Chapter 2

Understanding the Stakeholders as a Success Factor for Effective Occupational Health Care

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Additional information is available at the end of the chapter

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Abstract

Effective occupational health care at the workplace requires collaboration, partnerships and alliances with internal, interface and external stakeholders. Essential steps for solid work with various stakeholders are identification of key stakeholders, systematic analysis of their views and positions, and development of stakeholder participation and involvement. Stakeholder analysis aims to evaluate and understand stakeholders from the perspective of an organization. Stakeholder analysis starts with identifying and classifying the key stakeholders. After their identification, questions are asked about their position, interest, influence, inter-relations, networks and other characteristics of stakeholders, with reference to their past and present positions, and future potential. The results are presented as stakeholder maps as well as by the power-interest matrix of the stakeholders. Stakeholder analysis serves an organization and its various actors as a guideline in identifying, planning and implementing strategies for managing stakeholder relationships and utilizing the full potential of various stakeholders in developing occupational health care.

Keywords: stakeholders, stakeholder analysis, power-interest matrix, stakeholder strategy

1. Introduction

In the modern operating environment of work, successful occupational health care requires collaboration, partnerships and alliances between various actors. The various actors with clear interests ('stakes') in the work and operations within a workplace are called stakeholders. The changing nature of workplaces is accelerating the needs for collaboration between various stakeholders.

Some decades ago, the focus of occupational health care was either on a single illness or risk factor, or on changing a particular lifestyle habit or behaviour of individual employees. In countries like Finland, the development has clearly been towards a comprehensive approach in occupational health care, and thus the focus has been shifted towards active promotion of the work ability of individuals with an emphasis on structural developments [1]. In general, since the 1990s in many industrialized countries, occupational health care has been understood as more holistic and integrative by its nature [2].

Occupational health care can be understood today as the combined efforts of employers, employees and society to improve the health and well-being of people at work. This conceptual development has also meant that the number of actors in occupational health care has been increasing. Consequently, new types of collaboration between employees, employers and other actors in the field are required [1, 3]. The altering operational environment also requires new skills, such as networking skills, which are becoming essential for an effective occupational health care work [4].

Various stakeholders of occupational health care (e.g. employees, employers, shareholders and occupational healthcare providers) also have different key interests [5]. If their different interests are recognized and analysed, the operating environment of occupational health care can be improved. However, as the "Healthy workplaces: a model for action" by the WHO emphasizes, the various stakeholders in a workplace must work together in a collaborative manner [6].

The classic definition of a stakeholder according to Freeman is "an organization… [or] any group or individual who can affect or be affected by the achievement of the organization's objectives" [7]. While Freeman's groundbreaking book "Strategic Management: A Stakeholder Approach" in 1984 started the wider discussion and elaboration of stakeholders and their importance, an earlier concept of stakeholders had already emerged in the 1960s. In 1963, academics at the Stanford Research Institute stated that a firm also needs to be responsible – in addition to shareholders – to a number of stakeholders without whose support the organization would cease to exist [5]. Some scholars have even proposed that the roots of stakeholder thinking dates as far back as the 1930s [8].

The number of published titles in academic and professional literature about stakeholder management has grown rapidly since the 1980s. The main body of the stakeholder management literature still relates to the corporate environment, but the public sector [9] and the third sector [10] are becoming increasingly interested in the applications of stakeholder management as an element in their strategic management.

The concept of stakeholders and the potential for both convergent and competing issues in the corporate world have often been displayed through the consideration of corporate social responsibility and corporate ethics [10–12]. Some researchers argue that the fundamental concepts of stakeholder, stakeholder model, stakeholder management and stakeholder theory are explained by various authors in different ways and are supported or critiqued with diverse and often contradictory evidence and arguments [13].

The scientific literature concerning stakeholders in occupational health care is evolving, but still scarce, and there is an obvious lack of published research in this area [14]. The theme of

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stakeholders has been discussed in the context of national healthcare systems and healthcare organizations (see e.g. [15–18]). The importance of stakeholders and stakeholder positions for hospitals has also been discussed in the research literature (see e.g. [19, 20]). The importance of stakeholders in occupational health services has mainly been discussed in the context of the need for multiple stakeholder collaboration (see e.g. [21]), but a generic, structured approach to understand stakeholders and their positions in occupational health care is still covered only by few authors in the research literature.

Understanding the stakeholders is essential also in the altering environment of value creation in occupational health care. In modern approach to occupational health care, the individuals (employees) of an organization are essential for the value creation. As the most important determinant of an individual's health is his or her own health behaviour, the different types of service can support an individual in co-creating better health [22]. Co-creation implies meaningful engagements of interaction, activities and exchange between collaborators [22]. The co-creation approach is valuable, as it emphasizes the critical role and the involvement of the users in the value creation, but also the various encounters with different actors.

The critical involvement of the users is described with the term 'value co-creation' and the value provision as a collaborative action between various actors and players is described with the term 'value co-production'. Joint actions of various entities can provide novel opportunities and avenues for various users. Value co-production as such is not a recent innovation; the recent innovation is to organize the value co-production systematically [23]. Effective occupational health care should utilize both modalities, as it needs both the strong involvement of various actors into value creation as well as well-organized collaboration between various actors to enable comprehensive service provision for the users of occupational health care [24].

The implications of co-production are also visible to occupational health care and its value creation. The value creation can take place in a more synchronous, less sequential manner by various actors. However, it also provides new opportunities to provide a comprehensive service provision for the users of occupational health care [23].

The altering operating environment of occupational health care, its novel challenges and new opportunities in value creation urge also the more in-depth knowledge and analysis of the various stakeholders.

2. Stakeholder analysis as an important tool

The aim of stakeholder analysis is to evaluate and understand stakeholders from the perspective of an organization, or to determine their relevance to a project or policy [16]. In the undertaking of stakeholder analysis, various questions are asked about the position, interest, influence, inter-relations, networks and other characteristics of stakeholders, with reference to their past and present positions, and future potential [25].

More specifically, stakeholder analysis is an approach, a tool or set of tools for generating knowledge about 'actors' – individuals and organizations – so as to understand their behaviour,

intentions, inter-relations and interests. Furthermore, such analysis is beneficial in the assessment of the influence and resources stakeholders bring to bear on the decision-making or the implementation process [26].

Stakeholder analysis is the essential tool to be used in stakeholder management. Stakeholder management is an approach to strategic management of an organization, which emphasizes the crucial role of different stakeholders in the success of the operations of an organization [7, 27]. Stakeholder analysis and stakeholder management are of particular importance to public and non-profit organizations, which have more diverse groups of stakeholders than private for-profit organizations [9].

Although stakeholder analysis is an important building block in stakeholder management, stakeholder analysis itself can make a significant contribution as a research method and as a means of organizational change [28]. Thus stakeholder analysis presents its own, independent and intrinsic value even if an organization is not implementing a thorough stakeholder management approach.

'Stakeholder analysis' is not a clearly defined analysis technique; rather it includes an array of various techniques. Bryson has identified and presented 15 stakeholder identification and analysis techniques [9]. In this article, the stakeholder analysis is described to include the following key stages:

- identification of important stakeholders
- mapping and assessing of stakeholder positions and views
- undertaking a diagnosis of stakeholder positions and views.

Auvinen et al. used a similar approach in mapping and analysing the positions of Finnish stakeholders in workplace health promotion [14].

The first stage is to identify the key stakeholders. In the stakeholder literature, the definition of the 'wide sense of stakeholders' and the 'narrow sense of stakeholders' is an essential element (see e.g. [29, 30]). The 'narrow sense of stakeholders' limits the scope of stakeholders to groups or individuals who can affect the achievement of an organization's objectives or who are affected by the achievement of an organization's objectives; the 'wide sense of stakeholders' widens the scope of stakeholders to identifiable groups or individuals on which the organizations is dependent for its continued survival [29]. In this article, the wide sense of a stakeholder was applied, and thus the stakeholders were defined as all those who have a legitimate interest (either direct or indirect) in occupational health care and its activities.

The following stage is to classify the stakeholders as either primary or secondary stakeholders [9, 31]. According to Clarkson's widely used definition, the primary stakeholder groups are ones without whose continuing participation the corporation cannot survive as a going concern. Furthermore, the secondary stakeholder groups are those who influence or affect, or are influenced or affected by, the organization, but they are not engaged in transactions with the corporation and are not essential for its survival [31].

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The third stage in the stakeholder analysis is to assess the positions and views of the stakeholders, and based on this assessment construct a view of their 'relative importance'. As the analysis of the dynamics of the stakeholders is essential, this stage provides the basis for important activity. The literature of stakeholder analysis and management is rich on varieties of classifications of the stakeholders. Some authors classify the stakeholders according to power, legitimacy and urgency (see e.g. [30]) while another author classifies them according to the issue position and importance [9]. For the purposes of this article, the power/interest matrix was used, as it provides a comprehensive and understandable tool to present positions of the stakeholders (see also [32]).

3. Identification of key stakeholders

3.1. Classification of various stakeholders

In occupational health care, it is essential to involve a wide variety of stakeholders to the work. Various actors are to be taken into consideration, as occupational health care addresses many important issues. The continuous interaction with the various stakeholders is essential, and the active work with the stakeholders can be seen important in reducing uncertainty of the operating environment by identifying and following important actors and critical dependencies [27]. Furthermore, understanding the mutual dependencies and 'co-destinies' of the various actors is critical in an modern-operating environment. An essential factor to be taken into consideration is the potential impact of the multiple and conflicting stakeholder interests [33].

Comparative studies have shown that one success factor of occupational health interventions in organizations is the establishment and working of steering groups involving key stakeholders [34].

The effective stakeholder work requires also the recognition of the different roles of different stakeholders. Stakeholders differ according to their resources. In organizational contexts, where stakeholders are active, knowledgeable and inter-dependent, success is dependent on active, practical stakeholder relationship management [35, 36].

The diversity of the stakeholders has led to various classification structures. In this article, the starting point is the model developed by Fottler et al. for the stakeholders of hospitals. Their classification included three layers: internal stakeholders, interface stakeholders and external stakeholders [19].

It is generally understood, that in healthcare organizations the primary stakeholders are the patients [37]. Innovative pharmaceutical companies, such as Novo Nordisk in their diabetes drug development, have also placed the user in the middle of their stakeholder chart [10] (see **Figure 1**).

Another key internal stakeholder group is the management of an organization. The management includes senior management, line management and human resources management (HRM). All these groups and their collaboration are essential for successful occupational health care [34, 38, 39].

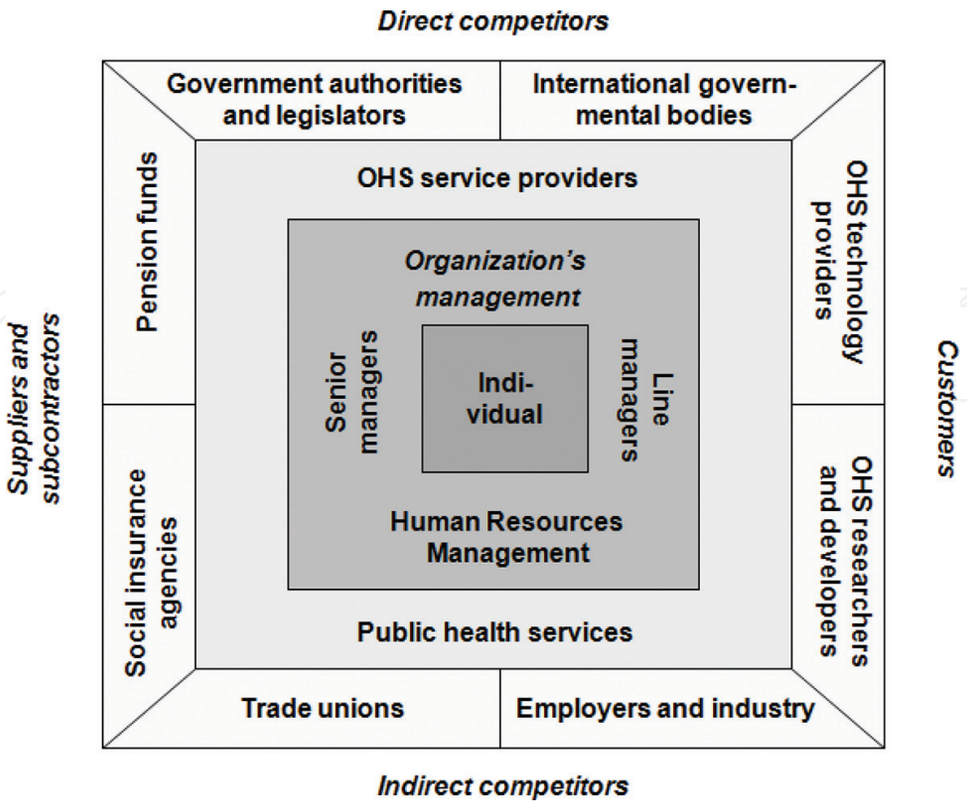

Figure 1. Key stakeholders of occupational healthcare (modified with permission from [14]).

The interface stakeholders are the occupational health-service providers, who provide their services to organizations and also take part in the development of occupational health care [40]. In addition, the public healthcare providers can also be seen as interface stakeholders (see e.g. [41]).

The external stakeholders consist of all the other important stakeholders, such as government and governmental agencies, trade unions, employers' unions, pension funds, municipalities, technology providers and service providers. Furthermore, other external stakeholders also, such as customers and suppliers of an organization as well as shareholders and competitors can be regarded as external stakeholders of occupational health care.

3.2. Internal stakeholders

The key rationale of occupational health care is to provide a safe working environment for the individuals and also to promote their health and well-being (see e.g. [6, 12, 34]). In this article the key stakeholder is an individual (employee) working in an organization, and thus they are in the centre of the stakeholder chart.

Various studies on occupational health care show that strong participation of the employees and utilization of participatory principles in the occupational health care interventions are critical success factors (see e.g. [34]). The wide variation in the health conditions of the individuals poses challenges to occupational health care activities in the workplace. For instance, disparities in living habits (including nutritional habits, exercising habits etc.) are wide within

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working age population in many countries and also within workplaces. It is also notable that these disparities are also partially linked to the socio-economic status of the individual, and thus are also out of the reach of the mandate of occupational health care.

Within the work environment, the occupational health care actions can also be supported by peer groups – in particular, in workplace health promotion (see e.g. [42]) – which can also be considered as important internal stakeholders.

The managers of an organization play an important role in occupational health care. Their decisions of policy guidelines, resource allocations as well as daily management define the destiny of occupational health care activities. Thus various managers must be regarded as major internal stakeholders (see e.g. [39]). For instance, a Canadian study showed that general managers and human resource managers differed in their attitudes and ambitions regarding workplace health promotion [43]. It is important to regard several managers, who have different roles in an organization, of different management levels as important internal stakeholders of occupational health care.

Senior management support for occupational health care has been seen in many studies as a critical success factor (see e.g. [34]). Recent comparative study showed, that there is considerable evidence of the negative impact of senior management support to occupational health care interventions, but less evidence about the positive impact of the management support component of intervention processes [34].

The middle managers are the actual key drivers of occupational health care work and thus their role is imperative within an organization (see e.g. [34, 38, 44]). The middle managers are the drivers of change also in this area, but they can also block important processes within a workplace [34].

Human Resources Management (HRM) is supporting both senior management and middle managers, and their support for the occupational health care activities for managers in formulating goals and implementing action plans are considerable [38, 45].

3.3. Intermediate stakeholders

The essential intermediate stakeholders for occupational health care can be defined to be occupational health services (OHS) providers and generic public healthcare providers.

The contemporary requirements for OHS providers are multifaceted ranging from health promotion of individuals to the development of the working environment (see e.g. [40]). It is also obvious that many employers do not have sufficient knowledge of occupational health care [40], and thus the OHS service providers can be strategically also an important partner in developing the working environment of an organization. The benefits of such a strategic partnership also require a lengthy and open process of collaboration between an employer and an OHS provider.

It is also critical to regard public health care service providers as important stakeholders of occupational health care, as there exist important differences in scope and options for various interventions between public health and workplace health contexts [46]. Although a country might have a well-working public health system, the organizations are willing to develop and

widen their occupational health care activities (see e.g. [43]). Understanding the potential and services of public health care can also focus on the occupational health services more effectively. Unfortunately, according to some studies, the cooperation between general practitioners and occupational health physicians is often lacking or sub-optimal [41].

3.4. External stakeholders

The legislative framework of the occupational health care has been developing during the last decades in most industrialized countries. The legal requirements create the necessary framework for occupational health care, and they are elementary in encouraging the employer engagement to the provision and development of occupational health care [47].

The development of the legislative framework, laws and regulations can also be initiated by international global organizations (such as the WHO or ILO, see e.g. [6]). For member states of the European Union, the policy and regulation development within the EU can be an important accelerator for occupational health care (see e.g. [48]).

Trade unions are important stakeholders, as they represent the interests of employees in an organization (see e.g. [12]). Furthermore, the interests of trade unions with regard to occupational health care can have a different emphasis from those of employers. Trade unions have an important role in improving workplace conditions. In a recent Finnish study on stakeholder positions of occupational health care, trade unions seem to fear that health promotion programs distract attention from workplace health hazards [14].

The organizations and conglomerates of employers have clearly understood the challenges in occupational health care, and they also understand the value of joint development actions to tackle common problems, such as increasing absenteeism and rising trend of problems linked to mental health challenges for employees (see e.g. [14]).

Pension funds are also important stakeholders in occupational health care. They do have an incentive to prevent disability and early retirement, since they have to pay a large part of the eventual pension expenses [49].

Social insurance agencies and other public authorities can benefit from well-organized and systematic cooperation between organizations, OHS providers and social insurance offices. A Swedish study showed the clear financial and operational benefits of systematic and solution-oriented co-operation for all parties involved [50].

Developers of new technological solutions for occupational health care can be interesting stakeholders, as they can provide novel solutions e.g. for workplace health promotion (see e.g. [22]). However, the challenges in such new technologies and services can often be, that the buyers, users and payers might be separate entities with disparate interests [51].

The role of researchers and developers of occupational health care can also be important for organizations. In some countries, like Finland, there are specialized research institutes for occupational health care [14]. The close collaboration between research institutions, universities and companies can be essential in developing novel solutions and methods for occupational health care (see e.g. [52]).

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A wide range of various external stakeholders are pushing organizations to improve their work and respond in more responsible ways to contemporary challenges (see e.g. [53]). Thus important occupational health care stakeholders are also the suppliers, customers and competitors of an organization. Well-organized occupational health care can be an important element of the image of an organization, as it competes of its customers as well as of highly-skilled professional workforce [12, 23].

4. Analysing key positions of stakeholders

4.1. Researching stakeholders

After the thorough identification on key stakeholders, it is essential to understand their key positions, arguments and interests in occupational health care work.

It is necessary to recall that the function of time is also an important issue to consider in stakeholder analysis, as stakeholder interests may converge over time. Stakeholder positions are not, however, static. Rather it is clear that stakeholder positions change and evolve over time [10].

A variety of methods can be used to map the opinions and positions of various stakeholders. Recommendable methods include face-to-face interviews using checklists, semi-structured interviews and structured questionnaires, which all can be used to collect data from primary sources [26]. Secondary methods could include analysis of published and unpublished documents, policy statements and various regulations [26]. An effective method can also be the utilization of focus groups, which might also be venues for development of novel ideas and tackling complex issues (see e.g. [54]). During the planning phase of stakeholder analysis, the strengths and weaknesses as well as the resource requirements of various methods should be clarified [54].

During a Finnish case study of stakeholder positions in workplace health promotion, 45–60-min long semi-structured, thematic interviews undertaken by two researchers was the main method used. The interviews were chosen as a key information collection method, as they also enabled the capturing of detailed knowledge, potential clarifications and the amplification of earlier questions [14].

4.2. Mapping and assessing stakeholder positions

The wide literature of stakeholder analysis provides many different examples of matrices, charts, position maps, network maps and other figures to present the data analysed and collected [26]. For the purposes of this article, two tools are used to illustrate the stakeholder positions. These are the division to primary and secondary stakeholders, and the power/influence matrix. These tools should be seen as complementary to each other.

According to the well-known definition of Clarkson, the "primary stakeholder group is one without whose continuing participation the corporation cannot survive as going concern" [31]. Furthermore, the "secondary stakeholder groups are defined as those who influence or

affect, or are influenced or affected by, the corporation, but they are not engaged in transactions with the corporation and are not essential for its survival" [31].

In the context of occupational health care, the classification into primary and secondary stakeholders shows the fundamental understanding of an organization of the key target groups of its occupational health care work, and which stakeholders it needs to take into consideration in fulfilling the objectives of its occupational health care work. Thus the primary stakeholders are the elementary groups to work with and the secondary stakeholders are necessary and required supporting groups.

A simplified visualization is to present the primary and secondary stakeholders of occupational health care in a two-column table which also includes short commentaries of their importance (see **Table 1**).

Primary stakeholders	Secondary stakeholders
Stakeholder A	Stakeholder G
- rationale 1	- rationale 11
- rationale 2	- rationale 12
Stakeholder B	Stakeholder H
- rationale 3	- rationale 13
- rationale 4	- rationale 14
Stakeholder C	Stakeholder I
- rationale 5	- rationale 15
- …	- …

Table 1. Classification to primary and secondary stakeholders.

However, the classification to primary and secondary stakeholders does not yet indicate the relative power, influence or interest of the stakeholders – this can be achieved by undertaking an evaluation of the power and interest of the various stakeholders. This is usually visualized with a power/interest matrix showing the assessment of the organization of the contemporary importance of the various stakeholders regarding occupational health care.

4.3. Power and interest of stakeholders

The implementation and development of effective occupational health care within an organization requires support from several key stakeholders. Thus it is also important to assess their relative power and influence. This is undertaken by reporting the stakeholder positions or power and influence, which can also be visualized as a power/interest matrix.

In the power/interest matrix there are two important sets of questions to be assessed. According to the classification proposed by Johnson and Scholes, the question "If we were to pursue this strategy with disregard to the views of this particular stakeholder, could/would they stop it?" assesses the power of the stakeholder. The interests of the stakeholder is assessed with

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the questions "How high is this approach on their priorities?" and "Are they likely to actively support or oppose this approach, or will their interest be short-lived?" [32].

The power dimension indicates the level of influence a stakeholder has in either supporting or resisting a strategic initiative. Stakeholders may exercise their power in many ways, for example through a legal position, possession of knowledge and key resources or even informal networking with other decision makers. The interest dimension depends on how high a priority this strategy is. Interests can be open or hidden, which makes their assessment challenging. Interests may be based on a stakeholder's anticipated economic gain, brand value or power position. The level of interest can be estimated by assessing whether a stakeholder has a long-term commitment to the strategy [32].

In a recent Finnish case study on stakeholder views on workplace health promotion, the researchers asked the 17 interviewees to describe their position among the stakeholders and also to assess the other stakeholders and their relative power and interest (see **Table 2**). The interviewees were asked to present arguments about the power and of the interest of the other

Stakeholder	Power/influence	P score	Interest	I score
Individuals (active)	Responsibility for the individual's own health is a prerequisite for the success of proactive health measures. Active individuals are promoters of healthy lifestyles. Active individuals will also use personal financial resources to promote their individual health.	Medium	There is a large disparity between groups of different socioeconomic status. The number of active individuals is growing. They can see the benefit in improved personal and working ability.	High
Individuals (passive)	No contribution to personal or corporate wellness development activities.	Low	Lacking interest, rather resistant towards healthy lifestyles. Need external motivation to participate in health programs.	Low
Occupational Health Service (OHS) providers	OHS providers are seeking more strategic partnerships with their customers. Potential linkages between pension funds and OHS providers could eventually lead to a new landscape for preventive OHS.	Medium	Current business models are based on charges per services–an alternative 'service contract' model could provide incentive for proactive health measures.	High
Pension funds	Pension funds have huge financial resources at hand, e.g. to prevent early retirement by improving the health conditions of the insured persons. Pension funds have power over vocational rehabilitation decisions.	Medium	Considerable benefits in avoiding expenses gained from the prevention of disability and early retirement, Value-added services are critical in the competition between pension funds, because in Finland they cannot compete with prices and other financial benefits.	High
Technology providers	Enablers of new technology-based business models for occupational health care.	Low	Occupational health services could potentially become a new market for technology products.	Medium

Table 2. Example of a Finnish study of stakeholder positions of workplace health promotion – a modified excerpt (applied from [14]).

stakeholders and these were summarized. Based on the interviews, the researchers assessed each stakeholder identified in the stakeholder typology according to their power and interest using a three-grade score (high, medium and low) [14]. This score was also used in building a power/interest matrix.

The results of the power/interest matrix can also be summarized as a two-dimensional power-interest matrix (see **Table 3**). Stakeholders in the upper right corner (high/medium power and interest) are the key players in driving the change towards effective occupational health care (see also e.g. [14]).

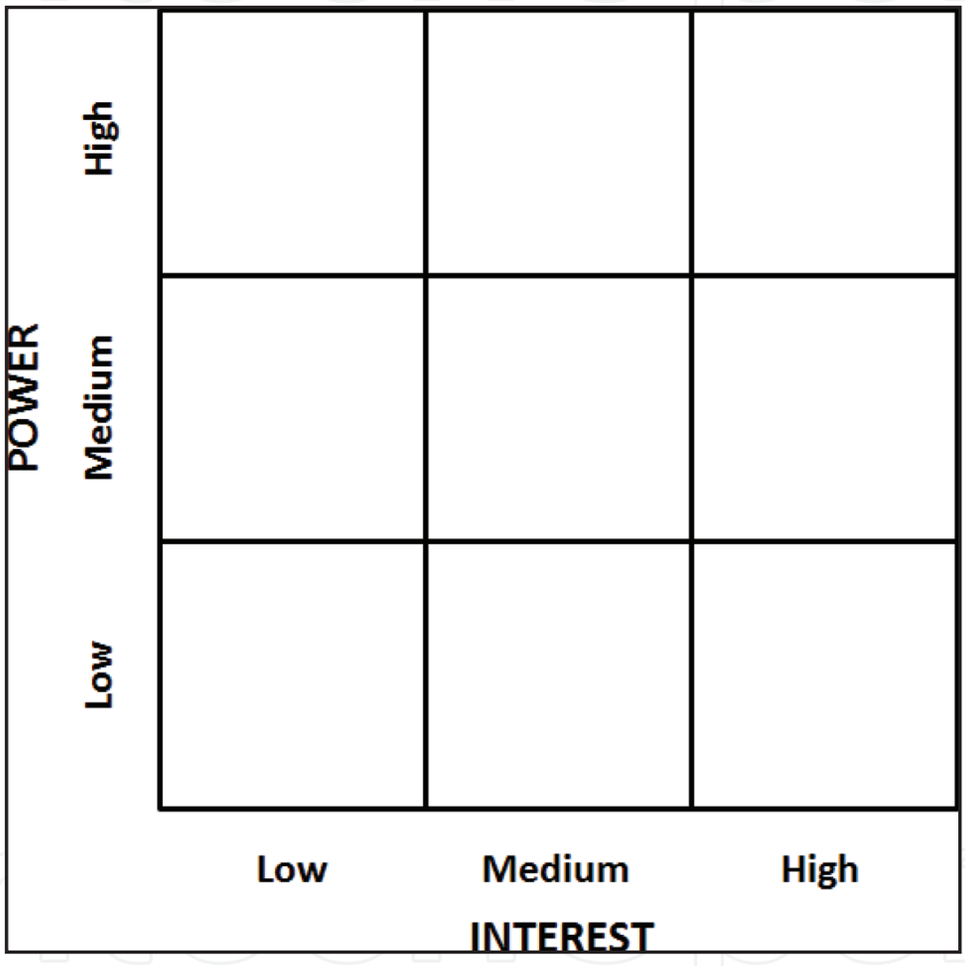

Table 3. Power / interest matrix.

5. Developing stakeholder strategies

The comprehensive stakeholder analysis is an important tool in identifying, planning and implementing strategies for managing stakeholder relationships and identifying current and future opportunities and threats (see e.g. [26]).

The results of the work of stakeholder analysis presented in the power/interest matrix are valid for establishing guidelines with regards for the work with various stakeholders

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(see **Table 4**). Naturally it should be understood that such a classification can only give rough guidance, as in every case the stakeholders vary from another in their activity, involvement and energy. However, such a simplified classification can ensure that all the stakeholders are regarded and that no identified stakeholder groups are left unnoticed.

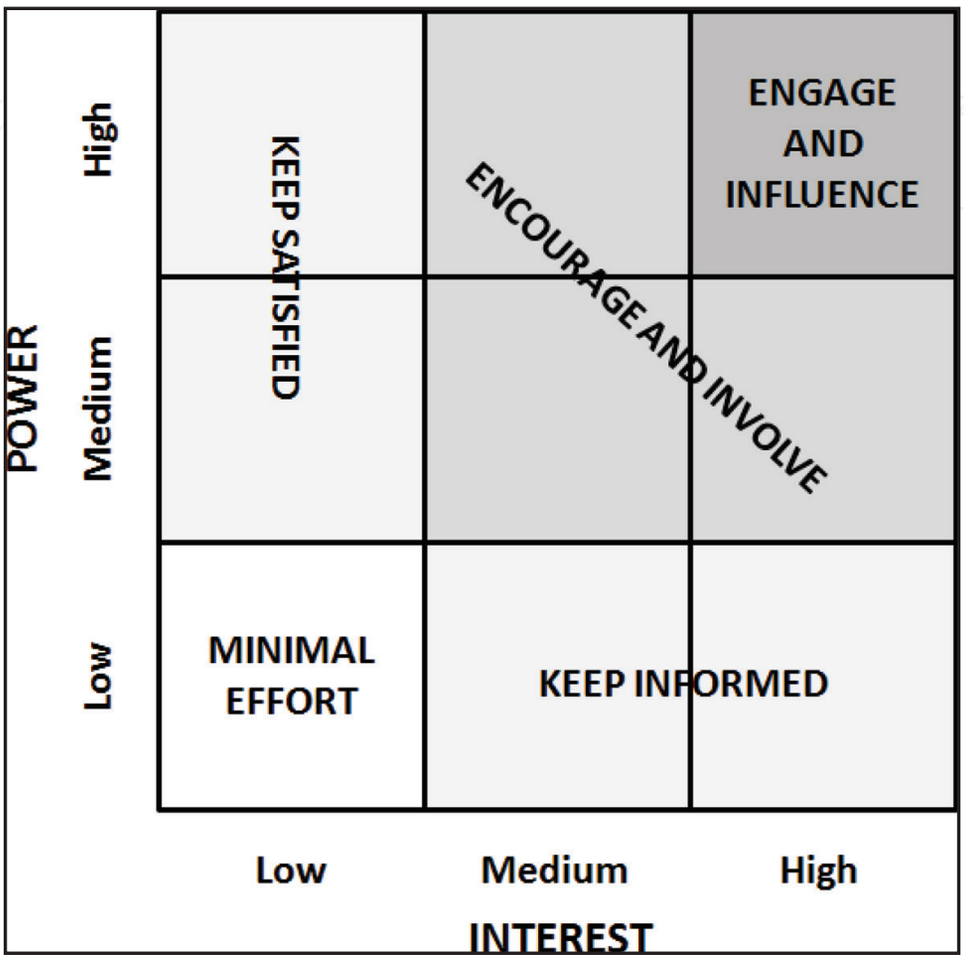

Table 4. Power / interest matrix and strategies according to stakeholders.

It is obvious that not much effort should be directed on stakeholders with little power and a low level of interest. It is good to note their presence, but no particular actions are needed for them.

The needs of stakeholders with low power, but high or medium interest should be addressed mainly through continuous, selected information distribution. Gaining the support of these stakeholders through lobbying can be a good tactic, because they can be valuable allies in influencing the attitudes of other, more powerful stakeholders (see e.g. [55]).

Stakeholders with high or medium power, but low interest, are often difficult to plan with and to develop consistent strategies. These stakeholders might, in general, be quite passive, but might unexpectedly exercise their power in reaction to a particular event or policy. Under-estimation of this group can have disastrous consequences for the adoption of the new approach. These stakeholders should be kept satisfied through continuous communication, and possibly also through selected involvement to focal activities.

Stakeholders in the middle of the power/interest matrix with relatively high power and interest should be encouraged for a solid and continuous support of the work and activities undertaken. These stakeholders can be valuable resources and also provide required support to plan and initiate new ideas.

The most important stakeholders, who are crucial to the success of any strategic development in occupational health care, are the ones with high power and with high interest. These might also be stakeholders, whose opinions and views need to be discussed and elaborated, as their views can also differ and vary.

One recommended method in occupational health care development is to utilize steering groups, which should include key stakeholders, and thus also include key agents for the work to be planned and undertaken. A comprehensive study of organization-level occupational health interventions concluded that the use of steering groups for projects was unanimously recommended by different developers [34].

Another recommended method is having for occupational health care clearly an owner within an organization, who also keeps up the communication with selected stakeholders. It is counterproductive to involve the stakeholders at the start of an activity and after that leave them out of the communication loop. Many studies confirm that active communication with different parties is an essential success factor for occupational health care activities (see e.g. [34]).

Furthermore, it should be noted that the level and intensity for participation to the work and development of occupational health care within one stakeholder group may vary significantly. For instance, all the individuals within an organization might not share the same ambitions and do not assess the value of workplace health promotion in a similar manner. Thus when developing strategies for stakeholder participation, it is also important to understand that the range of participation can be wide from passive participation to self-directed activities and work.

6. Summary

Occupational health care today consists of the combined efforts of employers, employees and other stakeholders to improve the health and well-being of people at work. This conceptual development has meant that the number of stakeholders in occupational health care is increasing. Modern successful occupational health care requires multifaceted collaboration, partnerships and alliances between various actors.

An essential element in occupational health care is well-structured work with various stakeholders. The work with stakeholders starts with stakeholder analysis. It aims to evaluate and understand stakeholders from the perspective of an organization. The first step is to identify the essential stakeholders of occupational health care in an organization. The stakeholders can be classified as internal, intermediate and external stakeholders. The most important internal stakeholders are the individual employees working in an organization; other internal stakeholders are peer employees and various managers (senior managers, line managers, HR managers) of an organization. Interface stakeholders include occupational health service

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providers and public healthcare providers. A wide range of various external stakeholders are pushing organizations to improve their work and respond in more responsible ways to contemporary challenges.

After identifying key stakeholders, the next step is to understand their key positions, arguments and interests in occupational health care work. A variety of methods can be used to map the opinions and positions of various stakeholders. It is important to summarize the views of the stakeholders and also analyse their relative positions according to power, influence and interest.

The stakeholder analysis should lead to planning and implementing strategies for managing stakeholder relationships and utilizing the full potential of various stakeholders in developing occupational health care within an organization.

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References

[1] Husman K, Husman P. Human resource needs of modern occupational health services—the case in Finland. Scand J Work Environ Health Suppl. 2005;1:46–50.

[2] Chu C, Breucker G, Harris N, Stitzel A, Gan X, Gu X,et al. Health-promoting workplaces—international settings development. Health Promot Int. 2000;15(2):155–67.

[3] Peltomäki P, Johansson M, Ahrens W, Sala M, Wesseling C, Brenes F, et al. Social context for workplace health promotion: feasibility considerations in Costa Rica, Finland, Germany, Spain and Sweden. Health Promot Int. 2003;18(2):115–26.

[4] Peltomaki P, Husman K. Networking between occupational health services, client enterprises and other experts: difficulties, supporting factors and benefits. Int J Occup Med Environ Health. 2002;15(2):139–46.

[5] Stoney C, Winstanley D. Stakeholding: confusion or utopia? Mapping the conceptual terrain. J Manag Stud. 2001;38(5):603–26.

[6] Burton J, World Health Organization. WHO Healthy workplace framework and model: background and supporting literature and practices. Geneva: World Health Organization; 2010. 123 p.

[7] Freeman RE. Strategic management: a stakeholder approach. Boston: Pitman Publishing; 1984. 275 p.

[8] Preston LE, Sapienza HJ. Stakeholder management and corporate performance. J Behav Econ. 1990;19(4):361–75.

[9] Bryson JM. What to do when stakeholders matter. Public Manag Rev. 2004;6(1):21–53.

[10] Freeman, RE, Harrison, JS, Wicks, AC. Managing for stakeholders. New Haven: Yale University Press; 2007. 200 p.

[11] Maignan I, Ferrell OC, Ferrell L. A stakeholder model for implementing social responsibility in marketing. Eur J Market. 2005;39(9/10):956–77.

[12] Amponsah-Tawiah K, Mensah J. Harmonising stakeholder interests: the role of occupational health and safety. Afr J Business Manag. 2015;9(9):394–401.

[13] Donaldson T, Preston LE. The stakeholder theory of the corporation: concepts, evidence, and implications. Acad Manag Rev. 1995;20(1):65–91.

[14] Auvinen AM, Kohtamäki K, Ilvesmäki, A. Workplace health promotion and stakeholder positions: a Finnish case study. Arch Environ Occup Health. 2012;67(3):177–84.

[15] Zinkhan GM, Balazs AL. A stakeholder-integrated approach to health care management. J Business Res. 2004;57(9):984–9.

[16] Murdock A. Stakeholder theory, partnerships and alliances in the health care sector of the UK and Scotland. Int Public Manag Rev. 2004;5(1):21–40.

[17] Keele RL, Buckner K, Bushnell S. Identifying health care stakeholders: a key to strategic implementation. Health Care Strateg Manag. 1987;5(9):4–10.

[18] Daake D, Anthony WP. Understanding stakeholder power and influence gaps in a health care organization: an empirical study. Health Care Manag Rev. 2000;25(3):94–107.

[19] Fottler MD, Blair JD, Savage GT, Whitehead CJ, Laus MD. Assessing key stakeholders: who matters to hospitals and why?. Hosp Health Serv Admin. 1989;34(4):525–47.

[20] Wells R, Lee SY, McClure J, Baronner L, Davis L. Strategy development in small hospitals: stakeholder management in constrained circumstances. Health Care Manag Rev. 2004;29(3):218–28.

[21] Tjulin Å, Stiwne EE, Ekberg K. Experience of the implementation of a multi-stakeholder return-to-work programme. J Occup Rehab. 2009;19(4):409–18.

[22] Reijonsaari K. Co-creating health-examining the effects of co-creation in a lifestyle intervention service targeting physical activity. Espoo: Aalto University; 2013. 166 p.

[23] Ramirez R. Value co-production: intellectual origins and implications for practice and research. Strateg Manag J. 1999;20(1):49–65.

[24] Auvinen AM. Personal health systems and value creation mechanisms in occupational health care. In: Proceedings of the 29th Annual International Conference of the IEEE EMBS; 23-26 Aug 2007; Lyon. New York: IEEE. p. 5882–5885.

[25] Brugha R, Varvasovszky Z. Stakeholder analysis: a review. Health Policy Plan. 2000;15(3):239–46.

[26] Varvasovszky Z, Brugha R. A stakeholder analysis. Health Policy Plan. 2000;15(3):338–45.

[27] Yläranta M. Between two worlds: stakeholder management in a knowledge intensive governmental organisation. Publications of the Turku School of Economics, Series A-7:2006. Turku: Turku School of Economics; 2006. 188 p.

[28] Simmons J, Lovegrove I. Bridging the conceptual divide: lessons from stakeholder analysis. J Organ Change Manag. 2005;18(5):495–513.

[29] Freeman RE, Reed DL. Stockholders and stakeholders: a new perspective on corporate governance. California Manag Rev. 1983;25(3):88–106.

[30] Mitchell RK, Agle BR, Wood DJ. Toward a theory of stakeholder identification and salience: defining the principle of who and what really counts. Acad Manag Rev. 1997;22(4):853–86.

[31] Clarkson ME. A stakeholder framework for analyzing and evaluating corporate social performance. Acad Manag Rev. 1995;20(1):92–117.

[32] Johnson G, Scholes K. Exploring corporate strategy—text and cases. 5th ed. Great Britain: Prentice Hall Europe; 1999. 588 p.

[33] Smith AM, Fischbacher M. New service development: a stakeholder perspective. Eur J Market. 2005;39(9/10):1025–48.

[34] Nielsen K, Randall R, Holten AL, González ER. Conducting organizational-level occupational health interventions: What works?. Work Stress. 2010;24(3):234–59.

[35] Peltokorpi A, Alho A, Kujala J, Aitamurto J, Parvinen P. Stakeholder approach for evaluating organizational change projects. Int J Health Care Qual Assur. 2008;21(5):418–34.

[36] Savage GT, Nix TW, Whitehead CJ, Blair JD. Strategies for assessing and managing organizational stakeholders. Acad Manag Exec. 1991;5(2):61–75.

[37] Werhane PH. Business ethics, stakeholder theory, and the ethics of healthcare organizations. Camb Q Healthc Ethics. 2000;9(02):169–81.

[38] Larsson R, Stier J, Åkerlind I, Sandmark H. Implementing health-promoting leadership in municipal organizations: managers' experiences with a leadership program. Nordic J Work Life Stud. 2015;5(1):93.

[39] Tappura S, Syvänen S, Saarela KL. Challenges and needs for support in managing occupational health and safety from managers' viewpoints. Nordic J Work Life Stud. 2014;4(3):31.

[40] Schmidt L, Sjöström J, Antonsson AB. Successful collaboration between occupational health service providers and client companies: key factors. Work. 2015;51(2):229–37.

[41] Moßhammer D, Natanzon I, Manske I, Grutschkowski P, Rieger MA. Cooperation between general practitioners and occupational health physicians in Germany: how can it be optimised? A qualitative study. Int Arch Occup Environ Health. 2014;87(2):137–46.

[42] Shain M, Kramer DM. Health promotion in the workplace: framing the concept; reviewing the evidence. Occup Environ Med. 2004;61(7):643–8.

[43] Downey AM, Sharp DJ. Why do managers allocate resources to workplace health promotion programmes in countries with national health coverage?. Health Promot Int. 2007;22(2):102–11.

[44] Mellor N, Webster J. Enablers and challenges in implementing a comprehensive workplace health and well-being approach. Int J Workplace Health Manag. 2013;6(2):129–42.

[45] Hasson H, Villaume K, von Thiele Schwarz U, Palm K. Managing implementation: roles of line managers, senior managers, and human resource professionals in an occupational health intervention. J Occup Environ Med. 2014;56(1):58–65.

[46] Karanika-Murray M, Weyman AK. Optimising workplace interventions for health and well-being: a commentary on the limitations of the public health perspective within the workplace health arena. Int J Workplace Health Manag. 2013;6(2):104–17.

[47] Martinsson C, Lohela-Karlsson M, Kwak L, Bergström G, Hellman T. What incentives influence employers to engage in workplace health interventions?. BMC Public Health. 2016;16(1):854.

[48] Leka S, Jain A, Zwetsloot G, Cox T. Policy-level interventions and work-related psychosocial risk management in the European Union. Work Stress. 2010;24(3):298–307.

[49] Piekkola H. Active ageing policies in Finland. Keskusteluaiheita; Discussion papers; No. 898. Helsinki: Etla; 2004. 42 p.

[50] Kärrholm J, Ekholm K, Ekholm J, Bergroth A, Ekholm KS. Systematic co-operation between employer, occupational health service and social insurance office: a 6-year follow-up of vocational rehabilitation for people on sick-leave, including economic benefits. J Rehabil Med. 2008;40(8):628–36.

[51] Ilvesmaki A. Drivers and challenges of personal health systems in workplace health promotion. In: Proceedings of the 29th Annual International Conference of the IEEE EMBS; 23–26 Aug 2007; Lyon. New York: IEEE. p. 5878–5881.

[52] Stone A, Usher D, Marklin R, Seeley P, Yager JW. Case study for underground workers at an electric utility: How a research institution, university, and industry collaboration improved occupational health through ergonomics. J Occup Environ Hyg. 2006;3(8):397–407.

[53] Waddock SA, Bodwell C, Graves SB. Responsibility: the new business imperative. Acad Manag Exec. 2002;16(2):132–48.

[54] Reed MS, Graves A, Dandy N, Posthumus H, Hubacek K, Morris J, Prell C, Quinn CH, Stringer LC. Who's in and why? A typology of stakeholder analysis methods for natural resource management. J Environ Manag. 2009;90(5):1933–49.

[55] Auvinen AM, Waddington L, Moretti M, Dondi C, Fischer T, Kretschmer T, et al. Understanding the stakeholders—key to successful implementation of adult learning projects. eLearning Papers Special edition 2010. 2010:1–15.

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