Application of the Stinson Personal Wellness Model in Making Workplace Health and Wellness Decisions

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Abstract: Indian corporate world has been fast adopting employee wellness practices, similar to their global counterparts. Employers are aware of the long term benefits of these practices on employee retention, employee productivity, attracting talent etc and are thus becoming strategic differentiators for the employer brand. The current pattern for implementation of wellness practices has been either through imitating/practicing prevailing industry practices or outsourced vendor suggestions. This blind adaptation does not serve the purpose of well thought out wellness process. In order to address the issue the author refers Stinson model of personal wellness in designing a well-structured wellness pathway for the corporate set up in India.

Introduction

The National Institute for Health and Clinical Excellence (NICE) has recently produced guidance on workplace health promotion (NICE, 2008). Part of this includes a practical tool to assist organisations with analysing the costs associated with implementing such a programme. The NICE report purports that addressing the health and wellbeing of the workforce is imperative for organisational success and states that, “a healthy, committed workforce is vital to business success”

Literature review

The origin and roots of wellness can be traced back in the history of Indian healing and medicine discipline of yoga and meditation as well as the system of medicine known as Ayurveda or “the science of living”. Ancient China had a traditional method of healing based on herbal medicine, diet, acupuncture and qigong (system of internal energy management). Other ancient systems of medicine also shared these common features including Unani in Persia, Native American Medicine, and shamanic medicine in numerous other cultures (Strohecker, 2010)

The underlying message of most of the ancient healing concepts was to adopt a healthy and natural approach towards life which would lead to overall well being of an individual. So the concept of wellness did exist in many of ancient healing cultures but its emergence reappeared with the concept and development of “Wellness” as a movement. The principles of these ancient holistic and healing approaches are playing a major role in defining the 21st century wellness wave.

Holism emerged from the approach used by scientists to study complex phenomena such as organisms and ecosystems (Richards & Bergin, 1997) and a shift in society toward a worldview that is more holistic and relational (Larson, 1999). The term wellness appeared as part of a parallel transformation in the definition of health toward a more holistic perspective that is inter-relational and positive in focus, namely, to examine healthy human functioning (Westgate, 1996).

Previous definitions of health held the view that health was concerned with illness and the body was considered in terms of isolated physiological systems (McSherry & Draper, 1998; Panelli & Tipa, 2007). The holistic perspective which is generally agreed upon as the initial model completely transformed this concept of health and the wellness movement and brought about the transformation (Anspaugh, et al., 2004; Corbin & Pangrazi, 2001; Hales, 2005; Kindig, 2007; Myers et al., 2005; Panelli & Tipa, 2007; Travis & Ryan 2004).

The wellness movement began after the end of the Second World War largely because society’s health needs changed. Medical advancements and technology drastically reduced the chances of death caused by infectious diseases through vaccines and antibiotics (Seaward, 1997, 2002). Instead a new wave of chronic and lifestyle illnesses (e.g., heart disease, diabetes, cancer), associated with sedentary lifestyle became the primary health concern. Dunn (1959) was the first author to
provide a modern-day definition of wellness through an integrated method of functioning, keeping in consideration an individual’s environment (Miller & Foster, 2010).

**Evolution of the concept of Wellness:**

The term ‘wellness’ emerged following the Second World War, after which advances in medical technology meant health included not just illness but also wellness (Panelli & Tipa, 2007).

While figures such as Kellogg, Quimby, Eddy and Fletcher contributed to the development of the concept of wellness, the use of the term wellness in connection with this concept was the accomplishment of Dr. Halbert Louis Dunn. Dr. Dunn was born in 1896 in New Paris, Ohio and died in 1975 in Silver Spring, Maryland (Miller, 2005). He defined high-level wellness as “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. The concept of wellness requires, “that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning” (Dunn 1961: 4-5). He expressed his holistic view on wellness through the diagram, figure 1.1, which he proposed to explain the concept of High level wellness. In the figure, the three interlocking orbits represent the human body as a manifestation of organized energy, and also symbolize the body, mind and spirit of man as an interrelated and interdependent whole. The dart symbolizes the life cycle of the individual as he strives to achieve his purpose in living and grows in wholeness toward maturity in self-fulfillment (Dunn 1961: vi).

![Figure 1: High-Level Wellness Symbol](cover)

**The Growth of Wellness movement:**

Wellness Resource Center was developed in Mill Valley, California during the same time as of Dunn’s death in 1975. The center was founded by John Travis (1943), who like Dunn had a background in public health. He was enrolled in a preventative medicine program at the Johns Hopkins University of Public Health when he first encountered Dunn’s ideas. Based on Dunn’s work, Travis developed what he called a wellness inventory to assess an individual’s state of wellness.
on a total of 12 dimensions, ranging from self-love to nutrition, exercise and social environment, among others (Travis, 1975). He also altered Dunn’s “Health Grid,” reducing it to a single continuum from premature death on one end to high level wellness on the other, Figure 1.2.

Figure 1.2: The wellness continuum. Source: Travis as cited in Ardell (1977), p. 10
While Dunn’s wellness philosophy remained a set of ideas without much immediate practical application, Travis translated Dunn’s ideas into a concrete eight-month program with a price tag of $1500. It involved various wellness strategies like learning relaxation strategies, self-examination, communication training, coaching to encourage creativity, improved nutrition and fitness, visualization techniques etc. The idea was to help clients to know themselves better, so they could take better care of themselves. As a handbook to accompany and reinforce these techniques, Travis developed the Wellness Workbook, which is now in its third edition and has sold more than 175,000 copies (Travis 1977, 1981, 2004).

Because of a very limited printing by a relatively unknown press, Dunn’s work was not very widely known, but Travis did much to popularize the basic concept of wellness. In addition, a 1974 report issued by the Canadian Minister of Health and Welfare, Marc Lalonde, gave the wellness concept much needed exposure (Miller, 2005).

Stinson personal wellness model

The Stinson personal model of wellness consists of major four pillars of wellness

The first pillar of wellness is purpose. People stagnate without a reason for what they are doing and a clear direction of travel. Consequently, developing and clarifying purpose is often the starting point for developing a wellness strategy. The second pillar is balance. If balance is not regularly assessed it can lead to imbalance and neglect. For example, when a person does not regularly assess work and family life balance, it is easy to become imbalanced and quickly find that he or she is neglecting one or the other. The third pillar of wellness is congruence. To live congruently from the inside out requires that a person know who they are and what they value and believe. Congruence develops over time as people discover their strengths and find ways to express their identity by embedding values and beliefs into their lifestyle. Sustainability, the fourth pillar of wellness, flows from prioritizing involvements based on personal values and beliefs in order to function at an optimal level for a long period of time. It involves balancing the notion of setting boundaries that limit

The Stinson Wellness Model does not prescribe what wellness looks like for any individual or group. Rather it takes an innovative approach by focusing on intentional decision-making, similar to Myers & Sweeney (2005), and aligning life from the inside out as a way to formulate personal wellness. In other words, wise decision-making by the individual leads to well-being both internally and externally. This fundamental principle of the Stinson Wellness Model is represented by the following formula:

$$W = C \times (D + A)$$

The degree of Wellness (W) one experiences is equal to the Circumstances (C) that surround their life and a multiplying factor of wise Decision-making (D) and Alignment (A). All people live within the context of life circumstances that change from time to time. Over a life’s journey, there are times when circumstances are enjoyable, and other times where a person may face very challenging situations. Some of these are due to previous decisions they have made, while others involve factors beyond their control. In either case, wise decision-making and alignment are multiplying factors. A few great decisions can provide significant movement toward wellness. In addition, it is the alignment from the inside out that strengthens a person’s ability to live well, by reducing the pull and pressure from outside sources. Aligning one’s life requires a person to articulate the values and beliefs that guide their thinking. By intentionally acting on those beliefs a person is able to live a principle driven life.
Emergence of Wellness at the Workplace:

Corporations first began helping employees with health-related issues such as alcoholism and mental health as early as the 1950s (Owens, 2006). These programs, which were often peer-led, were initial forms of the Employee Assistance Programs (EAPs) that we are familiar with today (Call, Gerdes, Robinson, 2009).

Corporate and worksite wellness programs first appear in the literature in the early 1980s in articles discussing physical fitness efforts at work and their effects on worker performance (McKendrick, 1982; Shepard, 1981). As early as 1982, articles appearing in the Journal of Occupational Health described how corporations could set up wellness programs to reduce health care costs, reduce illness related absences, and attract talented employees to the company (Call, Gerdes, Robinson, 2009).

In 1996, European Union for Workplace Health Promotion (ENWHP) was established where the union adopted the program for action on “Health, Education, Information and training” to improve public health standards in Europe in which workplaces were accorded a special role. The European network for workplace health promotion adopted the Luxemburg Declaration (28 November 1997) to announce the shared understanding of the aims, strategies and measures of the European network for workplace health promotion. The member organizations agreed that for future development and dissemination of workplace health promotion, effective cooperation and coordination was vital at all levels. The Luxemburg Declaration helped to establish the basis for future activities by identifying the priorities for action (Dr. Karl Kuhn, Dr. Maria Dolores Solé Chairpersons of the ENWHP, 1997).

Employee Wellness programs Across the Globe:

According to Buck consultant’s Global survey of health promotion, workplace wellness and Productivity strategy Report 2014, wellness programs are most common in North America but have strong and growing foothold across regions like Australia, Asia and Europe. The following has been the major objectives of different regions for implementing workplace wellness programs.
Table 1.2: Source – Buck consultant’s Global survey of health promotion, workplace wellness and Productivity strategy Report 2014
Following are some of the major components of wellness programs being practiced across Asia.

<table>
<thead>
<tr>
<th>Biometric health screenings (such as blood pressure, cholesterol, glucose, body fat)</th>
<th>All regions</th>
<th>Africa/Middle East</th>
<th>Asia</th>
<th>Australia/NZ</th>
<th>Canada</th>
<th>Europe</th>
<th>Latin America</th>
<th>United States</th>
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</thead>
<tbody>
<tr>
<td>62%</td>
<td>6%</td>
<td>15%</td>
<td>13%</td>
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<tr>
<td>Onsite occupational health programs</td>
<td>40%</td>
<td>6%</td>
<td>15%</td>
<td>18%</td>
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<tr>
<td>Regular communications (e.g., online mailings, posters)</td>
<td>58%</td>
<td>13%</td>
<td>10%</td>
<td>18%</td>
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<tr>
<td>Health risk appraisal (health and lifestyle questionnaires)</td>
<td>31%</td>
<td>20%</td>
<td>11%</td>
<td>16%</td>
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<tr>
<td>IRP policies</td>
<td>31%</td>
<td>15%</td>
<td>15%</td>
<td>18%</td>
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<tr>
<td>Workplace health challenges (e.g., walking, weight loss)</td>
<td>50%</td>
<td>17%</td>
<td>12%</td>
<td>20%</td>
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<tr>
<td>Personal health record (electronic summary of personal health information)</td>
<td>30%</td>
<td>16%</td>
<td>17%</td>
<td>24%</td>
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<tr>
<td>Onsite healthy lifestyle programs and coaching (e.g., nutrition, weight loss, stress reduction, smoking cessation)</td>
<td>47%</td>
<td>19%</td>
<td>10%</td>
<td>23%</td>
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<tr>
<td>Onsite medical facility</td>
<td>47%</td>
<td>7%</td>
<td>9%</td>
<td>38%</td>
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<tr>
<td>Employee Assistance Program (EAP)</td>
<td>46%</td>
<td>17%</td>
<td>16%</td>
<td>22%</td>
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<td>Ergonomic adaptations and awareness</td>
<td>45%</td>
<td>18%</td>
<td>11%</td>
<td>37%</td>
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<tr>
<td>Environmental support (e.g., tobacco-free campus, healthy vending machines, cafeterias that emphasize healthy options, walking trails)</td>
<td>65%</td>
<td>12%</td>
<td>14%</td>
<td>27%</td>
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<tr>
<td>Onsite fitness center</td>
<td>31%</td>
<td>15%</td>
<td>15%</td>
<td>20%</td>
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<tr>
<td>Onsite immunizations/flu shots</td>
<td>32%</td>
<td>5%</td>
<td>9%</td>
<td>54%</td>
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<tr>
<td>Other on-site services</td>
<td>32%</td>
<td>8%</td>
<td>18%</td>
<td>42%</td>
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<tr>
<td>Nurse line or other health/disease phone support</td>
<td>26%</td>
<td>7%</td>
<td>9%</td>
<td>55%</td>
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<tr>
<td>Telephonic physician support (telemedicine services)</td>
<td>37%</td>
<td>7%</td>
<td>17%</td>
<td>48%</td>
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<tr>
<td>Onsite employee health fairs</td>
<td>37%</td>
<td>12%</td>
<td>9%</td>
<td>37%</td>
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<tr>
<td>Worksite wellness support (e.g., legal, financial services, elder or child care support)</td>
<td>36%</td>
<td>11%</td>
<td>16%</td>
<td>36%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Telephonic chronic disease management support or coaching</td>
<td>24%</td>
<td>5%</td>
<td>14%</td>
<td>57%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Telephonic lifestyle coaching</td>
<td>23%</td>
<td>9%</td>
<td>10%</td>
<td>48%</td>
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<td></td>
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<tr>
<td>Other internet tools (provider quality and cost information)</td>
<td>27%</td>
<td>13%</td>
<td>20%</td>
<td>48%</td>
<td></td>
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<tr>
<td>Cycle to work program</td>
<td>37%</td>
<td>13%</td>
<td>25%</td>
<td>46%</td>
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<tr>
<td>Onsite child care</td>
<td>6%</td>
<td>2%</td>
<td>16%</td>
<td>75%</td>
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</tbody>
</table>

Figure 1.3: Health promotion/ wellness program components practiced across Asia., Source – Buck consultant’s Global survey of health promotion, workplace wellness and Productivity strategy strategy Report 201
Employee wellness programs in India and other emerging economies:

In order to understand the structure of wellness interventions in India and emerging economies the study focused on assimilating information on following grounds:

- Country-specific issues leading to differences in health and wellness programs

The health issues and working environment varies across different countries. According to world economic forum statistics, the major health issues for Indian working populations are cardiovascular disease and diabetes due to poor diet, lack of exercise, and tobacco consumption. Apart from these communicable and non-communicable diseases, including HIV/AIDS, tuberculosis, malaria, and pneumonia are some of the major health concerns among Indian working population. (24,25,26)

Whereas in China the major health concerns are lack of rural health care, ageing population, and infectious diseases. (27) Health care trends in China show that health care reforms are not at par with economic growth of the country. (28) This along with low rates of improvement of life expectancy and infant mortality. In Philippines major health concerns are addiction to illicit drugs, malnutrition and infectious diseases. The population has been struggling for quality health care, especially for the underprivileged section of the society. (29,30). Based on the country specific health issues and trends companies are designing interventions beat suited to target specific health outcomes.

- Ways employers are creating a healthy employee culture, including examples of promising practices

Employee wellness programs being conducted by companies can be categorized into two types. The first one are the programs bring conducted by local companies emulating need based wellness interventions and the second are multinational companies conducting global practices across their offices. In a study conducted by Metlife on Global Health and Wellness, four multinational companies (American express, GSK, PPG, CEMEX) have been studied regarding their strategic approaches to wellness practices and promising practices which they have implemented to address employee health and wellness needs across different countries. The study was conducted on employers’ programs in India, Mexico, China, the Philippines, the United Kingdom, and the United States. The findings reveal that the companies have encountered challenges and opportunities that vary by country, such as local culture, local government, employee acceptance, availability of healthcare facilities and communication with employees. Some of the major findings of the study are:

Organizations follow local custom of employee insurance along with dependent parents insurance under the plan coverage. Ageing parent dependency is a major risk for the insurance plan; hence the companies provide free medical check up to its employees which are inclusive of their parents at a discount. An online health risk data creates a suitable health plan for the employee and the adult dependent. Based on the health risk, appropriate health intervention with personalized counseling and tools are provided to employees. (31) An estimated 10-20% participation rate is determined by consulting companies and contacts in the industry. In India there are no current benchmarking practices. Employers across industries are opening up to the idea of implementing wellness programs as their international counterparts are bringing in their global network practices in India.

Traditionally, health policy and funding in India has concentrated on paying for the treatment of illness, not on its prevention. In India, Insurance schemes are provided by private companies, insurance companies (government or private), however the Government insurance scheme like ESI is the largest, compulsory, health insurance scheme which covers the lower income factory workers. However the scope of Government sponsored schemes is not comprehensive enough to include Employee wellness programs.

In the annual Executive opinion Survey (EOS) conducted by World Economic forum which generates much of the data used to construct the Global Competitiveness index suggests that Indian business executives are keenly aware of the risks that NCDs pose to their companies. Many companies have implemented policies to prevent and control NCDs among their workforces. The results also show that interventions are aimed at promoting physical activity and stress reductions have the largest potential for expansion. The following Table 1.3 shows the prevalence of workplace policies and programs to NCD prevention and support by year for 2010-2012. The existing policies and programs are related to smoking, alcohol free workplaces, exercise, mental health, and physical health. The most common and highly prevalent policy is about smoke free workplace, followed by alcohol free workplaces. The least prevalent policies and programs are related to mental health and exercise.
A significant gap exists between the nominal establishment and the implementation of all policies and programs, as shown in Table 1.2. The gaps are largest for the prevention, screening and support of physical health problems; the prevention, screening for and support of individuals with mental health problems; and incentives for exercise.

The Government in India has also taken steps in improving workplace wellness programs by establishing the National Institute for Health Promotion and Control of Chronic Diseases under the Central Health Education Bureau as a subordinate organization of Directorate General of Health Services, Ministry of Health and Family Welfare. The Government of India recognized Non communicable diseases (NCD) as a development issue and announced two programmes to address this challenge: the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), and the National Programme for Health Care of the Elderly (NPHCE) (UN, 2011). Both were introduced as pilot programmes, and on World Health Day 2013, the Government of India announced plans to expand the NPCDCS to cover all districts as part of the 12th Five Year Plan (2012-2017) (Ministry of Health and Family Welfare, 2013). The 12th five year plan has proposed possible strategies like executive health programs and initiation of fitness and yoga centers, to promote a healthy workplace. Besides these initiatives from the Government, there have also been various non-governmental organizations involved with in India as identified by the World Economic Forum which includes the Confederation of Indian Industry, Public Health Foundation of India and Indian Association of Occupational Health.

Application of Stinson personal wellness model making workplace health and wellness decisions

The four pillars of the Stinson model help to ask valuable questions that will lead to healthy and wise decisions. Each of the four pillars (Purpose, Balance, Congruence, and Sustainability) create a
broad range of perspectives to be considered when making decisions at an organizational level that will enhance the quality and outcome of the decision. Since the Stinson Wellness Model is not prescriptive in nature, but seeks to provide a decision-making framework that is flexible to almost any situation, the strength of the model is in the questions it asks and the framework used to address an issue. Employees can be taught the model and use it to make wiser personal decisions. By increasing personal wellness on a person-to-person basis, corporate wellness is increased. By extension, the model can also be used as a grid to analyze and explain company decisions. For example, by simply using the four questions as a framework to determine the wisdom of a decision that is being made within a company, a better outcome will result.

The model also provides a framework for explaining the decision-making process involved in a business decision, which can be beneficial in post-decision analysis. For example, when explaining organizational decisions to employee groups most questions asked fall into pillar categories: Is this the right direction for the company to move in? By making this decision, will it cause one part of the company to be overtaxed? Is it compatible with the company goals and values? Is the decision sustainable and will it be productive long-term? When explaining a business decision it would be useful to explain the rationale using the four pillars of wellness. This will alleviate many of the concerns employees will have. Another application is to use the model to assess the strategic alignment of the company. Such a grid would provide an assessment tool for the company to consider the broad impact of the strategic decisions being made.

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i S Lee, H Blake, S Lloyd. The price is right: making workplace wellness financially sustainable
iii Babu Abraham Samuel, Madan Kushal, Veluswamy Sundar Kumar, Mehra Rahul, Maiya Arun G., Worksite Health and Wellness Programs in India, Progress in Cardiovascular Diseases (2013), doi: 10.1016/j.pcad.2013.11.004