research question. After familiarization with the transcripts, QSR Nvivo 8 software [23] was used to code the data in an iterative process, frequently returning to the transcripts to refine codes and ensure text was not coded out of context. The coding structure was used to identify emergent themes, which were compared across and within participants’ data to develop meaningful constructs. Deviant cases were actively sought and compared with common themes.

No ethical approval was required for the service evaluation, but ethical approval for this qualitative case-study was granted by the London School of Hygiene & Tropical Medicine ethics committee in 2010.

Results

Interviews with 15 EHOs were analysed, highlighting emergent themes around EHOs’ perceptions of their role in relation to workplace health and identifying areas of dissonance among participants’ accounts. A summary of the key themes with examples from the data is presented in Table 1 below.

<table>
<thead>
<tr>
<th>Key concept</th>
<th>Notable themes</th>
<th>Example</th>
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<tbody>
<tr>
<td>Workplace health</td>
<td>Something to be maintained and protected, rather than promoted</td>
<td>'if you’re at a certain stage of health when you go into work, you shouldn’t come away any worse' (P12)</td>
</tr>
<tr>
<td></td>
<td>Conceptualized in terms of injury and physical ill health</td>
<td>'for the sort of premises we deal with, it’s probably more injury than ill health per se' (P04)</td>
</tr>
<tr>
<td></td>
<td>A perceived lack of ability to detect non-physical ill health, often conceptualized as ‘medical’</td>
<td>‘some of it is medical, some of it goes beyond our knowledge . . . ’ (P01)</td>
</tr>
<tr>
<td>The EHO role</td>
<td>Primary responsibility: ensuring compliance with legislation</td>
<td>‘the first thing is enforcement, making sure people comply with the law’ (P02)</td>
</tr>
<tr>
<td></td>
<td>Predominant problem-solving approach</td>
<td>‘Because of the work I do is driven by problems, if I think it’s a problem, I’ll deal with it’ (P04)</td>
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<td></td>
<td>Role is changing from principally safety focused</td>
<td>‘I think we’re moving very quickly from . . . what was a safety-based culture . . . to a much more holistic one involving health’ (P10)</td>
</tr>
<tr>
<td>Relevance of workplace health improvement</td>
<td>Some recognize value in offering something ‘positive’ to employers</td>
<td>‘I think it’s helped us tremendously to offer to employers something positive’ (P11)</td>
</tr>
<tr>
<td></td>
<td>Tension between enforcement role and promoting health improvement scheme</td>
<td>‘. . . they don’t really like to discuss any issues . . . because . . . they see us as enforcing officers’ (P06)</td>
</tr>
</tbody>
</table>

All EHOs perceived their primary responsibility as enforcement, ensuring compliance with legislation in the workplace through activities such as inspection, education and follow-up of complaints. Unsurprisingly, there existed a marked difference between the stated priorities of FT officers (ensuring compliance with food safety legislation) and H&S officers (complying with H&S legislation guided by the HSE). FT officers indicated that the H&S duties of their role were of lesser importance to them than food safety. Several FT officers indicated that assessment of workplace health was a relatively new focus and was described in terms of an ‘added thing’ to be completed in the inspection process.

A common concept emerging from EHOs’ discussions of their professional role was that of ‘problem solving’, indicating a largely reactive approach to workplace health. EHOs suggested that their work was ‘driven by problems’, and descriptions of workplace health issues were often framed as ‘problems’. Solving problems was typically conceptualized in terms of bringing H&S practice up to pre-determined, legislative standards, through ‘persuasion’ or enforcement. Thus, it appears that achieving legal workplace H&S standards is considered a chief goal of EHOs’ work.

Several H&S officers remarked on a perceived shift in their professional culture, moving from a safety-based focus to a more health-based focus. They acknowledged a realization within the profession that ill health in the workplace had been ‘overlooked’ previously, despite potentially posing a bigger burden than safety on sickness absence. A couple of participants remarked that many EHOs may still have a ‘traditional approach’ and may find adopting a more holistic approach to workplace health challenging.

Most apparent from the EHOs’ interviews was the conceptualization of workplace health in terms of ‘ill’...
health. Describing health in the workplace, all EHOs framed their responses to some extent around this negative concept, and most commonly, in terms of physical ill health. Physical ill health was frequently imagined in conjunction with safety, implicated in discussions of injuries, accidents and physical conditions such as muscular–skeletal disorders or back pain. The physical environment and physical attributes of work such as manual handling tasks were most commonly cited by EHOs as determinants of workplace health. As such, the EHO’s role was presented as safety focused and protective, ensuring the workplace was ‘free from any hazards’.

A concept of health beyond physical injury and safety was more problematic for many participants. Psychological ill health and psychosocial determinants in the workplace were less coherently defined than physical factors, and in some cases, not mentioned at all. The notion of stress was raised by EHOs, although most indicated difficulty in identifying and addressing stress and suggested a lack of skills or knowledge to deal with the issue. However, a minority of participants did convey some understanding of the psychosocial and organizational factors contributing to stress, such as poor working relations, and perceived the issue to be significant for workplace health.

For most EHOs, ill health other than physical injury was conceived as situated within a ‘medical’ domain, requiring clinical knowledge and expertise. As such, addressing ill health often appeared to be considered to fall largely beyond the scope of the EHO role. There was a strong indication that EHOs lacked confidence to assess broader determinants of health, and several EHOs indicated this area had sometimes been ‘overlooked’ in practice due to not feeling ‘competent’.

Ability to identify and address stressors or determinants of workplace health centred primarily on the practice of inspection, relating to visual examinations of the workplace and documentation. EHOs indicated their ability to detect threats to physical H&S centred on observation, without reliance on employers to provide information. Conversely, other aspects of ill health and its determinants were largely considered to be far ‘less tactile and less obvious’ and hence far more difficult to identify and address. A number of EHOs stated that unless an employer raised a problem with stress during an inspection, or unless it was ‘completely glaringly obvious’, they felt unable to detect and address such issues.

EHOs’ approach to workplace health was most commonly framed in terms of ‘maintenance’ of a health state, with a goal of ensuring that work did not adversely affect employees’ health. This predominantly protective perspective may explain some of the reported challenges EHOs experienced when promoting the WaW scheme to eligible businesses as part of their routine inspection work. Many found ‘switching’ from enforcement officer to promoter of a free service to be ‘awkward’ and reported that employers were often confused by the change and were suspicious of the separation between the scheme and enforcement activities. As such, engagement with workplace health improvement activities was perceived by these EHOs as complicating and making more challenging their primary professional role.

Involvement in workplace health improvement was typically characterized as arising simply from EHOs’ knowledge of local businesses and powers of inspection. As such, many EHOs suggested they became involved in the promotion of workplace health only when a specific issue had been identified through a routine inspection. In contrast a minority of EHOs in the study displayed a more proactive attitude towards engaging with workplace health improvement, perceiving it to complement a ‘very vital component’ of the EHO role. This minority described value in being able to offer access to health improvement activities that are not linked to enforcement, particularly as promoting WaW was perceived to help reduce the ‘generally negative’ perception of EHOs held by employers. A few indicated that they tried to promote the scheme to every eligible business. One EHO described taking extra time outside inspections to visit SMEs and promote the scheme. It was these EHOs who also acknowledged the importance of their role in a wider health improvement strategy around workplace health.

**Discussion**

There is a clear indication that the EHOs in this study saw themselves, first and foremost, as enforcement officers, with primary responsibilities in ensuring compliance with H&S legislation. Workplace health was framed chiefly in terms of physical determinants and ill health, linked to a focus on safety. The EHOs appeared to echo the CIEH definition of the EHO’s role from 2008 which is to address workplace H&S, emphasizing prevention of injury and ill health through the management and reduction of risk [4]. There appeared to be little association between the majority of EHOs’ conceptualizations of workplace health and the recent drive within the occupational H&S profession to adopt a holistic, bio-psychosocial approach to health, which recognizes the potential of the workplace as a health-supportive environment [6,24,25]. This tension between the traditional protective EHO approach in which EHOs confine themselves to addressing hazards and sources of injury within a regulatory role and the health-promoting approach has been widely debated [726]. A minority of EHOs recognized a shift in the profession towards a more holistic understanding of the determinants of workplace health. However, most EHOs expressed a lack of skills or knowledge to address health beyond physical H&S. Although a minority of EHOs appeared to engage with a more promoting approach to workplace health—proactively promoting WaW, valuing collaboration with employers—the majority
displayed a protective approach—problem solving and reactive.

This study addresses a current gap in literature by presenting EHOs' perspectives on workplace health, in light of a recent agenda for improving the health of the workforce. Although the findings are not generalizable beyond the study’s context, the qualitative design allowed for in-depth exploration of the ways in which a sample of EHOs perceives the professional role in relation to workplace health. Telephone interviews were conducted due to practical constraints, but may have restricted to some extent the flow of dialogue compared with face-to-face interviews. Despite this potential limitation, however, the study presents a useful base from which to explore further the possible contribution of EHOs to the workplace health improvement agenda, particularly as no similar studies have been conducted.

Workplace health improvement requires EHOs to move beyond the boundaries of traditional practice and to function as resource catalysts. In the unique situation of military employment, army EHOs play an active role, alongside occupational health workers, in taking preventative measures to reduce both physical and psychological work-related impacts on health [27]. However, it appears that beyond this highly specific context, EHO contribution to public health and health promotion is commonly restricted by organizational barriers, such as the need to comply with performance management demands and resource constraints [6]. The findings of this study correspond with that of an earlier study exploring EHOs' perceptions of mental health in the workplace [22] that EHOs hold a bio-medical understanding of (mental) health and lack confidence to address its social and psychological determinants. Thus, it appears that, despite recent rhetoric from the professional organizations such as the CIEH and changes to training and continuing professional development [6], many EHOs still do not demonstrate a holistic approach to workplace health or appear to recognize the workplace as an ‘opportunity for general health improvement’, as advocated by the HSE [28].

The findings from this study also resonate with literature from the wider health field, particularly the difficulties reported in incorporating health promotion values into nursing practice [29,30]. Whitehead argues that nursing practice remains entrenched in a traditional, bio-medical culture, and many nurses feel unable to move beyond the disease-centred, expert-led approach to a more holistic, collaborative, promoting approach [29,30]. Recommendations to address these challenges through improved education and professional support may also apply to the EHO profession and facilitate their contribution to workplace health improvement beyond simply ensuring compliance with legislation.

However, amongst a minority of EHOs in this sample, there appeared to be some understanding of psychosocial issues affecting health in the workplace, beyond traditional H&S, and it was these EHOs who acknowledged the value of engaging with health improvement activities. This should be used as a basis from which to explore further the potential contribution of EHOs into the workplace health improvement agenda.

This study indicates that there appears to be a gap between the professional rhetoric of the contemporary EHO role and perceptions of workplace health and the EHO role held by the majority of those ‘on the ground’. Furthermore, perceived ability to address determinants of workplace health beyond physical safety risks remains low across all the EHOs in this study. Clearer communication of the EHO role in improving workplace health to the ‘grassroots’ level, supported by appropriate education and training, may begin to address this gap and increase EHOs’ engagement with workplace health improvement.

Key points
- The contribution of environmental health officers to public health goals such as improving workplace health has been recognized at the professional and policy level in the UK, but little is known about how environmental health officers’ perceive workplace health improvement in relation to their role.
- Perceptions of workplace health improvement among environmental health officers in London indicate a predominantly protective, rather than promoting, approach and they perceive a lack of ability to address broader determinants of workplace health, beyond standard enforcement responsibilities.
- A small minority of environmental health officers indicated greater engagement with a health-promoting approach to workplace health, suggesting potential for contribution to the workplace health improvement agenda, with appropriate training and professional support.

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Conflicts of interest
None declared.

References


