Gordon Institute of Business Science
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How comprehensive are workplace wellness programmes?

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ABSTRACT

With increasing healthcare costs, more and more organisations are investing in wellness programmes to improve the health of their employees and therefore cut down on health care spend. Research has shown that companies with comprehensive programmes in place enjoy wellness programme outcomes of up to six times more than what they spend. The purpose of this study was to establish if South African workplace wellness programmes have the elements required for them to experience the outcomes they desire from a programme.

Through in-depth interviews with wellness experts and wellness programme custodians of companies in the public and private sector, this study looked at defining a comprehensive wellness programme and evaluated participant organisations against this definition.

This study found that South African wellness programmes were comprehensive however only those with goal-oriented wellness strategies in place enjoyed the benefits referred to in the literature. Due to a shortage of skilled wellness programme custodians, most organisations do not realise any significant benefits from their wellness programmes. Often any benefits attained are far less than expected.

KEYWORDS

Workplace wellness, employee productivity, absenteeism, employee wellness, comprehensive wellness programme.

DECLARATION

I declare that this research project is my own work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration at the Gordon Institute of Business Science, University of Pretoria. It has not been submitted before for any degree or examination in any other University. I further declare that I have obtained the necessary authorisation and consent to carry out this research.

9 November 2015

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Contents

Glossary

Employee benefits	Wellness programme benefits refer to programme activities, facilities or other received benefits that are employer-funded with the intent to improve employee health and wellness.
Elements of workplace wellness programmes	Components of wellness programmes that indicate how a programme has been implemented, managed and being monitored. These factors are enablers of a programme.
Employee Assistance Programmes (EAP)	An employer-funded service offered to employees where they can call a professionally –run call centre to receive emotional, financial, social, legal support. Other services may also be offered through this service.
Occupational Health and Safety	Discipline in health which looks after employee safety in the workplace. It is governed by the Occupational Health and Safety Act which mandates employers to ensure a safe working environment for all their employees.
Presenteeism	Being present at work but not productive
Cardiovascular disease	A term that describes diseases of the heart, the muscle of the heart and the blood vessels
Non-communicable diseases	Medical conditions that are not infectious. Mostly used for chronic diseases. Includes diseases of lifestyle such as hypertension, diabetes, cardiovascular diseases.

Chapter 1: Introduction to Research Problem

1.1 Introduction

In 2008, 40% of organisations in Europe, Asia and Africa offered employee health and well-being programmes, double the number recorded for the previous year. (Wellness policies expand globally, 2009). In the United States, the same study found that 82% of 600 employers surveyed not only had health and well-being programmes in place but these same programmes had realised reductions in absence and healthcare costs of up to 5%. The positive results seen with United States programmes were attributed to the comprehensive nature of the programmes in comparison to those seen in other parts of the world.

The growing importance of healthcare in the economy has made it a critical point of discussion. The World Economic Forum's Outlook on the global agenda 2015 has placed health in its top 10, elevating the discussion and creating awareness on how employee health and well-being affects workplaces (Outlook on the global agenda, 2015). This is due to increasing incidences of employee illness and therefore absenteeism, more out-of-pocket spend on health care services as well as reduced productivity and low morale are evidence of the impact of poor health. This same report highlights non-communicable diseases which stem from obesity, hypertension, diabetes, smoking and a sedentary lifestyle as the major challenges.

In an attempt to improve employees' health outcomes and engagement, employers by and large have invested in workplace wellness programmes that are wholly funded by the company and are designed to support employees to adopt and sustain behaviour that reduces health risks, improves quality of life, enhances personal effectiveness and benefits the organisation's bottom line (Berry, Mirabito, Braun, 2010). Research, mainly from the United States, has demonstrated a return on investment from various organisations who reported savings of up to six times the amount spent (Berry, 2010). Others have reported significant change in behaviour towards positive lifestyle choices. In comparing these organisations against those who reported no significant benefits, research concluded that in order for wellness programmes to yield better health and financial outcomes, the programmes have to be comprehensive (Goetzel, Henke, Tabrizi, Pelletier, Loeppke, Ballard, 2014).

In order to establish how South African employers can gain maximum benefit from their existing wellness programmes, factors of success must be identified and evaluated

against company programmes, thereby enabling them to map out gaps and fill them. Research has identified that successful programmes are those that meet their goals. Furthermore, they have good programme design and execution, based on evidence-based principles (Goetzel, 2014). This finding formed the basis for the need to investigate South African workplace wellness programmes for 'compliance' to these aspects of success. In establishing for the presence of factors of success, employers are better placed to continue investing in wellness programmes as their return on investment will be better guaranteed.

The focus of this study therefore, was to establish whether South African workplace wellness programmes have the essential elements required for them to experience the outcomes they desire from their programmes. The research targeted wellness programme custodians who were individuals who implement, manage and monitor their organisation's wellness programmes, such as Human Resource managers or executives, Wellness practitioners or specialists, Employee Benefits specialists and Employee Relations managers. Experts also formed part of this study. These were individuals who were involved with policy making and regulation of programmes in the public sector, medical aid schemes that provide workplace wellness services, service providers to company programmes, and wellness programme affiliation bodies.

In creating a robust research study, the research questions looked to understand if South African wellness programmes were comprehensive. The interviews probed what elements of wellness programmes experts in the South African context believed contributed towards creating an effective and successful programme as well as the degree to which these were present in local workplace programmes. This information together with the literature created an informative enquiry that allowed for an understanding of how programme design and implementation can be optimised in local programmes.

This study also evaluated the role of leadership influence on wellness programmes, thereby confirming to organisational management what their role is in contributing towards programme success. Companies experience different degrees of outcomes. Literature highlights companies who benefit in health outcomes (Mattke, Liu, Caloyeras, Huang, Van Busum, Khodyakov, 2013), financial savings (Baicker, Cutler, Song, 2010) or productivity improvements (Berry, 2010). This study evaluated what requirements should be in place in order for these levels of outcomes to be experienced.

Stats SA reported unemployment rates of 25.4% in the third quarter of 2014 (Quarterly labour force survey, 2014). With organisations likely to create temporary employment for the largely unemployed who are unskilled, research has found that this group of the population is in a poorer health condition than higher income earners who are more educated (Braveman, Cubbin, Egerter, Williams, Pamuk, 2010). This research highlights how workplaces disadvantage temporary low income workers through lack of benefits, creating opportunity for further study in this area. Employers can review how they can change current work practices in an effort to create shared value.

Lastly, this research illuminates the fact that wellness programme management is a specialised field requiring greater knowledge and expertise of disease management and risk mitigation in order to yield the desired benefits. Decision makers will be better informed through the findings of this study on how to appropriately allocate resources to manage programmes effectively.

1.2 Why the focus on programme design?

There is a common understanding around much of the research on employee health and wellness. Bad lifestyle choices such as smoking, lack of exercise and poor nutrition are a global problem, leading to an epidemic of heart disease and stroke around the world. Obesity is the leading cause of health related problems globally. Medical research has created scientific ways of assessing these risks and provided easy access that enables organisations to make it available at low cost to their employees. The causes of employee ill-health, ways of assessing them and their management are thoroughly understood and do not form part of what employer programmes struggle with.

Worksite wellness programmes either refer employees that have been identified with risks to their own practitioners for further management or the employer creates a platform to provide and facilitate the management.

The Economist (2014) reported:

> *"As US employers grapple with rising healthcare costs, many have established employee wellness programmes. Yet companies continue to struggle with low employee engagement and health ownership. These programmes are often limited by a lack of coherent data to guide their design and to facilitate evaluation of outcomes. Efforts to build comprehensive datasets are hampered by the difficulties of integrating data of different types from multiple sources (including emerging*

personal monitoring devices and tools), as well as employee reluctance to share personal information." The Economist, 2014 Pg 1

Wellness programmes rely on employee participation, especially those who have high risks and require the assessments and intervention needed to mitigate the risks. They also rely heavily on employees taking the advice and acting on it however, this has not been the reality. Research reports have qualified their findings regarding the outcomes from their programmes by stating that favourable results are obtained from 'comprehensive' wellness programmes. The success factors have been varied from one study to the next and therefore no clear guidelines exist on what constitutes a comprehensive wellness programme.

This research study has combined reported success factors from various studies in an attempt to highlight any trends in the most prevalent factors found in South African organisational wellness programmes. Furthermore, the organisations are requested to report on whether or not they have enjoyed any benefits from their programmes. This approach seeks to link any common programme success factors with positive outcomes, if any.

An additional focus of this study is to establish how employers measure their outcomes. The programme design influences the kind of data that is collected in order to arrive at the return on investment reported during evaluation. The manner in which the data is analysed and reported determines the method of evaluation that can be used to evaluate the outcomes. This enquiry forms part of the interview with the custodians

1.3 Significance of the study

The first of its kind in South Africa, in 2010 a campaign to promote worksite wellness was conducted in over 100 organisations to encourage companies to adopt workplace health promotion programmes (Patel, Goetzel, Beckowski, Milner, Greyling, 2013). This campaign has continued annually with more employers participating in the survey to be rated the Healthiest Company. The survey included factors such as company facilities as well as leadership involvement as part of the success factors that enable healthy companies. This suggests that the success factors have been defined.

In 2011, the United Nations held their first High-Level meeting on non-communicable diseases (NCDs), only the second time that health has been the focus of a high-level United Nations meeting. The purpose was to quantify the burden of non-communicable

diseases and their projected impact. The World Economic Forum's report showed that half of all business leaders surveyed worry that at least one NCD will hurt their company's bottom line in the next five years (The global economic burden of non-communicable diseases, 2011).

With more employers implementing wellness programmes to curb the rising impact of employee ill-health on their businesses, it is important that an understanding of the crucial elements of success is established for these programmes to drive the desired outcomes. This aspect of wellness programmes has yet to form part of common understanding.

Chapter 2: Literature Review

2.1 Burden of disease

Projections of future mortality and disability are useful in prioritising health research. The rates and patterns of ill-health are determined by socioeconomic developments, education, technological developments and their dispersion among populations, as well as exposure to hazards (Murray, Lopez 1997). This study conducted by Murray and Lopez highlighted that non-communicable diseases (NCDs) such as ischaemic heart disease, major depression and cerebrovascular diseases (such as stroke) will increase from 28.1 million deaths in 1990 to 49.7 million deaths in 2020. These same conditions were predicted to be the leading causes of disability.

The Global Burden of Diseases, Injuries and Risk Factors study 2010 (GBD 2010) supported the above predictions through identifying high blood pressure as the leading risk factor followed by smoking. Using estimated death and disability-adjusted life years (DALYs), which is the sum of years lived with a disability and years of lost life, high blood pressure causes 7% of DALYs while smoking caused 6.3%. If one DALY can be thought of as one lost year of healthy life, individuals with high blood pressure prematurely lose 7 years of productive life due to their illness while smokers lose 6.3 years (World Health Organization definition).

Tobacco smoking is another behavioural lifestyle factor that has been demonstrated the most common cause of chronic obstructive pulmonary disease (COPD), which ranks as the third most common cause of DALYs according to the World Health Organization (WHO, 2015). A study by DiBonaventura of employed adults over the age of 40 revealed that those with COPD had significantly lower quality of life and work productivity and utilised healthcare services more than employees without COPD. They reported higher presenteeism (present at work however not productive), overall work productivity impairment and impairment in daily activities on the Work Productivity and Activity Impairment (WPAI) questionnaire (DiBonaventura, Paulose-Ram, McDonald, Wagner, 2012).

In South Africa high blood pressure is estimated to have caused 9% of all deaths and 2% of all DALYs in the year 2000. High blood pressure, together with obesity, diabetes and high cholesterol are considered diseases of lifestyle which can be prevented and adequately controlled in order to slow their progression into complications such as heart attacks and strokes where stroke claims 25,000 lives every year and 95,000 years lived

with disability (Bertram, Katzenellenbogen, Vos, Bradshaw, Hofman, 2013). Stats SA (2013) reported 458 933 deaths in South Africa in 2013 where the top causes of death were infectious diseases such HIV and TB (22.6%), followed by diseases of the circulatory system such as heart disease (16.7%) and third were respiratory causes such as smoking-related illnesses (10.4%). Therefore half of all deaths in South Africa are due to mostly treatable and preventative diseases.

In 2014 the Human Sciences Research Council (HSRC) reported South Africa with the highest number of new HIV infections in the world (HSRC, 2014). A study of the impact of HIV and AIDS on South Africa's economic development by Dixon (2002) using economic theory predicted a reduction in labour supply, productivity, exports and imports. The average national economic growth rates were reported in this study to have reduced by 2 – 4% a year across the African continent as a result of this pandemic.

2.2 The cost of disease

The cost of illness is an intuitive way of evaluating the impact of disease on the economy or a country. In 2010, the global cost of cardiovascular disease was estimated at $863 billion dollars, which equates to an average per capita cost of US$125. The global cost of chronic obstructive airway disease (COPD) which has been proven to be caused 90% by smoking was estimated at US$2.1 trillion for the same year. Illness has a direct impact quantifiable through the diagnosis and treatment of diseases and their complications but there are indirect costs such as productivity loss, death costs and the cost of human welfare that most often go unaccounted for (GBD, 2010).

The costs of non-communicable diseases to the healthcare system, to businesses and individuals are quite significant and are continuing to grow. The greatest impact is seen on the working age population who are then not able to secure productive employment. The World Health Organisation proposed in their policy brief on non-communicable diseases that adequate prevention and early detection have been recommended as the most effective way to curb these rising costs and impact of disease (GBD, 2010)

2.2.1 Cost of treatment to the economy.

Up to 5700 life years could be saved by individual prevention programmes every year in South Africa. An average prevention programme would save US$7million of costs per year which is not a significant amount compared to the cost of the programme (US$35million) however, it will improve the health of the population at a rate much lower than the cost of treatment offered by the health system (OECD Health Statistics, 2014).

Not many studies have been conducted in South Africa to indicate the cost of treating chronic diseases except HIV but the case for preventative treatment has been made. Gandjour's (2010) cost-effectiveness model has been used to prove that implementation costs for disease management programmes have a better impact than downstream costs of disease treatment.

2.2.2 Cost of disease to employers.

Ill-health leads to increased healthcare expenditure. The adage by Benjamin Franklin "an ounce of prevention is worth a pound of cure" remains true particularly for chronic diseases. Despite having a shorter lifespan from diabetes, studies have shown that the costs of treating the disease far exceed the costs of prevention (Sangita & Ammatul, 2012). In 2006 – 2007 poor diet-related ill health cost the National Health Service in the United Kingdom £5.8 billion, physical inactivity cost £0.9 billion while smoking cost £3.3 billion and obesity cost £5.1 billion (Scarborough, Bhatnagar, Wickramasinghe, Allender, Foster, Rayner, 2011).

Approximately five percent of corporate payrolls in Europe was spent on health benefits for employees and increased by over three percent from 2008 to 2010. The United States on the other hand, healthcare costs incurred by employers amounted to more than seven percent of the wage bill (Skrepnek, Nevins, Sullivan, 2012). Studies that examined the relationship between an employee's health condition and costs incurred by the employer reveal that health-related productivity costs are significantly greater than medical and pharmacy costs alone. More than four times greater than medical costs and pharmacy costs combined, to be precise (Loeppke, Taitel, Haufle, Parry, Kessler, Jinnett, 2009). Put differently, employers incur costs both while the sick employee is at work but not being productive (presenteeism) and they continue to incur costs when this same employee finally goes off work due to ill-health.

A different level of cost is therefore being brought to the fore through studies that look at presenteeism. In 2004 Goetzel conducted a study looking at the top 10 healthcare cost drivers for medical insurers where he found that the economic burden of chronic health risks such as high blood pressure, glucose and cholesterol were higher than any other condition but the cost of presenteeism for these same conditions superseded those of treatment multiple-fold. Presenteeism costs made up almost 60% of costs (Goetzel, Long, Ozminkowski, Hawkins, Wang, Lynch, 2004). The cost of disease is evident not only in employees who are absent from work but even higher in those who are still at work.

This strong link between health condition and productivity has compelled employers to look at ways to contain costs. With the available information indicating high productivity costs, employers have looked at ways to improve employee health while cutting down on healthcare costs.

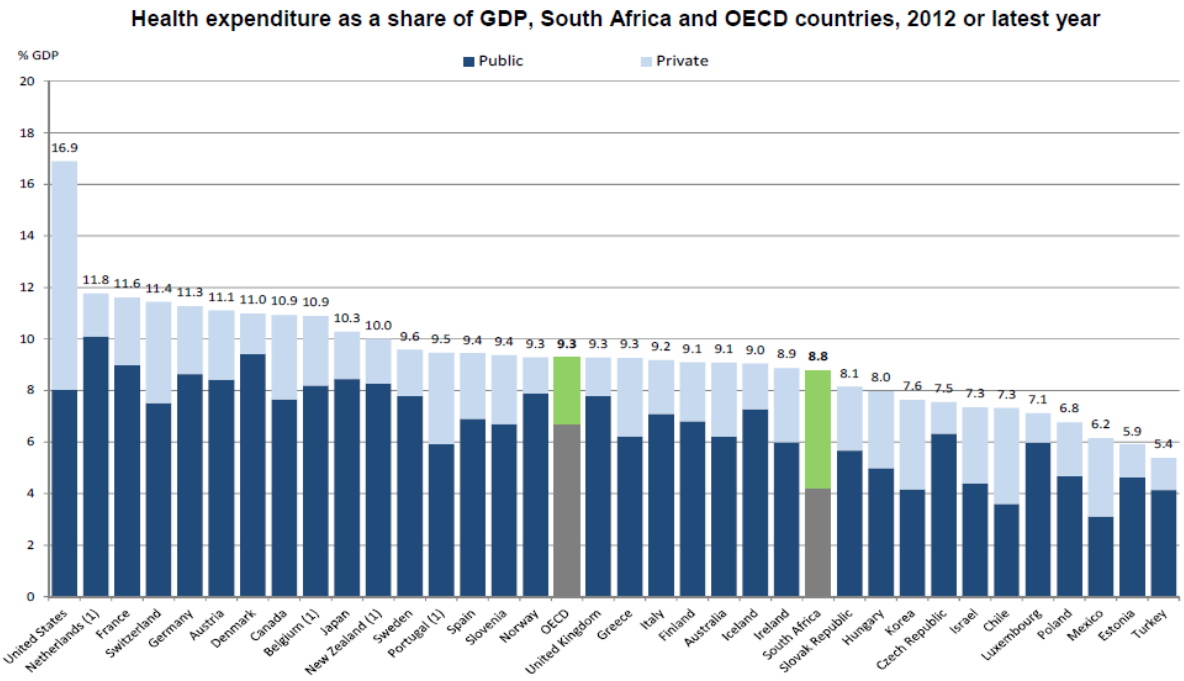
2.3. Management of disease

South Africa has a dual healthcare system which means there is a parallel public healthcare system funded by the government and a private healthcare system which receives up to 42% of its funding also from the government. The private healthcare system services only 18% of the population yet has 79% of the doctors and receives almost half of the 8.8% of gross domestic product (GDP) spent on healthcare When compared to similar countries in the OECD (Organisation for Economic Cooperation and Development) who contribute, on average 9.3% of GDP (see figure 2.1), the contribution is slightly less however, there are important points to be highlighted:

GDP spend increases the higher the income. South Africa spent $932 per capita on healthcare while OECD countries spend $3484 meaning OECD countries have a significantly higher purchasing power than South Africa and yet contribute only slightly higher towards healthcare costs (OECD Health Statistics, 2014).

Most healthcare spend in other countries such as the United States is funded from private health insurance while in South Africa, the government contributes almost 50% of the healthcare budget towards the public sector and almost 50% towards the private sector which only services 18% of the population. Essentially, the public healthcare system services four fifths of the population with one third of the budget when compared to the local private sector (OECD Health Statistics, 2014).

Figure 2.1: South Africa's health expenditure as a share of GDP



Source: OECD Health Statistics 2014, WHO Global Health Expenditure Database

Working age adults suffer the most from chronic conditions which impact on work productivity and necessitate that employers look at ways to manage these conditions. With escalating healthcare costs, this calls for increased preventative measures of addressing diseases. Since employers are paying for 30% of the national healthcare bill (Reardon, 1998), getting involved in the prevention of modifiable diseases is an imperative.

2.4 Workplace Wellness Programmes

"Workplace health promotion programmes or wellness programmes are organised employer-sponsored programmes that are designed to support employees (and sometimes their families) as they adopt and sustain behaviours that reduce health risks, improve quality of life, enhance personal effectiveness and benefit the organisation's bottom line" (Berry, 2010 Pg 1). They have also been described as on or off-site services sponsored by organisations which attempt to promote good health or to identify and correct potential health related problems (Wolfe, Parker, & Napier, 1994). They include initiatives designed to avert the occurrence of disease or delay the progression of disease from its early unrecognised stage to a more severe form.

Wellness programmes are designed to support employees and at times their families to adopt and maintain behaviours that reduce health risks and therefore improve quality of life. Another rationale for implementing wellness programmes at work is the potential to

reach a high percentage of employees, including many who would otherwise be unlikely to engage in preventive health behaviours (Glasgow, McCaul, Fisher, 1993).

2.4.1 The history of Workplace wellness programmes

The history of wellness programmes is not well-documented. The term wellness has different meaning based on context. In Europe, it has come to be associated with spas and treatments that are non-medical in nature whereas in the United States, its origins related to a movement of intellectuals and religious people with ideas of an active and healthy productive lifestyle (Miller, 2005).

An important association of the term wellness is the spirituality and health. The term wellness has been associated with Dr Halbert Louis Dunn (1896 – 1975) who was a Statistician and served in the office of public Health. He defined wellness as “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning.” (Dunn, 1961 Pg 4-5)

In the years following the Second World War, health promotion programmes aimed at executive leaders of organisations were initiated. Their focus was fitness, therefore they promoted gyms and massages. From the 1970s the American Association of Fitness Directors in Business and Industry created a platform that opened up these programmes to a broader base of employees and widened their focus of employee benefits beyond just fitness (Sparling, 2010).

According to a 2013 survey by Fidelity Investments and the National Business Group on Health, approximately 90% of companies in the United States with more than 50 employees had adopted some form of wellness programme. This number increased by 57% from 2009 (Wieczner, 2013).

2.4.2 The benefits of workplace wellness programmes

The Research and Development Corporation (RAND) study determined that well-designed, well-executed workplace wellness programs can reduce health risks, health care costs, and improve productivity. They have also found that although these programmes were becoming a standard component of benefit packages, some generated cost savings whereas others did not. The difference was in how programmes were designed and implemented (Mattke, Liu, Caloyeras, Huang, Van Busum, Khodyakov, Shier, 2013). A brief discussion of these listed benefits is outlined below.

2.4.2.1 Health outcomes

The Swedish American Health system initiated a wellness programme called CHIP (coronary health improvement project) aimed at making better lifestyle choices and preventing chronic diseases. An evaluation of participants of the programme at 6 weeks and 6 months after completing the programme showed that they had improved their cognitive understanding of good health, healthy behaviour and risk factors for chronic diseases (Aldana, Greenlaw, Diehl, Salberg, Merrill, Ohmine, 2005).

The RAND study (2013) evaluated public and private companies' wellness programmes and published findings indicating outcomes from some of the company wellness programmes. One such programme targeted weight loss using a one-year weight control programme. The outcomes in terms of weight lost experienced by the participants were translated into body weight reductions based on an average adult in the United States. The Center for Disease Control indicated an average adult female to be 63.8 inches tall and weighs 164.7 pounds whereas an adult male of average build is 69.4 inches tall and weighs 194.7 pounds. The findings in this study confirmed the assertion that wellness programmes yield positive outcomes and these kinds of benchmarks can be used as evidence with which to initiate similar initiatives and compare outcomes once the programmes are in place (Mattke, et al., 2013).

2.4.2.2 Cost cutting

Employee wellness programmes have not been viewed as a strategic imperative however data shows that the return on investment on comprehensive, well-run employee wellness programmes can be as high as 6 to 1. Adoption of such a health programme could prove beneficial to employers both from a productivity as well as cost perspective. This data provides a compelling argument for policies in employer settings to look at how they can take advantage of this (Berry, et al., 2010).

Large employers such as Johnson & Johnson, Citibank and Swedish American Health System published their case studies demonstrating the positive return on investment gained from investing in a workplace programme. They have shown that on average, medical costs drop by $3.27 for every dollar spent on wellness programmes and a reduction in absenteeism cost of $2.73 for every dollar spent (Baicker, 2010). In looking at data from the Global Burden of Disease study and Medical Expenditure Panel Surveys, Bolnick, Millard and Dugas (2013) calculated the annual savings that could result from lowering risks through a wellness programme and found that employers could save up to

18.4% per working-age adult, providing further proof that workplace wellness programmes provide savings.

2.4.2.3 Productivity

Fewer studies to prove the benefits of workplace wellness programmes on productivity have been conducted. Current methods for calculating productivity are subjective and rely on self-reporting questionnaires. A study by Loeppke (2009) looked at methods to measure health-related lost productivity linked to health promotion programmes. Using the Health and Work Performance Questionnaire he evaluated over 51 000 employees across 10 companies and looked at their medical aid claims and pharmacy costs. Health related productivity costs were higher than the costs of medicines and managers as well as executives experienced more productivity losses from mental illness and back pain. The study provided proof that there is a link between health and productivity and that in managing health data, evaluating productivity data may assist employers to quantify their cost savings.

2.4.3 Criticism of Workplace wellness programmes

Research that demonstrates the benefits of wellness programmes has been published however some questions and criticism have been labelled at the methods and results obtained by these studies. Public debate as well as articles in the media cited that wellness programmes have been overrated and the truth about areas where they do not provide benefits had not been revealed when research has been reported (Bottles, 2015). In the author's journal article on wellness programmes, Bottles raised concern that the cost-cutting amounts quoted in studies do not stand up to scrutiny. He further criticised employers for coercing employees to participate in the programme, as noted in the evidence provided in court when an employee brought a lawsuit against his employer. He further stated that incentives offered by the programmes favour white collar workers over blue collar workers thereby presenting inequities and discrimination. Lastly, he declared workplace wellness programmes as an invasion of privacy and an infringement on workers' rights.

In his 2014 review of workplace wellness programmes, Prof Goetzel together with several other researchers in the field of workplace health promotion programmes, looked at evidence drawn from existing wellness programmes to confirm or refute their benefits (Goetzel, et al., 2014). They arrived at the conclusion that programmes failed due to poor design, unstructured execution, lack of evidence-based best practices as well as inadequate resources (Goetzel, et al. 2014). They also highlight the fact that unsuccessful

programmes do not get reported due to publication bias. Programme managers are less likely to publicise negative findings.

The above study highlighted that although programmes may fail, no literature provides proof that workplace wellness programmes provide no value or disputes the improvement in health outcomes or cost savings. Return on investment for wellness programmes have largely been put at $3,27 for every $1 spent (Baicker, et al., 2010). When a programme does not yield this return on investment, it has been seen by some as a failed programme.

2.5 Effective workplace wellness programmes

It appears from literature that various programmes have been considered successful based on the health outcomes of the participants and on savings made on healthcare costs. Success in a workplace wellness programme according to a panel of wellness experts is when a programme accomplishes what it aimed to accomplish (Goetzel, et al. 2014). Based on this study by Goetzel, programme managers and executives wanted their programmes to create health awareness among their employees, reduce rate of injuries, make them the employer of choice and therefore reduce their staff turnover and attract the best talent. These and other outcomes outside of health improvements and cost savings constitute a measure of success of a wellness programme.

Wyatt, Brand and Ashby-Pepper (2015) conducted interviews with companies that have reported successful workplace programmes in order to understand how successful programmes were developed and implemented. They concluded that successful programmes were characterised by senior management endorsement, a collective sense of ownership, the presence of quick wins that participants could see as well as a sense that participation was easy and fun. They also identified trust as an important part of a programme and that it developed over time. They suggested that without creating an enabling environment, the programme will likely have a poor uptake and retention (Wyatt, et al., 2015).

Berry et al. (2010) sought to quantify return on investment of wellness programmes. Their findings included a list of six essential successful programme pillars: engaged leadership at multiple levels; strategic alignment with the company's identity and aspirations; a design that is broad in scope and high in relevance and quality; broad accessibility; internal and external partnerships; and effective communications. Companies in a variety of industries have included all six pillars in their employee wellness programs and have reaped big

rewards in the form of lower health care costs, greater productivity, and higher morale" Berry, et al., 2010.

It is evident from the literature that there is no single formula to a successful wellness programme, however, these research findings point to important aspects of wellness programmes, that they have to be comprehensive. A study by Ron Goetzel (2014) on whether workplace health promotion programmes work concluded that for programmes to work:

1. Well-designed programme
2. Well-executed programme
3. Founded on evidence-based principles
4. Employer goals
5. Organisational culture that can facilitate success

2.6 Definition of 'comprehensive' workplace wellness programmes

In looking at wellness programmes that yield positive results, a "comprehensive" wellness programme was considered a prerequisite. These positive outcomes are possible as a consequence of some aspects of wellness programmes being in place. The above principles of Goetzel's study (2014) were used as the basis for comprehensiveness. Literature findings indicate somewhat similar aspects of what have been documented as 'comprehensive' wellness programmes. Healthy People 2010 assessments, after 10 years of evaluating workplace health promotion programmes and objectives, highlighted five crucial elements of comprehensive wellness programmes as health education, supportive social and physical environment, integration of the worksite programme, linkage to related programmes and screening programmes (Healthy People, 2010).

The Healthy People 2010 survey was conducted by the Institute of Medicine and forms part of the United States Department of Health and Human Services initiative. It was launched in 2000 and has 467 objectives to improve the health of all people in the United States. In 2010 quantitative research findings indicating progress after a decade of implemented programmes and policies were published in Healthy People 2010. These objectives are grouped into categories where Leading Health Indicators provide crucial measures of public health (CDC, 2011).

The elements of comprehensiveness as outlined above have been divided into two parts for purposes of discussion in this research study:

1. Aspects of wellness programmes that constitute activities or undertakings from the employees or participants of wellness programmes. These have been named employee benefits.
2. Components of wellness programmes that indicate how a programme has been implemented, managed and being monitored. These factors are enablers of a programme.

Principles have been used in further research on workplace programmes to try to develop benchmarks for employer health and productivity management programmes (Goetzel, Shechter, Ozminkowski, Marmet, Tibrizi, Roemer, 2007) and to test the effectiveness of their recommended guidelines (Linnan, Bowling, Childress, Lindsay, Blakey, Pronk, 2008).

Table 2.1 Elements of a comprehensive workplace wellness programme

2.6.1 Health education	This aspect of the programme focuses on skills development and influencing lifestyle behaviour. This is achieved through education and awareness programmes. These lifestyle behaviours have to be in accordance to the employees' needs.
2.6.2 Supportive social and physical environment	The organisation implements policies and procedures that facilitate health promotion and reduce diseases. They are implemented in accordance to the company's expectations and goals.
2.6.3 Integration of the worksite programmes into the organisation's structure	Integrate the wellness programme into the culture of the organisation and other organisational structures and programmes.
2.6.4 Linkage to related programmes	Link different programmes that work towards similar goals to help employees.
2.6.5 Screening programmes	Measure employees' health status and the lifestyle behaviours.

2.7 Leadership

More studies in the field of employee wellness have highlighted leadership influence as an important aspect of wellness success. Healthy People 2010 did not indicate the value of leadership in its comprehensiveness factors. The study by Wyatt, et al. (2015) however,

highlighted leadership as a contributory factor to a successful wellness programme. In a study conducted on the Navy and Marine wellness programme called “Green H Award” where the objective was to address smoking, alcohol misuse and fitness issues, this was evident. There was an observed marked difference between the teams who were led by leaders who were very involved with the programme and those who were not. Leadership involvement in these commands led to a higher rate of successful implementation and maintenance of the programmes. Of interest was that the success of the programmes varied (Whiteman, Snyder, Ragland, 2001).

2.8 Programme design

Programme design and good programme implementation were noted by Goetzel (2014) to be essential to programme success. A well-designed programme however was not defined in this study. Of importance to employers were objectives of the wellness programme as well as the culture of the organisation. Programme design will therefore be influenced by environmental factors. Socio-economic factors are an example of influencers of health. A study that evaluated links between health and income and racial grouping found that employees of the lowest socio-economic status and poor levels of education had the poorest health conditions while those with intermediate income levels and education were better off and the wealthiest and most educated were of even better health (Braveman, Cubbin, Egerter, Williams, Pamuk, 2010). These findings encourage workplace wellness policies that design programmes specific to their populations. This research further found that blue-collar workers were more likely to make health behavior changes when health programmes were linked to occupational hazard assessments and changes in the work environment.

2.9 Participation in a programme as a success factor

Participating in wellness programmes has been proven to have a positive impact on employees. A study into whether participation in a programme has any moderating effect showed that employees who participated in programmes that were only focused on fitness and not in comprehensive programmes had reduced absenteeism rates and greater job satisfaction than employees who did not (Parks, Steelman, 2008). The same study further evaluated the methodological rigour of measurement used to assess impact of programme participation and found similar results, indicating positive results with participation on all studies.

2.10 Application of workplace wellness programmes in the South African context

2.10.1 Public sector entities

In April 2009 the Department of Public Service and Administration (DPSA) of South Africa issued a circular to all heads of national as well as provincial departments and provincial administrations to implement an employee health and wellness strategic framework in accordance to the guidance provided by the department. The Department of Public Service and Administration has a legislative mandate in accordance to the South African Constitution to set out basic values and principles that the public service should adhere to. This framework was intended to create uniformity amongst public service departments in how they implement health and wellness policies and programmes. In 2010 public sector organisations received a mandate from the state to implement readiness assessment tools to enable them to implement wellness programmes. They subsequently received a framework to guide the design and execution of their programmes. On an annual basis, they are graded based on this monitoring and evaluation tool. These organisations therefore have an additional body of influence over and above other organisations which shapes and impacts their design (www.dpsa.gov.za/dpsa2g/ehw_documents.asp)

2.10.2 Private wellness associations

The private sector has no regulatory body. There are private entities that provide expert consulting services to both organisations with wellness programmes as well as service providers who render wellness related services. Some are affiliations that use international benchmarks and standards which they provide seminars on and thereby encourage their member companies and service providers to subscribe to in order to enable them to realise results from their programmes (www.eapasa.co.za). There are no uniform standards or evaluation criteria implemented through these affiliations.

2.11 Conclusion

Non-communicable diseases are the leading causes of mobidity and mortality affecting the working age population. Workplace wellness programmes have proven to yield positive benefits for both employers and employees through implementation of comprehensive and well-designed programmes. The South African context can benefit from pursuing a culture amongst all sectors that increase evidence-based practices through all structures that influence workplace wellness programme implementation and management.

Chapter 3: Research Questions

3.1 Question 1:

How comprehensive is the worksite wellness programme?

3.2 Question 2:

How effective is the wellness programme?

3.3 Question 3:

What are the challenges to measuring the impact of the wellness programme?

Chapter 4: Research Methodology

4.1 Introduction

The purpose of this study was to establish if South African workplace wellness programmes have the elements required for them to experience their desired outcomes.

This study was influenced by American research which demonstrated that companies with comprehensive programmes in place enjoy wellness programme outcomes.

4.2 Choice of Methodology

This research employed a mixed method approach where qualitative and quantitative data was collected. Mixed methods research brings together different methodological frameworks and multiple analyses in order to provide a comprehensive understanding of the research problem (Cresswell, 2003). Creswell (2003) states that the convergence of quantitative and qualitative data into a mixed method came about as a result of the limitations that reside in using one or the other method. Researchers believed that the biases inherent in any one of the methods could neutralise the biases of the other. The data for this study was collected simultaneously and integrated in the overall results.

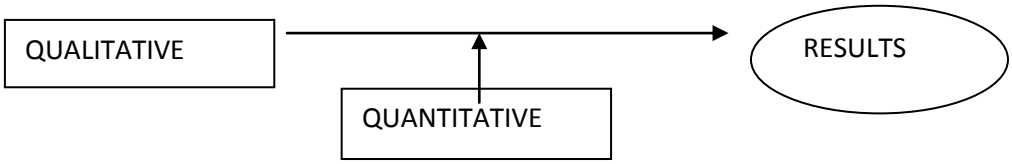
Qualitative research attempts to answer questions about the complex nature of a phenomenon and often with the purpose of describing and understanding the phenomenon from the participants' point of view (Leedy & Ormrod, 2001). This research interviewed custodians of workplace wellness programmes as well as experts in the field of wellness. The interviews were guided by a study questionnaire which allowed for the collection of data using both open and closed-ended questions. The in-depth and open-ended questions were oriented towards describing processes and providing the perspective of the respondents.

This study had two samples, the first being experts who were interviewed in order to understand their perceptions of the industry and the various companies who have programmes in place and the second sample was made up of the various company programme custodians. This approach was used in order to explore aspects of comprehensiveness of wellness programmes with experts and then obtain a better understanding through interactions with the second sample of custodians of those wellness programmes. Welman and Kruger (2003) describe this as explorative research where the study does not begin with a specific problem but is designed to find the hypothesis that requires testing. Therefore, it is used to determine whether or not a phenomenon exists. For this research, the phenomenon being explored was the comprehensiveness of a programme (Welman & Kruger, 2003).

The quantitative method of data collection required the respondents to rate information in a survey format and to rank information into a particular order. This mixed method

enabled the qualitative data to be richly enhanced through the quantitative methods of rating and ranking.

Figure 4.1: Mixed methodology approach



Source: Steckler, McLeroy, Goodman, Bird, and McCormick (1992)

The above Figure 4.1 illustrates the typology of the chosen mixed method approach where the quantitative methods were used to support a primarily qualitative study.

The disadvantages posed by a mixed method approach relate to the sample size available for analysis which may be small in a qualitative study and the two methodologies may have inconsistent units of analysis (Driscoll, Appiah-Yeboah, Salib, Rupert, 2007)

4.3 Population

A population is defined as the entire set of units for which the data is to be used to make inferences or to generalise (Cox, 2008). It is accepted, however that generalisations may not be applicable in qualitative studies, due to the small sample size.

Two populations were selected:

1. Experts on wellness programmes. These constitute individuals who are involved with policy making and regulation of programmes in the public sector, medical aid schemes that provide workplace wellness services, service providers to company programmes, and wellness programme affiliation bodies. They were deemed experts on the basis of their exposure to multiple wellness programmes in various sectors and economic industries. Their involvement with company programmes shape and influence workplace wellness programme designs either through the formulation of guiding frameworks and regulation of the industry or through service provision and reporting to company programmes.

2. South African private and public sector organisations with workplace wellness programmes made up the second population. The custodians to these programmes were the target. Programme custodians are mostly Human Resource managers or executives, Wellness practitioners or specialists, Employee Benefits

specialists and Employee Relations managers. They were deemed most appropriate to provide insight into their own organisation's wellness programme design, measurements and results as well as challenges.

Wellness programme custodians were considered primary sources. Welman and Kruger (2003) explain a primary source as the written or oral account of a witness or a participant. It represents first-hand evidence. Company wellness custodians were interviewed as primary sources in order to obtain their personal experiences and perspectives of their company programmes.

4.4 Sampling

4.4.1 Technique.

In selecting samples from the identified populations, different techniques were used. South African organisations are either privately owned or public sector entities managed by the government. This research sought to be fully representative by selecting organisations from both groups. Not-for-profit organisations were not included. The organisations selected all had their head offices in Gauteng province even though they may have offices in other parts of the country, some even internationally. Chapter 2 Section 2.10 provided insight into how the wellness programmes across the two groups vary.

4.4.1.1 Sample 1 – the experts.

Experts were selected using purposive sampling where the goal is to focus on particular characteristics of a population that are of interest and therefore best enable the researcher to answer the research questions. This technique "relies on the researcher's knowledge and experience to deliberately obtain units of analysis in such a manner that the sample obtained is regarded as representative of the relevant population" (Welman & Kruger, 2003, p. 63). It is important to indicate that the researcher has knowledge of the wellness industry and was in a position to use this knowledge to approach the appropriate influential entities. The benefit of purposive sampling resides in this very ability to select the best sample out of a population. Some potential respondents may be willing to participate in research however may not have the depth and breadth of understanding of a topic to be able to meaningfully contribute, leading the researcher to purposely select their candidates (Oliver, 2006). In this instance, they are senior and highly experienced experts with more than a decade of exposure in the industry.

The researcher sought to have a different expert for each area that has large-scale influence on workplace programmes. The disadvantage of using purposeful sampling is that different researchers could use different methods of selection when choosing a sample.

4.4.1.2 Sample 2 – Workplace wellness programme custodians.

In selecting this sample of respondents, non-probability quota sampling was used. Non-probability sampling involves the researcher drawing samples from a larger population without the requirement of random selection. This process uses subjective judgement to select a sample. The researcher decided which units of the population would be included in the sample. This however, carries the disadvantage that the findings are limited in the extent to which they can be generalised to the larger population (Oisin 2007). Once the sample had been selected, a quota method was applied which segregated clients into public and private sector, small, medium and large companies.

4.4.2 The step-by-step selection process

4.4.2.1 Sample 1- the experts.

In selecting Sample 1, the researcher considered both the public and private sector and identified entities which influence one sector and perhaps not the other in an attempt to ensure adequate representation. Chapter 2 Section 2.10 elaborates on how public sector entities are regulated differently from the private sector as well as provide a brief background to the South African wellness service provision industry. This sample size consisted of four experts from different backgrounds. Two of the respondents had some level of oversight over governmental wellness programmes. They were conversant on the design, influences, measurement outcomes and challenges of a variety of wellness programmes in the public sector. The other two experts were experienced in both sectors as service providers and in wellness affiliations. Only four experts were approached and all of them participated in this research.

4.4.2.2 Sample 2 - Workplace wellness programme custodians

A health care consultancy firm's list of clients was used to aid in the selection of the second sample group. The consultancy had a variety of clients in public and private sectors across a variety of sizes; small, medium and large.

In South Africa, the National Small Business Act 102 of 1996 defines small and medium sized enterprises in accordance to the size of employees (Smit & Watkins, 2012). Although there are other categories (turnover and sector) which can also be used to

define the size of enterprises, this research only utilised size of employee base to differentiate between the quotas above. Some literature was available on the definition of micro-, small and medium sized enterprises however, not much was available in defining entities larger than 200 employees or its sub-categorisation.

Step 1: Using Smit and Watkins' (2012) categorisation of small and medium sized companies, organisations with more than 200 employees were categorised as large. This information together with the sectors was used in segregating companies. The following groups of companies were targeted:

Table 4.1: Segregation of companies for Sample 2

Size of company	Public sector	Private sector
Small (Employee size <50)	No organisations were identified within this field.	4 organisations were identified within this field.
Medium (Employee size 50 – 200)	Only 2 organisations were identified within this field	13 organisations were identified within this field
Large >200 employees	Only 3 organisations were identified within this field	46 organisations were identified within this field

Table 4.1 indicates that Sample 2 companies were segregated into public and private sector, and again in accordance to their sizes. Organisations with less than 50 employees were classified as small, those with employee sizes between 50 and 200 were considered as medium sized and those with more than 200 employees were classified as large companies. The healthcare consultancy list of clients did not have any small sized public sector clients, only two who were medium sized and only three who were large. However, there were a large number of private companies in all three sized categories.

Step 2: Based on the relationships and knowledge of the wellness programme custodians, the health care consultancy recommended a selection of clients, firstly with wellness programmes in place and secondly, those likely to respond to a request for interview. In selecting to use a list of clients from a healthcare service provider, the researcher ensured that the important criterion of having a wellness programme in place was met. However, due to the nature of the study design not all companies could have been sampled.

4.4.3 Sample size.

A total of 14 organisations, out of the full list, were approached by the researcher with a request for an interview. These 14 were those recommended by the consultancy as organisations both with a wellness programme in place and most likely to agree to an interview. According to Guest, Bunce and Johnson (2006), there are no reliable guidelines for determining non-probabilistic sample sizes. Saturation is the most important determinant of size and it is greatly influenced by the skill of the researcher. The concept of 'saturation' indicates the point at which no new information or themes are observed in the data. Using in-depth interviews, Guest's et al. (2006) study demonstrated that saturation occurred within the first 12 interviews although basic elements for meta-themes were already present after six interviews.

The table below demonstrates the companies in accordance to the previously discussed segregated categories that made up part of this research.

Table 4.2: Companies approached and interviewed

	Companies approached		**Companies interviewed**	
	Public sector	**Private Sector**	**Public sector**	**Private Sector**
Small	0	3	0	0
Medium	2	3	1	1
Large	3	3	3	3
Total	**14** companies approached		**8** companies interviewed	

The above Table 4.2 demonstrates that no small public sector employer was approached for this research. In the public sector, only two medium sized and three large sized companies were available and all were approached however, only one medium sized company agreed to an interview while all three large companies agreed to the interview. In the private sector, three of each sized company were approached however no small companies agreed to an interview, only one medium sized and all three large companies were interviewed. Out of the 14 companies approached, only eight were interviewed for this research under Sample 2.

4.4.4 Unit of analysis

This research seeks to understand the comprehensiveness of wellness programmes as defined by factors that are present in the programmes, enabling the employer/employees to derive the desired benefits. The unit of analysis is the factors that are present in a

programme. The research has sought to elucidate those factors that qualify a programme as comprehensive.

4.5 Measurement Instrument

A questionnaire was used as a measurement instrument. As these were in-depth, semi-structured interviews, the questionnaire was used to guide the discussion in order to achieve the objectives of the study.

4.5.1 Instrument Design

Two questionnaires were designed for this study. The first questionnaire sought to understand the Experts' perceptions of South African workplace wellness programme designs, what elements they have and how they measure their outcomes by exploring the following points:

- Experts were required to provide their informed view of what an appropriate programme ought to be made of and how different or confirmative the landscape of programmes was to what they believed needed to be in place.
- Experts were provided the opportunity to indicate what their observations had been on the design of workplace programmes and where they believed the influence came from.
- With regards to measurement and the realisation of benefits, their opinion was sought on what constitutes a successful programme and how those success benefits were to be measured.
- The experts' opinions were sought on how they gauged and reviewed workplace programme successes. These opinions were sought independent of what literature stipulated in order to evaluate if those bodies that inform, regulate and influence company outcomes perhaps used different criteria to inform success. This was considered important as the analysis would require an understanding of whether the definition of success correlated with that found in the literature.
- Experts were not required to rank components of wellness programmes (as was requested of the company programme custodians) as their input here would have called on speculation rather than an informed opinion.

4.5.1.1 Design of questions relevant for RQ 1:

How comprehensive are workplace wellness programmes?

The RAND study (Mattke et al., 2013) determined that well-designed and well-executed workplace wellness programs reduce health risks, health care costs and improve

productivity. The difference between programmes that generate benefits and those that do not lies in how programmes are designed and implemented (Mattke et al., 2013). This informed how the research instrument was designed. The first set of questions were focused on understanding the programme design (the employee benefits of the programme) and how each company implemented the programme (the elements of the programme) in order to uncover if there is an essential combination of these factors that make up a comprehensive programme. Theory presented several definitions and combinations of factors that define a 'comprehensive' programme however, these were not included in the questionnaire in order to avoid the possibility of respondents assuming their answers had to be crafted in any particular fashion. Due to the multiplicity of the elements and components of wellness programmes, respondents were requested to indicate "yes" if the component is present in their programme and "no" if the component is not present. This was done to highlight the prevalence of programme components.

Further to the above, the elements of wellness programmes were broadly categorised in a Likert scale in accordance to a model by the Healthy People (2010) study. Respondents were requested to rate the degree to which these elements are present in their respective programmes. The purpose of this rating was to evaluate the degree to which elements that are considered crucial to the success of a programme are present with the respective company programmes. The analysis would also look at whether the mere presence of these elements is considered adequate or do they have to be significantly entrenched into company process to a particular degree for them to be impactful.

Lastly, implementing the right programme is important. In reviewing evidence from various wellness programmes, Goetzel et al (2014) came to the conclusion that programmes failed due to poor design, unstructured execution, a lack of evidence-based best practices and inadequate resources. The questionnaire sought to establish whether programmes used any evidence-based protocols or frameworks in their design. In order to present the question in a simple way, an example of the Centre for Disease Control and Prevention (CDC) Health Scorecard (2015) was used. It was explained that this scorecard is an evidence-based questionnaire used by various wellness programmes whose objective is management of cardiovascular disease. This was then followed by a question to the respondent whether their company used any evidence-based protocols. If so, which ones and what objectives they had.

Questionnaire items intending to answer research question 1 were divided into the two aspects of comprehensiveness:

1) Wellness programme benefits which was understood as programme activities, facilities or other received benefits that are employer-funded with the intent to improve employee health and wellness.

2) Elements of wellness programmes which were understood as those aspects of the programme that indicate how a programme is managed or enablers of a programme.

4.5.1.2 Design of questions relevant for RQ 2

How effective is the wellness programme?

In evaluating the effectiveness or outcomes of workplace wellness programmes, questions intended to answer research question 2 looked at measurement. Programme custodians were requested to indicate whether they believed their programmes were effective and to provide motivation for their views. The primary interest of these questions related to outcomes. The programme custodians had to indicate what they sought to achieve with their programme and what they, in reality, had benefited through the programme.

The questionnaire presented these questions in such a manner that programme custodians did not only reflect on their set objectives but stimulated a discussion on what they believed their programmes achieved, even if this was not what the programme had set out to do. In analysing these responses, the programme achievements as reported by the respondents would be evaluated against the programme design in an attempt to further understand if the programme was comprehensive enough to achieve the desired outcomes.

Questions intended to answer research question 2 were divided as follows:

1. Measured outcomes were understood by the respondents to indicate what they measure regularly and believe were the attained outcomes (if any) of their programmes. In elaborating on these outcomes, respondents were requested to highlight evidence of achieved outcomes. The evidence provided by the respondents, as proof of positive outcomes, has been utilised in Chapter 6 when analysing the programme measurements and outcomes. The interest here was what did they measure.

2. Desired outcomes which were understood by the respondents as the reason why the wellness programme existed. During the interviews, some programmes were noted to have been in place prior to the tenure of the respondents and may have had different

desired outcomes at the onset. However, the respondents were requested to indicate what they as the programme custodians were looking to achieve with the programmes.

3. Achieved outcomes were understood by the respondents as those positive outcomes, measured or observed, that were evident as a result of the wellness programme. The programme custodians had to have attributed them to the programme or measured them and found them to be present although they were not what the programme had set out to achieve.

4.5.1.3 Design of questions relevant for RQ 3:

What are the challenges to measuring the impact of the wellness programme?

The final part of the questionnaire sought to explore challenges that all programmes experienced which affected their ability to implement good and comprehensive programmes. The questionnaire also explored challenges to measuring the outcomes of these programmes. Respondents were requested to discuss what their challenges were to both programme implementation as well as measurement of outcomes.

4.5.2 Reliability and Validity

Reliability is the extent to which a measure is free from error and can therefore yield consistent results (Zikmund, 2003). Any response therefore is made up of two parts, the true response and the other part is the error. Improving the reliability of a measurement tool equates to reducing the part of the response that is error (Kimberlin & Winterstein, 2008). This means that the questionnaire should produce the same answers each time, consistently. This level of rigour of the questionnaire has been ensured through asking the same question in different ways. Inconsistencies in responses indicated either the question had been misunderstood or the respondent was not providing accurate answers. As this was a semi-structured interview, the researcher had opportunity to seek clarity from the respondent on their understanding or to interpret the question and align the understanding, in order to minimise errors. The most important element of the data remains the subjective view of the participant.

In order to improve the validity of the measurement tool, meaning the extent to which the tool measures what it claims to measure (Kimberlin & Winterstein, 2008), two samples were chosen and asked similar questions in order to answer the research question. Wellness, similar to health, is made up of non-measurable or intangible constructs such as good health outcomes, disease control, and so forth. In order to improve the ability of the questionnaire to provide answers that are valid, not only did two different samples

have to provide a view of the concepts but the respondents had to elaborate on their responses in a manner that demonstrated their understanding of the questions. In-depth interviews created a platform for respondents to elaborate on their responses. The same researcher was present with all interviews ensuring consistency in the way the questions were asked and explained and how probes were used.

4.5.3 Pre-testing

Pre-testing of a study instrument is important for picking up problematic items that respondents might struggle with or misunderstand. Pre-testing gives the researcher an opportunity to refine the questionnaire before roll-out and improve the reliability and validity of results. Table 4.3 below summarises the verification process which the researcher undertook in order to ensure that the most appropriate questions had been included in both questionnaires in order to stimulate satisfactory and relevant answers. The "Analysis" column summarises the value the questions served in contributing to answering the research questions.

Table 4.3: Consistency matrix

Proposition / Q / H	Questionnaire	Analysis
RQ1: How comprehensive are workplace wellness programmes?	Questions 1.1 & 1.3 & 1.5	A description of the composition of programmes and their strategic enablers that ensures programmes are optimised.
RQ 2: How effective is the wellness programme?	Questions 2.2 & 2.4 & 2.6	Linkage of programme elements and programme outcomes
RQ 3: What are the challenges to measuring the impact of the	Questions 3.1 &	Evaluate the validity of reported outcomes against methods used to obtain them

wellness programme?	3.2	

4.6 Data Collection Procedure

Data was collected through semi-structured in-depth interviews, using questionnaires. The researcher booked interview appointments with respondents via e-mail. Each respondent was provided with a copy of the questionnaire, the informed consent form to be signed and a copy of the GIBS ethics approval. Eight interviews were completed, despite more being scheduled. Three companies fell off the list of scheduled appointments for the following reasons: one small sized private sector client cancelled the appointment as they were of the opinion that their programme was not mature enough for them to be able to answer the questions. Another small private sector client postponed meetings on several occasions until the dates fell outside the data collection period. A third required their travelling Human Resource manager to be present in the interview which led to a few appointment cancellations and ultimately they did not go through with an interview.

Public sector employers all requested a formal letter on the GIBS letterhead indicating the purpose of the research, the institution through which the studies were conducted, contact details of the supervisor and detail on how the information will be analysed and stored. This letter had to receive approval from the company's senior management. For this reason, two meetings did not occur as the approval had not been granted after several weeks of waiting. Three approvals were granted and interviews held and the fourth interview was conducted with the senior executive as the respondent and therefore the approval process was very quick.

The experts were interviewed first. This was done in order to consolidate their views and opinions and use this insight in understanding the information received from the programme custodians. Two experts were interviewed together. This interview allowed them to reflect on each other's statements and provide varying opinions where applicable, based on their diverse experiences. The third expert provided their input via e-mail. A few e-mail exchanges occurred where areas of clarity on the response or questions were sought.

The wellness programme custodians were interviewed mostly at their workplaces. Only one interview occurred in a restaurant where the researcher and the respondent agreed to meet halfway. The shortest interview took 28 minutes while the longest took 53 minutes.

Table 4.4. List of interviewed respondents across the two sample groups

Co. Nr	**Reference**	**Sample 1** (experts)	**Sample 2** (programme custodians)
1	Expert 1	Expert on EAP, Health screening and chronic disease management	
2	Expert 2	Expert on company wellness programmes	
3	Expert 3	Public health specialist	
4	Expert 4	Department of Health	
5	Company A		Wellness Manager
6	Company B		Human Resource Manager
7	Company C		Country Manager
8	Company D		Head: Employee Wellness & Employee Relations
9	Company E		Human Resource Group Manager
10	Company F		Executive Manager: Employee Wellness
11	Company G		Wellness Specialist
12	Company H		Group Manager: Employee Benefits

Table 4.4 indicates the complete list of respondents interviewed as well as their designations. The reference column indicates how the respondents will be identified in this research report.

At the start of each interview process, the researcher provided an overview of what the research sought to understand and indicated what was expected from the respondent in answering questions. The researcher stressed the importance of having the questionnaire as a guide and that the 'conversation' required openness and elaborate responses in order to be meaningful. All respondents were assured of confidentiality prior to the commencement of the interview. In signing the consent form, the researcher explained that no names of companies or respondents would be revealed.

The role of the researcher in qualitative research is that of an instrument of data collection (Denzin & Lincoln, 2003). Data is mediated through this instrument rather than through questionnaires and other sources. In order for the consumers of the research to understand the data, they need to understand the instrument through which the data was collated (Simon, 2011).

Half of the 12 respondents in this research, including all the experts, were familiar with the researcher through workplace health promotion information that the researcher routinely circulates to various employers. Only three of the employers had previously worked directly on projects with the researcher. The other half were aware that the researcher is a wellness practitioner however, based on the observations made during the interviews and some of the comments, they had superficial knowledge of her exact role and level of knowledge of the wellness industry.

In reflecting on the role of the researcher, biases, assumptions, expectations and experiences influence the manner in which data is communicated and received (Greenbank, 2003). The researcher therefore was conscious and observant of the possibility that respondents may craft their responses in a particular fashion when they knew the background of the researcher. It was also important, in light of this, for the researcher to take on the role of listener and observer and not fall into the trap of influencing the respondents' answers.

In preparing for the interviews, the researcher enquired about the individual employer programmes from their respective consultants, who acted as mediators in introducing the researcher to the programme custodians. The researcher used this information to clarify questions and lead respondents to elaborate on their experiences. The added advantage posed by the wellness knowledge of the researcher was the ability to easily comprehend concepts and terminology without pausing to ask for clarity. Similarly, the researcher required the sense to recognise when she and the respondent were not of the same understanding.

During the data collection process, each respondent had a printed copy of the questionnaire in order to follow and look at the questions but also to allow those who wanted to draft their responses. Most respondents accepted the researcher making notes. In only three instances, respondents wrote down their responses while separate notes were also made by the researcher. Both copies were used for analysis. In addition, interview was recorded. The recordings only commenced after the researcher explained

the purpose of the research, informed consent form was signed and permission to record was obtained. Respondents were informed that the recording was purely for data analysis purposes, to ensure that no vital information was omitted.

The adequacy of a research method depends on the purpose of the research and the questions being asked (Locke, 1989). Having interviews with respondents instead of only using questionnaires provided the added benefit of allowing new concepts, not originally part of the discussion, to be explored. Once such a concept was highlighted, it was noted both in the routine notes as well as in a side notebook. All subsequent interviews engaged on the new concept, to tease out its relevance.

Conducting interviews presented an opportunity for the researcher to interact and therefore observe the behaviours of the respondents. Using direct observation to collect and analyse data, makes the observer the measuring instrument. Direct observation is only reliable and valid based on the experience and skill of the observer (Welman & Kruger, 2003).

Some of the respondents requested to be sent copies of the final research report, once concluded. The researcher will do so after submission of the final report to GIBS.

4.7 Data analysis approach

Thematic analysis was used for data analyses (Braun & Clarke 2006).
The following sources of data were analysed:

- Respondents' completed questionnaires
- Researcher's notes including: interview answers and notes recording new concepts
- Individual recordings
- The transcribed recordings
- The personal notebook where the researcher noted new concepts
- E-mail content for the respondent who provided their data electronically

The above information was imported into an excel spreadsheet and coded in such a way that each questionnaire question asked was allocated a number and these numbers were linked for each respondent. While analysing, the researcher listened to the recordings and looked through the notebook to be able to make additional notes on nuances that may not have been reflected in the responses.

In coding the data, all responses allocated the number 1, for instance, linked with answers from each and every respondent for the first question, which was the designation or job description of the respondent. All 12 number 1s were filtered and evaluated first in this isolated manner but second, in groups of responses designed to answer a particular research question.

In this way, themes were identified and so were minor themes or subcategories. This manner of analysis was used for detailed responses to qualitative data. The information obtained in a quantitative approach was filtered from the same spreadsheet and evaluated in terms of frequency. The number of “yes” responses were documented and looked at and compared to the number of “no” responses. The data was correlated further and matched with overall responses per company.

4.8 Assumptions

Goetzel (2014) highlighted the fact that unsuccessful programmes do not get reported due to publication bias. Programme managers are less likely to publicise negative findings. Participants may not be altogether truthful (Douglas, 1976) especially when they are the custodians of the programme which may be viewed as unsuccessful.
The researcher assumed that all respondents would provide accurate information about their organisations’ programmes and outcomes and that the programme custodians would be honest in spite of any negative outcomes because they had agreed to be interviewed.

4.9 Limitations

1. Interviews may be limiting in terms of the information that respondents may be comfortable with disclosing. Less than adequate information may be obtained through such a process that exposes the participant as well as their organisation (Marshall & Rossman, 2006).

2. The findings are limited in the extent to which they can be generalised. Only organisations based in Gauteng, South Africa were interviewed and approaching organisations that are likely to agree to such an interview may exclude programmes that are comprehensive and enjoy benefits.

3. Interviewer bias, a common occurrence among qualitative studies. When conducting an interview the researcher may have certain expectations, such as getting answers to the questions in the questionnaire. As a result of pursuing recordings and information

relevant only to the research questions, relevant information may be excluded. Also an interviewer may influence the way the respondent answers in order to obtain a particular answer. This is all mitigated through reflective thinking.

4. The sampling process favoured companies that were known to their servicing wellness consultants to have multiple employee benefits and wellness initiatives in place. The process also favoured employers more likely to want to discuss their programme outcomes.

Chapter 5: Results

This chapter outlines the quantitative results of interviews held with wellness experts (Sample 1) and wellness programme custodians (Sample 2). The data is reported in line with the research questions outlined in Chapter 3. Each section has a brief description of what the data indicates and how it has been used in the analysis. The sample consisted of 12 respondents in total, four of whom were experts and eight were workplace wellness programme custodians from various organisations.

5.1 Demographics

Table 5.1 Operational level of the respondents

Operational level	Experts	Programme custodians
Senior Management level	3	5
Executive level	1	3

Table 5.1 above indicates the operational level of the respondents. Three of the experts were senior managers involved with and overseeing operational work while the other had

an executive role. Three of the interviewed programme custodians were executives within their organisations while the other five were senior managers.

All the experts that were interviewed had roles and responsibilities exclusively focused on employee health and wellness. Three of the programme custodians interviewed had wellness training and experience. Their roles and responsibilities within their organisations were exclusively focused on employee health and wellness. Five of the programme custodians interviewed had employee wellness as one of their responsibilities. These five respondents had roles inclusive of other organisational management responsibilities. They were mainly in human resource management and wellness management was one portfolio, among many, of responsibilities. Other responsibilities included transformation and training.

Table 5.2 Age range of employees across companies

Average age of employees	31 - 35	36 - 40	41 - 45	>45
Number of companies	1	3	3	1

One company had an employee in the age range 31-35 years and one in the age range above 45. Three of the companies had employees in the age range 36 – 40 years while the other three had employee aged between 41 and 45.

Figure 5.1. Employee work status across companies

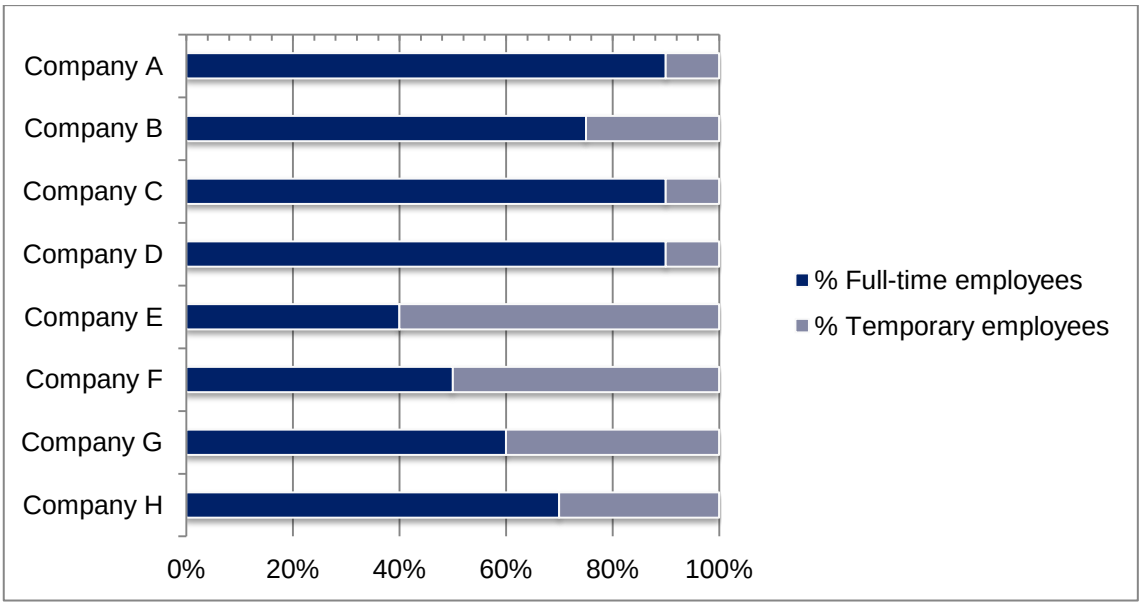
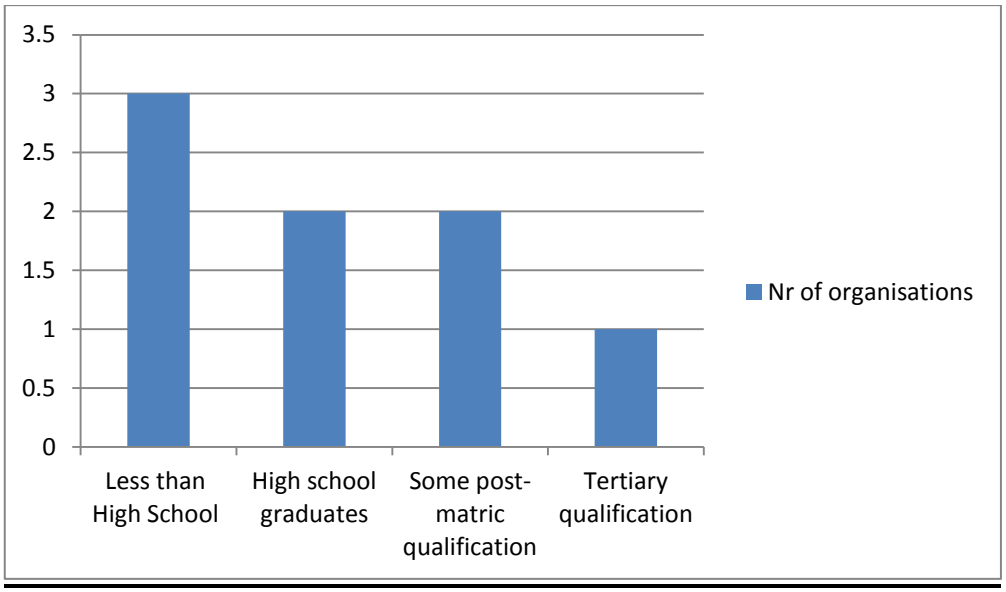


Figure 5.1 above only relates to sample 2 (wellness programme custodians) and does not include any information from experts as they did not represent any specific organisation.

The figure represents the staff complement of the eight companies according to respondents. The figure shows that three companies had 60% and less full-time staff. The rest of their employees within these organisations were temporary with high staff turnover. The programme custodians highlighted that their temporary staff either did not have access to any of the wellness programmes or their access was limited to telephonic support from the programme but not any other programme benefits. The presence of high numbers of temporary staff was also indicated as a challenge in wellness programme management. The other organisations had between 60% and 90% full-time staff. Their percentage of temporary staff was lower and these temporary employees had less staff movements and turnover was not highlighted as a major challenge.

Figure 5.2. Educational level of employees across companies



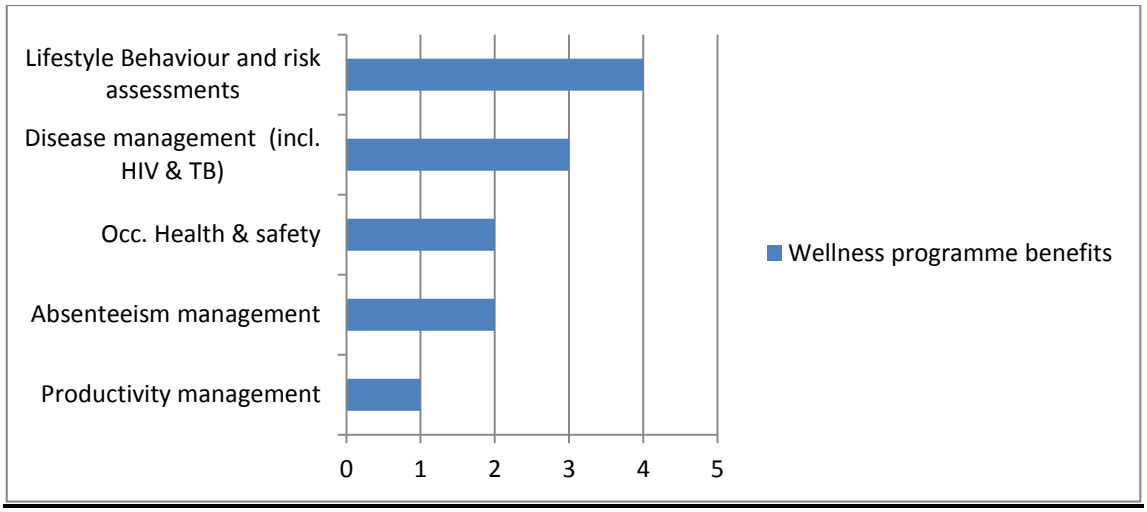
The above Figure 5.2 depicts the educational level of at least 50% of the targeted employees within the companies interviewed. Targeted employees are those who receive employee wellness benefits and whose results the respondents would highlight in this research study. One organisation had mostly employees with tertiary qualifications while three of the organisations interviewed had mostly employees without any high school qualification. Other categories were employees with matric and then those with some post-matric qualification.

5.2 Research Question 1: How comprehensive are workplace wellness programmes?

Questionnaire items intending to answer research question 1 looked at the two aspects of comprehensiveness: 1) wellness programme benefits and 2) elements of wellness programmes. The figures below summarise the interviewed experts' views regarding the benefits they believed were crucial in a wellness programme. These are then followed by the results of the interviewed companies indicating what they actually have in place. In Chapter 6, this will be compared to literature in order to define whether or not the evaluated organisations have comprehensive programmes.

5.2.1 Theme 1: Workplace wellness programme benefits

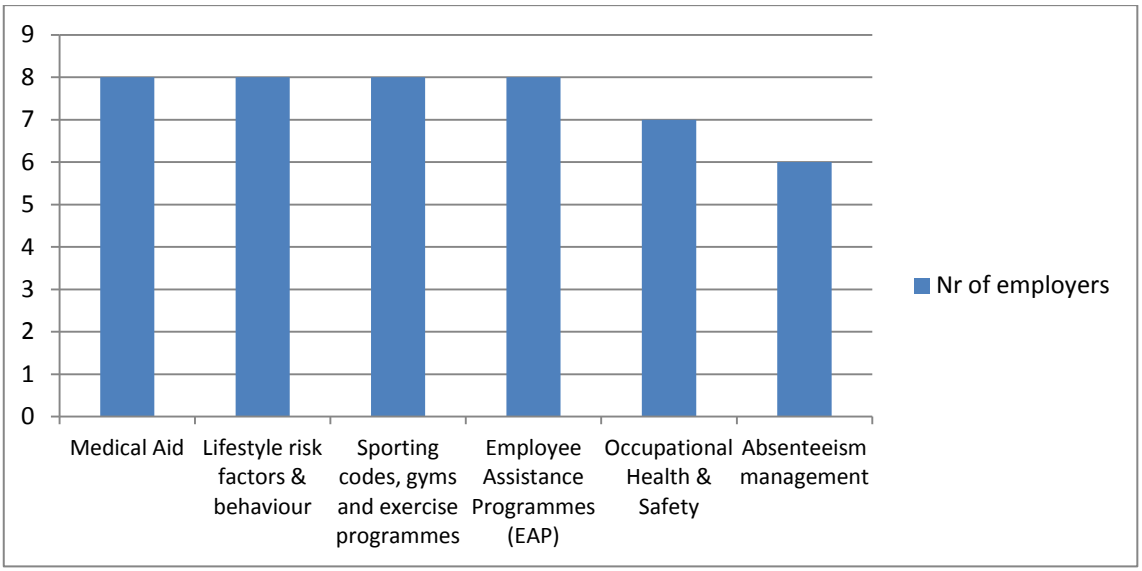
Figure 5.3. Experts' perceptions of important wellness programme benefits in order of ranking



Wellness programme benefits refer to programme activities, facilities or other received benefits that are employer-funded with the intent to improve employee health and wellness. Figure 5.3 highlights the perceptions of the four wellness programme experts (Sample 1) regarding elements of wellness programmes. All of them believed programmes had to have aspects that address lifestyle risks and behaviour. Only one of the experts did not mention disease management as an element that employers needed to focus on as part of their programme. Other elements that were indicated to be important according to the experts were occupational health and safety aspects as well as productivity and absenteeism management. Only one expert listed productivity management as a crucial element of a programme.

Sample 2 respondents, wellness programme custodians, were not asked of their opinion on crucial programme elements but rather requested to indicate the programmes that they did have in place.

Figure 5.4. Prevalence of workplace wellness programme benefits reported to be present by wellness programme custodians



This Figure 5.4 demonstrates the prevalence of various wellness programme benefits across the companies interviewed in this research study. All of companies reported having compulsory medical aid, lifestyle management programmes and a focus on physical exercise either through gym or sporting codes. All the employers had Employee Assistance Programmes (EAP) in place. Only one employer did not have an occupational health and safety focus. Of the eight employers, two did not have an absenteeism management programme.

In addition to the highlighted programmes, wellness custodians listed other varied programme benefits that they had in place. Among these were malaria awareness programmes, retirement preparation programmes and executive medicals. These have not been included in the list above for two reasons. Firstly, these programmes were targeted at a specific employees, for instance, the malaria programme was targeted at the staff that travel a lot, especially to malaria-endemic countries. Secondly, less than half of the respondents in this sample mentioned the programme. This was therefore not considered prevalent.

Table 5.3 indicates how the programme benefits, as depicted in Figure 5.4, were managed.

Table 5.3 Explanation of programme benefit management in Figure 5.4

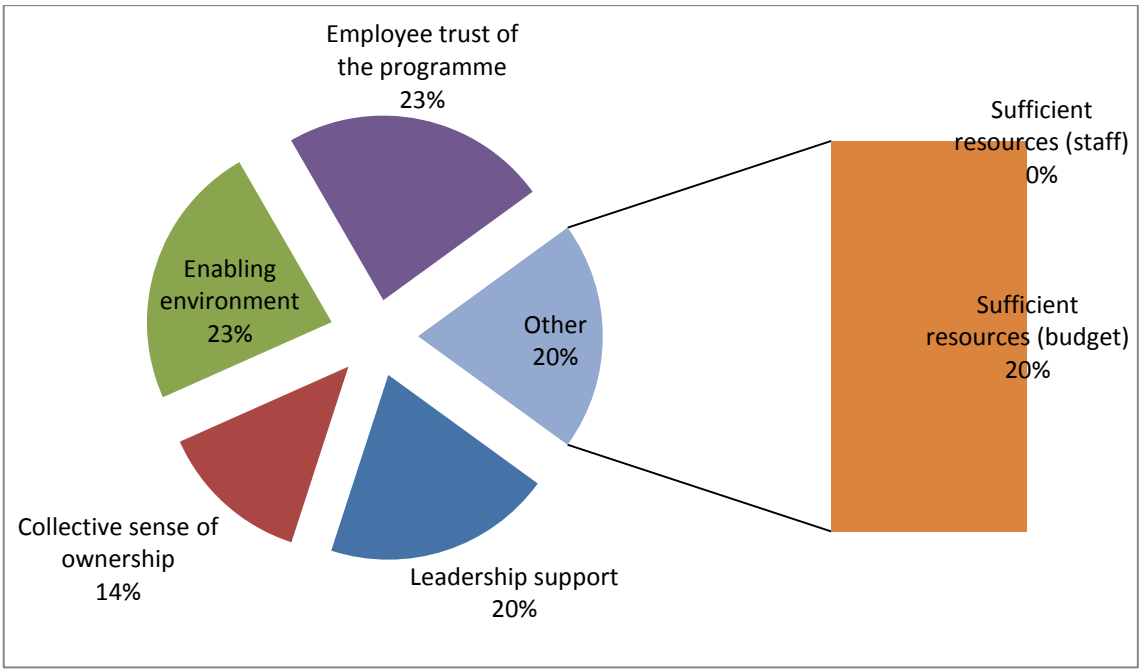
Programme benefits	**Explanation**

Medical Aid	Seven of the eight employers had compulsory medical aid requirements and of these seven employers, only one subsidised membership. Medical aid was used for personal health services and not for employer-funded services. Employers indicated that they held health events annually where some of the services would be paid for by medical aid if the employee wanted to access them.
Lifestyle risk factors & behaviour	All employers indicated that they follow the World Health Organisation (WHO) annual health calendar which promotes awareness of selected common medical conditions that can be managed through changes in lifestyle choices. Each month a different medical condition is recommended for entities such as employers to raise awareness on, through various modes of communication (articles, newsletters, health talks, etc.).
Sporting codes, gyms and exercise programmes	All employers had ongoing programmes aimed at promoting physical activities, such as onsite gyms, regular sport activities or fitness challenges that ran over a few months at a time. Although all employers had these programmes in place, all of them acknowledged that access to these programmes was not optimal, for instance one employer had an onsite gym at head office only and not at their satellite offices, while another employer indicated that gyms were present in most of their offices however the rates were similar to those payable at commercial gyms, for that reason, some employees could not afford them.
Employee Assistance Programmes (EAP)	All eight wellness programme custodians indicated that they had EAP in place. The programmes were outsourced to service providers who provided monthly reporting. Only one respondent had both an outsourced as well as an in-house-run EAP. Employers with large numbers of temporary staff only offered access to parts of EAP to these employees. Of three such employers, only two provided telephonic support while the third employer, whose temporary staff complement was more than 60% of the full staff complement, did not provide any wellness services to this group of staff.

Occupational Health & Safety	All but one respondent indicated that they have occupational health and safety programmes in place. One respondent of the seven had an occupational health based employee wellness programme which promoted health and wellness while attending to the legislative required health and safety regimens. This was the only programme of the seven where wellness programmes were integrated with health and safety. All other respondents with occupational health and safety indicated that the programmes are wholly managed by different divisions with little or no integration of services.
Absenteeism management	Only six of the eight respondents indicated that they had an absenteeism management programme in place. For some of the employers, this was completely integrated and managed by the wellness programme while some employers had different entities within their organisations that managed absence and were not integrated to the wellness programme. Wellness custodians had different ways in which they managed absence. Some programmes were more detailed and structured in comparison to others.
Executive wellness programmes	Five of the eight organisations interviewed had executive wellness programmes in place. These programmes targeted the most senior personnel within the organisation and provided personalised preventative lifestyle risk factor management. These programmes were also indicated by the respondents as having better follow up and chronic disease management. Measurement of outcomes was better conducted with these programmes as well.

5.2.2 Theme 2: Elements of workplace wellness programmes

Figure 5.5. Percentage of wellness programme custodians' reported elements of wellness programmes



Elements of a wellness programme are those aspects of the programme that indicate how a programme is managed or enablers of a programme. Elements of wellness programmes are the second aspect of programme 'comprehensiveness'. In collecting data to answer research question 1, questions related to programme enablers (elements of wellness programmes) were asked. Below is the data related to these questions.

Figure 5.5 shows the responses of Sample 2 (wellness programme custodians) to a list of wellness programme elements that were indicated in the literature as being crucial for programme success. The list had the following elements from which the respondents had to indicate "Yes" if they recognised this quality as a part of their programme and "NO" if they did not believe this was present in their programme:

- Visible senior management endorsement
- Collective sense of ownership
- Sufficient resources to support the wellness programme
- An enabling environment
- Employee trust in the programme

In responding to the question on available resources, all respondents differentiated between budget and human capacity to support them. All eight respondents cited that they did not have adequate staff to support their programme management. Six of the eight respondents indicated that an adequate budget was present for them to manage their programmes.

Two of the custodians out of eight reported that they did not enjoy adequate leadership support. Only half of the programme custodians believed that there was a collective sense of ownership of the programme amongst other managers and staff. Only one respondent believed the environment was not enabling for staff to fully utilise the services and the programme to be effective.

It is important to note that the list of wellness elements provided to the respondents to answer was interspersed with other questions related to employee experiences. This was done to eliminate the likelihood of respondents priming their responses thereby increasing bias. As a result the validity of the questionnaire as a measurement tool was potentially improved.

5.3 Research Question 2: How effective is the workplace wellness programme?

The following results relate to perceptions of effectiveness or success based on what companies measured. Sample 1 (experts) and Sample 2 (programme custodians) responses to measurement are reported here.

Questions designed to answer research question 2 were divided into three:

1. What were wellness programmes measuring? (**Measured outcomes**)

   This intended to establish what the programmes were measuring and evaluating in their programmes. By asking programmes to highlight what they report on regularly, this would confirm the type of outcomes they would be aware of or interested in. They were provided with a list of possible measurable outcomes to choose from through ticking the relevant measured outcomes.

2. What were they looking to achieve through their wellness programmes? (**Desired outcomes)**

   The programme custodians responded to questions regarding what they were looking to gain from the programme. This provided insight into what they should measure.

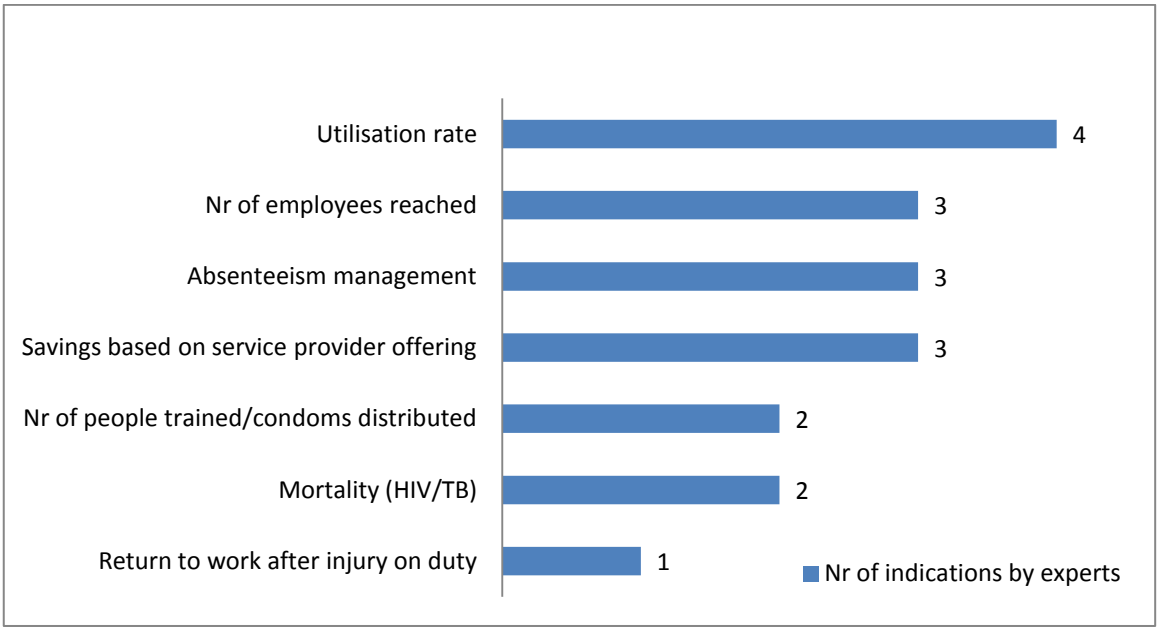
3. Lastly, what other measures outside of those on the list, did they achieve and were aware of or interested in measuring? (**Achieved outcomes**)

   This provided an opportunity to evaluate if wellness programmes were looking to achieve the same outcomes as those being sought by other programmes globally, i.e. health outcomes, cost savings and productivity.

5.3.1 Measured outcomes

Below, the view of experts (Sample 1) interviewed in this study regarding what they believe workplace programmes are measuring are presented first then followed by what the programme custodians (Sample 2) reported they measure. An indication is provided in Figure 5.7 of what the companies were looking to gain from the wellness programme by designing them in the manner that they did and whether this has been attained.

Figure 5.6 Most commonly measured indicators of wellness programmes according to Experts



The above Figure 5.6 demonstrates expert views on what employers' measure in their programmes. The experts were asked to name what, in their experience, has been measured by company wellness programmes.

Employee participation or programme uptake (utilisation rate) is the most measured outcome. The number of employees that were presented an opportunity to access a service (employees reached), absence from work and service provider effectiveness were some of the measures indicated to be prevalent amongst employer programmes. Service provider effectiveness was understood to be the service provider's feedback on how the company has benefited from the serviced being rendered to them. This is done either through demonstration of cost saving (return on investment) or through other means such as compliance of employees to treatment. According to experts, not many employers measure time away from work as a result of injury on duty. Only one expert indicated that to be a common measurement.

Employers with occupational health or legislative requirements were highlighted to be different in that they had hard measures of what was required from their measurement. "*If you've got a heavy manufacturing where there's a lot of legislation, your Occ health, your primary healthcare drives it. They're probably looking at more very strict evidence*" – Expert 3.

Figure 5.7 shows indicators that company programmes measure, ranked from the most measured to the least measured, as reported by the programme custodians. The respondents were provided a list of indicators based on literature findings. Respondents had to tick 'Yes' for indicators that they did measure and 'No' for those that were not measured. Below are the results of the measured indicators ranked in order of most measured to the least measured.

Figure 5.7 Indicators that company programmes measure according to wellness custodians represented from most measured to least

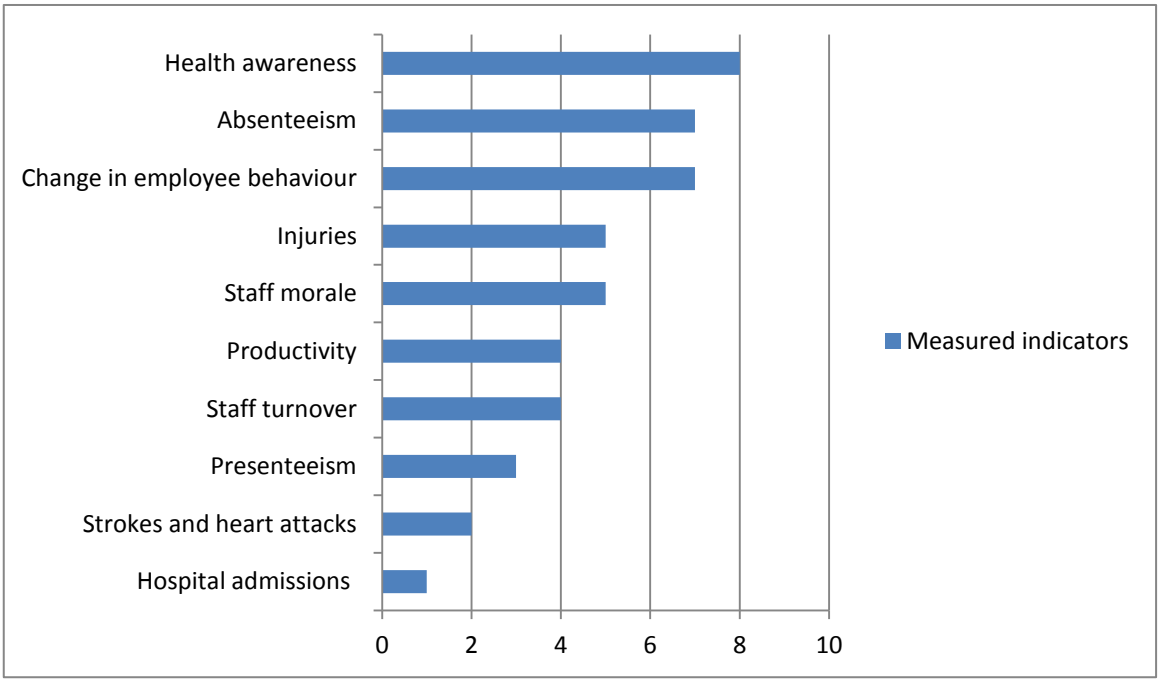


Figure 5.7 shows that all eight respondents agreed to measuring improvements in employee health awareness. All but one respondent indicated that they measure absence rate within their organisations. Health awareness, absence rate and changes in employee behaviour were the top three measured indicators by wellness programmes. The least measured from the provided list were hospital admissions, incidence of strokes and heart attacks as well as presenteeism.

In addition to the measures indicated above, some programme custodians highlighted the manner in which their measurements are done, which indicated dynamics of measuring outcomes. The detail did not relate to method but rather to the purpose of the measurement.

1. The wellness programmes were either not the only entities within the organisations that conducted health, wellness and occupational hygiene data measurements or the measured outcomes that they reported were not conducted by them.
    - Some measurements were conducted and managed by the wellness programmes.
    - Some were conducted by service providers who offer services to the employees and provide organisational reports, concealing confidential information. These services were common and necessary to ensure trust in the programme.
    - Some measures were reflective of wellness programme outcomes however entities who measured them were not linked to the programmes. Hospital admissions, for instance, were a desired measurable outcome that wellness programmes were interested and evaluated on however, the data is monitored by medical aid schemes. The focus therefore would vary based on who was conducting the measurement.

2. Respondents highlighted that entities within their organisations that oversee other aspects of employee wellness, such as occupational health and safety or injuries on duty divisions, did not link their operations with the wellness programmes. The different entities have meetings, share common strategic goals however, have separate operations and do not approach measurement of health or wellness indicators in similar patterns.

5.3.2 Desired outcomes

Programme custodians were further asked to indicate what their programmes were looking to achieve through their wellness programmes. This has been mapped out below and depicted alongside what the companies reported as their goals or objectives.

Figure 5.8 below ranks the desired outcomes as indicated by the programme custodians. In Chapter 6 these desired outcomes are discussed as programme goals and evaluated

against programme design to provide insight on whether companies enrol the right programme benefits and programme elements to support what they want to achieve.

Figure 5.8.Wellness programme desired outcomes according to wellness programme custodians

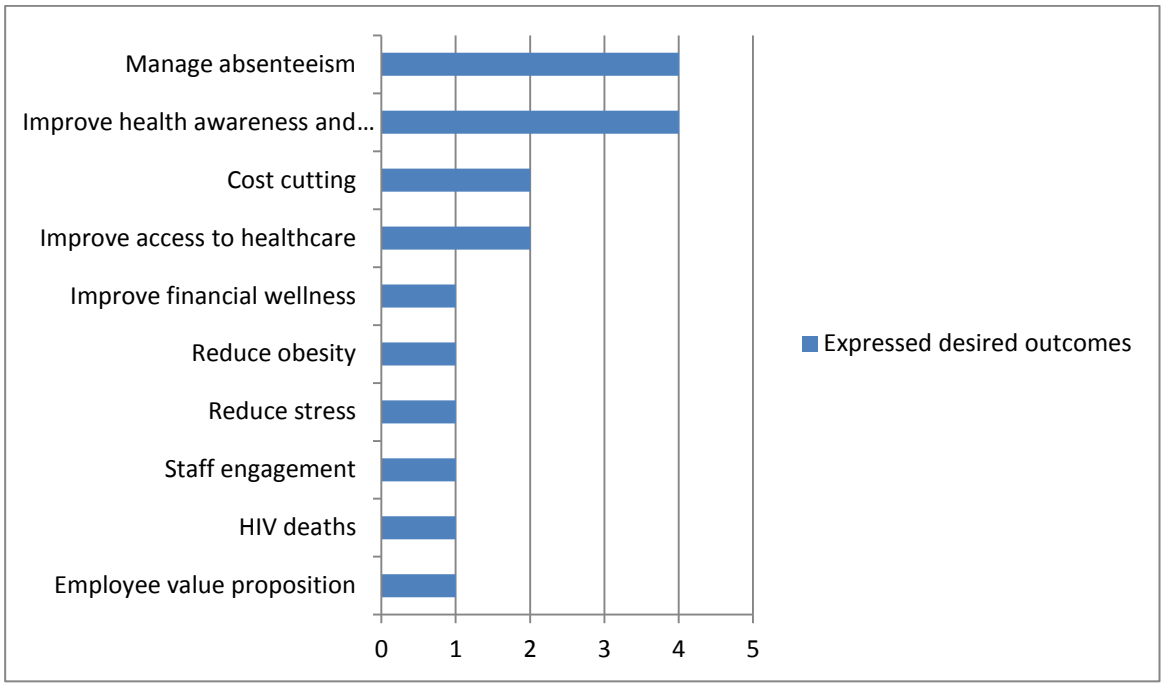


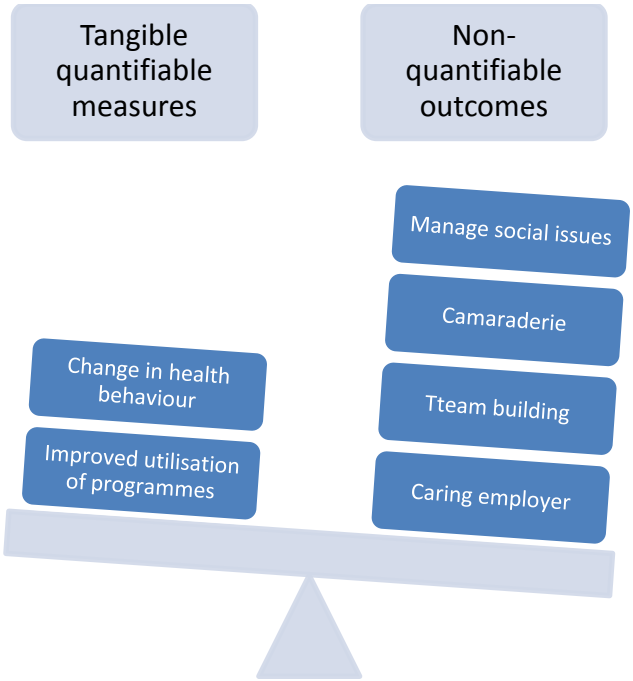
Figure 5.8 indicated that absenteeism management and improving employee awareness about healthy lifestyle were the two most important outcomes that programmes wanted to achieve. Cost cutting and improving access to healthcare were also most important to employers. It should be noted that experts were not requested to answer any questions regarding company desires as this would call more for speculation than an informed opinion.

5.3.3 Achieved outcomes

The third question intended to answer research question 2 required programme custodians to highlight what their programme had achieved which they were measuring and monitoring. This aspect of the question sought to highlight if South African programmes had any additional goals and objectives outside of the normal global outcomes (health outcomes, cost cutting and productivity). Experts were not requested to respond to this question.

Company responses varied widely on this question. Respondents highlighted achievements that are not quantifiable therefore not recognisable on reported outcomes however, very crucial to building organisations. Figure 5.9 depicts the varied responses of programme custodians on outcomes achieved by their programmes albeit unintended.

Figure 5.9 Responses of programme custodians on outcomes achieved by their programmes



In summary, questions aimed at answering research two were divided into those that evaluated measured outcomes, desired outcomes and achieved outcomes. Below, in Table 5.4, is a summary of responses as discussed above, aimed at answering research question two.

Table 5.4 Programme custodians' measured outcomes, desired outcomes and achieved (unexpected) outcomes

Company	Measured outcomes	Desired outcomes	Achieved outcomes
Company A	Reduced injuries on duty due to less stressed employees and reported	Absenteeism & cost cutting	Reduction in disciplinary hearings & better employer/employee relationship

	reduction in medical aid costs		
Company B	No demonstrable outcomes reported	Financial wellness, health awareness & reduced absenteeism	Utilisation rate of programme reported higher than benchmark
Company C	Record high utilisation rates	Improved health of employees & reduced absenteeism	Team building and perceived as caring employer
Company D	No demonstrable outcomes to report	Improved health awareness and access to healthcare	Positivity and trust of the programme by employees
Company E	Service provider reports indicate effective programme but custodian does not perceive it as such	Reduce obesity and stress	Line manager training increased referral of employees for support. Improved awareness.
Company F	Demonstrated return on investment on absenteeism management & high utilisation	Economic savings, improved absenteeism and staff engagement	Employees trust the programme
Company G	Quantified reduction in HIV deaths and exceptional utilization rates	Reduce HIV deaths & improve access to intervention	Improved employee relationships and camaraderie
Company H	Uptake so high, cannot keep up with demand & positive behaviour change	Good employee value proposition and preventative screening	Exceptionally high utilisation rates

In Table 5.4 above, Companies A, F and G have indicated that their measured and realised outcomes match those that they had set out to achieve (desired outcomes). These company outcomes are further analysed and discussed in chapter 6 and used to demonstrate crucial aspects that had been deemed essential in order to realise benefits in a workplace wellness programme.

5.4 Research Question 3: What are the challenges to measuring the impact of the wellness programmes?

The following results indicate responses related to challenges. They have been reported as challenges of implementing wellness programmes and challenges of measuring the outcomes of wellness programmes as experienced by wellness programme custodians.

In analysing the data from this study, the challenges reported by the interviewees, were evaluated against the programme design (where implementation challenges apply) or measured outcomes (where measurement challenges apply) to provide deeper insights into the comprehensiveness of wellness programmes. Both experts (Sample 1) of this study and wellness programme custodians (Sample 2) were asked to indicate what they believed were challenges experienced in implementing successful wellness programmes.

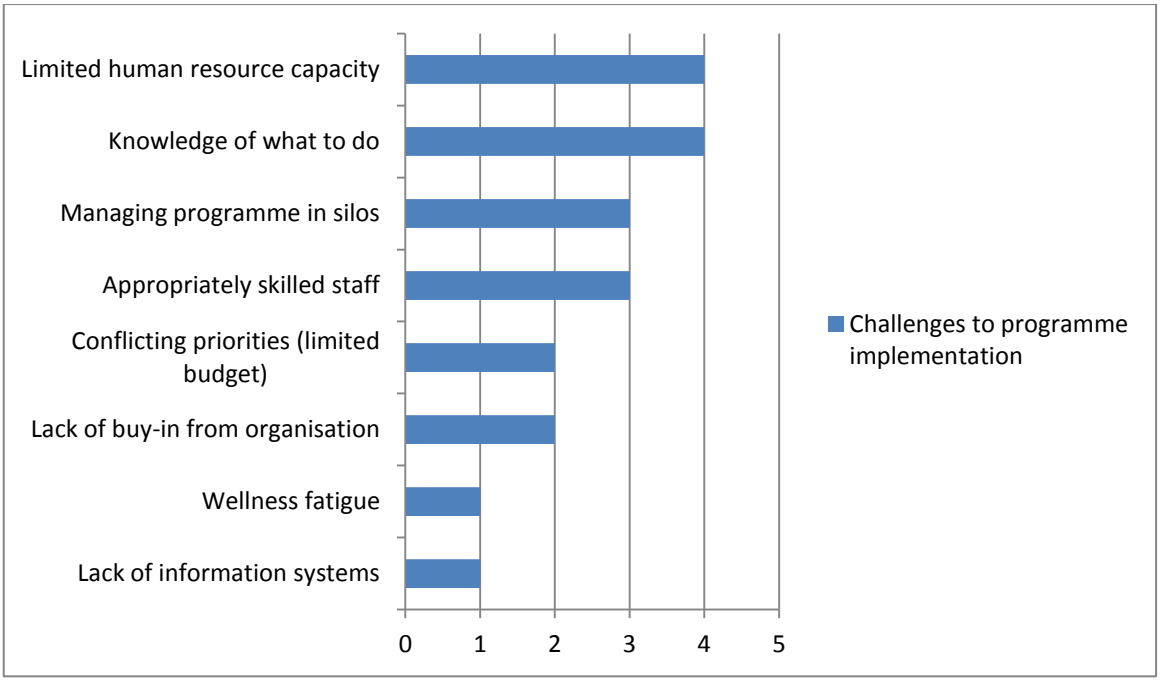
5.4.1 Implementation Challenges

Figure 5.10 highlights responses from the experts on challenges faced by companies in implementation of programmes. Limited human resource capacity, knowledge of what to do, programmes working in silos and lack of appropriately skilled staff were the top four challenges that wellness programme experts believe programmes are faced with. Wellness fatigue and lack of information systems were also indicated as programme implementation challenges, however, these did not appear to be prominent problems.

An expression from an expert to punctuate how programme implementation is managed in silos: *"... companies or corporates are not so good at doing is they view the information in isolation. So they don't often go here's my incapacity and disability information. Here is my absentee information. Here is even my pension provident fund information and my – and then connecting all those dots. They're not doing that*"- Expert 2

The wellness experts were required to indicate these challenges based on their experience and observation. It is notable that without any priming from the researcher or the questionnaire, all four respondents highlighted human resource capacity and knowledge and skilled programme management as the most abundant challenges.

Figure 5.10 Challenges to implementation of the programme according to experts (Sample 1)



Similar to the experts, Sample 2 respondents (wellness programme custodians) were requested to name what they viewed as presenting the most challenges to implementing successful programmes. Their responses are summarised in Figure 5.11 and ranked in accordance to frequency. Three of the most highlighted challenges were the lack of information systems to store and manage data, appropriately skilled staff and knowledge of what to do. The programme custodians acknowledged their limitations in employee wellness programme management. Challenges to lack of skill were highlighted both by programme custodians who reported achieving their goals and demonstrating positive wellness outputs, as well as those who did not report effective or successful programmes when outcomes of the programmes were discussed.

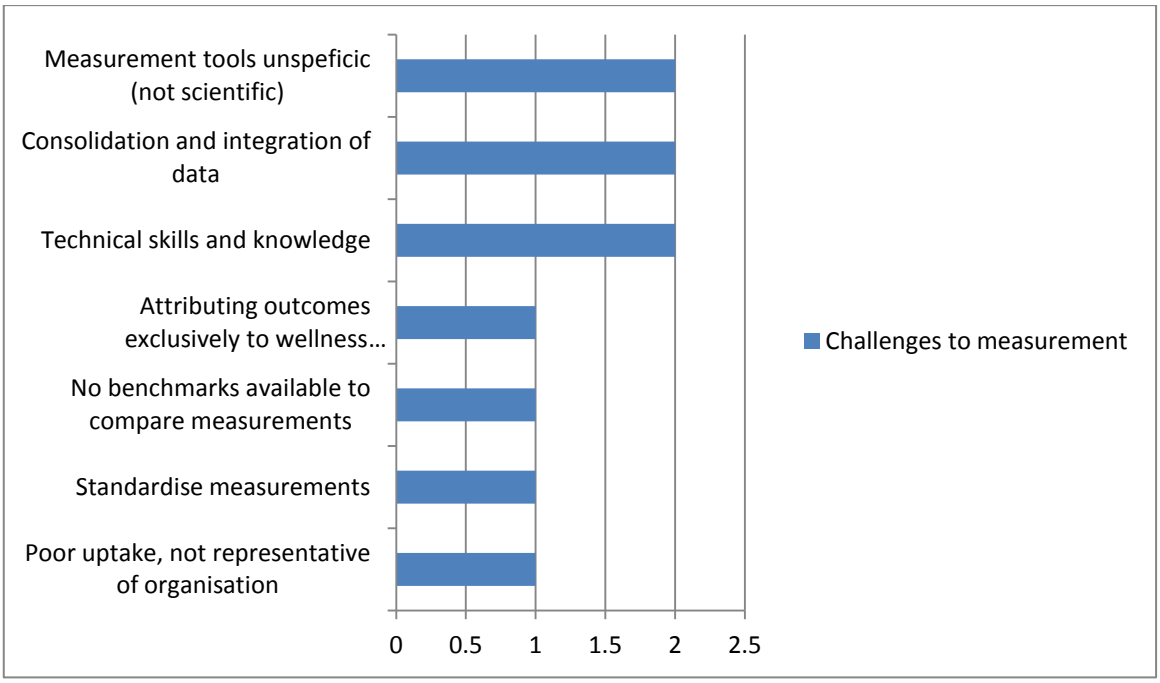
Figure 5.11 Challenges to implementation of the programme according to wellness programme custodians (Sample 2)

5.4.2 Measurement Challenges

Questions related to challenges also delved into what companies struggle with when measuring the outcomes of their programmes. Both experts (Sample 1) and wellness programme custodians (Sample 2) provided their views.

All four experts indicated that limited knowledge and lack of technical skills were the biggest challenges experienced by wellness programme custodians. In contrast, only two programme custodians believed their challenges rested with skills and technical measurement tools. There were no apparent highlights in the custodians' responses. They each indicated a different area of programme management. Consolidation and integration of data from different programmes were cited as other challenges while only one respondent (programme custodian) put forward their limited knowledge of managing wellness data and the lack of technical skills or understanding as a challenge (Figure 5.12).

Figure 5.12 Challenges to measurement of outcomes according to wellness programme custodians



5.5 Conclusion

The above data is reported alongside the research question it is intended to answer. The discussion on the significance of the above findings, in light of the theory available on programme comprehensiveness is found in Chapter 6.

Chapter 6: Discussion of Results

The purpose of this study was to establish if South African workplace wellness programmes have the elements required for them to experience their desired outcomes. This study was influenced by American research which demonstrated that companies with comprehensive programmes enjoy wellness programme outcomes.

The findings of this study first looked at what were the essential ingredients that needed to be in place for a programme to be considered comprehensive, with the understanding that once these factors are implemented, results would be guaranteed.
The findings of this research are discussed in line with the research questions as outlined in Chapter 3.

6.1 Demographics:

6.1.1 Average employee age

Studies on non-communicable diseases indicated that the most vulnerable population is the working age population, resulting in high employer costs (Reardon, 1998). Targeting preventative health programmes was therefore recommended as a solution not only for employer costs but for better employee health outcomes. High blood pressure and smoking were the leading lifestyle risk factors according to the Global Burden of Diseases, Injuries and Risk Factors study 2010 (GBD, 2012).

On evaluating average company age data, most employers had average employee ages between 36 and 45. This therefore indicated that they would be susceptible to similar health care related problems of non-communicable diseases. Healthy People (2010) objectives in relation to healthy workplaces which result in healthy employees, reduced health care costs and increased productivity, would be applicable to this group of employers when evaluating their data.

6.1.2 Educational level and employee work status

Health patterns are affected by different factors, amongst them, socio-economic developments and education. In fact, a study on the impact of socio-economic status on health found that employees with the lowest income and no education had the overall poorest health compared to those of higher income groups and higher levels of education (Braveman et al., 2010).

- Employee data collected in this research study highlighted five of the eight organisations interviewed had executive wellness programmes in place. There is an emphasis on senior management health outcomes amongst the organisations.
- The organisations interviewed provided perspectives on their programmes which serviced mostly their full-time employees. Three organisations had between 40% - 60% part-time employees. The part-time employees did not have full wellness programme benefits. In one of these organisations, the part-time staff had access to telephonic support only.
- In only one of the three organisations were the part-time staff skilled employees. They were mostly unskilled employees of low income level. Their outcomes were not included in the findings discussed.
- The one employer with an occupational health focus that integrated employee wellness objectives, the staff were mostly of less than high school qualification however all had full access to all services.

Glasgow (1993) highlighted that workplace wellness programmes provided services to employees who would otherwise not have engaged in healthy behaviour. In this research study the educational level of employees presented a disadvantage to the employees only if they were employed part-time. Because wellness programme benefits were only accessible to full-time staff, part-time staff who were mostly of low income level and poor educational level could not benefit from the programmes. Given that they were unlikely to access preventative healthcare services elsewhere, being a part-time employee did not improve access or health outcomes of this group of employees. Otherwise employers provided similar wellness benefits for all other employees. Senior management were prioritised in most of the organisations with specialised healthcare focus. Occupational health and safety services were compulsory for all employees who were employed in safety-critical roles therefore, their educational level was of no consequence. The organisations working in silo disadvantaged employees with a greater need for wellness services because of their low income level since they did not integrate their programmes.

6.2 Research Question 1: How comprehensive are workplace wellness programmes?

This research study identified two different aspects to comprehensiveness of a programme:

1. Employee benefits, those aspects that refer to programme activities, facilities or other received benefits that are employer-funded with the intent to improve employee health and wellness.
2. Elements of the programme, components of wellness programmes that indicate how a programme has been implemented, managed and being monitored. These factors are enablers of a programme.

In defining the comprehensiveness of a workplace wellness programme, literature contains much research that has outlined crucial components of workplace programmes. The most commonly used of these originate from the Healthy People (2010) report which evaluated outcomes of programmes in alignment with the objectives of the United States Department of Health and Human Services on healthy workplaces. They identified the crucial elements that define a comprehensive workplace wellness programme as: health education, supportive social and physical environment, integration of the worksite programmes into the organisation's structures, linkage to related programmes and screening programmes (Healthy People, 2010).

This research study identified various elements of wellness programmes in line with Healthy People (2010) however, the element of leadership was found missing from the Healthy People 2010 report.

A study by Wyatt, et al. (2015) which specifically looked at programmes that had reported successful outcomes concluded that successful programmes all had senior leadership endorsement, a collective sense of ownership, the presence of quick wins that participants could see and that participants believed the programme was easy and fun. This study included an explicit aspect of leadership which was not evident in the Healthy People (2010) study although discussed in other studies. Other stated elements of success addressed the role of managing the programme and strategically positioning the programme for success. Leadership was present in other studies as a crucial part of workplace programme success. The "Green H Award" wellness programme, by the US Navy and Marine, demonstrated better implementation and programme management success amongst groups where senior leadership involvement was high (Whiteman, 2001). The desired outcomes in these groups however, were varied (Whiteman, 2001).

Healthy People 2010 elements could be divided into activities (or staff benefits) that need to form part of the programme as well as strategic enablers or implementation factors that govern how programmes are managed. The former was represented by health education

and health screening, while the latter (strategic enablers) was represented by a supportive social and physical environment, integration of the programme into the organisation and linking the programme to other programmes. Wellness screening and health education were activities defined in the context of the United States healthy workplaces objectives. The RAND study (Mattke, 2013) found that most employers have begun to offer activities of wellness programmes as standard benefit packages. On reviewing research studies conducted over a 30 year period, in an attempt to prove whether workplace health promotion programmes work, Goetzel and Henke (2014) indicated that an important way to evaluate a successful programme from a failed programme is to measure it against its goals. This highlighted the importance of programme objectives when evaluating a programme.

In analysing the data found in this study to answer research question 1, employee benefits as indicated above were reviewed in line with activities that were mentioned in Healthy People (2010) while elements of wellness programmes were reviewed in line with the strategic enablers.

6.2.1 Employee benefits in wellness programmes

In evaluating which are the most prevalent employee benefits found in workplace wellness programmes, organisations were found to value:

1. Lifestyle risk assessments and behaviour change programmes
2. Exercise
3. Chronic disease management programmes
4. Employee Assistance Programmes (EAP)

This study found that employers had several programmes in place, all addressing various medical and health issues. The size of employer or the sector that they were in did not dictate which elements were in place. Workplace programmes appeared to address multiple health issues, even those that had a specified goal in mind, catered for several other medical conditions. For instance, employers whose programmes came about as a result of occupational health related legislation, where workplace hazards and mitigation were the focus, also had elements that addressed weight management and healthy diet.

In South Africa, a framework exists for public sector employers to implement programme benefits that focus on set pillars. These pillars seek to address lifestyle factors, disease management, occupational health and safety as well as absenteeism. None of the public sector employers interviewed used this framework strictly in their programme design.

Although they had the programme benefits reflected in this framework, they did not particularly refer to it as an instructive design that they used in designing their programmes. This research also found that employers did not integrate health and safety programmes with workplace wellness programmes. These departments were separately managed in all but one company and they each had their own focus. Wellness programme management monitored activities and benefits such as health promotion through events and informative articles, while occupational health and safety also monitored health risks related to workplace hazards and safety issues. Some of these health risks were similar but integration was noted not to be in place in these companies.

In looking at workplace programme benefits, the companies that were interviewed all had multiple benefits aimed at addressing different wellness issues. The average employee age and the sector or size of company did not seem to matter. Lifestyle risk factors that addressed behaviour were the most prevalent programme benefits found. These were all linked to exercise either in the form of gym or other physical activities. Employers all indicated that they follow the World Health Organisation (WHO) annual health calendar programmes that recommended raising of awareness on various common medical conditions. Wellness programmes also had elements necessary for comprehensiveness which will be discussed below.

6.2.2 Elements of wellness programmes

The second layer of programme design was inherent in 'how' the programme was implemented. This aspect referred to how a programme has been implemented, managed and monitored. The data pointed to aspects that engaged strategic intent, provided leadership endorsement and addressed resources required to roll-out the programme. These were the elements of the wellness programme.

According to Healthy People (2010), programme design elements are a supportive social and physical environment, integration of the wellness programme into the organisation's structure and linkage of the programme to others. In looking at these elements together with those indicated in Wyatt's (2015) study, presence of quick wins that employees can see, a sense that participation is fun and easy, trust in the programme and an enabling environment, were evaluated. The data from this study which relates to elements of wellness programmes was analysed in line with the findings of these two literature studies.

Literature on successful ingredients required in managing a wellness programme has yielded various findings with the most notable being the role of leadership. The study by Wyatt (2015) indicated that amongst other elements, successful programmes had senior leadership involvement and a collective sense of ownership. This research study found that the following in Table 6.1 were the elements of wellness programmes. The data in this study has been mapped against the different aspects of comprehensiveness and highlighted such that 'green' represents strongly present aspects of comprehensiveness, 'orange' represents weakly present aspects of comprehensiveness and 'red' represents aspects that are poorly present.

Table 6.1 The prevalence of elements of comprehensiveness in wellness programmes

Healthy People 2010	Wyatt, et al. (2015)	Data findings
Programme benefits (employee-focused factors)		
Health screening	Fun and easy activities	These were present in all employers
Health education	Quick wins	
Programme elements (programme design factors)		
	Leadership	Six of the two organisations reported leadership involvement
	Sense of ownership	
Supportive social and physical environment	Enabling environment	At least six of the respondents had these elements in place. Seven of the respondents indicated that they had adequate budget.
	Trust in the programme	
	Sufficient resources (budget)	
Integration into the organisation		One employer had integrated occupational health and safety and wellness programmes. One employer had organisationally aligned
Linkage to other programmes		

		surveys and feedback.

In Table 6.1 Wyatt's (2015) elements of comprehensiveness have been matched with those found in Healthy People (2010) and this study, in accordance to the areas of organisational involvement that they address. The blank spaces indicate that the relevant study did not highlight any elements that addressed areas of organisational involvement similar to the other study.

Leadership involvement, which influences wellness programme success and ownership, were found to be mildly present in the organisations interviewed in this study. Only one respondent indicated strong leadership involvement while other respondents acknowledged it could be much better. The least prevalent component was adequate staff resourcing. Although most of the respondents indicated adequate budget to manage their programmes, all of them cited inadequate human resource capacity.

Programme design elements associated with an environment that enabled the programme to thrive and induce trust in employees were reported by the respondents to be strongly present in their wellness programmes. In contrast, integration of wellness programmes into the organisation and across other organisational programmes were deemed absent by the respondents. These were depicted for instance in occupational health programmes where the ultimate outcomes are employee health and yet there was no collaboration with the wellness department in seven of the eight companies interviewed. Occupational health and safety measures are legislated and therefore compulsory for employees in safety-critical roles.

In response to whether they believed South African workplace wellness programmes were comprehensive, one of the experts indicated: "*Yes – where 'comprehensive' means ticking the boxes on a quantitative checklist example, counselling for employees (yes), health screening (yes), awareness programmes (yes), condom distribution (yes). 'No' – where 'comprehensive' includes programme services that achieve the goals/outcomes of the programme of for example reducing absenteeism. Many of them don't provide a service that is adequate and capable of producing these outcomes. Many such EWPs are not even measured in terms of proper return on investment*." - Expert 4. This quote punctuates the findings of research question 1 regarding the comprehensiveness of wellness programmes.

6.2.3 Conclusion on findings for research question 1

In reviewing the findings of this research study against literature, the organisations interviewed in this study had the required programme benefits indicated in the literature to consider their programmes comprehensive. It is notable however, that programme benefits outlined in the literature are largely aimed at addressing non-communicable diseases as these present the greatest global burden (GBD, 2012). Therefore, to qualify these findings, the data shows that only employers whose objectives were to manage non-communicable diseases had employee benefits that could be defined as comprehensive.

In so far as the elements of comprehensiveness were concerned, overall they were weakly present, most notably in how the wellness programme integrated and linked into the organisation's structures. Research does not indicate any of the elements as superior to others in contributing towards programme success. This research data did not provide any such indication either.

In response to whether wellness programmes are comprehensive, the interviewed organisations were only comprehensive in so far as providing employees with necessary programmes and creating an environment for them to access wellness programmes. However, they were found not to be comprehensive at strategic enablers required for the programmes to yield benefits.

6.3 Research Question 2: How effective is the wellness programme?

Introduction

This study looked to establish whether workplace wellness programmes had reported any positive outcomes or benefits. This is used to look back at the design of the programme to evaluate if it had been deemed comprehensive and therefore could attribute its benefits to the comprehensiveness of its nature.

Literature indicates that in evaluating data from wellness programmes, it is important to do so against the backdrop of programme objectives (Goetzel, 2014). The success or failure of a programme is in relation to the objectives that the programme had set. Other research conducted by Parks and Steelman (2008) found that participation in a wellness programme on its own, irrespective of the comprehensiveness of the programme, yielded positive results specific to absenteeism and job satisfaction. What was not highlighted was

the extent to which the benefits were evident between those organisations with comprehensive programmes and those with non-comprehensive programmes.

6.3.1 Measured outcomes

- Utilisation rate or participation in wellness programmes was the most prevalent outcome measured by wellness programmes. Employers reviewed the number of people who gained access to services and health promotion material.
- Absenteeism rates were the second most measured outcome by wellness programmes.
- The third most measured outcome related to whether implemented programmes were successful, such as employee behaviour changes.

Wellness programme custodians indicated that they outsourced services to specialist providers and utilised the reports on their findings to monitor their programmes. The benefit they derived from using such providers was reported utilisation rates in line with benchmarks. This provided the companies with a sense of how well they were doing in comparison to their peers.

Employers received various reports from service providers and some from other organisational structures such as Human Resources or Injury on Duty departments and monitored these results at regular intervals. Their views on the performance of the wellness programmes were based on these indicators over months, quarters and years.
Two organisations highlighted specific objectives in line with their programmes:

Company F: Organisational objective was to lower absenteeism rates. Various service providers who offer EAP, wellness screening, HIV/Aids management provide reports at regular intervals indicating how the services have impacted absence. Collectively, planning is done with these providers on how to further impact the rates of absence through the services they provide.

Company G: The wellness programme was established as a result of the high numbers of HIV deaths experienced by the organisation. They reported using both external service providers and internally dedicated staff with clinical training to manage the programme. The programme custodian indicated a lack of sufficient reliable measurement tools however, according to experience, *"I remember when I came I would visit them. They would be like at home for three months and nothing was going on. We no longer have that." – Company G*

In analysing the data from this study, two organisations reported specific goals which formed the basis on which they measured their outcomes, irrespective of the wellness service they engaged with. This was found to be in line with literature on having objectives. These organisations found articulated their measurements in line with their organisation's objectives, irrespective of the services, providing clarity on what required measurement and whether their targets were being met.

A second highlight from this study, outside of the goal-directed measurement of outcomes, was the use of utilisation rates as an important outcome to employers. All programme custodians highlighted this marker as useful, especially when accompanied by a benchmark. These rates were indicated by some employers as continuously improving while others reported the measures as fluctuant. Research from Parks and Steelman (2008) indicated that participation in wellness programmes on its own was adequate to impact absenteeism and job satisfaction. With most employers measuring absenteeism rates, most reported some improvement in absence however had no knowledge of how to evaluate what the reason for this change was.

In summary, employers mostly measured utilisation rates of services and absenteeism however most did not conduct these measurements against a backdrop of an organisational goal or strategic directive, except for two companies. Benchmarks were used instead as an indicator of good performance or poor performance. In view of the number of employers who reported measuring outcomes and experiencing positive results, albeit small or inconsistent, evaluation of the impact of comprehensiveness of the programme was not easy to establish. This means that programmes could have experienced positive outcomes from an absenteeism perspective not because the programmes were comprehensive but rather due to other factors which they could not explain since there were no moderators or measurements against a specified objective.

6.3.2 Desired outcomes

Wellness custodians had to identify what their wellness programmes had hoped to gain through the programmes that they had in place. These desired outcomes are reported below.

Literature highlighted health outcomes, cost savings on health-related spending as well as an improvement in productivity as the global objectives of wellness programmes (Mattke, 2013). In managing wellness programmes, success according to a panel of wellness

experts is when a programme accomplishes what it aimed to accomplish (Goetzel, et al., 2014).

Programme custodians reported what they measured within their programmes. This was compared to what they indicated as their desired programme outcomes to evaluate if they measured what they wanted to find from their programmes.

In this research study, programme custodians indicated absenteeism management and improvement of employee health as the main reasons they initiated their programmes.
In looking at what was measured, three organisations highlighted that they measured indicators reflective of what they reported were the main foci or desires of their programmes:

- The first programme came into being as a result of HIV deaths amongst the employees. The programme had a specific HIV management oriented focus. Although the programme grew to encompass multiple other elements and foci, HIV-concerted efforts were always distinct with the resultant increase in HIV screening uptake through the workplace programme, increased HIV registration on the disease management programme and ultimately a reduction in HIV deaths. The company also reports a reduction in absence duration (length of time spent away from work) from HIV related illness compared to nine years ago when the programme was initiated. The HIV-oriented programme demonstrated a reduction in absence frequency (the number of times an employee is absent) as a result of HIV. This programme also demonstrated a reduction in absence duration (the length of time an employee was absent) as a consequence of HIV illness. Incapacity management reported shorter and fewer employees with HIV. The custodian reported tangibly fewer deaths as a result of HIV (previously attended funerals of employees who died from HIV related illnesses) in quantified numbers. What was evident was that multiple platforms of measurement correlated the same information. Additionally, of interest was that this organisation did not report an overall reduction in employee absenteeism or productivity, only relative to HIV. The assertion was that there were potentially other factors affecting their absence rates however, they are certainly not due to HIV.

- The second programme was implemented to manage employee absenteeism. In the six years that goal-directed concerted effort was made to reduce employee absence, the programme grew in other ways and includes management of other health issues. The employer reported a quantified and proven reduction in employee absence and a quantified rand saving per rand spent on the programme.

- The third programme sought to reduce health care spend for both the organisation as well as the employees. The organisation reported measuring health care spend and reporting to senior management annually. The healthcare spend was quantified and measured by the company's closed medical aid scheme. The wellness programme provided no input into the measurements. The programme custodian indicated no integration between the scheme and the company wellness programme. The respondent could not attribute the reported reduction in healthcare spend by the medical aid to the wellness programme.

An important distinction existed between the two organisations with demonstrated outcomes and the organisation whose outcomes were measured outside the wellness programme. The management and ownership of measuring outcomes resided outside the programme with no integration between the medical aid services and the wellness programme. This research study requires further theory to substantiate this apparent gap. How accurately can outside entities measure the impact of a wellness programme? What are the factors that require being in place and what kinds of outcomes can be accurately measured in this manner?

In summary, when the desired outcomes of the organisations were viewed against what the employers were actively measuring (measured outcomes), in order to establish if wellness programmes were geared to enjoy benefits of their programmes, only three organisations reflected measurements in line with what they sought to achieve with their programmes. One organisation had an objective to reduce absence and actively measured absenteeism in their programmes, another established a programme due to HIV deaths and actively measured HIV impact in their programmes on an ongoing basis. The last sought to reduce health care costs and reported monitoring health care spend on a regular basis.

6.3.3 Achieved outcomes

Respondents highlighted positive wins from their programmes even though they may not be wellness related or in line with what they had hoped to achieve. These outcomes may be intangible however attributable to the programme.

Research conducted by Wyatt (2015) interviewed companies that had reported successful workplace programmes in order to understand how successful programmes were

developed and implemented. They concluded that successful programmes were characterised by senior management endorsement, a collective sense of ownership, the presence of quick wins that participants could see as well as a sense that participation was easy and fun (Wyatt, 2015). They also identified trust as an important part of a programme and that it developed over time. They further suggested that without creating an enabling environment, the programme would most likely have a poor uptake and retention (Wyatt, 2015).

This research looked at the factors similar to those in the Wyatt (2015) study in interviewing the various companies however, did not arrive at the same conclusion. Most employers reported the presence of quick wins, fun and easy activities, trust in the programme and an enabling environment. The literature indicates these elements will bring about increased uptake on the programme which has been reported by the interviewed organisations however, the custodians did not believe their programmes were successful.

Whether the programme was effective or successful seemed to be quite subjective for all the companies that were interviewed, including those who could demonstrate positive outcomes. Organisations that had not defined what success looked like, although their programmes indicated some positive outcomes, perceived their programmes as not effective.

Looking at Wyatt's (2015) elements of a comprehensive wellness programme, the organisations interviewed in this research study reported weak presence of leadership involvement. The strong presence of other elements and the weak presence of senior leadership involvement still enabled them to demonstrate the outcome highlighted in Wyatt's study, of increased uptake and utilisation. It is concluded then that increased uptake is not regarded by wellness programmes as an end-goal and that increased uptake can be achieved with minimal influence from senior leadership.

An important finding regarding outcomes or measurement resided in uptake or employee participation. At least two of the organisations interviewed cited the absence of benchmarks as a challenge faced by employers who sought to compare themselves against their peers. The value placed by wellness custodians on uptake was notable. This was the case as participation is an important reportable factor by wellness programme service providers. Participation is reported and benchmarked against other organisations,

creating a picture for the employer as to how entrenched wellness programmes are within their environment (in comparison to other companies).
Parks and Steelman (2008) found that participation in a wellness programme yielded results, even though the programme was not comprehensive. In view of employers who highlighted the need to provide access to healthcare services to their employees, uptake or participation was deemed an appropriate measure to evaluate success of the programme goals.

All the respondents to this research study identified some positive wins. These were reductions in absenteeism, although small or visible healthy behaviour amongst employees, increased trust in the wellness programme, a sense of camaraderie amongst employees regarding wellness services and other company-specific outcomes. These outcomes were not quantifiable outcomes. Studies have shown that wellness programmes provide direct outcomes such as cost savings or reductions in absenteeism and that they provide indirect results such as job satisfaction (Parks & Steelman, 2008) and improved quality of life (Berry, 2010).

In summary, the organisations interviewed in this research study had all experienced benefits from having wellness programmes. These benefits were not necessarily those the organisations had set out to achieve. They were mostly intangible outcomes involving social issues and aspects that created a sense of belonging, which employers could use for their employee value propositions.

The second finding was that leadership involvement was not a significant contributor to attaining results highlighted by Wyatt (2015), such as increased uptake or utilisation rates. Utilisation rates were found to be a good measure for employers looking to increase access to healthcare services for their employees.

In response to research question 2 on: How effective is the workplace wellness programme, this research study had sought to evaluate effectiveness of programmes through reviewing results obtained by organisations against their programme's design. If the company reported positive findings from their wellness programme, whether they were found to be comprehensive in their design would then be evaluated in order to establish if the results came about as a result of the programme being comprehensive. This research study found that there were various types of benefits from wellness programmes. Organisations all experienced what could be considered indirect results or benefits purely

from having a programme in place. These results were not identified to have been linked to any deliberate design of the programme. This supports literature findings that stipulate that absence and job satisfaction were found in employees who simply participated in programmes that were non-comprehensive. The direct results of wellness programmes, such as lowering HIV deaths (mortality rates) were only observed in employers who had set those goals firstly, secondly, had measured those outcomes in more than one programme.

6.4 Research Question 3: What are the challenges to measuring the impact of the wellness programmes?

This research question sought to understand why companies would not be as effective or as successful as they desired. This was also aimed at those companies with some success, to highlight what hurdles they identified to further success. Respondents were requested to highlight their challenges and relate them to where they believed their stumbling blocks were.

Two areas of challenges were identified in this research question:

1. Challenges to implementing a comprehensive wellness programme
2. Challenges to measuring outcomes of the wellness programme.

On evaluating what are the crucial aspects needed for programmes to be successful, Goetzel (2014) indicated that the design of the programme as well as its implementation were determinants of successful programmes. These aspects had to be based on evidence-based practices. The RAND study (Mattke, 2013) highlighted well-designed, well-executed workplace wellness programs as a requirement to reducing health risks, health care costs and improving productivity. In looking to identify challenges through this research study, the questions addressed challenges related to design and implementation separately from those of measurement.

6.4.1 Challenges to wellness programme implementation

The most notable challenge expressed by experts for failure of employers to implement comprehensive programmes was the lack of resources and funds. The experts believed that *"most organisations have not yet bought into the business case of wellness and so they don't see this expense as an investment."* – Expert 3. One of the programme

custodians indicated the inability to create a convincing picture to leadership to support allocation of funds, although the funds existed.

This research found lack of resources, human capacity in particular, as the most commonly cited reason by both experts and programme custodians, presenting an implementation challenge. This was indicated on two levels.

- Firstly, the skill of the programme custodian as a recipient of data and decision maker was crucial in determining implementation success. Five out of eight programme custodians indicated that they at times were not certain what they needed to do. They receive valuable data from service providers and from wellness programme events and activities however, they often are not sure how to effect changes to manage identified health risks.
- The second level of resource lack is in the form of support staff. Wellness programmes were resoundingly understaffed, as pointed out by both the custodians of programmes as well as the experts. Their human resources that facilitate events, activities, reporting and service provider management were scarce. *"We finally have the numbers but now cannot keep up with the demand" – Company H*.

6.4.2 Challenges to measurement of wellness outcomes

Gandjour's (2010) cost-effectiveness model has been used to prove that implementation costs for disease management programmes have a better impact than downstream costs of disease treatment. Similar other studies have indicated how wellness programmes can use models and calculators to quantify outcomes related to what could be considered the hard and fast outcomes such as cost savings and healthcare outcomes.

The findings in this research study related to challenges related to the wellness custodian's ability to manage the programme and not related to methods of measurement. The greatest challenge that respondents highlighted was the ability to credibly quantify all their reported positive outcomes. This was either due to lack of skill (the know-how) or resources to conduct proper measurement (feasibility studies or impact analysis conducted by actuaries). The lack of skill was most commonly cited. Even when calculations are made, the role of the custodian in interpreting and effecting the recommendations, were of utmost importance.

In summary, although this study attempted to highlight challenges related to implementation of wellness programmes separately from those related to measurement,

the overall finding was the skill of the wellness custodian which was deemed crucial in correct implementation and proper measurement of outcomes.
In response to research question 3, on the challenges wellness programmes experienced, firstly in implementing comprehensive programmes and secondly in deriving their desired benefits, this study found knowledge and skill of the wellness programme custodian an important factor.

In conclusion, this research study found that workplace wellness programmes had the appropriate employee benefits required for a comprehensive programme to be run. These benefits were found to be adequate in both large and small employers as well as public and private sector employers. The programmes were found to be lacking in elements of integration that would allow them to link wellness programmes to other facilities and services within the business. Elements of senior leadership involvement were found to be weakly present in wellness programmes however no direct impact of this element was noted in this study.

Two kinds of outcomes or measurables were evident from this study. Organisations that derived the outcomes that they desired were found to have goals in place that provided strategic direction and therefore positive results. Organisations that were not goal-directed only experienced the indirect results of wellness programmes such as staff morale boost and a sense of belonging amongst the stuff.

Comprehensiveness of wellness programmes was not found to be the obstacle to successful wellness programmes. The knowledge and skill of the wellness programme custodian was found to be greatest determinant of programme success. Programmes with skilled custodians were goal-directed and derived benefits despite the presence of poor senior leadership involvement and lack of integration between company programmes.

Chapter 7: Conclusion

7.1 Principal findings

The purpose of this study was to establish if South African workplace wellness programmes have the elements required for them to experience their desired outcomes. This study was influenced by American research which demonstrated that companies with comprehensive programmes in place enjoy wellness programme outcomes.

Following in-depth interviews with wellness programme experts and wellness programme custodians, this study found that South African wellness programmes were comprehensive. Using a combination of literature findings to define comprehensiveness, Healthy People (2010) elements were used together with elements found in Wyatt's (2015) study.

- South African workplace wellness programmes were found to be comprehensive. They had adequate employee benefits to enable employees to access healthcare services and optimise their health and had optimal enabling environments with the exception of human resource capacity. Wellness programmes were found to be sparsely resourced with staff to manage and monitor programmes.

- Leadership involvement did not positively influence the outcome of the programme. Workplace programmes that demonstrated good outcomes reported weak senior management involvement. Overall leadership involvement was poor amongst participant organisations. The level of leadership required to effect positive outcomes in the organisation was not clear from the custodians or the experts.

  This research interviewed fairly senior personnel within wellness programme structures who could be viewed as having moderating impact in that they influence employee perceptions of wellness programmes. Further research is required in establishing the level of leadership and the degree of influence it has.

- The impact of goal-oriented wellness programmes as demonstrated in Goetzel (2014) was evident in this study. Programmes with goal-directed wellness programmes were able to yield desired outcomes through measurement of the same outcome across various services. It is notable that cross organisational integration was absent in these companies that showed results. The additive impact of integration on these companies is expected to improve the outcomes even further.

- Utilisation rate was the most measured outcome amongst the wellness programmes. The benefit of the use of benchmarks was questionable amongst wellness programmes who sought the benchmark to gauge their performance amongst their peers. In goal-directed wellness programmes, utilisation rates were used to gauge improvement in implemented services, based on the company's own benchmark. The use of utilisation rates was notably beneficial for organisations who sought to measure access to healthcare services. With research findings indicating positive outcomes even with non-comprehensive wellness programmes (Parks & Steelman, 2008), companies can capitalise on the benefits of staff morale, job satisfaction and reduced absenteeism and improve their outcomes in those areas of focus. Some of the respondents in this study indicated employee value proposition as an important part of what the company looked for in a programme.

- Some organisations who participated in the study had up to 60% temporary staff who were of low income and lower education level. This group of employees had high staff turnover and did not have access to wellness benefits, except for one employer who provided limited access. The health outcomes of these employees who do not access wellness benefits were not discussed (as the organisations do not offer any benefits to them) in this study however research showing that these employees have poorer health conditions (Braveman, 2010) indicates they are compromised on both ends. Offered employment does not provide access to basic healthcare benefits nor does it compensate adequately for these employees to afford private healthcare. Currently, temporary employment for these employees does not improve healthcare outcomes.

7.2 Implications for management

Findings from this research study are relevant for senior organisational leadership as well as heads of human resource divisions and wellness programme custodians.

1. <u>Recommendations to senior leadership</u>

a. Workplace wellness programmes have been proven to benefit employees in various indirect ways and offer good value proposition for organisations looking to attract and retain good talent. Employees who utilise any wellness programme services were noted to have reduced absence from work and a sense of belonging or camaraderie.

b. Wellness programmes provide potential to reach a high percentage of employees, including many who would otherwise be unlikely to engage in preventive health

behaviours (Glasgow, 1993). Furthermore, low income employees with poor educational levels have the poorest health in comparison to employees of higher income and better education (Braveman, 2010). Organisations with temporary employees who are of low income and educational level and have no access to wellness programme services disenfranchise this group while robbing the organisation of an opportunity for improved absence and productivity rates.

2. Recommendations to heads of human resource divisions

a. Investments into wellness programmes which focus on preventative health have been shown to be beneficial down the line from a cost perspective when compared to management of non-communicable diseases (Sangita, 2012). However, in order to derive maximum benefit from the programme, a highly skilled wellness programme custodian has proven to provide better programme outcomes than a custodian without the knowledge and backround of wellness programme management.

b. Wellness programmes that were goal-directed where monitoring and evaluation of the desired outcome occurs throughout all programmes yielded better outcomes than organisations without any such goals. Organisations should link their wellness programme strategies into the organisational strategy in order to have better management and understanding of outcomes.

3. Recommendations to wellness programme custodians

Utilisation rate or uptake is a good indicator of access to healthcare services by employees however, when it is not tied to a programme goal, utilisation rate on its own is a weak indicator of programme success. Successful wellness programmes are goal-directed and evidence-based.

7.3 Limitations of the research

The following were limitations of this research study:

1. Interviews may be limiting in terms of the information that respondents may be comfortable with disclosing. Less than adequate information may be obtained through such a process that exposes the participant as well as their organisation (Marshall, & Rossman, 2006).

2. The findings are limited in the extent to which they can be generalised. Only organisations based in Gauteng, South Africa were interviewed and approaching organisations that are likely to agree to such an interview may exclude programmes that are comprehensive and enjoy benefits.

3. Interviewer bias, a common occurrence among qualitative studies. When conducting an interview the researcher may have certain expectations, such as getting answers to the questions in the questionnaire. As a result of pursuing recordings and information relevant only to the research questions, relevant information may be excluded. Also an interviewer may influence the way the respondent answers in order to obtain a particular answer. This is all mitigated through reflective thinking.

4. The sampling process favoured companies that were known to their servicing wellness consultants to have multiple employee benefits and wellness initiatives in place. The process also favoured employers more likely to want to discuss their programme outcomes.

7.4 Suggestions for future research

1. Given that organisations outsource wellness programme services to more skilled and better capacitated service providers, what are the differences in impact of programmes with heavy reliance on service providers compared to those managed by internal resources with better knowledge of organisational culture. Based on findings that wellness programmes performance is improved with integration into the organisation's culture and linkage to other structures within the organisation, how effective are externally managed programmes with limited ability to influence organisational culture and cross organisational structures.

2. Goal-directed wellness programmes were shown to yield better results. The results evident in this research study related to one goal. How many focused goals can organisations have and monitor with optimum outcomes. The single-goal directed focus enabled programmes to address a single outcome through all other services creating better focus. Could this approach be effective with multiple goals.

3. How can employers structure wellness programme benefits in a cost effective manner for high staff turnover groups of workers, such as temporary workers. Low income earners are most likely to be employed as temporary workers and have high staff

turnover. In improving access to healthcare to these workers who mostly do not receive employee benefits, workplaces can investigate options available to offer temporary employees wellness benefits. How can this be achieved in a cost effective manner.

THE END

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APPENDICES

1. CONSENT FORM FOR SAMPLE 1 (EXPERTS)

[Sample 1]

CONSENT FORM FOR PARTICIPATING IN A STUDY

Study Title:	How Comprehensive are Worksite Wellness Programmes?
Principal Researcher:	Dr Lerato Motshudi
Institution:	Gordon Institute of Business Science (GIBS)

Researcher:
Dr Lerato Motshudi
leratomotshudi@gmail.com
072 741 6210

Research Supervisor:
[redacted]

AVAILABLE ON REQUEST

Dear participant,

1. Introduction

You are invited to participate in a research study conducted by Dr Lerato Motshudi. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions which are not fully explained in this leaflet, do not hesitate to ask.

2. The nature and purpose of this study

Literature suggests that in order for wellness programmes to yield benefits, they have to be comprehensive. The aim of this study therefore is to evaluate whether worksite wellness programmes are comprehensive, if they have shown any benefits and the challenges experienced by companies in getting their programmes to be effective and measuring the benefits.

3. Explanation of procedures to be followed

Your participation will involve answering questions where you will be requested to elaborate on your view and experience. The questions relate to worksite wellness programme designs, the elements that are found in the programmes, how companies measure the benefits they derive from the programmes as well as the challenges they experience.

4. Risks and benefits

There are no known risks or benefits to participating in this study. This study will help in the understanding of wellness programme designs, what informs the elements of the programmes, how effective you believe the elements of the programmes have been and the challenges experienced in measuring the effectiveness and benefits.

5. Ethical approval

This study was submitted to the Gordon Institute of Business Science Ethics Committee as well as the University of Pretoria Research Ethics Committee and written approval has been granted.

6. Confidentiality

The names of the participants will be included in the research report however the results will be published or presented in such a fashion that the wellness programme details and the individuals interviewed remain unidentifiable.

7. Voluntary participation

I have read the above information before signing this consent form. The content and meaning of it is clear to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate I will not be disadvantaged in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

_____	_____	_____
Name	**Signature**	**Date**
_____	_____	_____
Researcher's name	**Signature**	**Date**
_____	_____	_____
Witness' name	**Signature**	**Date**

2. CONSENT FORM FOR SAMPLE 2 (WELLNESS PROGRAMME CUSTODIANS)

[Sample 2]

CONSENT FORM FOR PARTICIPATING IN A STUDY

Study Title:	How Comprehensive are Worksite Wellness Programmes?
Principal Researcher:	Dr Lerato Motshudi
Institution:	Gordon Institute of Business Science (GIBS)

Researcher:
Dr Lerato Motshudi
leratomotshudi@gmail.com
72 741 6210

Research Supervisor:
[redacted]
AVAILABLE ON REQUEST

Dear participant,

1. **Introduction**

You are invited to participate in a research study conducted by Dr Lerato Motshudi. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions which are not fully explained in this leaflet, do not hesitate to ask.

2. **The nature and purpose of this study**

Literature suggests that in order for wellness programmes to yield benefits, they have to be comprehensive. The aim of this study therefore is to evaluate whether worksite wellness programmes are comprehensive, if they have shown any benefits and the challenges experienced by companies in getting their programmes to be effective and measuring the benefits.

3. **Explanation of procedures to be followed**

Your participation will involve answering questions from a standardised questionnaire about your company's wellness programme and to elaborate on some of the answers provided.

4. **Risks and benefits**

There are no known risks or benefits to participating in this study. This study will help in the understanding of your company's wellness programme design, what informs the elements of the programme, how effective you believe the elements of the programme have been and the challenges you have experienced in measuring the effectiveness of your company's benefits.

5. Ethical approval

This study was submitted to the Gordon Institute of Business Science Ethics Committee as well as the University of Pretoria Research Ethics Committee and written approval has been granted.

6. Confidentiality

The names of the participating companies will be included in the research report however the results will be published or presented in such a fashion that the wellness programme details and the individuals interviewed remain unidentifiable.

7. Voluntary participation

I have read the above information before signing this consent form. The content and meaning of it is clear to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate I will not be disadvantaged in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

3. QUESTIONNAIRE FOR SAMPLE 1 (EXPETS)

Questionnaire [Sample 1]

How Comprehensive are Workplace Wellness Programmes?

There are two parts to this study. This study interviews subject matter experts, as well as participating companies with wellness programmes in place.

Sample 1 – Subject matter experts

Subject matter experts in the field of employee wellness programmes will be interviewed in order to gain a perspective on their experience with companies that have wellness programmes. The experts will be asked questions related to the elements that in their experience make up wellness programmes in local companies and their view on how comprehensive these are. Their opinion will be sought on whether or not they deem these companies' programmes to be comprehensive enough to yield desired outcomes. In addition, they will be asked to indicate challenges that they believe these companies experience in trying to refine their programmes to make them comprehensive as well as those experienced in trying to measure outcomes or effectiveness of their programmes.

Section A

Personal Information

Full Name: _____

Last **First** **Initials**

Name of organisation: _____

Job title: _____

E-mail address: _____

Section B

RESEARCH QUESTION 1: How comprehensive is the worksite wellness programme?

1.1 What are the common elements found in worksite wellness programmes?

1.2 What do most company worry about with regard to wellness?

1.3 What do companies use to decide on the components of their wellness programmes?

1.4 Do companies use evidence-based methods to decide on the design of their wellness programmes (e.g. CDC health score card)?

1.5 What do you believe are the elements of a comprehensive wellness programme?

1.6 Do you believe most companies have comprehensive wellness programmes in place?

RESEARCH QUESTION 2: How effective is the wellness programme?

2.1 In your experience do companies measure the outcomes of their wellness programmes?

2.2 If so, what outcomes do they usually measure?

2.3 If not, what are the possible reasons for not doing so?

2.4 Which of the following outcomes are companies usually interested in?

	YES or NO
EMPLOYEE LEVEL	
Lower absenteeism	
Lower presenteeism (Presenteeism means being present at work but not productive)	
Improved work productivity	
Visible signs of healthy behavior	
Awareness of risk factors for chronic conditions	
Reduced rate of injuries	
Reduced acute incidents such as strokes or heart attacks	
Reduced rate of hospital admissions	
Reduction in staff turnover	
Improved staff morale	
ORGANISATIONAL LEVEL	
Visible senior management endorsement	
Collective sense of ownership	
Structured execution of wellness programme	
Presence of quick wins that participants can see	
Participation is easy and fun	
Sufficient resources to support the wellness programme	
Quantified savings on healthcare costs	
An enabling environment for uptake and retention	
Employees appear to trust the objectives of the programme	

2.5 Are the measured outcomes relevant to the company's pressing concerns?

2.6 What do you think companies should be measuring?

RESEARCH QUESTION 3: What are the challenges to measuring the impact of the wellness programme?

3.1 What do you believe are the challenges that companies experience with implementing comprehensive wellness programmes?

3.2 What challenges do you think companies experience with measuring the effectiveness of their wellness programmes?

3.3 Of the following wellness programme elements, which ones do companies struggle the most with measuring, and why? Number the elements, using the blocks on the left, in line with what you believe is decreasing amount of difficulty to measure, and elaborate on the reasons in the box on the right.

	Compare participants with non-participants of the wellness programmes	
	Measure the incidence of health outcomes and compare to previous years e.g. number of strokes, hospital admissions, HIV positive new infections, etc.	
	Compare health outcomes of the same participants before and after participating in various wellness programmes	
	Evaluating programme features, employee-feedback surveys, accomplished wellness projects, etc. in order to refine wellness offering	

The End

4. QUESTIONNAIRE FOR SAMPLE 2 (WELLNESS PROGRAMME CUSTODIANS)

Questionnaire [Sample 2]

Introduction

Sample 2 – Participating companies with wellness programmes in place.

Worksite wellness programme managers or human resource managers overseeing wellness programmes will be interviewed. These participants have to be directly involved with the design and management of the wellness programmes in order to answer questions from this study.

Employer Information

Personal Information

Full Name: _____

Last **First** **Initials**

Name of organisation: _____

Job title: _____

E-mail address: _____

Work Phone: _____ **Alternate Phone:** _____

Employee Characteristics

Number of employees who benefit from the worksite wellness programme:							
	<100		**100 - 249**		**250 -749**		**≥750**
Average Age:							
Work status:	**% Full time**		**% Part time**		**% Temporary**		
Education level:	**% less than high school**						
	% High school graduates						
	% Some post-matric qualification						
	% Tertiary qualification						
	% Post graduate/advanced qualification						

Organisation's Business Type

Public sector: _____ **Private sector:** _____

Other (Specify): _____

Employee Benefits

Which of the following programmes does the employer contribute to?

Medical aid cover	
Health education **(e.g. awareness articles; newsletters or posters; health talks)**	
Any form of Employee Assistance Programme (EAP)	
Supportive health improvement programmes **(e.g. subsidized gym membership; occupational health; primary health clinic)**	
Employee health screening with follow-up **(health risk assessments (HRAs) and biometric screen)**	
Other (specify)	

Data Collection Questions

RESEARCH QUESTION 1: How comprehensive is the worksite wellness programme?

This part of the questionnaire seeks to understand all the elements that make up your worksite wellness programme, as well as how those elements were decided upon.

Are you aware of the Centre for Disease Control and Prevention's (CDC) Worksite Health Scorecard?

Yes ☐ **No** ☐

If yes, how have you used it in any way in your organisation's wellness programme?

If not, what guidelines has your organisation used to inform the implementation and management of your wellness programmes?

Which elements are represented in your organisation's wellness programme? Tick the relevant box on the left.

	ELEMENTS	DESCRIPTION
	Organisational support	All levels of management are committed and openly endorse the programme; wellness permeates through to other organisational policies; company-sponsored incentives; wellness committee
	Lifestyle behaviour	Tobacco control; nutrition; physical exercise
	Diseases of lifestyle	High blood pressure control; Diabetes control
	Mental illness	Screening for depression; awareness and training for managers on working with employees with depression
	Managing Complications	Awareness of symptoms and signs of stroke and heart attacks
	Emergency response	First aid Marshalls; training in CPR (cardiopulmonary resuscitation); Defibrillator in the building
	Occupational Health and Safety	Training on injury-avoidance; injury-on-duty policy and benefits
	Infection control and prevention	Flu vaccines; hand-washing posters; TB screening
	Affiliation with community resources	Medical aid broker; cancer-support groups; local TB clinic; GP practices

What additional wellness programmes does your organisation offer?

(e.g. Travel vaccines; executive wellness medicals; stress management; lactation centre)

1.2.2 How did your company identify which programmes to offer?

Do the programmes apply to all employees or only some of the employees?

1.2.5 If the programmes do not apply to all employees, what is the inclusion criteria?

Please rate the degree to which the following elements are reflected in your organisation's wellness programme.

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Your organisation's wellness programme includes health education					
Health education is communicated on multiple platforms					
Health education is varied (articles, posters, newsletters, health talks, etc.)					
Health education is directed at different lifestyle diseases (diabetes, cancer, high blood pressure) lifestyle behavior (smoking, weight loss, exercise, etc.)					
The wellness initiatives support the social environment and physical environment					
Your work environment a smoke-free environment					

Your cafeteria has healthy food options					
Your vending machines have healthy snacks					
There is a focus on ergonomics					
Your organisation has an on-site gym facility					
Your organisation incentivizes physical exercise (allocated bike racks; pedometer competitions, etc.)					
Wellness concepts are linked to other structures or functions of employee benefits					
The wellness programme educates managers on how to manage employee absenteeism					
The wellness programme supports salaries, payroll and other departments that require direct intervention **(e.g. employees with garnishee orders are referred for financial wellness, etc.)**					
Your employees undergo screenings with adequate treatment and follow-up					
The company facilitates employee health risk assessments					

The programme has referral processes for managing employees with abnormal findings					
The programme provides for employees to be followed up to assess improvement					
The treatment facilities are easily accessible **(optometry, biokineticist, physiotherapy, nurse, etc.)**					
The programme provides treatment for HIV					

RESEARCH QUESTION 2: How effective is the wellness programme?

This part of the questionnaire seeks to understand whether your company periodically measures the outcomes of your wellness programmes. If so, are there any benefits derived from these programmes, and were these the outcomes you were hoping to achieve.

2.1. Do you believe the worksite wellness programme is effective?

Yes ☐ **No** ☐

Please explain:

_____

_____

2.2. In attempting to understand how effective the wellness programme is from an employee and organisational level, please answer YES or NO if you are aware of the following factors:

	YES or NO
EMPLOYEE LEVEL	
Lower absenteeism	
Lower presenteeism (Presenteeism means being present at work but not productive)	
Improved work productivity	
Visible signs of healthy behavior	
Awareness of risk factors for chronic conditions	
Reduced rate of injuries	
Reduced acute incidents such as strokes or heart attacks	
Reduced rate of hospital admissions	
Reduction in staff turnover	
Improved staff morale	
ORGANISATIONAL LEVEL	
Visible senior management endorsement	
Collective sense of ownership	
Structured execution of wellness programme	
Presence of quick wins that participants can see	
Participation is easy and fun	
Sufficient resources to support the wellness programme	
Quantified savings on healthcare costs	
An enabling environment for uptake and retention	
Employees appear to trust the objectives of the programme	

2.3 Which of the outcomes listed above are in line with what your company sought to achieve with its wellness programme?

2.4 Are there any additional positive outcomes that you have experienced?

RESEARCH QUESTION 3: What are the challenges to measuring the impact of the wellness programme?

Do you measure the benefits of your wellness programmes?

Yes ☐ **No** ☐

If not, why have you not measured the effect of your wellness programme?

If yes, what benefits have you experienced?

How do you measure the benefits?

In the box on the left, tick the categories that represent the methods your organisation uses to measure the impact of your programme.

In the box on the right, elaborate on the actual elements or statistics that you use to measure the impact of your wellness programmes.

	Compare participants with non-participants of the wellness programmes	
	Measure the incidence of health outcomes and compare to previous years e.g. number of strokes, hospital admissions, HIV positive new infections, etc.	

	Compare health outcomes of the same participants before and after participating in various wellness programmes	
	Evaluating programme features, employee-feedback surveys, accomplished wellness projects, etc. in order to refine wellness offering	

What are the challenges to measuring the impact of your wellness programme?

The End