

CORPORATE HEALTH AND WELLNESS IN NORTHERN IRELAND

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Much attention is currently being directed in the business community to optimising the human resource. Manpower planning strategies have recently been advocated by Cairns and Thompson (1988) to provide efficient and effective utilisation of this principal resource. Of central concern to this objective should be the health and wellness of the individual employee. This article portrays the findings of a survey on health and wellness in the workplace for a sample from the four industrial sectors in Northern Ireland. Attention was directed at current practice, level of awareness and attitudes to the concept of corporate health and wellness among senior executives. Implications for the introduction of some form of company programme were also investigated.

It is now widely accepted that health is not simply freedom from disease but a subtle blend of physical, emotional, psychological and social elements resulting in an individual's relative state of well-being, or wellness. This notion has been advocated by Stroot (1989) as a priority for the World Health Organisation. Over the last decade, in particular, there has been a growing trend for companies, notably in North America, to provide health promotion programmes at the worksite (Klarreich, 1987). The broad underlying assumption currently being examined by Shephard (1989) and Work (1989) is that optimal health can be aspired to through improved lifestyle resulting in the employee avoiding illness while the company enjoys increased productivity.

Corporate health and wellness programmes (CHWP's), along with their various pseudonyms, are widely varying in contained elements and their level of sophistication. Examples of these elements include clinical health screening, physiological function, dietary analysis and nutritional guidance, stress management, weight management and provision for physical fitness training. The number of CHWP's in the United States is

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reported by Saxl (1984, cited in Klarreich, 1987) to have increased 100-fold between 1979 and 1982 while a more recent survey of the 'Fortune 500' companies cited by Jones (1987) indicated that 70% of 239 responding companies had specific programmes with an average age of five to six years.

A survey conducted by the ministry of tourism and recreation in Ontario, Canada (1984) found that one-third of all companies in Ontario (about 2600) offered at least one of three major identified kinds of programme. In Australia in 1979 the Commonwealth Department of Health stated:

"... the potential of worksite health promotion is largely unrealised, but that the occupational health services are better placed for a positive program of health promotion than almost any other community agency"

as cited by Jones (1988, p13). The same author goes on to illustrate the findings of a survey conducted by the National Heart Foundation throughout Australia which revealed health promotion initiatives in 53% of the companies investigated. In mainland Britain, a recent survey (Petty, 1989) found that only four out of forty top companies (thirty-six of which were listed in The Times 1000 Index) were able to offer comprehensive facilities at work to cater for the needs of health, activity, diet, nutrition and the psychological well-being of their employees. No such data are currently available for Northern Ireland businesses, hence the reason for undertaking this survey.

Method

A judgement sample of 55 firms was selected from a total of 293 companies in Northern Ireland employing over 100 people. The sample was drawn from the four industrial sectors of manufacturing, engineering, service and the food and drink trades. An initial contact letter and telephone call requesting an interview met with a 57% response rate, resulting in a sample of 30 companies concentrated in the Greater Belfast catchment area of the University along with some large employers in the North-West of the Province.

A qualitative investigation was conducted in the form of "depth" interviews with the managing director of these companies (where practical) or with an alternate senior executive (usually the personnel manager). The interview lasted 30-45 mins and covered the following discussion topics: company employment profile, provision for sport/leisure, provision for medical screening, absenteeism and special policies, e.g. alcohol, smoking.

Current Provision

Sixty percent of the sample had active sports and social clubs, open to all employees. In many cases, the social aspect of the club was given equal weight, if not more than the sporting activities and in companies where the level of club membership was particularly high, this did not automatically imply a strong commitment to health and fitness-related aspects and participation in physical activity.

All respondents expressed an interest in corporate sport, even those without a formal sports club. The most common sports club activities are shown in Table 1. These activities were normally available to retired employees and family members as well as to current employees. Sports clubs were more frequently found in the service sector with banks in particular having large active clubs where individual sports were more popular, whereas in engineering firms team sports predominated.

Table 1: *Types of activity available*

	%
Football	94
Golf	67
Squash	33
Swimming	33

The sports clubs were all jointly managed by employee/management committees. Equally, the clubs were jointly funded with the company generally providing an annual capital grant and employees paying a nominal membership subscription. Only 13% of companies had any "in-house" sports facilities (gym, weights room and soccer pitches). The remainder of the sample used local leisure centres and public amenities.

Pre-employment health screening was common to 83% of the sample. In these companies, employees at all levels were screened and in all cases the company paid for medical screening. There were two common forms of screening:—

- (i) questionnaire completed by either the individual or a local general practitioner which concentrated on medical history rather than on health, wellbeing and fitness.
- (ii) medical examination completed either by a local doctor or company medical examiner which varied from a preliminary basic screening to a detailed clinical testing.

The type and degree of initial medical screening depended upon two variables:—

- (i) job characteristics — 24% of respondents noted that skilled and manual jobs had particular characteristics which required employees to be fit and healthy. Accordingly, the screening process tended to concentrate on specific tests, e.g., ear and eye tests, blood pressure profiles.
- (ii) levels of seniority — 24% of the sample's senior executives were more rigorously tested than manual employees. In these cases the screening process involved more detailed testing, e.g., heart and lung functions, blood/urine testing and cholesterol screening and blood pressure monitoring.

Few of the respondents reported that the initial employment screening was routinely followed up.

Corporate Healthcare

Twenty four percent of the sample reported that some of their employees worked with hazardous materials (usually radioactive materials or X-rays). These companies complied with the statutory obligation to test exposed employees every twelve months. However, these tests were specifically designed to check exposure levels rather than to monitor the employees' general level of health and fitness.

Manufacturing companies reported a number of varied hazards ranging from dust to caustic substances. A particular hazard reported in service companies was VDU exposure. In all cases Health and Safety regulations were followed and where necessary employees were offered regular eye and ear testing. In contrast, senior managers were more likely to be offered regular health screening as a "perk" of the job.

Twenty four percent of the sample reported an increasing demand, from all levels within the company, for some type of health screening. In the last 24 months, 33% of companies had introduced cholesterol screening, cervical cancer screening and/or blood pressure monitoring. However, respondents noted an uneven take-up rate for these evaluations even though in all cases the tests were funded by the company.

The survey used absenteeism rates as an indication of both job satisfaction and the relative health/wellbeing of a workforce. However, 33% of the sample did not regularly monitor absentee rates. The remainder of the sample reported absentee rates ranging from almost 3% to 13% at various levels within the company. Rates were found to be universally higher for manual/hourly paid employees than for middle/senior management.

Almost all respondents remarked that often the "stated" reasons for absences was not the "real" reason. The most commonly stated reasons for absence are provided in Table 2, the speculated "real" reasons included "sunshine", "parades" and the "Monday morning syndrome".

Table 2: *Stated reasons for absence from work*

Seasonal Illnesses (Colds, flu etc.)
Stomach Upsets
Nervous Debility
Back Problems
Family Problems

Most of the companies had designated smoking areas, particularly in production areas, but it was normally left to individual offices to declare a no-smoking zone. Thirty percent of the sample referred to their company's alcohol policy and saw this as a way of promoting fitness and wellness.

Attitudes to corporate health and wellness

All respondents agreed that health and wellness, both in emotional and physical terms, could affect an employee's contribution to their organisation. Almost all the sample linked health and wellness directly to job satisfaction and felt that "good" health led to increased morale among the workforce, lower absenteeism and therefore higher productivity. Stress was seen as a management/executive problem rather than a major concern at factory floor level where physical ill-health was associated with repetitive jobs. The respondents acknowledged that a fitter person might cope with stress more effectively.

The concept of CHWP's was given an enthusiastic response. No one argued against the basic value of such programmes in terms of increased well being for the individual. However, most respondents were unsure about the value of a programme to their own company. The first question asked by almost all respondents was "*what will it cost the company in terms of hard cash and time-off*". Cost was seen as a critical factor in the decision to participate and in addition, many interviewees saw health/wellbeing as the responsibility of the individual rather than a company responsibility.

At an average cost of approximately £150-£200 per individual for the complete programme, most respondents felt that any participation would have to be limited to senior management. The cost to the company of instigating the programme on the shop-floor was seen as prohibitive. However, this restrictive approach concerned some managers who thought that it may cause problems with unions.

It was agreed that it was often difficult to encourage employees to take advantage of voluntary screening. One Managing Director was concerned that his workforce would regard this type of programme as “*management trying to inflict its own values on the employees*”. Another noted that if a corporate health and wellness programme was offered as an optional extra, a number of employees would ask for the “*money*” instead.

In most cases the proposed model for a CHWP (see Table 3) was seen as a possible perk for top management. However, as absenteeism rates at this level were usually extremely low the direct benefits to the company were difficult to appreciate. Respondents agreed that the greatest need for health/wellness was at shop-floor level. Several respondents suggested that questionnaires or pamphlets were a much more cost effective way of tackling the problem at this level.

Appropriateness of Programme Type

Generally, it was accepted that all four stages contained within the proposed CHWP were worthwhile (see Table 3). However, because of the cost many thought Stages I and II would be most relevant. Several respondents indicated that they considered parts (a) and (b) of Stage I to be most appropriate.

Table 3: *A Corporate Health and Wellness Programme*

Stage I: Initial Screening to assess:

- (a) Clinical Health Status
- (b) Exercise/Physical Activity patterns
- (c) Stress Status/Coping Strategies
- (d) Dietary/Nutritional status

Stage II: Assessment

Information acquired in Stage I would be investigated in-depth within each of the areas examined which would involved a variety of recognised health assessment procedures.

Stage III: Intervention

- (a) Resource Package dissemination
- (b) Design and implementation of a programme
- (c) Referral to specialist

Stage IV: Evaluation

Each stage could be evaluated as a unit and suitable modifications made for subsequent progression through entire programme.

Evaluation

The majority of respondents were sceptical about the appropriateness of

a health and wellness programme for their company and expressed doubts about the cost-savings benefits. They would need to consider carefully details with respect to:

- (i) the cost of behalf of the company
- (ii) the time involvement for all staff
- (iii) the precise details of programme
- (iv) the specific benefits to their company.

All companies were interested in the suggested programme to the extent that they considered further discussion of the issues and implications worthwhile. Sixteen percent of the companies interviewed expressed a high level of interest and were enthusiastic about the programme outlined in the proposed CHWP model.

Conclusions

The objectives of health and wellness programmes, in general, are to decrease illness, improve health awareness and to lower medical care costs. In North America in particular, different sectors of society have responded to this challenge. Patton (1986) outlines the specific roles played by the commercial setting, the corporate sector and the community setting including — social service agencies, schools and medical agencies. As Jones (1987) states, the cost burden of medical care is being progressively transferred from government agencies to the private sector. This is in response to the projected trend for this expenditure to dramatically increase with health care costs totalling \$384 billion in 1984, \$489 billion in 1987 rising to an estimated value of \$1 trillion in the year 2000.

Several companies in North America have initiated CHWP's, some of which have been referred to and evaluated in Klarreich (1987). Overall, the response to these evaluations has been a reported improvement in health awareness among employees, improved morale and a decrease in absenteeism. Shephard (1989) thoroughly investigates the economics of CHWPs concluding that such programmes are beneficial in terms of cost-effectiveness even in the short term, particularly when exercise is provided as part of the total package. The cost-benefit ratio for certain industrial programmes has been reported to be between \$2 and \$5 for every dollar invested (Shephard, 1989).

It has been pointed out by Klarreich (1987) that today 50-80% of premature deaths are caused by lifestyle generated maladies or "diseases of choice". Yet over the last three decades there has been a 40% decline in the incidence of coronary heart diseases in North America (Feinlieb, 1984) which may be attributed to the direct and overt change in lifestyle

of North Americans. By contrast, age-standardised mortality rates from heart diseases in 1985 places Northern Ireland at the top of the world league table (Uemura and Pisa, 1988) with no observed decline to date. While other sectors of Northern Ireland society have begun to address and implement the directives of health and wellness, the corporate sector clearly lags behind its North American and even its U.K. counterparts. In Britain, CBI has estimated that approximately 350 million working days are lost each year due to absence, resulting in a £5 billion pound loss to the economy, yet there has been little response from industry to tackle this problem. Thus, it may be said that the value of employee health care provision appears to be low on the priority list for improvement in the operational effectiveness of the workforce in general.

The present study of awareness and implementation of CHWPs in Northern Ireland highlights a significant gap between current attitudes and current practice. Generally, respondents were positive to the concept of CHWPs but were not convinced that it was a company responsibility. The advantages of CHWPs were seen by senior management as increased efficiency, greater job satisfaction and better morale. Disadvantages were perceived to be costs, time involved, motivation of employees, possible union objections and location and availability of facilities. Industry in the Province generally has a reactive rather than a proactive approach to health and wellness and while most firms have access to medical/occupational health facilities, these tend to cater for industrial injuries and routine illnesses rather than to promote positive health initiatives. It is evident that the corporate sector in Northern Ireland could play an important role in addressing the current levels of premature morbidity and mortality by implementing some form of health and wellness initiatives. Attention should be focussed on all levels of the workforce, albeit with particular emphases on specific subgroups within the tier structure. Table 3 illustrates the various elements of a comprehensive CHWP which may be used as a model from which a company could select those components most suited or relevant to its particular needs. For example, initial screening could be extended to include stress status and dietary habits as well as the conventional clinical health status appraisal. More in-depth assessment of identified maladies could be performed with specific intervention methods designed and implemented. These in turn should then be evaluated to provide subsequent progression through the entire programme. In particular, some form of intervention strategy could be operationalised right away which would encourage employees to become more aware of positive health issues as well as to promote subtle lifestyle changes. Examples of such measures might include canteen food appraisal, lunch-time seminars on a range of topics and facilitation for regular participation in physical activity. The latter may include in-house

provision in some instances, but for the majority would involve accessing local leisure/recreational centres.

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