

EMPLOYEE HEALTH AND WELLNESS PRACTICES IN SOUTH AFRICA

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FOR THE READER'S ATTENTION

The reader is reminded of the following:

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- Each chapter of this thesis has its own reference list.
- The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the NRF.

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SUMMARY

Title: Employee health and wellness practices in South Africa

Key words: Health, wellness, employee health and wellness programmes, organisations, service providers, labour unions, stress, legislation, management standards.

Research regarding employee health and wellness programmes is lacking in South Africa. The objective of this research was thus to describe employee health and wellness in South Africa by investigating the management and infrastructure of employee health and wellness programmes (EHWPs), and to investigate the role that legislation and management standards can play in promoting employee health and wellness. The sample is cross-sectional and surveys perspectives on employee health and wellness of 16 organisations ($n = 16$), service providers ($n = 4$) of employee health and wellness programmes (EHWPs), and labour unions ($n = 7$) in South Africa.

Employee health and wellness management in South Africa was researched by investigating the types, foci and perceived success of employee health and wellness programmes. The results show that employee health and wellness is defined differently by role players within the sector and that reasons for, and perceptions about reasons for, implementation across organisations, service providers and labour unions also differ. Almost half of the participating organisations have no baseline measurement with which to compare the effectiveness of their EHWPs. Generally, results of programmes are reasonably presented in all the organisations, and yet funding of programmes amounts to very little overall cost.

Employee health and wellness programmes' infrastructure and information management systems were also investigated. An assessment was made of the educational requirements of employee health and wellness staff, and the need for further required training was identified. Further objectives included determining whether there is a return on investment on the employee health and wellness programme by investigating injuries, sickness, absenteeism, stress and HIV/AIDS management within organisations. The general conclusion was that, although organisations claim to be running employee health and wellness programmes, at the utmost these can be regarded as Employee Assistance Programmes (EAPs), functioning at different levels of efficiency. Recommendations were made regarding adequate employee

health and wellness infrastructure, education and training of staff and employee health and wellness information management.

Legislation that influences employee health and wellness was discussed and a literature review was done. Relevant European case studies were discussed as well as South African labour law that influences employee health and wellness. Suggestions were made regarding use of legislation and management standards to govern and promote employee health and wellness, and the onus on different relevant role-players were discussed.

OPSOMMING

Opskrif: Werknemersgesondheids- en -welstandspraktyke in Suid-Afrika.

Sleutelwoorde: Gesondheid, welstand, werknemersgesondheids- en -welstandsprogramme, organisasies, diensverskaffers, vakbonde, stres, wetgewing, bestuurstandaarde.

In Suid-Afrika bestaan daar 'n gebrek aan navorsing wat betref werknemersgesondheids- en -welstandsprogramme. Gevolglik was die doelstelling van hierdie navorsing om werknemersgesondheid en -welstand in Suid-Afrika te beskryf deur die bestuur en infrastruktuur van werknemersgesondheids- en -welstandsprogramme (WGEP'e) en die rol wat wetgewing en bestuurstandaarde in die bevordering van werknemersgesondheid en -welstand kan speel, te ondersoek. Die steekproef is van 'n kruissnit-aard, en verteenwoordig 'n opname van die perspektiewe van 16 organisasies ($n = 16$), diensverskaffers ($n = 4$) van werknemersgesondheids- en -welstandsprogramme (WGEP'e) en vakbonde ($n = 7$) in Suid-Afrika wat betref werknemersgesondheid- en -welstand.

Die bestuur van werknemersgesondheid en -welstand is nagevors deur die tipes, fokusse en waargenome sukses van werknemersgesondheids- en -welstandsprogramme te ondersoek. Die resultate dui daarop dat rolspelers binne hierdie sektor werknemersgesondheid en -welstand op verskillende wyses definieer, en dat die redes vir, en die persepsies rakende die redes vir die implementering van sodanige programme ook verskil van organisasie tot organisasie, van diensverskaffer tot diensverskaffer, en van vakbond tot vakbond. Amper 'n helfte van die deelnemende organisasies beskik nie oor basislyn-maatstaf waarmee die effektiwiteit van hulle WGEP'e bepaal kan word nie. Algemeen gesproke, word die resultate van programme redelikerwys binne al die organisasies bekendgemaak, maar terselfdertyd verteenwoordig die befondsing van sodanige programme weinig van die totale organisasiekostes.

Die infrastruktuur en inligtingsbestuursisteme wat betref werknemersgesondheids- en -welstandsprogramme is ook ondersoek. 'n Assessering is uitgevoer wat betref die opvoedkundige vereistes waaraan werknemersgesondheids- en -welstandspersoneel behoort te voldoen, en daaruit is 'n behoefte aan verdere vereiste opleiding van sodanige personeel geïdentifiseer. Verdere doelwitte was daarop gerig om te bepaal of daar 'n opbrengs op die

belegging in werknemersgesondheids- en -welstandsprogramme waargeneem kan word deur beserings, siektes, werksafwesigheid, stres en HIV/VIGS-bestuur binne organisasies te ondersoek. Die algemene gevolgtrekking wat gemaak is, was dat, alhoewel organisasies daarop aanspraak maak dat hulle werknemersgesondheids- en -welstandsprogramme aanbied, hierdie programme op die meeste as Werknemer-bystandsprogramme (WOP'e), wat op verskillende vlakke van effektiwiteit funksioneer, beskryf kan word. Aanbevelings word gemaak wat betref voldoende infrastruktuur wat betref werknemersgesondheids- en -welstandsprogramme, die opvoeding en opleiding van personeel en werknemersgesondheids- en -welstands-inligtingsbestuur.

Wetgewing wat werknemersgesondheid- en -welstand betref, is bespreek en 'n literatuuroorsig is uitgevoer. Relevante Europese gevallestudies, asook Suid-Afrikaanse arbeidswetgewing wat werknemersgesondheid- en -welstand beïnvloed, is bespreek. Voorstelle word gemaak wat betref die benutting van wetgewing en bestuursstandaarde ten einde werknemersgesondheid- en -welstand te beheer en te bevorder, en die onus wat op die verskillende relevante rolspelers rus, is bespreek.

CHAPTER 1

INTRODUCTION

This thesis deals with Employee Health and Wellness practices in South Africa. In this chapter the problem statement is discussed, whereupon the research objectives are set out. Following this, the research method is discussed and the division of chapters is given. This chapter also gives a complete account of the development of the project up to completion.

1. PROBLEM STATEMENT

Occupational stress has been a major focus in Industrial/Organisational Psychology. This is an area of psychology in work context that is associated with increases in negative stress outcomes such as job dissatisfaction, ill health, absenteeism, higher turnover and lower productivity (Jones & Bright, 2001). The negative effects of occupational stress have also been shown to include impaired performance, diminishing levels of customer service, health problems, industrial accidents, increased alcohol and drug usage and purposefully destructive behaviours (e.g. spreading of rumours and stealing) (Karasek & Theorell, 1990; Perrewé, 1991; Quick, Quick, Nelson, & Hurrell, 1997; Wright & Smye, 1996). However, work might also contribute to well-being (Rothmann, 2003).

Due to the stress it induces in individuals, work may lead to work-related health problems (Paoli, 1997), but it can also lead to good health (Turner, Barling, & Zacharatos, 2002). Work requires effort, and is associated with a lack of freedom, negative feelings and the expenditure of energy. On the other hand, work may give energy, enable development and generate positive feelings. As the nature of work in the developed world undergoes more and more change, and as organisations de-layer and outsource, the relevance of wellness at work is becoming more significant, and practices to accomplish or enhance wellness at work, are increasing (Kompier & Cooper, 1999). Employees are also increasingly threatened by psychological stress, due to aspects such as over-population, competition, economic crises, a lack of meaningful relationships and time pressures (Van den Bergh, 2001). Stress seems to be a reality of working life, it is unavoidable and potentially good and bad at the same time, constructive as well as destructive.

Bakker and Schaufeli (2001) show that some people dealing with high job demands are not burned out but find pleasure in working hard and dealing with high job demands. Rothmann (2003) then asks the question whether these could be committed employees who are energetic and show dedication and absorption in their work. Thus, though the work may be stressful, it creates energy for the employee, and the work has a positive effect on the employee. Fredrickson (2001) also describes positive emotions as typically brief reactions to some personally meaningful event. Positive emotions include happiness and other feelings of well-being. It may be concluded that if an employee experiences his/her work to be meaningful, it can create feelings of well-being. Therefore, work can also contribute positively to well-being.

In the United States alone, it is estimated that the overall business and industry costs associated with dispirited employees are in the range of \$150 to \$180 billion per annum (Wright & Smye, 1996). Handy (1988) and Meyerson (1994) point out that an important consideration in terms of stress research should be that stress occurs within a particular context, since individuals differ in the meaning they attribute to stressful experiences. Therefore, the influence of the social construction of stressful experiences should be taken into account. The problem is that many organisations have implemented practices that attempt to reduce costs and increase productivity, which often lead to a mentality that favours profitability over the welfare of people (Turner et al., 2002).

An extensive survey conducted by the European Foundation shows that the most common work-related health problems are backache, stress and fatigue, and that these conditions are related to poor working conditions (Paoli, 1997). This study also shows that 45% of European employees work at high speeds or under tight deadlines for half of the time. An epidemiological survey conducted in the United Kingdom concludes that stress is the second most frequently reported condition of individuals who disclose a work-related illness, next to musculoskeletal disorders which are responsible for most reported work-related illness (Jones & Hodgson, 1998). Moreover, occupational stress has now become one of the most common reasons for medical retirement (Cooper & Cartwright, 1994).

Pienaar (2002) reports that in a sample of South African Police officers, 15% experience stress-related problems. Various studies in South Africa show high levels of physical and

psychological ill health at work, amongst others in academic and support staff of higher education institutions (Barkhuizen & Rothmann, 2004), employees in the insurance industry (Coetzer & Rothmann, 2006), teachers (Jackson & Rothmann, 2005), and in correctional settings (Botha & Pienaar, 2006). It is evident, however, that in order for any organisation to address stress-related issues and implement effective interventions, it is necessary to

- diagnose the job-characteristics and working conditions that the workforce perceive to be stressful,
- investigate the outcomes of any stressors that are experienced, and
- establish whether any particular sub-group of the working-population is at greater risk (Kinman, 2001).

Occupational and organisational psychologists generally consider work-related stress to be the product of an imbalance between environmental demands and individual capabilities (Lazarus & Folkman, 1984). However, most researchers adopt the fairly common practice of using the term ‘stress’ to describe either the external *stimulus* from the environment or the *response* of the individual, or sometimes, both meanings simultaneously. Lu (1999) argues that stress has become one of the most serious health issues, a problem not just for individuals, but also for employers. Research over the past three decades has shown that the experience of occupational stress is closely related to the health and safety of individuals and has definite implications for the well-being of organisations or institutions (Rees, 1995; Rees & Redfern, 2000). According to Sadri (1997, p. 1), “...*stress may be defined as a situation wherein factors interact with a person to change (i.e. disrupt or enhance) his/her psychological and/or physiological condition, such that the person is forced to deviate from normal functioning*”.

In order to address occupational stress, it is important for organisations to focus interventions at all levels of stress occurrence. Three types of interventions are generally distinguished, namely primary, secondary and tertiary, each with a different purpose. Where primary interventions focus on altering stressors in the work situation, secondary interventions focus on helping employees who are already showing signs of stress from getting sick, by for example increasing their coping capacity. Tertiary prevention is concerned with treatment activities for employees with serious stress-related health problems (Kompier & Cooper, 1999). Most activities are primarily aimed at the individual rather than at the workplace or the

organisation; in other words a worker-orientated approach prevails, for instance by improving employees' skills to manage, resist or reduce stress, as opposed to a job or organisational/oriented approach, for instance by job redesign or in some way transforming the incapacitating corporate culture or management style.

In the United States, it is estimated that as much as 54% of sickness absence is in some way stress-related (Elkin & Rosch, 1990). In many developed countries, the total cost of workplace pressure has been estimated at roughly 10% of gross national product. This stems from sickness absence, labour turnover, premature retirement due to ill health, escalating health insurance and the expenditure on the treatment of the consequences of stress (Cartwright & Cooper, 1997; Karasek & Theorell, 1990). These alarming figures are mostly from the developed world, where the economy has overwhelmingly shifted to one of service. Considering the South African context, as a growing economy in the developing world, it is anticipated that the situation might be far worse. One has only to think of the physical labour delivered in South African underground mining, the country's ever-growing AIDS pandemic and levels of unemployment due to privatisation to realise that we are worse off. In South Africa annually, 122 889 employees fall victim to accidents or sickness as a direct result of their work. Of these, 889 are fatal. The amount of money spent on benefits to sufferers range from R1 275.70 for people with medical aid, up to R 226 828.80 for fatal injuries. The number of working days lost annually due to sickness is put at more than twelve million (12 044 550), with further losses due to labour unrest (Workmen's Compensation Fund, 1999).

South Africa is also characterised by underemployment in the form of 'inadequate employment' or 'low-quality jobs'. These include jobs characterised by low wages, lack of training and promotion opportunities, exposure to excessive occupational health and safety risks and a lack of job security and worker representation and collective bargaining at the workplace (South African Human Development Report, 2003). It is estimated that three out of ten people in the formal sector, and six out of ten in the informal sector, work in these kinds of jobs. For these employees, employee health and wellness is an illusion that does not exist in reality. It is especially in the interest of these individuals that employee health and wellness at work should be promoted.

Given the world of work as described above, inevitably questions arise as to what organisations are doing to keep their employees working well. South Africa, as a developing

country with the associated economic limitations and social and political problems, especially presents an interesting case. Are employee health and wellness or employee assistance programmes in place? It seems not to be the case. In spite of the pivotal role that Employee Assistance Programmes (EAPs) play in promoting employee health and wellness, less than half of South Africa's top 100 companies have such programmes in place (Naidoo & Jano, 2003). Where an Employee Assistance Programme (EAP) is present, it does not constitute part of the core business structure (Bennett, 1999).

In a survey conducted by Terblanche (1992) about the conceptual sophistication of EAPs operating in South Africa, it was found that 69% of employer respondents offer direct assistance to their employees, but that only 58% offer assistance according to a structured programme. The rest is offered in various unstructured ways. For example, 58% of the companies indicate that management actively participates and gives their support, but only 25% of the respondents indicate that their employees have contributed to designing and implementing the EAP in the organisation. Most organisations also do not actively market their EAPs to internal customers. The most commonly used techniques are orientation courses, posters and newsletters. Of the organisations that participated in the Terblanche study, 8% do not undertake any kind of marketing. It was also determined that only 19% of union representatives are informed about the EAPs in their organisations. The overall impression from this survey indicates that Employee Assistance Programmes in South African organisations are not utilised to their full capacity. Terblanche recommends that Employee Assistance Programmes can be improved by means of proper supervisory training, but more importantly, by training of EAP professionals and enhancing the company's marketing of the EAP to its employees.

Considering the political changes that have taken place in South Africa during its first decades of democratic rule and the impact these have had on legislation, the world of work and the South African economy, it seems necessary to take a new look at the phenomenon of not just employee assistance, but employee wellness in general. In the fifteen years that have passed since the work of Terblanche (1992), South Africa has introduced a whole new labour law, practices like affirmative action to address ethnic and gender inequalities that were the result of the apartheid political system, and has re-entered an international community where the health and wellness of employees has long since been a topic of concern, research and investment.

Many South African EAPs are used primarily as a source of information and advice. South African employees are using EAPs increasingly for work-related problems like supervisor-subordinate conflict, perceived policy unfairness, discriminatory practices, sexual harassment and work-induced family stress (Naidoo & Jano, 2003). EAPs in South Africa still have a vital role to play in kindling organisations' commitment to the health, welfare, and wellness of workers. The EAP has to maintain the human machinery. The EAP should be a humane, comprehensive process which is proactive in its approach and has measurable benefits like dealing with performance deficiencies, reducing absenteeism, systems abuse, and time spent on disciplinary hearings and staff turnover (Langley, 1999).

(The) World Health Organisation (2002) describes health as a state of complete physical, mental, and social well-being; it is not merely the absence of disease and infirmity. Apart from the contribution of an EAP, the benefits of an employee health and wellness programme may also include a reduction in absenteeism, labour turnover and medical costs, and aim at the improvement of productivity and employee relations. It is important to remember that an employee health and wellness programme is not there to make sick employees better and/or reduce stress, but rather to make well employees function even better and to prevent excessive amounts of stress for a prolonged time. It is therefore proposed that employee wellness or organisational wellness should be viewed in a holistic way, looking at the whole person and the balance between physical, social, emotional, occupational, spiritual and intellectual dimensions, while also taking into account the effect the environment has on these dimensions (Hettler, 1979, 1991). Up to now, health education has focused primarily on physical wellness, whereas counselling has focused primarily on emotional, social, and occupational wellness (Chandler, Holden, & Kolander, 1992). A more contemporary conceptualisation of employee health and wellness has to incorporate all of these approaches.

The purpose of implementing wellness programmes in an organisation is to create an awareness of wellness issues, to facilitate personal change and health management and promote a healthy and supportive workplace (Andrew, 1999). Wellness is the dynamic process of promoting and pursuing ideas, attitudes and behaviours, and making choices towards a culture and a way of life that focuses on attaining balance, good health and peace of mind. Wellness conditions are encouraged by incorporating lifestyle-enhancing processes, policies, environments, attitudes, activities, programmes and incentives into the methods

according to which an organisation does business (Andrew, 1999). Employee health and wellness promotion also makes sense at the bottom-line, because it helps to link productivity directly to the health issue by emphasizing prevention. Given the direct and indirect savings in costs, compared to the apparent nominal cost of an employee health and wellness programme, it could certainly be worth the time spent by management to consider it. Whether the programme is an isolated scheme paid for by the employer, or is attached to a medical scheme, its rewards go far beyond that which money can buy (Clarke, 2003).

Four major role-players influence employee health and wellness in South Africa. These are

- the Government, by means of the laws it imposes,
- the Employer, by means of the implementation of employee health and wellness or assistance programmes,
- the Employee, by means of the things he/she does to keep him/herself well, and lastly
- the Environment in which the employer and employee function, which may be thought of as either conducive or limiting to employee health and wellness (for example, whether it is characterised as polluted or a high-noise workplace, whether issues of employee wellness receive attention in the popular media, or the amount of support an employee receives at home or at work).

It is important to determine the motivation of an organisation to implement an employee health and wellness programme or an EAP, and also to determine to what extent such programmes are successful. Previously, organisations thought of their contribution to medical aid for their workers as a financial liability, but that has changed. Organisations now think of it as an asset (Van Tonder, 2004). There are three main reasons for this:

- In the current climate of high and increasing competitiveness, medical aid contribution is a method for the organisation to improve productivity. This is also a way to reduce high-risk payments that flow from the health status of employees. It has also been realised that stress leads to lowered productivity: if a worker is not able to pay medical aid, it becomes a source of stress that lowers productivity.
- In future, the proposed national health insurance system in South Africa will make it compulsory for employees who earn a certain salary to belong to a medical aid scheme.

Employers, employees and medical aids will contribute in different ways to finance the compulsory membership.

- Employers compete for the scarce skills of employees, and also compete against one another to be employers of choice. It is necessary that a work environment which contributes to a feeling of responsibility for employee health be part of the package. Employers are realising even more that healthcare and being healthy should be part of the work environment.

Traditionally, psychology as science was more interested in discovering the causes of ill health rather than the causes of health and well-being (Strümpfer, 1990). Knowledge gained by answering the question of what made people ill was then used to find ways of treating and preventing diseases. Positive psychology emerged because not enough attention was given to the strengths and the positive characteristics of people that make life worth living. Antonovsky (1987) introduces the construct of *salutogenesis* (Latin: *salus* = health, Greek *genesis* = *origin*), proposing that the origins of health rather than disease should be studied. Strümpfer (1995) argues that the construct of *salutogenesis* should be broadened from a focus on health only, to *fortigenesis* (Latin: *fortis* = strong), referring to strength. Wissing and Van Eeden (1997) suggest that not only the origins of psychological well-being should be studied, but also the nature, manifestations and ways to enhance psychological well-being. Studying wellness in organisational context thus presents a study of not just assisting the employees who have succumbed to the pressures of work, but promoting the strengths and health that the employees have within them. This can be done by keeping them healthy and preventing them from developing illness.

Seligman and Csikszentmihalyi (2000, p. 5) recently suggested that the purpose of positive psychology "*is to begin to catalyse a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities*". Studying positive organisational behaviour can also contribute to the perspective that the study and application of positive-oriented human resource strengths and psychological capacities can be measured, developed, and effectively managed for performance improvement in today's workplace (Luthans, 2002).

Lately, organisational research scholars have suggested that studying positive organisational behaviour has become lacking in relevance and meaning. Wright and Wright (2002) suggest

that one possible reason for this apparent lack of relevance (and concomitant (over)emphasis on the negative aspects of work and life) is the failure of much organisational research to be responsive to the needs of all potential research stakeholders. Wright and Wright propose that the prevailing values perspective in organisational research, emphasizing a utilitarian or cost-benefit approach, have strongly influenced the framing and interpretation of organisational research questions. Epitomizing this utilitarian approach is termed by the authors' committed-to-management research (CMR) and committed-to-science research (CSR) perspectives. While the utilitarian perspective has provided a significant addition in value - for those interested in the 'bottom line' for business success - , it has been much less articulate in proposing an agenda to proactively assist employees in their pursuit of healthier and more meaningful lives. Therefore, research must not only focus on how to get employees to be more productive, but also on employee health and wellness. In addition, addressing potential limitations of these approaches, and defining approaches which complement the positive psychology movement, Wright and Wright propose a third value perspective: the committed-to-participant research (CPR) perspective. Simply stated, a CPR approach considers issues surrounding the individual well-being and betterment of all research stakeholders, irrespective of their perceived instrumentality to future organisation-based outcomes as appropriate and worthwhile topics in organisational research.

In approaching this research, the spotlight has to fall on how organisations can make their employees '*stronger, fitter and happier*', and which ways are being used to enhance employee psychological well-being and wellness. In doing this, it is important to determine how human resource strengths can be measured, developed, and effectively managed for performance improvement in today's workplace, by the implementation of EAPs or employee health and wellness programmes. This research could also be important in estimating whether the implementation of such programmes makes a fundamental difference to organisations that do invest in such interventions.

Employee health and wellness is a construct within Industrial Psychology that has not yet been well defined. There is also a lack of research regarding specific practices implemented by organisations in South Africa to promote employee health and wellness at work. In carrying out this research, the researcher aims to contribute to research in Industrial Psychology by doing a baseline study on the best employee health and wellness practices in South African organisations. The aim of this study is therefore to find out and consider which

wellness practices are used by organisations to assist in the maintenance and enhancement of the wellness of their employees.

From the problem statement the following research questions emerge:

- How is employee health and wellness defined and how are employee health and wellness programmes managed in South African organisations?
- What infrastructure is needed to support employee health and wellness initiatives in South African organisations?
- What role can legislation play in the enhancement of employee health and wellness of South African employees?
- What recommendations can be made to South African organisations for the improvement of employee health and wellness in their organisations?

2. AIM OF THE RESEARCH

The aim of this research can be divided into a general aim and specific objectives.

2.1 General aim

The general aim of this research is to conceptualise employee health and wellness and the management thereof in the South African context, to determine the infrastructure needed to promote employee health and wellness practices in organisations, and to evaluate current legislation that can influence employee health and wellness in South Africa.

2.2 Specific objectives

The specific objectives are discussed for each article, which aims to answer the research questions.

Management of employee health and wellness in South Africa (Article 1)

- To conceptualise and define employee health and wellness as it currently manifests in selected South African organisations.

- To investigate reasons for implementation of employee health and wellness programmes in South African organisations.
- To investigate management involvement in the management of employee health and wellness in their organisations, and presentation of results of employee health and wellness programmes.
- To determine how organisations rate the successfulness and effectiveness of their employee health and wellness programmes.
- To determine employee input, participation rates, and how organisations fund their programmes.

Infrastructure of employee health and wellness programmes in South Africa (Article 2)

- To evaluate the occurrence of employee “un”-well behaviours by investigating absenteeism, strikes, accidents, turnover, HIV/AIDS management and leave utilisation within South African organisations.
- To assess the effectiveness of employee health and wellness information management and make recommendations regarding improvement.
- To assess the nature of Employee Health and Wellness Program (EHWP) policies and infrastructure and make recommendations regarding improvement.
- To assess the reporting lines, staffing, educational levels of employee health and wellness staff, and identify further training requirements.
- To assess employee health and wellness interventions by investigating reasons for implementation, focus, targets of intervention and the services rendered.
- To assess the benefits and training provided by organisations to their employees.
- To evaluate the marketing and awareness-raising of Employee Health and Wellness Programs (EHWPs) and to evaluate the consultation of employees in development of EHWPs.

Employee health and wellness in South Africa: The role of legislation and management standards (Article 3)

- To investigate the role that legislation and management standards might play to ensure employee health and wellness
- To make recommendations regarding a national strategy to promote employee health and wellness in South African organisations.

3. METHOD

3.1 Phase 1: Literature review

In phase 1 a complete literature review regarding the following is obtained: The number of employees in South Africa who suffer from excessive pressure in the workplace, the number of employees who fall victim to accidents or sickness as a result of their work and the number of these that actually result in fatalities, the amount of money spent on benefits to sufferers of occupational diseases and accidents and the number of working days that are lost annually due to sickness. The literature review further concentrates on previous studies of a similar nature in South Africa which may have considered employee assistance or wellness programmes. The literature review also considers other sources of information like relevant popular magazines, books and websites. In doing the literature review it is necessary to determine how sickness and disability are defined in South Africa and how South African statistics compare to those of other countries, both developed and developing. The direct and indirect costs of sickness and disability and the nature of working conditions in South Africa are also of importance. It is also deemed necessary to establish the socio-political and legislative background regarding employee health and wellness, and to determine whether there are any results available regarding the effectiveness of employee health and wellness activities.

3.2 Phase 2: Empirical study

Phase 2 consists of the empirical study and comprises the research design, the participants, measuring battery and statistical analysis.

3.2.1 Research design

To achieve the research objectives a survey design is used (Shaughnessy & Zechmeister, 1997). By making use of the cross-sectional design, the information collected is used to describe a population at the specific time and to assess interrelationships among variables within a population. This design is ideally suited to the descriptive and predictive functions

associated with correlational research, and also because the main focus is to describe the current situation in South Africa regarding employee health and wellness practices in organisations.

3.2.2 Study population

The study population consists of organisations from various sectors of the South African economy, with programmes in place which contribute to employee health and wellness. Organisations that specifically indicated that their programmes promote employee health and wellness of their employees are included in the study. As such, *employee health and wellness programmes*, rather than traditional EAPs, are surveyed.

3.2.3 Measuring instruments

A survey, *The Employee Health and Wellness Survey*, was developed to determine the nature, content, context, participants, role players and anticipated benefits and possible drawbacks of an employee health and wellness programme in a specific organisation. To ensure content validity of the questionnaire, it was developed based on a comprehensive literature study. Furthermore, the questionnaire was submitted to experts in the field of employee health and wellness (both in academia and organisations) to judge its validity. A trial run was used to assess whether the items are understandable and to detect problems in the questionnaire. The questionnaire was eventually divided into seven sections:

Section 1: Organisational information

This section consists of ten questions about the type of organisation, sector of operations, annual turnover, number of full-time employees and the Sectoral Education and Training Authority (SETA) the organisation is registered with. Most of the questions offer various possible alternatives, from which participants only have to select the relevant option.

Section 2: Reasons for implementation, functions and successfulness of employee health and wellness programme

This section consists of ten questions relating to reasons for implementation, functions, and effectiveness of the organisation's employee health and wellness programme. Examples of questions asked include the organisation's definition of employee health and wellness,

reasons for implementation of an employee health and wellness programme, and a rating of the perceived successfulness of the employee health and wellness programme. Some of the questions are open-ended questions and some are structured so that the relevant option can just be indicated.

Section 3: Determination of effectiveness, activities and level of employee participation in organisations' employee health and wellness programmes

This section consists of 12 questions relating to activities that form part of the employee health and wellness programme, the level of employees that form the focus of the employee health and wellness programme and the provider(s) of employee health and wellness services in the organisation. Some of the questions are open-ended, some require yes/no answers with substantiation of the answer, others require respondents to indicate their choice of answer and discuss reasons for their choice, and others are merely fill-in questions.

Section 4: Organisational contributions, strikes, absenteeism and staff turnover

This section consists of 15 questions relating to contributions made by the organisations to employees regarding medical aid, retirement funds and other benefits. Questions are also asked about the number of strikes in the organisation, absenteeism and staff turnover. Questions are asked concerning the reasons for strikes, benefits provided, days lost because of strikes, amount of leave and working hours lost because of accidents. Some of the questions are open ended, some require yes/no with a discussion of the answer and some are rateable on a five-point scale.

Section 5: Budget, needs analyses and types of interventions of organisations' employee health and wellness programmes

This section consists of 22 questions relating to the budget, needs analyses and types of interventions of the organisation's employee health and wellness programme. Questions are asked about how the employee health and wellness programme is funded, the percentage of annual payroll spent on the employee health and wellness programme, how employee needs are determined, and also how often needs are determined. Some of the questions are open-ended, some require yes/no with substantiation of the answer, others require respondents to indicate their choice of answer and discuss reasons for their choice, others are merely fill-in questions, and some are rateable on a five-point scale.

Section 6: HIV/AIDS Programme

This section consists of four questions relating to HIV/AIDS activities in the organisations. Questions are asked about the components of the organisation's HIV/AIDS programme and whether it is part of the employee health and wellness programme. A question is also asked about the objectives of the HIV/AIDS programme. One of the questions requires the respondent to mark the answer, one is open-ended, and two are yes/no questions.

Section 7: Employee Health and Wellness Legislation

This section consists of three questions regarding legislation that influences employee health and wellness in South Africa, and the influence of unions in employee health and wellness activities.

3.2.4 Procedure

After the development and validation of the *Employee Health and Wellness Survey*, it was distributed to 300 organisations. Some questionnaires were handed to the persons in charge of their organisations' EAPs/Employee Health and Wellness Programmes at the Employee Assistance Programme Association of South Africa (EAPA-SA) Annual conference. Further copies of the survey were emailed to organisations that were identified through telephonic interviews as having Employee Health and Wellness Programmes in their organisations. Further copies of the survey were distributed with the help of the two major EAP Service-providers in South Africa. After intensive follow-up for three months, only one questionnaire was received back and it was clear that the large-scale quantitative approach was not suitable.

The process of data collection was then redesigned because of the poor response rate. Interviews were then set up with some of the more prominent organisations in South Africa, as well as with some government institutions ($n = 16$). Each organisation was then interviewed by using the survey that was developed, as base of the interview.

Unions were also targeted as part of the data collection, and seven unions ($n = 7$) were interviewed to explore their opinions of employee health and wellness in South Africa. Four service providers ($n = 4$) were also interviewed to establish the nature of employee health and wellness services provided in South Africa. By using this mixed-method approach to gain information from all major stakeholders within the sector, it is anticipated that a good

representation of the current situation regarding employee health and wellness practices in South Africa can be obtained.

3.2.5 Statistical analysis

The statistical analysis is carried out with the help of SPSS (SPSS, 2007). Descriptive statistics (for example means, standard deviations) were used to analyse the data.

4. CHAPTER DIVISION

Chapters are divided as follows:

Chapter 1: Introduction

Chapter 2: Management of employee health and wellness in South Africa

Chapter 3: Infrastructure of employee health and wellness in South Africa

Chapter 4: Employee health and wellness in South Africa: The role of legislation and management standards

Chapter 5: Conclusion and recommendations

5. CHAPTER OVERVIEW

In this chapter the problem statement and motivation for the research was discussed. The purpose of the research was formulated, the methodology of the research is outlined and the methods used for the statistical analysis are described.

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CHAPTER 2

RESEARCH ARTICLE 1

MANAGEMENT OF EMPLOYEE HEALTH AND WELLNESS IN SOUTH AFRICA*

ABSTRACT

Research regarding the management of employee health and wellness programmes is lacking in South Africa. The objective of this research is thus to describe employee health and wellness management in South Africa by investigating the types, foci and perceived success of employee health and wellness programmes deemed as enhancing the health and wellness of the recipients of their service. The sample is cross-sectional and surveys perspectives on employee health and wellness of 16 organisations ($n = 16$), service providers ($n = 4$) of employee health and wellness programmes (EHWPs), and labour unions ($n = 7$) in South Africa. The results show that employee health and wellness is defined differently by role players within the sector and that reasons for, and perceptions about reasons for, implementation across organisations, service providers and labour unions also differ. Almost half of the participating organisations have no baseline measurement with which to compare the effectiveness of their EHWPs. Generally, results of programmes are reasonably presented in all the organisations, and yet funding of programmes amounts to very little overall cost.

Keywords: Employee health and wellness; management of; implementation of; role players; results; funding.

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OPSOMMING

In Suid-Afrika is daar 'n gebrek aan navorsing wat betref die bestuur van werknemergesondheids- en welstandsprogramme. Die doel van hierdie navorsing is dus om werknemergesondheids- en welstandsbestuur in Suid-Afrika te beskryf deur 'n ondersoek uit te voer na die tipes, fokusse, en waargenome sukses van werknemergesondheids- en welstandsprogramme wat geag word bevorderend te wees van die gesondheid en welstand van die gebruikers van die dienste wat sodanige programme bied. 'n Langssnitsteekproef, wat die perspektiewe rakende werknemergesondheid en -welstand van 16 organisasies ($n = 16$), vier diensverskaffers ($n = 4$) van werknemergesondheids- en welstandsprogramme (WGWP'e) en sewe vakbonde ($n = 7$) in Suid-Afrika verteenwoordig, is geneem. Die resultate dui daarop dat rolspelers binne hierdie sektor werknemergesondheid en -welstand op verskillende wyses definieer. Net so verskil die redes vir, en persepsies rakende die redes vir die implementering van werknemergesondheids- en -welstandsprogramme van organisasie/diensverskaffer/vakbond tot organisasie/diensverskaffer/vakbond. Bykans die helfte van die deelnemende organisasies beskik oor geen basisvlak-maatstaf waarmee die effektiwiteit van hulle WGWP'e vergelyk kan word nie. Algemeen gesproke, word die resultate van programme op 'n redelike wyse binne al die organisasies bekendgemaak – tog bring die befondsing van die programme baie min oorhoofse kostes mee.

Sleutelwoorde: Werknemergesondheid en -welstand; Bestuur van; Implementering van; rolspelers; resultate; befondsing.

INTRODUCTION

Presently, organisations are becoming more aware of issues related to employee well-being (Hooper, 2004), and there is enhanced public interest in the integration of well-being and wellness activities with the responsibilities of the employer (Hillier, Fewell, Cann, & Shephard (2005). Due to developments within the world of work, various models of Employee Assistance and Employee Wellness continue to proliferate in the marketplace, resulting in various Programmes, namely Employee Assistance Programmes (EAPs) and Employee Wellness Programmes (EWPs). However, a shift has taken place in this area in terms of the motivation for these programmes. Where organisations previously used to motivate their EAPs for reasons of social responsibility, organisations nowadays base their rationale on a body of Human Resource (HR) theory, which draws clear links between employee well-being, productivity, absenteeism and staff turnover. Organisations have also become increasingly aware that people in distress may place the organisation at risk through their behaviour, and that subsequent losses to the organisation may be extremely expensive (Hooper, 2004).

The history of EAPs is intertwined closely with that of Alcoholics Anonymous (AA), which started in 1935. The first programmes, called Occupational Alcoholism Programmes (OAPs) were so successful in terms of saving money, increasing productivity, and of ultimately 'rehabilitating' skilled workers, that it was reasonable to assume that such an approach to the problem of alcoholism would be effective for other human problems as well (Dickman & Challenger, 2003). These programmes were expanded to reach the families of alcoholic workers and also persons with other life problems. This enlarged scope of OAPs led to the modern Employee Assistance Programme (EAP), and is known as the "broad brush" approach. This approach basically increases the services of the assistance programme to include assistance with marriage and family problems, emotional problems, financial and legal problems, and, in addition to alcoholism, other substance abuse problems. This became the typical industrial counselling approach by the end of the 1970's.

During the 1980's, the approach to employee health and wellness again changed to that of Employee Enhancement Programmes (EEPs) (Dickman & Challenger, 2003). The EEP followed a preventive approach by concentrating on stress management, holistic health concepts, and other addictive problems such as smoking, overeating and overworking. It purported that if stress was controlled and employees were taught healthy lifestyles, such

problems as those dealt with by OAPs and EAPs might be prevented (Dickman & Challenger, 2003). Today, Employee Wellness Programmes (EWPs) are implemented with a focus greatly similar to that of EEPs, but incorporating new thinking from the realm of Positive Psychology.

The purpose of implementing a wellness programme in an organisation is to create an awareness of wellness issues, to facilitate personal change and health management, and to promote a healthy and supportive workplace (Anonymous, 2005). Generally, such implementation also aims to prevent risk to employees. Wellness is a holistic concept that considers a person as a whole and works from the assumption that the well-being of the employee influences the well-being of the organisation, and even colleagues; therefore well-being must be maintained and improved. Employees and organisations seek a balance between current levels of functioning and continuous improvement. The underlying assumption is therefore that the more support the individual experiences from within and from the organisation, the more likely he/she will be to enjoy higher levels of wellness. By initiating a wellness programme, the organisation wants employees to take charge of and responsibility for their own well-being. EAP interventions are increasingly targeting workplace and worker wellness (Derr & Lindsay, 1999). This move towards healthy workplaces and empowered employees mirrors trends between positive psychological states and organisational well-being (Maslach, Schaufeli, & Leiter, 2001; Van Den Bergh, 2000). Early efforts to incorporate wellness programmes within EAPs were focused on the promotion of healthy lifestyles. However, these programmes have located the responsibility for well-being within the individual rather than within the work setting (Csiernik, 1995). EAP providers are now being encouraged to offer early interventions that encompass health and well-being programmes which take rise from the perspective of developing the strengths which are inherent within both the client and the organisation (Van Den Bergh, 2000).

This article focuses on the way(s) in which South African organisations are managing their employee health and wellness programmes in order to keep their employees well at work, by means of either their Employee Assistance or their Employee Health and Wellness programmes. EAPs in South Africa only started to emerge in the 1980's, and the emergence of Employee Wellness programmes in South Africa is a relatively new development. The development of EAPs in South Africa was initiated by the Chamber of Mines of South Africa, when a feasibility study was carried out in the mining industry in 1983 by a

consultant appointed by the then Chamber of Mines of South Africa (Terblanche, 1992). This feasibility study presents a milestone in the development of EAPs in South Africa. Since the 1983 study, many studies have been done by various authors on the conceptual sophistication and focuses of different programmes (Bennet, 1999; Maiden, 1992; Terblanche, 1992). However, up to date, no studies have been done on Employee Health and Wellness programmes (EHWPs) in South Africa. When EAPs were first introduced, resistance to the use of the EAPs' services was evident. This was attributed to the perception that people who make use of the services offered would be regarded as alcoholics (Gerber, 1995; Naidoo & Jano, 2003). Likewise, participation in Employee Wellness programmes is sometimes problematic because employees do not trust the confidentiality of the employee wellness practitioners, and employees consider participation in the programme to be another demand, rather than a resource. EAPs have come a long way to shrug off these earlier characterisations. On the other hand, many employees now associate employee health and wellness with health checks rather than with practices that improve the work and organisational environments of employees.

Less than half of South Africa's top 100 organisations have EAPs in their organisations, in spite of the important role that such programmes can play in promoting employee health and wellness, and in assisting organisations and employees to adjust to rapidly changing contexts (Naidoo & Jano, 2003). This is alarming, seeing that change is a factor that greatly reduces wellness at work (Hillier et al., 2005). In the cases where an EAP does exist, it is often not part of the core business structure (Bennett, 1999). This implies that organisations do not realise the extent to which employee health and wellness contributes to the organisation's bottom-line. Organisations that invest time and resources in an employee health and wellness culture, with the focus on being proactive rather than reactive, can expect a return on such investment. The possible return on investment might include lower absenteeism, healthier employees, fewer accidents and lower staff turnover (Dhanesar & Hales, 1994). No data is available on how many of South Africa's organisations have employee wellness programmes in their organisations.

Terblanche (1992) conducted a survey to determine the conceptual sophistication of EAPs operating in the South African business community. According to the survey, only 69% of employer respondents actually offered direct assistance to their employees and of this percentage, only 58% offered it in a structured programme. Terblanche also found that 58%

of the companies surveyed had active management participation and support, and he concluded that management participation and support in South Africa was quite strong.

It is important that organisations realise that EAPs can be of help in maintaining and improving productivity, and can assist in meeting the new labour legislation requirements (Naidoo & Jano, 2003). Organisations are also beginning to realise that a direct relationship exists between employee wellbeing and productivity (Harper, 1999). Also, Employee Health and Wellness programmes can make a contribution to organisations by means of improved morale, increased loyalty, improved employee relations, improved productivity, reduction in absenteeism, reduction in number of accidents, coping with stress and better decision making, increased energy and creativity, and an improved corporate image (Andrew, 1999). Naidoo and Jano (2003) therefore suggest that problems should be approached in a structured way, focusing on the individual and on the organisation. The reasoning behind this approach is that the wellness of an employee can influence the wellness of an organisation, and vice versa.

Central to the thesis of this study is the need to differentiate between Employee Assistance and Employee Wellness Programmes. An Employee Assistance Programme (EAP) is a worksite-based programme to assist in the identification of problems associated with employees impaired by *personal* concerns including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other *personal* concerns which may (but not necessarily do) adversely affect employee job performance. These interventions are person-directed and are targeted toward changing personal characteristics without the explicit aim to improve employee functioning at work. Thus, the EAP is there to assist the employee with general problems that would not *necessarily* have an influence on the improvement of his/her job performance if the problems were to be resolved, although the implied assumption is that solving these problems will contribute to such improvement. An Employee Wellness Programme (EWP) is a worksite-based programme to assist in the identification of problems associated with employees impaired by *work-related* concerns including, but not limited to: job redesign, restructuring, ergonomic improvements, job training, improving coping skills, job stress management and other *work-related* concerns which adversely affect employee job performance.

An Employee Assistance Programme or an Employee Wellness Programme is an intervention and can therefore be classified according to the target or the level of intervention. These

interventions are *work-directed* and focus on factual changes in the work content and/or relations at work; they are geared towards eliminating, reducing, or altering stressors in the work situation. These interventions apply to all members of the organisation or in a particular job. Interventions focusing on the *person/work interface* are usually intended to increase employee resistance to specific job stressors, with the explicit aim of improving particular aspects of the employee's functioning at work. Thus, these interventions focus on the working individual in the context of the organisation, and aim to improve the match between the person and his or her work environment. These interventions apply to all employees performing a particular task and not only to employees who perform poorly or who show signs of stress. Lastly, *person-directed interventions* are targeted toward changing personal characteristics without the explicit aim to improve employee performance at work. This does not imply that performance at work may not improve as a result of these measures, but rather that no explicit link is made with particular stressors in the work situation. Thus, benefits of such programmes may include improved employee performance within and outside the work context (Taris et al., 2003).

Interventions are also classified according to their levels, namely primary, secondary and tertiary interventions, all with different purposes. Where *primary interventions* focus on altering stressors in the work situation, *secondary interventions* focus on preventing employees from getting sick. *Tertiary intervention* is concerned with treatment activities for employees with serious stress-related health problems (Kompier & Cooper, 1999) Most activities are primarily aimed at the individual rather than at the workplace or the organisation; in other words, a worker-oriented approach is followed, for instance by improving employees' skills to manage, resist or reduce stress, as opposed to a job or organisationally-oriented approach, by for instance job redesign, or in some way transforming the incapacitating corporate culture or management style.

Based on the problem statement outlined above, the general aim of this research is to conceptualise employee health and wellness management in the South African context, by investigating the types, focus and successes of employee health and wellness programmes.

Specific aims

1) To conceptualise and define employee health and wellness as it currently manifests in selected South African organisations, 2) To investigate reasons for implementation of employee health and wellness programmes in South African organisations, 3) To investigate management involvement in the management of employee health and wellness in their organisations, and presentation of results of employee health and wellness programmes, 4) To determine how organisations rate the successfulness and effectiveness of their employee health and wellness programmes, 5) To determine employee input, participation rates, and how organisations fund their programmes.

METHOD

Research design

To achieve the research objectives a survey design was used. A cross-sectional design was used which means a sample is drawn from the available population at a particular point in time (Shaughnessy & Zechmeister, 1997). By making use of the cross-sectional design, information collected is used to describe a population at that time and to assess interrelationships among variables within a population.

Participants

The participants consisted of organisations that contribute to employee health and wellness and employee assistance in various sectors of South Africa. A total of 16 organisations ($n = 16$) were targeted and provided data deemed suitable for analysis. Also, the opinions of four service providers ($n = 4$) on employee health and wellness in South Africa were incorporated. A total of seven labour unions ($n = 7$) were also approached, in order to incorporate their opinions on employee health and wellness in South Africa into the holistic understanding of employee wellness management.

Characteristics of participating organisations (See Appendix, Table 1 and 2, p 59)

The sample consisted of 16 organisations, of which 37,50% were public companies and 25% private companies. The other 37,59% of the organisations were made up by multinational

companies, joint ventures, national government and universities. Most of the organisations were from the Transport, Storage and Communications sector (25%), as well as the Manufacturing and Education sectors (both 12,50%). Approximately 31% of the organisations have between 1001 and 3000 employees and 25% have between 5001-10 000. One quarter of the organisations (25%) did not want to disclose their turnover. However, 12,50% of the organisations indicated their annual turnover to be between R 1 000-R 1 250 million, while 12,50% of participating organisations' turnover was more than R 3 500 million per annum. Half of the organisations (50%) could not provide information regarding their annual payroll expressed as a percentage of annual turnover; however, for those organisations where this information was available, 18,80% indicated that their annual payroll expressed as a percentage of annual turnover ranged between 31-40%. Considering just the companies where information was available, 62,50% indicated that they spent 40% or less of turnover on annual payroll. Only 25,10% of the organisations were established after 1994, and the youngest organisation is only six years old, while the eldest has been in operation for over a century.

All of the participating organisations were registered at their relevant Sector Education and Training Authority (SETA) for skills development purposes. SETAs are to ensure that the skills requirements of the various sectors are identified, and that the adequate and appropriate skills are readily available. However, 68% of the organisations were unable to provide information regarding their skills levy costs per month.

Characteristics of the Participating Service Providers (See Appendix, Table 3, p 62)

Four service providers participated in this study, of which 50% had between 201-500 organisations they provide services too. The smallest indicated that they provide services to between five (5) and ten (10) organisations, while the service provider with the second largest customer base indicate that they service between 11 and 50 organisations. The longest established service provider was nine (9) years old and the most recent established only two (2) years old.

Characteristics of the Participating Labour Unions (n=7) (See Appendix, Table 4)

In this study, there were seven (7) participating labour unions and of these, 57,10% had members across all the sectors of operations. The smallest membership was between 3001-5000, and the largest union had more than 500 000 members. The oldest union is more than

100 years old and was established in 1905, and the youngest in 2001. In this study, 32% of the unions were established after 1994.

Measuring instruments

A survey, The *Employee Health and Wellness Survey*, was developed by the researcher to determine the nature, content, context, participants, role players and anticipated benefits and possible drawbacks of a work wellness programme in a specific organisation. To ensure content validity of the questionnaire, it was developed based on a comprehensive literature study. Furthermore, the questionnaire was submitted to experts in the field of employee health and wellness (both in academia and organisations) to judge its validity. A trial run was used to assess whether the items are understandable and to detect problems in the questionnaire. The questionnaire was divided into seven sections (**See Appendix, Measuring instruments, p 63, for full description.**):

Section 1: Organisational information.

Section 2: Reasons for implementation, functions and perceived successfulness of employee health and wellness programme.

Section 3: Determination of effectiveness, activities and level of employee participation in organisations' employee health and wellness programme.

Section 4: Organisational contributions, strikes, absenteeism and staff turnover.

Section 5: Budget, needs analysis and focus of interventions of organisations' employee health and wellness programme.

Section 6: HIV/AIDS Programme.

Section 7: Employee Health and Wellness Legislation.

The *Employee Health and Wellness Survey (Service Providers)* was developed to determine the amount of organisations they provide services to, the nature of services they provide and how they define employee health and wellness.

The *Employee Health and Wellness Survey (Labour Unions)* was developed to determine the sector in which the labour unions operate, how many members they have, how they define employee health and wellness and how they influence employee health and wellness issues in their members' respective organisations.

Statistical analysis

The statistical analysis was carried out with the help of the SPSS programme (SPSS, 2007). Descriptive statistics (for example means, frequency counts, and percentages) were used to analyse the data. Descriptive statistics are deemed suitable and sufficient for this analysis as the aim of the study is descriptive in nature.

RESULTS

Employee Health and Wellness as Defined by Participating Organisations, Service Providers and Labour Unions

Employee Health and Wellness was defined by organisations, service providers and labour unions. The dimensions were categorised by first grouping together similar responses. After the responses were grouped, a name was allocated to the dimension that described the collective responses as a group. A total of 14 dimensions were identified as constituting employee health and wellness, as conceptualised by participating organisations, service providers and labour unions. The 14 dimensions were defined as the following (See **Appendix, Table 5 for full description.**):

- 1) Health.
- 2) Occupational health and safety (OHS).
- 3) Dimensions of wellness
- 4) Work wellness
- 5) Self development.
- 6) Employee benefits.
- 7) Legal requirements.
- 8) Performance dimension.
- 9) Recognition of dual benefits. .
- 10) Employee services.
- 11) Employee responsibility.
- 12) Wellness management.
- 13) Stress.
- 14) Holistic.

Next, the definitions of employee health and wellness as given by participating organisations, service providers and labour unions are given separately. This was done in order to gauge to what extent these different role players have the same concept in mind. The categories as developed above are used in the following descriptions (Tables 1, 2 and 3). Table 1 shows how the different organisations each defined Employee Health and Wellness regarding the different dimensions.

Table 1

Definitions of Employee Health and Wellness as Reported by Participating Organisations

Organisation		Definition				
1	Holistic	Recognition of Dual benefits	Wellness Management	Employee Responsibility	Dimensions Of Wellness	
2	Health	Stress	Employee Responsibility			
3	Dimensions Of Wellness	Positive work influences	Recognition of Dual benefits	Employee Services		
4	Health	Dimensions Of Wellness	Self Development	Positive work influences		
5	Self Development	Positive work influences	Stress			
6	Self Development	Work Wellness	Holistic	Employee Responsibility	Health	
7	Health	Holistic	Stress			
8	Legal Requirements	Health	Employee Services	Stress	Work Wellness	Positive work influences
9	Employee Benefits	Positive work influences	Employee Services			
10	Dimensions Of Wellness	Wellness Management	OHS			
11	Dimensions Of Wellness	Positive work influences				
12	Health	Positive work influences				
13	Dimensions Of Wellness	Self Development	Legal Requirements	Positive work influences		
14	Health	Employee Responsibility	Wellness Management	Dimensions Of Wellness		
15	Dimensions Of Wellness	Holistic	Self Development			
16	Health	Dimensions Of Wellness	Wellness Management			

Table 1 shows which organisation classified Employee Health and Wellness regarding which dimensions. Most of the organisations (seven (7)) referred to only three (3) dimensions (in

total) when they defined employee health and wellness. Half of the organisations referred to Health in their definitions and nine organisations referred to the “Dimensions of Wellness” in their definition of employee health and wellness.

Table 2 shows how the different service providers each defined Employee Health and Wellness regarding the different dimensions identified (See Appendix, Table 5 for full description.):

Table 2

Definitions of Employee Health and Wellness as Reported by Participating Service Providers

Service Provider		Definition				
1	Health	Recognition of Dual Benefits	Employee Responsibility	Positive work influences		
2	Dimension of Wellness	Holistic	Legal requirements	Work Wellness		
3	Dimension of Wellness	Recognition of Dual Benefits	Positive work influences	Self Development	Employee Responsibility	Work Wellness
4	Recognition of Dual Benefits	Wellness Management				

Table 2 indicates how the participating service providers defined Employee Health and Wellness regarding the 14 dimensions. Only two (2) of the service providers referred to Work wellness and to Positive work influence in their definitions of employee health and wellness. Two (2) of the service providers referred to Employee responsibility in their definition of employee health and wellness.

Table 3 shows how the different labour unions each defined Employee Health and Wellness regarding the different dimensions. (See Appendix, Table 5 for full description.)

Table 3

Definitions of Employee Health and Wellness as Reported by Participating Labour Unions

Labour Union		Definition			
1	Health	OHS	Work wellness		
2	Health	Dimensions of Wellness			
3	OHS	Work Wellness	Positive work influences	Self development	Legal requirements
4	Employee Services	Employee Benefits	Legal requirements		Employee Benefits
5	Health	OHS	Legal requirements		
6	Health	Employee Benefits	Legal requirements	Holistic	
7	OHS	Legal requirements	Self development	Employee responsibility	

Table 3 indicates how the participating labour unions classified employee health and wellness regarding the identified dimensions of wellness. Of all the labour unions, 57,14 % referred to Health in their definition of employee health and wellness and 57,14 % to Occupational health and safety (OHS). Most of the labour unions (71,43%) referred to Legal requirements and only 14,30% referred to Employee responsibility.

Table 4 indicates the reasons for the implementation of Employee Health and Wellness programmes, as it was reported by the participating organisations. Percentages are expressed as a percentage of all reasons stated.

Table 4

Reasons why Organisations Implement Employee Health and Wellness Programmes, as Reported by Participating Organisations

Item	Frequency	Percentage
High incidence of sick leave	5	10,90
Social responsibility	4	8,70
High absenteeism	4	8,70
Addressing stress	3	6,50
Employee needs for services	3	6,50
HR incidents	3	6,50
High amount of people working overtime	3	6,50
OHS law compliance	2	4,30
HIV/Aids legislation	2	4,30
Making employees more productive	2	4,30
Management thought it necessary	2	4,30
High number of accidents	2	4,30
Employer of choice	1	2,20
Proactive approach to problems	1	2,20
Retaining employees	1	2,20
Outcome of Wellness assessment	1	2,20
Organisational change	1	2,20
Work/Life balance	1	2,20
Employee should not have excuses for not being productive	1	2,20
Wellness should make financial sense	1	2,20
Annual medical for employees working with food	1	2,20
Union pressure	1	2,20
New legislation	1	2,20

Table 4 shows that the main reason for the implementation of Employee Health and Wellness programmes were indicated as high incidences of sick leave. The second group of reasons, related mostly to high rates of absenteeism, and social responsibility. The third group of reasons given mostly for implementation related to addressing stress, employee needs and services, because of HR incidents or due to the fact that a high amount of people were working overtime.

Table 5 indicates the perceived reasons why organisations implement Employee Health and Wellness Programmes as perceived by participating service providers.

Table 5

Reasons why Organisations Implement Employee Health and Wellness Programmes, as Reported by Participating Service Providers

Item	Frequency	Percentage
Social Responsibility	2	16,70
Employer of Choice	2	16,70
Medical cost reduction	1	8,30
OHS law compliance	2	16,70
HIV/Aids Legislation	1	8,30
Influence on Bottom-line	1	8,30
Unhappy employees negatively impact on production	1	8,30
Reacting to problems	1	8,30
Proactive to problems	1	8,30

Table 5 shows that the main reasons why the participating service providers perceived that the organisations they provide services to implemented employee health and wellness programmes were for reasons of social responsibility, in order to become an employer of choice and compliance with OHS law.

Table 6 indicates the reasons why organisations implement Employee Health and Wellness Programmes, as perceived by participating labour unions.

Table 6

Reasons why Organisations Implement Employee Health and Wellness Programmes, as Reported by Participating Labour Unions

Item	Frequency	Percentage
Social Responsibility	2	14,3
Medical cost reduction	1	7,1
OHS law compliance	2	14,3
Influence on Bottom-line	1	7,1
Employees more productive	5	35,7
Retaining of employee	2	14,3
Dual benefit for employee and employer	1	7,1

Table 6 shows that according to labour unions, the reasons why their members' employers implement Employee Health and Wellness programmes are mainly to make their employees more productive, social responsibility, compliance with OHS law and employee retention.

In rating the effectiveness of their organisations' employee health and wellness programmes, 62,50% participating organisations rated their programmes as 70% successful, or higher. Of the remainder, 18,80% rated their programmes as 60% successful, and only 12,50% of the organisations gave their programme a rating of only 50% successful. One organisation indicated that their programme is not yet rateable.

Implementation dates. Most of the organisations (87,50%) surveyed have implemented their employee health and wellness programmes since the year 2000. One organisation did not know the implementation date of their programme, and one organisation's programme has been running since 1970.

Negative consequences of employee health and wellness programme implementation. When asked about negative consequences of implementing their employee health and wellness programmes, 50% of the 16 organisations that participated in the study said that the implementation of the programme did not have any negative side effects. The other half (50%) indicated that implementation did have negative side effects.

Table 7 indicates the negative side effects which were noted as resulting from the implementation of the employee health and wellness programme.

Table 7

Negative Side Effects of Implementation of Employee Health and Wellness Programmes

Item	Frequency	Percentage
Trust and confidentiality issues	4	36.3
Implementation problems	2	18.2
Logistical problems with remote locations	2	18.2
Staff not sensitive to employees	1	9.1
Low uptake on programme	1	9.1
Management were concerned they were getting soft	1	9.1

Table 7 indicates that most of the negative side effects because of the implementation of the programme were because of trust and confidentiality issues (36,30%). Implementation problems and logistical problems with remote locations (18,20%) were the second most noted reasons for negative effects of employee health and wellness programme implementation.

Table 8 indicates the reasons why organisations rated their employee health and wellness programme as successful.

Table 8

Reasons given for Rating of Employee Health and Wellness Programme as Successful

Organisation	Rating	Reasons	Reasons	Reasons	Reasons	Reasons
1	70% and higher	Good in-house EAP	Network to solve problems	Train line managers to EAP	Services address staff needs	HIV programme best in sector
2	70% and higher	Participation High	High % of self referrals	70% of staff with HIV is on treatment		
3	70% and higher	Services address staff needs	Good counselling services	Good Health Services	Use a service provider	
4	60%	Good counselling services				
5	70% and higher	Wellness Assessment was done	Feedback on assessments	Implementing interventions	Pro active	
6	60%	No reasons				
7	70% and higher	Reduction in Absenteeism	Voluntary testing			
8	60%	Participation High				
9	70% and higher	Reduction in Absenteeism	High % of self referrals	Staff feedback Positive		
10	70% and higher	High uptake on VCT	Increase participation	Support of executive members		
11	70% and higher	Focus on Psychosocial	Good Health Services			
12	70% and higher	Participation High	Wellness days at branches	HIV training high		
13	50%	Reporting from service provider not adequate	Wellness not measurable	Reports from service provider provide poor information	Service provider can't cope with emergencies	
14	50%	Staff feedback Positive	Raised awareness	Good counselling services		
15	Not rated	Not yet rateable				
16	70% and higher	Suicide dramatically down	Used in Senior selection	Reduction in absenteeism	Medical incapacity reduced	

Table 8 shows the reasons given by organisations for rating the successfulness of their employee health and wellness programme were quite different from one organisation to the next. Three of the organisations that gave themselves ratings of 70% and higher, indicated that a reduction in absenteeism was the reason for their rating. Organisation number 13 (see Appendix 1 Table 2) contributed their rating of 50% due to problems with their service

provider and the fact that wellness according to them is not measurable. Organisation number 6 (see Appendix, Table 2) gave no reasons for their rating of 60% for the employee health and wellness programme.

Organisations that gave their programme a poor rating were also given the opportunity to indicate reasons for their rating. Table 9 indicates the reasons that organisations gave that contributed to the reduced effectiveness of their employee health and wellness programme.

Table 9

Reasons given for Rating of Employee Health and Wellness Programme as Less Successful

Organisation	Rating	Negative reasons	Negative reasons	Negative reasons
4	60%	Not yet holistic	Other areas like stress not yet developed	
7	70% and higher	HIV is high	New infections rates is High	Safety record is low
9	70% and higher	No measurable outcome		
13	50%	Report from Service Provider not adequate	Wellness not measurable	Service provider can't cope with emergencies
14	50%	No measurable outcome	Lack of knowledge about programme	

Table 9 reflects the reasons organisations gave a rating of reduced effectiveness to their employee health and wellness programme. Three organisations indicated that the measurability of their programme was a problem. Two of these organisations that gave the poorest ratings to their programmes related it to measurability. Organisation number 14 also indicated that not being able to measure the outcomes of their programme reduced to their inability to measure its effectiveness, but still gave themselves a rating of 70% and higher.

Table 10 shows the frequencies with which indicators of effectiveness were named by organisations.

Table 10

How Effectiveness of Programme is Determined

Item	Effectiveness not measured (n=7)	Effectiveness measured (n=9)
Utilisation rate	2	4
Absenteeism measured	1	2
Feedback from staff		2
HIV registration		1

Table 10 continued

How Effectiveness of Programme is Determined (continue)

People on HIV that return to work	1	
Medical boardings down		1
Success of smoking cessation		1
Extensive marketing		1
Reach more people		1
Psychological rate		1
Chronic disease report from Medical Aid	1	
Problems with report from Service providers	1	
Buy-in	1	
Targeted projects focus on real needs		1
Good planning		1
Look at different indicators		1
Exit interviews		1
Amount of suicides down		1

It can be seen from Table 10 that seven (7) of the organisations do not measure effectiveness of their employee health and wellness programme, but that they do look at aspects such as utilisation rate, absenteeism, chronic-disease reporting and buy-in. Though they took these aspects into consideration, the organisations acknowledged that those are not true effectiveness measures. One (1) organisation stated that effectiveness could not be measured because of a problem experienced with the report from the service provider. Nine (9) of the organisations indicated that they did measure effectiveness of their employee health and wellness programmes as indicated by utilisation rate, measuring of absenteeism and feedback from staff.

Improvement of employee health and wellness programme service delivery

It was indicated that 87,50% of the organisations felt that the service delivery of their employee health and wellness programme could be improved.

Table 11 shows organisations' suggestions to improve service delivery of their employee health and wellness programmes.

Table 11

Organisations' Suggestions Regarding Improvement of Service Delivery of Employee Health and Wellness Programmes

Item	Frequency	Percentage
Holistic and integrated	7	21.20
More resources and personnel	6	18.20
In-house EWP	4	12.10
Accurate assessments	3	9.10
Targeted intervention	2	6.10
Improved training	2	6.10
Follow up on intervention	2	6.10
New Ideas	2	6.10
Return on investment	1	3.00
Support employees more	1	3.00
Communications and marketing	1	3.00
Busy implementing	1	3.00
Coordinator focus more on the wellness programme	1	3.00

Table 11 indicates the organisations' suggestions to improve service delivery of their employee health and wellness programmes. Most of the suggestions were regarding the programme being more holistic and integrated (21,20%), more resources and personnel being allocated to the programme (18,20%) and that the organisation must provide their employee health and wellness programme in-house.

Table 12 indicates how often organisations determine their employees' needs regarding employee health and wellness.

Table 12

How often Employees' Needs regarding Health and Wellness is Determined

Item	Frequency	Percentage
Monthly	5	31,25
Quarterly	4	25,00
Annually	3	18,75
Every six months	2	12,50
Every two years	2	12,50

Table 12 shows that 31,25% of the organisations determine their employee needs regarding employee health and wellness monthly, 25% determine it quarterly and 18,75% determine it annually.

Table 13 shows how organisations determine their employees' needs regarding employee health and wellness in their organisation.

Table 13

How Employees' Needs are Determined Regarding Employee Health and Wellness

Item	Frequency	Percentage
Surveys and questionnaires	4	12,10
Feedback and discussions with employees	8	24,20
Organisational assessment	2	6,10
Feedback from service providers	3	9,10
Health risk assessments	4	12,10
Inputs from management	3	9,10
Inputs from EHW personnel	5	15,20
Feedback form Unions	2	6,10
Look at trends and tendencies	1	3,00
Profile of employees	1	3,00

Table 13 indicates the ways in which organisations determine the needs of their employees regarding employee health and wellness. The most reported "tool" that organisations used were, Feedback and discussions with employees (24,20%), Inputs from employee health and wellness programme personnel (15,20%), Surveys and questionnaires (12,10%) and Health risk assessments (12,10%). Only 24, 20% of participating organisations did an Organisational assessment to determine the needs of employees that need to be addressed.

Table 14 shows the participation rates of employees in their respective organisations' employee health and wellness programmes.

Table 14

Percentage of Employees that Participate in their Organisation's Employee Health and Wellness Programmes

Item	Frequency	Percentage
Unknown participation rate	2	12,50
8,00%	1	6,25
10,0%	1	6,25
17,00%	1	6,25
20,0%	2	12,50
30,0%	2	12,50

Table 14 continued

Percentage of Employees that Participate in their Organisation's Employee Health and Wellness Programmes

40,0%	1	6,25
50,0%	2	12,50
Between 10% and 50%	1	6,25
60,0%	2	12,50
71,00%	1	6,25

Table 14 indicates the percentage of employees which participate in their organisation's employee health and wellness programmes. Of all the organisations 12,50% could not provide a participation rate, 31,25% of the organisations' participation rate was 20% and below, 31,25% of the organisations' participation rate was between 30% and 50% and 18,75% of the organisations' participation rate was above 60%.

Presentation of results of employee health and wellness programme

It was indicated that of all the organisations, 87,50% present the results of their employee health and wellness programme to various stakeholders and at various events. Table 16 shows *where* the results of the Employee Health and Wellness programme are presented.

Table 15 shows *when* the results of the Employee Health and Wellness programme are presented.

Table 15

When the Results of Employee Health and Wellness programmes are Presented

Item	Frequency	Percentage
Once a year	4	25,00
Two (2) times per year	3	18,75
Quarterly	3	18,75
Executive meeting (ad hoc)	2	12,50
After Health days	1	6,25
Monthly	1	6,25
Not presented	2	12,50

Table 15 shows that of all the organisations, 25% presented their results once a year, 18,8% presented the results twice a year and 18,8% presented it quarterly.

Table 16 indicates where the results of the employee health and wellness programme are presented.

Table 16

Where the Results of Employee Health and Wellness Programme are Presented

Item	Frequency	Percentage
Board meetings	2	12,50
Business unit	2	12,50
Not presented	2	12,50
Corporate office	1	6,25
Council meeting	1	6,25
Employee Wellness programme committee meeting	1	6,25
Executive meetings	1	6,25
In Parliament	1	6,25
Institutional meetings	1	6,25
Regional County Chair	1	6,25
Senior management meetings	1	6,25
To all Business unit managers	1	6,25
To CEO	1	6,25

Table 16 shows that most of the organisations (12,50%) present their results at Board meetings and Business unit meetings. Also, 12,50% indicated that results of their programme are not presented anywhere.

Table 17 shows how the organisations rated the support they receive from management regarding employee health and wellness in their organisation.

Table 17

How Employee Health and Wellness Programme Managers Rated their Support from Management Regarding Employee Health and Wellness

Item	Frequency	Percentage
Average	1	6,25
Good	13	81,25
Excellent	2	12,50

Table 17 shows that 81,25% of the organisations rated the support they receive from management regarding employee health and wellness as “Good”, 6,25% indicated “average” and 12,50% indicated their received support as “excellent”.

Funding of employee health and wellness programmes

Most of the participating organisations (13 out of 16), reported having a budget to fund their employee health and wellness programme activities. The allocated budget ranged from R140 000 to R5 million per year. Three (3) out of 16 organisations used a flat-rate, meaning that they paid a fixed amount per employee per year. The flat-rate amount ranged from R38 000 to R1,4 million per year for all employees for the services received. This translates to between R5 and R187 spent per employee. Seven (7) of the organisations used a fee-for-service system and the cost ranged between R600 000 and R800 000, and only one (1) organisation used sponsorships of R17 000 to fund a part of their programme. Four (4) organisations used a combination of budget and fee-for-service to fund their programme and one (1) used a combination of budget and sponsorships to fund their Employee Health and Wellness Programme.

Table 18 shows the main activities on which the budget of the employee health and wellness programme is spent.

Table 18

Main Activities on which the Budget of the Employee Health and Wellness Programme is Spent

Item	Frequency	Percentage
HIV and Health services	11	37,90
EAP providers	6	20,70
Wellness services	4	13,80
Counselling	3	10,30
Training	2	6,90
Assessment	1	3,40
Social responsibility	1	3,40

Table 18 indicates that the main activities on which the budget of employee health and wellness programmes are spent were HIV and health services (37,90%), EAP providers (20,70%), wellness services (13,80%) and counselling (10,30%).

The main activities on which the flat-rate style programmes spent on was counselling, E-care (Health tips and advice via internet), HIV/Aids, and a disease risk management programme.

Main activities on which the fee-for-service style programmes spent were alcohol abuse, wellness activities, HIV/Aids services, counselling and EAP providers.

Table 19 shows the percentage of annual payroll that is spent on the employee health and wellness programme

Table 19

Percentage of Annual Payroll Spent on Employee Health and Wellness Programme

Item	Frequency	Percentage
0 - 1%	6	37,5
1,1 - 2%	3	18,75
2,1 - 3%	1	6,25
3,1 - 4%	1	6,25
No information available	5	31,25

Table 19 shows that in 37,50% of the organisations, less than 1% of the annual payroll is spent on the employee health and wellness programme. In 18,75% of the organisations the percentage was between 1,10 - 2%. A total of 31,30% of the organisation did not know the percentage of annual payroll they spent on the employee health and wellness programme.

Table 20 shows whether or not the organisations' budget for the employee health and wellness programme has changed from the previous year.

Table 20

Organisations' Indication whether or not the Budget of Their Employee Health and Wellness Programme has Changed from the Previous Year

Item	Frequency	Percentage
Increased	13	81,25
Unchanged	2	12,5
Decrease	1	6,25

Table 20 shows that 81,25% of the organisations indicated that their budget for their employee health and wellness programme increased from the previous year and 12,50% said the budget stayed the same. Only 6,25% of the organisations indicated that their budget decreased from the previous year.

Table 21 shows whether or not the organisations' budget for the employee health and wellness programme will be changed in the next year.

Table 21

Organisations' Indication whether or not the Budget of Their Employee Health and Wellness Programme will Change in the Next Year

Item	Frequency	Percentage
Increase	13	81,25
Unchanged	2	12,5
Decrease	1	6,25

Table 21 shows that 81,25% of the organisations expected that the budget for their employee health and wellness programme will increase for the next year, and 12,50% said they expect the budget to stay the same. Only 6,25% of the organisations expected that their budget will decrease for the next year.

DISCUSSION AND RECOMMENDATIONS

This study set out to describe the management of employee health and wellness in South African organisations by conceptualising and defining employee health and wellness as it currently manifests in selected South African organisations, determining the reasons why organisations implement employee health and wellness programmes in their organisations and the possible problems they experience in doing so, investigating how management is involved in the management of employee health and wellness programmes in their organisations and whether or not the results of the programme are presented to management. Also, it is considered how organisations rate the successfulness and effectiveness of their employee health and wellness programmes. The last objective was to determine the targets of employee health and wellness interventions.

Employee Health and Wellness is an ill-defined concept within South Africa and around the world. When the participating organisations, labour unions and service providers were asked to define Employee Health and Wellness, a total of 14 dimensions were identified. To complicate the matter more, none of the organisations, labour unions or service providers could agree on what Employee Health and Wellness is. In short, Employee Health and Wellness was defined in 27 different ways, by 16 organisations, four service providers and

seven labour unions. Even when separated into groups, nor the organisations, service providers or labour unions amongst themselves could agree on a single definition of the concept of Employee Health and Wellness. Most of the organisations and service providers referred to the “Dimensions of wellness” (see Table 5) in their definitions, while only one of the labour unions did. This could indicate that organisations and service providers focus more holistically on employee health and wellness than labour unions, though this is not necessarily reflected in the kinds of services provided as part of employee health and wellness programmes. Most of the labour unions also referred to health, Occupational Health and Safety (OHS) issues or legal requirements in their definitions of employee health and wellness. Although half of the organisations referred to health in their definitions, only one of the service providers did, and not one of the service providers referred to OHS in their organisations. Only one organisation referred to OHS in their definition, and legal requirements was not a dimension that featured pertinently with either the organisations or service providers. Although this is a dire situation, it is generally a reflection of existent literature, where different authors define the concept differently. Terms often used refer to “employee wellbeing” (Noblet & Rodwel, 2007, p. 2) “wellness at work” (Hillier et al., 2005, p. 1), “workplace wellness” (Wojcik, 2007, p. 3) and “work related wellbeing” (Launis & Pihlaja, 2007, p. 604; Lindfors et al., 2007, p. 816). In the literature many a time “Wellness” and “Health” is viewed as the same concept (for example DeMoranville, Schoenbachler, & Przytulski, 1998; Merina, 1992; Porter, 2005). Although the different terms all relate to the improvement of the employee by means of improved health, fitness or otherwise, the focus of different organisations are not necessarily on improving work related issues of employees. Thus, in defining employee health and wellness, the *organisations* mostly focused on health, dimensions of wellness and positive work influences. The *service providers* focused mostly on recognition of dual benefits to organisations and employees, and *labour unions* focused on legal requirements, OHS, and health. It is clear that the three groups differ in their definition of employee health and wellness. Also, labour unions strongly associated wellness with adherence to the legal requirements (Occupational Health and Safety Act and other legislation that influence employees). Though definitions of the three important role players in the employee health and wellness sphere in South Africa differs, the analyses of input from all of them present a broad and robust definition within which employee health and wellness can be conceptualised.

There were also many varying reasons why organisations implemented Employee Health and Wellness programmes in their organisations. The main reasons were high incidences of sick leave, high absenteeism and for reasons of social responsibility. These reasons indicate a reactive approach, and perhaps indicate that organisations should start investigating work factors that might contribute to employees being sick and absent from work. South Africa's HIV/AIDS rate is of the highest in the world and this can also contribute to employees being sick. Work stress can affect the health of employees directly (McClenahan, Giles, & Mallett, 2007), and current high levels of sick leave and absenteeism may thus be seen as symptoms of already existing problems. Social responsibility was also a major reason why employers implemented an employee health and wellness programme in their organisations. The reason for this can be that organisations are beginning to see a link between corporate social responsibility and an improvement in their shareholder value and morale of employees. Also, since organisations are asked to list their corporate responsibility activities in government tenders, it "pays" to invest in social responsibility (van den Ende, 2004). The fourth most reported reason why organisations implemented employee health and wellness programmes in their organisations referred to issues like addressing stress, occurrence of HR incidents and many employees working overtime. It may be considered that if organisations focused more on these issues, sickness leave and absenteeism might be lower and employees may perceive the organisations as more caring. Reasons previously cited for implementation of employee health and wellness programmes include a reduction in health care or medical costs (Anonymous, 2005; Janice & Ho, 1997; Naydeck, 2008; Pallarito, 2007;), increased employee productivity, welfare benefits and morale, and to enhance the corporate image of the company (Janice & Ho, 1997), staff morale and productivity (Watkins, 2003), to assist employees to stop smoking, lose weight and monitor their blood pressure (L. D., 2007) and reductions in sickness absence, improvement in recruitment and retention and improvement in productivity and well-being (Brockett, 2007). From this it is clear that there is a whole range of reasons why organisations implement employee health and wellness programmes. The existing literature seems to focus more strongly on issues of productivity and health, while the participating South African organisations focus more on reducing sickness leave and meeting aims of social responsibility. Although there is overlap in the reasons for programme implementation given by South African organisations and those cited in the literature, most still relate to individual health issues and not on organisational issues that might affect the employee.

The main reasons why service providers perceived organisations to implement Employee Health and Wellness programmes were because organisations want to be seen as an employer of choice, they need to be compliant with Occupational Health and Safety Law, or because of meeting their aims of social responsibility. Social responsibility was thus an important reason for organisations implementing employee health and wellness programmes, and was also so perceived by service providers. As employees in a developing country, many individuals in South Africa still live in poor conditions and do not always have access to good medical care. Thus, while organisations can provide services like medical care and counselling services to their employees as a wellness benefit, they can also claim to be acting socially responsibly to their employees and their families.

The major reasons why labour unions perceived their members' organisations to implement Employee Health and Wellness programmes were because organisations want their employees to be more productive, for reasons of social responsibility, Occupational Health and Safety Law compliance and retaining of employees. It is important to note that although labour unions and service providers perceived one of the main reasons why organisations implement Employee Health and Wellness programmes to be in compliance with Occupational Health and Safety Law, only 3% of participating organisations endorsed this reason for implementation. Possible reasons might be that organisations see other benefits to employee health and wellness or that they do not see how employee health and wellness initiatives might assist with compliance to the Occupational Health and Safety Act. Although social responsibility emerged as a major reason for programme implementation across the surveyed stakeholders, (organisations, service providers, labour unions) the result should be viewed with caution. For example, organisations may use their programmes as a marketing tool rather than as a concrete employee benefit. Analysts have shown that in South Africa only 1% of a R1.7-trillion investment industry goes toward social responsibility investments (Finlay, 2004). Also, perceptions of what it means to be 'socially responsible' may vary widely among these role players, especially where their objectives may be seen as competing (for example between s aiming for profit, and unions who may be more focused on protection of employees).

In implementation of the EHW programmes, the main problems regarded trust and confidentiality occur rather when the people who provided the EHW programmes services were also employees of the organisation. The importance of EHW programme personnel

confidentiality in dealing with employees' sensitive issues cannot be overemphasized. In cases where trust and confidentiality problems may arise it may be wise to make use of a service provider to provide the EHW services. Ethical conduct for employees servicing EHWP's thus becomes an important issue. Other problems noted in programme implementation related to the provision of services to remote locations. In making use of service providers that problem can be reduced somewhat because many services are delivered via communication technology and can be provided telephonically and via e-mail or the internet. Especially in smaller organisations which do not necessarily have the technological infrastructure to render such services, the aide of service providers with existing infrastructure might present a more cost-effective way of managing employee health and wellness.

Almost all of the organisations presented the results of their Employee Health and Wellness programme to management in the form of Board meetings, Business unit meetings or to the CEO. Most of the organisations presented the results once or twice per year or quarterly. Except for one organisation, the results of the programme were all presented in-house. It can be assumed therefore that the results of the programme are not sufficiently utilised to attract employees or stakeholders. In order for employee health and wellness to be utilised as a competitive advantage, it should be marketed as such. Because of a lack of research on employee health and wellness, no benchmarks exist about how often results about EHW programmes should be presented. However, this information can be employed as a competitive tool for organisations, and the visibility thereof could be improved. However, this marketing should be done responsibly, and based on fact.

Regarding the successfulness of their employee health and wellness programmes, the ratings and reasons differed for the different organisations. Where a large number a lot of organisations defended their rating by indicating that they provide for a good range of services (EAP, counselling, HIV, Health), very few referred to measurable, objective outcomes like reductions in absenteeism or sickness leave. Quite a few referred to high or increased participation by employees as an indicator of success, but it is wrong to equate high uptake with successfulness. Two organisations specifically indicated that their employee health and wellness programme is less than effective because the wellness construct is not measurable. This relates again to the problem underlying the multiplicity of definitions: An ill-defined and poorly conceptualised construct is difficult to operationalise and measure.

Also, where one organisation felt that the use of a service provider contributed to making their programmes successful, another organisation felt that poor reporting from the service provider made their programme less effective as they could not properly focus their interventions. It is important in measuring the effectiveness of an employee health and wellness programme that an assessment must be done to address root causes for problems. Also, after implementation of any intervention, a reassessment is needed in order to determine whether or not the intervention was successful. The necessity for accurate, in-time data in the management of employee health and wellness is clearly indicated. Kompier, De Gier, Smulders, and Draaisma (1994) suggest that to do effective health and safety management not only should organisations do an audit, but also a review. This can ensure that organisations will be able to measure effectiveness and successfulness of their employee health and wellness programmes.

Regarding determining the effectiveness of programmes there is however also some disparities between organisations. While nearly half of the organisations indicated that they did not measure effectiveness, they did consider things like utilisation rates, declines in absenteeism, people with HIV returning to work, chronic disease reporting and buy-in from employees. In contrast, more than half of the organisations said that they did measure effectiveness, but also indicated things like utilisation rates and declines in absenteeism as measures of effectiveness. Thus, indicators of effectiveness, or the understanding of what should be indicators of effectiveness, differ across organisations. The organisations that did indicate that they measure the effectiveness of their Employee Health and Wellness programmes also indicated effectiveness measures to be things like extensive marketing, good planning, reaching more people and the use of exit interviews, none of which actually contribute to determining effectiveness. They did however also look at declines in amounts of suicides, the success of smoking cessation programmes and decreases in medical boardings, which may be attributed to effectiveness of the Employee Health and Wellness programme. In general, it must thus be concluded that the true effectiveness of these programmes is difficult to determine, as ultimately it rests upon the subjective perceptions of the organisations. However, it can be suggested that an improvement in positive employee outcomes and reduction in negative employee outcomes could be an indication of the effectiveness of an employee health and wellness programme. These might be a reduction in stress and emotional exhaustion, improvement of social support at work (Taris et al., 2003),

improved morale, increased loyalty, improved employee relations, improved productivity, reduction in absenteeism and a reduction in accidents (Andrew, 1999).

Most of the organisations also felt that they can improve their service delivery by means of making the EHW programme more holistic and integrated, and that more resources and personnel must be allocated to the EHW programme. The organisations also felt that it would be best to provide the EHW programme in-house. In providing the services in-house, not only can the programme be custom made for the organisation but the EHW team can work closely with managers to make sure the EHW programme aligns with business goals and issues around employees (Lesch, 2005). As noted previously, a balance however needs to be struck with managing perceptions of confidentiality.

A quarter of the organisations did a determination of the employees' needs 4 times (quarterly) a year. However, this was not an assessment of the employee health and wellness states in the organisations, but rather employees were asked what services they would like to form part of the employee health and wellness programme. If organisations did a proper needs assessment, based on the state of employee health and wellness in the organisation, including ergonomic assessment, the types and intensity of interventions and the level of risk can be assessed and addressed much more clearly.. Simply asking employees what they think they need ultimately provides a biased picture of the true state of affairs. Also, implementation of interventions after an employee health and wellness assessment takes time, and defects might be delayed. Sufficient time has to elapse after the implementation of interventions to determine their effectiveness.

Regarding participation of employees in their organisations' employee health and wellness programme, in 50% of the organisations not more than 50% of the employees participated in such programmes. The reasons for low participation rates can be attributed to a number of factors. On the one hand, overloaded employees may see participation in the programme as another demand, rather than a resource. Also, the programme might not address the specific problem employees are experiencing. A possible reason for this can be the fact that most of the organisations did not conduct an objective survey to determine the problem areas in the organisations before implementing 'solutions'. This most likely resulted in the interventions not being focused enough on the real problems and needs of both the organisation and employees. However, 75% of the organisations indicated that they did consult their

employees in the development of the programme. In some instances unions and wellness coaches were also consulted. The density of such consultation can however be questioned, as participation rates may be considered low.

Most of the organisations used a budget for funding of their EHWP, but some used a flat-rate, meaning that they paid a fixed amount per employee per year. In some cases, the budget the organisations spent on their employee health and wellness programme was less than R100 per person per year. Organisations have to comply with the Occupational Health and Safety Act, but employee health and wellness is still considered a soft issue and not an issue that warrants investing in the organisations' human capital in order to improve organisational profitability. SETAs can also play a major role in the provision of funds for the training of employee health and wellness practitioners for organisations. Almost half of the organisations used an allocated budget supplemented with a fee-for-service model to fund their employee health and wellness programme. Most organisations expected their budget for their employee health and wellness activities to increase in the following year. This might be an indication that organisations are increasingly willing to invest more money in their employee health and wellness programmes.

In conclusion it can be said that in order for organisations to provide the necessary employee health and wellness services to their employees, it is important to start with a proper assessment of the state of employee health and wellness in their organisations. Improvements in employee health and wellness states will only be visible if organisations start implementing focused interventions, because only then will organisations start addressing the root of their employee health and wellness problems. Also, it is important that organisations monitor the health and wellness states of their employees in order to effectively manage the process of employee health and wellness in their organisations. This will only become possible when information management relating to employee health and wellness is improved. In the end, an employee health and wellness programme must positively influence employee outcomes like productivity, satisfaction, presenteeism, Industrial Relations incidences, accidents and safety behaviour.

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APPENDIX

Table 1 provides the characteristics of the participating organisations.

Table 1

Characteristics of the Participating Organisations (n=16)

Item	Frequency	Percentage
<i>Type of organisation</i>		
Multi national companies	2	12,50
Public companies	6	37,50
Private companies	4	25,00
Joint venture	1	6,25
National Government	1	6,25
Universities	2	12,50
<i>Sector of operations</i>		
Mining and quarrying	1	6,25
Manufacturing	2	12,50
Construction	1	6,25
Retail and motor trade and repair services	1	6,25
Transport, storage and communications	1	6,25
Finance and business services	4	25,00
Education	2	12,50
Petroleum	1	6,25
Hospitality	1	6,25
Health care	1	6,25
Safety and security	1	6,25
<i>Total full-time employees</i>		
2001-500	1	6,25
501-1000	1	6,25
1001-3000	5	31,25
3001-5000	2	12,50
5001-10 000	4	25,00
10 001-20 000	1	6,25
More than 20 000	2	12,50

Table 1 (*continued*)*Characteristics of the Participating Organisations (n=16)*

Item	Frequency	Percentage
<i>Estimated annual turnover</i>		
R50-100 million	1	6,25
R250-500 million	1	6,25
R750-999 million	1	6,25
R1000-1250 million	2	12,50
R1250-1500 million	1	6,25
R2500-2750 million	1	6,25
R2750-3000 million	1	6,25
More than R3500 million	2	12,5
57 Million profit	1	6,25
<i>Estimated annual turnover (continue)</i>		
Budget	1	6,25
Not disclosed	4	25,0
<i>Annual payroll expressed as % of annual turnover</i>		
11-20%	2	12,50
31-40%	3	18,75
51-60%	1	6,25
71-80%	2	12,50
No information provided	8	50,00

Table 2

Description of the Participating Organisations in Terms of Full-time Employees and Annual Turnover

Organisation	Type of organisation	Sector of operations	Total full-time employees	Annual turnover
1	Public companies	Retail and Motor trade and Repair services	10 001-20 000	R1250-1500 million
2	Private companies	Construction	501-1000	R750-999 million
3	Private companies	Transport, Storage and Communications	3001-5000	R2750-3000 million
4	Public companies	Manufacturing	1001-3000	R2500-2750 million
5	Public companies	Finance and Business Services	1001-3000	Not Disclosed
6	Universities	Education	3001-5000	R1000-1250 million
7	Public companies	Manufacturing	5001-10 000	R1000-1250 million
8	Multi national companies	Petroleum	1001-3000	Not Disclosed
9	Joint Venture	Hospitality	5001-10 000	R250-500 million
10	Private companies	Finance and Business Services	More than 20 000	More than R3500 million
11	Public companies	Mining and Quarrying	5001-10 000	More than R3500 million
12	Public companies	Finance and Business Services	5001-10 000	Not Disclosed
13	Multi national companies	Health Care	1001-3000	R57 million profit
14	Universities	Education	1001-3000	R50-100 million
15	Private companies	Finance and Business Services	201-500	Not Disclosed
16	National Government	Safety and Security	More than 20 000	Budget

Note. For clarity, the same numbers allocated to organisations in this table are used in subsequent tables.

Table 2 provides a snap shot of each of the participating organisations in terms of amount of employees and annual turnover per organisation. It can be seen that Organisation 2 has the fewest employees, while Organisations 10 and 16 have the most. In terms of turnover, Organisations 10 and 11 generate the highest annual turnover, while Organisation 14 generates the lowest.

Table 3

Characteristics of the Participating Service Providers

Item	Frequency	Percentage
<i>Amount of organisations services are provided to</i>		
5-10	1	25,0
11-50	1	25,0
201-500	2	50,0
<i>Established</i>		
1998	1	25,0
2000	1	25,0
2002	1	25,0
2005	1	25,0

Table 4

Characteristics of the Participating Labour Unions (n=7)

Item	Frequency	Percentage
<i>Sector of operations</i>		
Transport, Storage and Communications	2	28,60
Education	1	14,30
All Sectors	4	57,10
<i>Membership</i>		
3001-5000	1	14,30
5001-10 000	1	14,30
10 001- 20 000	1	14,30
20 001-100 000	1	14,30
100 001-200 000	1	14,30
200 001-500 000	1	14,30
More than 500 000	1	14,30

MEASURING INSTRUMENT

The Employee Health and Wellness Survey (Seven sections described)

Section 1: Organisational information. This section consisted of ten questions regarding the type of organisation, sector of operations, annual turnover, number of full-time employees, and Sector Education and Training Authority (SETA) the organisation is registered with. Most of the questions offered various possible alternatives, from which participants only had to select the relevant option.

Section 2: Reasons for implementation, functions and perceived successfulness of employee health and wellness programme. This section consisted of ten questions that related to reasons for implementation, functions and effectiveness of the organisation's employee health and wellness programme. Examples of questions that were asked included giving the organisation's definition of employee health and wellness, reasons for implementation of employee health and wellness programme(s), and a rating of the perceived successfulness of the employee health and wellness programme. Some of the questions were open-ended questions and some were structured, where the relevant option could just be indicated.

Section 3: Determination of effectiveness, activities and level of employee participation in organisations' employee health and wellness programme. This section consisted of 12 questions that related to activities that form part of the employee health and wellness programme, level of employees that form the focus of the employee health and wellness programme, and the provider(s) of employee health and wellness services in the organisation. Some of the questions were open-ended, some were yes/no with a discussion of the answer, and some were indicated as (?) fill-in questions where participants could elaborate on their answer.

Section 4: Organisational contributions, strikes, absenteeism and staff turnover. This section consisted of 15 questions which related to the organisations' contributions made in terms of employee medical aid, retirement fund and other benefits. Questions were also asked about the number of strikes in the organisation, absenteeism and staff turnover. Questions relating to the reasons for strikes, benefits provided, days lost because of strikes, amount of leave and working hours lost because of accidents were asked. Some of the questions were

open-ended, some were yes/no with a discussion of the answer and some were rateable on a 5 point scale.

Section 5: Budget, needs analysis and focus of interventions of organisations' employee health and wellness programme. This section consisted of 22 questions that related to the budget, needs analysis and types of interventions of the organisation's employee health and wellness programme. Questions related to how the employee health and wellness programme was funded, the percentage of annual payroll spent on the employee health and wellness programme, how employee needs were determined and how often needs were determined. Some of the questions were open ended, some were yes/no with a discussion of the answer, some were mark with discussion, some fill-in questions and some were rateable on a 5-point scale.

Section 6: HIV/AIDS Programme. This section consisted of 4 questions relating to HIV/AIDS activities in the participating organisations. Questions were asked about the components of the organisation's HIV/AIDS programme and whether it formed part of the employee health and wellness programme. A question was also asked about the objectives of the HIV/AIDS programme. One of the questions allowed respondents to tick the answer, one was open-ended and two were yes/no questions.

Section 7: Employee Health and Wellness Legislation. This section consisted of 3 questions regarding legislation that influences employee health and wellness in South Africa, and unions' perceived influence in employee health and wellness activities.

Table 5

Employee Health and Wellness as Defined by Participating Organisations, Service Providers and Labour Unions

Dimension	Items
Health	Health, medical, HIV, organisational health
Occupational health and safety (OHS)	Safety, environment
Dimensions of wellness	Mental/psychological/emotional/mind Financial Physical/body Wellbeing/wellness of employees Social dimension of wellness Spiritual Wellness as a continuum Wellness as a concept
Work Wellness	Happy at work, occupational wellness, work style, organisational wellness
Self development	Growth/self-development/improve individual/reach full capacity, training
Employee Benefits	Social benefits (Insurance, funeral, policies), benefits
Legal Requirements	Basic, OHS, LRA, labour relations, legal
Performance Dimension	Performance: productive, motivated, committed lifestyle, engaged, sense of coherence, staff morale, vitality, meaning and purpose
Recognition of dual benefits	Benefit organisation and employee/shared responsibility/reduce absenteeism, balance, reduce negative impact of employees on organisation and reduce impact of organisation on employees
Employee Services	Counselling, family responsibility, employee services, specialised treatment and support
Employee responsibility	Employee responsibility, employee, personal level
Wellness Management	Behaviour risk management, continuous process Managed wellness, identify problems/identify risk rectify problems, organisational level, interpersonal level
Stress	Interaction job demands and job resources/stress/distress
Holistic	Holistic/wide focus/integrated

Table 5 shows that 14 dimensions were identified as constituting employee wellness, as conceptualised by participating organisations, service providers and labour unions. The **14 dimensions** were defined as the following:

- **Health.** This dimension includes information relating to employee health, medical issues, HIV management and organisational wellness, and refers to the improvement of health of the employee in the organisation as part of the organisation's definition of employee health and wellness.

- **Occupational health and safety (OHS).** This dimension includes items like work safety and the environment in which employees work, which can influence the employee health and wellness in their organisation. Thus, according to the participating organisations, occupational health and safety is a part of how employee health and wellness is defined.
- **Dimensions of wellness.** This dimension includes items relating to the psychological, physical, financial, spiritual and social aspects of wellness. Further information included seeing wellness as a continuum that ranges from unwell to well, and wellness as a concept
- **Work wellness.** This dimension included information relating to employees being happy at work, enjoying occupational wellness and efficient work styles. The definitions referred to a work-related concept in defining employee health and wellness
- **Self development.** This dimension included items that concern the growth, self-development and personal improvement of the individual employee, in order for them to reach their full capacity. This is achieved through training. Generically, the definitions referred to the development of the individual in some way in defining employee health and wellness.
- **Employee benefits.** This dimension included items like the social, insurance, funeral, and other benefits employees enjoy as part of their remuneration package. These all refer to benefits that the organisations need to provide to employees in order to influence employee health and wellness.
- **Legal requirements.** This dimension related to the legal imperatives for employee health and wellness. Reference was made to the Basic conditions of Employment Act, the Occupational Health and Safety Act, the Labour Relations Act, and general labour relations. These items all refer to concepts of law that need to be adhered to in order to facilitate employee health and wellness.
- **Performance dimension.** This dimension included items covering employee performance, productivity, motivation, commitment, lifestyles, engagement and their sense of coherence, staff morale, vitality, meaning and purpose. These items all referred to improved employee functioning in defining of employee health and wellness.
- **Recognition of dual benefits.** This dimension involved the benefits of wellness to both organisations and employees, their shared responsibility, the hope of reducing absenteeism, achieving balance, reducing the possible negative impact of unhealthy employees on the organisation and reducing the impact of the organisation on its employees. These items all referred to the positive influence that employee health and wellness should have on both the

organisation and the individual if employee health and wellness is present in the organisation.

- **Employee services.** This dimension covered the services that were available to employees. It included services such as counselling, availability of leave for family responsibilities, general employee services and specialised treatment and support. These items referred to services that are provided to employees in order to promote employee health and wellness in organisations.
- **Employee responsibility.** This dimension focuses on the employees' responsibility, on a personal level, for their own health and wellness. The items refer to the fact that organisations felt that employee health and wellness was the responsibility of the employee.
- **Wellness management.** This dimension covers management aspects of wellness, and that organisations felt that identifying and rectifying existing problems form part of employee health and wellness. Management activities that were included are behavioural risk management, recognition that it is a continuous process, that wellness can be managed and that problems and risks can be identified and rectified. Reference was made to both the organisational, interpersonal and personal levels.
- **Stress.** This dimension refers to the interaction of job demands and job resources and employees' experienced stress and distress. These items referred to the fact that organisations felt that these things need to be addressed in order to promote employee health and wellness in their organisations.
- **Holistic.** This dimension referred to the fact that employee health and wellness efforts need to be holistic, have a wide focus and need to be integrated. These items referred to the fact that organisations felt that in addressing employee health and wellness, a broad spectrum view of the employee needs to be taken.

CHAPTER 3

RESEARCH ARTICLE 2

INFRASTRUCTURE OF EMPLOYEE HEALTH AND WELLNESS PROGRAMMES IN SOUTH AFRICA*

ABSTRACT

The objective of this research was to determine the nature of the necessary infrastructure and information management systems which form part of an optimally-functioning employee health and wellness programme. In addition, an assessment is made of the educational requirements of employee health and wellness staff, and the need for further required training is identified. Further objectives included determining whether there is a return on investment on the employee health and wellness programme by investigating injuries, sickness, absenteeism, stress and HIV/AIDS management within organisations. The sample was cross-sectional and the research surveyed 16 organisations ($n = 16$) 7 labour unions ($n = 7$) and 4 service providers ($n = 4$) as case studies. The general conclusion was that, although organisations claim to be running employee health and wellness programmes, at the utmost these can be regarded as EAPs, functioning at different levels of efficiency. Recommendations are made regarding adequate employee health and wellness infrastructure, education and training of staff and employee health and wellness information management.

Keywords: Infrastructure of; Employee health and wellness programme; education; training; information management.

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OPSOMMING

Die doel van hierdie navorsing was om vas te stel wat die aard van die noodsaaklike infrastruktuur en inligtingstelsels is wat deel uitmaak van 'n program vir gesondheid en welstand van werknemers wat optimaal funksioneer. 'n Assessering word verder gedoen van die opvoedkundige vereistes wat gestel word aan die personeel betrokke by die gesondheid en welstand van werknemers, en die behoefte aan voortgesette opleiding word ook bepaal. Verdere doelstellings was onder andere om vas te stel of dit die moeite werd is om te belê in werknemers se gesondheids- en welstandprogram deur ondersoek in te stel na beserings, siekte, afwesigheid, stres en die bestuur van MIV/VIGS binne organisasies. 'n Langssnitsteekproef is geneem en die navorsing het sestien organisasies, sewe vakbonde en vier diensverskaffers as gevallestudies ondersoek. Die algemene gevolgtrekking was dat, alhoewel organisasies hulle daarop roem dat hulle wel programme aanbied vir gesondheid en welstand van werknemers, diesulkes bloot as bystandprogramme vir werknemers beskryf kan word wat op verskillende vlakke van doeltreffendheid funksioneer. Aanbevelings word gemaak ten opsigte van voldoende infrastruktuur vir werknemersgesondheid en –welstand, die opvoeding en opleiding van personeel en die bestuur van inligting rakende gesondheid en welstand.

Sleutelwoorde: Infrastruktuur van; werknemersgesondheid en –welstand; onderwys; opleiding; informasie bestuur.

INTRODUCTION

Managing and intervening in employee health and wellness through structured organisational programmes is an international phenomenon. While American programmes focus on individual behaviour rather than on promoting work environments that are healthy, the European approach promotes well-being and health and safety by means of changes at the individual as well as at organisational and environmental levels (Maes, Kittel, Scholten, & Verhoeven, 1992). For example, Dutch Labour law describes wellness at the worksite in terms of individual rights and working conditions (Kompier, De Gier, Smulders, & Draaisma, 1994).

In a Dutch project that started in the 1990s, work-based interventions focus on all levels, individual, as well as work. At an individual level, the interventions include individual health risk assessment and counselling, physical exercise and health education, stress management and communication training. Interventions at an organisational and environmental level include behavioural changes and identification and modification of unhealthy working conditions (Maes et al., 1992). In order for organisations to implement the above-mentioned interventions, they need to set up the correct infrastructure and employ the correct personnel or service providers to provide the services.

A serious problem which exists in the context of employee health and wellness is how to assess the issues which should be addressed. It makes sense to audit the well-being, experienced health and work satisfaction of employees. Should problems exist regarding the well-being and health of employees, it would be a good idea to talk to them to find out what is going on and what can be done to alleviate the problem(s). The Dutch programme started with a large scale assessment of quality of working life (for example levels of burnout, work load and job control) in all organisations in different sectors. After the organisations had received the feedback regarding the assessment (*diagnoses*), organisations could then decide on which actions to take (*interventions*) (Taris et al, 2003).

Lessons could be learned from the Dutch programme that might assist Employee Health and Wellness programme managers in South Africa in establishing the correct infrastructure for their programmes. It is vital that in order to set up an infrastructure for an employee health and wellness programme, and in order to recruit and train adequate employee health and wellness staff, that the correct information management system be set in place and that

organisations should start with an assessment of their employees' health and wellness states at work. There would be little use in employing dieticians in an organisation to provide services to the employee health and wellness programme if no weight problems exist in the organisation. Likewise, it would be of little use to build or set aside counselling rooms if employees are not in need of counselling by psychologists. Thus, the only way in which adequate infrastructure, information management systems can be established, as well as the employment of the correct employee health and wellness programme staff can take place, is when organisations start with an organisational assessment of employee health and wellness.

The inputs of employees are crucial; after all they are experts at their own well-being and would have the greatest interest in improvement (Schabracq, 2003). This is also confirmed by the Health Care systems of the Johnson & Johnson Live for Life programme. According to Johnson & Johnson, certain questions need to be answered before any type of programme development takes place. These questions include the following: What type of wellness programme is needed? Does management support the creation and continuation of the programme? How will the success of the programme be assessed? They also support the use of qualitative as well as quantitative techniques to address these questions before any development of a programme takes place (Sulsky & Smith, 2005). These questions are vital in that they would prescribe what infrastructure, education and training of employee health and wellness personnel would be needed, and what information management system should be used. A programme that focuses on employee health infrastructure, the type of employee health staff, and the informational management system will definitely be different from one that focuses on employee wellness issues such as job overload, poor supervisory relationships and poor organisational communication.

Legal and labour issues are often the driving forces behind businesses undertaking occupational health care programmes for their workers. However, the choice of which programme to institute can be viewed as a basic business decision. Organisations are usually delighted to discover that productivity improvements and legal compliance usually outweigh the cost of providing such services (Mead, 1998). While there is cost involved in preventing accidents, studies have shown that prevention costs are usually much less than the cost of an accident. Work accidents hamper productivity and there are other benefits to an organisation exhibiting a good Occupational Health and Safety record. In 1997, Minister Tito Mboweni estimated a single work accident to cost R 15 708.00. In 1996, more than 300 000 such

injuries were reported to the Compensation Commissioner, which implies a cost to the economy of almost R 4,7 billion a year. Thus, if the infrastructure of employee health and wellness programmes can support interventions that reduce and prevent accidents in organisations, the economic benefits can be significant.

The UK Health and Safety Executive (HSE, 2001) suggests the following considerations in improving work stress: Attention must be paid to *Demands* (including workload, work patterns and work environment), *Control* (how much an employee has a say in the way the work is done), *Support* (including encouragement, sponsorship and resources provided by organisation, line management and colleagues), *Relationships at work* (including promoting positive working practices to avoid conflict and dealing with unacceptable behaviour), *Role* (do the employees understand their roles in the organisation and does the organisation insure the roles are not conflicting), *Change* (how is organisational change managed and communicated in the organisation) and *Culture* (to which extent does the organisation demonstrate management commitment and have procedures which are fair and open). If organisations use the suggestions provided by the HSE, the infrastructures of traditional human resource departments and personnel can be used to address the above-mentioned issues. Thus, the infrastructure, education of employee health and wellness staff, and the information management system should enable organisations to address the above-mentioned aspects.

Employee Health and Wellness programmes in South Africa are still in their infancy. Although South African organisations are not new to the concept of trying to improve employees' wellness or wellbeing through Employee Assistance or Health Care programmes, very few organisations focus on improving their employees' wellness through factors that influence them *at work*. Currently South African organisations have to deal with a range of issues that might be indicative of "un"-well organisational states present in these organisations. These include high incidences of sick leave and absenteeism (Vaida, 2005), a high level of HIV/AIDS rates (The South African Institute of International Affairs, 2004), accidents, grievances and high staff turnover (Noemdoe, 2002), and low productivity (Mead, 1998). The notion of employee wellness as an achievable state has received considerable attention in the popular press: "Workplace wellness makes cents" (Mead, 1998), "Employee Wellbeing, a hard issue" (Hooper, 2004), "Employee Wellness and beyond" (Halls & Rhodes, 2004), and "Prioritising health promotion and employee wellness" (Matlala, 1999).

Unfortunately, terms related to wellness are inconsistently used, defined and conceptualised in popular as well as in academic publications (Dana & Griffen, 1998).

Today, Employee Health and Wellness is conceptualised rather broadly within South African (SA) organisations, but many organisations still mainly focus on health-related issues of employees within employee health and wellness programmes. Sieberhagen (2008) indicates “health” to still play a central part in organisations’ definition of employee health and wellness and that the most reported reason for implementation of Employee Health and Wellness Programmes (EHWPs) in SA organisations has been indicated as “high incidences of sick leave”. Since employee health and wellness as a concept has not been delineated and conceptualised scientifically, and because of a dearth of research in this regard, further research is needed to clear up the many misunderstandings surrounding the nature of employee health and wellness, as well as the nature of employee health and wellness programmes.

It is important to look at the health and wellness of employees by focusing on their work demands, resources, stressors and other work factors that influence their health and wellness. Thus, in providing adequate infrastructure to support employee health and wellness in organisations, there should be health care practitioners to address the “health” issues, and industrial psychologists and human resources (HR) personnel to address the “wellness” issues. It is important that employee health and wellness practitioners have the correct education and training to address the needs of employees who experience problems at work. In no way should employees be exposed to people who are not professionals in dealing with issues related to employee health and wellness (Matlala, 1999).

Although employee health and wellness as a “state” is theoretically achievable, it is not yet clear how this state of wellness is brought about in practice, and how it is linked to organisational gains. In order to facilitate employee health and wellness in an organisation, four things should be in place (Schabracq, 2003). Firstly, employee health and wellness should be *assessed*. It must first be determined what needs to be addressed. In bigger organisations it makes sense to audit employees’ wellbeing, experienced health and work satisfaction periodically. It is no use addressing ergonomic factors if there is a problem with work overload in the organisation. An employee health and wellness assessment will also enable organisations to set up the correct infrastructure to address the issues and critical

aspects that came out of the assessment. Secondly, employee health and wellness should be *promoted*. After employee health and wellness has been assessed, the problems/issues must be improved and/or changed. The infrastructure of the Employee Health and Wellness Programme (EHWP) should be established accordingly to promote employee health and wellness in the organisation. This infrastructure may include industrial psychologists, clinical psychologists, social workers, medical doctors and occupational health nurses, but also new policies, procedures and standards for service delivery. The human resources needed to support the infrastructure of the EHWP will depend on the employee health and wellness areas that need to be promoted. Thirdly, it should be *managed*. It is a process of levelling the highs and lows of employee health and wellness, and should focus on sustaining the employee health and wellness state in the organisation. Lastly, employee health and wellness must be *predictable*. Information management systems should be set up in order to predict certain employee health and wellness behaviours. Information management is a key part of the infrastructure of an EHWP in that it will enable EHWP managers and practitioners to gather business intelligence and pick up trends in the organisation. An effective information management system will improve the way employee health and wellness can be managed and promoted effectively, focusing on prevention rather than cure. Naidoo and Jano (2003) also suggest that it is important to maintain an information system that would assist in identifying problems and trends. The information system should also support the implementation of all three levels of interventions (primary, secondary, tertiary) and must be able to reduce negative factors/aspects in the organisation and promote positive factors/aspects.

Work is the prime consumer of time in an adult's life and rates second only to sleep in the sheer number of hours occupied (Dhanesar & Hales, 1994). Large global organisations have responded to the needs of their employees and escalating healthcare costs by adopting innovative strategies to remould their corporate culture. Many organisations have recognised health promotion to be an attractive and viable vehicle for achieving multiple goals. These goals may include reducing risks and indirect costs of loss of productivity (absenteeism, turnover, reduced on-the-job performance, stress) as well as the direct cost of medical treatment, with the benefit of a motivated and focused workforce. An organisation's health improvement programme must focus on health care and not disease care, be proactive rather than reactive, and promote health rather than address sickness (Dhanesar & Hales, 1994). When organisations focus on disease care they will set up an infrastructure that enables doctors and occupational health nurses to deal with the sick employees, whereas, if the focus

is on health care the infrastructure will have to support the promotion of health by looking at procedures, policies, and processes in the organisation that may adversely influence the health of employees and thus try to eliminate these. Therefore, the infrastructure of an EHWP should be established in such a way that the programme can implement proactive (primary) interventions and not just reactive (secondary or tertiary) interventions

The infrastructure of an EHWP should be established in such a way as to enable it to demonstrate its nature, purpose, and value to the organisation. It has been found that South African organisations are not aware of the contribution Employee Assistance Programmes (EAPs) can make, or what its nature and purpose is, or what value an Employee Assistance Programme (EAP) can add to the organisation (Terblanche, 1992). Regarding the infrastructure of EAPs, Terblanche also finds that most EAPs are staffed by personnel practitioners, nursing staff and medical officers, which indicate that the infrastructure of such programmes strongly supports and addresses health issues of employees. Terblanche also finds that most respondents indicate that the offices of the EAPs should be easily accessible to all employees. Thus, the infrastructure that supports the EAPs should be available to all employees (Terblanche, 1992).

To instigate “healthy” or “well” work, Turner, Barling, and Zacharatos (2002) suggest that organisations pay attention to work redesign, teamwork and transformational leadership, which all influence employees at work. Focusing on “healthy” and “well” work aspects could lead to positive outcomes for both the employee and the organisation. Thus, the infrastructure of an EHWP should support interventions that focus on “healthy” and “well” work aspects like work redesign, teamwork, and transformational leadership. Schabracq (2003) also suggests that in setting employee health and wellness as an objective, interventions should include aspects like job redesign, training and coaching, and job rotation, which all fit into the function of human resource management. Also, many of these interventions could have a preventive effect in managing employee health and wellness.

Carrol (1996) notes that sick companies produce sick employees. Therefore, organisations need to move towards establishing and developing workplace wellness in addition to worker wellness if organisations want to provide organisational relevant and effective services (Csiernik, 1995). Taris et al. (2003) suggest that if interventions are work-directed the interventions should apply to all members of the organisation, would be more effective in that

they are geared towards eliminating or reducing stressors in the workplace and should make factual changes to the work-situation. This is a much more effective strategy than person-directed interventions; which only address individual needs with no clear link to improvement of the individual's performance at work (Taris et al, 2003). Within the framework of human resource management, employees are viewed as the human and main capital of organisations. Therefore, it would be foolish to expose employees to stress and other threats to their health and wellness because it would lead to the destruction of this valuable and rather irreplaceable capital (Schabracq, 2003).

The question could be asked if it is worthwhile for organisations to invest in activities to improve the employee health and wellness of employees. The Anglo American company (South Africa) found that by giving their employees antiretroviral medicine (ARM), the absenteeism and hospital treatments were so much reduced that the savings from the reduction could probably finance the treatment plan within the first year of treatment. It was found that 95% of employees that used ARM were healthy and back at work. It was also found that absenteeism because of all reasons within the first twelve (12) months of the giving of the ARM treatments was drastically reduced from more than 6000 days a month to fewer than 2000. The saving because of the reduction in absenteeism covers an estimated 70% of the cost of the ARM treatment plan. Where employers provide medical care, the rest of the cost of the treatment plan is covered because of a reduction in medical care cost (Pienaar, 2005). Thus, the effective implementation of programmes like these can have positive effects for organisations. However, adequate infrastructure is essential to support programmes like these. For programmes like these, adequate infrastructure that has already been noted in the literature relate to clear identification of employee needs, adequately trained physical and mental health care staff, accessibility of programmes and proper information management of data generated by such a programme.

Looking after the psychological well being of employees is as important as caring for their physical well being, improving not only organisational effectiveness but also staff loyalty, attraction, and attention (Noemdoe, 2002). A wealth of statistics confirm that at any given time roughly around one quarter of the nation's (South Africa's) workforce is affected by problems that contribute to a deterioration in performance at work (Noemdoe, 2002). The cost to the employer is reflected in an increase in absenteeism, sick leave, accidents, low staff morale, lateness, grievances and staff turnover, which result in a greater need for managerial

supervision. Organisations should therefore invest more in holistic EHWP and the organisational programme infrastructure should support the addressing of employee health and wellness matters in a holistic way.

It is important to note that although existing research has associated wellness with organisational benefits, it has not considered exactly how a state of wellness is achieved and then linked to organisational gains (Porter, Kraft & Claycomb, 2003). Workplace wellness programmes have been instituted to counter the effects of job stress. The major component, physical health promotion programmes, has benefited organisational programmes in many ways, such as reducing medical aid cost, improving productivity, reducing human resource development costs and enhancing the images of organisations (Dhanesar & Hales, 1994).

Based on the problem statement outlined above, the general aim of this research is to clarify the infrastructure of EHWP in the South African context by investigating the components of the infrastructure of current EHWP in South Africa, determining the educational levels of EHWP managers and evaluating information management systems used to enhance EHWP in South Africa.

General aim

The general aim of this research is to conceptualise the infrastructure, education and information management systems required for successful employee health and wellness management in South African organisations.

Specific aims

- To evaluate the occurrence of employee “un”-well behaviours by investigating absenteeism, strikes, accidents, turnover, HIV/AIDS management and leave utilisation within South African organisations.
- To assess the effectiveness of employee health and wellness information management and make recommendations regarding improvement.
- To assess the nature of EHWP policies and infrastructure and make recommendations regarding improvement.

- To assess the reporting lines, staffing, educational levels of employee health and wellness staff, and identify further training requirements.
- To assess employee health and wellness interventions by investigating reasons for implementation, focus, targets of intervention and the services rendered.
- To assess the benefits and training provided by organisations to their employees.
- To evaluate the marketing and awareness-raising of EHWP's and to evaluate the consultation of employees in development of EHWP's.

METHOD

Research design

In order to achieve the objectives of the research a survey design was used. The sample was drawn from the population at a particular point in time indicating a cross-sectional design (Shaughnessy & Zechmeister, 1997). The cross-sectional design enables researchers to use information collected to describe a population at that time and to assess interrelationships among variables within a population.

Participants

Participants in the project included organisations, labour unions and service providers. A total number of sixteen ($n = 16$) organisations that indicated that they have EHWP's in their organisations were included. The organisations were from various sectors within South Africa. Service providers ($n = 4$) that provided employee health and wellness services as well as labour unions ($n = 7$) were incorporated in order to analyse their opinions on employee health and wellness practices in South Africa.

Characteristics of the Participating Organisations ($n = 16$) (See Appendix, Table 1, p 113)

The sample consisted of sixteen (16) organisations, of which 37,50% were public companies and 25% private companies. The other 37,59% of the organisations was made up by multinational companies, joint ventures, national government and universities. Most of the organisations were from the Transport, Storage and Communications sector (25%), as well as the Manufacturing and Education sectors (both 12,50%). Approximately 31% of the

organisations have between 1001 and 3000 employees and 25% have between 5001-10 000. One quarter of the organisations (25%) did not want to disclose their turnover. However, 12,50% of the organisations indicated their annual turnover to be between R 1 000-R 1 250 million, while 12,50% of participating organisations' turnover was more than R 3 500 million per annum. Half of the organisations (50%) could not provide information regarding their annual payroll expressed as a % of annual turnover; however, for those organisations where this information was available, 18,80% indicated that their annual payroll expressed as a percentage of annual turnover ranged between 31-40%. Considering just the companies where information was available, 62,5% indicated that they spent 40% or less of turnover on annual payroll. Only 25,10% of the organisations were established after 1994, and the youngest organisation is only six years old, while the oldest has been in operation for over a century.

All of the participating organisations were registered at their relevant Sector Education and Training Authority (SETA) for skills development purposes. SETA's (Sector Education and Training Authorities) are to ensure that the skills requirements of the various sectors are identified, and that the adequate and appropriate skills are readily available. However, 68% of the organisations were unable to provide information regarding their skills levy costs per month.

Characteristics of the Participating Service Providers ($n = 4$) (See Appendix, Table 2, p 115)

Four service providers participated in this study, of which 50% had between 201-500 organisations they provided services to. The smallest indicated that they provided services to between 5 and 10 organisations, while the service provider with the second largest customer base indicated that they serviced between 11 and 50 organisations. The oldest service provider was nine years old and the youngest only two years old.

Characteristics of the Participating Labour Unions ($n = 7$) (See Appendix, Table 3, p 116)

In this study, there were seven (7) participating labour unions and of these, 57,1% had members across all the sectors of operations. The smallest membership was between 3001-5000, and the largest union had more than 500 000 members. The oldest union is more than

100 years old and was established in 1905, and the youngest in 2001. In this study, 32% of the unions were established after 1994.

Measuring instruments

The *Employee Health and Wellness Survey* was developed by the researcher to determine the nature, content, context, participants, role players and anticipated benefits and possible drawbacks of a work wellness programme in a specific organisation. To ensure content validity of the questionnaire, it was developed based on a comprehensive literature study. Furthermore, the questionnaire was submitted to experts in the field of employee health and wellness (both in academia and organisations) to judge its validity. A trial run was used to assess whether the items are understandable and to detect problems in the questionnaire. The questionnaire was divided into seven sections. (*See Appendix for full description of sections.*):

Section 1: Organisational information

Section 2: Reasons for implementation, functions and perceived successfulness of EHWP

Section 3: Determination of effectiveness, activities and level of employee participation in the EHWP of organisations.

Section 4: Organisational contributions, strikes, absenteeism and staff turnover

Section 5: Budget, needs analyses and focus of interventions of the EHWP of organisations.

Section 6: HIV/AIDS Programme

Section 7: Employee Health and Wellness Legislation

The *Employee Health and Wellness Survey (Labour Unions)* was developed to determine the sector in which the labour unions operate, how many members they have, how they define employee health and wellness and how they influence employee health and wellness issues in the respective organisations of the members.

The *Employee Health and Wellness Survey (Service Providers)* was developed to determine the number of organisations they provide services to, the nature of services they provide and how they define employee health and wellness.

Statistical analysis

The statistical analysis was carried out with the help of the SPSS programme (SPSS, 2007). Descriptive statistics (for example means) were used to analyse the data. Descriptive statistics are deemed suitable and sufficient for this analysis as the aim of the study is descriptive.

Method

Interviews were set up with sixteen (16) of the major organisations in South Africa, as well as some government institutions. Each organisation was interviewed by using the Employee Health and Wellness Questionnaire that was developed. Four service providers were also interviewed to establish the nature of employee health and wellness services provided in South Africa. Major labour unions were also surveyed. By using this mixed-method approach to gain information from all major stakeholders within the sector, it was anticipated that a good representation of the current situation regarding employee health and wellness practices in South Africa would be obtained.

RESULTS

Below, information is discussed regarding organisational events which might be considered indicative of organisational and employee health and wellness.

Absenteeism

Almost two-thirds (62.5%) of the participating organisations did not know how many days were lost because of absenteeism in the organisation per year.

Strikes

A large percentage (87,5%) of the organisations did not have any strikes in the previous year, 6,25% of the organisations did not know if they had any strikes and 6,25% of the organisations had a strike in which four days were lost. The organisations with strikes could not provide the total number of days lost because they did not have the information regarding how many employees participated in the strike. The reason for the strike was wage negotiations.

Productivity of employees

Just more than two-thirds (67,5%) of the organisations said their employees were above average in terms of productivity, 18,75% of the organisations said their employees were average on productivity, 6,25% of the organisations said their productivity was below average, 6,25% did not know how productive their employees were and 6,25% of the organisations said their employees were very productive, the highest score possible.

Accidents

Three quarters (75%) of the organisations had accidents in their organisations over the last year, 18,75% did not have any accidents and 6,25% did not know whether they had any accidents. Of the organisations that had accidents, only half knew the hours they had lost, and these ranged from nought (0) hours to 106 419 hours

Table 1 shows the main reasons why employees left their organisations.

Table 1

Main Reasons why Employees Left their Organisations

Item	Frequency	Percentage
Career decision	11	23,90
Resignation	10	21,80
Contract termination	4	8,70
Dismissal	4	8,70
Retirement	4	8,70
Death	3	6,50
Conflict at work	2	4,30
Job content dissatisfaction	2	4,30
Retrenchment	2	4,30
Family reasons	1	2,20
Illness	1	2,20
Relocation	1	2,20
Studies	1	2,2

Table 1 shows that the main reasons why employees left the participating organisations were because of Career decisions (23,90%) and Resignations (21,80%). Dismissal, Retirement and Contract Termination each represented 8,70% of the reasons why employees left the organisation. The least reported reasons why employees left were Relocation, Studies, Illness and Family Reasons (2,20% each).

HIV/Aids programme

In the sample of organisations, 93,75% of the organisations did have an HIV/AIDS programme and in 75% of the organisations the HIV/AIDS programme formed part of the EHWP. Of the organisations that participated, 50% provided anti-retroviral medication to their employees. Table 2 indicates the components of the HIV/AIDS programmes in the participating organisations.

Table 2

Components of HIV/AIDS Programme

Organisation	Awareness-raising	Education and training	Creating a non-discriminatory environment	STI prevention and treatment	Infection control	Voluntary counselling and Testing	Promotion of the use and distribution of condoms
1	X	X	X	X	X	X	X
2	X	X	X			X	X
3	X	X	X	X	X	X	X
4	X	X	X		X	X	X
5	X						
6	X	X	X			X	X
7	X	X	X	X	X	X	X
8	X	X	X			X	X
9	X	X	X	X		X	X
10	X	X	X	X	X	X	X
11	X	X	X	X	X	X	X
12	X	X	X	X	X	X	X
13	X	X	X	X	X	X	X
14	X	X	X	X	X	X	X
15		X					
16	X	X	X	X		X	X

Table 2 shows that 50% of the organisations addressed the seven issues regarding HIV/AIDS that were asked in the questionnaire. Half of the organisations that addressed all seven issues were private companies, two were public companies, one a university, and one a multinational company (for a description see Appendix, Table 4, p 116). Most of the organisations (93,76%) did awareness raising and education and training; also 87,50% of the organisations did voluntary counselling and testing, promotion of the use and distribution of condoms and assisted employees in creating a non-discriminatory environment. Of the organisations 62,50% also did (STI) prevention and treatment as part of their HIV/AIDS programme. Organisation number 5 (see Appendix, Table 4) indicated that they just focused on awareness raising about HIV/AIDS as part of their HIV/AIDS programme, while organisation number 15 (see Appendix, Table 4), who indicated they did have an HIV/AIDS programme, only did education and training.

Table 3 shows the additional leave information provided by the organisations.

Table 3
Additional Leave Information

Item	Frequency	Percentage
<i>Amount of sickness leave granted</i>		
30 Days	6	37,50
36 Days	5	31,25
90 Days	2	12,25
45 Days	1	6,25
84 Days	1	6,25
No Information	1	6,25
<i>Sickness leave cycle</i>		
3 year cycles	13	81,25
2 year cycle	1	6,25
No Information	1	6,25
No cycle	1	6,25
<i>Family responsibility leave</i>		
3 days per year	7	43,75
5 days per year	7	43,75
7 days per year	1	6,25
No information	1	6,25
<i>Paid Maternity leave</i>		
4 month	10	62,50
3 month	2	12,50
No info	2	12,50
1 month	1	6,25
90 days	1	6,25
<i>Unpaid Maternity leave</i>		
No unpaid maternity leave provided	9	56,25
2 month	2	12,50
1 month	1	6,25
1.5 month	1	6,25
3 month	1	6,25
30 days	1	6,25
No info	1	6,25
<i>Study leave paid</i>		
10 days per year	4	25,00
No info	4	25,00
2 days per exam	3	18,75
Paid study leave provided (days not provided)	2	12,50
12 days per year	1	6,25
12 to 24 days per year	1	6,25
4 days per exam	1	6,25

Table 3 shows that 37,50% of the organisations provide 30 days sick leave per cycle and 31,25% provide 36 days sick leave per cycle. In 81,25% of the organisations the sick leave cycle is three years. In 43,75% of the organisations they give three days family responsibility

leave per year and in 43,75% of the organisations they give five days family responsibility leave per year. In 62,50% of the organisations they provide four months paid maternity leave and in 56,25% of the organisations employees can not take extra unpaid maternity leave. In 25% of the organisations, the organisations provide ten days study leave per employee per year and in 18,75% organisations provide employees two days per exam day.

Annual Leave

Of all the participation organisation 62,50% could not provide us with the amount of leave employees had taken for the previous year. The 37,50% that did provide the researcher with the information admitted that they couldn't provide the researcher with an accurate number because they did not have access to the data.

Sickness leave

The amount of sickness leave taken in organisations ranged from 708 days to 101 454. The days per person ranged from 1,75 days to 19,08 days per employee per year. Again, 62,50% of the organisations did not know the amount of sickness leave taken in their organisations. Of the organisations 37,50% of the organisations did not know the reasons employees take sick leave. The main reasons why employees take sick leave were flu, gastro and headaches. Again the organisations were not sure why employees take sick leave.

Policy for employee health and wellness programme

Less than half of the organisations indicated that they do have a policy that governs the employee health and wellness initiatives in their organisations. Many of the organisations also did not want to make the policy available for inspection, though they claimed to have one. Only one of the organisations did have a comprehensive employee health and wellness policy for their organisation.

Service delivery of employee health and wellness programmes.

It was indicated that 87,50% of the organisations felt that the service delivery of their EHWP could be improved.

Table 4 shows suggestions from organisations to improve service delivery of their EHWP.

Table 4

Organisations' Suggestions regarding Improvement of Service Delivery of Employee Health and Wellness Programmes

Item	Frequency	Percentage
Holistic and integrated	7	21,20
More resources and personnel	6	18,20
In-house EWP	4	12,10
Accurate assessments	3	9,10
Targeted intervention	2	6,10
Improved training	2	6,10
Follow up on intervention	2	6,10
New ideas	2	6,10
Return on investment	1	3,00
Support employees more	1	3,00
Communications and marketing	1	3,00
Busy implementing	1	3,00
Coordinator focus more on the wellness programme	1	3,00

Table 4 indicates the organisations' suggestions to improve service delivery of their EHWP. Most of the suggestions were regarding the programme being more holistic and integrated (21,20%), more resources and personnel being allocated for the programme (18,20%) and that the organisation must provide their EHWP in-house.

Table 5 indicates to whom the EHWP manager reports to in the organisations.

Table 5

To whom the Employee Health and Wellness Programme Manager Reports in the Organisation

Item	Frequency	Percentage
CEO	3	18,75
HR manager	2	12,50
Company Health Advisor	1	6,25
Executive director HR	1	6,25
Executive manager HR	1	6,25
GM Employee relations	1	6,25
Head of HR	1	6,25
Head Personnel services	1	6,25

Table 5 continued

To whom the Employee Health and Wellness Programme Manager Reports in the Organisation

HR Admin manager	1	6,25
HR Director	1	6,25
HR Executive	1	6,25
Institutional Director, Equity, Diversity and human rights	1	6,25
MD Health Services	1	6,25

Table 5 shows that in 18,75% of the organisations the manager of the EHWP reported directly to the CEO and in 12,50% of the organisations he/she reported to the HR manager. In 50% of the organisation the manager of the EHWP reported to a human resource (HR) function. Table 6 shows the number of people employed to manage the EHWP in the organisation.

Table 6

Number of People Employed to Manage the Employee Health and Wellness Programme

Number of people employed	Frequency	Percentage
1	6	37,50
2	1	6,25
4	2	12,50
9	1	6,25
13	1	6,25
16	1	6,25
20	1	6,25
37	1	6,25
150	1	6,25
400	1	6,25

Table 6 shows that in more than one third of the organisations (37,5%), only one person was employed to manage the EHWP. The number of people employed by the EHWP to provide services to employees ranged from 1 to 400.

Table 7 indicates the job title of the Employee Health and Wellness programme manager.

Table 7

Job Title of Employee Health and Wellness Programme Manager

Item	Frequency	Percentage
Employee wellness manager	2	12,50
Commissioner	1	6,25
Contract manager	1	6,25
Employee Health Care coordinator	1	6,25
Employee support manager + Ethics officer	1	6,25
Employee Wellbeing manager	1	6,25
Employee wellness coordinator	1	6,25
Facilitator Employee wellness	1	6,25
General Manager HR	1	6,25
HR Health Coordinator	1	6,25
HR Manager	1	6,25
Manager Employee Wellness	1	6,25
Manager HIV/AIDS	1	6,25
Occupational Health and retirement manager	1	6,25
Wellness manager	1	6,25

In table 7 it is indicated that in only six of the participating organisations the manager of the EHWP had the word “wellness” in his/her job title. In three organisations, the EHWP manager was related to a human resource (HR) position. Table 8 indicates the Qualifications of the organisations’ EHWP manager.

Table 8

Qualifications of Employee Health and Wellness Programme Manager

Item	Frequency	Percentage
Industrial Psychologist	2	12,5
PhD Industrial Psychology	2	12,5
BA Communication	1	6,25
BA English	1	6,25
BA Psychology	1	6,25
Clinical Psychologist	1	6,25
Honours in Industrial Psychology	1	6,25
Honours in Psychology	1	6,25
Honours in Biokinetics	1	6,25
Master in Social work	1	6,25
Masters in Industrial Psychology	1	6,25
Matric (Grade 12), on the job training	1	6,25
Medical doctor	1	6,25
Social worker	1	6,25

Table 8 shows the qualifications of the EHWP managers and practitioners. Of these, six have an Industrial Psychology background, two have a background in Social Work and two a background in Clinical Psychology. Table 9 indicates the main functions, objectives and focus areas of the EHWP of organisations.

Table 9

Main Functions, Objectives and Focus Areas of Organisations' Employee Health and Wellness Programmes

Item	Frequency	Percentage
Health promotion	13	22,40
Wellness	9	15,50
Organisational Efficiency	8	13,80
Counselling services	7	12,10
Care and Support of employees	7	12,10
Life skills	3	5,20
Safety	2	3,40
Stress management	2	3,40
Balanced lifestyle	1	1,70
Employer of choice	1	1,70
A pro and re active programme	1	1.70
Telephonic legal and financial help	1	1.70
90/10 principle	1	1.70
Improved work environment	1	1.70
Mitigate risks	1	1.70

Note: The main functions, objectives and focus areas responses were grouped into 17 dimensions. For a full definition of focus areas, refer to Appendix, Table 5

Table 9 shows that most of the organisations focused on health promotion (22,40%), wellness (15,50%), organisational efficiency (13,80%) and counselling services (12,10%). Only 3,40% indicated that they focused on stress management and only 1,70% said that being an employer of choice was the focus of their programme.

Stress surveys

Of the participating organisations, 50% indicated that they had done a stress survey as part of their EHWP. The main concerns that manifested from the stress surveys related to work and career stress, high work loads and work demands, high levels of employee exhaustion,

employees experiencing post traumatic stress, finding that certain employees were at greater risk and that there were organisational systems that caused stress for employees.

The addressing of the concerns pointed out in the stress survey included activities like providing and implementation of interventions, presenting of workshops and courses, suggestions to management, setting up of a support centre, implementation of a wellness programme, team development, feedback to specific employees and instruction of employees.

Of the organisations that did do a stress survey, one organisation did it only once; four organisations do it every year, one organisation does it every two years, one organisation every two to three years and one does a stress survey four times per year.

Types of Programmes

More than half of the participating organisations (56,25%), indicated that they offered a combination of an Employee Assistance and Employee Wellness Programme, 31,25% indicated that they had an Employee Wellness Programme, and 12,50% indicated that they had a programme that was aimed at providing employee assistance.

Table 10 gives the activities that form part of organisations' EHWP. Percentages are expressed as a percentage of the total number of activities reported by organisations.

Table 10

Activities that Form Part of Organisations' Employee Health and Wellness Programme

Item	Frequency	Percentage of total responses (n = 182)	Percentage of total organisations (n = 16)
HIV programme	14	7,70	87,5
Training concerning social skills (e.g., assertiveness training, dealing with emotional situations)	13	7,10	81,25
Leadership development	12	6,60	75,00
Increased budgets for education and training	9	4,90	56,25
Opportunities for employees to ask for ergonomic advice (like how to do their job better so that it is less straining, e.g. teaching nurses how to lift patients better)	9	4,90	56,25
On-the-job training	9	4,90	56,25
Chronic disease	9	4,90	56,25

Table 10 continued

Activities that Form Part of Organisations' Employee Health and Wellness Programme

Non-communicable disease information	9	4,90	56,25
Diversity management	9	4,90	56,25
Gender issues	9	4,90	56,25
Tailor-made employee benefits (e.g., day care and free membership of a gym)	8	4,40	50,00
Employees regularly receiving a newsletter concerning their working conditions	8	4,40	50,00
Special opportunities, for example anonymous reporting of offences, for handling complaints regarding sexual harassment, intimidation, aggression and violence	7	3,80	43,75
New protocols	6	3,30	37,50
Employee participation in the planning of tasks and shifts	6	3,30	37,50
Training concerning task-related issues	6	3,30	37,50
Opportunities to visit congresses and/or symposia	6	3,30	37,50
Information about company policy by means of a newsletter	6	3,30	37,50
Additional personnel to decrease workload	5	2,70	31,25
Implementation of structured meetings concerning the planning of task and shifts (at least once a month)	5	2,70	31,25
Employee participation in the organisation of the team or department	5	2,70	31,25
Employees receiving tools to reduce physical demands	5	2,70	31,25
Free work clothes	3	1,60	18,75
Task restructuring to allow for informal possibilities for contact with colleagues (either individually or in groups)	2	1,10	12,50
Implementation of semi-autonomous or self-directed work teams	1	0,50	6,25
Discounts on insurance	1	0,50	6,25

It can be seen in Table 10 that a whole range of activities form part of the EHWP surveyed in the different organisations. Most of the activities centred on HIV programmes (7,70% of all responses; 87,50% of all organisations), social skills training (7,10% of all responses; 81,25% of all organisations) and leadership development (6,60% of all responses; 75% of all organisations). Table 11 shows the activities that are outsourced by the participating organisations as part of their EHWP.

Table 11

Employee Health and Wellness Activities that are Outsourced by the Organisations

Item	Frequency	Percentage
HIV/Aids services	10	18,90
Counselling services	9	17,00
EAP Services by EAP Service Providers	7	13,20
Health services	13	24,50

Table 11 continued

Employee Health and Wellness Activities that are Outsourced by the Organisations

Financial services	4	7,50
Legal Services	2	3,80
Coordination and Administration of programme	2	3,80
Assessment of employees	1	1,90
Implementation of programme	1	1,90
Report writing and Feedback	1	1,90
Injuries on duty	1	1,90
Id's and Passports	1	1,90
National and International driving licences/permits	1	1,90

Note: Employee health and wellness activities that are outsourced were grouped into 13 dimensions of services. For a full definition of focus areas, refer to Appendix, Table 6.

Table 11 shows that 18,90% of the organisations' outsourced services related to HIV/Aids management, 24,50% to health services and 17% to counselling services. A further 13,20% of the remainder were services that were provided by a service provider which was not specifically specified, but just classified as "traditional EAP services".

Services provided in-house

In this study 68,80% of the organisations indicated that they provided certain services in-house as part of their Employee Health and Wellness Programme. Of the participating organisations, 31,20% did not provide any services in-house. Table 12 shows the services that some of the organisations provided in-house.

Table 12

Services Provided In-House by Participating Organisations

Item	Frequency	Percentage
Training (job, leadership, Stress management, diversity, soft skills)	7	20,00
Health service	5	14,30
HIV services	4	11,40
Counselling	4	11,40
Employee wellness programme coordination	3	8,60
EAP services	3	8,60
OHS services	2	5,70
Injuries on duty/Disability management	2	5,70
Managing performance	1	2,90
Absenteeism management	1	2,90
Wellness interventions	1	2,90
HR activities	1	2,90
Report feedback	1	2,90

Table 12 shows that most of the services provided in-house related to the activities (20%) of training, 14,30% to health services, and 11,40% to both HIV services and counselling. Table 13 shows the spread of services that are provided by service providers.

Table 13

Services Rendered by Service Providers to Organisations

Services Dimensions	Item	Frequency	Percentage
Health Promotion Services	Preventative health, VCT, Disease risk, On-site wellbeing clinics, Executive wellbeing assessment, HIV assessment, Physical Health assessment	9	23,10
Counselling Services	Call centre, Telephone counselling, Face to Face counselling, Trauma services, In-person support, Psycho-social support	5	12,80
Health and Safety Assessment	Health and Safety Assessment	2	5,10
Legal Wellbeing Services	Legal Wellbeing	2	5,10
Financial Wellbeing Services	Financial Wellbeing	2	5,10
	Financial Concerns		
Ergonomics Services	Ergonomics	2	5,10
	Ergonomics risk		
Organisational Diagnoses Services	Risk Diagnoses	2	5,10
	Organisational Audits		
Life style services	Quality of life	2	5,10
	Work/Life style		
Organisational Services	Healthy organisational culture	2	5,10
	Organisational wellness		
Preventative support	Preventative support	1	2,60
Family Care	Family Care	1	2,60
Managed wellness care	Managed wellness care	1	2,6
Online analytical process tools (OLAP)	Online analytical process tools (OLAP)	1	2,6
Organisational Specific support	Organisational specific support	1	2,6
Data warehousing	Data warehousing	1	2,6
Training infrastructure	Training infrastructure	1	2,6
Incapacity and absenteeism management	Incapacity and absenteeism management	1	2,6
Occupational Therapy	Occupational Therapy	1	2,6
Behaviour risk management	Behaviour risk management	1	2,6
Suggest interventions	Suggest interventions	1	2,6

Table 13 shows the services provided by services providers to organisations. The services were classified into 20 dimensions by grouping item responses together and then indicating a generic name for the services grouped together. Most of the services provided were related to health promotion services (23,10%) and Counselling services (12,80%). Only 2,60% of the service providers provided services like Managed Wellness Care, Online Analytical Processing (OLAP), Data Warehousing and Suggesting of interventions, indicating that only

one of the service providers was actually able to measure and manage the effectiveness of the wellness services they provide.

Different Services provided per Individual Service Providers (See Appendix, Table 7)

Different services were provided by the participating service providers. The spread of services differed quite a lot for the service providers. Of all service providers, three provided health promotion services, two provided counselling services, two provided health and safety assessment, two provided legal wellbeing services, two provided financial wellbeing services, two provided ergonomic services and two did organisational diagnoses. There was no further overlapping of services. Most of the overlapping services except for the health and safety assessment and organisational diagnoses were more traditional EAP services.

Ergonomic surveys

Of the participating organisations, 56,25% indicated that they had carried out an ergonomic survey as part of their EHWP, 37,50% indicated they did not, and 6,25% indicated that it did not form part of their organisation's conceptualisation of wellness. The main concerns organisations noted from their respective ergonomic surveys regarded lighting and ventilation that needed to be changed. Some of the organisation did not have any new problems, and in some organisation the survey was still ongoing. Specific changes to certain workplaces were also made. One organisation appointed a new Health and Safety manager following the results of their ergonomic survey. The organisations addressed the noted concerns by installing new air-conditioning, lighting and ventilation and ergonomic redesigning of offices also took place.

Only six of the organisations indicated how often they did ergonomic surveys. Of these one organisation did the survey every three months, one organisation quarterly, one organisation when required, one organisation once a year, one organisation every two years and one organisation did a base-line study as required by law, and then with every new project.

Table 14 indicates the ways in which organisations market their EHWP to their employees.

Table 14

Ways in which Organisations Market their Employee Health and Wellness Programmes to Employees

Item	Frequency	Percentage
Posters and pamphlets	9	16,10
Intranet	7	12,50
E-mails and sms	6	10,70
Newsletters	5	8,90
Employee training	4	7,10
Induction	4	7,10
Website	3	5,40
Notice board	3	5,40
Internal communications	2	3,60
Wallet cards	2	3,60
Through Aids Committees	1	1,80
Booklets	1	1,80
Online magazines	1	1,80
Session with employees	1	1,80
Planned roll out of EAP	1	1,80
Toolkits	1	1,80
Health days	1	1,80
Word of mouth	1	1,80
Inserts in payslips	1	1,80
Promotional items	1	1,80
Service providers	1	1,80

It can be seen from Table 14 that the most reported ways in which the EHWP's were marketed to employees were posters and pamphlets, use of an organisational intranet, e-mails and a short message service (sms).

Levels of employees to which services are rendered

All of the organisations indicated that the focus of their EHWP's was on all levels of their employees, and that anyone employed in the organisation could make use of the services offered by the programme.

Consulting of employees

It was indicated by 75% of the organisations that they did consult their employees in the development of the EHWP.

Table 15 shows which levels of employees were consulted in the development of the EHWP.

Table 15

Employee Levels Involved in Development of Employee Health and Wellness Programme

Item	Frequency	Percentage
All Levels	9	56,25
Not consulted	4	25,00
All levels + Unions	1	6,25
Through Unions	1	6,25
Through wellness coaches networks	1	6,25

Table 21 indicates that 56,25% of the organisations consulted all levels of employees, 6,25% consulted all levels and unions, 6,25% consulted unions and 6,25% employees through wellness coaches networks.

Benefits

All of the organisations provided medical aid as a benefit although that did not mean all employees were on medical aid. All of the organisations also provided retirement funds as a benefit to employees. Other benefits that organisations provided to their employees included group life insurance, housing subsidies, meals on duty, discounts on food and clothing, clothing subsidies, study loans, personal loans and work uniforms provided free of charge.

Table 16 shows the percentage of annual payroll spent on training in the participating organisations.

Table 16

Percentage of Annual Payroll that the Organisations Spent on Training

Item	Frequency	Percentage
1%	2	12,50
2%	2	12,50
2.5%	1	6,25
4%	1	6,25
No information	10	62,50

Table 16 shows that 62,50% of the organisations did not know what percentage of annual payroll that is spent on training in their organisations. The percentage of annual payroll spent on training ranged between 1% and 4 %

Training

Of all the organisations 81,25% indicated that training was compulsory for everyone in the organisation and 18,75% indicated that it was not compulsory. Table 17 shows the number of days of training the average employee received per annum in the participating organisations.

Table 17

Number of Days of Training an Average Employee Receives per Annum

Item	Frequency	Percentage
2 Days	1	6,25
3 Days	1	6,25
4 Days	1	6,25
5 Days	1	6,25
6 Days	1	6,25
8 Days	1	6,25
10 Days	2	12,50
12 Days	1	6,25
No info	7	43,75

Table 17 shows that in 43,75% of the organisations they did not know how many training days the average employee received in their organisation. The training days of the organisations that did know ranged from 2 day to 12 days, with 12,50% of the average employees of the organisations receiving 10 days of training per annum.

DISCUSSION

This study set out to describe the infrastructure of employee health and wellness in South African organisations by investigating the components of infrastructure and policies of current employee health and wellness programmes in South Africa, determining the educational levels of managers, evaluating information management systems used to enhance employee health and programmes in South Africa and to assess the benefits and training provided by organisations to their employees.

More than half of the participating organisations did not know how many days they lost due to absenteeism in the organisation. Most of the organisations did not have a strike in the year preceding the completion of the employee health and wellness survey (2006), but those organisations that did have strikes could not provide a total number of days lost as they did not know how many people had participated in the strike. Three quarters of the organisations

had accidents in their organisations during the preceding year. Yet, only half of these organisations knew the number of hours lost, and these ranged from none to more than 100 000 hours lost, due to the accidents. Thus, organisations might not be aware of the cost of accidents in their organisations if they are not aware of the amount of time lost due to accidents. All these cases are evidence of poor information management. A number of the EHWP managers complained that they had difficulty accessing employee data. Most of the organisations reported that their employees were above average in terms of productivity, although this was completely subjective and could not be substantiated by any objective data. The United Kingdom Health and Safety Executive (Health and Safety Executive, 2008) indicates that unwell behaviours like high level of stress experienced by employees can increase employee ill-health, sickness absenteeism and accidents. Therefore, it is important that “un”-well behaviour in organisations should be addressed in order to minimize the negative impact on the organisation. Proper information management could also aid organisations in moving from a reactive to a proactive approach in managing employee health and wellness. A good information management system enables organisations to identify problems and allow for necessary preventative actions to be taken (Harper, 1999).

The most reported reasons why employees left the participating organisations were indicated as related to career decisions and because of resignation. This might indicate problems regarding career and succession planning in organisations. In order to retain highly skilled employees, they must be provided with opportunities to learn, promotion opportunities and recognition for good work (Bhasin, 2000). Unfortunately, the situation in the South African employment industry is currently a situation where the demand for talented and skilled workers is higher than the supply (Bakos, 2007). Organisations could employ strategies such as personal career development plans, individualised development programmes and career tracking in order to retain employees (Bakos, 2007). If these plans are not in place, it could lead to key employees leaving the organisations to further their careers elsewhere.

Most of the organisations surveyed have HIV/Aids programmes. The components of the HIV/AIDS programmes were quite broad and included awareness raising, education and training, creating a non-discriminatory environment, prevention and control of sexually transmitted diseases, infection control, voluntary counselling and testing and promotion and distribution of condoms. The HIV/AIDS prevalence of the formal workforce is not always well described. With more accurate information organisations can focus prevention and care

services to employees and their families. Prevalence information is also important for emerging efforts by organisations to provide their employees with access to antiretroviral medicine (Evian, Fox, Macleod, Slotow, & Rosen, 2004). Half of the organisations provide antiretroviral medicine, which has been shown to be beneficial for employers (Pienaar, 2005). Providing employees with antiretrovirals might also be a way of dealing with the current skills shortage in South Africa. With almost 20% of the workforce HIV positive (The South African Institute of International Affairs, 2004) it is beneficial to organisations to keep their HIV positive employees healthy enough to work. In submitting government tenders, organisations are asked to list their corporate responsibility activities (van den Ende, 2004). Thus, in providing antiretrovirals to their employees can increase their social responsibility scores and improve the chances of acquiring government tenders.

More than a third of the organisations granted the minimum days of sick leave of 30 days within a three year cycle, and almost a third of the organisations gave 36 days within a three year cycle. The most sickness leave given was 90 days within a three year cycle. In one of the organisations an employee could accumulate sick leave, thus if you befall some serious illness you could take all the sick leave which you had not taken for all the years that you had been with the organisation. Almost half of the organisations gave three or five days family responsibility leave per year which is the least the law requires (Basic Conditions of Employment Act, no. 75 of 1997). In two-thirds of the organisations women could take four months paid maternity leave. However, in more than half of the organisations they could not take additional unpaid maternity leave. In three-quarters of the organisations they did provide study leave to their employees, the other quarter of the organisations did not have information regarding study leave to employees. In all cases regarding leave issues all the organisation fulfilled the minimum requirements as set by the law. (The requirements stipulated in laws can be seen as minimum requirements, thus all the organisations met at least minimum requirements.) Further research would be needed to determine whether or not the minimum compliance to the Law is adequate to really promote employee health and wellness in South African organisations.

Most of the organisations (62,50%) could not provide the amount of annual leave or sickness leave taken by employees for the preceding year. The organisations that did provide a number of days for annual leave admitted that this was not accurate because they did not have direct access to the data. Not managing employees' leave effectively may lead to increased

exhaustion among employees, especially if the employees work at a fast pace and do a large amount of work. The organisations that did provide the amount of sickness leave taken did not know why employees took sick leave, even in cases where sick leave taken was as high as 19 days per employee. Again, the lack of an information management system and access to data presents a major pitfall in employee health and wellness.

It was evident from the interviews with the participating organisations that the information management system regarding employee health and wellness was not adequate in most of the organisations. Organisations did not carry out an assessment of employee health and wellness needs before starting up their programmes, thus improvement as a result of the implementation of the programmes could not be substantiated. In many cases, organisations could only provide “educated guesses” regarding the productivity, amount of sickness leave taken, absenteeism rates, time lost due to accidents, amount of annual leave taken, staff turnover and stress levels of their employees. Depending on the information gathered, in some cases up to two-thirds of the organisations could not or did not have access to such information. In many cases, this was attributed to the fact that the EHWP did not have access to the data or that they had difficulty obtaining the data from the human resource department. Therefore, it could be suggested that employee health and wellness should develop their own information management systems that would enable them to not only pick up trends and implement interventions before problems start, but also better monitor interventions and address existing problems.

Almost all the organisations indicated that service delivery of the EHWP could be improved. Most of the suggestions regarding improvement related to the programme needing to be more holistic and integrated, the need for more resources and personnel, and that the organisations felt that the employee health and wellness services should be provided in-house. Especially the provision of in-house services is important because it is important to understand the “culture” of the organisation in customising interventions. This of course will only be possible if an objective, reliable assessment of the state of employee health and wellness has been done and intervention profiles compiled. Leong and Every (1997) also support the internal provision of service to employees in that in-house service utilization rates are higher and are more cost effective for organisations.

Less than half of the organisations had a policy governing the employee health and wellness initiatives in their respective organisations. Many of the organisations did not want to provide the researcher with the policy, and only one organisation really had a comprehensive employee health and wellness policy. Due to the fact that only a few policies could be evaluated no real discussion of the policies could take place. It is however alarming that many of the organisations did not have a policy to govern employee health and wellness in their organisations. Harper (1999) suggests that is important to have a written policy in place that defines the purpose of the programme, organisational mandate, record maintenance, role and responsibilities of personnel, programme procedures and service mix. A formal policy should thus serve to govern and clarify the purpose of an employee health and wellness programme

In most of the organisations the EHWP manager reported either to a CEO, Executive, General Manager or Head of a Department in the organisation. In half of the organisations, the person who the EHWP manager reported to was within the Human Resources Department. Thus, in half of the organisations the EHWP was under the umbrella of the Human Resource Department or formed part of the Human Resource Department in some way. Therefore the question could be asked why the EHWP's paid so little attention to work-related issues, if human resources deal with these issues on a daily basis. This might be attributed to the fact that traditionally, only health-related and personal issues are dealt with by the EHWP – this mindset has apparently not yet changed. Also, people working in human resource departments do not always have the necessary training to deal with work related issues that affect employees at work.

In more than a third of the organisations, there is only one person responsible to manage the EHWP. Two of the organisations had four people employed and then the number of EHWP employees ranged from 13 to 400 people. In one organisation there were 400 people to manage the EHWP, though that organisation has 150 000 members, making the ratio of employee health and wellness practitioner to employees 1:375. The worst ratio was 1:7500; the best ratio was 1:50. There were thus big organisations with only one person running the show, while in others the EHWP was better staffed. In the organisations where the EHWP is poorly staffed, it may be an indication that the organisation does not view the issue of employee health and wellness as important, or that organisations might not believe that the EHWP can contribute to positive employee outcomes. Almost two-thirds of the managers of

the EHWP evaluated did not have the word “Wellness” in their job titles. These findings may indicate that ‘wellness’ to a large extent is still only lip-service in the participating organisations. Wellness is not considered seriously enough to appoint managers with clear designations for managing this important aspect of work-life, and even where programmes are in place, they can be extremely understaffed. If EHWP can show a stronger link between the value they can add by improving positive employee outcomes like increased satisfaction morale, and productivity, decreases in turnover, accidents, absenteeism and IR and HR incidences; management might regard EHWP as more important. EHWP would be regarded as more important by management if they could prove that the value they add by improving positive employee outcomes (increased satisfaction, morale and productivity) would counteract or prevent decreases in turnover, accidents, absenteeism and HR and Industrial Relations (IR) incidences.

Most of the EHWP managers had relevant physical and psychological health training. Most of them came from an Industrial Psychology, Psychology or Social Work background. One of the managers was a medical doctor and one had a degree in Biokinetics. Of all the managers, only three did not really have relevant training in employee health and wellness. This opens the question to why organisations would employ somebody to manage an EHWP with no relevant background. The answer might lie in the fact that EHW is not well defined and therefore a lack of training exists for the people who need to manage the EHW programme. Currently there is no professional training available in South Africa for employee health and wellness practitioners. The reason for this can be because there apparently still exists confusion about what employee health and wellness really is (Sieberhagen, 2008). Industrial Psychologists could play a major role in implementing and managing Employee Health and Wellness in organisations, as this issue falls within their scope of practice. Within this scope, as set out by the Health Professions Council of South Africa (HPCSA, 2008), Industrial Psychologists are “authorised” to address issues in the work situation in order to optimise individual, group and organisational well-being and effectiveness. A clear need exists in South Africa for training regarding employee health and wellness.

Only one organisation implemented their programme as an outcome of wellness assessment in their organisation. For the rest, none did any kind of employee wellness assessment to determine what was wrong in their organisation in the first place. This is alarming, seeing that 15 of the 16 participating organisations guessed about what was wrong in their

organisation. This finding provides further proof that wellness in organisations is still regarded as merely a fad, and serious, considered intervention is not yet receiving the necessary attention. It is impossible to focus interventions on the right issues if you do not know what to address. South Africa has 3,7 million HIV-positive economically active people, which translates to roughly 25% of the workforce, which is estimated at 16 million (The South African Institute of International Affairs, 2004). The high rate of HIV infection could contribute to high incidences of sick leave and absenteeism. However, all the organisations provided some form of a HIV/AIDS service, either as part of their EHWP or as an HIV/AIDS education programme. This is at least one example of focused intervention, since HIV/AIDS is a real concern to South African organisations. Unfortunately, as only one of the organisations did an initial problem assessment, it may be that most organisations have activities and services in their programmes that employees do not need.

The focus areas of the EHWP of organisations cover issues of health promotion, wellness, organisational efficiency and counselling services. The reason for this might be that the organisations define employee health and wellness with a strong emphasis on health. In the literature, “wellness” and “health” is often still viewed as the same concept (e.g. DeMoranville, Schoenbachler, Przytulski, 1998; Merina, 1992). The UK Health and Safety Executive (2008) also refer to “wellness” many times in relation as to how stress impacts on the health of employees. Although organisational efficiency was one of the most reported functions of the programme, very few of the activities of programmes supported this function. Only half of the organisations conducted a stress survey as part of their EHWP. This is also notable seeing that stress is reported to be the second most frequently reported condition of individuals who disclose a work-related illness, and illness due to stress can cost the economy millions annually (Health and Safety Commission, 2007). Although the concerns were addressed by the organisations surveyed, none of the interventions were preventative in any way and in most cases; the interventions would not remove the stressors but only alter them. This was because the interventions were mostly focused on the individual (tertiary) and not on the organisation or workplace (primary).

More than half of the organisations that were included in this study indicated that they offered a combination of an Employee Health and Wellness and an Employee Assistance Programmes. However, the activities that were provided by the organisations differed greatly. Only a small percentage of the activities referred to the HIV programme, social skills training

and to leadership development. The concern is still that a lot of the activities did not necessarily relate to improving the employees' situation at work, which ultimately has the biggest effect on the individual.

Outsourced EHW activities ranged from HIV/AIDS services to counselling services, EAP services and health services. They also included activities like injuries on duty, implementation of the programme and providing ID documents and licences to personnel. The question could be asked, though, what the provision of IDs and licences has to do with employee wellness. Clearly, the latter activities fall under the rubric of the classic EAP. Thus, employee **health** is well looked after but issues that affect employee **wellness** at work are not the focus of outsourced activities.

More than two-thirds of the organisations provided their Employee Health and Wellness services in-house. These services ranged from HIV services to report feedback, which consisted of feedback to employees regarding surveys they completed. The main services rendered dealt with employee health, counselling, training and EAP and OHS services. Wellness interventions, managing performance, absenteeism and HR activities each only accounted for a small percentage of the service rendered in-house. This is an indication of the Wellness issues that organisations most focus on and by focusing on these activities it is clear that organisations still consider wellness and health to be very much the same and that the focus is still on curing the problem rather than preventing it.

The services provided by the four service providers were classified into 20 categories. Most of the service providers provided services including health promotion, counselling, health and safety assessment, legal wellbeing, financial wellbeing, ergonomics and organisational services (promotion of health organisational culture and organisation wellness). Thus, a third of the services were provided by half of the service providers. For the other 13 categories, only one of the service providers provided the service. Only one of the service providers suggested Employee Health and Wellness interventions to the organisations. At least half of the service providers provided services to organisations that never assessed if they needed such a service. Thus, the focus is still skewed in terms of health issues, and even service providers provide a wide array of services, which they all purport are able to contribute to employee health and wellness. Unfortunately, organisations remain at the mercy of service providers owing to a total lack of gaining business intelligence by making use of employee

health and wellness data to predict and prevent work-related issues that may negatively impact on the employees.

More than half of the surveyed organisations conducted an ergonomic survey as part of their EHWP, and they indicated that they addressed the concerns that manifested out of the survey. This is also a good example of focusing interventions after a reliable assessment. In addressing the issues the employee health and wellness of employees could be improved. Unfortunately, no benchmark or legal requirements exist for such surveys in South African organisations. The UK Health and Safety Executive (2008) expect every employer to conduct risk assessments for health and safety hazards, including work-related stress. The pilot study of the HSE took 12 months to complete, so it can be suggested that the work-related stress risk assessments should be done at least every 12 to 18 months. Although ergonomical issues are not governed by legislation in South Africa, it can be suggested that an assessment should be done to offices and then only a reassessment if changes to the offices are effected.

All of the organisations provided medical aid as a benefit to their employees, though this did not mean that employees were on a medical aid. All of the organisations provided retirement funds as a benefit to employees. The different organisations provided different other benefits although not many of the benefits were overlapping between organisations. One organisation provided meals for their employees on duty. This might be a good way to influence the health and wellness of employees especially if the employees come from lower income groups and have to perform physical labour (for example in the mining or manufacturing industries). Most of the organisations did not know what percentage of their payroll they spent on training of their employees every year. For those organisations that did know, it was less than 4% a year. In most of the organisations training was compulsory for everyone in the organisations. Almost half of the organisations did not know how many days were spent on training employees annually.

Posters and pamphlets were the most popular way in which organisations marketed their EHWP. Other popular marketing tools included the use of an organisational intranet, e-mails and short message systems (sms). Previous research indicated that popular marketing tools of EAP programmes in South Africa included orientation courses for new employees, posters and newsletters (Terblanche, 1992). In this instance, the use of modern communication methods has clearly eased communication with employees. All of the organisations focused

on all levels of employees to provide employee health and wellness services to. This is commendable, seeing that the programme is for everyone and not just for example available to top management. Also, in 75% of the organisations, employees were consulted before the EHWP was implemented. In more than half of the organisation all levels of employees were consulted and some organisations even consulted labour unions about the implementation of the EHWP. This is an improvement, as in a previous survey only 25% of the organisations indicated that employees were involved in the designing and implementation of EAP programmes in their organisations (Terblanche, 1992). It should, however, be noted that “consulted” in this case refers to organisations asking employees what kind of services they would like to form part of their EHWP and not to an assessment of the employee health and wellness state in the organisation. Thus, even though more employees were “consulted” it was not done in an objective and reliable way which allowed the EHWP to be implemented with a focused intervention plan.

RECOMMENDATIONS

It is imperative that employee health and wellness be adequately defined in South Africa. It is also essential that a South African assessment tool be used to measure employee health and wellness in South Africa and that South African norms and benchmarks regarding employee health and wellness be established. Before starting an EHWP, organisations should do a proper assessment of what needs to be addressed by such a programme in their specific organisation. When doing this, organisations will also be able to better determine benefits derived from the EHWP and to compare employee wellness states with those of other organisations and programmes.

Together with a standardised South African assessment tool, individual organisations need an adequate information management system. Organisations need to provide their EHWP with a comprehensive, computerised information management system. This will enable employee health and wellness practitioners to quickly identify problems and trends, which could assist them in taking the necessary preventative actions and also gain business intelligence from their employee health and wellness efforts. Types of information captured may include absenteeism, accidents and injuries, and HR incidences.

Employee health and wellness should also be standardised in South Africa. It should be determined what employee health and wellness in the South African context entails and who should play a role in its optimisation. Standardised training for employee health and wellness practitioners should also be developed and presented. This will enable employee health and wellness practitioners to establish the adequate infrastructure and ensure the effective functioning of their EHWP and determine the education and necessary competencies that EHWP staff need in their organisations in order to address employee health and wellness issues in their organisations.

Lastly, new employee health and wellness programmes can learn from the success of established HIV/AIDS programmes by looking at what makes these successful and how they address the needs of their employees and assist organisations who have employees with HIV/AIDS.

LIMITATIONS

This study is limited by the fact that in many cases the EHWP did not have access to the data required. Also, the sample was small and more organisations might need to be included in future studies in order to get a clear picture of the issue regarding employee health and wellness in South Africa.

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APPENDIX

Table 1 provides the characteristics of the participating organisations.

Table 1

Characteristics of the Participating Organisations (n=16)

Item	Frequency	Percentage
<i>Type of organisation</i>		
Multi national companies	2	12,50
Public companies	6	37,50
Private companies	4	25,00
Joint venture	1	6,25
National Government	1	6,25
Universities	2	12,50
<i>Sector of operations</i>		
Mining and quarrying	1	6,25
Manufacturing	2	12,50
Construction	1	6,25
Retail and motor trade and repair services	1	6,25
Transport, storage and communications	1	6,25
Finance and business services	4	25,00
Education	2	12,50
Petroleum	1	6,25
Hospitality	1	6,25
Health care	1	6,25
Safety and security	1	6,25
<i>Total full-time employees</i>		
2001-500	1	6,25
501-1000	1	6,25
1001-3000	5	31,25
3001-5000	2	12,5
5001-10 000	4	25,0
10 001-20 000	1	6,25
More than 20 000	2	12,5
<i>Estimated annual turnover</i>		
R50-100 million	1	6,25
R250-500 million	1	6,25
R750-999 million	1	6,25
R1000-1250 million	2	12,5
R1250-1500 million	1	6,25
R2500-2750 million	1	6,25
R2750-3000 million	1	6,25
More than R3500 million	2	12,5

Table 1

Characteristics of the Participating Organisations

57 Million profit	1	6,25
Budget	1	6,25
Not disclosed	4	25,0
<i>Annual payroll expressed as % of annual turnover</i>		
11-20%	2	12,5
31-40%	3	18,75
51-60%	1	6,25
71-80%	2	12,5
No information provided	8	50,0

Table 2 gives the characteristics of the participating service providers in the employee assistance and employee wellness industry that were included in the survey.

Table 2

Characteristics of the Participating Service Providers

Item	Frequency	Percentage
<i>Amount of organisations services are provided to</i>		
5-10	1	25
11-50	1	25
201-500	2	50
<i>Established</i>		
1998	1	25,0
2000	1	25,0
2002	1	25,0
2005	1	25,0

Table 3 provides a brief description of the participating labour unions in terms of their sector of operations and total membership.

Table 3

Characteristics of the Participating Labour Unions (n=7)

Item	Frequency	Percentage
<i>Sector of operations</i>		
Transport, Storage and Communications	2	28,60
Education	1	14,30
All Sectors	4	57,10
<i>Membership</i>		
3001-5000	1	14,30
5001-10 000	1	14,30
10 001- 20 000	1	14,30
20 001-100 000	1	14,30
100 001-200 000	1	14,30
200 001-500 000	1	14,30
More than 500 000	1	14,30

Table 4 provides a further description of the participating organisations in terms of amount of employees and annual turnover.

Table 4

Description of the Participating Organisations in terms of Sector of Operations, Full-time Employees, and Annual Turnover

Organisation	Type of organisation	Sector of operations	Total full-time employees	Annual turnover
1	Public companies	Retail and Motor trade and Repair services	10 001-20 000	R1250-1500 million
2	Private companies	Construction	501-1000	R750-999 million
3	Private companies	Transport, Storage and Communications	3001-5000	R2750-3000 million
4	Public companies	Manufacturing	1001 – 3000	R2500-2750 million
5	Public companies	Finance and Business Services	1001 – 3000	Not Disclosed
6	Universities	Education	3001-5000	R1000-1250 million
7	Public companies	Manufacturing	5001-10 000	R1000-1250 million
8	Multi national companies	Petroleum	1001 - 3000	Not Disclosed
9	Joint Venture	Hospitality	5001-10 000	R250-500 million
10	Private companies	Finance and Business Services	More than 20 000	More than R3500 million
11	Public companies	Mining an Quarrying	5001-10 000	More than R3500 million

Table 4 continued

Description of the Participating Organisations in terms of Sector of Operations, Full-time Employees and Annual Turnover

12	Public companies	Finance and Business Services	5001-10 000	Not Disclosed
13	Multi national companies	Health Care	1001 - 3000	57 million profit
14	Universities	Education	1001 - 3000	R50-100 million
15	Private companies	Finance and Business Services	2001-5000	Not Disclosed
16	National Government	Safety and Security	More than 20 000	Budget

Note. For clarity, the same numbers allocated to organisations in this table are used in subsequent tables.

Table 4 provides a snap shot of each of the participating organisations in terms of amount of employees and annual turnover per organisation. It can be seen that Organisation 2 has the fewest employees, while Organisations 10 and 16 have the most. In terms of turnover, Organisations 10 and 11 generates the highest annual turnover, while Organisation 14 generates the lowest.

Measuring instruments

The *Employee Health and Wellness Survey* was developed by the researcher to determine the nature, content, context, participants, role players and anticipated benefits and possible drawbacks of a work wellness programme in a specific organisation. To ensure content validity of the questionnaire, it was developed based on a comprehensive literature study. Furthermore, the questionnaire was submitted to experts in the field of employee health and wellness (both in academia and organisations) to judge its validity. A trial run was used to assess whether the items are understandable and to detect problems in the questionnaire. The questionnaire was divided into seven sections:

Section 1: Organisational information

This section consisted of ten questions regarding the type of organisation, sector of operations, annual turnover, number of full-time employees and Sectoral Education and Training Authority (SETA) the organisation is registered with. Most of the questions offered various possible alternatives, from which participants only had to select the relevant option.

Section 2: Reasons for implementation, functions and perceived successfulness of employee health and wellness programme

This section consisted of ten questions that related to reasons for implementation, functions and effectiveness of the organisation's employee health and wellness programme. Examples of questions that were asked included giving the organisation's definition of employee health and wellness, reasons for implementation of employee health and wellness programme(s), and a rating of the perceived successfulness of the employee health and wellness programme. Some of the questions were open ended questions and some were structured, where the relevant option could just be indicated.

Section 3: Determination of effectiveness, activities and level of employee participation in organisations' employee health and wellness programme

This section consisted of 12 questions that related to activities that form part of the employee health and wellness programme, level of employees that form the focus of the employee health and wellness programme, and the provider(s) of employee health and wellness services in the organisation. Some of the questions were open-ended, some were yes/no with a discussion of the answer, and some were indicated and fill-in questions where participants could elaborate on their answer.

Section 4: Organisational contributions, strikes, absenteeism and staff turnover

This section consisted of 15 questions which related to the organisations' contributions made in terms of employee medical aid, retirement fund and other benefits. Questions were also asked about the number of strikes in the organisation, absenteeism and staff turnover. Questions relating to the reasons for strikes, benefits provided, days lost because of strikes, amount of leave and number of working hours lost because of accidents were asked. Some of the questions were open-ended, some were yes/no with a discussion of the answer and some were rateable on a 5 point scale.

Section 5: Budget, needs analyses and focus of interventions of organisations' employee health and wellness programme

This section consisted of 22 questions that related to the budget, needs analyses and types of interventions of the organisation's employee health and wellness programme. Questions related to how the employee health and wellness programme was funded, the percentage of annual payroll spent on the employee health and wellness programme, how employee needs

were determined and how often needs were determined. Some of the questions were open ended, some were yes/no with a discussion of the answer, some were mark with discussion, some fill-in questions and some were rateable on a 5-point scale.

Section 6: HIV/AIDS Programme

This section consisted of 4 questions relating to HIV/AIDS activities in the participating organisations. Questions were asked about the components of the organisation's HIV/AIDS programme and whether it formed part of the employee health and wellness programme. A question was also asked about the objectives of the HIV/AIDS programme. One of the questions allowed respondents to tick the answer, one was open-ended and two were yes/no questions.

Section 7: Employee Health and Wellness Legislation

This section consisted of 3 questions regarding legislation that influences employee health and wellness in South Africa, and the perceived influence of unions in employee health and wellness activities.

The *Employee Health and Wellness Survey (Labour Unions)* was developed to determine the sector in which the labour unions operate, how many members they have, how they define employee health and wellness and how they influence employee health and wellness issues in the respective organisations of their members.

The *Employee Health and Wellness Survey (Service Providers)* was developed to determine the number of organisations they provide services to, the nature of services they provide and how they define employee health and wellness.

Table 5

Main functions, Objectives and Focus Areas of Organisations' Employee Health and Wellness Programmes

Item	Dimension	Frequency	Percentage
Health, Reduce medical care, Fitness club, Healthy employees, Online health site, Managing Health, Health issues, Health awareness for employees, Employees take responsibility for own health, Physical health, Identify health risk, HIV/AIDS, Employee health promotion, Identify health risk	Health Promotion	13	22,40
Organisational, individual and interpersonal wellness; Individual, Physical, Emotional, Spiritual wellness, Create wellness link, Spiritual and Mental Wellness. Social/Emotional wellness, Physical, 6 Wellness areas: Physical, Occupational. Social, Spiritual, Mental and Emotional; Influence things that affect employee wellness, Employee Wellness Promotion	Wellness	9	15,50
Improve productivity, Enhance organisational effectiveness, Performance issues, Reduce absenteeism, Management of absenteeism, Make thriving employees, Work problems, Contribute to bottom-line, Absenteeism, Productive employees	Organisational Efficiency	8	13,80
Counselling, Provide counselling, Counselling for Personal problems, Counselling for Family Problems, Counselling for work problems , Psychological counselling, Prevention and treatment of psycho-social problems	Counselling services	7	12,10
Support employees, Care and support commitment from organisation, Organisation is caring Employee support, Support to troubled staff and managers Offer services that provide needs of staff	Care and Support of employees	7	12,10
Life skills	Life skills	3	5,20
Safety, Safe employees	Safety	2	3,40
Stress management	Stress management	2	3,40
Balanced lifestyle	Balanced lifestyle	1	1,70
Employer of choice	Employer of choice	1	1,70
A pro and re active programme	A pro and re active programme	1	1.70
Telephonic legal and financial help	Telephonic legal and financial help	1	1.70
Focus on the 90% healthy personnel and not just the 10% sick	90/10 principle	1	1.70
Improved work environment	Improved work environment	1	1.70
Mitigate risks	Mitigate risks	1	1.70

Note: The main functions, objectives and focus areas responses were grouped into 17 dimensions

Table 6

Employee Health and Wellness Activities that are Outsourced by the Organisations

Dimensions	Items	Frequencies	Percentages
HIV/Aids services	Antiretroviral	10	18,9
	HIV/AIDS		
	HIV training		
	Aids interventions		
	VCT		
	HIV treatment testing		
Counselling services	Counselling	9	17,0
	Trauma counselling		
	Trauma debriefing		
EAP Services by EAP Service Providers	Traditional EAP services	7	13,2
Health services	Eye screening	13	24,5
	Alcohol + Drug abuse		
	Health days		
	Clinics		
	Hearing		
	blood donation		
	flu vaccination		
	Clinic		
	E-Care (health)		
	Addictions		
	Executive Meds		
	Health services: Doctors, Physiotherapist, Weigh less, Medical aid, Dieticians		
Financial services	Financial services	4	7,5
Legal Services	Legal services	2	3,8
Coordination and Administration of programme	Coordination and administration of programme	2	3,8
Assessment of employees	Assessment of employees	1	1,9
Implementation of programme	Implementation of programme	1	1,9
Report writing and Feedback	Report writing and feedback	1	1,9
Injuries on duty	Injuries on duty	1	1,9
Id's and Passports	Identity documents and passports	1	1,9
Nat + International driving licences	National and international driving licences	1	1,9

Table 7 shows the service that are provided by the different service providers

Table 7

Different Services provided per Individual Service Providers

Services Offered	Service Provider 1	Service Provider 2	Service Provider 3	Service Provider 4
Health Promotion Services	X	X	X	
Counselling Services		X		X
Health and Safety Assessment			X	X
Legal Wellbeing Services		X		X
Financial Wellbeing Services		X		X
Ergonomics Services			X	X
Organisational Diagnoses Services	X			X
Life style services			X	
Preventative support		X		
Family Care				X
Organisational Services			X	
Managed wellness Care	X			
OLAP tools	X			
Organisational Specific support	X			
Data warehousing	X			
Training infrastructure	X			
Incapacity and absenteeism management				X
Occupational Therapy				X
Behaviour risk management				X
Suggest interventions	X			

Table 8

Types of Programmes

Item	Frequency	Percentage
Combination of Employee Assistance and Employee Wellness Programme	9	56,25
Employee Wellness Programme	5	31,25
Employee Assistance Programme	2	12,50

Table 8 shows that of the participating organisations, 56,25%) indicated that they a offered a combination of an Employee Assistance and Employee Wellness Programme, 31,25% indicated that they had an Employee Wellness Programme, and 12,50% indicated that they had a programme that was aimed at providing employee assistance.

CHAPTER 4

RESEACRH ATRICLE 3

EMPLOYEE HEALTH AND WELLNESS IN SOUTH AFRICA: THE ROLE OF LEGISLATION AND MANAGEMENT STANDARDS*

ABSTRACT

Organisations in South Africa are becoming increasingly aware of issues concerning employee health and wellness. The Occupational Health and Safety Act of 1993 determines that an employer must, as far as is reasonably possible, establish and maintain a work environment that is safe and without risk to the health of employees. Therefore, cases of ill health and injury due to work, as well as physical symptoms of ill health, are matters of high priority. However, it seems that there is a lack of guidance in the laws and statutes with regard to dealing with employee health and wellness. Employers need to identify work activities that will expose employees to physical and psychological risks, but currently little is done in terms of risk analysis and occupational stress interventions. The South African Labour Relations framework provides a mechanism for employee health and wellness interventions through different pieces of labour legislation.

Key words: Legislation, employee, health, wellness, management standards, stress

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OPSOMMING

Organisasies in Suid-Afrika word al meer bewus van die welstand en gesondheidsake van werknemers. Die Wet op Beroepsgesondheid en –Veiligheid van 1993 bepaal dat ‘n werkgewer, sover dit redelik moontlik is, ‘n werkomgewing moet vestig wat veilig is en geen risiko inhou vir die gesondheid van werknemers nie. Daarom is gevalle van siektes en/of beserings wat deur werk veroorsaak is, sowel as fisiese simptome van enige siektetoestand, prioriteit. Daar skyn ‘n gebrek te wees aan leiding by die wette en statute ten opsigte van die hantering van die gesondheid en welstand van werknemers. Werkgewers moet bedrywighede by die werk identifiseer wat fisiese en sielkundige risiko mag inhou vir werknemers, maar op die oomblik word weining gedoen ten opsigte van die analisering van risiko en intervensie by beroepstres. Die raamwerk vir Suid-Afrikaanse Arbeidsverhoudings verskaf, deur middel van verskeie gedeeltes arbeidswetgewing, ‘n meganisme vir intervensie in die gesondheid en welstand van werknemers.

Sleutelwoorde: Wetgewing, werkers, gesondheid, welstand, bestuurstandaarde, stres

According to estimates, job-related accidents and illnesses claim more than two million lives annually, while 270 million accidents and 160 million illnesses occur over the same period worldwide. These accidents and illnesses account for 4% of the cost of the global economy of the Gross Domestic Product annually. World estimates show that small and medium size enterprises account for 90% of those enterprises where poor working conditions are prevalent (South African Department of Labour, 2004). Estimations, which are generally regarded as underestimations, show that 1,1 million deaths occur worldwide because of illnesses or injuries at work. This adds up to 3000 deaths caused by work-related factors every day (Takala, 1998).

Politicians, policymakers, labour unions and employers need to be convinced of the importance of occupational health and safety (Rantanen, Lehtinen, & Savolainen, 2004). This is particularly important in developing countries, which also face occupational health and safety hazards, but lack the resources to deal with these hazards. According to Rantanen et al. (2004), approximately 2,4 billion of the 3,2 billion workers in the world (i.e. 80%) live in developing countries, compared to the 600 million in industrialised countries. However, developing countries produce only 20% of the Gross Domestic Product in the world (compared to 80% of the industrialised countries).

Occupational accidents and diseases amount to a cost for South Africa in the region of 3,5% of the Gross Domestic Product, which translates to about R30 billion per annum (South African Department of Labour, 2004). A total of 122 889 employees fall victim to accidents or sickness as a direct result of their work, and almost 1 percent (0,72%, or 884 employees) of these are fatal. The number of man-days lost annually due to sickness is put at over 12 million, with further losses due to labour unrest (Workmen's Compensation Fund, 1999). The South African Government gives occupational health and safety high priority, and advocacy and awareness campaigns as well as inspection blitzes are being carried out regularly (Mdladlana, 2007). The South African Department of Labour listed mining, construction, steel and agriculture as high-risk sectors of employment. Employees in these sectors are at a higher risk of getting hurt or being involved in accidents at work. Between 1997 and 2006, an average of 173 mine workers died annually in South African gold mines (De Beer, 2007). The Occupational Health and Safety Act deals quite well with issues regarding health and safety in the workplace. In terms of the Act, *safety* is defined as “to keep employees free from hazard” and *health* is defined as “free from illness or injury attributable to occupational

causes". The problem with this definition is that it is not clear whether it also refers to psychological illness (e.g. because of occupational stress).

Legislation might be necessary to ensure that the safety, health and wellness of employees are taken seriously. However, it seems that priorities in industrialised and developing countries differ substantially. According to Rantanen et al. (2004), priorities regarding employee health and safety in industrialised countries include stress, the aging workforce, the right to know, informed consent and transparency, working with or exposure to chemicals, ergonomics, allergies, the quality of indoor air, new technologies, management and safety culture, and occupational health services. Priorities regarding employee health and safety in developing countries include agriculture, dangerous occupations, the transfer of hazardous technologies, major accidents and fires, safety, housekeeping and productivity, occupational and work-related diseases, toxic metals and solvents, organic dusts, vulnerable groups, child labour, heat stress and heavy physical work. Although some overlap exists (e.g. in terms of exposure to toxic metals and exposure to chemicals), it is clear that employee safety, health and wellness are given higher priority in industrialised countries as compared to developing countries. Health and safety aspects are covered by occupational health and safety legislation, but legislation regarding employee wellness still lacks to a large extent. Psychosocial stressors seem to be a priority in industrialised countries, while issues such as dangerous occupations and heavy physical work are important focus areas in developing countries.

Wynne and Rafferty (1999) point out that psychosocial stressors at work were traditionally regarded as unimportant and even a taboo subject in Europe and the United States of America. This resulted in a lack of consideration of the effect of psychological stressors on employees. Furthermore, the trend in organisations was to treat psychosocial stressors as an individual problem to be managed by enhancing the coping skills of the individual employee. In other words, a worker-orientated approach prevails: for instance by improving the skills of employees to manage, resist or reduce stress, as opposed to a job or organisational-oriented approach, for instance by job redesign or in some way transforming the incapacitating corporate culture or management style (Taris et al., 2003).

There have been a number of developments in recent years that have begun to lead a change in approach to dealing with wellness in the workplace (Wynne & Rafferty, 1999). In the first place, occupational stress has begun to lose its taboo status and its previous association with

mental illness in the public mind. Popular media, conferences, newspaper articles and television programmes deal with well-being or employee wellness in an open manner. Secondly, medical practitioners have begun to use the terms “stress” and/or “burnout” as a reason for absence from work. Thirdly, the growing exposure of society to the issue has led to the issue being talked about in the workplace.

Employee health and wellness

Definition of terms

The World Health Organisation (WHO) defines health as “...a complete state of physical, mental and social well-being and not just the absence of disease” (World Health Organisation, 2002, p. 2). Since 1950, the International Labour Organization (ILO) and the World Health Organization (WHO) have shared a common definition of occupational health. The definition reads: "Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers, in their employment situation, from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological needs and capabilities; and, to summarize, the adaptation of work to man and of each man to his job” (Stellman, 1998, p. 28). Although this definition of health includes physical and psychological dimensions, legislation is interpreted to focus on physical health (e.g. prevention and management of occupational diseases) rather than psychological health (e.g., prevention and management of stress and depression).

Nonetheless, the International Labour Organization (ILO) and the World Health Organization (WHO) are committed to primary prevention means and of the opinion that intensive actions for better work environments are required in virtually every country (Goldstein, Helmer, & Fingerhut, 2001). Criteria and actions need to be considered for the planning and design of healthy and safe work environments that are conducive to physical, psychological and social wellbeing (Goldstein et al., 2001). Wellness can be defined as the experience of optimal health, good relationships with others, being emotionally and cognitively well stimulated and experiencing significance and purpose in life (Els, 2005). A person who is in a state of wellness can therefore maximise his or her potential. Rothmann and Rothmann (2006) define

employee health and wellness as a state in which employees are energetic, motivated, healthy, productive, and committed to the organisation and its goals.

In studying employee health and wellness, various paradigms can be used. Strümpfer (1995) refers to three paradigms which could be relevant for studying employee health and wellness. They are the *pathogenic* paradigm (which focuses on the origins of illness), the *salutogenic* paradigm (which focuses on the origins of health), and the *fortigenic* paradigm (which focuses on the origins of strength). The salutogenic and fortigenic paradigms are evident in the positive psychology movement (Seligman, 2002). Seligman and Csikszentmihalyi (2000, p. 5) suggest that the purpose of positive psychology is "... to begin to catalyse a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities". Applied to the work context, Luthans (2002) recommends that positive organisational behaviour be researched and practiced. In positive organisational behaviour positive-oriented human resource strengths and psychological capacities are the focus of study and intervention. Nelson and Simmons (2003) suggest that work stress should be viewed from a more holistic perspective, incorporating eustress. Eustress is associated with the positive effects of the stress response.

In line with the assumptions of the pathogenic paradigm, the traditional focus of research and practice regarding employee health and wellness was illness, distress, dissatisfaction and unhappiness (Nelson & Simmons, 2003). However, research and practice in employee health and wellness should also focus on the origins of health and strength (Strümpfer, 1995). Therefore, the focus of employee health and wellness should not only be on which factors in the workplace affect employees negatively (e.g. stress and strain), but also on how to promote the positive aspects of employee health and wellness (e.g. good supervisory relationships, collegial support, growth opportunities and adequate job resources).

Health and wellness in organisations

Studies in the United Kingdom showed that stress and stress-related illness were second only to musculoskeletal disorders as the major cause of occupational ill-health (Jones & Hodgson, 1998). Stress resulted in 6,5 million working days lost to industry and commerce in the United Kingdom, accompanied by a financial burden to the economy of £3,7 billion per annum. In a 1997 survey in the Netherlands, 58% of Dutch employees indicated their pace of

work to be 'high' more than 50% of the time, compared to a European average of 42%. Work disability rates in the Netherlands are twice as high as in other European countries. One third of the disability benefit recipients are assessed to be disabled for work on mental health grounds (Lourijssen, Houtman, Kompier, & Gründemann, 1999).

In 1998, mental health disorders were the largest diagnostic group for work incapacitation (32%), followed by musculoskeletal disorders. Inspection revealed that 80% of the mental health cases did not suffer from major psychopathology (e.g. psychosis, neurosis or personality disorder), but from adjustment disorders (including job stress and burnout). Specific problem areas include physical workload, mental workload, general working conditions, unfavourable social climate, and low payment. Twelve percent of the workers' days of absence were because of mental or psychological disorders, with a sickness absence rate of 5,6% amounting to \$25 billion in 1995, which is about 8% of the Dutch Gross Domestic Product. However, productivity was also higher in the Netherlands than in other European countries.

Poor health is an outcome of stress, which can be used to ascertain whether workplace pressures have positive and motivating (salutogenic) or negative and damaging (pathogenic) effects. However, poor health may not necessarily be indicative of workplace stress. Individuals may, for example, be unwell because they choose not to live a healthy lifestyle or may be unaware of how to do so (Cartwright & Cooper, 2002). The experience of high levels of stress may lead to feelings of anger, anxiety, depression, nervousness, irritability, tension and boredom. The negative effects of stress on the individual may lead to poorer job performance and motivation, lower creativity, a reduced quality of social relations and overall diminished individual effectiveness (Schabracq, Winnubst, & Cooper, 2003). Effects directly related to job stress which may influence the organisation include low production and increased production errors, increased accidents, high labour turnover, increased absenteeism and increased medical cost.

Low production, high production errors and accidents, high labour turnover, high medical costs and increased absenteeism and presenteeism can all be considered symptomatic of the experience of workplace stress. Statistics confirm that at any given time one fourth of South Africa's workforce is affected by problems that contribute to a deterioration in performance at work, and South Africa's workforce productivity is ranked 31st out of 45 countries

(Noemdoe, 2002). In 1996, the cost of injuries at work in South Africa amounted to R4,7 billion a year (Noemdoe, 2002). Also, South African employees are generally unhealthy, due to unhealthy living conditions in squatter camps and unhealthy lifestyles and diets due to their economic circumstances (Mead, 1998). Also, almost a quarter of the economically active population is HIV positive which contributes to high labour turnover rates, lower worker productivity and constitutes an increased burden on employee benefit programmes (The South African Institute of International Affairs, 2004). In South Africa, it is estimated that 6,3 days per employee per annum are lost to unapproved absences from work (Vaida, 2005). About 4,5% of the South African workforce are absent on any given day, although the absenteeism rate is sometimes as high as 18% in some South African organisations (Vaida, 2005).

South Africa's population is estimated at 47,9 million people. Africans make up 80% of the population at nearly 38,1 million. KwaZulu-Natal has the largest share of the population (approximately 21%), followed by Gauteng (20%). Fifty-one per cent (approximately 24,3 million) of the population is female (Statistics South Africa, 2007). The economically active population for all race groups is estimated at 16 million. Most people employed by the formal sector work within community, social and personal services, wholesale or manufacturing (Perold & Jooste, 2006).

Stress is regarded as a serious occupational risk in South Africa (Barkhuizen & Rothmann, 2004; Pienaar & Rothmann, 2005; Rothmann, 2005; Temkin, 2004). The ten most general claims accepted by medical schemes are for the treatment of stress-related illnesses (i.e., high blood pressure, high cholesterol, asthma, depression, menopause, type 1 diabetes, epilepsy, type 2 diabetes, ischemic heart diseases and gastro-oesophageal reflux). Furthermore, 75% of the visits to primary health care facilities are stress-related (Van der Merwe, 2005). However, a strong pathogenic approach still exists in that it is managed as a cause of illness and the positive effects of job stress are not explored.

Rothmann (2005) analysed occupational stressors in 14 different occupations in South Africa and concluded that stress levels are high in workers in some occupations, especially in the health sector (such as hospital pharmacists, nurses, and emergency workers), correctional officers, university educators, call centre operators and police officers. Inadequate salaries, colleagues not doing their work, poorly motivated co-workers and insufficient staff were

severe stressors identified across many occupations. Statistics show that an average of 10 000 police officers in South Africa are absent from work daily because of high levels of occupational stress (Pienaar & Rothmann, 2005). Educators (specifically in secondary schools) in South Africa also seem to experience high levels of stress. Twenty percent of the educators in Gauteng are absent for more than 10 days per year (Naidu, 2005). Executives in South Africa also experience high stress levels. Their stress levels are fuelled by the exchange rate volatility, commodity prices, fluctuating interest rates, changing legislation and empowerment charters (Temkin, 2004).

Occupational stress could be a serious treat to employees, organisations and to South Africa as a country. Research has shown the negative effect of stress on the health and wellness of employees, and therefore this can also influence organisations negatively. Organisations can feel the impact of stress in increased absenteeism, higher staff turnover and lower productivity of employees that will ultimately influence the organisation's bottom-line. These effects can also have an adverse impact on the economic growth of South Africa through lower productivity and increased numbers of employees who are incapable or unwilling to work.

Role-players in managing employee health and wellness

There are different role-players that can participate in efforts to ensure the health and wellness of employees. The four major role-players can include the employee, by means of the things he/she does to keep him/herself well (Cartwright & Cooper, 2002); labour/trade unions (Cousins et al., 2004) through negotiating health and wellness issues of their employees on their behalf with their employers; management of organisations by means of the implementation of employee health and wellness or assistance programmes; and the national government, by means of the laws and national strategy it imposes.

The aim of this study was to investigate the role that legislation and management standards might play to ensure occupational health and wellness, and to make recommendations regarding a national strategy in order to promote employee health and wellness in South African organisations.

The role of legislation in managing employee health and wellness

Legislation could play an important role in governing employee health and wellness, but that would only involve national government as a role-player and might be bureaucratic. An alternative might be to involve all the role-players in the development of management standards to ensure the health and wellness of employees. However, the government can have a large influence through imposing legislation that promotes and protects employee health and wellness and through providing the infrastructure to support that management standards approach.

According to Kompier and Schaufeli (2001), an active government policy towards job stress may prevent it from remaining a mere taboo subject, and may put it on political and company agendas. Modern working conditions legislation should not only address traditional health and safety issues, but also psychosocial work characteristics (e.g. job content and social relations at work). From the point view of the modern worker such legislation is crucial. Legislation and corresponding national working conditions administrative infrastructure (Occupational Health and Safety Services) is important to stimulate organisations to take action. Special attention should be given to small and medium sized companies that often lack special expertise for risk assessment and prevention (Kompier & Schaufeli, 2001).

Next, trends in legislation in especially European countries are analysed, followed by a review of relevant South African legislation.

International trends regarding health and wellness legislation

In Europe, three developments in the early 1990s gave rise to an increased need for practical ways for managers to prevent and manage work stress, namely an increasing incidence of occupational stress, requirements of European and national legislation and an increase of employee litigation (Geurts & Gründemann, 1999). In 1989, the European Commission published its “Framework Directive on the Introduction of Measures to Encourage Improvements in the Safety and Health of Workers at Work” (Geurts & Gründemann, 1999). These requirements had to be made into laws in each of the member states of the European Union. The directive required employers to avoid risks, to evaluate the risks which cannot be avoided, to combat risks at their source, to keep themselves informed of the latest advances in

technology and scientific findings concerning workplace design, and to consult workers and their representatives and allow them to take part in the discussions on all questions relating to safety and health at work. Employers were required to be in possession of an assessment of the risks to safety and health at work and decide on the protective measures to be taken (Kompier & Cooper, 1999). Situations from various European countries are considered below.

United Kingdom. In the United Kingdom, provisions were catered for in the Health and Safety at Work Act (1974) and Management of Health and Safety at Work Regulations (1992). These laws made risk assessment and management essential. An important court ruling was in the case of John Walker, a social services manager (Walker versus Northumberland County Council). Walker lodged a case against his former employers for failure to prevent him from trying to cope with a health-endangering workload. Although there were reports regarding out of court settlements regarding stress claims in the UK, the Walker case was the first of its kind to come before a UK court (Whatmore, Cartwright, & Cooper, 1999). The court ruled in favour of the plaintiff and stated that there is no reason why psychological damage should be excluded from the scope of an employer's duty of care. The Court held that employers had a duty not to cause their employees psychiatric damage by giving too much work and/or insufficient backup support. The general principle is that an employer is usually entitled to assume that the employee can withstand the pressures of the job. However, if it is reasonably foreseeable that there is a risk of injury (which must be a clinically recognisable condition) due to stress at work, then the employer owes the employee a positive duty to make the working environment less stressful (Hawson, 2003).

The Netherlands. In the Netherlands, work stress has become an important policy issue and provisions were catered for in the Working Condition Act (WCA) of 1990 (Lourijssen, Houtman, Kompier, & Grudenmann, 1999). The WCA goes beyond merely protecting employee health and safety by promoting their well-being within the organisation. The WCA states that the workplace, working methods, tools, machines and the work content should be in accordance with the personal characteristics of employees, and that monotonous and repetitive work should be avoided. It is believed that an active policy of employers to foster safety, health, and well-being must be based on a thorough written and regularly conducted inventory and assessment of all work-related risks, including psychosocial risks. Risk inventory and assessment should include a plan of action to reduce risks and be sent to the Occupational Health and Safety Services (OHSS) for approval. Employers should engage

experts from the OSHH to assist in carrying out risk assessments and develop a plan of action, and they need to give social-medical guidance to sick employees and carry out periodical medical examinations. The WCA is administered by the Labour Inspectorate, which can fine employers or prosecute them criminally. Compliance is encouraged by providing information and disseminating knowledge, by granting the development of instruments for assessing psychosocial risks and by stimulating preventative programs. OHSSs are independent commercial enterprises that operate in the private market by selling their services to companies. In 1998, 95% of Dutch companies had a contract with an OHSS (Lourijssen et al., 1999).

Sweden. In Sweden, work environment regulation includes psychosocial factors and work organisation. The Work Environment Act of 1976 in Sweden stated that psychosocial factors were just as important as the physical working environment (Theorell & Whalstedt, 1999). The Act states that the “working environment should adapt to people’s differing physical and mental aptitudes, that the employee should be given the opportunity to participate in designing his/her own working situation, and in processes of change and development affecting his/her work and technology, work organisation and job content should be designed in such a way that the employee is not subjected to physical and mental strain which could lead to illness” (Theorell & Whalstedt, 1999, p. 196).

Belgium. A law concerning the well-being of employees at work in Belgium came into effect in August 1996 (Poelmans, Compennolle, De Neve, Buelens, & Rombouts, 1999). The law states that the employer should take the necessary measures to promote the well-being of employees in the execution of their work by a) preventing risks, b) evaluating the risks which cannot be avoided, c) combating the risks at source, d) replacing what is dangerous by what is not or less dangerous, e) giving priority to measures aimed at collective protection, f) adapting work to the individual, especially with regard to the design of workplaces, the choice of work equipment and the choice of working and production methods and in particular to make monotonous work and work at a predetermined rate more tolerable, g) limiting risks as much as possible, h) planning prevention and implementation of an employee well-being policy, and j) informing the employee about the nature of his/her job, the job-related risks and the measures that aim to prevent or reduce the risks. In Belgium, employers are not only held responsible for the health and safety of employees, but also for psychosocial stress caused by work (Poelmans et al., 1999).

Denmark. In Denmark the Working Environment Act of 1975 lays down the functions and responsibilities of the institutions, authorities and persons responsible for the working environment in all sectors except domestic work and the armed forces. The Act makes it compulsory for work to be conducted in such a way that employees' health and safety is protected. Its objective is to ensure that working conditions are such that workers will not be subjected to accident or disease and/or to physical and psychological problems (Netterstrøm, 1999). In Denmark, psychosocial risk factors are divided into two categories, depending on their cause. The first category comprises psychosocial problems arising from management's general decisions concerning the enterprise, the interaction between management, the employees and their representatives, the interaction between employees themselves, or factors arising from external circumstances (e.g. pay, promotion, training, job uncertainty, harassment and bullying). The second category comprises psychosocial problems which are directly or indirectly related to work methods, products used or the physical framework for performance (e.g. organisation of the workplace, noise, repetitive work, risk of violence, solitary work, and human service work) (Netterstrøm, 1999).

Finland. The Finnish Occupational Health Care Act of 1978 specifies that all employers are obliged to organise occupational health services for his/her employees, that such services must be available for the self-employed, that prevention be emphasised, and that sufficient staff should be available for the service system (Kalimo & Toppinen, 1999). According to the Act and the lower level statutes, working conditions, including work organisation and psychosocial factors have to be monitored systematically. The statutes stipulate that occupational health professionals must participate in regular training. The targets of occupational health care cover the prevention of risks, a healthy and safe working environment, a well-functioning work organisation, the prevention of work-related diseases, and the maintenance and improvement of the individual's ability to work. Furthermore, the Occupational Safety Act of 1987 states that employers have to ensure that work is not harmful to the (physical and mental) health of employees. It stipulates that employers should take into account the mental well-being of the employee when planning the work and work conditions. Furthermore, the employee's psychological resources have to be taken into account in adjusting the work and work methods to suit the worker. Training and guidance in risk prevention must be given.

Germany. The German industrial relations system is characterised by cooperative conflict solution mechanisms based on societal and industrial consensus. Safety and health are affected by the national labour law and by social security law (Beermann, Kuhn, & Kompier, 1999). Those who can contribute to reducing the risks of accidents and hazards to health are obliged to cooperate, viz. employers, work councils as representatives of employees, work safety experts and company doctors and health and safety committees. The employer is responsible for implementing health and safety measures to protect employees through early prevention, informing and instructing employees. Work councils have the duty to monitor inadequacies in preventive measures, organise work, co-determine the health and safety measures to be carried out, provide assistance regarding safety and health and have the right to information and participation. Work and safety experts and company doctors advise the employer and other persons responsible for health and safety, check safety aspects before they are introduced and see that health and safety measures are carried out. Beermann et al. (1999) however point out that most German employers still think of occupational stress as a personal issue, rather than a work-related issue.

Greece. The legal framework regarding working conditions in Greece follows the regulations of the European Union (Petsetaki, 1999). The regulations in Greece cover such areas as the prevention of work accidents, occupational diseases, training and counselling of employees. The law in Greece makes specific provision for high-risk work, including mining, heavy-duty transport, handling of explosive/hazardous materials and work involving radioactivity. Employees also have the right to choose their representatives on health and safety committees. Specific articles in the law refer to the provision of services in the area of protection and safety, the employment of occupational health and safety staff as well as the training of such staff. Petsetaki (2001) points out that there is a lack of consciousness by both the employer and employee concerning the importance of health and safety in the workplace. There is also a lack of awareness of stress in the workplace and its effects on health, safety, morale, and the productivity of workers.

Ireland. The legislative situation in Ireland had been strongly influenced by the approach followed in the United Kingdom (Wynne & Rafferty, 1999). In 1989, the Safety, Health and Welfare at Work Act was implemented in Ireland. This law does not specifically require employers to act on occupational stress by name, but its provisions concerning the work environment and working methods cover many of the workplace elements that give rise to

occupational stress. The Act states general duties of employers to manage systems of working so that they are not harmful or hazardous to health. This has been interpreted to cover occupational stress (Wynne & Rafferty, 1999). Generally, trade unions have been in favour of dealing with stress at work, while employers have been more reserved.

In European countries stress prevention directives have clearly been added to the laws on working conditions (Kompier, De Gier, Smulders, & Draaisma, 1994). It seems that in European countries that have such a statutory framework, corporate initiatives are implemented to prevent stress. In South African labour law, statutory modifications of the common law were effected by imposing minimum conditions of employment for employees, promoting equal opportunities for races and genders, promoting collective bargaining, and developing specialist tribunals to create equitable principles for the workplace (Comprehensive Labour Market Policy, 1996).

South African labour legislation

The main employment-related Statutes in South Africa that influence employee's health and wellness by protecting them, include the Constitution of the Republic of South Africa, the Occupational Health and Safety Act, the Labour Relations Act, the Basic Conditions of Employment Act, the Compensation for Occupational Diseases and Injuries Act, the Unemployment Insurance Act, the Employment Equity Act and the Skills Development Act.

The Constitution of the Republic of South Africa: (Section 23) The Constitution can have implications for the health and wellness of South African employees. The Constitution states that: "Everyone has the right to fair labour practices; every worker has the right to form and join a trade union, to participate in the activities and programs of a trade union, and to strike; every employer has the right to form an employer's organization and to participate in the activities thereof and every trade union, employer's organization and employer has the right to engage in collective bargaining" (Grogan, 2005, p. 129). Thus, every South African employee has the right to be protected from unfair labour practices.

The Occupational Health and Safety Act (nr. 85 of 1993) applies to all employers, with the exception of miners, owners of certain shipping vessels, those exempted by the Minister and temporary employment services. It establishes a council to advise the Minister on

occupational health and safety. This Act imposes a general duty on employers to provide a reasonably safe and healthy working environment, to provide information, training and supervision as is necessary to ensure health and safety, and to report to an inspector any incident in which an employee dies or is injured or when dangerous situations arise. Employees are obliged to obey health and safety rules and to report unsafe or unhealthy situations or incidents to employers or health and safety representatives. Employers with more than twenty employees must, after consultation with employees or their representatives, appoint one or more full-time employee(s) as health and safety representatives, and employers are obliged to provide training and facilities to these representatives. Employers with more than one safety representative must establish health and safety committees, with which they are obliged to consult on health and safety issues. Inspectors are empowered to enter the premises of employers and examine compliance with the Act (Grogan, 2005). Under this act special mention is made regarding facilities regulation.

Facilities Regulations make provision for the following in the workplace: Sanitation facilities, facilities for safekeeping, changing rooms, signs for prohibition of smoking, eating and drinking in certain workplaces, dining rooms, drinking water, conditions of rooms and facilities and offences and penalties (Grogan, 2005). This ensures minimum standards regarding issues that might affect the health of employees at work, and thus employee health and wellness.

The Labour Relations Act (nr. 66 of 1995) aims to encourage collective bargaining and the settlement of disputes by enhancing powers of forums designed to facilitate these objectives. It contains specific rules and rights on contravention or infringement, which fall under the auspices of either the Commission for Conciliation, Mediation and Arbitration (CCMA), accredited bargaining councils or a specialised Labour Court. A commissioner, bargaining council or labour court refers disputes not settled by conciliation to arbitration. Furthermore, employers have to consult with workplace forums on a regular basis (Grogan, 2005). Thus, the Act ensures that employees' voices can be heard and that employee health and wellness issues can be addressed through workplace forums which employers have to consult.

The Basic Conditions of Employment Act (nr. 75 of 1997) ensures that working hours do not exceed certain maxima, that employees are granted adequate breaks during the working day, that they are given prescribed annual and sick leave, and that they are paid a premium

for overtime and work on Sundays and public holidays. It requires employers to maintain records and to provide the means by which rates of pay and working hours are to be calculated. The Act also regulates the minimum notice that must be given on termination of the contract. Furthermore, it creates an Employment Conditions Commission that advises the Minister and labour inspectorate to mediate disputes arising under the Act (Grogan, 2005). This act protects the health and wellness of employees through strict rules that ensure rest periods for employees, adequate leave and overtime pay.

Code of Good Practice: Working Time: The objective of this code is to provide information and guidelines to employers and employees concerning the arrangement of working time and the impact of working time on the health, safety and family responsibilities of employees. This code governs the regulation of working time through Section 7 of the BCEA and requires employers to regulate the working time of each employee - with due regard to the health and safety of employees. This Code is of particular significance for employees who perform shift work or regular night work. The regulation of working time is closely connected to the protection and promotion of the health and safety of employees. Employers must do a risk assessment regarding the effects of night and shift work on employees, implement appropriate measures to eliminate or control hazards identified in the risk assessment, train and supply information to employees about the risks to their health and safety and the measures taken to control such risks. Employers who engage employees to perform regular night work must ensure that the employees are informed of the health and safety hazards associated with the work that they will be expected perform (Department of Labour, 2008).

The Compensation for Occupational Diseases and Injuries Act (nr. 130 of 1993) ensures that employees or their dependants who have suffered injury, illness or death arising from the execution of their work are compensated. This Act excludes soldiers, police officers, domestic workers and contract workers. It specifies that compensation is payable only if the accident that caused the injury, illness or death occurred within the scope of the employee's employment and was not predictable. No payments in respect of temporary disabilities of three days or less, those resulting from wilful misconduct by employees, or non-physical damages like pain and suffering (Grogan, 2005) are catered for. Post-traumatic stress has however recently come to be regarded as an occupational disease (De Bruin, 2006), proving a watershed in terms of compensation for psychological disease and injury. This act influences

health and wellness of employees in that it ensures compensation for employees whose health and wellness were negatively affected while performing their work.

The Unemployment Insurance Act (nr. 30 of 1966) provides for payment of benefits to employees who have lost their employment through pregnancy or other circumstances beyond their control. Only employees who earn less than an amount determined by the regulation (R 106 032.00 p.a.) can claim benefits under the Act. The Act only applies if the claimant has been in employment previously and is seeking and willing to accept work, or is unable to find work because of a scheduled illness (Grogan, 2005). This act can influence the health and wellness of women in that it ensures income while they are on maternity leave. The Basic Conditions of Employment Act only stipulates that women should receive four months' maternity leave, but the maternity leave does need not be paid leave. In view of the current economic situation this reduces stress for women, who otherwise would have had to cope without an income for the stipulated four-month period.

The Skills Development Act (Act 56 of 1997) establishes a National Skills Authority, Sector Education and Training Authorities (SETA), and Skills Development Planning Units (Grogan, 2005). This act influences the health and wellness of employees in that it promotes the development of skills levels of employees. Increased skills levels can reduce stress because employees who previously lacked skills will feel more confident and experience less job stress than when they had to perform jobs for which they did not have the necessary competencies. A lack of skills might also imply more time needed to complete the job, and working under tight deadlines is associated with more stress and feelings of incompetence (Cope, 2003). By providing employees with adequate time management skills, employers and employees can reduce their stress through better job planning.

Employees' Duties: Workers must take reasonable precautions to ensure their own health, wellness and safety at work. They must follow any precautions and rules concerning safety and health (Department of Labour, 2008). They must report any unsafe circumstances or an accident as soon as possible to the safety representative. Anyone who acts in a reckless way or damages any safety equipment can be charged. Also, if the worker does this damage on purpose, then the employer can claim damages from her or him (Grogan, 2005). This indicates that although organisations should take responsibility for the health and wellness of

their employees, the individuals must take some responsibility themselves to ensure their own and their colleagues' health and wellness.

Currently employee health and wellness is not explicitly covered by legislation in South Africa. Many organisations still lack policies regarding employee health and wellness.

The role of management standards in managing employee health and wellness

Legislation is not the only way through which health and wellness issues of employees in South Africa can be addressed - another possibility can be the introduction of management standards for employee health and wellness. Where the government enforces legislation, the use of management standards is more self-regulatory.

The term 'management standard' refers to a set of principles agreed on by organisations in consensus in order to enhance health and wellness by identifying work-related stress hazards and reduce associated risks. Although a management standard does not necessarily impose obligations of adherence, it is important that a management standard regarding work-related stress and the influence on employee health and wellness in South Africa should be developed.

By using the management standards approach all the role-players can be involved in the government of employee health and wellness. The role-players can agree on the standards to be used by organisations to measure themselves against the management standard and "states to be achieved". Thus, encouraging continues improvement. The different role-players in employee health and wellness should all be involved in the development of policy to govern or regulate employee health and wellness on organisational level. A fine example of the development and use of management standards to manage work-related stress can be found in the United Kingdom in the form of UK Health and Safety Executive (HSE) management standards (Mackay, Cousins, Kelly, Lee, & McCaig, 2004). These standards are designed to help simplify risk assessment for stress, to encourage employers, employees and their representatives to work in partnership to address work-related stress throughout the organisation, and to provide a yardstick by which organisations can gauge their performance in tackling the key causes of stress.

The UK Health and Safety Executive (HSE) (2001) have identified six stressors that may negatively influence employee wellness, viz.: Job demands, Control over work, Support, Relationships at work, Role in the organisation and Change in the organisation (Cousins et al., 2004). Management standards include targets for organisations to aim towards or “states to be achieved” (Cousins et al., 2004, p. 121). One standard is identified for each risk factor. “Job demands”, for example, covers workload, work patterns, and the work environment. The standard includes guidance on what should be happening in the organisation if the standard is being achieved. The target for demands is then achieved if 85% of employees can cope with the demands of their jobs (Cousins et al., 2004). As for the other stressors: Control over work refers to how much say an employee has in the way they do their work; Support refers to encouragement, sponsorship and resources provided by the organisation, line management and colleagues; Relationships at work refers to promoting positive working attitudes to avoid conflict and dealing with unacceptable behaviour, Role in the organisation refers to whether employees understand their role in the organisation and whether the organisation ensures that employees do not have conflicting roles and Change refers to how organisational change is managed and communicated in the organisation. Management standards have the following implications for employers (Cousins et al., 2004). Employers will have to:

- Assess the risk for and potential causes of stress within the organisation, e.g. by looking at sickness absence patterns, and surveys.
- Use the information to assess the organisation’s performance in relation to the six factors.
- Decide on improvement targets and action steps in conjunction with staff or their representatives.

DISCUSSION

This article was set to review trends in legislation and management standards regarding occupational health and wellness in various countries, to analyse the South African case as it applies to occupational safety, health and wellness, to determine the role-players in health and wellness, and to make recommendations regarding South African legislation and management standards for promotion of employee health and wellness in South African organisations.

It seems that the South African labour law is not clear on the definition of occupational health and still favours physical health. Employee wellness is also not defined within South African labour law. The law is clear in defining health and safety and in paying attention to health and safety. While inadequate safety measures usually have an immediate effect, inadequate attention to psychological health may take considerable time before it manifests as an occupational disease.

The South African Labour Relations framework provides a mechanism for employee health interventions. However, there is a lack of guidance in the case law and statutes with regard to dealing with psychological stress. Employers have to identify work activities that will expose employees to physical and psychological risks, but currently little is done in terms of risk analysis and occupational stress interventions. South Africa needs a national strategy to deal with physical and psychological risks at work that influences the health and wellness of employees.

The Occupational Health and Safety Act requires an employer to provide and maintain a healthy working environment by providing safe systems of work, plants and machinery, taking reasonable steps to eliminate or mitigate potential hazards, making arrangements for ensuring safety when working with or transporting articles or substances, establishing the health and safety hazards attached to work performed and implement and provide precautionary measures in order to protect employees, providing the necessary information, training and supervision, not permitting employees to do any work unless the precautionary measures have been taken. Although the Act provides for precautions to prevent the negative effects on employee's health, the Act does not explicitly prescribe any prohibiting of factors that might influence the wellness of employees.

To comply with the Occupational Health and Safety Act, an employer will need to identify the health and safety hazards (including chemical, physical, radiation, biological, ergonomical and psychosocial hazards) in his specific workplace, measure these and control exposure to them. Work activities might expose employees to physical (e.g. working on a scaffold or working in confined spaces) and psychological risks (being subjected to numerous deadlines and office politics). The employer must ensure that workers are informed and understand the health and safety hazards of work or risks associated with these hazards.

Implicit within the South African Labour Relations practice is the understanding that every manager is expected to demonstrate skills in performance management through coaching and support. However, it seems that there is a lack of guidance in the case law and statutes with regard to dealing with psychological stress - analysis of cases show that while there are cases of ill-health and injury because of work, only physical symptoms of ill-health are normally attended to.

It is important that South African labour legislation should be modernised in order to address not only traditional health and safety issues but also psychosocial work characteristics (roles, demands, relationships at work). It is important that risk assessment regarding psychosocial issues at work should be done and special attention should be given to small and medium-sized companies that often lack special expertise for risk assessment and risk prevention. It is important for national government to set up the necessary legislation and administrative infrastructure in order to stimulate organisations to take action regarding psychosocial issues that are affecting their employees' health and wellness.

There is proof of the symptomatic experience of workplace stress by South African employees, and this is affecting their health and wellness. Organisations experience the symptoms through unapproved absences from work (Vaida, 2005), low productivity (Noemdoe, 2002) and high labour turnover rates (The South African Institute of International Affairs, 2004). There is ample proof in the literature on how to manage the outcomes of stress and its effect on the health and wellness of employees. The best practices and examples regarding stress legislation can be taken from a number of European countries like the UK, Ireland, Belgium, The Netherlands and Sweden. The UK's Health and Safety Executive (HSE) provides clear guidelines on how to address stress and psychosocial issues at work.

To manage health and wellness risks, it is essential for employers to conduct a risk assessment. This requires that they identify hazards and assess the risks that they pose to the health and safety of employees. The results of this risk assessment must be recorded. Employers must implement appropriate measures to eliminate or control hazards identified in the risk assessment. Furthermore, they must provide training and supply information to employees about the risks to their health and safety and the measures taken to control such risks. Elected worker health and safety representatives and committees are entitled to participate in the risk assessment and control of hazards.

The employee health and wellness practitioner plays an important coordinating role in the occupational health, safety and wellness system, and also monitors the level of legal compliance in organisations. It is important that guidelines should be provided to employee health and wellness practitioners regarding employee health and wellness management and compliance in order to optimise employee health and wellness in their organisations.

Employees are obliged to obey health and safety rules and to report unsafe or unhealthy situations or incidents to employers or health and safety representatives. They must take care of their own health, wellness and safety and those of others who might be affected by their behaviour. Furthermore, they should cooperate with the employer where the Act imposes such a duty, give information to an inspector from the Department of Labour if required, wear the prescribed clothing and use the prescribed safety equipment, and report unsafe or unhealthy conditions to the employer or the health and safety representative.

Currently the Labour Relations Act (nr. 66 of 1995) aims to encourage collective bargaining and the settlement of disputes by enhancing powers of forums designed to facilitate these objectives. Thus, the Act ensures that employees' voices can be heard and that employee health and wellness issues can be addressed through workplace forums which employers have to consult. This Act can play a major role in the management standards approach to employee health and wellness in that it will encourage role-players to negotiate issues regarding employee health and wellness.

RECOMMENDATIONS

South Africa can learn from the European approach to health and safety that encourages primary prevention where collective protective measures are given priority over individual protective measures (Mackay et al., 2004). The situation in South Africa is unique, but note can be taken of best practices in other countries. The challenge however lies in finding our own solution to problems that affect the health and wellness of South African employees. A national strategy needs to be developed that addresses all the factors that influence employee health, wellness and safety in South African organisations. Although organisations can play a major role in addressing work-related issues, government should play a role in other factors like primary health care and living conditions of citizens.

Labour legislation in South Africa provides a framework for addressing employee health and wellness. It is recommended that legislation should only play a role in the interim to govern employee health and wellness. Legislation is bureaucratic in nature in that it is governed one sided by only one role-player in employee health and wellness: the national government. Alternatively, control measures (management standards) can be used for practical workplace action. The management standards approach is more self-governed, and involves all the role-players (employees, labour unions, organisations and government) in the regulation of employee health and wellness. Role-players in the South African labour context (employees, labour unions, organisations and government) should work together to compile a national strategy to address the issues that influence employee health and wellness in the South African context today.

In order to promote employee health and wellness strategies, certain conditions are prerequisites:

- **Legal and policy instruments.** Legislation and regulations should be regarded as adequate, and laws and regulations that exist should be adequately enforced. South African organisations lack adequate policies to govern employee health and wellness. It is important for organisations to develop employee health and wellness policies in order to regulate employee health and wellness in their organisations. Management standards should promote the use of primary interventions like job redesign in favour of tertiary interventions which focus on individuals (Mackay, Cousins, Kelly, Lee, McCaig, 2004).

South Africa should also establish an executive body to deal with policy and operational matters relating to occupational health, wellness and safety matters. Within such a body infrastructure can be established through a special commission to take the lead in the overall reduction of work-related stress in South Africa. Currently such a body, the Health and Safety Executive (HSE) already exists within the UK and South Africa can learn from their already established practices. The proposed South African Health, Wellness and Safety body should give guidance to South African organisations on how to deal with health, wellness and safety issues of their employees. Special attention should be given to how organisations should conduct risk assessment of health, wellness and safety issues and how they should manage the improvement of health, wellness and safety in their organisations.

- **Infrastructure.** A working labour inspection system and an occupational health service system are key elements in supporting adequate occupational health and safety legislation, regulations and standards, e.g. through the setting of minimum standards and through adherence to regulations. The education of healthcare professionals is a crucial aspect in this regard.
- **Information.** Knowledge and facts are needed if occupational health, wellness and safety are to be improved in South Africa. Researchers should undertake longitudinal research regarding employee health, wellness and safety. Research regarding employee health and wellness should consider multiphase and multiple case-study designs. This will enable researchers to understand issues regarding employee health, wellness and safety better, but at the same time researchers will have to invest time and resources to acquire new skills in order to analyse the data. Organisations and employee health, wellness and safety practitioners will benefit from such research in that they will have proof of the effects of stress or interventions on employees over time. Multiple case studies on the impact of stress on employee health and wellness may lead to evidence-based prevention in South Africa. Kompier, Cooper and Geurts (2000) found in their multiple case study that it was to the benefit of both the individual and the organisation when preventative measures were based on adequate diagnoses of risk factors and risk groups and when the measures were implemented in a proper way. In order to develop the management standards and to do risk assessment in South Africa a relevant measurement tool should be developed. The indicator tool is a way in which performance can be measured against a standard. In setting a threshold for work-related stress the management standard could indicate whether organisations are conforming to good practices, which may prevent the occurrence of occupational stress (Mackay et al., 2004). Government can support the process in funding the development of such a tool and providing it to organisations free of charge. South African “cut-off” points regarding work-related stress should be developed in order for South African organisations to determine whether or not they are negatively influencing their employees’ health and wellness.

- **Education and training.** Educational institutions in South Africa should be involved in occupational health and safety training. This should be supplemented by conferences, symposia, and workshops. Employees should be trained on how to address and promote their own health and wellness; labour unions should be trained on issues of employee health and wellness of their members and also how to negotiate the issues with employers, and relevant people in organisations should be trained on how to effectively manage and implement employee health and wellness in their organisations.
- **Recording, storing and disseminating information.** Registers for the collection of employee health and wellness information are crucial in obtaining a systematic evaluation of the occupational health situation in a specific organisation, community and country. Examples of registers include cancer registers, registers for occupational diseases and work accidents, registers on numbers and causes of deaths, and registers on communicable diseases. Journals, newsletters and websites could deal with the dissemination of information to other professions and health care professionals.

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CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

The purpose of this chapter is to provide an analysis and discussion of the literature and empirical results of the study. Conclusions are made with regard to the set research objectives. The first part of the chapter answers the research questions put forth in the three research articles (Chapters 2, 3, and 4). The limitations of the current study will be pointed out. Finally, recommendations regarding employee health and wellness in South Africa and future research are made.

5.1 CONCLUSIONS

Conclusions are made in the following sections in respect of the specific objectives and the empirical findings obtained in the present study.

Article 1: Management of employee health and wellness programmes in South Africa

- *To conceptualise and define employee health and wellness as it currently manifests in selected South African organisations.*

Employee Health and Wellness (EHW) is an ill-defined concept within South Africa and around the world. The participating organisations, service providers and labour unions could not agree on a single definition of the concept of Employee Health and Wellness. It was suggested that organisations and service providers focused more holistically on employee health and wellness than did labour unions. Although the definitions of the organisations, service providers, and labour unions in the employee health and wellness sphere in South Africa differ, the analysis of input from the three role players presents a broad and robust definition within which employee health and wellness can be conceptualised. Employee health and wellness role-players should agree on a definition of employee health and wellness in South Africa.

Incorporating the responses of organisations, service providers and labour unions, employee health and wellness in the South African context can be defined as consisting of healthy, well employees whose personal states (physical and psychological) influence their work positively. The pursuit of such a state is done in recognition of the fact that it carries dual benefits for employee and the organisation. Also, employee health and wellness improves organisational adherence to legal requirements in terms of the Occupational health and safety Act. The analyses of input from organisations, service providers and labour unions present a broad and robust definition within which employee health and wellness can be conceptualised.

- *To investigate reasons for implementation of employee health and wellness programmes in South African organisations.*

There were many different reasons why organisations implemented Employee Health and Wellness programmes in their organisations. The main reasons were high incidences of sick leave, high absenteeism and for reasons of social responsibility. Most of the reasons indicated a reactive approach, and perhaps indicates that organisations should be more proactive in their employee health and wellness efforts. Organisations should start investigating work factors that might contribute to employees being sick and absent from work in the first place. Doing this, organisations should be able to address the issues before it negatively affects their employees. Organisations should also focus on all three levels of interventions (primary, secondary and tertiary), but the main focus should be on primary interventions (Kompier & Cooper, 1999). This will enable organisations to change the factors in the work environment that is negatively affecting employees rather than trying to change the employees.

- *To investigate management involvement in the management of employee health and wellness in their organisations, and presentation of results of employee health and wellness programmes.*

Almost all of the organisations presented the results of their Employee Health and Wellness programme (EHWP) to management in the form of Board meetings, Business unit meetings or to the CEO. In most of the organisations, the results were presented once or twice per year, or quarterly. Except for one organisation, the results of the programme were all presented in-

house. It can be assumed therefore that the results of programmes are not sufficiently utilised to attract employees or stakeholders. Organisations could use the proper implementation of EHWP as a competitive advantage to retain employees and so address the current skills shortage. Most of the organisations indicated that they perceived the support they received from management regarding employee health and wellness initiatives as “good”.

- *To determine how organisations rate the successfulness and effectiveness of their employee health and wellness programmes.*

The reasons and ratings regarding the successfulness of employee health and wellness programmes (EHWPS) differed across organisations. A lot of organisations defended their rating by indicating that they provide for a good range of services but very few referred to measurable, objective, work-related outcomes. Some organisations specifically indicated that their employee health and wellness programme is less than effective because the wellness construct is not measurable. It is important to measure the effectiveness of an employee health and wellness programme with an initial assessment to identify and address root causes for problems. Also, after implementation of any intervention, a reassessment is needed in order to determine whether or not the intervention has been successful.

Nearly half of the organisations indicated that they did not measure effectiveness. It was concluded that the true effectiveness of these programmes is difficult to determine, as ultimately it rested on the subjective perceptions of the organisations. However, it was suggested that an improvement in positive employee outcomes and reduction in negative employee outcomes could be an indication of the effectiveness of an employee health and wellness programme. Very few of the South African organisations could make this link objectively. It was also determined that implementation of interventions after an employee health and wellness assessment takes time, and effects might be delayed. Sufficient time has to elapse after the implementation of interventions in order to determine their effectiveness. Organisations have to agree on how effectiveness of EHWP will be managed and measured in the South African context.

Most of the organisations also felt that they can improve their service delivery by making the EHWP more holistic and integrated (more and different services), and that more resources and personnel must be allocated to the EHWP. The organizations also felt that it would be

best to provide the EHWP in-house. However, providing EHWP services in-house might lead to confidentiality issues arising from employees making use of the services. Organisations should in all cases ensure the confidentiality of the employee who uses the services of the EHWP. It is recommended that sensitive services like HIV/AIDS or counselling services be contracted out to service providers to enhance their credibility.

- *To determine employee input, participation rates, and how organisations fund their programmes.*

None of the organisations did an objective needs assessment regarding the employee health and wellness (EHW) of their employees. Most organisations simply asked their employees what health and wellness services they think they needed. This could provide a biased picture of the true state of employee health and wellness affairs, because employees' perceptions about what wellness issues need to be addressed is not necessarily the issues that are important or necessary to be addressed.

Most of the organisations struggled with low participation rates. This may again be attributed to the fact that most of the organisations did not conduct an objective survey to determine the problem areas in the organisation before implementing 'solutions'. Thus, services were provided that were not necessarily needed. Organisations should conduct an employee health and wellness risk assessment in order to ensure that the employee health and wellness needs of employees are adequately addressed.

Most of the organisations used a budget for funding of their EHWP, but some used a flat-rate, meaning that they paid a fixed amount per employee per year. Half of the organisations used an allocated budget supplemented with a fee-for-service model to fund their EHWP. The amount of money spent on EHWP's was in some cases very little. It was suggested that employee health and wellness is still considered a soft issue and not an issue that warrants investing in the organisations' human capital in order to improve organisational profitability. It is recommended that organisations use a budget supplemented with a fee-for-service model to fund their EHWP. This will enable them to plan ahead but also to have funds available for different forms of interventions needed as a result of the risk assessment.

Article 2: Infrastructure of employee health and wellness programmes in South Africa.

- *To evaluate the occurrence of employee “un-well” behaviours by investigating absenteeism, strikes, accidents, turnover, HIV/AIDS management and leave utilisation within South African organisations.*

The evaluation regarding the occurrence of employee “un-well” behaviours could not be done effectively. The reason for this was due to poor information management relating to indicators in participating organisations. Organisations could not always provide the researcher with statistics regarding absenteeism, strikes, accidents, turnover, or leave utilisation in their organisations. The United Kingdom Health and Safety Executive (2001) indicates that unwell behaviours like high levels of stress experienced by employees can increase employee ill-health, sickness, absenteeism and accidents. Therefore, it is important that un-well behaviour in organisations should be investigated and recorded, in order to act as indicators of decline, and in order to minimize the negative impact on the organisation. Proper information management could aid organisations in moving from a reactive to a proactive approach in managing employee health and wellness. A good information management system enables organisations to identify problems and allow for necessary preventative actions to be taken (Harper, 1999). It is recommended that organisations improve their information management system regarding employee health and wellness. Organisations clearly need to show the value that EHWP’s can add, and the use of an effective information management system is the only way to do it.

Most of the organisations had an HIV/Aids programme. The components of the HIV/AIDS programmes were quite broad and included awareness raising, education and training, creating a non-discriminatory environment, prevention and control of sexually transmitted diseases, infection control, voluntary counselling and testing and promotion and distribution of condoms. Half of the organisations provide antiretrovirals, which has been shown to be beneficial for employees (Pienaar, 2005). Providing employees with antiretrovirals might also be a short-term way of dealing with the current skills shortage in South Africa. Organisations still have to invest more time to educate employees on HIV/AIDS in order to prevent employees from contracting HIV/AIDS, rather than trying to deal with employees who have already contracted the disease. With almost 20% of the workforce HIV positive (The South

African Institute of International Affairs, 2004), it is beneficial to organisations to keep their HIV positive employees healthy enough to be able to work.

- *To assess the effectiveness of employee health and wellness information management and make recommendations regarding improvement.*

It was evident from the interviews with the participating organisations that the information management system regarding employee health and wellness was not adequate in most of the organisations. Organisations did not carry out an assessment of employee health and wellness needs before starting up their programmes, thus improvement as a result of the implementation of the programmes could not be substantiated. In many cases, organisations could only provide “educated guesses” regarding the productivity, amount of sickness leave taken, absenteeism rates, time lost due to accidents, amount of annual leave taken, staff turnover, and stress levels of their employees. Depending on the information gathered, in some cases up to two-thirds of the organisations could not access or did not have such information. In many cases, this was attributed to the fact that the EHWP did not have access to the data or that they had difficulty in obtaining the data from the human resource department. Managers of EHWP’s need to have better access to employee information regarding productivity, amount of sickness leave taken, absenteeism rates, time lost due to accidents, amount of annual leave taken and staff turnover. This information, together with a proper risk assessment, can be used to show effectiveness of the EHWP.

- *To assess the nature of EHWP policies and infrastructure and make recommendations regarding improvement.*

Less than half of the organisations had a policy that governs the employee health and wellness initiatives in their respective organisations. Many of the organisations did not want to provide the researcher with the policy, and only one organisation really had a comprehensive employee health and wellness policy. Due to the fact that only a few policies could be evaluated, no real discussion of the policies could take place. It is however alarming that many of the organisations did not have a policy to govern employee health and wellness in their organisations. Harper (1999) suggest that it is important to have a written policy in place that defines the purpose of the programme, organisational mandate, record maintenance, roles

and responsibilities of personnel, program procedures and service mix. A formal policy should thus serve to govern and clarify the purpose of an employee health and wellness programme.

- *To assess the reporting lines, staffing and educational levels of employee health and wellness staff, and identify further training requirements.*

In most of the organisations the EHWP manager reported to either a CEO, Executive, General Manager or head of a department in the organisation. In half of the organisations, the person who the EHWP manager reported to is within the Human Resources department. Thus, in half of the organisations the EHWP was under the umbrella of the human resource department or formed part of the Human resource department in some way. Organisations have to look more holistically at employee health and wellness and should incorporate more than traditional HR personnel to develop and manage the EHWP in their organisations.

In more than a third of the organisations, there is only one person responsible to manage the EHWP. The worst ratio of employee health and wellness practitioners to employees was 1:7500; the best ratio was 1:50. There were thus big organisations with only one person running the show, while in others the EHWP was better staffed. In the organisations where the EHWP is poorly staffed, it may be an indication that the organisation does not view the issue of employee health and wellness as important, or that organisations might not yet be convinced that the EHWP can contribute to positive employee outcomes. Since employee wellness is not governed by South African labour legislation explicitly, role-players (organisations, labour unions and employees) in employee health and wellness should negotiate a ratio of employees to employee health and wellness practitioners, in order to promote employee health and wellness.

Most of the EHWP managers had relevant wellness training. Most of them came from an Industrial Psychology, Psychology or Social Work background. One of the managers was a Medical doctor and one had a degree in Biokinetics. Of all the managers, only three did not really have relevant training in employee health and wellness. Currently there are no guidelines regarding, or professional training available, in South Africa for employee health and wellness practitioners. The reason for this may be because there apparently still exists confusion regarding what employee health and wellness is (Sieberhagen, 2008). Industrial

Psychologists could play a major role in implementing and managing Employee Health and Wellness in organisations, as this issue falls within their scope of practice. Within this scope, as set out by the Health Professions Council of South Africa (HPCSA, 2008), Industrial Psychologists are “authorised” to address issues in the work situation in order to optimise individual, group and organisational well-being and effectiveness. A clear need for training regarding employee health and wellness in South Africa exists. Training needs regarding employee health and wellness may include employee health and wellness risk assessment, development of interventions and employee health and wellness information management.

- *To assess employee health and wellness interventions by investigating reasons for implementation, focus, targets of intervention, and the services rendered.*

Only one organisation implemented its programme as an outcome of a wellness assessment in its organisation. For the rest, none did any kind of employee wellness assessment to determine what was wrong in their organisation in the first place. This is alarming, seeing that 15 of the 16 participating organisations made a guess about what is wrong in their organisation. This finding provides further proof that wellness in organisations is still merely a fad, and serious, considered intervention is not yet receiving the necessary attention. It is impossible to focus interventions on the right issues if one does not know what to address. South Africa has 3,7 million HIV-positive economically active people, which translates to roughly 25% of the workforce, which is estimated at 16 million (The South African Institute of International Affairs, 2004). The high rate of HIV infection could contribute to high incidences of sick leave and absenteeism. However, all the organisations provided some form of HIV/AIDS service, either as part of their EHWP or as an HIV/AIDS education programme. This is at least one example of a focused intervention, since HIV/AIDS is a real concern to South African organisations. Unfortunately, as only one of the organisations did an initial problem assessment, it may be that most organisations have activities and services in their programmes that employees do not need. Proper employee health and wellness risk assessment is especially important in order for South African organisations to address the influence of occupational stress on employees. Focused interventions need to be implemented in order to address the root causes of stress at work. This can only be achieved if an assessment was done to effectively determine the problem.

The focus areas of the organisations' EHWP's cover issues of health promotion, wellness, organisational efficiency and counselling services. The reason for this might be that the organisations define employee health and wellness with a strong emphasis on health. The UK Health and Safety Executive (2001) also refers to "wellness" many times in relation to how stress impacts the health of employees. Although organisational efficiency was one of the most reported functions of the programme, very few of the activities of programmes supported this function. Only half of the organisations conducted a stress survey as part of their EHWP. Although the concerns were addressed by organisations, none of the interventions were preventative in any way and in most cases the interventions will not remove the stressors but only alter them. This was due to the fact that the interventions were mostly focused on the individual (tertiary) and not on the organisation or workplace (primary).

More than half of the organisations that were included in this study indicated that they offered a combination of an Employee Health and Wellness and an Employee Assistance Programme. However, the activities that were provided by the organisations differed greatly. Only a small percentage of the activities related to the HIV programme, social skills training, and to leadership development. The concern is still that a lot of the activities did not necessarily relate to improving the employees' situation at work, which ultimately has the biggest effect on the individual. The focus of most of the EHWPs was on health promotion, wellness, organisational efficiency and counselling services.

Outsourced EHW activities ranged from HIV/AIDS services, counselling services, EAP services and Health services. It also included activities like injuries on duty, implementation of the programme and providing help in obtaining Identification Documents and driving licences to personnel. The question could be asked though what the provision of IDs and licences has to do with employee wellness.

More than two-thirds of the organisations provided their Employee Health and Wellness services in-house. These services ranged from HIV services to report feedback, which consisted of feedback to employees regarding surveys they completed. The main services rendered dealt with employee health, counselling, training and EAP and Occupational Health Services (OHS). Wellness interventions, managing performance, absenteeism and Human Resource (HR) activities each only accounted for a small percentage of the services rendered

in-house. This is an indication of the wellness issues that organisations mostly focus on. By focusing on these activities it is clear that organisations still view wellness and health as very much the same and that the focus is still reactive rather than preventative.

The services provided by the four service providers were classified into 20 categories. Services rendered by service providers included health promotion, counselling, health and safety assessment, legal wellbeing, financial wellbeing, ergonomics and organisational services (promotion of health, organisational culture, and organisation wellness). A third of these services were at least provided by half of the service providers. For the other 13 categories (lifestyle services, preventative support, family care, organisational services, managed wellness care, OLAP tools, organisation specific support, data warehousing, training infrastructure, incapacity and absenteeism management, occupational therapy, behaviour risk management, suggesting interventions), only one of the service providers provided the service. Only one of the service providers suggested Employee Health and Wellness interventions to the organisations. At least half of the service providers provided services to organisations that had never assessed if they needed such a service. Thus, the focus is still skewed in terms of health issues, and even service providers provide a wide array of services, which they all purport able to contribute to employee health and wellness. Unfortunately, organisations remain at service providers' mercy due to a total lack of gaining business intelligence by making use employee health and wellness data to predict and prevent work-related issues that may negatively impact on the employees.

More than half of the organisations have conducted an ergonomic survey as part of their EHWP, but it focussed primarily on "office"-type work environments, and then only because of the type of business conducted by the said organisations), and they indicated that they addressed the concerns that came out of the survey. This is also a good example of focusing interventions after a reliable assessment. In addressing these issues, health and wellness of employees could be improved. Unfortunately, no benchmark or legal requirements exist for how regularly such surveys should be done in South African organisations. Although ergonomical issues are not governed by legislation in South Africa, it can be suggested that an assessment should be done at offices and other places of work, and then a reassessment if changes to the place of work does take place.

- *To assess the benefits and training provided by organisations to their employees.*

All of the organisations provided medical aid as a benefit to their employees, though this did not mean that employees were necessarily on medical aid. Organisations offer their employees packages rather than salaries which mean that they can choose to be on a medical aid or not. All of the organisations provided retirement funds as a benefit to employees. The different organisations provided different other benefits, although not many of the benefits were overlapping between organisations. One organisation provided meals for their employees on duty. This might be a good way to influence the health and wellness of employees, especially if the employees come from lower income groups and have to perform physical labour (for example in the mining or manufacturing industries). Most of the organisations did not know what percentage of their payroll they spent on training of their employees every year. For those organisations that did know, it was less than 4% per annum. In most of the organisations training was compulsory for everyone in the organisations. Almost half of the organisations did not know how many days were spent on training employees annually.

- *To evaluate the marketing and awareness-raising of EHWP's and to evaluate the consultation of employees in development of EHWP's.*

Posters and pamphlets were the most popular way in which organisations marketed their EHWP. Other popular marketing tools included the use of an organisational intranet, e-mails and short message systems (sms). Previous research indicated that popular marketing tools of EAP's in South Africa included orientation courses for new employees, posters and newsletters (Terblanche, 1992). In this instance, the use of modern communication methods has clearly eased communication with employees. All of the organisations focused on all levels of employees to provide employee health and wellness services to. In 75% of the organisations, employees were consulted before the EHWP was implemented. In more than half of the organisations all levels of employees were consulted and some organisations even consulted labour unions about the implementation of the EHWP. However, it should be noted that "consulted" in this case refers to organisations asking employees what kind of services they would like to form part of their EHWP and not an objective assessment of the state of employee health and wellness in the organisation. Thus, even though more employees were "consulted" it was not done in an objective and reliable way which allowed the EHWP to be implemented with a focused intervention plan. It might also be useful to include labour

unions in the consultation process of the EHWP. If organisations get buy-in from labour unions about the EHWP, employees would be more likely to make use of the EHWP.

Article 3: Employee health and wellness in South Africa: The role of legislation and management standards

- *To investigate the role that legislation and management standards might play to ensure employee health and wellness.*

South African labour law is not clear on the definition of occupational health and still favours physical health. Employee wellness is also not defined within South African labour law. The law is however clear in defining and paying attention to health and safety. While inadequate safety measures usually have an immediate effect, inadequate attention to psychological health may take considerable time before it manifests as an occupational disease.

The South African Labour Relations framework provides a mechanism for employee health interventions, but there is a lack of guidance in the case law and statutes with regard to dealing with psychological stress. Usually, only physical symptoms of ill-health are normally attended to. South Africa needs a national strategy to deal with physical and psychological risks at work that influences the health and wellness of employees. South African labour legislation should be modernised in order to address not only traditional health and safety issues but also psychosocial work characteristics (including roles, demands and relationships at work). It is important that risk assessment regarding psychosocial issues at work should be done.

Currently the Labour Relations Act (nr. 66 of 1995) encourages collective bargaining and the settlement of disputes by enhancing powers of forums designed to facilitate these objectives. Thus, the Act ensures that employees' voices can be heard and that employee health and wellness issues can be addressed through workplace forums, which employers have to consult. This Act can play a major role in the management standards approach to employee health and wellness in that it could encourage role-players to negotiate issues regarding employee health and wellness.

- *To make recommendations regarding a national strategy to promote employee health and wellness in South African organisations.*

South Africa can learn from the European approach to health and safety that encourages primary prevention where collective protective measures are given priority over individual protective measures (Mackay et al., 2004). The challenge for South African organisations lies in finding our own solution to problems that affect the health and wellness of South African employees. Although organisations can play a major role in addressing work-related issues, government should play a role in other factors like primary health care and living conditions of citizens.

South African labour legislation provides a framework for addressing employee health and wellness, but it is suggested that legislation should only play a role in the interim to govern employee health and wellness. Legislation is bureaucratic in nature in that it is governed one-sided by only one role-player in employee health and wellness, namely national government. Alternatively, control measures such as management standards can be used for practical workplace action. The management standards approach is more self-governed, and involves all the role-players (employees, labour unions, organisations and government) in the regulation of employee health and wellness. Role-players in the South African labour context should work together to compile a national strategy to address the issues that influence employee health and wellness in the South African context presently.

5.2 LIMITATIONS

This study is limited by the fact that in many cases the EHWP did not have access to the data required. Most of the organisations did not do an assessment to determine the state of employee health and wellness in their organisations. Therefore, most of the organisations could not determine whether or not the EHWP had an impact on their employees.

Also, the sample was small because of poor response on the initial large-scale attempt by use of the questionnaire. Relatively speaking, all the organisations had a large number of employees (more than 500), thus one does not know what smaller sized organisations in South Africa are doing to address the health and wellness of the employees in their organisations.

A survey was used to do this research and it was for a large part descriptive in nature. Thus, causes between constructs could not be determined. Also, because employee health and wellness is still so ill-defined, aspects that may influence employee health and wellness could have been excluded from the survey, and thus do not form part of the research.

5.3 RECOMMENDATIONS

5.3.1 Recommendations for the Organisation(s)

Organisations need to develop policies to govern their employee health and wellness programmes. A policy will give clear guidelines regarding purpose of the programme, organisational mandate, record maintenance, roles and responsibilities of personnel, program procedures, and service mix.

Interventions should also start with a proper assessment of the state of employee health and wellness in organisations. It is important that organisations monitor the health and wellness states of their employees in order to effectively manage the process of employee health and wellness in their organisations. Organisations should start implementing focused interventions in order to address the root causes of their employee health and wellness problems. This will only become possible when information management relating to employee health and wellness is improved. An employee health and wellness programme must positively influence employee outcomes like productivity, satisfaction, turnover, presenteeism, industrial relations incidences, accidents, and safety behaviour.

Employee health and wellness should be adequately defined in South Africa. A South African assessment tool should be used to measure employee health and wellness in organisations and South African norms and benchmarks regarding employee health and wellness should be established. Before starting an EHWP, organisations need to do a proper assessment of what needs to be addressed by such a programme in their organisation. In doing this, organisations will also be better able to determine benefits derived from their EHWP and compare employee wellness states with that of other organisations and programmes.

Together with a standardised South African assessment tool, individual organisations need an adequate information management system. Organisations need to provide their EHWP with a comprehensive, computerised information management system. This will enable employee health and wellness practitioners to quickly identify problems and trends, which could assist them in taking the necessary preventative actions and gain business intelligence from their employee health and wellness efforts.

Employee health and wellness may also be standardised in South Africa. It should be determined what employee health and wellness in the South African context entails and who should play a role in its optimisation. Standardised training for employee health and wellness practitioners should also be developed and presented. This will enable employee health and wellness practitioners to establish the adequate infrastructure and ensure the effective functioning of their EHWP and determine the education and necessary competencies that EHWP staff need in their organisations to address employee health and wellness issues.

Lastly, new employee health and wellness programmes can learn from the success of established HIV/AIDS programmes by looking at what makes these successful and how they address the needs of their employees and assist organisations who have employees with HIV/AIDS.

5.3.2 Recommendations for future research

It is vital that researchers, organisations, the government and labour unions collaborate in defining employee health and wellness in the South African context. Improvements in the employee health and wellness field will not take place in an organised manner without a concerted effort in this regard.

Future research on employee health and wellness should include longitudinal studies. Researchers should assist organisations to do an assessment of the health and wellness states of their employees. The researchers should assist organisations to implement an employee health and wellness programme through customised and focused interventions based on the results of the assessment. Progress should be tracked regarding implementation of interventions to adequately manage the process. Re-assessment should be done to determine the effectiveness of these interventions. Researchers will then be able to objectively

determine the effectiveness of EHWP's and share best practices regarding effective interventions with other organisations.

The initial response to the survey being sent out was very poor. In future, researchers should aim to include more organisations in their research. Reducing the length of the survey might help as well as exploring other ways to obtain the data.

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