

**AN INVESTIGATION INTO THE STATUS OF WELLNESS
INTERVENTIONS IN THE SOUTH AFRICAN BUSINESS
CONTEXT**

By

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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December 2001

ABSTRACT

Wellness is the desired optimum level of existence an individual can experience and is conceptualized to be the balance among six dimensions, namely physical, emotional, social, vocational, spiritual and intellectual. An imbalance may be created through various factors that could affect the individual adversely and disturb the balance or wellness aspiring for.

This study was prompted by the significant influence of unhealthy behaviours on the South African population and its concomitant effects on the workplace. The wellness of the individual is gaining new interest in times where human beings are plagued by increased levels of stress, disease as well as constant and unpredictable change. Wellness programmes are at the forefront of restoring the balance of the working population and the strive towards excellence presents advantages to both the employer and employee.

There appears to be an increase in the emergence of wellness interventions since its initial origin in the mining industry of South Africa. There is, however, a lack of research conducted on these programmes to support the development and future improvement and expansion of this vital intervention. This study aimed to investigate the extent of wellness programmes in South African organisations as well as the sophisticated conceptualization of these programmes within this context. The study further extended to the formulation of a model presenting the system of wellness as well as its practical application. In order to investigate and explore these factors, a research questionnaire was developed and presented to a sample of 58 respondents for completion.

The results indicate that there are various sophisticated methods applied in the structure and maintenance of wellness programmes in those organisations with such programmes implemented. A tendency towards appreciating the concept of wellness was further identified among respondents. It was however, also ascertained that specific guidance and information about the field of wellness programmes could be advantageous to the future development and frequency of such interventions in the South African business framework.

OPSOMMING

“Wellness” is die begeerde optimum vlak van bestaan wat ’n individu kan ervaar en word voorgehou as die balans tussen ses dimensies naamlik die fisieke, emosionele, sosiale, beroepsgerig, sowel as geestesingesteldheid en intellektualiteit. ’n Wanbalans kan geskep word deur verskillende faktore wat die individu nadelig kan raak en die balans versteur of die “wellness” waarna hy streef benadeel.

Hierdie studie is aangespoor deur die belangrike invloed van ongesonde gedrag op die Suid Afrikaanse bevolking en gepaardgaande invloed by die werkplek. Die “wellness” van die individu wek nuwe belangstelling in tye waar mense se lewens al meer versuur word deur verhoogde stresvlakke, siektes sowel as voortdurende en onvoorspelbare verandering. “Wellness” programme is aan die voorpunt om die balans van die werkende bevolking te herstel en die strewe na perfeksie verteenwoordig ’n tweeledige voordeel vir sowel die werkgewer as die wernemer.

Dit kom voor asof daar ’n vermeerdering is in die toetrede tot die “wellness” programme se bestaansvlak sedert die aansprong daarvan sy beslag gekry het in die mynwyse van Suid Afrika. Daar is egter ’n gebrek aan navorsing wat gedoen is aangaande hierdie programme om die ontwikkeling daarvan te ondersteun asook die toekomstige verbetering en uitbreiding van hierdie lewensbelangrike intervensie in die individu se lewe.

Met hierdie studiestuk is daar beoog om die omvang van “wellness” programme in Suid Afrikaanse organisasies te ondersoek sowel as die gesofistikeerde begrip van hierdie programme in konteks te plaas. Die studie is verder verbreed tot die ontwikkeling van ’n model wat die stelsel van “wellness” en sy praktiese toepassing uitbeeld. Om hierdie faktore te ondersoek is ’n navorsingsvraelys ontwikkel en voorgelê aan 58 respondente vir voltooiing.

Die resultate dui aan dat daar verskeie gesofistikeerde metodes aangewend word in die samestelling en onderhoud van “wellness” programme in daardie organisasies wat wel sulke programme ingestel het. ’n Tendens is waargeneem dat die konsep van “wellness” meer en meer na waarde geskat word soos aangedui deur die resultate behaal. Diesnieteenstaande is daar ook vasgestel dat spesifieke leiding en inligting omtrent

hierdie veld van “wellness” voordeling kan wees vir die toekomstige ontwikkeling en behaling van sulke intervensies in die Suid Afrikaanse besigheidskonteks.

Dedicated to my parents, Willem and Erna

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Appendix A

1 CHAPTER 1: INTRODUCTION

The health of people worldwide has always been a social concern. The ability of people to achieve goals set or live a fulfilling and meaningful life is dependent in numerous ways on their health status. Abraham Maslow (1968) claims that individuals have a natural, intrinsic need for what is positive and to pursue a condition of self-actualization. Maslow sees self-actualisation as a “being” need, which means self-fulfilment of an individual’s entire being on earth, and that the pursuit of health must be accepted as a widespread and perhaps universal tendency. Carl Jung (as cited in Witmer and Sweeney, 1992) observed that the human psyche seeks integration, that there is an instinctual drive towards wholeness and health.

Humans often inhibit their potential to function optimally, whether intentionally or not, through various “unhealthy” actions, thoughts or mindsets. Both one’s health and performance are affected by one’s lifestyle (Cole-Hamilton, 1994). By ensuring the health of an individual, one may contribute to the quality of life such a person may have. The health status of an individual will affect the performance of that individual at work, directly or indirectly, in a positive or negative manner (Cox, Gotts, Boot & Kerr, 1988).

The workplace is a primary environment for adults, where they spend most of their waking hours. Ntsamai (1991) postulates that work is perceived as a central dynamic of modern industrial society. Wilsnack (as cited in Beach & Martin, 1995) examines the workplace as one of the several institutions, which have considerable importance for the individual’s self-concept and wellbeing. Work has become the primary source of financial support as well as an activity that organizes routine for life. Work further represents a time commitment that exceeds all other single activities. This time should be satisfying and contribute to the individual’s quality of life and overall well-being. However, rather than contributing to health, work serves as a catalyst for physical and mental health problems and further detracts from adding quality to life (Landy, Quick & Kasl, 1994; Csiernick, 1995). “Authoritative surveys repeatedly confirm that there is substantial increased pressure and stress at work, for managers and employees alike, as a result of job problems, legal and financial issues, substance abuse, relationships, personal

anxieties and, importantly, future employment prospects” (King, 1994, p.38). Wilsnack (as cited in Beach & Martin, 1995) highlights a largely ignored link between work and health by showing that unwanted statuses at work might increase a significant health risk behaviour. The workplace is becoming an arena where employers have to make certain calculated changes in order to preserve the productivity of employees and safeguarding the survival of their organisations. “Our main strategy should be to adapt working conditions to the workers, for example by lowering job stress so as to reduce psychosocial risks. Those aspects of working life that are detrimental to health should be eliminated. In addition to potential health risks, social epidemiological research has also discovered factors that are conducive to health, such as social support at work. These should be strengthened” (World Health Organisation, 1986, p.122). Moore (as cited in King, 1994) says that the introduction of wellness interventions will provide an extra support system for staff as major organisational change is occurring at rapid speed and occupational stress is escalating.

Albertyn and McCann (1993) believe that the workplace is the most appropriate and potentially most successful setting for dealing with the behavioural health problems of employees. They say that the workplace provides a population who are already structured in their working environment and where it is easier to control the development of such problems. Van den Heever (1988, p.30) says: “die ineenstorting of verdwyning van die belangrike ondersteuningstelsel in die gemeenskap soos die gesin, familie, vriende, kerk ens. bring mee dat die werkgewer as ‘n belangrike ondersteuningstelsel na vore tree.”

Changes in the nature of work have resulted in the psychosocial aspects of work becoming more challenging and these aspects have significant effects on personal behaviour and on illness (Wolfe & Parker, 1994). Reacting to increased global and domestic competition many organisations have engaged in cost reduction & downsizing; job, but not work, elimination; reductions in equipment repair and maintenance; and job speedup and combination, all of which tend to increase overwork, job stress, and accidents (Wolfe & Parker, 1994). In addition, technological changes have facilitated work concentration - an employee at a workstation doing what several employees had

previously done. Wolfe & Parker (1994) state that this situation can increase a number of major stress producing factors: work overload, work pressure and job security. Work related stress is increasing and according to researchers such as Landy et al. (1994) such stress may lead to injuries and psychological disorders.

One of the greatest dangers facing human welfare in the immediate future is a meta-factor which could destroy the human condition in general and has in fact already started to destroy the quality of contemporary lifestyles, namely the unsuccessful coping with stress (Viviers, 1998). There is further growing empirical evidence that “stress” is linked to disease and that psychosocial hazards (Witmer & Sweeny, 1992) such as too many changes within the job, unscheduled overtime, unclear duties, unrealistic expectations, and discrimination will produce health problems (Shain, 1996). Besides the stress factors at work, employees may also have to battle with their own personal situations, which at times may cause as much or more stress than the factors at work.

As global competition becomes tougher, those who survive and those who excel will be separated by different elements, one of which will be the wellness of their employees (Vermeulen, 1999). Gavelli (as cited in Gerber, Nel & van Dyk, 1998) has the following view of competitiveness: “ the softer side of competitiveness reflects the shift towards a knowledge-based economy. In the industrialised world today, only 15% of the active population physically touches a product. The other 85% are adding value through the creation, the management and the transfer of information. As a result the human dimension of competitiveness has become a key success factor in modern economy.”

Developed countries have been known for assisting their employees with various problems, historically starting with alcoholism intervention programmes in the 1940's. From there programmes have become more ‘broad brush’ and aim at more specific needs of the workforce (Berridge, Cooper & Highley-Marchington, 1997). Hewitt Associates, 1993 (as cited in Haltom) did a survey of 1034 employers in the USA, and found that 76% of respondents had health policies in place. Casjens (1996) highlights that proactive organisations are taking steps to ensure job security for employees who they view as the key to their successful future. The more pressure employees have to perform under

competitive conditions, the greater the need to create outlets for them to unwind and have fun (Capowski, 1998).

In SA, the concept of health and wellness as an organisational responsibility has not yet been widely accepted or implemented. South African workers have many unhealthy behaviours such as smoking, lack of exercise and unhealthy eating habits to name but a few (Te Water, 1999). These behaviours cause poor health and may result in diseases and an imbalance in the wellness of people. According to Bradshaw (as cited in Dreyer, Coetsee, Strydom and van der Merwe) chronic illnesses such as coronary heart disease, cancer, strokes and lung diseases have been responsible for 39,1% of all deaths in South Africa. Ainsworth postulates (in Dreyer et al., 1997) that these illnesses are directly related to the lifestyle of the modern individual. Approximately 50% of the factors that affect an individual's health are lifestyle related. Risk factors that contribute to the chances of developing disease can be controlled somewhat through wise and prudent living; behaviour can be taught through health-promotion programmes (Keaton & Semb, 1990).

There is little doubt that wellness interventions in the workplace, which have been proliferated through the Employee Assistance Programme (EAP), are a necessity for long-term survival in business industry, especially when it is been advocated that the human resources of any organisation can positively contribute to the creation of a competitive advantage (Beer, 1997, Daniels, 1997, Miller, 1995). Du Plessis (1988) says that the well-being of employees have been brought out of the corporate closet and placed on the corporate agenda, albeit in a revised form from those previously mistrusted paternalistic efforts. She continues by saying that the urgent needs of employees in the currently stressful socio-political and economic climate of South Africa has demanded this change.

In South Africa, EAPs have been introduced largely in the 1980s and are modelled after programmes in the US and were introduced to South African work organisations by social workers and psychologists who had studied programmes in the United States (Maiden, 1992). Although EAPs in South Africa have moved beyond their infancy these

interventions are not managed and utilized to their fullest potential (Terblanche, 1992). Terblanche (1992) further found that EAPs in South Africa are somewhat rudimentary and that employers require a high degree of information, regarding employee assistance and wellness. Many employers are uncertain about the nature and value of employee assistance. Those employers that have wellness interventions in operation in their organisations have established these within the conceptual parameters as intended, however they lack operational and functional specifics (Terblanche, 1992).

There may be a need for more specific focus in programmes implemented in South African organisations. In order for South African employers to implement employee assistance programmes and wellness interventions, which will satisfy the needs of their employees and result in an economic advantage for the organisation, it is imperative to have complete information and guidance in this endeavour. Research literature focuses mostly on the advantages of having wellness interventions and employee assistance programmes in the organisation, but little is said about how to ensure proper programme implementation and what the structure and design of such programmes should be. An EAP needs to be introduced according to a specific model to meet the specific needs and demands of a particular organisation. An ideal and suitable model could contribute to the enhancement of an effective service to employees (Terblanche, 1992).

The first goal of this research was to obtain information regarding the current structure and design of implemented wellness interventions in South African organisations as well as the general attitude regarding wellness and health programmes in organisations. This involved a survey with specific questions aimed at creating a clear picture of how South African organisations develop, structure and manage these interventions. It also provided information on the extent to which organisations have wellness or health policies implemented and what the general feeling towards the implementation of these interventions is.

The second goal of this research was to develop a model, to serve as a guideline for employers that wish to implement wellness interventions in their organisations. This

included the investigation of implemented programmes as per the abovementioned survey, as well as a formulating the needs of South African organisations.

It is anticipated that the research will contribute to firstly emphasizing the critical importance of such interventions in the South African labour market; secondly to establish a view of the current design, structure and management of implemented wellness interventions in organisations, and thirdly to develop a model, which will positively contribute to the effective development and implementation of wellness interventions in the South African labour market.

2 CHAPTER 2: LITERATURE REVIEW

2.1 Understanding wellness

The most commonly quoted definition of health is that presented in the Constitution of the World Health Organisation. They define health as a “state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (Downie, Fyfe & Tannahill, 1992, p.9). This definition, according to Seeman (1989), is actually a radical definition. He says that it is radical because the phrase “and not merely the absence of disease or infirmity” modifies the limited concept of health historically associated with Western medicine and suggests a broader agenda. Seeman further says that secondly, the initial clause “health is a state of complete physical, mental, and social well-being” opens the way to a system-based model of health. “The domains *physical*, *mental* and *social* combine to encompass the major dimensions of the human organism and lead us directly to a human-system framework for conceptualising health. Lennox (1995) states that health is identified as the state of an organism in which sub-systems successfully function to sustain the ultimate goal of the organism, life.

According to Patton, Corry, Gettman & Graf (1986) Dunn developed the term *wellness* in a deliberate attempt to fashion a new way of thinking about health. Dunn saw wellness as the style of living that permits or facilitates human excellence, high energy levels, and optimal functioning. He believed that people could be assisted so as to experience “upward direction, greater potential of functioning, an ever-expanding tomorrow and an integration of mind, body and spirit”. According to this concept, even people who are disabled or who suffer from some health impairment can be considered well if they make an active effort to live their lives as fully as possible within the limitations of their condition.

Ardell 1977, (as cited in Csiernik, 1995) believed that wellness focuses on meeting needs in a positive manner and that in pursuing wellness, the mind, body and spirit are not only integrated, but inseparable. Health can be viewed as a continuum, which helps to categorize the various stages of health. White (1986, p.745) says that wellness represents the ideal pole of the continuum and is defined as ‘a lifestyle of well-being that a person

chooses to reach optimal potential. It implies that we are responsible for the consequence of the choices we make in daily living regarding the aspects of wellness viz physical, intellectual, social, spiritual, or occupational.’

The term wellness is more encompassing than the term health, since it deviates from the historical emphasis of physical well-being as health (Jasnoski & Schwartz, 1985). The focus of wellness programs is on assisting and enabling individuals to lead quality lives of optimal functioning. Ardell (as sighted in Patton et al.1986, p.25) notes “a wellness system intends to maximise good health, moving a person to higher levels of health from the point of initial contact. In contrast, the illness system seeks only to minimise the impact of disease - arresting its progress, minimising its complications, sustaining a person when the disease process is irreversible. In an illness system all efforts are directed toward the disease: the goal is to defeat the disease. According to Patton et al. (1986) medical therapists have accomplished enormous breakthroughs in curing disease, by focusing exclusively on illness. They have not, however, traditionally been concerned with human excellence or facilitating optimal health.

The rationale behind total wellness as health promotion strategy is based on the fact that human behaviour (lifestyle) is related in a complex manner to psycho-social, environmental and biological factors (Dreyer et al., 1997). Addictive disorders, mental health disorders, many cancers, most types of diabetes, and many forms of cardiovascular disease are affected by life style issues that can be favourably influenced through wellness interventions (McClelland, 1990). Wellness should thus be the focus when considering the human being in its balanced entirety, aiming at obtaining optimum well-being.

Wellness should be further explained so that its relationship to the functioning of the individual and the external environment can be fully comprehended.

2.2 Systems nature of wellness

Wellness can be defined through the application of systems theory. The essence of systems theory lies in its definition, which is according to Senge, Roberts, Ross, Smith and Kleiner (1994) a perceived whole whose elements “hang together” because they

continually affect each other over time and operate toward a common purpose. Schwartz (1983) states that a system is hypothesized to be a whole composed of a set of interacting parts. The unique behaviours of a given system are hypothesized to be an emergent property of the dynamic interactions that occur among the system's parts as the system interacts with the environment.

Wellness consists of different interrelated parts, which affect each other directly and indirectly. According to Hettler (as cited in Benjamin & Looby, 1998) wellness is conceptualised as a six-dimensional paradigm involving the physical, emotional, mental, social, occupational and spiritual dimensions. Crose et al (1992) propose similar dimensions for wellness: physical, emotional, social, vocational, spiritual, and intellectual. In order to understand the practical application of the dimensions of wellness and its operation within the life of the individual, more detailed information regarding the different dimensions are required. The following table outlines the practical components of each dimension. These components are surely not exhaustive, but provide an indication of what need to be considered when thinking of a specific dimension on a practical every day level (Crose et al, 1992).

Table 1: Multidimensional assessment components of wellness

ITEM	COMPONENTS
Physical health and wellness	Medical history/medications Reproductive health history Body awareness/body image Exercise and eating behaviours Attitudes toward physical fitness and health care
Emotional health and wellness	Psychiatric history/medication Coping style/patterns Self-awareness/self-image Attitudes toward emotional expression/self-disclosure
Intellectual health and wellness	Education/learning history Mental status

	Cognitive style/flexibility Attitudes toward learning
Social health and wellness	Psychosocial history/history of significant relationships Social network/density Relational style/patterns Attitudes toward relationships and seeking help from others
Occupational health and wellness	Work history Vocation/avocation/leisure patterns and balance Vocational goals Attitudes toward work and leisure
Spiritual health and wellness	Religious/spiritual history Life satisfaction Purpose and meaning in life/beliefs about death Attitudes toward transpersonal aspects of living

Source: Crose et al. 1992, p.153

2.2.1 The biosychosocial model and systems theory as theoretical base for wellness

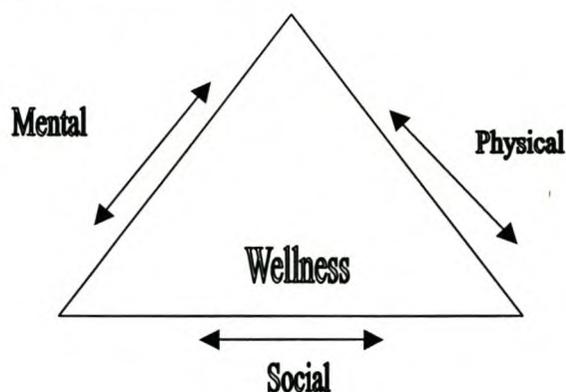
Rappaport (1991) states that this widely accepted model of disease explains that biological, psychological and social factors operate and interact at all stages of health and illness. Jarnoski and Schwartz (1985) say that science, medicine and psychology have cross-fertilized, spawning the synchronous model. Focusing on healthy functioning, biological and ecological sciences in particular have helped propel medicine - or the study and practice of healing unhealthy functioning - from the biomedical model into biopsychosocial zeitgeist ripe for the synchronous systems model. This synergistic whole has a functional structure composed of interactive connections of communication that cannot be altered without disturbing the overall system's functioning (Jarnoski & Schwartz, 1985).

According to Engel (1981) the biopsychosocial model is in fact systems-oriented. Merki and Merki (1989) state that a positive relationship exists among physical, mental and

social health. Seeman (1989) says that health is a state of complete physical, mental and social well-being, which opens the way to a systems-based model of health. The principles of systems theory say that each element in the system affects every other element. The biopsychosocial model, being systems-oriented, therefore indicates that an individual's mental health for example will affect his level of physical health and so can one's mental health be affected by your social health. Every element in the system of wellness affects each other in an interdependent manner. This constitutes the main focus of wellness, which refers to the fact that not only one element of the human life refers to optimal health. That would be a very narrow view of the functioning of the human being and its strive for wellness.

Merki and Merki (1989) illustrate the relationship of the biopsychosocial model with the following figure (Fig.1). It can be seen that if all three factors of the model are not achieved in equal levels, an imbalance will be created. An imbalance in the individual's physical, mental or social health levels means that such a person is not achieving overall wellness.

Fig 1: The Biopsychosocial Model



The six different life dimensions operate as a system within the life of any particular individual. According to Witmer and Sweeney (1992) these life dimensions or life tasks interact with the life forces of family, community, religion, education, government, media and business/industry. They continue by saying that global events, both natural and human, have an impact on and are affected by the life forces and life tasks. These life

dimensions therefore have feedback loops, which assist communication between them as the system functions and operates over the life span of an individual.

Croese et al. (1992) stated that central to the understanding of wellness from a systems view are the concepts of cybernetic self-regulation and emergence. According to Jasnosi & Schwartz (1985) cybernetic functions refer to those automatic control or feedback mechanisms that regulate a system, usually through exchange of information, energy or matter. These control processes have been termed “feedback loops”. Carver and Scheiner (as cited in Croese et al., 1992) say that the discrepancy-reducing, negative feedback loop is the basic unit of cybernetic control. Croese et al. (1992) explain the functioning of wellness as a system beginning with input, which come from a variety of sources of stimuli. This can include for example fever, tension or chills. At the emotional level, system input may include fear in response to perceived danger or sadness or loneliness. Once input occurs, a comparison process begins in which the perceived condition is compared to some reference value. For example a reference value at the physiological level is normal body temperature. If, in this comparison process, there is a perceived discrepancy, a system output will occur. System output is a process in which the system responds in some manner to “correct” the perceived discrepancy, to negate or reduce the discrepancy and thereby return the system to some “normal” range of variability or equilibrium in the system. According to Seeman (1989) when regulatory processes go askew, disregulation prevails, and the harmonious working of the system is disrupted.

Emergence is described by Croese et al. (1992) as the concept that form the interaction of the parts of a system, new, unique, not previously seen characteristics “emerge”. Emergence is implied in the often-used phrase “ the whole is greater than the sum of its parts”. The concept of emergence emphasizes the importance of studying a system as a whole, not just its isolate, component parts. According to Seeman (1989) when all feedback loops are free from excessive noise or impedance, the system functions in a state of harmonious and dynamic equilibrium that may be characterized as a state of health. This refers to the application of the wellness concept in an individual’s life and

means that when wellness is achieved an individual will get more from his/her life than when all the dimensions of wellness are not functioning in an appropriate manner.

Brody (1973) proposed systemic definitions of health, disease and wellness highlighting the abovementioned properties. A systemic definition of optimal health that emphasizes cybernetics is the state of the living system during which “all feedback loops are intact and free from excessive noise or impedance to signal flow”. Crose et al. (1992) state that when these feedback loops are clear, the system is open and receptive to feedback; the system is healthy. Wellness emerges from the state of the living, human system in optimal health. Total wellness would be represented when all six dimensions were in the same situation and in its proper position (Eberst, 1984).

2.3 Principles of wellness

According to Crose et al. (1992) there are four basic principles of wellness or health:

1. Health is multidimensional;
2. Health is variable, not static;
3. Health is self-regulating within life dimensions;
4. Health is self-regulating across life dimensions.

2.3.1 Health is multidimensional

The six life dimensions in Fig 2 illustrate this principle. According to Eberst (1984) health is a construct consisting of a variety of health domains or life dimensions, which affect wellness. Optimal health and wellness are affected by a variety of life dimensions, and are certainly not simple in nature or functioning.

2.3.2 Health is variable, not static

Crose et al (1992) state that health is not a static endpoint, but rather a dynamic, fluctuating state of the organism that exhibits normal degrees of variability around some upper and lower limits. These upper and lower limits, as represented by the tubes in Fig 2, set the range of normal variability, within which there is constant, dynamic fluctuation,

as represented by the variable, wavy lines within each tube. These patterns of variability represent the ongoing “reverberations” within each life dimension. The reverberations represent the unique, individual differences across persons, gender and culture.

2.3.3 Health is self-regulating within life dimensions

Croese et al. (1992) state that the wave pattern that fluctuates within the normal range of variability, beginning at a midrange position before experiencing increased variability, and finally returning, via the cybernetic, self-regulating feedback process, to a midrange position. This means that any one of the life dimensions of the wellness model may experience a change in its normal functioning due to any external or internal influences, but since health is self-regulating, balance will be restored. This will, however only occur if the factors creating the imbalance do not proceed beyond the normal.

2.3.4 Health is self-regulating across life dimensions

This principle focuses on the interrelatedness of the dimensions as well as its self-regulating properties. Croese et al. (1992) explain that if an imbalance occurs in one life dimension, the imbalance will affect other life dimensions in various ways. It further illustrates the fact that such an imbalance in one dimension can be restored by any of the other dimensions. This principle illustrates the open systems properties of the functioning of the various dimensions in order to reach a state of wellness and balance.

It is important to note, however, that this multidimensional model (of wellness) is proposing that in the optimally functioning human system, the system that is open and receptive to feedback, there are self-regulating properties that help to maintain a balance across these many life dimensions (Croese et al., 1992). Lennox (1995) says that organisms actively and selectively extract certain materials from the environment and convert them, through complex coordinated biochemical processes, into the structures and forms of energy required to maintain themselves. He argues that the concept of health identifies the state of successful performance of these functions. Therefore, the human system can to a degree regulate imbalances experienced toward what would be regarded as the norm.

2.4 The spillover model

This model posits that individuals do not or cannot compartmentalize their lives and that negative characteristics of their jobs or lives create stressful emotional, mental and physical states within the worker (Grunber, Moore & Greenberg, 1998, Daniels, 1997). This model coincides with the rationale of the biopsychosocial model of wellness and emphasizes the open systems nature of the human being. Each dimension of wellness is affected by every other dimension and further affects every other dimension in return, therefore indicating the interrelated relationship of the components of wellness. When an external stimulus impacts on the emotional component of a person (i.e. stress), any of the other dimensions may be directly or indirectly affected by this stimulus, e.g. insomnia as a result.

Excessive stress in either realm can cross over and interfere with life in the other. The stress people experience at work is not simply a reflection of their personal problems but is accentuated by acute and chronic workplace stressors (Csiernik, 1995). Quick, Murphy, Hurrell & Orman (1992) says that it seems clear that most workers do not leave the pressures of the job behind after leaving work. Indeed, there is increasing evidence of a 'spillover' effect of work-related stress to the home environment. Barling (as cited in Beach and Martin, 1995) highlights connections between the workplace, the family setting and important health-related behaviours and family problems, which may be influenced by the EAP professional. The element, which is ignored by employers (not necessarily due to indifference), is the ecological nature of the troubled employee (Csiernik, 1995). This is where the focus of the wellness model is critical. The holistic and systems nature of human health and wellness is the basis for attempts to restoring imbalanced wellness in employees. In application, an individual cannot ignore external stimuli and cannot function in a vacuum. High-level wellness thus emerges only once balance is attained among all the dimensions, and stress is managed.

2.5 Salutogenesis

Antonovsky's (1987, p.2) core assumption is "of heterostasis, disorder, and pressure toward increasing entropy as the prototypical characteristic of the living organism." The

living organism thus according to Antonovsky continuously exists in a state of stress and imbalanced wellness. Salutogenesis implies that stress in the workplace and in the private lives of individuals need not necessarily affect their lives negatively or harmfully. Salutogenesis, as a relatively new proactive paradigm in the study of stress, coping and wellness, seems to be gradually replacing the traditional, reactive pathogenic paradigm with its remedial approach to the enhancement of coping behaviour (Viviers, 1998). Salutogenesis emphasizes the proactive promotion of wellness through the management of various constructs, which will result in the concurrence of high stressor loads with survival and healthy functioning. These include to a greater or lesser degree a variety of constructs such as potency, stamina, self-efficacy, internal/external locus of control, personal causation and self-directedness (Stumpher, 1990).

Wellness interventions may need to focus on coaching employees to attain these constructs in order to minimise the effects of stress on their health and functioning. Salutogenesis can thus be seen as a functional element in the promotion of wellness.

2.6 Conclusion

The idea of wellness is based on the philosophy of holism. This includes a belief in the interactive effects of the mind, body, spirit and environment; the existence of functional interdependence among parts and wholes, the oneness of the entities; the concept of balance and harmony among parts and the idea of individual responsibility (White, 1986). Wellness is a lifestyle for well-being that a person chooses, regardless of the presence or absence of disabling conditions, to reach optimum potential. It implies that we are responsible for the consequences of choices we make in daily living regarding any of the aspects of wellness - the six life dimensions.

Wellness is not a static state. Just as there are degrees of illness there are levels of wellness. Positive wellness focuses on the living state rather than on categories of disease that may cause morbidity or mortality. There is a clear paradigmatic shift from the traditional medical health model, which focuses on the disease element. The synchronous model of wellness and health emphasizes the multi-dimensionality of the

human being and advocates the focus on creating health and wellness through positioning all the dimensions in similar “areas”.

The main focus of wellness is that the individual person can be unhealthy due to other ecological factors impeding on his/her functioning and not only physical disease. This is purely a result of the systems nature of the human being and therefore the spillover effect, which is created when he/she experiences problems. Wellness is the ultimate goal of life, since high level wellness will assist an individual in experiencing an increased quality of life. This state will be attained once all the dimensions are in similar positions and in balance with each other. This balance should thus be the aim of individuals in order to create and sustain health and wellness.

3 CHAPTER 3: THE APPLICATION OF WELLNESS

3.1 The value of work

A person's work and occupational stature may play an important role in an individual's sense of identity, self-esteem, and psychological well-being. For most individuals, work is the central and defining characteristic of life. For such individuals, it is through the work role that life achieves its primary meaning and value (Quick, Murphy, Hurrell & Orman, 1992). Freud (1930) argued that intellectually, work has a more powerful effect than any other aspect of human life to bind a person to reality. Quick et al. (1992) say that work may have intrinsic value, instrumental value, or both. Intrinsically, the value of work is found in its central role as one important aspect of a person's psychological well-being. The intrinsic value of work is the value an individual finds in performing the work, in and of itself, outside of its utilitarian function. Instrumentally, the value of work is found in its identity-defining characteristics; its basis for providing the necessities of life; its role in giving meaning and structure to the adulthood years; and serving as a channel for the individual's talents, abilities and knowledge. The level of job satisfaction that individuals experience is therefore very important to their overall wellness and health.

Locke 1976 (as cited in Quick et al., 1992) outlined six conditions that lead to job satisfaction for a worker: a) work is mentally stimulating, providing challenges with which workers can cope successfully; b) work includes physical exertion and activity, but not overtiring; c) the rewards of work are viewed as just, fair and indicative of performance; d) the work environment facilitates work goals and is physically compatible with worker needs; e) work enhances self-esteem and enriches self-identity in the work force and; f) work leaders and supervisors facilitate the work process and work goal attainment.

According to Ho (1997) job satisfaction has become a major concern in the workplace. She continues by stating that previous studies indicated that job satisfaction affects the well-being of employees and exerts a considerable impact on the organisation. According to Gerber, Nel, van Dyk (1998) various researchers have found that job

satisfaction is essential if employees are to be happy and enjoy a long life. On the other hand, lack of recognition, uninteresting work, poor relationships with colleagues, poor working conditions and stress in the work situation cause job dissatisfaction. Masi and Friedland (1988) highlight that, as it is possible that just as personal problems can have a negative effect on work, work can have a positive influence on an individual's personal well-being. They further state that many studies have demonstrated that a good part of an individual's self-esteem and identity are tied to his or her job and occupational self-concept.

3.2 Wellness in industry

Employers used to treat employees as individuals that were only good for completing their day-to-day tasks they are employed for, and saw employees for not being capable of doing much more than that. Employees were seen as commodities to be used as cheaply as possible and were discarded when they were no longer useful under this approach. The human factor was at best irrelevant in employment decisions (Litwack, 1962; Johnson & Indvik, 1997). Some employers for example, viewed employees' desire for education as harmful, spoiling these people for the realities of hard work. The result of this was that and minimum attention was paid to the welfare of workers. Masi & Friedland (1988) stated that traditionally, employers felt that employees' problems were just that: their problems and, therefore they should be dealt with a distance.

This management approach was somewhat adapted when the Hawthorne experiments in the 1930's showed that good human relations resulted in increased productivity, that people could be motivated and that pleasant working conditions could increase productivity (Gerber, Nel & van Dyk, 1998). Employers began to apply a more paternalistic approach to workers and attempted to help them with certain problems they experienced. In the early 1940's employers began to assist employees with alcohol related problems and from there, employee assistance became more sophisticated. Other issues such as drug dependency became part of the problems employers set out to deal with among their employees and over time the social responsibility of employers stretched to include much more. In the 1980's and 1990's the beginnings of a health promotion orientation and wellness programming have begun to emerge in the workplace

although the primary focus has essentially been only upon physical well-being (medical model) (Csiernik, 1995). The present day approach to the quality of work life advocates that work should be made more meaningful, that employees need to develop personal skills, that they should participate in the management process and that control of any system should be voluntary rather than mandatory (Gerber et al., 1998).

The changed demographic, social, economic and political character of society, is according to researchers, responsible for the fact that the human being lost contact with himself on a spiritual level, separated from his God and has trouble with viewing life as meaningful. The emphasis of modern society on aspects such as individualism, achievement, and independence lead to the breaking of family ties and social support networks (Dreyer, Coetsee, Strydom & van der Merwe, 1997). This again leads to uncertainty, feelings of powerlessness, alcoholism, drug dependence, depression, stress and loneliness. As a result of these conditions, it was necessary for the employer to emerge as an important support system (van den Heever, 1988).

This situation, which is clearly open for disaster and is aggravated by work related stress, (Landy, Quick & Kassel, 1994) will hold adverse consequences for employers if they are not proactive in dealing with it. Researchers have estimated that employers spend up to 25% of their payroll expenses in an attempt to recover decreased productivity due to absenteeism and reduced effort relating to controlling health problems (Violette & Violette, 1990). The same authors highlight that studies have clearly demonstrated that smokers, non-exercisers, and overweight individuals have higher health care costs and longer hospital stays. With the pressure of being lean and mean competitors in industry, no organisation can afford to loose vast amounts of money as a result of factors, which can be influenced through various proactive interventions. Peterson (as sited in Cohen, Vogt, Naughton & Sullivan, 1997) says that we are in an era where human adaptability, change, knowledge and commitment are critical factors to success, yet we've done a better job of preventative maintenance on our plant and equipment than on our human capital.

3.3 Social responsibility

Organisations have for a long time acknowledged their responsibility towards the community and the environment in which they operate. According to Gerber et al. (1998) the social responsibility of an organisation is becoming even more important today. Organisations are expected to become involved in real social problems of the community within which they function. Du Plessis (1988) says that social responsibility is also a function of an organisation's role as employer - the internal effort - of which EAPs as a programme for employees is an important example. Gerber et al. (1998) highlight that in the past, many organisations probably had maximum profits as their only goal. Today organisations pursue multiple goals with emphasis on social awareness, social care and social commitment. Cox (1997) claims that because work organisations may create for unhealthy work conditions – thereby creating a risk to health - they also hold a clear responsibility for reducing that risk. In most developed countries this responsibility is recognized in law, and the relevant duties on employers and managers are often spelled out. According to Bellingham and Isham (1990) more and more employees are filing suit against companies for prolonged stress and strain without any attempt by the organisation to reduce that stress.

3.3.1 Current social responsibility developments

Social responsibility has undergone several directional changes internationally and various trends have emerged in recent times. According to Jensen and Fagan (1997) it appears that in the external environment businesses focus more on how to remain competitive and to stay ahead of the pack. The internal social responsibility focus thus seems to have abated slightly because in developed countries in-house appear to be at an acceptable level i.e. employee well-being, security, human dignity, advancement, job satisfaction and so on.

In South Africa the focus is different (Gerber, 1998). The internal social responsibility focus of businesses is limited by government's intentions to legislate affirmative action, the already implemented new Labour Relations Act, which gives preference to trade union and worker freedoms and the institution of structures like workplace forums on

demand of trade unions (Gerber et al., 1998). In similar vein, the Basic Conditions of Employment Act will further entrench the rights of workers, such as a 45-hour week, 3 weeks leave and limitations on certain types of work and so on. Businesses are not entirely enthusiastic about enhancing and expanding social investment, since external pressure is in the offing via legislation to entrench the positions of employees (Gerber et al., 1998).

3.4 The influence of work related stress

It is now generally recognized that the workplace exacerbates existing difficulties while also creating and supporting its own unique complement of problems (Csiernik, 1995). These problems are caused by the nature of work itself; the necessity to interact at work with colleagues, supervisors, customers and clients; and the propensity for workers to bring their home life to work and their work life home. According to Sloan (1987) the consideration of organisational-level factors such as work design or climate, which are beyond the control of the individual, yet may contribute heavily to illness and absenteeism of employees, are typically omitted in wellness interventions. These factors and others at work need to be considered carefully by management so that existing and potential stressors can be minimized. Interventions at the level of these stressors, rather than training individuals in compensatory coping skills, can have an impact on stress and thus on illness and medical-care costs (Sloan, 1987).

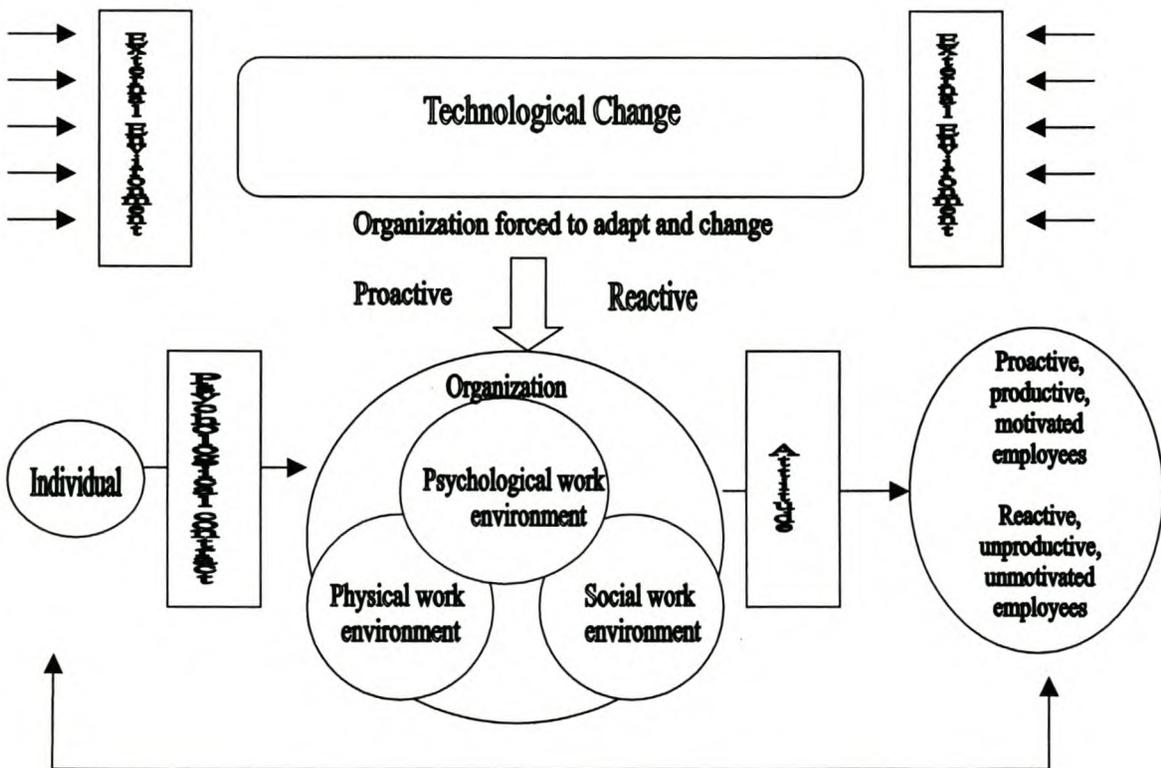
3.4.1 The governance and design of work

Work is changing rapidly. No one can ignore the revolution in work as a result of technological advancement. Technological changes not only have resulted in reduced work concentration and efficiency, they have also created several stress-producing factors: work overload, work pressure and job security (Ho, 1997). She continues by stating that high technology affects what workers do, the skills and training they need, and the duration and nature of their work lives. Landy et al. (1994) postulates that with every piece of technology, extensive correlative changes take place such as modifying work methods, social interaction patterns, patterns of supervision, and productivity goals. This in effect refers to inherent change in the development and implementation of work

processes, which in return results in change impacting on the workforce. Technology thus forces the employee to change or adapt to change and this is a source of stress.

Gerber et al. (1998) refer to the socio-technological system, which is described as the fusion of the human (social) system and the technical system for a number of reasons to produce a desired result. These systems must work in unison to produce the desired result. According to Herholdt (1984) efforts to adapt (usually reactive) or change (proactive) results in increasing pressure on employees and drastically affect the demands made on them. These demands are often vague, obscure, conflicting, incomprehensible and characterized by limited guidance, unrealistic deadlines, too much information and irrelevant information (Gerber et al. 1998). Employees are also faced with conflicting value systems, norms and objectives of the community (Schein, 1970). All these factors mentioned might contribute a disturbance in the balance of the individual, which will then in effect influence the productivity of the employee.

Fig 2: Socio – technological system



Coupled with such technological changes, there are also dramatic changes occurring in the workforce (Cascio, 1995). Work groups are becoming older and new members of the working population are more demographically diverse, with different skills and value sets. Employees will have to ensure that they possess the right skills to market themselves or just to remain within the market. Job descriptions are being redefined and there is a growing disappearance of the job as a fixed bundle of tasks. Companies employ fewer people and business processes are constantly reengineered in order to remain competitive (Cascio, 1995). Factors such as these will further impact greatly on the stress levels of employees.

Uncertainty has been identified as one of the elements of work design, which seriously impacts on the employee and creates high levels of stress (Landy et al. 1994). Jackson, 1989 (as cited in Quick et al., 1992), defined uncertainty from an organisational perspective as “inadequate knowledge about an event that requires action or resolution”. In a study of the U.S. Navy’s major weapon systems project managers, Bodensteiner, Gerloff, and Quick (1989) found evidence that perceived environmental uncertainty led to increased levels of psychological distress for the project managers. Uncertainty (perceived as stress) has a direct path to psychological symptoms (first order distress/strain outcome) and a sequential path then to burnout (second order distress/strain outcome) (Bodenstein et al., 1989).

Researchers have found certain stressors or psychosocial hazards in the workplace which impact greatly on the individual (Bisseker, 1998, Csiernik, 1995; Shain, 1996). These are inter alia:

- 1) uncontrollable demands over work;
- 2) too many changes within the job;
- 3) monotonous and repetitive work;
- 4) lack of participation in the workplace;
- 5) too much or too little responsibility;

- 6) lack of feedback on performance;
- 7) lack of social contact as part of on-going work;
- 8) unrealistic expectations held by supervisors or managers;
- 9) role conflict/ambiguity;

Shehadeh and Shain 1990, (as cited in Csiernik, 1995) found in a multivariate analysis four related sets of variables that influenced the workplace wellness:

- 1) perceived psychosocial stressors in the workplace and home environments;
- 2) personal resources in the form of social support and of self-efficacy as related to work and personal health;
- 3) personal health practices (sleep, alcohol and tobacco consumption); and
- 4) specific socio-demographic variables (education and age).

Shain (1999, p.2-3) talks about the abatement of harm in the workplace. He refers to similar factors as mentioned above, which he calls the management and governance of the workplace. These include ensuring that employees have a sufficient degree of control over their work, a manageable workload as well as equitable reward for the amount of effort exerted. Shain (1999) states that numerous studies indicate that when management chooses to find ways of increasing employee control and reward, benefits can be expected in regard to decreased rates of almost all adverse health outcomes of the kind we can measure over relatively short periods of time.

To sustain such positive changes of this nature requires a long standing commitment to the abatement of conditions of work that give rise to adverse health outcomes.

3.5 The stress and health relationship

There is a heightened awareness that occupational stress contributes to a significant portion of worker compensation claims, health-care costs, disability, absenteeism and

productivity losses (Murphy, 1995). According to Wilson, 1991 (as cited in Kotschessa, 1994) job pressures have been cited in 75% of workers' compensation claims in which mental stress was the major complaint; 94% of these claims were the result of cumulative workplace trauma. Litigation for employee stress related health conditions has not emerged in South Africa as it has in the United States. That is, however no reason not to pay attention to this evolving matter.

Psychoneuroimmunology (PNI) is the discipline that studies the link between emotions, the nervous system and immune function. It consists of studies that demonstrate that your thoughts, moods, emotions and belief system have a fundamental impact on some of the body's basic health and healing mechanisms (Vermeulen, 1999). Recent PNI studies suggest a role for work stress in the immunological process (Murphy, Hurrell & Quick, 1999). According to Borysenko & Borysenko, 1982 (as cited in Murphy et al., 1999) a large number of animal studies, for examples, have demonstrated that experimentally induced stress increases susceptibility to a variety of infectious agents, as well as the incidence and rate of growth of certain tumours. Jemmott & Locke, 1984 (as cited in Murphy et al., 1999) say that although fewer in number, human studies have shown that psychosocial factors, including stressful life events, are related to disease that are under immunologic regulation. There is every reason to believe that stressful elements in the work environment also may elicit changes in immunocompetence and thereby influence health status. Stress per se, whether work related or personal, may be harmful to the health and wellness of the individual and this situation may have adverse effects on the organisation.

According to Gerber et al (1998) it must be emphasized that work stress and work pressure do not have to be negative or have a dysfunctional effect on work performance. Some employees for example, work better under mild stress and work pressure and are more productive if they know that they must complete a task within a given time period. Stress reactions differ from individual to individual. However prolonged exposure to stress and repeated failure in one's efforts to adjust and change can cause depression and eventually culminate in the so-called burnout syndrome. Perlman & Hartman (1982,

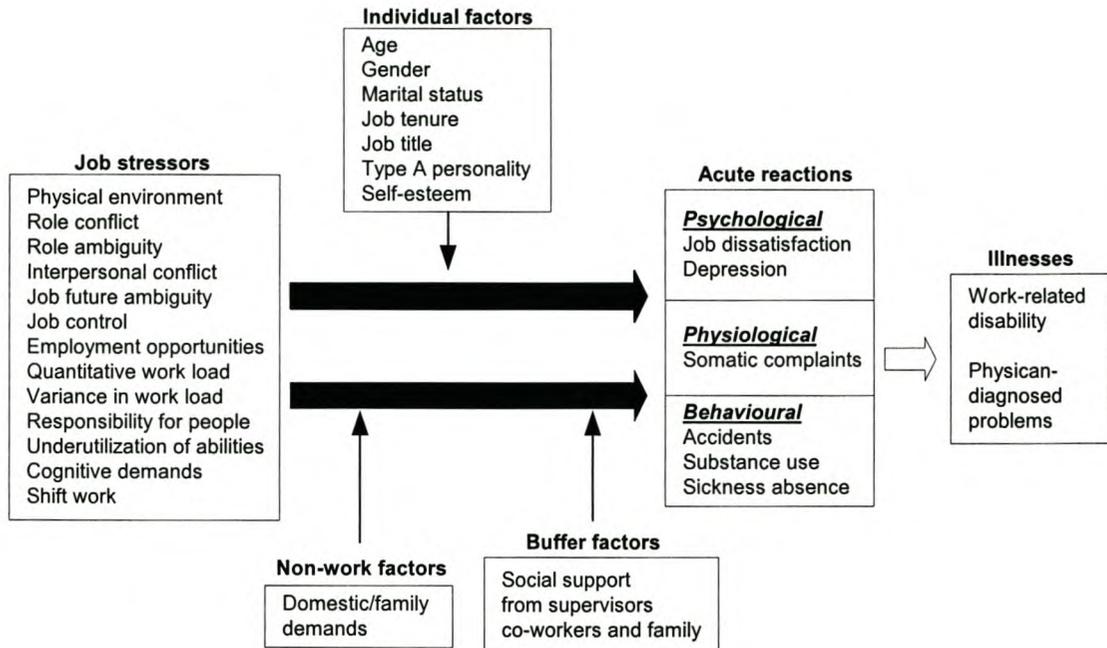
p.283) describe burnout in the context of the organisation as follows: "...burnout (is) a response to chronic emotional stress with 3 components:

1. emotional and/or physical exhaustion;
2. lowered job productivity;
3. over- depersonalisation".

Burnout is an extreme condition. Literature clearly shows that burnout, as the term implies, has a strong element of finality, irreversibility and permanent damage (Gerber et al. 1998). Employers should therefore attempt to create health and wellness for employees so that conditions such as burnout can be prevented to the advantage of both employee and employer.

The areas where the employer can intervene in preventing employee illnesses are, as illustrated in Figure 3 on page 28, at the job stressors level as well as the buffer factors. An opportunity for proactive as well as reactive intervention lies with these areas. The employer can investigate and assess the extent of work design, processes and systems and its role as stress producing elements. Here lies the opportunity for the employer to create wellness through carefully planned and implemented programmes and services.

Fig 3: The stress/health relationship at work



3.6 The workplace as ideal area for wellness interventions

The workplace is the area where employees spend most of their waking time. It is the ideal place to try and influence the lifestyles of individuals for the betterment of their health and wellness (Rorke, 1991, Miller, 1995, World Health Organisation (WHO), 1986). The framework for dealing with employees' personal and work related problems will be through corporate wellness programmes. Corporate wellness programmes can be defined as long-term organisational activities designed to promote the adoption of organisational practices and personal behaviour conducive to maintaining or improving employee physiology, mental and social well-being (Wolfe & Parker, 1994). Hollander & Lengermann (1988) say that the workplace is an environment well suited for organized interventions to promote healthy behaviours.

The following reasons why the workplace is an ideal area for wellness interventions have been found in the literature.

3.6.1 Employees are usually “captive” at work

Employees have to be at work and they are obligated to work a certain amount of hours per day (DeFrank, & Cooper, 1987). It is difficult to imagine that employees will not take notice of health related information, which is strategically well planned and aimed at their specific needs and requirements, if they spend 8 hours a day, 5 days a week in such an environment (Dreyer et al., 1997). It is also difficult not to be influenced with regards to your health habits if you are constantly motivated and supported within your work environment (Shepard, 1986).

Strong positive improvements in absenteeism, performance, relationships with both colleagues and line managers were found by researchers after the implementation of employee assistance services (Guppy & Marsden, 1997, Thompson, 1997). A South African paper mill in Kwazulu-Natal, found that alcohol intoxication decreased from 40% to 4% after the alcohol policy was in operation for 6 months. The workplace provides the perfect structure to influence the lifestyles of employees.

3.6.2 Incentives can be provided

Organisations may decide to make use of incentive programmes to motivate employees to make use of the wellness programmes and services provided. Some employers provide incentives for reaching health targets set or for even having a regular health check with the doctor. Many people do not visit their physicians unless something goes wrong (Ziegler, 1997). If correctly administered incentives may contribute to employees becoming healthier and thereby contributing to their overall wellness.

3.6.3 The workplace provides the possibility for social support

According to Oswald (as cited in Dreyer et al., 1997), wellness programmes that provide support groups or where a culture of supporting peers and colleagues are maintained, will positively contribute to the success of interventions. The workplace provides ample opportunity to create support structures for employees where co-workers can help reinforce lifestyle changes in each other (Ho, 1997, McMahan, 1984).

3.6.4 The lifestyles of family members may also be affected

Wellness can be promoted within the families of employees if the programmes make provision for the inclusion of family members. This may in effect result in a healthier home environment for the employee, which will naturally contribute to the wellness of such an employee. This way the community may also be positively influenced by a wider group of people being reached regarding their health.

3.6.5 Both employers and employees will benefit

Corporate wellness programmes have been proven to have significant positive impact on the employees as well as on the organisation (Cooper, 1996; Cox, Gotts, Boot & Kerr, 1998; Gemignani, 1998; Maes, Verhoeven, Kittel, Scholten, 1998; Reese, 1998). Employees may experience higher levels of health and wellness, which contributes to their quality of life and employers benefit by the decreased costs related to employee health care, retention of employees and higher productivity levels.

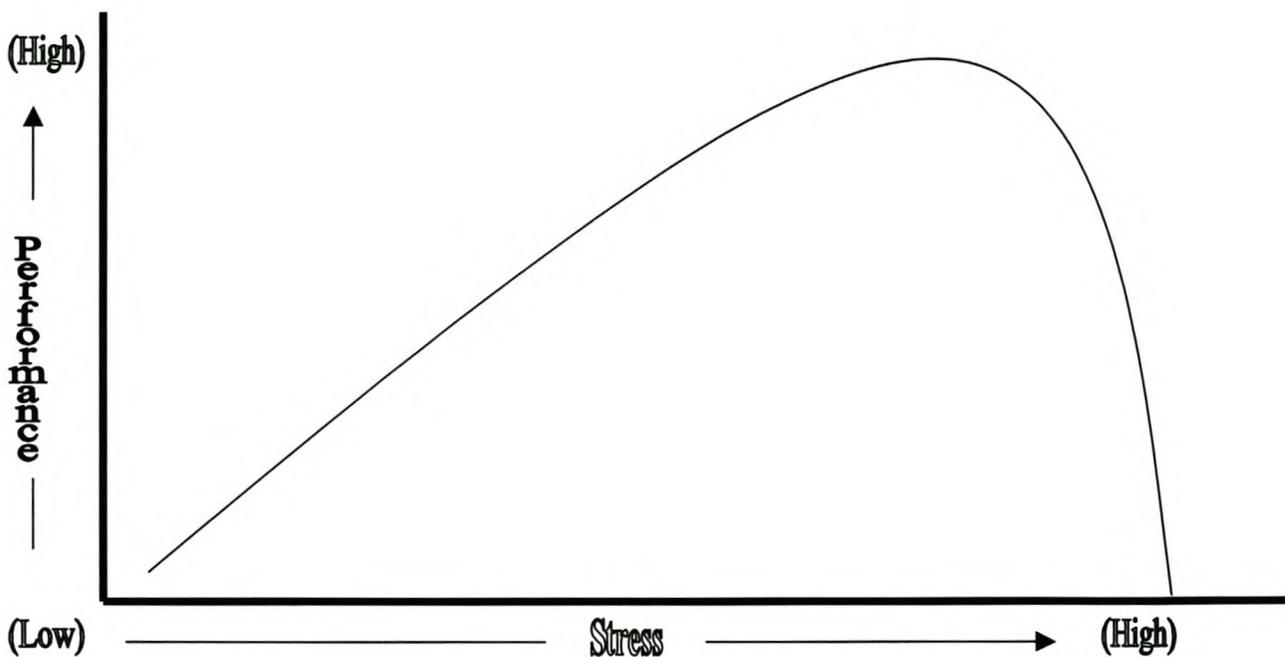
3.7 The relation of health and productivity

Coshan (1991) states that highly intensified competition in the global marketplace in this decade, the international redistribution of corporate ownership and control, new technologies, job redundancy and creation will produce a concerted push toward efficiency and quality in the workplace. Health or wellness is a determining factor of the performance and productivity of workers (Bailey, 1990; Cohen Mason, 1992; Cohen, Vogt, Naughton & Sullivan, 1997; Dutton, 1998; Keaton & Semb, 1990; Violette, 1991). Nothing threatens the achievement of a productivity mission and the resultant profits of an employer like an unhealthy workforce. Davidson (1998) states that events and behavioural health disorders impact productivity and well-being. Cutbacks, techno-stress, and the loss of opportunity will combine to produce work-related problems for employees trying to cope with change (Coshan, 1991).

Corporate initiatives have evolved from simply having onsite exercise facilities to offering sophisticated health promotion programmes. Prince (1999) claims that this shift has occurred as employers have recognized that healthier employees are more productive, which ultimately can boost profitability. Gerber et al (1998) claim that it is obvious that

poor employee health will lead to high absenteeism and low productivity. Sullivan (as cited in Prince, 1999) highlights that making worker productivity the ultimate measurement of the success of health promotion, more clearly moves wellness from being a health issue toward being a business issue. As mentioned, stress is increasingly playing a more definite role in the workplace. Although individuals respond differently to stress, prolonged unrelieved stress will take its toll on the human health system. Employers should attempt at preventing or minimizing stressors.

Fig 4: Inverted – U relationship between stress and productivity



Source: Robbins (1996, p.618)

3.8 Wellness interventions in the workplace

Wellness interventions may include various programmes and services provided by employers in order to promote the health and wellness of employees. The most applied wellness intervention in organisations is the Employee Assistance Programme (EAP). The other intervention, which emerged in the 1980's, is the Health Promotion Programme

(HPP). In the next section an overview of the literature regarding these two wellness interventions and their application and structure is provided.

3.9 Employee assistance programmes

As previously mentioned EAPs developed from alcohol assistance programmes over time to become highly sophisticated programmes aiming at the needs of employees at work. In essence, an EAP is a systematic, organized and continuing provision of counselling, advice and assistance, provided or funded by the employer, designed to help employees and (in most cases) their families with problems arising from work-related and external sources (Berridge, Cooper, Highley-Marchington, 1997)

EAPs tend to have 2 primary objectives (Berridge et al. 1997, p.16):

1. To help employees of the organisations distracted by a range of personal concerns, including (but not limited to) emotional, stress, relationship, family, alcohol, drug, financial, legal and other problems, to cope with such concerns and learn to themselves the stresses produced;
2. To assist the organisation also in the identification and amelioration of productivity issues in employees whose job performance is adversely affected by such personal concerns.

The intended beneficiaries of the EAP are thus the employee, the employee's family and the organisation and its constituents.

Table 2: Cited reasons/expectations for EAP introduction

Assist with	Reduce	Improve	Manage
Policy implementation	Litigation	Success	Change
Downsizing	Costs	Morale	Problem people
Out counselling	Absenteeism	Commitment	Stress
Reactions to crises	Staff turnover	Performance	Uncertainty
Specific needs	Accidents	Profits	Environment
Problem diagnosis	Estrangement	Productivity	
Problem expression	Conflict	Quality	
Problem dissipation	Stress	Image/PR	
Problem solution	Anxiety	Perks	
		Benefits Packages	
		Feedback	
		Coping skills	
		Health	

Source: Alker & McHugh (2000, p.306)

3.10 The components of the EAP

No single wellness programme can be implemented across all organisations. Each organisation differs in various degrees with regards to factors such as the nature of business, type of workforce, organisational culture, values, norms and many more. According to Berridge et al. (1997) the essential components of an EAP should reflect the employer's preferred practice model, the resources available to the organisation, the needs of its employees as well as the size and the configuration of the organisation. All EAPs should be tailor-made to reflect the needs of the organisation.

3.10.1 Needs assessment

Each organisation has to assess and analyse the needs and requirements of its workforce as a first step toward EAP implementation (Miller, 1995). Balzer and Pargament (1987) say that needs assessment is both a research and a scanning activity. Several categories

of information are collected, including types of problems experienced; frequency and relative importance of employee problems; current ways in which problems are handled; barriers to the use of community services etc. According to Kim (1988) this is a process of verification and mapping out the extent and location of the problems to which the programme would be directed. This type of information should be collected from all employees, and such participation would prove to be advantageous to the effective implementation and operation of the EAP. Too often, decisions about EAPs are made on subjective, intuitive grounds (Balzer et al. 1987). A needs assessment offers a more objective, systematic tool to assist in the decision-making process, and it can lead to a more cost-effective and useful EAP (Kim, 1988). The information obtained in the needs assessment may for example indicate that the organisation does not need an EAP and that community services are sufficient for the problems experienced by the particular workforce.

According to Thorne (1987) objective baseline data of personnel or health care problems in the organisation can assist in establishing whether employees will be receptive to utilizing the EAP. This is an important aspect, since it could be economically detrimental for the organisation if an EAP is implemented according to employee needs but employees are not ready to make use of the programme. The objective assessment of the workforce as well as the utilization of the information is therefore crucial when implementing an EAP. An intervention programme needs to reach employees alleviate their problems needs to be developed (Kim, 1988). In addition, it is also possible to utilize the information from the needs assessment as a benchmark to determine whether the programme is working, and if so, whether its goals are being accomplished in a cost-effective manner (Balzer et al., 1987).

3.10.2 Policy

No EAP can function effectively without a written EAP policy (Balgopal & Patchner, 1988, IPM, 1989, King, 1994, Luthans & Waldersee, 1989). A written policy is further essential not only for EAPs, but also for all wellness interventions implemented by the organisation (Balgopal & Patchner, 1988). According to Peters (1988) the most important step is top management's publication of the programme policy and procedures.

Policy formulation and publication represent top management's support to the wellness intervention namely the EAP. Top management support is always vital for the success of any change effort executed by the organisation.

Besides being evidence of top management support, a policy furthermore gives a clear statement on the purpose, nature and benefits of the programme; it provides a frame of reference to programme implementation, and it should encourage self-referrals since it will stress confidentiality and job security (du Plessis, 1988). The (IPM) Institute for Personnel Management (1989, p.2) suggest the following principles on which a policy should be based:

1. that personal problems can and do affect job performance
2. that treatment of personal problems is less costly than dismissal and replacement
3. that the EAP does not replace disciplinary procedures, but provides an alternative method of managing poor performance, often while discipline is suspended
4. that the employer's concern is with job performance and not the personal lives of employees: this is often included to preclude the image that the EAP represents a 'witchhunt' for employees with personal problems. Maller (1988) talks specifically about the paternalistic nature of the EAP. She highlights that employees may perceive the wellness interventions as paternalistic, particularly if it is tied very closely to productivity requirements. This conflict in perceptions may be detrimental to the efficient functioning of the EAP. Employers need to emphasize the voluntary nature of the EAP as well as any other wellness interventions.

The IPM (1989, p.2) further propose the inclusion of certain guarantees within the policy:

1. people identified as having personal problems will not be discriminated against; promotional opportunities will not be affected;
2. if required, special sick leave will be granted to accommodate assistance;

3. discipline will be suspended, if involved, while the employee is on the EAP;
4. that confidentiality will be respected, in terms of giving feedback to referring supervisors.

The process of strategy and policy development should include all constituents of the EAP as wellness intervention. Recently, unions have become instrumental in supporting wellness programmes (Cohen Mason, 1992). Union involvement will be highly important in these developments and some issues may need to be negotiated on (Maller, 1988). Wellness programmes could further also be used as a benefit in negotiations for salaries. According to Ntsamai (1991) this will also emphasize the collaborative efforts of the union and management for employee health and may result in improved industrial relations.

3.11 Types of EAPs

The literature emphasizes the following types of EAPs:

3.11.1 In-house treatment model

With the in-house model organisations basically have their own resources on site to which employees are referred. The IPM (1989) highlights that with this model the organisation may have its own multidisciplinary team of social workers, psychologists, doctors and sisters who offer counselling services to employees and their families. And as a 'pure' model this isn't often found since it requires a large number of employees to justify the employment of professionals. According to Peters (1988) the main advantage of the internal programme is that the organisation has more control over its quality. In addition, the EAP specialist can often handle job-related problems because of a better understanding of the organisation and the nature of its business. He mentions certain disadvantages to the in-house treatment model. Confidentiality is a contentious issue; employees may question how their participation in the EAP will affect their careers. Another obstacle is when the EAP specialist is placed in the organisational hierarchy. Superior employees hesitate to seek assistance from someone on a lower level than themselves (Peters, 1988).

3.11.2 External or contractual model

With external or contractual model the actual EAP is based at a different location and is managed by people (usually) not employed by the organisation the employee belongs to. With external programmes, employees contact the EAP specialist in various ways. This can be telephonically, through personal visits or through the co-ordinator at the employee's organisation. It may also be required of the EAP staff to visit the organisation at time. Peters (1988) says that costs are usually based upon the number of employees and the types of services required. Peters (1988) further states that the strengths of the internal programme become the weaknesses of the external programme. Many people will not want to go to something outside the organisation. The programme may not receive the same amount of support, and the external EAP specialist may have little understanding of the jobs, working conditions, and management practices that are contributing the growth of a problem for an employee.

Straussner (1988) did specific research on the in-house versus the external EAP model. Straussner (1988) states that comparative analysis of in-house and contractual programmes indicates that contracted EAPs tend to be newer, are more likely to have originated as a broadbrush programme, report to a higher level within the organisation, and cost more per employee. They are also more likely to see self-referred employees with mental health or legal problems, and to offer employees several community referral resources.

In contrast, in house programmes, while more numerous, tend to be older, are more likely to have originated as alcohol-based programmes, report to lower within the organisation and cost less per covered employee (Straussner, 1988). They are also more likely to provide consultation and training to unions in their company. In-house programmes receive a higher % of supervisory and medical referrals, and are more likely to see employees with alcohol problems than are contractors (Straussner, 1988).

Such comparative analysis shows that each programme mode tends to serve different groups of workers. In order to maximise the advantages inherent in each EAP model, the ideal EAP may need to be composed of two separate components (Peters, 1988). One,

exemplified by the contractual EAP model, would aim at employees behavioural problems based on job performance with the identification of alcohol and drug problems as its central focus. A separate component, exemplified by the contractual EAP model, would aim at reaching a different segment of the workforce through the provision of information and referral services and short-term counselling to self-referred employees with a variety of problems.

3.11.3 The consortium model

The noun 'consortium' indicates some kind of group, combination, association or partnership or an effort to accomplish something of common interest. Applying this to the field of EAPs it means that a group of employees in a given geographic area, who join together, in order to accomplish a common interest of effective EAPs (Beugger 1987). Participants who for economic or other reasons do not wish to initiate programmes under their own internal sponsorships use the consortium approach. The two advantages of sharing can be highlighted as follows: firstly, when there is a financial investment, the participants have the incentive to use the programme right from the beginning and secondly when there is an active governing role, each participant can effect change in policy as well as in the programme or service delivery (Beugger, 1987). This involvement also ensures a lesser dropout possibility because the service rendered is not beneficial to the participant. The services received from a consortium are not different from those received from an EAP within a larger self-contained organisation. The important difference is that the services are shared. Beugger (1987) highlights that there are some variations to the consortium model, which do not include the financial or governing components. The participant may only be interested in the purchase of the service and not having any real control over the functioning and operation of the consortium. Another variation mentioned by Beugger (1987) is where the consortium seeks funds from a public or government service to function as a community resource and participants continue to have a governing role or input. It all depends on the needs and requirements of the organisation and its workforce.

3.12 Procedural - classification models of EAPs

The procedural-classification models analyse the difference between EAPs on the basis of a number of criteria that can be aggregated into various commonly found combinations (Berridge et al., 1997, p.51). As a result, a classification of EAPs can be constructed as a basis for analysis. The criteria can include:

1. the physical location of the service (on or off the worksite);
2. the locus of direct control of the service (provided by in-house employee counsellors, or by external counsellors);
3. the extent of counselling services provided (whether referral and assessment only, or external into short- or long-term counselling);
4. the period of time over which counselling normally is provided (whether constrained in the number of sessions or open-ended within the programme).

The above criteria are procedural characteristics of EAPs and will have certain implications in such regard. The implications include:

1. whether the EAP is staffed by lay counsellors or professional staff,
2. at which stage of the EAP sequence;
3. whether the EAP procedure involves corporate line management, and in what role;
4. whether the EAP has a connection (input or output) with other organisational control mechanisms, such as the performance review and appraisal, development, and disciplinary processes.

Berridge et al. (1997) state that such secondary and downstream considerations are essentially technical choices that are internal to the operation of the EAP, rather than initial definitional characteristics. In practice these matters can assume large proportions in the eyes of the decision-makers or actors within the system.

Hellan (1986), (as cited in Berridge et al., 1997) developed a classificatory model, which illustrates the procedural approach to models of EAPs and is based on the criteria listed above.

Table 3: Classificatory model

Type No	Characteristics	Commentary
1	In-house, lay assessment and referral if needed	Reflects origins in industrial alcoholism movement
2	In-house professional assessment and referral	'Classic' US model of earlier EAPs
3	Open-ended treatment often with self-referral	Reliance on community health resources in many instances
4	Closed-end full service, usually short-term counselling	Cost-effective EAP model, external contractors used

Berridge et al. (1997) emphasize that this model is not to be interpreted as a sequence along which a particular EAP progresses, although numerous US examples have done so. A development of the procedural classificatory model is provided by Masi & Friedland (1988) in Table 4, who use many of the same elements as Hellan above with a less implicit sequence of types. This model is driven primarily by the nature of the provider of the EAP, being less centred on the nature of the counselling service. Berridge et al., (1997, p.53) continue by saying that "it is not axiomatic that a certain type of provider will *sui generis* furnish a certain type of EAP service."

Table 4: Procedural classificatory model

Type No	Characteristics	Commentary
1	In-house: integrates with corporate policies, and all staff are directly employed	Employer-controlled; hence may lead to conflicts of interest and ethics
2	Out-of-house: objectives may fit into corporate goals, but provision contracted to external provider	Problematic linkages and inter-knowledge between provider and organisation
3	Consortiums: several firms pool	Smaller firms share overheads this

	resources using external contractor	way: co-ordination and premises come through contractor
4	Affiliate: resembles type 2, but provided more loosely by co-operating independent professionals for a group of firms	High client focus, and reduced organisational involvement, if any

Straussner (1988) developed a very different classificatory model as an incidental product to her study of the relative benefits of in-house and out-of-house EAPs (Berridge et al., 1997).

Table 5: Classificatory model

Type No	Organisational stakeholder who benefits from EAP	Commentary
1	Employer-favouring EAPs	Associated more with in-house EAP. Organisational knowledge and integration provides flexible, dedicated EAP - at expense of clients needs?
2	Employee -favouring EAPs	Associated more with externally provided EAPs and professional identification with clients as individuals; tends to produce less managerial satisfaction
3	EAP staff - favouring EAP	May result from a need to avoid polarization, or from a lapse into bureaucratic routinization. Best practice or merely its continuance can lead to excessive internal focus, and consequent dysfunctionality.

According to Berridge et al. (1997) all three procedural - classificatory models have considerable limitations in analytical terms. They further say that this is because of their lack of precision in definition, and of their basis in a diverse range of practices. Few operational EAPs fit easily into the specified types, and hybrids or mixed types are often

likely to be found. Since EAPs have to be tailored to organisational contexts, they also show immense diversity.

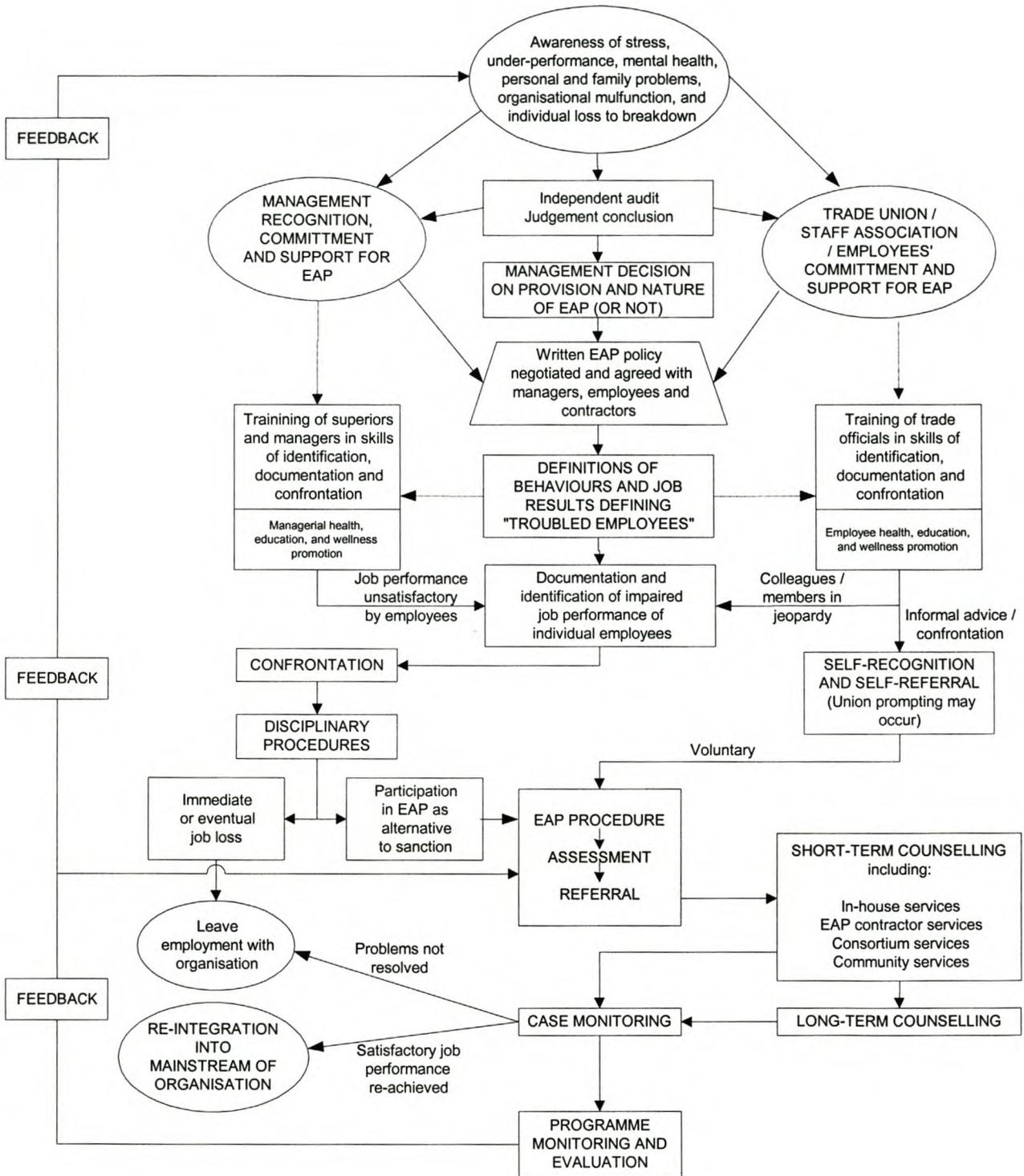
Roman and Blum (1992) developed a more prescriptive EAP model in an attempt to produce a definitive statement of the EAP that could serve as a practice yardstick (Berridge et al., 1997). It is claimed that the 'core technologies' represent the unique contribution of EAP presence in the workplace.

Table 6: Seven 'core technologies' approach to EAPs

No	Description of core technology	Commentary
1	Identification of problem employees via documented evidence of impaired job performance	Clear performance standards are required to avoid vague 'labelling' of employees with supposed behavioural problems
2	Provision of consultative assistance to supervisors, managers and shop stewards by the specialist designated to operate the EAP	Training and education at all levels of employees prepares a climate in which the EAP becomes part of the HR policy
3	Constructive confrontation of the problem employee by management to obtain recognition of troubles and a willingness to act	This unique aspect of EAP derived from the occupational alcoholism origins, but has of late taken on a 'softer' nature
4	Creation of micro-linkages between the employee and community resources most appropriate to assist	Both clinical and practical community knowledge can ensure effective direction of employees to sources of help
5	Creation of long-term macro-linkages between workplaces and service provider systems in the community	Workplaces can thus become informed consumers of treatment - leading to more effective managed care
6	Promulgation of an organisational culture to provide constructive assistance in dealing with employees' problems	Neither benign neglect nor punitive discipline, but a culture of responsible cooperative mutual help
7	Evaluation of employee and EAP in terms of job performance adequacy	Resolution of job-related problems rather than judged on clinical or other criteria

According to Berridge et al. (1997) all the EAP models above are either typologies or taxonomies, or are prescriptive in the case of the US-based 'core technologies' model. Shain & Groeneveld (1980), aimed at creating a systems-based practice model (Berridge et al., 1997). Their desire was not to categorize or prescribe, nor to create a perfect model for emulation and imitation, but rather they sought to identify, but in systems terms, the essential elements of the EAP (Berridge et al., 1997). It will be noted that the technical elements of the EAP itself compose only a relatively small part of the total system, which, of course, itself functions in a wider organisational and societal environment. The research-based analysis of the need for an EAP, its constitutional basis in the enterprise, and the nature of preparation of education are all essential prerequisites for the effective installation of an EAP (Berridge et al., 1997). Any EAP cannot stand still, and it will change continually by means of the imports and exports to its system across its various boundaries with the organisational stakeholders, the community and the economic environment. The model shows how the EAP is in no way an isolated or encapsulated organisational intervention. Nor is it a short-run 'band-aid' but a considered intervention in the organisation's cultural and efficiency processes, which have to be woven into the web of organisational mechanisms, values and beliefs.

Fig 5: Ideal typical model of an EAP



Source: Berridge et al. (1997, p.60)

This model basically indicates the possible flow of the EAP process in organisations and all the relevant procedures and structures. It is important to emphasize that the structure and design of EAPs or any wellness intervention for that matter, is organisation specific and should be implemented in such a way as well. The chosen model and flow of EAP processes may be determinants of the success or failure of the EAP.

3.13 Services provided by the EAP

The ‘broad brush’ EAP refers to the wide spectrum of services a programme may offer the employees of the organisation. The selection of services or assistance should be based on the information the needs analysis provided. The importance of the needs analysis is profound in this respect. Berridge et al. (1997) included the following counselling issues in a ‘broad brush’ EAP:

Table 7: Counselling issues in ‘broad brush’ EAPs

Accident	Goal setting	Risks at work
AIDS	Grievances	Smoking
Alcohol abuse	Indebtedness	Stress
Bereavement	Induction	Substance Abuse
Career development	Job change	Suicide
Chronic Illness	Job training	Supervisory Style
Demotion	Lay-off	Technology changes
Disability	Legal matters	Test failure
Disaster	Literacy	Verbal abuse
Discipline	Marital Problems	Violence
Dismissal	Mental health	Vocational guidance
Divorce	Performance evaluation	Weight control
Drug abuse	Physical fitness	Women’s issues
Family problems	Promotion	Young workers’ problems
Financial advice	Racial harassment	Retirement

Some of the services mentioned may also be dealt with under the typical Health Promotion Programme, where issues related to physical health and fitness are considered (De Joy & Wilson, 1994).

3.13.1 The role of the supervisor

Sell & Newman (1992) highlights that EAPs rely upon supervisors' observation and constructive confrontation as the catalysts for troubled employees to seek help. Roman & Blum (1987) say that supervisors are the referring link between management and troubled employees. Supervisors need only to perform their traditional roles - that is observing and monitoring the job performance of their employees. Observing deteriorating work performance offers the promise of earlier identification and referral to treatment. Supervisors should be well informed about the services of the EAP and what the benefits of making use of the programme are (Luthans & Waldersee, 1989). They should further have some knowledge regarding the symptoms of certain problems (psychological or physical) in order for them to confront employees with the correct information and assist them in making use of the right treatment services.

3.13.2 Confidentiality and record keeping

The nature of the issues EAPs usually deal with is of such a nature that confidentiality is crucial. Not only should the policy statement include the emphasis of confidentiality, but employees should also be ensured that they do not have to be concerned about confidentiality. Employers should implement record keeping systems that are viewed only by those who deal with the employee regarding treatment or supervisors given permission to view the records by employees themselves.

Employees should feel comfortable to make use of the EAP and they will only do so if they are sure that their personal information is kept confidential. A further element is that management should further ensure that employees know that these EAP records will not be used in any human resource related decision making such as transfers, promotions or job assignments.

3.14 Health promotion programmes

3.14.1 The nature of health promotion programmes

According to Patton, Corry, Gettman & Graf (1986) health promotion is a combination of health education and related organisational, economic, or political interventions designed to facilitate behavioural or environmental changes conducive to health. According to Sloan (1987) interest in workplace health promotion programmes springs primarily from the expectation that organisations can reduce the high healthcare costs. A secondary reason for such interest is the belief that HPPs have a positive influence on employee morale, job satisfaction, and productivity. Gebhardt & Crump (1990) postulate that the exponential growth of worksite health promotion programmes has resulted partially from the belief that an organisation should take some responsibility for the welfare of its most valuable resource, the worker. De Joy & Wilson (1994) say that the current generation of worksite health promotion programmes tend to be more comprehensive in scope and more ambitious in intent.

For many forward-looking organisations, health promotion is emerging as an important element of the company's strategy to control health care costs, to optimise employee productivity and satisfaction, and to enhance the company's overall competitive position within the marketplace. Pelletier (1991) states that the strength of worksite health promotion lies not in its potential to save dollars, but rather to save and improve lives in a cost-effective manner. This conservative view contrasts strikingly with the both implicit and explicit argument that worksite health promotion can produce dramatic cost savings. Pelletier (1991) elaborates by saying that in the implicit category are claims or reductions in employee health care costs and absenteeism of as much as 25 to 50 %, one to five years following implementation of health promotion programmes. In the implicit category is the compelling evidence that individual businesses spend millions of dollars on behaviour-related health care costs, costs that many wellness analysts consider preventable through health promotion. Gebhardt and Crump (1990) health promotion in the workplace should be designed to encourage healthy behaviours and to continue these behaviours outside the work setting.

Similar as with the EAP the HPP offers the potential of affecting not only the health of the individual worker, but also the health of the organisation and community as a whole. De Joy & Wilson (1994) say that ideally worksite health promotion should be a health partnership among the employer, employee and the health community because all three have strong incentives to improve individual and organisational health. The employer benefits because healthy employees are more productive, are absent less, have higher energy levels and use fewer medical benefits. The organisation also benefits from improved recruitment and retention capabilities, enhanced company image, & higher morale. Employees gain direct access to services to improve their health at a convenient location, and benefit personally from working in a safe and healthy environment. Health care providers benefit from the easy accessibility the worksite provides and from the opportunity to impact the health practices of significant groups of people through multifaceted approaches. The ideal approach to health promotion is an independent one (De Joy & Wilson, 1994).

3.14.2 HPP activities

The typical activities of HPPs are among the following (De Joy & Wilson, 1994, p.8):

Table 8: Typical HPP activities

Health status questionnaires	
Health checks including: Blood pressure screenings	
Cancer screenings	
Cholesterol screenings	
Information or activities on:	
Blood pressure	AIDS education
Cholesterol	Sexually transmitted diseases
Cancer	Alcohol/other drugs
Smoking	Stress management
Exercise/fitness	Mental health
Nutrition	Prenatal education
Weight control	Back care

According to De Joy & Wilson (1994) many of the companies they surveyed in their research on HPPs offered traditional types of risk education and health enhancement programmes that concentrated on the modification of diet, exercise, smoking and other health behaviours. However, behaviour change efforts should be broadened to include emotional development (self-esteem and interpersonal skills), intellectual development (creative thinking and problem solving), and spiritual development (managing change and connectedness). As indicated in the previous chapter, these dimensions are inherent in the system of creating high-level wellness and should therefore be included in programmes aiming at creating or restoring such wellness in employees.

The following table from Bellingham & Isham 1990 shows the levels of Health Promotion Programming in organisations.

Table 9: Levels of health promotion programming

Programme Level Outcome	Activities/ Programme Elements	Desired
Awareness (health promotion activities are offered)	Newsletters, informational brochures, films, lectures	Intention
Motivation (health promotion seminars and testing opportunities)	Screenings, risk assessments, orientation, self-help materials	Commitment
Behaviour change (skill-based momentum programmes to reduce risks and enhance health)	Smoking cessation, stress management, fitness, nutrition programmes	Positive
Maintenance (programmes to improve environmental support)	Support groups, follow-up sessions, relapse prevention programmes	Self-efficacy
Culture change (systematic change process to impact the norms and values of worksite through	Team building, interpersonal communications, creative thinking incentives	Normative

organized health system efforts)

3.14.3 Supportive environment

De Joy & Wilson (1994) say that it is critical to shape the organisational culture so that it is congruent with employee health services goals and values. For example, in a healthy culture, operating norms would promote individual and organisational health. Without supportive norms even the most innovative and well-developed employee health strategies will be unlikely to succeed. Gebhardt & Crump (1990) say that specific goals and objectives are set and all levels of employees should be involved. They further suggest that management should demonstrate a long-term commitment to the wellness interventions by obtaining support from all departments in the organisation.

De Joy & Wilson (1994) highlight that interdisciplinary and interfunctional coordination is required to develop a supportive organisational culture and to ensure effective implementation of health and safety programmes and services. This collaboration can be achieved by taking the initiative to incorporate other business functions in every possible intervention and by thinking interdependently. Strategic integration with the Human Resource function is critical to the success of any wellness intervention.

3.15 Culture audit

In De Joy & Wilson (1994), Rosen, maintains that a culture audit will help managers to understand the diversity of their employees and to detect culture clashes and culture inconsistencies. Rosen suggests conducting a survey to assess employee demographics, personal characteristics, working styles and lifestyle value. Demographic surveys should cover not, only gender, age and job category, but also race, ethnicity, primary language, and regional influences. These factors can be extremely important in understanding a particular group's health problems, practices and preferences for preventative action and treatment. It can further also be used in the evaluation process of the wellness interventions.

3.16 Ethical considerations

Ethical issues affecting the individual employee are important to consider when developing wellness interventions. Many individuals may not wish to make use of the programmes provided due to them feeling coerced into utilising these programmes or that they may feel wellness to be a personal issue divided from the work relationship.

3.16.1 Paternalism

Worksite health promotion programmes are paternalistic by nature because they are designed to protect employees from what is seen as self-inflicted harm (De Joy & Wilson, 1994). Paternalism is based on the notion that the employer needs to protect its employees against unreasonably risky actions on the job and increasingly off the job. The employer is seen as the caretaker. The employees on the other hand, are viewed paternalistically as incapable of behaving in healthful ways. Sloan (1987) says that there is this tendency where the culture of wellness interventions is to blame the individual employee and overlook other factors and situations where employees are stressed due to work related problems such a limited control over their work function, and the design of work and systems. According to De Joy & Wilson (1994) it is important that employers and unions realize that they can go only so far in prescribing or proscribing the lifestyles and off-work behaviour by employees. More over, the boundaries beyond which an employee's behaviour constitutes a threat to health or work performance may not always be clear.

3.16.2 Coercion

Coercion strategies limit employee choices and seek to control perceptions in accordance with organisational goals. Because employers stand to gain from a healthier, more productive workforce, employees may see encouragement of participation as coercion. Employees may perceive that they are being coerced by policies that require them to participate in exercise and lose weight, or that restrict their choices at work. This is especially a problem when programmes were not developed with employees' needs or expectations in mind (De Joy & Wilson, 1994). In most cases, employees should have the right to decide for themselves whether they shall participate and they should not be

made to feel embarrassed, ostracized or penalized for failing to do so. The organisation's wellness policy should clearly state that employees are not coerced into making use of these programmes.

In the context of legally binding health and safety procedures, such as the wearing of protective clothing or using protective equipment, employers will be obliged to coerce employees in utilizing such items. De Joy & Wilson (1994) say that in the absence of legislative mandates requiring specific behavioural compliance designed to ensure safety, it is the concept of voluntariness of participation, together with expanding the employees' choices rather than limiting them, that differentiates the ethical practice of health promotion and other approaches.

3.17 EAP/HPP contrasts and complements

HPPs and EAPs have an overriding and fundamental difference. HPPs emphasize primary prevention of employee health problems while EAPs emphasize identifying and aiding employees who have already developed behavioural problems that are having an impact on their jobs (De Joy & Wilson, 1994). However HPPs and EAPs have the common feature of being novel mechanisms for intermingling health care and work.

The following contrasts and complements of EAPs and HPPs are adopted from De Joy & Wilson (1994). HPPs focus on reducing the risks of employee health problems that presumably would be ultimately costly to both the employer and the employee. In this sense HPPs represent a typical primary prevention strategy (White, 1986). EAPs deal with employees' symptoms that have emerged already. These programmes attempt to provide early interventions for behavioural problems before they become costly for the employer and the employee. They channel the employee to a source of assistance selected with the guidance of an EAP counsellor; this referral presumably will provide the most cost-effective help for the employee's problem. EAPs thus represent secondary prevention.

One of the advantages that HPPs typically have over EAPs in dealing with behavioural change is the measurability and quantitative nature of the HPP, for example weight, percentage of body fat, amount of exercise, blood pressure level or period of abstinence

from tobacco. However, for both HPPs and EAPs the outcome problem increases in complexity as one moves away from looking only at single behaviours, symptoms or physical traits. It is difficult to index global improvement that encompasses areas of job functioning. Here one must generate consensus regarding productivity, attendance at work, interpersonal relations with work groups and supervisors. EAP activities have been found by Roman and Blum, 1988 (as cited in De Joy & Wilson, 1994) to be structurally similar across multiple workplaces while the expected commonality across HPPs is much lower.

The technologies that underlie the implementation of HPPs and EAPs are an important consideration. The technology of HPPs possess face validity in the benefits that are expected to be produced by weight reduction, smoking cessation, increase in physical activity, and/or intake of nutritious foods. Such goal directed behaviours enjoy cultural support as techniques for reducing illness risk and enhancing subjective well-being. HPPs may require both “software” and “hardware” for the implementation of different regimens. Examples of “software” include access to knowledgeable advice about appropriate exercise, diet, steps in smoking cessation or techniques of stress management. Examples of “hardware” are HPP staff positions, gym-type space for carrying out HPP activities, changing and shower rooms, running tracks, and exercise equipment. The HPP is proactive by definition, which is a feature that adds considerably to its attractiveness as a programme concept. EAPs in contrast are sets of reactive mechanisms that provide assistance to supervisors, union representatives, and employees when requested.

With HPPs, relatively few employees may be injured by losing weight, stopping smoking, or improving nutrition, however some may get hurt through exercise regimens. With EAPs the consequence of misguided referral of treatment may produce substantial difficulties for employees and employers where employees may be wrongly exposed to harmful physiological interventions or experiences that crystallize a negative sense of self-worth. EAPs are further distinctive from HPPs in their central emphasis on confidentiality. HPPs likely succeed only if their services are highly visible so that employees can observe those using the services. In contrast, EAPs must use a low-profile mode of offering expert guidance and assistance and ensuring that identities are not

revealed, except as appropriate. This is also where the wellness policy of the organisation should clearly guarantee that EAP related information would not be used negatively against any employee.

The primary motive for organisations to adopt an EAP is performance related, while with the HPP the motive is the containment of health care costs. De Joy and Wilson (1994) emphasizes that more research is required on the specific reasons for utilizing various wellness interventions. There are important contrasts in the manner in which the consequences of HPPs and EAPs become visible in organisational life. In an HPP there can be both formal and informal public attention to the achievements of employees who stopped smoking, lost weight or entered marathons. But the results of the work of the EAP are often in process for lengthy periods of treatment, aftercare, and rehabilitation. Furthermore, confidentiality issues do not lend the EAP to make public any successes experienced. Thus the value of the HPP typically has up-front validation through the visibility of its inputs (especially exercise) and the rapid consequences of visibly healthier employees. By contrast, the value of an EAP may have down-the-road validation in that the nature of its inputs is usually confidential. Its outputs may not be evident for lengthy periods of time, if ever (De Joy & Wilson, 1994).

There is a distinct difference between HPPs and EAPs regarding the level of organisations toward which each type of effort was historically directed. HPPs have moved down organisations in their coverage, while EAPs have moved up. Terborg (1986) notes that in the past, participation in on-site health promotion activities was usually limited to top executives and provided as a management perquisite. The EAP historically carries a blue-collar imagery as a result of its then alcohol related focus. As EAPs developed, the guiding literature routinely stressed the importance of organisation wide EAP coverage (De Joy & Wilson, 1994).

Both EAPs and HPPs centre on models of mutual benefits to both employers and employees - that is, behavioural changes that enhance individual health while contributing to both productivity and containment of health care costs. When companies have both of these programmes implemented it is vital that they operate synergistically.

De Joy and Wilson (1994) highlight that these two interventions should complement each other rather than being perceived as substitutable. Blum, Roman & Patrick, 1990 (as cited in De Joy & Wilson, 1994) found in a research study on the synergism between HPPs and EAPs that both these interventions are better and statistically significant predictors of the presence of each other in organisations than any one of the organisational variables. One can thus conclude that the two interventions have mutually supportive ingredients. De Joy & Wilson (1994) say that it may be predicted that, given the commonalities of goals of the two programme types and their potentials for cross-referral, such mutual support may increase in the future.

3.18 Evaluation of wellness interventions

Masi (1997) says that the evaluation of an EAP is important, since operating an EAP is not always beneficial to a company's employees. It is essential, therefore, to evaluate whether the company's investment in the EAP is actually helping its employees (Masi, 1997, p.378). Pelletier (1991) states that 'comprehensive' wellness programmes refer to those programmes that provide an ongoing, integrated programme of wellness interventions that knits the particular components into a coherent, ongoing programme that is consistent with corporate objectives and includes programme evaluation. Gebhardt and Crump (1990) say that an ongoing evaluation and testing programme must be established to provide feedback to employees and to assist management in determining whether the programme contributes to organisational goals. According to the Kim (1988) evaluation of the wellness interventions of the organisation is a research activity devoted to collecting, analysing and interpreting vital information on the need, implementation and impact of a given intervention for the purpose of improvement, adaptation or justification of the wellness efforts. This evaluation also includes analysing the cost effectiveness of programmes and services provided by the organisation.

Masi (1997) states that evaluation is not research, it is a quality assurance and there is tremendous advantage to tailoring the programme information at the onset of the programme to achieve effective evaluation results. Haltom (1995) says that the process require employers to gathering data in order to target their health promotion efforts at risks, specific at-risk populations, and even individuals, and to measure the impact of

their programmes when they involve themselves in measurement. Evaluation of the organisational wellness interventions is as important as any other step in the process of managing such programmes (Masi, 1997). This step in the process can provide the organisation with helpful and insightful information in order to provide more effective programmes and services. Many organisations ignore this important step in the process and do not evaluate the wellness interventions of the organisation (Myers, 1984, as cited in Holosko, 1988).

Holosko (1988, p.60) says that any one or a combination of the following may be reasons for not evaluating wellness interventions: 1) there is a lack of resources devoted to evaluating interventions, 2) there is a lack of scientific instruments developed for use in this field, 3) organisations are reluctant to evaluate their interventions for one or other reason, 4) there has been a lack of attention directed toward planning wellness intervention evaluations.

According to McClellan (1989, p.76) there are several key indicators of EAP performance. The most notable indicators are: 1) employee utilization of the EAP generally expressed as number of new cases divided by number of employees at risk; 2) the percentage of employees identified and intervened with who have chemical dependency problems; 3) the average number of counselling sessions per case; and 4) employee attitudes toward the EAP. Gebhardt & Crump (1990) state that quantifiable measures, such as worker productivity and reduced health care costs, which indicate whether the organisation's performance was enhanced as a result of the wellness interventions, should be collected. According to Masi, (1997) it is the employer's responsibility to ensure the effectiveness of the programme and to determine if it requires change. It is also important for the organisation to ascertain whether the programmes is reaching and serving all levels of the employee population: men, women, all management levels, families, previously disadvantaged groups and so forth (Masi, 1997).

Reddy (in Highley & Cooper, 1994, p.49) believes that "the way in which organisations evaluate their EAP, and what they call success, will be related to their reasons for embarking on it in the first place". The needs assessment information utilized in the

development phase is used in the evaluation phase in order to identify whether the goals and objectives of the initial programme were met. There are different types of evaluation methods for wellness interventions. The following methods were identified in the literature.

3.19 Outcome evaluation

Highley & Cooper (1994) say that outcome evaluation is needed to ensure that the wellness intervention is correctly designed for the organisation and its employees. Outcome evaluation can encompass a whole range of activities, which include evaluating effectiveness, cost-benefits, cost-efficiency, cost-effectiveness and utilization analysis. “Bottom line” information as collected in the needs assessment can be used as a benchmark for wellness intervention outcomes.

3.19.1 Effectiveness

Effectiveness usually addresses the issue whether those who receive treatment improve (Highley & Cooper, 1994).

3.19.2 Cost-benefit analysis

The aim here is to evaluate costs and benefits solely in monetary terms. According to Highley & Cooper, (1994) it is useful to distinguish between “hard” and “soft”. Hard data refers to the quantifiable information such as medical expenses, or disability payments, where as soft data refers to the information collected from different sources. Kim (1988) states that in this analysis, the benefits and costs have to be translated into a common measure, usually monetary values, for a straightforward comparison. Kim (1988) says that this method has clear comparative meanings when alternative approaches are under consideration for resource allocation. This method of analysis could be used either prospectively or retrospectively (Dejoy & Wilson, 1994). Prospectively it are projections, and incorporate many modelling assumptions to derive estimates to assist senior managers charged with making corporate decisions under conditions of uncertainty. Retrospectively it can be used to assess how well a program met its objectives and to help managers to decide whether to continue the investment. Masi (1997) believes that cost-benefit analysis addresses the question of whether an

organisation can expect a reasonable return for its investment of resources in a program in terms of identifiable cost reduction. He says that this involves measuring the total cost of an occupational programme and comparing this to the benefits accrued by the organisation. Direct and indirect costs, including programme operational expenses and costs attributable to employee problems are measured to determine the total dollar expenditure for implementation of the programme. This is compared to costs incurred without the programme. These two figures are weighted to evaluate whether the programme can be justified economically.

3.19.3 Cost-effectiveness analysis (CEA)

Cost-effectiveness looks at more unspecified outcomes. The aim is to establish which intervention achieves the best therapeutic results in relation to the cost implementation (Highley & Cooper, 1994). Dejoy & Wilson (1994) state that cost-effectiveness analysis is more commonly used outside the corporate environment. While CEA measures costs in monetary value in the same manner as CBA does, it also measures nonmonetary outcomes, such as lives saved or injuries prevented. This method can also be used prospectively or retrospectively to provide information for decision-making.

3.19.4 Cost-efficiency

Highley & Cooper (1994) defines this evaluation measure as the comparison of two or more interventions in terms of the cost achieving a specific outcome, such as getting an individual back to work.

Other forms of evaluation can also be made use of. Haltom (1995) suggests medical claims analysis where a simple investigation is made into what type of claims are lodged and whether there are any decrease in claims.

Employers can go so far as to have control group studies in order to establish cause and effect relationships between wellness interventions and improved health, productivity and quality of life (Haltom, 1995). Another option would be integrated data analysis where control of variables could possible more controlled. Linking medical claims, health screenings and other data can show how costs change as behaviour changes (Haltom,

1995). Masi (1997) states that one of the most important standards to follow in conducting an evaluation is the client contractor. He refers to the legal agreement between the employer and the vendor or company programme. In this agreement the standards are set for staffing, counselor credentials, number of session, client eligibility, penetration rate, clinical referral line response turnaround, and other criteria (Masi, 1997). Employers need to ensure that these benchmarks are upheld.

All the information gathered should provide management with a picture from different angles to ascertain whether the wellness interventions of the organisation are effective and what changes should be made. Masi (1997) highlights that as the health and wellness field is changing and integrating with managed care, ongoing evaluation is necessary to tailor a programme that meets the needs of people today. This should be done regularly in order to ensure that programmes are effectively improving the wellness of employees (Masi, 1997).

3.20 Conclusion

Wellness is manifested in organisations through the implementation of EAPs and HPPs. The development, structure and implementation of these programmes in organisations are primary to their success and the consequent wellness of employees. Masi & Friedland (1988) state that with the correct design, programmes can service a variety of needs and have an impact on reducing costs and raising productivity.

A shift occurring in wellness interventions is not to focus only on the individual's poor health and lifestyle, but to take a closer look at the work related factors that cause stress, such as limited control over job tasks and responsibilities. The design of work processes and tasks need to be included in the services wellness interventions provide, especially the EAP which deal with numerous emotional and stress related issues.

A further important aspect of organisational wellness programmes is their potential to play important roles in change and transformation initiatives in the organisation. EAPs specifically have the skills to contribute to change processes and to facilitate programmes such as diversity or technological plans.

Wellness interventions should ideally be included in the Human Resource strategy of the organisation and then also ultimately in the overall corporate strategy. This will provide wellness interventions with the commitment from top management, which is needed to attain success as well as creating an integrated systems operation of these programmes.

4 CHAPTER 4: WELLNESS IN SOUTH AFRICA

4.1 Introduction

In the past seven years, political, economic and social change has occurred at breakneck speed in South Africa. Most institutions had to undergo major societal changes and transformations, so dramatic, few societies and their members will ever share such an experience. The workplace has experienced equally dramatic shifts (Maiden, 1999). Besides dealing with the pressures of increasing globalized competition, organisations have to attend to factors such as increasing workforce diversity, new labour legislation, and social problems such as training and development, healthcare and infrastructure development (Maiden, 1999). There is increasing pressure and demands on organisations with regards to managing their human resources, and many of these issues have put the human factor high on the organisational agenda.

Due to the political, economical and social changes in South Africa, there is an increasing entrance of previously disadvantage individuals into the labour market. This is creating a workforce with a social background characterized by lower education, a varying degree of poverty, bad health and social problems. These individuals will need to be attended to by the organisation if productivity were to be sustained over time.

“A stable society is much more likely to incorporate satisfactory social support systems than a society with unstable political, economic or social conditions, e.g. high unemployment or large re-housing schemes. Rapid modernization can lead to severe social disruption with consequent isolation and alienation. Under these conditions it is essential to maintain or reweave the social fabric and to establish or re-establish both formal and informal social networks to support individuals and give people assistance in their pursuit of health” (WHO, 1986, p.122).

Employee assistance programmes were the origin of industrial social work and proliferated through alcohol and drug rehabilitation programmes (du Plessis, 1988; IPM, 1989). The mining industry in South Africa placed much emphasis on their employee assistance programmes and services and contributed greatly to the development of these

interventions in organisations (Maiden, 1992). EAPs expanded over the years and became a broad-brush programme, providing different services to employees than in the past (IPM, 1989). EAPs in South Africa have continued to evolve and are now generally recognised as a viable workplace service (Maiden, 1999). Since the 80's many South African organisations have recognized the potential of EAPs to play a role in improving employees' performance by improving their health and life-management knowledge and skills and also for its economic value; others have considered it a form of "internal social responsibility (Harper, 1999; Keshwar, 1989).

According to Rorke (1991) progressive and forward-thinking South African organisations have accepted the challenge and responsibility of becoming health-enhancing organisations, though the progress in this domain remains disappointing when compared to the commitment to wellness interventions shown by United States corporations. Many South African organisations have been reviewing and considering the role of EAPs in their infrastructure in helping them to improve and maintain employees' health and productivity (Harper, 1999). However wellness development is far from reaching a saturation point (Maiden, 1999). Maiden further highlights that the wellness field should be grown beyond the mining industry that is traditionally the largest employer of EAP professionals. According to Harper (1999) to date, the EAP infrastructure has not been perceived by most South African companies' decision-makers as an integral and essential part of effective human resource management, or as the ideal vehicle for taking an integrated approach to managing the impact of AIDS, violence substance abuse, transformation etc, on employee functioning and the pursuit of business objectives.

The field of wellness has specific challenges pertaining to it in the South African market (Maiden, 1999). Maiden include the following as challenges among other- promotion of services to smaller businesses; how to help organisations and employees deal with downsizing and retrenchments that have occurred at an alarming rate in order to compete effectively in the global market place; how to deal with a rapidly growing use of hard drugs that are bound to infect and impact the workplace resulting from the growing influx of drugs into a new open South Africa, and finally how to deal with these issues while trying to add value to the EAP for it to grow beyond the core technology.

Harper (1999) postulates that the South African EAP has incorporated the country's unique cultural, political, social and economic values into the EAP field of practice. The EAP can be very useful in assisting with transformational issues such as change and dealing with the adaptation problems some employees may have due to an affirmative action policy, all of which are currently significant issues in the South African labour market. According to Mkhize (1999) the EAP can contribute a lot to transformation processes in work organisations, especially in the area of managing diversity.

Considering these social conditions in South Africa it may be required that more organisations familiarise themselves with the concept of employee assistance and wellness in order to ensure that the highest level of productivity and human excellence can be attained (Harper, 1999). Organisations should recognize the diverse service wellness interventions could provide to employees and the organisation as a consequence.

4.2 Wellness practice in South Africa

According to Du Plessis (1999) in occupational social work, one of the major influences from North America has been the notion of EAPs. Until North American practitioners visit South Africa, it is hard for them to understand the past imperative for local EAPs to try to become, in the words of Maiden (1992, p.2-3) “ the social conscience of the organisation in which they are ensconced, viewed by employees for the most part as an agent to change for social conditions in the work environment”. Therefore, the usefulness of importing EAP models that focus heavily on clinical work has up until now been limited in the South African context (du Plessis, 1999).

Harper (1999) found in her research that in South Africa, behavioural, mental and biopsychosocial healthcare is in its infancy. Her results indicate that the key focus is on physical disease management through lifestyle change and support programmes such as cholesterol, high blood pressure, nutrition, exercise, smoking cessation and weight management. Harper (1999) further postulates that there is a cultural tendency in South Africa to have a moralistic and stigmatised perception of mental and biopsychosocial (i.e. HIV/AIDS, substance abuse) health.

Traditionally, South African medical practice has focussed on curative rather than preventive approaches to disease (Goslin, 1986). With the rise of trade unionism, and a likely changing pattern of illness profiles across population groups in South Africa, it is conceivable that wellness interventions will have to adapt its services for and posture in the workplace (Rorke, 1986). “EAPs cannot remain separate from their economic and socio-political context, as witnessed by their emergence during a period in South African history characterized by major challenges in those two arenas’ (du Plessis, 1991, p.35). Rorke (1991) upholds that the target group in the South African workplace for wellness interventions will no longer be a select elite group of employees, but the workforce as a whole. Seen in this regard the provision of such services will not be a dispensable luxury, but an absolute essential part of any corporate social responsibility programme.

4.2.1 EAPs in South Africa

The in-house EAP model is currently preferred in South Africa, however other models are gaining ground (du Plessis, 1991). There appears to be some suspicion in South Africa toward for-profit EAP service providers. Some South Africans currently believe that the principle of linking basic welfare services and profit in a developing country with a history of political, educational and social deprivation for the majority of citizens is less defensible than it is in the United States (du Plessis, 1991). This may still be a concern considering that health and welfare costs are continuously escalating as well as corporate medical aid premiums. “Massive price increases of between 20% and 30% will price medical aids completely out of the market, spelling the end of private sector healthcare and ushering in a national health system which the already cash-strapped government would be hard pressed to implement” (The end of private, 2000). Adding to the problem is the fact that as one of the consequences of South Africa’s residual welfare philosophy is that resource programs are scarce, often inadequately staffed and funded, and frequently divided along racial lines (du Plessis, 1991). According to Rorke (1986) the development and management of a typical South African centre is likely to be strongly influenced by economic factors, such as the cost of equipment, salaries of health specialists and the like. These scenarios further emphasise that the pressure will be on

organisations to take proactive action to secure the health and welfare of their employees and in return to save themselves the costs involved with troubled employees.

The majority of EAPs in South Africa have a relatively short history and were broadbrush in focus from the start. Combined with this is the fact that South Africa does not have a history of occupational alcoholism as the United States for instance (du Plessis, 1991,). As a consequence South African EAP professionals are generally poorly trained in chemical dependence, a circumstance that can result in misdiagnosed and under diagnosed cases. It is also evident that social work outnumbers other professions that contribute to the employee assistance field (du Plessis, 1991). “The implication for EAPs run by competent social work practitioners is that direct services are offered alongside preventive services and programs; further, change efforts should go beyond individual concerns and embrace organisational wellness and change. These issues are of specific significance in South Africa, where structural causes are frequently a factor in problem etiology” (du Plessis, 1991, p. 37).

The problems commonly dealt with in South African EAPs parallel those typically handled by United States EAPs – emotional problems, chemical dependence, family problems, divorce, health problems, and legal issues (du Plessis, 1991). Research performed by Independent Counselling and Advisory Services SA (Fontyn, 2000) indicates that approximately 25% of staff in South African companies that subscribe to the service uses the counselling service, against 10% to 15% in the UK. The main problem areas presented in the centre last year were marital (16.8%); AIDS (16.1%); and alcohol and drugs (10.9%). Other significant problems were depression, stress and financial worries.

Du Plessis (1999, p.22) has conducted an analysis, and identified eight factors that have facilitated or hindered employee assistance services that are within the realm of human resource management (HRM) in South Africa.

Table 10: Factors that have facilitated and hindered EAP services in South Africa

Factor One	Individual HR managers in organisations have championed the cause of employee assistance interventions, often because of a personal commitment to the issue of employee care.
Factor Two	The value of employee assistance in the promotion of solving industrial relations procedural problems
Factor Three	During times of economic growth or expansion employee assistance services were employed, however many were retrenched when recessionary times demanded staff cutbacks.
Factor Four	Lobbyists, such as South African National Council for Alcohol and Drug Abuse (SANCA), have encouraged the development of counselling services in the workplace by emphasizing and publicizing two important points. The first relates to the hidden cost of alcohol abuse to an organisation's bottom line and the second is that alcoholism is a treatable illness, not a self-inflicted condition.
Factor Five	Paternalism and the will to care for employees have promoted employee assistance services and interventions. The link between productivity and personal health and well-being was often used as a central rationale for such services and interventions.
Factor Six	Union bargaining demands have played a major role in the employment of EAP practitioners. Management has always aspired to keep a step ahead of union demands. This has been seen in aspects such as health and safety.
Factor Seven	Socio-political changes have affected the incorporation of employee assistance in the workplace. The soft issues, which are part of change and transformation, fall within the realm of the employee assistance practitioner's skills. Opportunities arose in processes such as affirmative action, community development, workplace communication and the promotion of cross-cultural awareness.
Factor Eight	In South Africa, legislation both proposed and passed will enforce processes in the workplace that reflect the value prevailing democracy: equality and equity, democracy at the workplace, transparency, capacity building and empowerment are a few examples.

4.3 The need for wellness interventions in South African organisations

There are various problems experienced by South African organisations, which may be solved or their effect on organisational functioning minimized through the implementation of wellness interventions. Employers are faced with low productivity levels, escalating AIDS figures, constant required change as well as workforce diversity. In South Africa stress and employee health problems are compounded by a pace of change that is so rapid, the old system of having a resident doctor or an occupational sister on duty is insufficient (Fontyn, 2000). Wellness interventions in the form of EAPs have been shown to contribute to the effective management of many of these issues. A further motivating factor for EAPs is that there is a linkage between provision of wellness interventions and organisational success (Carroll, 1996).

4.3.1 Productivity

With the focus now on increasing efficiency and enhancing productivity, more organisations are seeking advice on the “management of health needs” (Miller, 1995). South Africa has constantly performed dismally in the World Competitiveness Report, coming in at 42nd out of 47 countries in the 1999 report (Bennet, 1999). People are one of eight factors used to measure a country’s competitiveness capacity, and in 1999 South Africa came in dead-last (Bennet, 1999). Many of the factors that would promote productivity were artificially regulated by laws - access to education, job advancement, ability to own property in urban areas - and all of this in the circumstances of the majority of workers being denied the right to vote (du Plessis, 1999). For many workers, discrimination in the workplace reflected the above in the general society and to commit to productivity did not present as a fair expectation (du Plessis, 1999).

Besides the above mentioned influences, other human factors related to low productivity levels are absenteeism, sick leave, depression, low energy levels, mental disorders, alcoholism, drugs and many more. The effect of wellness on productivity, as elsewhere stated, has been proven by various studies (Cohen et al., 1997). It is clear that employers can affect the levels of productivity in their organisations through the promotion of employee wellness (Rothwell 1994). Wirt (1998) supports this view by stating that with 20% of all workers affected by personal problems that might affect job performance it is

no wonder that every day a new wellness intervention is introduced into an American workplace.

4.3.2 Health care costs

The cost of private health care is rising so rapidly that it is in danger of becoming unaffordable to all but the wealthy (Bisseker, 2001). Bisseker continues by stating that health-care spending in South Africa is alarmingly skewed - the State spends R27,2 bn to cater for 35 million people (about 85% of the population), while the private sector spends R35,5bn on just 7 million people each year. About 85% of employers have reported a rise in costs following the reform of private health care under the Medical Schemes Act (Heard, 2001). For most of the Nineties, medical inflation exceeded general inflation, causing employee health care benefits to double in six years. They now consume almost 10% of the average company's payroll. Employers can no longer afford these annual price hikes and are scaling back employee benefits (Bisseker, 2001).

These conditions will increasingly aggravate the health problems of employees from the point of view that sufficient assistance and care will not always be possible and this will have a detrimental effect on the productivity of employees. Organisations will again incur rising costs though manifested in a different form. Bisseker (1998, p.38) says that "several new wellness programmes have been launched in South Africa, promising a fast route to reducing medical aid costs while improving health". She continues by stating that some medical aids are following this trend by incentivising healthy lifestyles. CEO of Discovery Health Adrian Gore (1998) says "all these wellness programmes take several years to work. It is simplistic to think they'll reduce the claims rate in the first year, but I expect the long-term effects to be dramatic."

Against this background of continual rising health care costs, it will be fundamental to proactively manage employee health and wellness for the dual benefit of employer and employee to sustain survival of organisations. Appropriately structure and managed wellness interventions could facilitate such objectives to certify healthy outcomes.

4.3.2.1 Underlying causes influencing the need for wellness programmes

4.3.2.1.1 AIDS in South Africa

It has already become somewhat of a truism to state that in its relatively short history Acquired Immunodeficiency Syndrome (AIDS) has come to be recognized as a major world problem (Strebel, 1995, p.12). The AIDS epidemic in South Africa is serious and rapidly growing and as a result of the growth in HIV prevalence and the failure to control the spread of HIV, South Africa faces a major AIDS epidemic. Instead of being able to focus purely or even largely, on prevention activities the country is about to have to deal with the consequences of large-scale conversion from HIV to AIDS (Whiteside & Sunter, 2000).

While there are limitations in extrapolating the general population, it is estimated that 3.6 million South Africans were HIV positive in 1998, compared to approximately 2.7 million in 1997. According to Whiteside & Sunter (2000) in 2000 the HIV affected individuals in South Africa amounted to 4.2 million. These statistics indicate that HIV/AIDS is spreading at a rapid rate throughout the country, with more people infected daily. It clearly poses a sincere threat to society at large and will obviously affect the workplace greatly in various ways.

The impact of HIV/AIDS on the labour market and stakeholders is daunting and intimidating. According to Whiteside & Sunter (2000) the growth of the working population will decline from over 2% in 2000 to under 0.5% by 2008. Household structures and behaviour will change as the size composition and productivity of the labour force is affected. Labour productivity will decrease owing to absenteeism and illness of workers and unit labour costs will increase as firms pay more for medical aid and group life or disability cover. Whiteside & Sunter (2000) further state that due to its impact, HIV/AIDS will leave more orphaned children and child-headed households, combined with fewer economically active people, family support systems will be burdened with implications for the future development of South Africa's social security systems.

AIDS primarily kills young and middle aged adults during their most productive years (Whiteside & Sunter). This means that it is unlike any other disease with which

companies have had experience. Whiteside and Sunter (2000, p.100) name the following HIV/AIDS related factors that will affect organisations in South Africa:

- Absenteeism is increasing not only because of the ill health experienced by employees, but also because workers take time off to care for their families (especially females) and for funerals;
- The morale of the workforce is sagging;
- Sick workers are less productive at work and cannot carry out the more demanding physical jobs;
- Accidents occur more frequently because of fatigue in the workplace;
- Employees who die or retire on medical grounds have to be replaced. Their replacements may be less skilled and experienced and therefore require training;
- Employers are increasing the size of their workforces to provide for deaths during apprenticeship and because of absenteeism in general;
- The cost of health care, medical aid and hospitalisation are rising and will affect employers' bottom line;
- Managers will have to spend more time on AIDS related issues.

When considering HIV/AIDS infections, women are especially at risk. The infection rate in young women aged 15-19 had increased from 12.7% in 1997 to 21.0% in 1998 (aids.org.za). Women are more likely than men to be low income, lacking health benefits or disability (Mason, 1994). Mason (1994) further says that the coincident rise in the numbers of employed women and the numbers of women affected by HIV challenges EAP professionals to plan HIV services relevant to women and families.

Studies regarding the occurrence of HIV/AIDS within the biopsychosocial framework give considerable weight to the argument that psycho-social stress is associated with emotional adjustment, and that social support is a significant factor in facilitating the psychological adjustment of people with HIV/AIDS (Schlebusch & Cassidy (1995).

They continue by stating that social support exerts a mediatory, stress-buffering effect in these patients, which is of positive nature for the promotion of wellness in such individuals. Wellness services developed with a specific focus on HIV/AIDS support may assist companies to a great degree in sustaining the productive services of such affected employees.

Producing and the economy will suffer as a result of AIDS related illness and death of productive people and the consequent fall in productivity (Whiteside & Sunter, 2000). South Africa can most definitely not afford to have further declining productivity levels and employers will have to take specific measures to limit the effects of HIV/AIDS on the survival of their businesses. According to Business Leaders urgent intervention is required from the government and the private sector (Jordan, 2001). They further state that companies will have to train three people for every job because of the AIDS death toll, projected to reach 500 000 a year by 2008. The compounding pressure of AIDS related consequences would require a certain commitment from employers to firstly assist and support human resources and secondly ensure organisational survival.

4.3.2.1.2 Substance abuse

South Africa is emerging as one of the most lucrative countries for drug trafficking, substance abuse and the crime that typically follows (Maiden, 1999). The country has become a net exporter of cannabis, and a major trafficking centre for mandrax, concaine, heroin and LSD, which dominate the local market. It has been estimated that 70% of all mandrax produced in the world is consumed in South Africa (Maiden, 1999). As mentioned, employee assistance and health programmes started as a result of the intention of organisations to support and assist substance abusers. There has been lively debate amongst EAP practitioners and occupational social workers in South Africa as to what the “correct” percentage of substance abuse services should be in respect of problem identification in programme usage. At the beginning of many programmes the percentage was over 50%, but over time this dropped to 20% or lower (du Plessis, 1999).

The need exists for some form of assistance in this regard for many South Africans in general and the workplace is a practical arena for such support. The amount of time spent on any particular problem will very much depend on the needs of the specific group

of individuals and organisations should systematically ascertain these needs (Berridge & Cooper, 1994). Each EAP will be developed and managed according to the culture of the organisation and the goals and objectives to be achieved.

4.3.2.1.3 Transformation and diversity in organisations

Change is rampant in many organisations today, and will continue. According to Miller (1995) wellness interventions can assist in identifying the changes, helping people to understand how these changes affect them, and assisting them to cope with the related pressures associated with these changes. The ecological perspective, or spill over effect, views the individual as being in continuous transaction with the environment, and this person-environment transaction has significant implications for the professional intervention (Mkhize, 1999). The ecological perspective adds value to transformation programs in that it provides insight that goes beyond the workplace and EAP practitioners have the skills and knowledge to support and assist such processes (Mkhize, 1999). Mkhize (1999) further highlights that the EAP practitioner could facilitate and enhance the process of gaining insight into interpersonal transactions, specifically for designated groups (blacks and women), as well as create acceptance and group cohesion among a diverse workforce. Alker and McHugh (2000) motivate in their research that the rationale for implementing wellness interventions is in most companies to underwrite change and transformational processes as well as put new working practices into place.

According to Berridge & Cooper (1994) what is distinctive about the EAP is the fact that, being more or less deeply embedded into the organisational processes of the firm, it becomes part of the organisational discourse, it reflects and nourishes the organisational culture and it becomes part of the organisational learning, problem solving and adaptation mechanisms. Wellness should facilitate the functioning of the organisation's human resources in respect of assisting in maintaining the survival of the organisation over time. In South Africa this is of prominent importance, especially in the light of the various developments and changes of the past and of those anticipated for the future.

4.4 Wellness Model for South Africa

The following systems model of wellness (Fig 6) has been developed as a guide to understand the current functional classification of wellness in South Africa as well as indicating the processes inherent in attaining wellness. The model draws on the status of this notion as presently experienced.

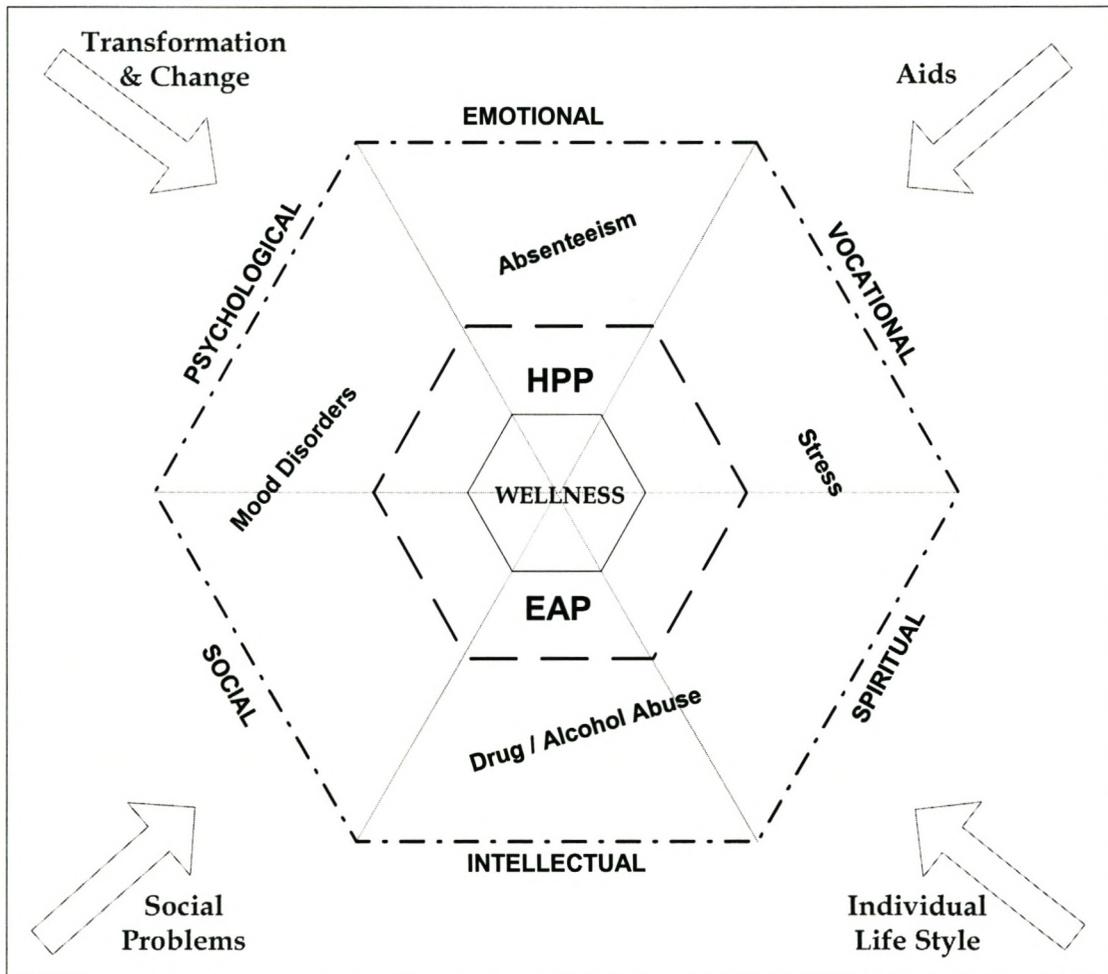
The wellness model is based on the conceptual view of wellness as a six dimensional paradigm involving physical, emotional, mental, social, occupational and spiritual dimensions in a systems perspective (Hettler, cited in Benjamin & Looby, 1998, p.92). The model aims at presenting the theory of wellness as broadly explained in Chapter 2, but with the practical application specific to the South African context.

Certain factors or elements have been identified which may have a potential effect on the wellness of the individual and may create an imbalance in the makeup of that individual. These factors are individual lifestyle, social problems, Aids, transformation and change, which are presented on the outside of the hexagon in Fig 6. As pointed out in Chapter 2, an imbalance is created once one or more of the dimensions are disrupted from its normal state of functioning.

Once this imbalance exists, the individual may revert to certain measures of coping, or the imbalance may manifest itself through certain behaviours. The most common behaviours that may occur are drug or alcohol abuse, stress, emotional or mood disorders and absenteeism. For the organisation the consequence of these behaviours is a lower productivity level.

In order to regulate the imbalance and ascertain wellness again, particular measures can be implemented. These include the most popular wellness interventions, namely Health Promotion Programmes (HPP) and Employee Assistance Programmes (EAP) as shown in Fig 6.

Fig 6: A Systems model of wellness in South African organisations



4.5 Conclusion

This chapter focuses on the reasons why wellness programmes would be of an advantage to employers in South African organisations. The greatest factor, which demands action to be taken, is productivity. All the various elements touched on in this chapter affect the productivity levels of employees in various degrees and productivity again is connected to a range of other organisational issues. The South African government and other welfare agencies are not able to completely assist in this regard, and it will be up to industry to ensure that these issues are dealt with effectively to provide genuine results for future survival.

5 CHAPTER 5: RESEARCH METHODOLOGY

5.1 Introduction

While decision makers have come a long way in accepting the social responsibility of looking after employees and its subsequent impact on global business, the scanning of research literature has proven that few studies have been conducted on wellness interventions in South Africa.

This chapter focuses on the research methodology applied in this study in order to attain certain objectives. These objectives are 1) to establish the extent of wellness programmes in a sample of South African organisations; 2) to ascertain how organisations structure, develop and manage these programmes; 3) to investigate attitudes and perceptions towards the implementation of wellness programmes; and 4) to develop a model of wellness for future use.

The study is investigative in nature and supported by the literature available in this field as well as specific research conducted in the early 1990's by Lourens S Terblanche on the status and art of employee assistance services in South Africa at the time. Terblanche (1992) based his research on the standards of EAPs as compiled by American organisations: National Council on Alcoholism; Occupational Program Consultants Association; National Institute on Alcohol Abuse and Alcoholism; US office of Personnel Management and the American Federation of Labor and Congress of Industrial Organisations.

This research can be seen as a study, which will provide information on the conceptual sophistication of wellness programmes, their focus as well as the attitudes of participants to such programmes in South African organisations. These results will extend into the development of a systems model of wellness for the South African organisation.

5.2 Research design

For the purpose of this study, which is investigative in nature and therefore has no hypothesis, a non-experimental design, namely the correlational design was used, (Huysamen, 1994). In this type of design a single group of subjects are obtained, each

individual in the group is measured on two or more variables at about more or less the same point in time, and the relationship(s) between these variables are analysed. According to Huysamen (1994) data collected in such designs do not necessarily have to be analysed by means of correlational techniques.

The group of participants were measured on various variables related to the objectives of the study. No criterion groups were assigned in this study, since it is also an important aspect of the research to identify those participants who do not have any form of wellness interventions in operation in their organisations. This would further provide information on the difference between the attitude statements of participants with operational wellness interventions versus those participants with no interventions in place.

5.3 Sample

The sample drawn for this study was done randomly from a database of organisations listed with the Johannesburg Stock Exchange and the Durban Chamber of Commerce. The questionnaire was sent via electronic mail and post to 450 different organisations. In total 58 (12.88%) questionnaires were received of which 29 (50%) completed the entire questionnaire and 29 (50%) completed the attitude statement section. This further implies that 50% of participants have a form of wellness programmes operational in their organisation and 50% of participants do not have any wellness programmes implemented in their organisation.

5.4 Measuring instruments

For the purpose of this study, a survey questionnaire (Appendix A) was used. The questionnaire is divided into three sections, namely Demographic Information, Design and Structure of Wellness Programmes and an Attitude Scale.

5.4.1 Demographic information

Section one focus on demographic information of the participant as well as the organisation. There are five close-ended questions in this section, which aims at identifying the type of wellness interventions in the organisation, if any, as well as the

level of operation in the organisation with regards to size and usage of the programmes over the last 12 months.

This section is important in order to establish which participants have wellness programmes in place and further to distinguish between having EAP's or HPP's or both programmes operational in the organisations of the participants.

5.4.2 Design and structure of wellness programmes

Section two, question one, incorporate questions on the design and structure of wellness programmes in organisations. These questions are close-ended questions where participants choose various options for each question applicable to their particular organisation. There are nine questions in this section. Structure of Programmes refers to the design of wellness programmes and how the programmes are planned and structured in terms of models and services. Management of Programmes focuses on how organisations manage these interventions and their maintenance. Outcomes of Programmes relates to the results achieved and the evaluation and assessment of wellness interventions.

The dimensions measured in this section are as follows:

Table 11: Sub dimensions: Section 2, Question 1

Dimension	Questions
Structure of Programmes	1.1; 1.2; 1.3; 1.4; 1.6; 1.9
Management of Programmes	1.7; 1.8
Outcomes of programmes	1.9

Question two in this section is an extension of the investigation into the structure and design of wellness programmes, but provide a Yes, No and Not Applicable option for participants to indicate their answers. The dimensions in this section are Structure of Programmes as explained above. Human Resource Department refers to the scope of the involvement of Human Resource specialists in wellness in the organisation and the

interface between the various Human Resource systems and Wellness as one of these systems. Wellness Committee is a structural component, however it is necessary to evaluate the existence and operation of this component in particular, therefore the inclusion of specific items in the questionnaire. The dimension Evaluation of Interventions is directly related to assessment of programmes and outcomes as elaborated on above. Training refers to education as well as orientation of employees and management on the functioning of the wellness programmes in the particular organisation as well as the objectives and reasons for the implementation thereof. Policy is also a component such as committee, which relates to the structure of the wellness programmes in the organisation, but requires specific exploration due to its influence on the structural sophistication of the wellness programmes.

Table 12: Sub dimensions: Section 2, Question 2

Dimension	Questions
Structure of Programmes	2.1; 2.10; 2.11; 2.13; 2.14; 2.15; 2.18; 2.22
Human Resource Department	2.16; 2.17; 2.19; 2.20
Wellness Committee	2.2; 2.3; 2.4; 2.7
Evaluation	2.5; 2.6; 2.21
Training	2.8
Policy	2.9; 2.12

Items in this section can be described as direct and closed statements. Thus, participants are forced to provide answers within a previously established framework. According to Oppenheim (1992), the closed questions can ensure the comparison of the results of different individuals. It further ensures that all the participants consider the same options and scenarios, which is advantageous to the reliability of this section.

5.4.3 Attitude Scale

Section three is a Likert type attitude scale, which measures the attitude of participants towards various aspects and elements of organisational wellness and such programmes. This section consists of seventeen items, which ranged from strongly disagree to strongly agree. There are five possible answers for each statement: strongly disagree, disagree, undecided, agree and strongly agree. The maximum value that can be scored on an item is 5, while the minimum is 1.

Table 13: Scoring of Likert type attitude scale

This consists of five options as follows:

Strongly Disagree = 5	Strongly Agree = 2
Disagree = 4	Agree = 1
Undecided = 3	

This section was included to measure the feelings of participants towards the various statements with regards to the need and value of wellness programmes. It was further included to measure the difference in attitude, if any, between those participants who have wellness programmes in operation in their organisation versus those participants who do not have such programmes implemented.

The dimensions in this section are set out as below. Employee problems at work focus on the attitude of participants towards the extent of problems experienced in their organisations as well as whether such problems should be addressed at the workplace. Benefits to Company measures the perceived value of wellness programmes for organisations. The dimension Time Involvement further probes into the attitude of participants to wellness at work. It specifically measures perception on time available to deal with the wellness programme requirements from a management and Human Resource perspective. Use of Programmes refers to whether employees would make use of these programmes and services if available as well as the perception on which levels of employees would be more prone to utilising the services provided. The dimension

Complexity of Programmes measures the attitude or perception of participants on the complexity of the implementation, operation and maintenance of wellness programmes.

Table 14: Sub dimensions for Section 3

Dimension	Questions
Employee problems at work	1.1; 1.2; 1.3
Benefits to Company	1.4; 1.5; 1.16
Time Involvement	1.6; 1.7
Use of Programmes	1.8; 1.9; 1.14; 1.15
Complexity of Programmes	1.10; 1.17
Structure of Programmes	1.11; 1.12; 1.13

5.5 Statistical measurements

Frequency tables are presented in the research to indicate the distribution of responses. Various statistical concepts and measures are used to carry out this objective. What follows is an explanation of these measures and how they relate to the study.

The mean is a measure of central tendency that uses all the data obtained to provide a single, most representative score to characterise the performance of an entire group (Anastasi & Urbina, 1997). The mean is also utilised for this purpose in the study.

Pearson's Product-Moment Correlation Coefficient is utilised in the establishment of correlations between various items as well as dimension within sections. These are discussed in more detail in Chapter 6. According to Anastasi & Urbina (1997), the Correlation Coefficient expresses the degree of correspondence, or relationship, between two sets of scores. The Pearson Product-Movement Correlation Coefficient takes into account not only the position of the scores in the group but also the amount of deviation above or below the mean.

The standard deviation indicates the spread of data across a distribution (Underhill & Bradfield, 1998). It is for this purpose that the standard deviation is used in the study and the subsequent results are explained in Chapter 6.

5.6 Reliability and validity

Reliability refers to the consistency of scores obtained by the same persons when they are re-examined with the same test on different occasions or with different sets of equivalent items or under other variable examining conditions (Anastasi & Urbina, 1997). The internal consistency of items of two sections, Section 2, Question 2 and Section 3, of the questionnaire was measured. In order to compute this form of reliability, the Kuder Richardson Reliability measure and Cronbach's Coefficient Alpha were used. The results are discussed in Chapter 6.

Validity is an indication of what a test measures and how well it does so (Anastasi & Urbina, 1997). In order to establish the validity of the questionnaire, factor analysis was conducted. The purpose for this measurement is to firstly reduce the number of factors in the questionnaire. A second, important reason for the factor analysis is to verify and confirm the sub dimensions as identified for each section of the questionnaire. The results of the factor analysis are presented in Chapter 6.

5.7 Pilot study

Since the Organisational Wellness Questionnaire has been newly developed a pilot study was conducted with professionals in business environment. This was done in order to assist the researcher in refining the questionnaire. The feedback presented valuable information, which led to changes being made to the language as well as some of the items of the questionnaire.

5.8 Conclusion

This chapter deals with the way the data used for this study was collected and compiled for the research purposes as outlined. The various sections of the questionnaire used are described to further the understanding of this research and the objectives of the study.

The processes of collection as well as the sample of participants were also outlined. The next chapter will describe and present the results obtained through the questionnaire.

6 CHAPTER 6: RESEARCH RESULTS AND INTERPRETATION

6.1 Introduction

The purpose of this study is to investigate the conceptual sophistication of wellness programmes and interventions in South African organisations, which refers to the structuring and developmental practices applied. The methodology utilised in order to achieve this objective was described in chapter five. This chapter focuses on the results obtained in the study and further reports as such in order to attend to the abovementioned objective.

The questionnaire used for the collection of the data was explained and described in the previous chapter and as indicated was specifically developed for the purposes of this study based on the literature in this field as well as previous studies of similar nature conducted in South Africa.

The descriptive statistics pertaining to the various sections of the questionnaire will be discussed as well as the various correlations drawn among sub dimensions in the questionnaire as described in the previous chapter.

6.2 Reliability of questionnaire

The inter-item reliability of Section 2, Question 2 and Section 3 of the questionnaire was measured through the application of Coefficient Alpha. Cronbach's Coefficient Alpha is a measure of the internal consistency of a questionnaire (Huysamen, 1994). A high internal consistency implies a high degree of generalisability across the items within the test (Huysamen, 1994).

Section 2, Question 2 consists of 21 items and a total of 31 responses were received for this question. The reliability score for this question is 0.8395. This value indicates a high degree of internal consistency. The results of this item analysis are shown in Table 15.

Section 3 consists of 17 items and a total of 57 responses were received for this section. The reliability score for this question is 0.6334, which indicate a moderate degree of internal consistency. The results of this item analysis are shown in Table 16.

Table 15: Results of the item analysis of Section 2, Question 2

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Alpha if Item Deleted
Q103	30.2581	36.1312	.4310	.8318
Q104	30.3548	36.6366	.4459	.8317
Q105	29.9032	33.8237	.4011	.8377
Q106	30.6129	37.1785	.3782	.8342
Q107	30.5806	34.1183	.6531	.8211
Q108	30.3548	34.1032	.5494	.8256
Q109	30.2903	33.0129	.7458	.8155
Q110	30.2581	35.3312	.4521	.8308
Q111	30.4839	36.0581	.5402	.8283
Q112	30.3548	36.6366	.3867	.8337
Q113	30.4194	37.1849	.3002	.8371
Q114	30.6129	36.9785	.3534	.8349
Q115	30.6774	35.3591	.6494	.8241
Q116	30.7742	36.4473	.4557	.8312
Q117	30.7742	40.0473	-.1250	.8476
Q118	30.4839	36.4581	.3289	.8366
Q119	30.2581	35.2645	.5039	.8283
Q120	30.1613	37.0731	.3237	.8361
Q121	30.2581	39.1978	.0156	.8473
Q122	30.3226	38.7591	.0755	.8455
Q123	30.5161	34.4581	.6525	.8218

Reliability Coefficients

N of Cases = 31.0

N of Items = 21

Alpha = .8395

Table 16: Results of the reliability analysis of Section 3

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Alpha if Item Deleted
Q130	46.6316	37.3083	.3679	.5975
Q131	47.1053	37.3102	.5226	.5798
Q132	46.8246	36.7544	.4477	.5848
Q133	46.8596	37.4442	.4674	.5854
Q134	46.1930	37.5514	.4358	.5892
Q135	46.8947	41.3102	.1599	.6303
Q136	46.6667	40.7262	.1825	.6278
Q137	45.9825	35.9461	.4265	.5855
Q138	46.2105	39.5263	.2520	.6175
Q139	46.6842	39.6128	.3749	.6030
Q140	45.3333	47.8333	-.3568	.6792
Q141	46.6667	39.2619	.3048	.6095
Q142	46.0702	39.6021	.3169	.6086
Q143	45.3509	47.5175	-.3893	.6714
Q144	46.6491	38.6961	.4394	.5938
Q145	46.0877	49.0815	-.4241	.6929
Q146	46.2807	40.9555	.2778	.6156

Reliability Coefficients

N of Cases = 57.0

N of Items = 17

Alpha = .6334

6.3 Validity of questionnaire

In order to establish the validity of certain sections of the questionnaire a factory analysis was done to confirm that the items relate to the sub-dimensions as indicated in Chapter 5 (confirmatory factor analysis). For Section 2, the factor analysis determined six sub-dimensions/components, which contribute to 76.689% of total variance. Table 17 indicates the Total Variance Explained. To determine the items that fall within a certain component, a Rotated Matrix was done.

As indicated in Table 18, from the rotated matrix for Section 2, Question 2, Q107, Q108, Q109, Q112, Q113, Q115 group together to form Component 1 which relates to Structure of programmes. In order to form Component 2, HR Department, Q103, Q104, Q105, Q109 is group together. Component 3, Committee is made up of Q110, Q114, Q115, Q120. Component 4, Evaluation constitutes Q107, Q111, Q119, Q122, and Q123. Component 5 constitutes Q108, Q116, Q118 and Component 6 is made up of Q106, Q110 and Q113.

In Section 3, 75.289% of the variance is explained by six sub-dimensions/components as indicated by Table 19, which indicates the Total Variance Explained.

Table 20 indicates the rotated matrix for Section 3. Component 1, Problems at work is made up of Q133, Q135, Q136, and Q139. Component 2, Benefits to company is made up of Q130, Q131, Q132 and Q144. Component 3, Time involvement, constitutes Q 134, Q137, Q138 and Q146. Component 4, Use of programmes is made up of Q141, Q142 and Q146. Q 132 and Q133 group together to form Component 5, which is Complexity of programmes and finally Q143 indicates Component 6 namely Structure.

Table 17: Total variance explained for Section 2, Question 2

Total Variance Explained

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.937	28.270	28.270	3.191	15.194	15.194
2	3.173	15.111	43.381	3.138	14.944	30.133
3	2.580	12.288	55.669	2.816	13.407	43.545
4	2.002	9.534	65.202	2.601	12.388	55.933
5	1.277	6.083	71.285	2.380	11.335	67.263
6	1.135	5.404	76.689	1.978	9.421	76.689
7	.836	3.979	80.668			
8	.774	3.686	84.355			
9	.655	3.118	87.472			
10	.542	2.580	90.052			
11	.440	2.097	92.149			
12	.359	1.708	93.857			
13	.328	1.561	95.418			
14	.247	1.176	96.594			
15	.207	.987	97.581			
16	.153	.730	98.311			
17	.124	.591	98.902			
18	.105	.502	99.404			
19	6.865E-02	.327	99.731			
20	4.420E-02	.210	99.941			
21	1.236E-02	5.888E-02	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix^a

a. 6 components extracted.

Table 18: Rotated component matrix for Section 2, Question 2

Rotated Component Matrix^a

	Component					
	1	2	3	4	5	6
Q103	.082	.745	.304	.172	.235	-.229
Q104	.001	.896	.002	.059	-.097	.297
Q105	.034	.929	.099	.154	-.106	.089
Q106	.158	.092	-.230	.045	.179	.837
Q107	.637	.041	.352	.553	.238	-.090
Q108	.626	-.108	-.022	.169	.409	.340
Q109	.622	.502	-.128	.185	.393	.023
Q110	.189	.170	.414	.174	-.022	.729
Q111	-.072	.395	.044	.676	.251	.153
Q112	.878	-.013	-.129	-.108	-.067	.163
Q113	.587	-.002	-.224	.048	-.337	.545
Q114	.328	.238	.426	.037	.185	-.035
Q115	.603	.139	.445	.159	.349	.231
Q116	.291	-.065	.292	.178	.762	.082
Q117	.258	-.193	-.656	-.302	.022	.168
Q118	-.007	.022	.059	.177	.857	-.001
Q119	-.009	.025	-.018	.799	.344	.174
Q120	.034	.215	.644	.240	.234	-.019
Q121	-.011	.245	-.754	.173	-.110	-.009
Q122	.136	-.306	-.620	.466	.168	-.086
Q123	.418	.374	.123	.742	-.164	-.009

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 9 iterations.

Table 19: Total variance explained for Section 3

Total Variance Explained

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.580	26.940	26.940	2.986	17.563	17.563
2	2.938	17.283	44.224	2.546	14.977	32.541
3	1.800	10.589	54.813	2.485	14.619	47.160
4	1.472	8.658	63.471	1.801	10.593	57.753
5	1.055	6.209	69.680	1.553	9.138	66.890
6	.952	5.601	75.281	1.426	8.391	75.281
7	.785	4.618	79.899			
8	.585	3.441	83.340			
9	.561	3.298	86.638			
10	.524	3.082	89.720			
11	.408	2.397	92.117			
12	.336	1.978	94.095			
13	.312	1.838	95.933			
14	.249	1.465	97.398			
15	.197	1.157	98.555			
16	.136	.798	99.353			
17	.110	.647	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix^a

a. 6 components extracted.

Table 20: Rotated component matrix for Section 3

Rotated Component Matrix^a

	Component					
	1	2	3	4	5	6
Q130	.031	.885	.165	-.042	.010	.034
Q131	.071	.877	.171	.109	.051	-.165
Q132	.112	.464	.370	.141	.447	.224
Q133	.648	.192	.033	.231	.519	-.009
Q134	.045	.094	.903	-.028	-.031	.064
Q135	.881	-.046	-.026	-.066	-.081	-.134
Q136	.817	-.022	-.100	.023	.133	.018
Q137	-.130	.162	.813	.050	.236	-.071
Q138	-.210	.103	.752	.012	-.175	-.291
Q139	.721	.150	-.010	.210	.173	.007
Q140	-.188	-.022	.022	-.092	-.848	.281
Q141	.016	.160	-.060	.780	.323	-.035
Q142	.114	.018	.073	.867	-.059	-.078
Q143	-.088	-.211	-.135	-.059	-.221	.818
Q144	.277	.547	-.065	.326	.245	-.381
Q145	-.594	-.450	.162	-.023	-.020	.273
Q146	.186	-.313	.425	.427	-.053	-.510

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 8 iterations.

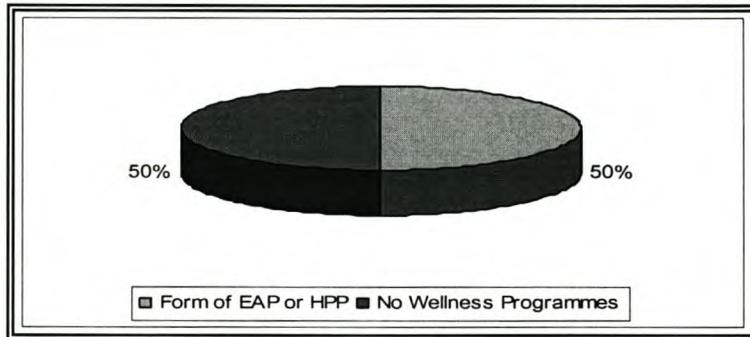
6.4 Descriptive statistics of questionnaire

The descriptive statistics of the Questionnaire will now be discussed. As indicated, the purpose of the study is to analyse and report on the critical factors related to the development and structuring of wellness programmes in South African organisations.

6.4.1 Distribution of wellness programmes among participants

In total 58 individuals participated in the study of which 29 (50%) had a form of wellness programme in operation in their respective organisations and 29 (50%) did not have any form of wellness programmes in operation in their respective organisations.

Fig 7: Distribution of wellness programmes



6.4.2 Amount of employees employed

Most of the companies that responded to the questionnaire and who also have wellness programmes implemented employ more than 500 employees (27.6%).

Table 21: Amount of employees employed

	Frequency	Percent	Valid Percent	Cumulative Percent
0-100	5.00	8.60	16.10	16.10
101-200	4.00	6.90	12.90	29.00
201-300	1.00	1.70	3.20	32.30
301-400	1.00	1.70	3.20	35.50
401-500	4.00	6.90	12.90	48.40
500 and above	16.00	27.60	51.60	100.00
Total	31.00	53.40	100.00	

6.4.3 Availability of wellness programmes

All companies with wellness programmes implemented made them available to all their employees.

Table 22: Availability of wellness programmes to staff.

	Frequency	Percent	Valid Percent	Cumulative Percent
All staff	29.00	50.00	100.00	100.00
Directors/Executives				
Managers				
Supervisors				
General staff				
Total	29.00	50.00	100.00	

6.4.4 Reasons for implementing wellness programmes

The main reasons for organisations implementing wellness programmes are for increased productivity (58.62%), social responsibility (58.62%) and HR strategy (65.52%).

Table 23: Reasons for implementing wellness programmes

	Frequency	Percent	Valid Percent	Cumulative Percent
Increased productivity	17.00	58.62	100.00	100.00
Total	17.00	58.62	100.00	

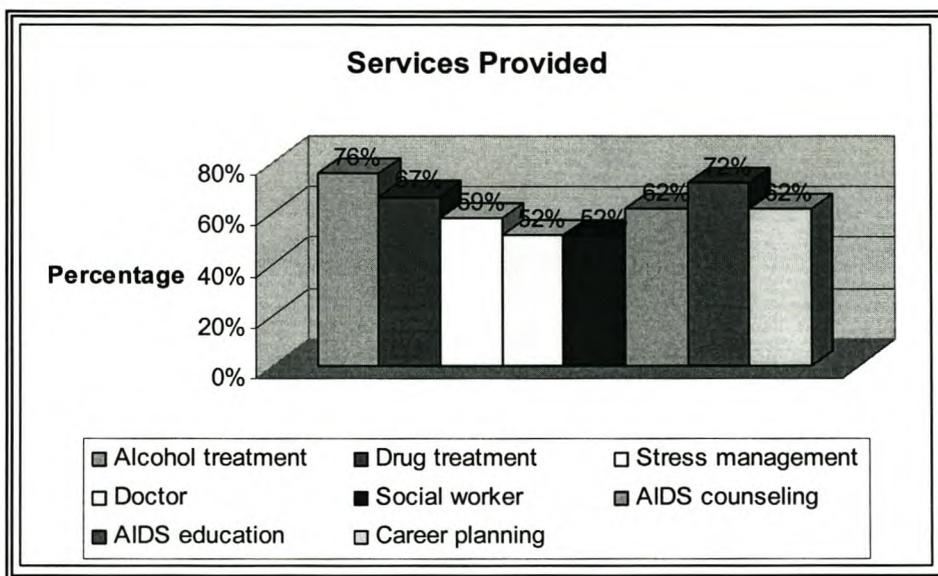
	Frequency	Percent	Valid Percent	Cumulative Percent
Social responsibility	17.00	58.62	100.00	100.00
Total	17.00	58.62	100.00	

	Frequency	Percent	Valid Percent	Cumulative Percent
Human Resource Strategy	19.00	65.52	100.00	100.00
Total	19.00	65.52	100.00	

6.4.5 Types of Services

As shown in Fig 8, the services mostly provided for in organisations with wellness programmes are alcohol treatment (76%); drug treatment (67%); stress management (58.6%); the availability of a doctor (51.73%); the availability of a social worker (51.73%); AIDS counselling (62%); AIDS education (72.4%), career planning (62%). Alcohol treatment is the most popular service provided to staff and AIDS education is the second most popular service provided.

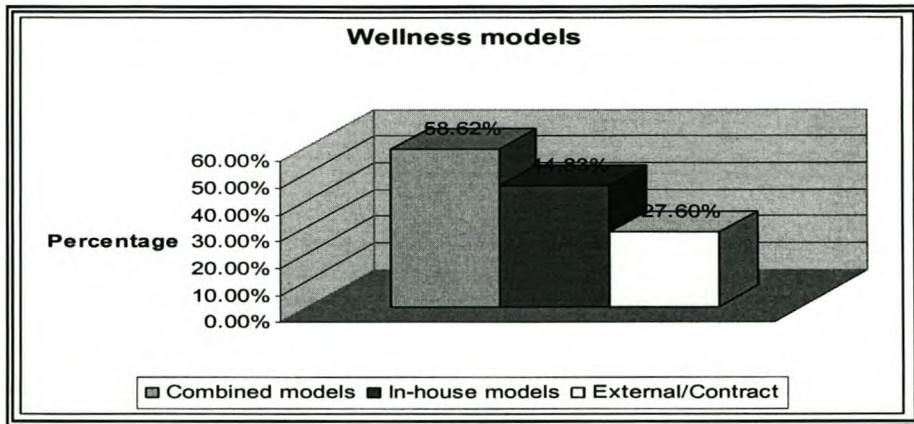
Fig 8: Services provided



6.4.6 Wellness programme models

The combined form of wellness programme is most found among the participants with wellness programmes implemented in their organisations (58.62%). Combined refers to providing services in-house as well as through external providers. In-house developed wellness programmes are also popular (44.83%) among the participants with wellness programmes.

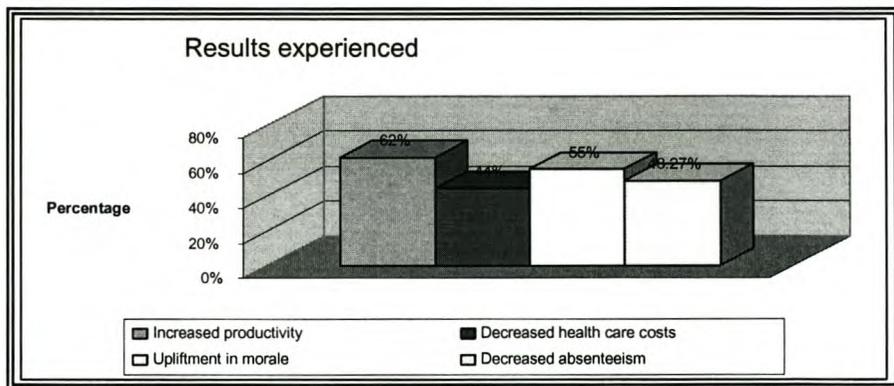
Fig 9: Wellness models



6.4.7 Results experienced as a result of wellness programmes

Five factors were indicated as results experienced by organisations that have wellness programmes implemented. These are: increased productivity (62%); decreased health care costs (44.83%); upliftment of morale (55%); decreased absenteeism (48.27%); increased job satisfaction (41.38%).

Fig 10: Results experienced

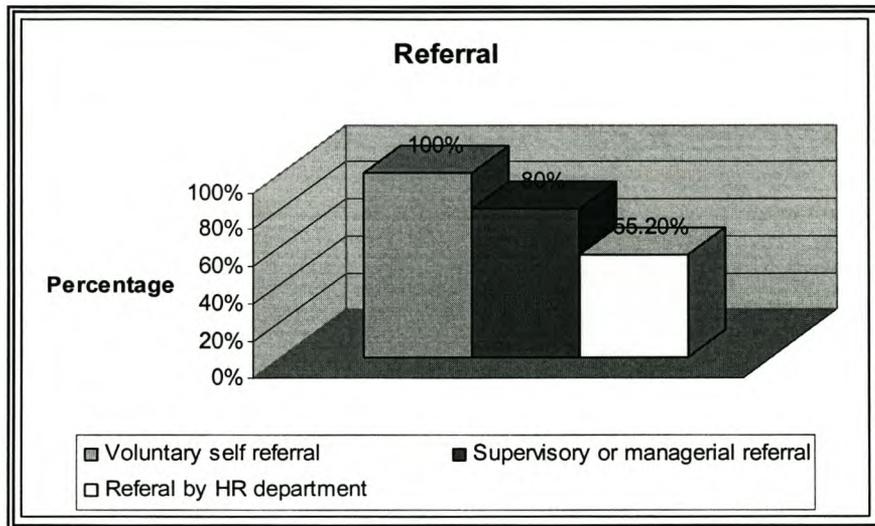


6.4.8 Methods of referral

The methods for referral of employees to the various services provided by organisations focused primarily on voluntary self-referral; supervisory or managerial referral and

referral by the Human resource department. All participants indicated that self-referral is promoted in their organisations. 80% of participants allow for supervisor and/or managerial referral and 55% allow for referral by the Human Resource Department.

Fig 11: Referral to wellness programmes and services



6.4.9 Training

Training provided to managers and supervisors in those organisations with wellness programmes implemented, focus on the functioning of the wellness programmes implemented (48.25%); referral of employees (48.25%) and awareness training with regards to the advantages of employee wellness (51.72%). Results are shown in Table 24.

Table 24: Training provided

	Frequency	Percent	Valid Percent	Cumulative Percent
Advantages of Programmes	15.00	51.72	100.00	100.00
Total	15.00	51.72	100.00	

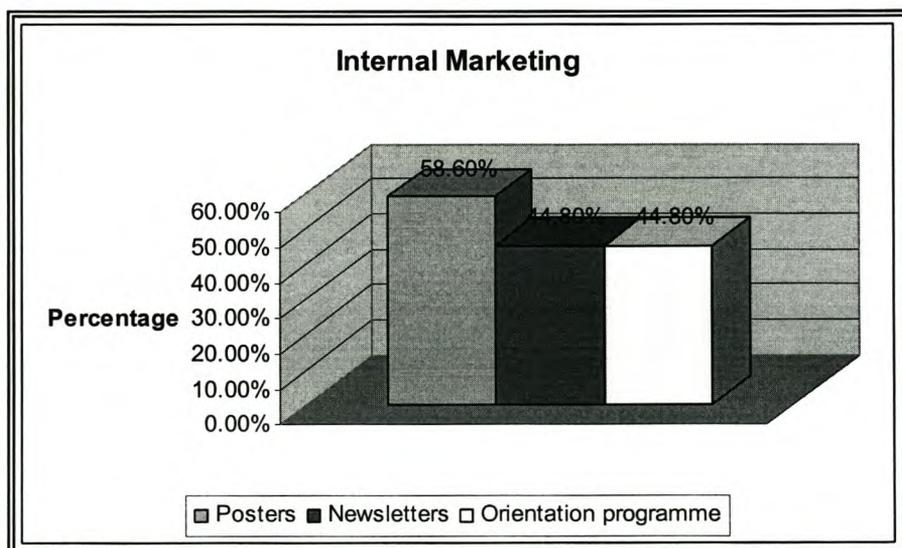
	Frequency	Percent	Valid Percent	Cumulative Percent
Functioning of Programmes	14.00	48.28	100.00	100.00
Total	14.00	48.28	100.00	

	Frequency	Percent	Valid Percent	Cumulative Percent
Referral of employees	14.00	48.28	100.00	100.00
Total	14.00	48.28	100.00	

6.4.10 Internal marketing of programmes

As described in Fig 12, 58.6% of organisations with wellness programmes implemented make use of posters to market the various wellness services; 44.8% make use of newsletters as well as orientation programmes.

Fig 12: Internal marketing



6.4.11 Aftercare service

As indicated in Table 25, 55% of organisations with wellness programmes implemented provide continued support to employees. The professional staff of the wellness programmes mainly provides this support. The table further shows that 31% of organisations with wellness programmes do not provide any form of after care support services.

Table 25: Aftercare support

	Frequency	Percent	Valid Percent	Cumulative Percent
No aftercare support	9	31.03	100	100
Total	9	31.03	100	

	Frequency	Percent	Valid Percent	Cumulative Percent
Professional aftercare service	16	55.17	100	100
Total	16	55.17	100	

6.4.12 Structure and design of wellness programmes

6.4.12.1 Needs analysis

As indicated by Table 26, more than half of organisations that participated in the study do not conduct a needs analysis before implementing wellness programmes. It is further indicated that 40.63% of organisations with functional wellness programmes do conduct a needs analysis before implementing such programmes and services.

Table 26: Needs analysis

	Frequency	Percent	Valid Percent	Cumulative Percent
No needs analysis	17	53.13	100	100
Total	17	53.13	100	

	Frequency	Percent	Valid Percent	Cumulative Percent
Conducts needs analysis	13	40.63	100	100
Total	13	40.63	100	

6.4.12.2 Committees

Majority of organisations with wellness programmes do not have a committee specifically assigned to such programmes (56%). There are however 44% of organisations that do have such committees functioning. All these participants further allow for employee representation on this committee.

6.4.12.3 Wellness co-ordinators

65.6% of those participants with wellness programmes in place have specifically assigned co-ordinators who deals primarily with the management and control of these interventions. The results are shown in Table 27.

Table 27: Wellness co-ordinators

	Frequency	Percent	Valid Percent	Cumulative Percent
Wellness co-ordinators	21	65.63	100	100
Total	21	65.63	100	

6.4.12.4 Feedback on wellness programmes

The majority of organisations with wellness programmes indicated that feedback about the programmes is provided to management (72%). Of those that provide feedback, 56% indicated that management utilises this information to make changes in the organisation.

6.4.12.5 Union involvement

With regards to the involvement of the labour union in the wellness programmes provided by the organisation, 47% of organisations with programmes indicated such involvement.

6.4.12.6 Wellness policy

The policy statement is a crucial component of wellness programmes, which provides the opportunity to stipulate specifics with regard to those aspects that need to be addressed. As indicated by Table 28 a small majority of employers (53%) indicated that they do have a formal written policy in place.

Table 28: Wellness policy

	Frequency	Percent	Valid Percent	Cumulative Percent
Formal written policy	17	53.13	100	100
Total	17	53.13	100	

6.4.12.7 Top management support

As with many organisational systems, support from top management is vital for successful operation of wellness programmes. As shown in Table 29 the majority of participants with wellness programmes in place (69%) indicated that there is clear top management support for these programmes.

Table 29: Top management support

	Frequency	Percent	Valid Percent	Cumulative Percent
Top management support	22	68.75	100	100
Total	22	68.75	100	

6.4.12.8 Record systems and confidentiality

In this study, a vast majority of participants with wellness programmes implemented (75%), indicated that they keep specific record systems. With regards to the confidentiality component of wellness programmes, 88% of participants specified that they take specific measures to ensure the confidentiality of employees as well as the information obtained during the utilisation of these programmes by such employees. The results are shown in Table 30.

Table 30: Record keeping

	Frequency	Percent	Valid Percent	Cumulative Percent
Keep records	24	75.00	100	100
Total	24	75.00	100	

	Frequency	Percent	Valid Percent	Cumulative Percent
Ensuring confidentiality	28	87.50	100	100
Total	28	87.50	100	

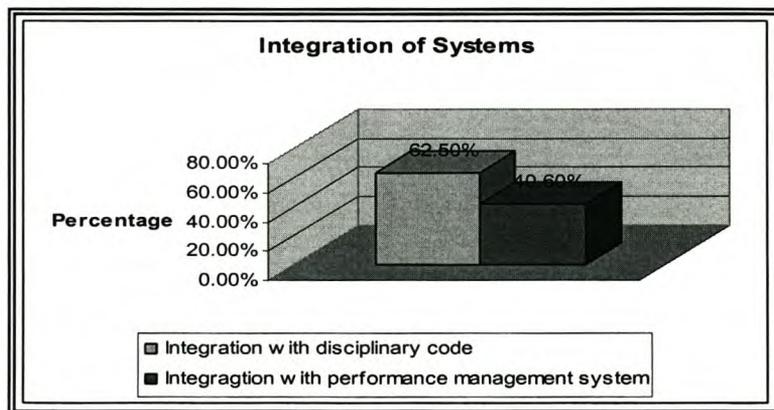
6.4.12.9 Individualised services

A significant amount of employers (81.3%) provide for individual needs employees may have, which is not catered for by the organisation’s wellness programmes.

6.4.12.10 Integration with other HR systems

Ensuring that wellness programmes are integrated with other employee related systems may enhance the effectiveness of such programmes. As shown in Fig 13, majority of employers (62.5%) with wellness programmes in their organisations indicated that there are integration between these programmes and services and the disciplinary procedures and codes of the organisation. 40.6% of these employers indicated that the performance management system of the organisation integrates with the wellness programme.

Fig 13: Integration of systems



6.4.12.11 Health insurance coverage

Only 34% of participants with wellness programmes in place provide health insurance coverage for long term treatments when required. 41% of participants indicated that the wellness programmes in their organisations fall under company benefits. The results are shown in Table 31.

Table 31: Health insurance

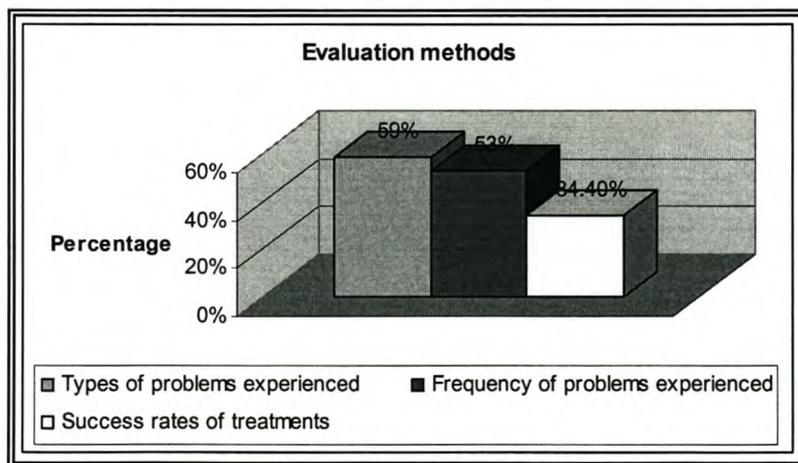
	Frequency	Percent	Valid Percent	Cumulative Percent
Health coverage	11	34.38	100	100
Total	11	34.38	100	

	Frequency	Percent	Valid Percent	Cumulative Percent
Company benefits	13	40.63	100	100
Total	13	40.63	100	

6.4.12.12 Evaluation of wellness programmes

The majority of participants with wellness programmes in place (64.5%) assess and evaluate the benefits of these programmes and services. As indicated by Fig 14, of the 64.5% of participants that conduct evaluation of their organisation’s wellness programmes, the most applied evaluation methods used by organisations are the frequency of problems experienced (53%); the types of problems experienced (59.4%) and the success rates of treatment or health services (34.4%).

Fig 14: Evaluation methods



6.5 Description of Sub dimensions

The following explanation relates to the sub dimensions of Section 2, Question 2 (Table 12) and Section 3 (Table 14), as set out in Chapter 5.

6.5.1 Section 2, Question 2

The mean for the dimension Structure of Programmes is 10.13, with a lower bound of 9.43 and upper bound of 10.82 at the 95% confidence interval. The dimension consists of 8 items. The maximum score for this dimension is 16 and the minimum is 7. The range is 9 and the standard deviation is 1.89. This indicates that the majority of respondents have the same regard for the items measuring this dimension and there is not a great spread of responses.

For the dimension Human Resource Department there are 4 items. The mean is 6.42 with a lower bound of 5.84 and upper bound of 7.00 at the 95% confidence interval. The maximum score for this dimension is 11, the minimum is 4, and the range is 7. The standard deviation is 1.59. It can be said that the majority of respondents felt the same about the items in this dimension.

The mean for the dimension Committee is 4.35, the lower bound is 5.82 and the upper bound is 7.34 at the 95% confidence interval. There are 4 items in this dimension. The maximum score for this dimension is 10, the minimum is 4 and the range is 6. The standard deviation is 2.06, which indicates a somewhat higher dispersion of scores.

There are 3 items for the dimension Evaluation. The mean is 4.35, the lower bound is 3.74 and the upper bound is 4.97 at the 95% confidence interval. The maximum score for the dimension is 8, the minimum is 3 with a range of 5. The standard deviation is 1.66. Again, the majority of respondents felt the same regarding the questions in this dimension.

The dimension Training consists of only one item and the mean in this case is 1.75 with 1.46 at the lower bound and 2.04 at the upper bound of the 95% confidence interval. The maximum for this item is 4, the minimum score is 1 and the range is 3. The standard deviation is 0.80. The mean fall within the lower and upper bound of the 95% confidence

interval indicating and the standard deviation is low, which indicates that the majority of respondents felt the same on this dimension.

The last dimension in this section is Policy with two items. The mean is 2.84, the lower bound is 2.53 and the upper bound is 3.16 at the 95% confidence interval. The minimum score for this dimension is 2 and the maximum is 5, with a range of 3. The standard deviation is 0.88, which indicates that majority of respondents had the same regard for the items in this dimension.

6.5.2 Section 3 – Attitude Scale

Section 3 of the questionnaire measures the attitude of participants on various statements regarding wellness and certain particular aspects thereof. There are six dimensions in this section as set out in Table 14. What follows is a discussion of the results obtained with regards to the various sub dimensions of Section 3 of the questionnaire.

For the dimension Problems at work, the mean is 7.28, with 6.54 at the lower bound and 8.02 at the upper bound of the 95% confidence interval. The dimension comprises of 3 items, the minimum score is 3 and the maximum is 12 with a range of 9. The standard deviation for this dimension is 2.80, which is somewhat higher and indicates a greater dispersion of scores. Respondents had more varied answers to the questions in this dimension. The majority of respondents (73.7%) indicate that the workplace could be considered as an avenue where employee problems can be addressed. However, half of respondents indicate that employees should not bring their problems to the workplace.

For the dimension Benefits to Company there are also 3 items. The minimum score is 4 and the maximum is 12 with a range of 8. The mean for this dimension is 8.70, the lower bound is 6.54 and the upper bound is 8.02 at the 95% confidence interval. The standard deviation is 1.53. Respondents seem to be divided over the benefits of wellness interventions for organisations. 31.6% indicated that wellness programmes do not provide monetary results and 36.2% indicated that these programmes do provide monetary results. The other respondents were unsure about the statement. Further under this dimension, 31% agree that they have experienced positive changes in productivity,

57.9% indicated that they are unsure about this aspect and 10.5% that they did not experience positive changes in productivity due to wellness interventions.

There are only 2 items in the dimension that measures Time Involvement. This dimension refers to the time spent due to their involvement, by various groups in the organisation on the wellness programmes. The mean of this dimension is 5.00, the lower bound is 4.48 and the upper bound is 5.52 at the 95% confidence interval. The minimum score for this dimension is 2 and the maximum is 10. The range is 8 and the standard deviation here is 1.95. The mean falls within the lower and upper bound of the 95% confidence interval, which indicates that most respondents felt the same about the items in the dimension. Majority of respondents (70.2%) felt that the Human Resource Department would have enough time to spend on employee wellness and assistance. 60% of respondents indicated that the supervisors and managers of the organisation have the time to spend on the wellness of their employees.

The dimension Use of Programme has 4 items and the mean is 12.93, with a lower bound of 12.34 and an upper bound of 13.52 at the 95% confidence interval. The minimum score on this dimension is 8 and the maximum is 17 with a range of 9. The standard deviation is 2.23, which indicates that the scores are more dispersed and respondents did not all feel the same about the items. This results in varying attitudes with regards to the use of wellness programmes in organisations. More than half of the respondents agree to varying degrees that lower level employees will make use of the wellness programmes implemented in organisations. 47% of respondents agreed that managerial employees would make use of such programmes if available.

The Complexity of Programmes dimension has only two items and the mean is 5.60, with a lower bound of 5.25 and an upper bound of 5.94 at the 95% confidence interval. The minimum score for this dimension is 2 and the maximum is 8 with a range of 6. The standard deviation is 1.31 and indicates that most respondents had a high perception for this dimension. More than half of respondents felt that the design and development of wellness programmes are not too complicated to implement. 23% were unsure whether wellness programmes are complex to implement. Majority of respondents (57%)

indicated that they are unsure about the difficulty or complexity of evaluating the progress or changes in the organisation or productivity brought by the implementation of wellness programmes. 24% agreed that they find it difficult to assess or evaluate such changes in the organisation.

The mean for the dimension Structure is 9.77 with a lower bound of 9.31 and an upper bound of 10.23. There are 3 items measuring this dimension. The minimum score would be 6 and the maximum 13, with a range of 7. The standard deviation is 1.73 and it can be said that respondents seem to have a similar perception towards this dimension. The majority of respondents (59%) indicated that ensuring and maintaining confidentiality would not pose a problem for organisations. 53.4% of respondents felt that employees would be concerned with the use of the information gained when making use of the various services of wellness programmes.

6.6 Correlation Matrix

Table 32 indicates the relationships between the six components identified for Section 2, Question 2. A positive correlation at the 0.01 level (2-tailed) is shown between the Structuring of programmes and the structural components of these programmes namely, Committee (0.569); Evaluation (0.768); Training (0.484) and Policy (0.458). A strong correlation is found specifically with the dimension of Evaluation (0.768). This indicates that respondents who had a high regard for structure of the programmes also have a high regard for evaluation as well as the other components as mentioned above. This correlation between Structuring of Programmes and the other mentioned components is significant in indicating the understanding of the practices of wellness in organisations and the manner of implementation of these programmes according to preferred practice.

A positive correlation which is significant at the 0.05 level (2-tailed) was further found between the role of the Human resource department and the Evaluation dimension (0.369). The Human Resource department usually partakes in the evaluation of employee related interventions.

As indicated by Table 32 there is positive correlations between organisations that have Committees operating as part of their wellness programmes and Evaluation (0.404);

Training (0.450) and the dimension of Policy (0.516). This correlation indicates components of structure and shows that organisations with committees in place is likely to also attend to other practices that are required to ensure proper implementation and functioning of wellness programmes.

The component Evaluation is found to have a positive relationship with the component Policy (0.510) at the 0.01 level of significance (2-tailed) and a positive relationship with the component Training (0.387) at the 0.05 level of significance (2-tailed). Organisations that evaluate their services and programmes are likely to have a policy and some training programmes in place. This again indicates practices that contribute to the efficient functioning of programmes and services.

In Table 33 the relationships between the components identified in Section 3 are indicated. A positive relationship between Problems at work and Use of programmes are shown (0.490) at the 0.01 level of significance (2-tailed). Participants who indicated that their employees have problems also indicated that they feel employees of the organisation will use the programmes.

Benefits to the company correlates positively at the 0.01 level of significance (2-tailed) with Use of programmes (0.563). This correlation is significant in indicating that respondents that felt that there are benefits to wellness programmes also indicated that the programmes will be used by the employees in their organization is provided. It is further found that Benefits to the company correlates with Complexity of the programmes (0.331) at the 0.05 level of significance (2-tailed).

A positive correlation was established between Time involvement and Complexity of programmes (0.447) at the 0.01 level of significance (2-tailed). Those respondents that felt that stakeholders would not have enough time to spend on wellness programmes also felt that these programmes are complex to implement and operate. Complexity of programmes was also found to have a positive correlation with Structure (0.266) at the 0.05 level of significance (2-tailed). This is a moderate correlation.

Very few correlations were found between the dimensions of Section 2, Question 2 and Section 3. As shown in Table 34, a positive correlation was found between Structure of programmes and Use of programmes (0.441) at the 0.05 level of significance (2-tailed).

This indicates that respondents that have a high regard for the structure of programmes also have a high regard for the use of such programmes. The other correlation found is between HR department and Problems at work, (0.368) also at the 0.05 level of significance (2-tailed). Those respondents that indicated that had a high regard for the items related to the HR department’s involvement and systems with regards to the wellness programmes also have a high regard for employees utilising these programmes if available.

Table 32: Correlation matrix of sub dimensions of Section 2, Question 2

		Correlations					
		Section Q2 Structure of programmes	Section 2 Q2 HR Dept	Section 2 Q2 Committee	Section 2 Q2 Evaluation	Section 2 Q2 Training	Section 2 Q2 Policy
Section Q2 Structure of programmes	Pearson Correlation	1.000	.192	.569**	.768**	.484**	.458**
	Sig. (2-tailed)	.	.300	.001	.000	.006	.010
	N	31	31	31	31	31	31
Section 2 Q2 HR Dept	Pearson Correlation	.192	1.000	.188	.396*	.006	.259
	Sig. (2-tailed)	.300	.	.311	.027	.975	.159
	N	31	31	31	31	31	31
Section 2 Q2 Committee	Pearson Correlation	.569**	.188	1.000	.404*	.450**	.516**
	Sig. (2-tailed)	.001	.311	.	.024	.010	.003
	N	31	31	32	31	32	32
Section 2 Q2 Evaluation	Pearson Correlation	.768**	.396*	.404*	1.000	.387*	.510**
	Sig. (2-tailed)	.000	.027	.024	.	.032	.003
	N	31	31	31	31	31	31
Section 2 Q2 Training	Pearson Correlation	.484**	.006	.450**	.387*	1.000	.488**
	Sig. (2-tailed)	.006	.975	.010	.032	.	.005
	N	31	31	32	31	32	32
Section 2 Q2 Policy	Pearson Correlation	.458**	.259	.516**	.510**	.488**	1.000
	Sig. (2-tailed)	.010	.159	.003	.003	.005	.
	N	31	31	32	31	32	32

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

Table 33: Correlation matrix of sub dimensions of Section 3

Correlations

		S3 Problems at work	S3 Benefits to Co	S3 Time involvement	S3 Use of programmes	S3 Complexity of programmes	S3 Structure
S3 Problems at work	Pearson Correlation	1.000	.257	.029	.490**	.109	.116
	Sig. (2-tailed)	.	.054	.828	.000	.418	.388
	N	57	57	57	57	57	57
S3 Benefits to Co	Pearson Correlation	.257	1.000	.054	.563**	.331*	.055
	Sig. (2-tailed)	.054	.	.692	.000	.012	.687
	N	57	57	57	57	57	57
S3 Time involvement	Pearson Correlation	.029	.054	1.000	-.127	.447**	-.005
	Sig. (2-tailed)	.828	.692	.	.346	.000	.969
	N	57	57	57	57	57	57
S3 Use of programmes	Pearson Correlation	.490**	.563**	-.127	1.000	.168	.153
	Sig. (2-tailed)	.000	.000	.346	.	.212	.255
	N	57	57	57	57	57	57
S3 Complexity of programmes	Pearson Correlation	.109	.331*	.447**	.168	1.000	.266*
	Sig. (2-tailed)	.418	.012	.000	.212	.	.045
	N	57	57	57	57	57	57
S3 Structure	Pearson Correlation	.116	.055	-.005	.153	.266*	1.000
	Sig. (2-tailed)	.388	.687	.969	.255	.045	.
	N	57	57	57	57	57	57

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

Table 34: Correlation matrix: dimensions of Section 2, Question 2 and Section 3

Correlations

		Section Q2 Structure of programmes	Section 2 Q2 HR Dept	Section 2 Q2 Committee	Section 2 Q2 Evaluation	Section 2 Q2 Training	Section 2 Q2 Policy
S3 Problems at work	Pearson Correlation	.273	.368*	-.071	.276	-.114	-.114
	Sig. (2-tailed)	.145	.045	.705	.140	.542	.541
	N	30	30	31	30	31	31
S3 Benefits to Co	Pearson Correlation	-.052	.034	-.204	-.148	-.114	-.252
	Sig. (2-tailed)	.784	.857	.272	.436	.542	.171
	N	30	30	31	30	31	31
S3 Time involvement	Pearson Correlation	.297	.042	.184	.302	.300	.273
	Sig. (2-tailed)	.111	.826	.323	.105	.101	.137
	N	30	30	31	30	31	31
S3 Use of programmes	Pearson Correlation	.411*	-.081	.054	.196	.168	-.216
	Sig. (2-tailed)	.024	.672	.772	.299	.367	.242
	N	30	30	31	30	31	31
S3 Complexity of programmes	Pearson Correlation	.302	.069	.280	.226	.052	-.001
	Sig. (2-tailed)	.105	.716	.127	.230	.782	.996
	N	30	30	31	30	31	31
S3 Structure	Pearson Correlation	-.068	-.291	.068	-.195	-.020	-.300
	Sig. (2-tailed)	.720	.119	.715	.302	.914	.101
	N	30	30	31	30	31	31

*. Correlation is significant at the 0.05 level (2-tailed).

6.7 Chi square Tests

In order to assess the different wellness structures and components of the various organisations that responded to the questionnaire, chi square tests were conducted in order to establish assorted relationships. Some of the significant relationships found in Section 2, Question 2 are as follows.

As indicated in Table 35, a significant relationship ($p=0.005$, 2-sided) was found between those respondents that evaluate and assess the wellness programmes in their organisations and those that provide management with feedback on these programmes. This indicates that those respondents who conduct evaluations also provide management with feedback on the effects of the programmes.

Table 35: Item 2.21 & Item 2.5

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.094 ^a	4	.005
Likelihood Ratio	16.180	4	.003
Linear-by-Linear Association	13.953	1	.000
N of Valid Cases	31		

a. 7 cells (77.8%) have expected count less than 5. The minimum expected count is .19.

A significant relationship ($p=0.00$) was also found between respondents with induction and/or training programmes in place and those with a written policy governing the operations of the organisational wellness programmes. This is presented in Table 36. Here every respondent who indicated that they have an induction and/or training programme in place also indicated that they have a policy in place that governs the operations of the wellness programmes. This may indicate progression towards the sophisticated structuring of wellness programmes in organisations.

Table 36: Item 2.9 & 2.8

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	35.098 ^a	6	.000
Likelihood Ratio	11.964	6	.063
Linear-by-Linear Association	5.580	1	.018
N of Valid Cases	32		

a. 8 cells (66.7%) have expected count less than 5. The minimum expected count is .03.

Majority of respondents who provide feedback on the effects of the wellness programmes to management also indicated that there is clear support from top management for these programmes. As shown in Table 37, a significant p value of 0.013 was found for this relationship.

Table 37: Item 2.12 & 2.5

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.080 ^a	6	.013
Likelihood Ratio	11.617	6	.071
Linear-by-Linear Association	4.553	1	.033
N of Valid Cases	32		

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .03.

Significant relationships in Section 3 include the following. A significant relationship ($p=0.003$), shown in Table 38, was found between respondents that felt wellness programmes provided monetary results and those who have experienced positive results in productivity. Respondents therefore had a high perception towards the outcomes and effects of wellness interventions.

Table 38: Item 1.16 & 1.5

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	42.000 ^a	20	.003
Likelihood Ratio	33.595	20	.029
Linear-by-Linear Association	.305	1	.581
N of Valid Cases	57		

a. 26 cells (86.7%) have expected count less than 5. The minimum expected count is .05.

As indicated in Table 39, a significant relationship ($p=0.00$) was found regarding the attitude of respondents towards which employees in the organisation would make use of the various services and interventions provided. Every respondent that felt that lower employees would make use of wellness programmes and services also felt that managerial employees would make use of such programmes.

Table 39: Item 1.8 & 1.9

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	69.831 ^a	16	.000
Likelihood Ratio	57.590	16	.000
Linear-by-Linear Association	15.529	1	.000
N of Valid Cases	57		

a. 23 cells (92.0%) have expected count less than 5. The minimum expected count is .42.

6.8 Attitudes of respondents with wellness programmes versus respondents with no wellness programmes

As indicated in the section on descriptive statistics, 50% of respondents have wellness programmes in operation in their organisation and 50% of respondents indicated that they do not have wellness programmes implemented. Statistical analysis was conducted on the responses of both these groups, those with wellness programmes in place versus those respondents who do not have these programmes in place, and their attitudes towards the various statements in Section 3 of the questionnaire. Significant relationships found at the 95% significance level, on the following statements.

As shown in Table 40, respondents with or without wellness programmes indicated a high perception ($p=0.011$) towards the statement that the employees in their organisations do not have problems that justify the implementation of wellness programmes or employee assistance programmes. 56.1% of respondents of both groups indicated agreement with this statement.

Table 40: Item 1.3

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.087 ^a	3	.011
Likelihood Ratio	13.898	3	.003
Linear-by-Linear Association	3.803	1	.051
N of Valid Cases	57		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.32.

A significant relationship ($p=0.010$) was found between both groups on the statement that EAPs are too costly for the value that it contributes to the organisation. Table 41 displays these results. 45.6% indicated that they do not agree to varying degrees with this statement.

Table 41: Item 1.4

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.263 ^a	4	.010
Likelihood Ratio	17.561	4	.002
Linear-by-Linear Association	10.159	1	.001
N of Valid Cases	57		

a. 5 cells (50.0%) have expected count less than 5. The minimum expected count is .47.

As shown in Table 42, a significant p value of 0.032 was found indicating that 54.4% of both groups felt that the Human Resource department in their various organisations has enough time to spend on employee wellness and assistance.

Table 42: Item 1.6

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.563 ^a	4	.032
Likelihood Ratio	11.587	4	.021
Linear-by-Linear Association	10.137	1	.001
N of Valid Cases	57		

a. 6 cells (60.0%) have expected count less than 5. The minimum expected count is .47.

A further significant relationship ($p=0.025$), Table 43, was found between the two groups on the statement that the design and implementation of wellness programmes are not too complicated to conduct. This represents 50.9% of the scores of the two groups.

Table 43: Item 1.10

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.353 ^a	3	.025
Likelihood Ratio	10.679	3	.014
Linear-by-Linear Association	8.825	1	.003
N of Valid Cases	57		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.42.

6.9 Conclusion

Organisational wellness programmes are increasing in South Africa. These programmes may not yet be as sophisticated as in other developed countries, but will certainly contribute to the advancement of the quality of work life for employees in organisations where these are properly implemented. As indicated, advantages for the organisation are certainly inherent in the productive functioning of these programmes and could only become more vital for surviving over time. It is important that the dual benefits of

wellness programmes to both employer and employee are never left out when considering such interventions.

South African organisations may need to be educated and provided with more information on the concept of wellness and its practical application in their business. What is important though is that decision makers address the issue of employee wellness even in its simplest application to begin the movement of striving for employee and ultimately human excellence.

7 CHAPTER 7: RECOMMENDATIONS AND CONCLUSION

7.1 Limitations of the study

This study was investigative in nature and aimed at broadening the research conducted on wellness programmes in South Africa in the absence of similar studies in this context.

One limitation to this study was the restricted number of questionnaire respondents, which in effect minimise the generalisability of the research findings. A more generalisable picture of the extent of the application of wellness interventions in organisations may be possible with a larger sample of respondents.

Due to the study being investigative and explorative in nature, there were no hypotheses and as a result the scope and depth of the statistical potential and possibilities were limited. With specified hypotheses the study may have had more statistical strength.

The research questionnaire covers the main areas of literature related to wellness, however, expanding or refining the questionnaire may result in obtaining more specified information for different purposes.

7.2 Recommendations for future research

Wellness in the workplace is a topic, which should enjoy increased attention and should be more extensively researched in the South African context. Since few studies have been conducted on South African EAP's or other wellness interventions, there are many options for valuable research that could valuably contribute to the expansion of this field.

Some ideas for future research include studying the long-term effects of some of the primary services offered by organisations and the ultimate relationship to the productivity of that organisation and the effects on employees. Longitudinal studies on newly implemented programmes could be conducted in order to verify the cost effectiveness of the programmes amongst other advantages. This study includes the development of a model of wellness in the South African context, however this model is not nearly exhaustive in theory or application and future research could include the growth and intensification of this important aspect of wellness.

Other recommendations include investigating the requirement of knowledge or information organisations may need about the field of wellness at work, specifically related to various industries and sizes of businesses.

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APPENDIX A

Wellness Questionnaire

Section 1: Demographic Information

Office Use

Question1

1.1 What is your position in the organization?

Human resource manager		1
Operations manager		2
Wellness/EAP coordinator		3
Other		4

1.2 Please indicate which of the following wellness programmes are available at your organization?

	Employee Assistance Programme (This is an intervention driven by the employer to assist employees with various problems that may affect their performance at work such as emotional problems or stress.)	2	5
	Health Promotion Programme (This is an intervention driven by the employer to assist employees with adopting healthy habits such as smoking cessation, fitness and weight loss).	3	6

If you do not have any of these programmes implemented in your organization, complete only Section 3 of the questionnaire and please mail the questionnaire back to the sender. Thank You

1.3 How long have these programmes or interventions been implemented in your organization?

0-2 years		7
3-4 years		8
4-6 years		9
7-8 years		10
9 and above years		11

1.4 How many employees work at your organization?

0-100		12
101-200		13
201-300		14
301-400		15
401-500		16
500 and above		17

1.5 How many employees have made use of the wellness programmes available in your company over the last 12 months?

- 0-100
- 101-200
- 201-300
- 301-400
- 401-500
- 500 and above

18	
19	
20	
21	
22	
23	

Section 2: Design and Structure of Wellness Programmes

Question 1

1.1 The company's wellness programmes are available to the following employees.

- | | |
|--|----------------------|
| | All staff |
| | Directors/Executives |
| | Managers |
| | Supervisors |
| | General staff |

24	
25	
26	
27	
28	

1.2 Which of the following statements best describe the reasons why your company provide wellness programmes.

- | | |
|--|-------------------------|
| | Increased productivity |
| | Decreased health costs |
| | Higher morale |
| | Social responsibility |
| | Retention of employees |
| | Business needs |
| | Human Resource Strategy |
| | Other |

29	
30	
31	
32	
33	
34	
35	
36	

1.3 Which of the following programmes and/or services are available at your company.

<input type="checkbox"/>	Regular health checks	37	<input type="checkbox"/>
<input type="checkbox"/>	Primary health care	38	<input type="checkbox"/>
<input type="checkbox"/>	Family planning	39	<input type="checkbox"/>
<input type="checkbox"/>	Nutrition education	40	<input type="checkbox"/>
<input type="checkbox"/>	Smoking cessation	41	<input type="checkbox"/>
<input type="checkbox"/>	Alcohol treatment	42	<input type="checkbox"/>
<input type="checkbox"/>	Drug treatment	43	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension control	44	<input type="checkbox"/>
<input type="checkbox"/>	Weight management	45	<input type="checkbox"/>
<input type="checkbox"/>	Stress management	46	<input type="checkbox"/>
<input type="checkbox"/>	Life skills programmes	47	<input type="checkbox"/>
<input type="checkbox"/>	Psychologist	48	<input type="checkbox"/>
<input type="checkbox"/>	Doctor	49	<input type="checkbox"/>
<input type="checkbox"/>	Social worker	50	<input type="checkbox"/>
<input type="checkbox"/>	Optometrist	51	<input type="checkbox"/>
<input type="checkbox"/>	Dentist	52	<input type="checkbox"/>
<input type="checkbox"/>	Orthopedic specialist	53	<input type="checkbox"/>
<input type="checkbox"/>	Child care	54	<input type="checkbox"/>
<input type="checkbox"/>	Single mother support	55	<input type="checkbox"/>
<input type="checkbox"/>	Diversity management	56	<input type="checkbox"/>
<input type="checkbox"/>	Cultural support	57	<input type="checkbox"/>
<input type="checkbox"/>	Sabbatical	58	<input type="checkbox"/>
<input type="checkbox"/>	Physical fitness centre	59	<input type="checkbox"/>
<input type="checkbox"/>	AIDS counseling	60	<input type="checkbox"/>
<input type="checkbox"/>	AIDS education	61	<input type="checkbox"/>
<input type="checkbox"/>	Crime support	62	<input type="checkbox"/>
<input type="checkbox"/>	Career planning	63	<input type="checkbox"/>
<input type="checkbox"/>	Transportation benefits	64	<input type="checkbox"/>
<input type="checkbox"/>	Other	65	<input type="checkbox"/>

1.4 Are these programmes and/or services available at the company or at an external location?

<input type="checkbox"/>	In-house	66	<input type="checkbox"/>
<input type="checkbox"/>	External/Contract	67	<input type="checkbox"/>
<input type="checkbox"/>	Consortium	68	<input type="checkbox"/>
<input type="checkbox"/>	Union - based	69	<input type="checkbox"/>
<input type="checkbox"/>	Combined: In-house/Contract	70	<input type="checkbox"/>

1.5 Which of the following best describe the result(s) experienced as a consequence of the implemented wellness programmes?

<input type="checkbox"/>	Increased productivity	71	<input type="checkbox"/>
<input type="checkbox"/>	Decreased health care costs	72	<input type="checkbox"/>
<input type="checkbox"/>	Upliftment in morale	73	<input type="checkbox"/>
<input type="checkbox"/>	Decreased absenteeism	74	<input type="checkbox"/>
<input type="checkbox"/>	Decreased labour turnover	75	<input type="checkbox"/>
<input type="checkbox"/>	Increased job satisfaction	76	<input type="checkbox"/>
<input type="checkbox"/>	Other	77	<input type="checkbox"/>

1.6 Which of the following methods describe referral of employees to the various wellness programmes?

<input type="checkbox"/>	Voluntary self referral	78	<input type="checkbox"/>
<input type="checkbox"/>	Supervisory or managerial referral	79	<input type="checkbox"/>
<input type="checkbox"/>	Referral by Human Resource Dept	80	<input type="checkbox"/>
<input type="checkbox"/>	Referral by co-workers	81	<input type="checkbox"/>
<input type="checkbox"/>	Referral by family or friends	82	<input type="checkbox"/>

1.7 Which of the following are included in the wellness programme training of managers and supervisors?

<input type="checkbox"/>	Referral of employees	83	<input type="checkbox"/>
<input type="checkbox"/>	Functioning of the programmes	84	<input type="checkbox"/>
<input type="checkbox"/>	Advantages of employee wellness	85	<input type="checkbox"/>
<input type="checkbox"/>	Support of employees	86	<input type="checkbox"/>
<input type="checkbox"/>	Other	87	<input type="checkbox"/>
<input type="checkbox"/>	No education or orientation of managers and supervisors	88	<input type="checkbox"/>

1.8 Which of the following indicates the techniques your company uses for the marketing of the services and programmes of the employee assistance and wellness interventions?

<input type="checkbox"/>	Posters	89	<input type="checkbox"/>
<input type="checkbox"/>	Pamflets	90	<input type="checkbox"/>
<input type="checkbox"/>	Talks	91	<input type="checkbox"/>
<input type="checkbox"/>	News letters	92	<input type="checkbox"/>
<input type="checkbox"/>	Orientation programmes	93	<input type="checkbox"/>
<input type="checkbox"/>	Informal marketing	94	<input type="checkbox"/>
<input type="checkbox"/>	Other	95	<input type="checkbox"/>
<input type="checkbox"/>	Not Applicable	96	<input type="checkbox"/>

1.9 Which of the following best describes the after care services available at the organization?

- Support groups
- Formal management or supervisory support
- Continued support from professional staff
- Liason with family members or friends
- Not applicable

97	<input type="checkbox"/>
98	<input type="checkbox"/>
99	<input type="checkbox"/>
100	<input type="checkbox"/>
101	<input type="checkbox"/>

Question 2

Please answer the following questions as truthfully as possible.
Please tick only one box per question.

- | | YES | NO | N/A | |
|---|--------------------------|--------------------------|--------------------------|------------------------------|
| 2.1 Did the company conduct a needs analysis related to the employees's physical and psychological health before implementing the wellness programme? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 102 <input type="checkbox"/> |
| 2.2 Does the company have a committee dealing primarily with the wellness of employees and all the services provided? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 103 <input type="checkbox"/> |
| 2.3 Are the employees of the company represented on this committee? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 104 <input type="checkbox"/> |
| 2.4 Does the company have a coordinator specifically assigned to the operations and functions of the wellness interventions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 105 <input type="checkbox"/> |
| 2.5 Is feedback regarding the effects of the wellness programmes provided to management? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 106 <input type="checkbox"/> |
| 2.6 Is the feedback used in order to make changes regarding the company's functioning eg. Job design or minimizing stressors in the workplace? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 107 <input type="checkbox"/> |
| 2.7 Is the labour union involved in the wellness programmes provided by the company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 108 <input type="checkbox"/> |

	YES NO N/A	
2.19 Does the company provide health insurance coverage for long term treatments?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	120 <input type="checkbox"/>
	YES NO N/A	
2.20 Does any of the components or services of the wellness programme fall under company benefits?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	121 <input type="checkbox"/>
	YES NO N/A	
2.21 Does the company engage in evaluating and assessing the benefits of the wellness interventions?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	122 <input type="checkbox"/>
2.22 Which of the following best describes the evaluation methods the company makes use of?		
<input type="checkbox"/> reasons why employees use interventions		123 <input type="checkbox"/>
<input type="checkbox"/> types of problems experienced		124 <input type="checkbox"/>
<input type="checkbox"/> frequency of problems experienced		125 <input type="checkbox"/>
<input type="checkbox"/> success rates of treatments		126 <input type="checkbox"/>
<input type="checkbox"/> cost benefit analysis of interventions		127 <input type="checkbox"/>
<input type="checkbox"/> Other		128 <input type="checkbox"/>

Section 3: Attitude Statements

Please select the block which displays most closely your feeling towards the statement being made.
Please do not select more than one block per statement.

	Office Use					
1.1 Employees must leave their personal problems at home and not bring them to work.						129 <input type="checkbox"/>
	<input type="checkbox"/>					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	
1.2 Work is not the place for employees to find help for their problems.						130 <input type="checkbox"/>
	<input type="checkbox"/>					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	

1.3 Employees in our organisation do not have problems justifying the implementation of wellness and employee assistance programmes.

131

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.4 Wellness and employee assistance programmes are too costly for the value they contribute.

132

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.5 Wellness and employee assistance programmes provide monetary results to the organisation.

133

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.6 The Human Resource Department does not have the time to spend on employee wellness and assistance.

134

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.7 Managers and supervisors do not have the time to spend on employee wellness and assistance.

135

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.8 Lower level employees will make use of wellness and employee assistance programmes.

136

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.9 Management employees will make use of wellness and employee assistance programmes.

137

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.10 The design and implementation of wellness programmes are too complicated.

138

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.11 Unions will show a positive attitude towards the implementation of wellness programmes.

139

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.12 The confidentiality of employee information related to wellness programmes pose to be problematic.

140

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.13 Our employees would be concerned about the use of the personal information obtained in the wellness programme.

141

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.14 Employees would make use of wellness programmes if these were available.

142

<input type="text"/>				
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1.15 Employees will revert back to their old habits regardless of the wellness programmes being offered.

143

Strongly
Disagree

Disagree

Undecided

Agree

Strongly
Agree

1.16 Our organisation has experienced positive changes in productivity since the implementation of the wellness programmes.

144

Strongly
Disagree

Disagree

Undecided

Agree

Strongly
Agree

1.17 We are finding it difficult to assess and evaluate any progress or changes related to the implementation of the wellness programmes.

145

Strongly
Disagree

Disagree

Undecided

Agree

Strongly
Agree