2.1 INTRODUCTION

The present chapter discusses the concept of organizational health and impact on organizational performance.

The literatures collected were analyzed as per the following sections:-

- Concept, Definition and Theory of Health and Organizational Health
- Diagnosing Tools of Organizational health
- The Organizational Health dimensions developed by Miles
- The Organizational Health dimensions developed by Hoy
- The Organizational Health dimensions developed by WHO
- Organizational Health – A global perspective
- Organizational Health – Indian perspective
- Influence of the HR functions in Organizational Health

Section I discusses about the concept and definition of Organizational health, while this is followed by Section II where various diagnosing tools used to measure organizational health would be reviewed in this section. Section III focused on organizational health from a global perspective, where the concept reviewed from both developed and developed countries, followed by Indian studies (Section IV). Section V is critical, where it reviews the previous studies on organizational health and its impact on business growth and development. In specific, studies that had organizational health as dependent variable and leadership, communication, culture, team, training and development, work life balance and performance management as independent variables are reviewed. Finally, section VI focused on Ayurveda from the context of world of health care and from Indian especially from Kerala perspective.
2.2 Concept, Definition and Theory of Health and Organizational Health

Health is a positive concept emphasizing social and personal resources as well as physical capabilities (Ramnik Ahuja & Debasis Bhattacharya, 2007). It describes our ability to flourish and enjoy life, and to cope and survive in adversity. Ironically, the concern for health and well-being in the organizational context are no means new. From an almost exclusive focus on the physical work environment (the realm of traditional occupational health and safety), the definition has broadened to include health practice factors- lifestyle (Addley, McQuillan & Ruddle, 2001); psychosocial factors (Lowe, Schellenberg, & Shannon, 2003; James Campbell Quick, Marilyn Macik-Frey & Cary L. Cooper, 2007); and a link to the external environment (Ian Saunders & Steve Barkers, 2001); all of which can have a profound effect on employee health and well-being (Brad Gilbreath & Philip Benson, 2004; Grawitch, Gottschalk & Munz, 2006). To say so, we observe a paradigm shift in conceptualizing health from a ‘bio-medical concept’ (health as the absence of disease) to a ‘humanistic health concept’ (health as individual perceived well-being). (Organisational Health is no the sum total of the Health of all employees, No ‘Bio-Medical’ concept, but the health we define as the capacity of the organization to perform today and the evolution of this research paradigm now takes the term “organizational health” which undermines the range of organizational and job related opportunities that are available to an individual person to meet his or her needs of well-being, productivity and positive self-experience (Sauter, Lim & Murphy, 1996; Aaron De Smet, Mark Loch & Bill Schaninger, 2007). According to Cox (1988), organizational health embeds the Notion of health into work organization with an underlying assumption that it should be possible to identify healthy from the unhealthy ones. This means that as a construct, the framework of organizational health helps us in understanding how individual and organizational factors interact and influence particular employee and organizational outcomes.

Although the concept of organization health was first used by Argyris in the 1950s (Tutar, 2010), its foundations way back to the 1960s, when the specialists of human relations and behavioral sciences who strived to produce a solution to the question of how the employees should be treated (Güll, 2007) Accordingly, the concept of organizational health, first put forward in 1969 by Matthew Miles, is a simulation developed on the climate of schools (Miles, 1969). The relations between the
students, teachers and managers in school were defined by this simulation (Polatc. et al., 2008). Thus, this approach of Miles was adopted also in the field of organizational behavior, and was as an introduction to the studies in this topic (In this context, Miles suggested a model for organization health analysis of schools, and defined the healthy organization as follows. “Healthy organization is one that does Not survive only in the environment it exists, but also constantly develops in the long term, improves its coping and surviving skills” (Miles, 1969).

In general, organization health is expressed as the capabilities possessed by an organization to adapt to its environment successfully, create cooperation between its members and achieve its targets (Altun, 2001). According to another definition; it is such an organization that supports organizational success, environment, employees’ welfare and happiness with its authority structure, values system, Norms, reward and sanction systems (Karagüzel, 2012). Current thinking suggests that individual level well-being leads to a higher level of individual-level performance (Judge et al., 2001) in turn leading to better organizational performance (Bakker, & Schaufeli, 2008), motivates workers, enhances morale, reduces absenteeism, reduces personnel and welfare problems, competitiveness and public image (Chu, Breucker, Harris & Stitzel, 2000; Kramer & Cole, 2003). Similarly, the consequences of unhealthy work organization are many and include work-related accidents, high rates of absenteeism, a high turnover, high levels of stress, loss of productivity and a high incidence of health-related litigation (Whitehead, 2006). Aspects of organizational health traditionally, in the literature of health promotion, concepts like occupational health, healthy workplaces and workplace health promotion have been used to describe and analyze health issues in organizations. These concepts have mainly focused on individual and group dimensions of health at the workplace, but more recently, organizational dimensions have also been included.

There have been very few empirical studies of organizational health in health organizations. In an American dissertation, the organizational health of a hospital was defined in general terms as the ability of the organization to create and foster value symbols that provide meaning to the external and internal participants in the culture. With this foundation, a new concept of organizational health can be
developed by linking it to the value tensions in health organizations. In general terms, organizational health can be defined as how well an organization is able to cope with the tensions of diverse values for the benefit of the patients, the professionals and the organization as a whole. This requires an organizational level of analysis. It also requires a dialectical perspective of organizations, focusing on conflicts and diversity of values, but also on their mutual dependencies. The following sections will outline different aspects of organizational health regarded from this perspective.

Organizational health is determined by a distinct combination of strategic, structural, cultural and behavioral characteristics. Organizational theorists have made fleeting references to a diverse range of features considered to be indicative of organizational health, or the lack of it. Bennis (1996) was one of the first theorists to use the term health in organizational context. According to him an organization is “healthy” when; “First, it has to be stable which is the essence of orderliness, and the opposite of chaos, anarchy, or disintegration. Second, the system should be growing or mature. Third, the system must be adaptable, because healthy, complex organisms can adjust to a large number of environmental contingencies. Further, adaptability is evidence of survival potential, and of course this has to be highly regarded in times of rapid change” (Bennis, 1996). French et al., (1982) appraised that health, or the lack of it, is likely to be reflected in the attention given to ensuring the correct fit between the person and his/her environment. Cox, Leather, and Cox (1990) identified three primary sources of work demands: the work itself, the tools and technologies used in the work, and the social/organizational and physical environments in which the work is performed. Smith et al., (1995) examined five organizational factors for organizational health: organization–person balance, organizational treatment, discrimination, decision-making climate, and quality of supervision. Sauter, Lim, and Murphy (1996) identified management practices, organizational culture/climate, and organizational values as key organizational factors for health and wellbeing at workplace.

Danna and Griffin (1999) proposed an antecedents–consequences model featuring three sets of antecedent factors: work setting (primarily safety and health risks), personality traits, and occupational stress factors. In this model, occupational stress factors encompass both job demands and broader organizational characteristics such as climate and career development opportunities. NIOSH has adopted a multi-level
or ecological approach that features three interacting tiers (Landsbergis, 2003; NIOSH, the National Institute for Occupational Safety and Health, 2002): the external context (economics, political trends, etc.), the organizational context (management structures, etc.), and work content (job characteristics, work roles, etc.). DeJoy, Wilson, and colleagues (DeJoy & Wilson, 2003; Wilson, DeJoy, Vandenberg, Richardson, & McGrath, 2004) focused on three domains of work life: job design, organizational climate, and job future and their relationships to the leadership and cultural resources of the organization in a major validation study for the Healthy Work Organization Model concluded that management practices held the promise of ‘preventing work-related stress whilst simultaneously promoting organizational effectiveness’ (Browne, 2002.). Given, the understanding of organizational health from different author, the following section briefly discusses the diagnosing tools to measure organizational health.

2.3 Diagnosing Tools of Organizational health

People usually do not know the value of their health and pay the necessary attention to their health until they get sick. Likewise, in the organization management, methods of doing business, policies and practices are not paid attention to until a warning is received. Managers usually do not measure organization health until they encounter a crisis. However, in order to achieve and sustain organizational health, a healthy organization structure should be formed beginning from establishment of the organization, measures should be taken against the problems that may occur, and organization health should be measured periodically. The aim of measuring health of the organizations is Not only to reveal the situation, but also to prepare improvement plans based on the obtained results. The organization’s being healthy or unhealthy is an evidence for need of change and innovation. The essential thing is determining what causes the unhealthy organization structure. Briefly, measurements set the conceptual basics in identification and solution of the problems. The strengths and weaknesses of the organization as well as the opportunities and threats it has are revealed through measurement of organization health. Thus, it is strived to derive more resources from the strengths, and to improve and strengthen the weaknesses (Polatc et al., 2008: 146).
Several tools have been identified by previous researchers to measure the health of organization. For instance, the study by Aaron De Smet, Mark Loch & Bill Schaniger (2007) proposes five overarching organizational dimensions that signify organizational health dimension such as:

2.3.1 Resilience

Beyond the everyday problem, managers of today have to contend with unpredictable and often threatening disruptions: financial-market meltdowns, extreme weather conditions, power failures, even terrorism. Healthy companies are practiced at spotting and managing key risks (including low-probability but high impact catastrophes), and they build mechanisms and have the resources- cash reserves or back up IT systems- to face up such eventuality e.g. Wal-Mart response after Hurricane Katrina in US.

2.3.2 Execution

Even as companies hedge against external shocks, they need to get the basics right, make good decisions, and perform essential tasks. The companies that execute well share certain attributes/distinctive capabilities: the ability to make sound and timely decisions, strong forecasting skills, and employees who understand their roles and responsibilities.

2.3.3 Alignment

A healthy organization sketch a compelling vision of the future for everyone connected with them- employees in particular- by articulating a shared identity that rises above individuals, functions, and business units; by reflecting stakeholder concerns in corporate values; and by reinforcing the sense of common purpose with formal mechanisms, such as performance contracts.

2.3.4 Renewal

Healthy companies invest in their future by expanding into well-chosen markets where existing assets and competencies provide real leverage, usually with the help of a winning formula that has been honed from experience and facilitates smooth integration across the entire value chain and the efficient extraction of synergies. The success of Nike’s has been attributed to its renewal capability that requires attention
to softer issues, to generate ideas and adapt to change, both culturally and strategically.

2.3.5 Complementarity

The concept of complementarities refers to those organizational practices, such as hiring policies, training programs, and consistent and mutually reinforcing behavioral incentives that are crucial to ensuring that assets, processes, relationships, and management practices act in concert e.g. Toyota Motors. These attributes are emergent characteristics of a company’s performance system

2.4 The Organization Health Dimensions Developed by Miles

According to the model brought forward by Miles, dimensions of the organization health may be summarized as follows (Buluç, 2008, Karagüzel, 2012).

2.4.1 The Task Needs Dimension

(a) **Objective-Focus:** The objectives are easily understandable, acceptable and achievable by the organization members.

(b) **Communication Adequacy:** An in-organization communication system preventing misunderstandings is available. Thus, the employees access correct information and increase organization efficiency.

(c) **Optimal Power Uniformity:** Distribution of the power within the organization is relatively uniform. They always think that those at lower levels can influence those at the immediate upper level.

2.4.2 Survival Needs Dimension

(a) **Effective Use of Resources:** Task distribution within the organization is done in the most effective way - neither less nor more than as required. There is coherence between the demands and needs.

(b) **Organizational Commitment:** The employees like the organization and want to stay there. They are influenced by the organization, and spend all their powers for unity of the organization.
(c) **Morale:** There is employee welfare and team satisfaction in the organization in general.

### 2.4.2 Growth and Development Needs Dimension

(a) **Innovativeness:** The organization develops new procedures, sets new targets and constantly develops.

(b) **Autonomy:** It is proactive to the organization. It shows several independent characteristics to the outer factors.

(c) **Adaptation:** The organization has the skill of making the necessary changes in itself for growth and development.

(d) **Problem Solving Competency:** The problems are solved with minimum energy. Problem solving mechanism is constantly supported and strengthened.

### 2.5 Organization Health Dimensions Developed by Hoy

Hoy and Feldman examined organization health in seven dimensions. These seven dimensions are as follows (Hoy & Feldman, 1987, Buluç, 2008, Karagüzel, 2012):

(a) **Organizational Integrity:** The organization’s ensuring integrity in its programs through its capability of adaptation to its environment.

(b) **Influence of the Organization Manager:** The organization managers can influence decisions of the senior system they are subordinate to. The ability to convince their decision organs, having reputation and Not being blocked by the hierarchic impediments are important factors of the organization managers.

(c) **Respect:** This involves the friendly, supportive, overtly and sincerely behaviours exhibited by the organization managers to the employees. Such behaviours are important for increase of performances of the employees.

(d) **Work Order:** This involves behaviours of the organization manager relating to his/her tasks and achievements. Expectations from the
employees, performance standards and polices are clearly expressed by the organization manager.

(c) **Resource Support:** This involves availability of sufficient machinery and equipment in the organizations, and procurement of additional resources when requested.

(f) **Morale:** This is the sum of friendship, openness between the organization members, and the senses of excitement and confidence they feel about the work they do. The employees treat each other tolerantly, they help each other, feel proud of the organization they work in, and completing the works make them happy.

(g) **Importance of the work:** This is about the organizations’ seeking for work excellence. Work is started by setting high but achievable targets for the employees and production activities are carried out in a serious and orderly fashion. It is possible to group these dimensions as organization health dimensions at the institutional, managerial and technical level. Accordingly, Institutional Level consists of institutional integrity dimension, Managerial Level consists of the dimensions of work order, respect, influence of the organization manager and resource support, and Technical Level consists of the levels of morale and importance of the work (Polatc et al., 2008,).

### 2.6 Organization Health Dimensions Developed by World Health Organization

With a more general classification in regard to the dimensions of organization health, the World Health Organization (WHO) examines the organization health in 4 dimensions. These are as follows (Cooper & Williams, 1994)

Environmental Health: This involves the work area factors such as physical environment of the workplace, Noise, heat, light, dangerous substances and machinery.

(a) **Physical Health:** This involves the physical health of the employees in the organization, illness, injury, and activities such as medicine treatment.
(b) Psychological Health: This involves self-confidence of the employees, their stress, depression, anxiety states, and behavioural styles.

(c) Social Health: This involves friendships in the workplace, social support, workplace relations, and factors outside business.

According to the World Health Organization, there are not precise lines between these factors, and there are connections among these four dimensions. According to this perspective, only physical and spiritual health of the employees is addressed, and the managerial and organizational output dimensions are not included (Altun, 2001,).

2.7 Organizational Health – A global Perspective

A Swedish study that examined human service organizations which is a fast developing body of knowledge on health of organizations, showed a positive relationship between work attendance and male gender, high income, work commitment, job satisfaction, and positive feelings towards work (Dellveet al., 2007, Olukmi 2005; Jaja& Lucille, 2008). The views expressed by these authors are robustly in line with the vitality that organizations will strategically acquire to achieve their goals. Nashba (2007) clearly linked the theory or organizational health to that which can be described in terms of performance. It reiterated that a healthy firm is that which had overtime achieved its strategic contents in terms of goals and objective. In another instance, Phill (2007) had argued that the state of health provides the platform for long term performance assessment which means that it is a means-end relationship. Kormane (2009) espoused that the thinking on health of firm can only be properly conceptualized if viewed in the light of performance parameter which if objectively viewed through replicates or showcase the state of the health. The authors view would ordinarily suggest that any omnibus measure of performance that meets organization owners desired target in terms of goals would have stated the health position of firms. Perfney (2009) theorized that a firm is healthy when it has the capabilities to create value for its buyer and agile enough to proactively respond to environment changes. This seeming relationship is reported in many strategic research works. Olukemi (2010) pointed out that organizational health grows fundamentally through strategic organizational and employee behavioral actions to position the organization for competitiveness. In other words, the basic characteristics of a healthy organization are those that strengthen it and channel performance outcomes. This means that health is integration, or a process of being
integrated, in the environment. On the other hand, periods of disintegration are necessary for being in health. Disintegration means a lack of integration, which may be a reaction to grief and stress. Analogously, organizational health may also be characterized by integration as well as disintegration. Integration of diverse and competing values, for example, quality of patient care and efficiency of service production, may be achieved by dialogue.

With the proliferation of New Public Management, efficiency has become the main criterion for priority setting in many health organizations. Such a development may have been necessary to cope with increasing healthcare expenditures. As a result, however, there has been a transition from individualized patient care to more standardized industrial service production, which has implied increasing value squeezes for health professionals and managers. Under such conditions, disintegration may be necessary for keeping the competing values alive in collective sense making processes among professionals and managers. In many organizations, however, competing values are neither integrated nor disintegrated. Instead, the value tensions are fragmented or simply swept under the carpet.

In a health organization, fragmentation takes place when important values are separated from each other, for example, when some of them are discussed in economic terms while others are discussed in professional terms. There are also many different ways of sweeping value tensions under the carpet, but none of them is healthy for an organization. In the long run, tricultural may even lead to ‘organizational schizophrenia’. From a bicultural to a approach Studies of crises and reactions in health organizations, when professionals are confronting the value tension between the quality of patient care and the efficiency of service production, have suggested that a ‘bicultural’ approach may be optimal for the professionals as well as the organization. Such an approach implies an acknowledgement that it is hardly possible to solve the value conflict, but maybe possible to learn to live with it. On an individual level, this may be an effective compromise when professionals are facing different cross-pressures and value tensions, and when scarcity of resources makes comprehensive patient care a never fulfilled ideal. In the long run, however, such an approach may be harmful to the health of the professionals. Organizational health implies not only a bicultural approach but a ‘tricultural’ approach to value tensions, adding a concern for the health of the professionals to the considerations of
quality and efficiency. This means an increased attention to workplace health issues on an operational as well as an organizational level, which also explains the difference and the relationship between workplace health and organizational health. With a tricultural approach, the workplace health issues are related to the value tensions of the organization. In a health organization, such an approach may include not only the tension between human and economic values, but also a special concern for the integrity of the professionals. Recent research has shown that if professionals are not able to work in accordance with their own values, their health may be at risk.

A tricultural approach to organizational health is consistent with a dialectical perspective on the tensions between quality, efficiency and effectiveness in a health organization. Moreover, the tricultural approach points towards an analysis of health organizations in terms of ‘value pyramids’, which can be used to develop a conceptual model of organizational health Implications for health management. In health organizations, like in many other human service organizations, professionals are managing themselves in work processes and multidisciplinary teamwork. Highly autonomous, they usually desire a minimum of management involvement. In such organizations, there may be intensive discussions regarding the substance and quality of the service production, challenging the authority of managers as well as professionals. Communication between these groups is often difficult because of their different roles and the different values involved. Managers are usually focusing on efficiency, while professionals are focusing on quality. Therefore, to promote organizational health, new forms of health management are required. Hybrid management Organizational health in health organizations requires managers who can handle and reflect upon different and conflicting logics and change dynamics. Hybrid management means a combination of professional and management knowledge. Such combinations exist by tradition in hospitals, where physicians and nurses often have ‘clinico-managerial’ roles and retain a professional as well as a managerial identity. Hybrid roles may be adopted willingly or reluctantly. For example, in Finland, the medical profession was ‘hybridized’ in the 1990s by a willing adoption of management accounting techniques in the context of New Public Management. This development was in contrast to the UK, where professionals have strongly resisted the intrusion of accounting practices into the medical domain. Hybrid management in health organizations is usually bicultural, combining
considerations of quality and efficiency, but it may also be tricultural, including a concern for the health of the professionals as well. Such a tricultural approach may be necessary to manage the different components of a health organization. A focus on the patients is the raison d’être for the organization, a focus on the production of health services is necessary because of the limited resources available, and a focus on the professionals is necessary because of their workplace health challenges and the increasing shortage of professional competence. Although the bicultural form of hybrid management has been questioned, it seems that a tricultural form of hybrid management could offer large benefits for the development of organizational health in health organizations.

Christopher Akpotu1 and Lebari, EebahDumka (2013) investigated the relationship between relational virtues and organizational health of the Nigerian Aviation sector. In order to conduct this investigation, the relationship virtue construct is examined with its components as trust, integrity, reciprocity and esprit de corps. The study primarily relied on the questionnaire instrument for generating data. The data generated were analyzed and the results showed that relational virtues strongly relates with organizational health in the studied sector. We concluded that such intangible relational virtues like trust, integrity reciprocity and esprit de corps are strong predictors of organizational health. It has been recommended that evolving the culture of emphasizing relational virtues should be considered strategic to position the aviation sector in line with desired organizational and national goals. As summarized in a review of research across multiple disciplines (Grawitch, Gottschalk, &Munz, 2006), the PHWP (Psychologically Health Workplace Program) focuses on five categories of workplace practices linked to employee and organizational outcomes: employee involvement, employee growth and development, work–life balance, health and safety, and employee recognition.

2.8 Organizational Health - Indian Perspective

From organizational science, Human Resource Management has emerged and evolved as one of the most important area and it is not evolved as a individual entity, rather in the context of industrial change and economic development. The uniqueness of the HR approach requires a totally different type of attention from managers.
Indian organizations normally direct their HRM efforts towards the development of competencies, culture and effectiveness among employees individually or in groups (Singh, 2003). Organizations may use many mechanisms to achieve their HRM goals as without competent and committed employees, an organization can achieve very little even it has excellent technological and other resources at its command. Such an assertion gains better credibility in the context of developing countries like India, that is, typically in early growth stages in terms of economic development and growing more rapidly than the ‘traditional’ developed economies of Japan, North America and Europe. This also includes most South East Asian, South Asian and some Latin American countries.

Selection in organizations is based on Non-job related criteria a general lack of concern for value congruence (Prakash, 1994). This practice would require a complete reversal where congruencies of values should find a place in selection and training. Only then would it possible to achieve linkages with the values of the wider socio-cultural context in India. The values of the society and the cultural milieu should be synthesized with those of the organization and it’s functioning to make the organization effective.

HRM practices and organizational culture, in selected private sector organizations in India was studied by Anil Kumar Shing, (2009), further he examined the relationship between HRM practices and organizational culture in private sector organizations operating in India. Organizational culture has developed in the Indian environment along with global work values. This study is based on a survey of 95 respondents working in two private sector organizations. Although the HRM practices in these organizations differ a lot, there is a significant relationship between HRM practices and organizational culture.

Sivapragasam and Raya (2011)study was initiated by observing the enormous gap between how people experience work and kind of experiences to that would make an organization more likely to endure and fulfil its vision. (i.e.) the influence of healthy workplace practices on employee well-being. Works of prominent writers on organizational health and well-being were then reviewed so as to present it as a framework for analysis and discussion. It is assumed that healthy organizations have conditions, which satisfy an individual’s self- esteem and increase trust between the
members. Such conditions are believed to cause an effective coping on the part of the organization to the changes in environmental conditions. The review study also scrutinizes the specific characteristics of the healthy organization in the hope that a more analytical approach would not only lead us to understand why there are few such organizations, but would offer insights into how to create them.

The factors involved in the organizational health, among knowledge professionals, in the hope that a more analytical approach would offer insights into how to create them was studied by Sivapragasam and Raya (2013). The results suggest that managerial efficiency, HRM practices, employee citizenship, team work orientation and value-based management are critical; otherwise the goal of sustained performance will remain elusive. An initial item pool of 30 items thought to be factorial dimensions of organizational health was completed by a sample of 200 employees belonging to various organizations in the knowledge based category in the Chennai City. Factor analysis extracted five factors such as managerial efficiency, HRM Practices, Organizational Values, Employee Citizenship and Team Orientation. This means that when employees feel that they are employed by a good employer with competency in managing the performance cycle, respects the employees for their contribution, provides them with opportunities to have a meaningful and satisfying work life; the employees are more likely to align their values to that of their organization, tend to be more likely to be productive, committed to their work teams and exhibit citizenship behaviour – which are the hallmarks of an healthy organization.

2.9 Influence of the ‘HR Functions in the Organizational Health leads to the Development of the ‘People’ and their Efficiency and Business Growth & Development.

The global turmoil has witnessed the growing importance of HRM in business and public life. The HR play an important role in the health of the organization, which includes the employees development and their effective output, in turn leads to the achieve the goals and objectives of the organization. They perform the two sets of the functions, namely managerial functions and operative functions. The managerial functions are the basic functions performed by the HR managers in their capacity as
managers or heads of their own departments which includes planning, organizing, staffing, directing and controlling. The operative functions, on the other hand, are specialized activities performed exclusively by the HR managers, usually for all the departments, like the processes of hiring, training, compensating, appraising and retaining employees, and attending to their labour relations, health and safety, and equality concerns.

To develop the suitable outcome measures, it is important to measure and analyze health in working life. The subjective feelings of health and its dimension of psychosocial well-being are revolved around the definition of health applied in this thesis, which is discussed earlier. Sick leave will play an important role in determining factor of the employee’s health. In this context, Health may be correlated with the biomedical diagnosis of the disease but not necessarily will be the case for all the time. Many research indicated that the sick leave may indicate employees’ health because it always goes hand in hand with the physical, mental and social well-being of the employees (Marmot et al., 1995). Moreover, the decreased rate of illness may not always be conducive to healthy employees.

Another study showed that leadership support, resources for performing work and being content with the quality of performed work correlate with a low rate of sick leave at work (Aronsson & Lindh, 2004). Many study analyzed that the employee presented with sickness leads to the future sick leave, which is the strongest health determining factor (Bergström et.al, 2009; Aronsson & Gustafsson, 2005). Aronsson, Dallner & Gustafsson, (2000) reported that the greatest rates of presenters were found in the sectors like, care, welfare and education. Another important factor leads to the outcome measures related to employee health is job satisfaction, organisational commitment and turnover intention (Shain & Kramer, 2004; Grawitch et.al., 2007). In human service organizations a positive relationship between work attendance and male gender, high income, work commitment, job satisfaction, and positive feelings towards work were analysed by Dellve et al.,(2007).

The healthy individuals experience a sense of coherence which includes comprehensibility, manageability and meaningfulness (Antonovsky, 1987), which can be compared to the concept of positive health, where experiences of well-being likely contribute to reduced biological risk for disease (Ryff et. al., 2004). Research
emphasize that a sense of meaning always correlates with employee health (Hochwälder & Brucefors, 2005).

Scandinavian research on work environment has long been in the frontline, studying the importance of psychosocial work conditions for employee health and well-being (Sverke, 2009). Different aspects of what the literature has defined as the organizational work environment are important for employee health. The work environment includes a wide range of organizational determinants for health, including social relations, management style, and organisation of work tasks, time schedules, mental and physical workload and gender segregation (Frick, 2004).

Antonovsky (1987) in his research illustrates that healthy individuals experience comprehensibility, manageability and meaningfulness, which he labelled as a sense of coherence. This can be compared to the concept of positive health, where experiences of well-being (e.g., self-development, personal growth and purposeful engagement) likely contribute to reduced biological risk for disease (Ryff et. al., 2004). Research confirms that a sense of meaning correlates with employee health (Hochwälder et. al., 2005).

Different aspects of the organizational work environment were studies which are important for employee health. Scandinavian research on work environment has long been in the frontline, studying the importance of psychosocial work conditions for employee health and well-being (Sverke, 2009). A wide range of organizational determinants for health are involved in work environment, which includes social relations, management style, and organisation of work tasks, time schedules, mental and physical workload and gender segregation (Frick, 2004). Other studies depicted that the high job demands in combination with high job control increases the capacity to learn and develop (Karasek, 1979, De Witte et al., 2007; Weststar, 2009). The important factor for the demand control model is the ability to increase the competence at work promotes health and well-being (Mikkelsen et al., 1999).

The demand-control model is not supported by all the studies. Sparks et al., (2001) strongly believe that the individual differences (e.g., the desire or need for control as well as coping skills) must be considered when contemplating changes in job autonomy or decision-making responsibilities. This is to perceived lack of control which may be stressful to some employees.
A review study examined the kinds of workplace health promotion efforts showed that these efforts increase mental well-being and may also promote work ability and decrease sickness absence. On the other hand, No effects on employees’ physical well-being and well-being in general were reported (Kuola et al., 2008). How the individuals’ health issues relate to broader models of organizational health and health-promoting workplaces were systematically tested by few other researchers. Grawitch et. al., (2006) investigated the characteristics of healthy workplaces and concluded that work-life balance, employee growth and development, health and safety programmes, recognition and employee involvement link to both employee well-being and organizational performance. A model of healthy work organisation which includes organizational attributes, organizational practice, job design, job future, psychological work adjustment and employee health and well-being was validated and tested by Wilson et.al. (2004) which infers that the work characteristics influence psychological work adjustment factors, which ultimately influence employee health and well-being.

In the context of “What practices promote workplace health?” Cotton and Hart (2003) argue that research on stressors and strain in organizations overemphasizes the individual and neglects the broader organizational context. Further he departs from the dominant discourse of occupational stress associating it with individual psychological distress, shifting the focus to “occupational wellbeing.” DeVries (2001) recommends that work does not need to be stressful, but rather can potentially provide psychological wellbeing, establish identity, and maintain self-esteem. He further suggests that organizations are ideal locales for members to cope with the stress and strain of daily living. Lindberg and Vingard (2012) conducted a systematic review of the literature to find indicators of healthy work environments and found 9 factors of a healthy workplace to include (in descending order): (1) collaboration/teamwork, (2) growth and development of the individual, (3) recognition, (4) employee involvement, (5) positive, accessible and fair leader, (6) autonomy and empowerment, (7) appropriate staffing, (8) skilled Communication, and (9) safe physical work. To be strategic, an organization health focus should link both the wellbeing of employees and the performance of the organization.

Many researchers emphasizes that the simultaneous focus on employee wellbeing and performance recognizes the practical reality that having happy and satisfied staff
is of little value to an organization unless staff are also performing effectively and productively. Likewise, having an efficient and productive organisation is of little value if this is achieved at the expense of staff wellbeing. They also acknowledge that this mutual relationship between individual and organizational wellbeing operates in a larger context that includes customers, communities, shareholders, and government. They also challenge the Notion that individual or organizational distress is the same as morale and point out that a person may be distressed about an aspect of her job (i.e., a deadline or conflict), yet experience high morale for her work and organization. Several of the studies reviewed advocate excellent communication programs, employee involvement and engagement in the initiative, and healthy interpersonal relationships among employees and leaders.

The literature is clear that an organizational health initiative is not an individual intervention. That is not to say that individualized programs are not a part of organizational health, it is just that it would be impossible to achieve without a strategic, systemic, organization-level focus. One of the most widely advocated interventions is for organizations to adopt an employee involvement approach to the health initiative (Grawitch, Gottschalk, & Munz, 2006; Grawitch, Ledford, Ballard, & Barber, 2009).

Grawitch, Gottschalk, and Munz (2006) developed the PATH Model of organization health, synthesizing previous research on employee wellbeing and organizational improvement, to include five categories of organization practices that promote healthy workplaces. These healthy workplace practices include: (1) work-life balance (e.g., flexitime, dependent care, and job security), (2) employee growth and development (e.g., opportunities to expand knowledge, skills, and abilities; application of new competencies), (3) health and safety (e.g., employee assistance programs, wellness screenings, stress training, counselling, and safety training), (4) recognition and (5) employee involvement. The intent of this model is to create employee wellbeing evidenced by levels of physical and mental health, stress, motivation, commitment, job satisfaction, morale, and climate. Indicators of organizational improvements include: Competitive advantage, performance and productivity, absenteeism, turnover, accident and injury rates, cost savings, hiring selectivity, product and service quality, and customer service and satisfaction.
"The leadership style of the principal assumed as a critical source of organizational health". Based on the many studies conducted by Hoy, Tarter and Kottkamp (1991), teachers in a healthy school are committed to teaching and learning. They set high expectations related to student performance goals, maintain high expectations, and promote a serious learning environment. Students working hard and are motivated to achieve at high levels. The principal ensures that instructional materials and classroom supplies are readily accessible to support the teaching and learning that is taking place in the school. Unhealthy schools in contrast are places filled with uncooperative faculty and staff (Korkmaz, 2007).

Tarter, Sabo and Hoy (1995) found a positive relationship between middle school health, and faculty trust, an open climate, and school effectiveness transformative leaders try to empower those around them by allowing them opportunities to grow professionally and by modelling expected behaviors. Silins (1993) explained that transformative leaders help build a collaborative relationship between the leader and the follower which ultimately impacts the performance of the whole organization resulting in a responsive and modern environment (Khademfar & Idris, 2012).

The present research tries to investigate the relationship between managers' leadership style (MLS) and organizational health (OH) in Ramsar and Tonekabon cities in (2012-2013) academic years. Results showed that there is direct and significant relationship between MLS and OH level in schools. There is direct and significant relationship between relationship-oriented leadership style and OH. There is not a significant relationship between task-oriented leadership style and OH. Furthermore, there is positive and significant relationship between integrative leadership style and OH.

Akbaba (1999) reported on the organizational leadership, organizational integration, environmental interaction, organizational identity and organizational product and investigated OH. There is significance difference between teacher and managers opinions concerning their schools OH. In the study related to the relationship between leadership styles in primary schools and high schools, there is significant difference between gender, school size, experiences and leadership styles Hiler (1999). Walente (1999) conducted a research titled "investigation of relationship
between leadership and OH in Chicago public schools" and concluded that influence of teachers on schools OH is less than managers’ influence of that school.

Murphy and Detnow (2003) found that mangers ideas success depends on establishment of a participative relationship between teachers and managers. Gronn's research also verified the results of the previous study, i.e. adaptation of participative strategies by managers improve personal and group performance of teachers and managers can provide a healthy organization for schools. Moreover, studies have shown that OH is an effective variable in many dimensions of educational system. For example, these studies have verified linear relationship between OH and leadership style and students success (Hoy & Hannum, 1997; Hoy &Sobu, 1998; Goddard, Sweetland & Hoy, 2000). Bernard (2008) conducted a research on "investigation of relationship between transformational leadership and OH in primary schools of southern Karolina" and concluded that there is a positive and significant relationship between the two variables. Results showed that perceived leadership style influences on perceived organizational health. Kieww (2010) investigated the leadership style by studying 151 skilled workers in It field who were working in USA. The study concluded that the transformational and transactional leadership is positively and significantly related to organizational performance. Transformational leadership is an efficient predictor for organizational performance in comparison with transactional leadership. Scholars (2010) in his PhD thesis titled: "manager's relationship trust and school's managerial board and its influence on OH" stated that confidence of managerial board, managers and teachers' union managers (the three groups that have the most influence on organizational trust) in each other influence on formation of OH, which is an important factor in students' success. In another research conducted by Hiks (2011) titled "relationship style of leadership and OH". This research showed that relationship style has great influence on workers satisfaction. This research shows the quality of constructive relationship and influence on OH. Furthermore, inappropriate relationship which may reduce workers' satisfaction was investigated in the research.

In the workplace, health-promoting efforts often depend on the good will of the management (Meggeneder, 2007). Some criticize the applications of the settings approach for not giving enough consideration to power relations that already exist within the setting (Poland et al, 2000). When implementing workplace health
promotions, the support and participation of top management is obviously important (Breucker, 1997; Sparling, 2010). Leadership can legitimate health-promoting efforts and participate importantly in motivating and supporting subordinates (Yeatman & Nove, 2002). A study on health and safety interventions in the workplace identified several factors that hinder and facilitate implementation (Whysall et al., 2006). Hindering factors include management commitment, managers’ general attitudes towards health, insufficient resources and prioritization of production. Facilitating factors include supportive managers, local control over budget spending for health as well as good communication.

Research shows that leadership style may also influence the health of employees (Gilbreath & Benson, 2004; Nyberg et al., 2008; Nyberg et al., 2009; Kuoala et al., 2008). One study concludes that leaders who use rewards, recognition, goal clarity and respect generate a high level of work attendance among employees of human service organisations (Dellve et al., 2007). A study that reviewed the influence of leadership on employee health showed leaders who show consideration; initiate needed structure and job satisfaction. Other positive factors include the characteristics of a transformational leadership (e.g., leaders who inspire employees to see higher meaning at work, provide employees with intellectual stimulation or are charismatic) (Nyberg et al., 2005).

Attributes of transformational leadership (e.g., promoting empowerment and having a clear vision) are important elements for employee job satisfaction and commitment (Lok & Crawford, 2004). Transformational leadership contributes to self-development and reduces stress among employees. Conversely, transactional skills (i.e., task achievement) contribute to employees’ well-being by clarifying performance expectations and reducing uncertainty (Sparks, Faragher, & Cooper, 2001). A literature review concluded that both a purely relationship-oriented leadership and a combined relationship- and task-oriented style yield positive effects on employee job satisfaction and productivity (Boumans & Landeweerd, 1993).

The literature also discusses the importance of support and supervision among employees. When work is difficult, management support contributes importantly to low levels of absenteeism due to sickness (Aronsson & Lindh, 2004). Satisfaction at work also relates to a high frequency of communication between supervisors and
employees as well as a supportive leadership style for relating and communicating (Callan, 1993; Yukl, 2006). One study shows that regular communication from supervisors can buffer perceived job strain among employees (Harris & Kacmar, 2005).

According to DeVries and colleagues (1998), contextual factors (e.g., individual, task and organisational characteristics) determine the need for supervision among employees. The authors assumed that employees with extensive work experience will require little leadership when they receive extensive feedback about their tasks and cohesion in their work teams is strong. They show that a strong positive relationship between leaders’ inspirational skills and job satisfaction, and between leadership support and work stress, can exist only when there is a high need for leadership. However, leadership that imposes too much structure when subordinates need little leadership may negatively influence subordinates’ organizational commitment (DeVries et al., 1998).

Moreover, leadership behavior and employee health are linked in a feedback loop, a two-way reciprocal process. Employees who report a higher level of well-being also perceive that their manager has a more supportive leadership style (Dierendonck et al., 2004). Hersey and Blanchard (2008) suggest that leadership style must adjust to the employees’ shifting competence and commitment. However, employee motivation can be hard to predict (Thylefors, 1991).

A democratic leadership style contains fewer perceived stressors for subordinates (Sparks et al., 2001). Yukl (2006) concluded that 40 years of research on participative leadership has produced some studies that show increased satisfaction, effort and performance while others suggest the reverse. For example, one study showed that a high level of sick leave correlates with a democratic leadership style, including a high degree of participation in decisions. The same study showed that less frequent sick leave is associated with a leadership style that included goal clarity and a systematic way of organising work (Tollgerdt-Andersson, 2005). Waldenström and Härenstam (2006) conclude that good working conditions include a clear division of responsibilities and formal decision structures subordinates’ organizational commitment (DeVries et al., 1998).