

"Union members concerned about corporate 'wellness' programs should consult this important collection on the latest form of healthcare cost shifting. Imposing medical plan 'sin taxes' on individual employees is not the way to reform our health insurance system or encourage healthier behavior."

Suzanne Gordon, healthcare journalist, author of *Nursing Against the Odds*

**WHICH WAY TO
WELLNESS:
A Workers' Guide to Labor and
Workplace Strategies for Better
Healthcare**

Cal Winslow, Editor

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National Union of Healthcare Workers

Contents

<u>Preface</u>	1
Cal Winslow	
<u>Introduction</u>	8
Carl Finamore: Do You Trust Your Boss With Your Health?	
<u>Chapter 1</u>	17
DeAnn McEwen: Workplace Wellness-At Whose Benefit? An Examination of Program Drawbacks and Limitations.	
<u>Chapter 2</u>	32
Faith Simon: Wellness: It's More than Your BMI.	
<u>Chapter 3</u>	40
Lewis Maltby: Employer Wellness Programs, The Good, the Bad, and the Ugly.	
<u>Chapter 4</u>	48
Jacqueline Hart: Corporations and the Bottom Line: Can Wellness Hurt You?	
<u>Chapter 5</u>	57
John Borsos: The Surrender of Oakland: The 2012 National Agreement between the Coalition of Kaiser Permanente Unions and Kaiser Permanente	
<u>Appendix:</u>	73
<i>JoAnn Volk and Sabrina Corlette</i> , Premium Incentives to Drive Wellness in the Workplace: A Review of the Issues and Recommendations for Policymakers	
<u>Contributors</u>	75

Preface

Miner's life is like a sailor's
'Board a ship to cross the wave
Every day, his life's in danger
Still he ventures, being brave
Traditional

I often think of the workplace as a place of danger, a place where workers are at risk and where employers must be restrained, controlled. I still recall reading, shocked as a youngster, of the Triangle Shirtwaist Factory Fire in New York City on March 25, 1911, the disaster that caused the deaths of 146 garment workers from fire, smoke inhalation, and falling to their deaths. Most of the victims were recent immigrant women, aged sixteen to twenty-three; and the youngest was an 11 year old. They had been locked in by their employers; otherwise they might have been saved.

I recall the miners' union (UMWA) reporting that in the twentieth century alone more than 100,000 coal miners died on the job. And in this new century it's not altogether so different, consider the April 5, 2010 disaster at the Upper Big Branch Mine in Raleigh County, West Virginia where 29 miners lost their lives. The Mine Safety and Health Administration subsequently reported the employer, Massey Energy, was guilty of flagrant violations of

government safety codes. In the 1970s the miners themselves struck for compensation for black lung disease (pneumoconiosis). The coal operators had denied this deadly affliction existed. 40,000 miners in West Virginia alone walked out of the mines, marched on the state capitol in Charleston and demanded passage of a Black Lung Bill. Three weeks later, after the Governor signed the bill, the miners went back to work. This was one of the largest and longest strikes ever on a single issue of occupational health. It was a great victory in the last period in this country of widespread working class rebellion.¹ But closer to home, a few decades later, California nurses, led by the California Nurses Association, won a comparable victory in the state's historic safe hospital staffing law.

OSHA – the Occupational Safety and Health Administration, the federal agency that regulates workplace safety and health was founded by an Act of Congress in 1970. The employers still oppose it and right-wing politicians routinely call for it to be abolished. OSHA reports that statistics show that each year nearly 6000 US workers die on the job. Fatalities continue to be highest among blue collar workers, but there is no shortage of health and safety issues among white collar workers, above all stress and stress related

¹ Aaron Brenner, Robert Brenner and Cal Winslow, eds, *Rebel Rank and File, Labor Militancy and Revolt from Below in the Long Seventies* (New York: Verso, 2010) p.79.

injuries. Carpal Tunnel Syndrome (CTS), the condition related to forceful and repetitive use of the hands and wrists is suspected to affect millions and costs victims tens of thousands of dollars in medical bills and lost time from work, yet employers dispute this as well as the evidence assembled by OSHA establishing CTS as work-related.

While fatalities may not top the list of dangers facing healthcare workers, other afflictions do. John Borsos, who has worked in California healthcare unions for twenty years, refers to Nursing Homes as the sweatshops of the 21st century. And, no surprise, nursing aides, orderlies, and attendants had the highest rates of musculoskeletal disorders of all occupations in 2010. That same year, the healthcare and social assistance industry reported more injury and illness cases than any other private industry sector– 653,900 cases. That is 152,000 more cases than the next industry sector: manufacturing.

Dangers include needle sticks, HIV, and infectious diseases. Others include (but are not limited to) potential chemical and drug exposures, waste anesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, workplace violence, and x-ray hazards. Some of the potential chemical exposures include formaldehyde, used for preservation of specimens for pathology; ethylene oxide, glutaraldehyde, and

paracetic acid used for sterilization; and numerous other chemicals used in healthcare laboratories.²

Surely, then, this is an area of great concern and an argument that OSHA needs strengthening, not abolishing. And it is an argument that employers and trade unions must make health and safety their priorities.

The growing concern of employers for the “wellness” of their workers is to be welcomed then. Of course it is. Stop smoking. Eat properly. Exercise. But the problem, as the chapters that follow reveal all too clearly, is that workplace wellness programs remain problematic, few showing substantial results. At the same time, their promoters often appear oblivious to occupational health and safety issues and instead shift attention from what are clearly social issues to individual concerns. Worse, and all too often, one finds that the concern at the top of the agenda is not health but cost. And finally, employers eager to enhance the health of their workers might consult a new study from Duke University, one that finds that loss of employment causes a similar rate of heart attack as hypertension, diabetes or smoking.³ We must ask, as Carl Finamore does in his introduction to this collection: “Do you trust your boss with your health?”

²www.osha.gov/sltc/healthcarefacilities

³www.theheart.org/section/heartwire.do. *Heartwire*, November 21, 2012.

So how did the workplace become a site to get healthy? Here we present a series of arguments. Of course we begin by agreeing that we all want to be well, we want our families well and we'd all like to live longer, healthier lives. The chapters that follow reflect diverse approaches to the subject; Finamore, who introduces the pamphlet, is a veteran trade unionist; DeAnn McEwen is a leader of the California Nurses Association/National Nurses United; Faith Simon is a Family Nurse Practitioner in rural Northern California, Lewis Maltby is President of the National Workrights Institute (formerly the National Employment Rights Office of the ACLU). Jacqueline Hart, PhD, is a member of the Graduate Faculty at Sarah Lawrence College, a sociologist, ethnographer, and activist who has devoted her career to social justice. John Borsos is the secretary-treasurer of the National Union of Healthcare Workers (NUHW).

JoAnn Volk and Sabrina Corlette are Georgetown University scholars; they have graciously allowed us to add the executive summary of their highly useful study of Wellness programs as an appendix. Their entire report including its extensive notes can be found on-line at <http://chir.georgetown.edu/publications.html> .

The pamphlet's origins are in a conference at the University of California Berkeley in July 2012. There we convened a day long symposium, "Which

Way to Wellness, "a round-table discussion of workplace wellness programs, bringing together academics, healthcare practitioners, activists, trade unionists and consumers, including the writers below. Here we have collected some of that discussion.

We must thank the University of California, Berkeley, Geography Department for arranging the space for us to meet, as well as Richard Walker, now Emeritus Professor, for his assistance and departmental staff Kristen Vogt and Natalie Vonnegut. The conference was supported by the National Union of Healthcare Workers (NUHW), the California Nurses Association/National Nurses United (CNA/NNU), the International Association of Machinists (IAM), the California Federation of Teachers (CFT) and the United Auto Workers (UAW, Local 2865), all of which co-sponsored the event and sent representatives.

In addition we want to thank Ken Jacobs, Dr. Jeffery Ritterman, Paul Kumar, Joe Lindsay, Mike Eagan, Suzanne Gordon, Katy Roemer, Samantha Winslow and Steve Early for their participation. We also must thank Fred Seavey, Pavel Vanegas, Ed Herzog and Rosie Winslow for assistance in conference arrangements and for assistance in editing this collection. And finally we must thank Paul Delehanty. Without his work this project could not have been completed.

This pamphlet is free and available for any and all who share our interests and concerns. Please pass it along – in old Wobbly tradition of “singlejack solidarity.” We only ask that it be shared as it is, not amended, edited, or revised.

Cal Winslow, Mendocino County, CA

November, 2012

Introduction

Do You Trust Your Boss With Your Health?

By Carl Finamore

It's against federal law for corporations to discriminate by charging employees different insurance rates based on their health. Everyone at work is generally charged the same.

However, there is an exception when "bona fide wellness programs" exist. These programs allow an employer to vary premiums up to 20 percent based on risk factors such as cholesterol, weight, blood pressure and smoking.

As Cancer Society lobbyist Dick Woodruff told a October 7, 2009 National Public Radio broadcast, "The whole point of health care reform is to make sure that everyone gets insurance. And if people have to pay more because they're unhealthy, that's a barrier. It defeats the whole purpose."

But it gets worse. The 2010 Affordable Care Act boosts the employee insurance premium share up to 30 percent in 2014. Based on average costs of employer-offered insurance today, Kaiser Health News reports that firms will then be able to offer annual discounts, or impose penalties, of more than \$4,500 a family or \$1,600 for individuals.

Of course, these penalties would be a huge savings advantage for businesses and, critics say, explains the big corporate push for wellness programs at workplaces across this land. According to another Kaiser Family Foundation survey, for example, around two-thirds of businesses that provide medical insurance have also established wellness programs. And, they are growing.

"We're seeing a big move in this direction driven by employers' concern about rising health costs and their sense that employee behavior has a lot to do with high costs," says Kevin Volpp, a professor at the University of Pennsylvania School of Medicine, who has studied the use of incentives in health insurance programs.

Under the soothing, holistic parlance of "wellness," these employer-sponsored programs are ostensibly designed to improve health. For example, most programs urge employees to stop smoking, lose weight, improve cholesterol and lower blood pressure.

Seems like a good idea, everyone wins. Employees get healthier and companies save money on rising health insurance costs.

"It seems almost too good to be true. Get my drift?" Lewis Maltby, president of the National Workrights Institute, dryly observed to an audience

of labor, community activists, academics and health policy experts attending a July 27, 2012 Wellness conference at the University of California, Berkeley.

Indeed, wellness programs are a mixed bag, some do better than others. But clearly, they are most ineffectual when ignoring medical science and following the uniform business model of faulting workers, in this particular case, blaming them for steep increases in insurance costs.

The worst plans actually infer workers are unhealthy because of careless attitudes, poor behavior or bad judgment. There are several problems with this corporate blind spot. To begin with, a genuinely comprehensive health care program must involve more than changing personal behavior.

Jacqueline Hart, a sociologist at Sarah Lawrence College, told the Wellness conference audience that “all of us want people to take personal responsibility for their health but most corporate wellness programs focus on the mind, essentially abandoning the body.”

By ignoring crucial warning signals generated by the body’s defense system, wellness staff of large businesses repeatedly told Hart that “attitude is the biggest part of health.”

“In other words,” Hart explained to me and others in the audience, “it’s all in the mind. Thus, for example, de-legitimizing use of sick leave” when the body just finally gives out and pleads for a break.

This is bad health policy. Contagious or physically impaired employees should not be at work. This is only one example of how corporate wellness programs, primarily interested in lowering medical insurance costs, often depart from appropriate medical standards of care.

Wellness conference organizer Faith Simon agreed. Employers often use wellness programs to suggest inadequate, simplistic or just plain wrong remedies that focus on changing employees' lifestyle when far more complex diagnoses are required. Simon is an RN, Family Nurse Practitioner and a primary care provider in a rural northern California town.

"It's not the job of the boss, their appointees or fellow employees to evaluate or to make judgments and recommendations about health. That's my job and the job of other health care providers voluntarily selected by workers," Simon emphasized to me.

In other examples cited, the worst of these programs actually penalize employees financially who do not stop smoking, do not reduce their weight, do not lower their cholesterol or do not decrease their blood pressure.

It's All in Your Mind, Or Is It?

But medical data clearly shows there are many factors that affect these benchmarks that have nothing to do with personal behavior. DeAnn McEwen RN, MSN and vice president, National Nurses United (NNU), explained to me

during the Berkeley conference that “In addition to socio-economic factors, genetic predisposition plays a significant role in determining many health factors including excess weight, high blood pressure, blood sugar, and cholesterol levels.”

This advice was echoed and expanded upon by wellness conference panelist Dr. Jeff Ritterman, a retired 30-year Kaiser Permanente cardiologist and prominent community health activist: “Anti-biotics and vaccines play a huge part improving our health but social factors have by far the biggest influence.”

“For example, mortality and class are inextricably linked. The poor die quicker and just like a step ladder your health advantage keeps getting better by degree of your wealth and education.”

Dr. Ritterman described how this all works. More income gives you more options and “more autonomy” to make healthy lifestyle choices such as the kind of food you eat. He gave a vivid example of Richmond, California where he serves on the city council. “Soda-drink companies target the poor communities and those children suffer far higher rates of obesity and diabetes because of its excessive availability.”

In middle and upper class communities, Ritterman explained, there are many more product alternatives. People have more choices.

Nurse McEwen agreed: “Low-income individuals or racial and ethnic minorities are more likely to have the health conditions that wellness programs target, and, they often face more difficult barriers to achieving better health. These include unsafe neighborhoods, substandard/decaying housing, poor air quality, lack of access to affordable healthy food, and little or no access to public transportation.”

So, it appears, the underlying precepts of the worst of these corporate wellness programs are influenced far less by genuine health science and far more by decidedly ulterior pecuniary motives. As a result, their bad medicine also leaves a bad taste by targeting workers who are in poor health for more complex reasons than simplistic behavioral misrepresentations often suggested by wellness programs.

In comments made to me, journalists Suzanne Gordon and Steve Early exposed the hypocrisy resulting from this type of corporate wellness-speak.

“Consider, for example, the chutzpah of PepsiCo’s insistence that its Teamster-represented drivers and warehouse workers in upstate New York pay a ‘sin tax’ of \$50 a month if they smoke or have weight-related medical issues like hypertension, high-blood pressure, and diabetes.

“As PepsiCo spokesperson Dave DeCecco rationalized to Bloomberg News last February, ‘These programs enable our associates and their families to have a healthier lifestyle.’ But DeCecco didn’t say whether that lifestyle change should include not eating the salty, sugary, and high-fat junk food that generates billions in profits for PepsiCo, while playing a major role in our national epidemic of obesity.”

This is not an isolated example of corporations avoiding social responsibility for their own unhealthy practices and it’s not a small problem. National Geographic News recently reported that one in four workers say their job is the most stressful part of their life.

In California’s healthcare industry, for example, such corporate hypocrisy is in full affect.

Some of the same hospital chains which have pushed hardest for “wellness” penalties like at PepsiCo, don’t want to make changes in working conditions that would significantly reduce job stress, fatigue, unsafe workloads, and other causes of occupational illness and injury.

For example, better nurse patient staffing ratios, limits on forced overtime, guaranteed lunch and break time and more lift equipment to reduce back injuries would all contribute to employee “wellness” and lower

healthcare costs by increasing patient safety. But management resists making these changes.

This is the direct experience of John Borsos, a contract negotiator and vice-president for the National Union of Healthcare Workers (NUHW), who told me that “Kaiser Permanente, Daughters of Charity Health System, Sutter and Dignity Health want to shift the focus in contract bargaining away from their own unhealthy practices to the off-duty behavior of individual employees.”

Real Wellness, About Health not About Money

Despite all the problems discussed, healthcare advocates still believe wellness programs could actually improve one’s health and successfully convince employees to make better health choices if enrollment is genuinely voluntary and without penalties, if privacy of their health status is absolutely guaranteed and if healthy choices are rewarded such as by employers subsidizing gym memberships, lowering prices for healthy meals in the employee cafeteria and paying for recommended physical examinations.

The concept of wellness originally developed from a critique of western medicine’s primary reliance on treatment, largely with drugs from big pharmaceutical companies. Critics describe big medicine this way: “How much

can we poison you to kill the thing that is ailing you without actually killing you?"

On the contrary, traditional wellness philosophy emphasizes proper nutrition, exercise, adequate rest and emotional and spiritual balance. It treats the whole body and not just our various parts and it prioritizes prevention.

If we can successfully introduce these concepts into the wellness debate at the workplace, it will perhaps open further a "healthy" examination within our society of why major corporations pushing their version of wellness are yet allowed to enormously profit from the production and marketing of so many fatty foods, sugary beverages and empty caloric snack products.

In the end, we as a society must decide whether health policy should be dictated by corporate biases or by medical facts. Let the discussion continue, our wellness depends upon it. The contributions that follow by Maltby, Hart, Simon, McEwen, and Borsos are submitted with this in mind.

Chapter 1

Workplace Wellness-At Whose Benefit?

An Examination of Program Drawbacks and Limitations

By: DeAnn McEwen, RN

Introduction

Ensuring quality patient healthcare is the number one concern of Registered Nurses across the country. RNs are patient advocates, committed to providing quality care to every patient irrespective of economic status. An RN's own health is also of paramount concern. As employees of hospital systems, RNs are exposed to a variety of factors which negatively impact health, including airborne illnesses and environmental, on-the-job stressors. Hospital employers are increasingly developing and offering Workplace Wellness Programs for healthcare employees, including RNs. Because of their intimate connection to promoting health and wellness, RNs are uniquely qualified to explore workplace wellness programs, and can highlight drawbacks and limitations of these growing employer-provided arrangements.

1. What is a Workplace Wellness Plan?

According to the United States Department of Health and Human Services, workplace wellness is a program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings. However, not all wellness plans are created equal. Many so-called wellness plans serve employer interests rather than those of the employees.

2. Why are Employers Offering Workplace Wellness Plans?

The Patient Protection and Affordable Care Act of 2010 (“ACA”) includes as one of its goals reducing medical spending by promoting health and wellness and the use of preventative tests and services. Specifically, the ACA mandates that most individual and employer insurance plans cover “essential health benefits,” which include: emergency services, hospitalization, maternity and new baby care, prescription medications, laboratory services,

mental health services, chronic disease management, and preventive and wellness services. Beginning January 1, 2014, the ACA provides for increased discounts that workers pay for their employer-provided health insurance. Group health plans may offer significant reductions of up to 30% of premiums paid by employees who participate in wellness programs.

Wellness programs must be designed with care if they are to truly improve employee health. If not, the difference in premium costs may function primarily as a cover for employers to shift costs to employees. Individual employees, particularly if they don't have a union, don't usually know the overall costs of healthcare coverage, but the employer does. The employer can adjust the amounts paid by individual employees and reduce the employer's overall costs behind the scenes. For example, the CEO of Safeway, Steven Burd, wrote in 2009 that his company maintained per capita healthcare costs flat during a recent four-year period, compared with an average 38% increase experienced by other companies during the same time period (Wall Street Journal, June 12, 2009, <http://online.wsj.com/article/SB124476804026308603.html>). He identified “health-care plans that reward healthy behavior” as “[t]he key to achieving these savings.” Yet, according to Dr. Don McCanne, Senior Health Policy Fellow

of Physicians for a National Health Program, Safeway's savings were really only from shifting their employees to high-deductible health plans.

Finally, wellness programs shift the focus from socio-economic determinants of health and structural issues within our healthcare non-system to individual behavior. In so doing, they undermine solidarity by encouraging workers to blame each other for the high cost of healthcare to their employer and, increasingly, to themselves.

3. What are Drawbacks and Negatives of Wellness Plans?

One point of concern of employee participation in workplace wellness plans is that participation be truly voluntary, rather than coercive. But an employer may coerce employees to join a wellness program in exchange for receiving a preferred insurance plan and/or preferred employee co-pays or plan premiums.

A distinct negative to the emergence of wellness programs is predicating an employee's receipt of health insurance on an economic scale of incentives or disincentives. The academic term for this financial-focused arrangement is "Behavioral Economics."

Behavioral Economics, shifts costs to sick; incentives v disincentives

“Behavioral Economics” and “Choice Architecture” are being used to shift health care spending from the healthy to the sick by directly or indirectly assessing financial penalties against those who are unfortunate enough to have greater health care needs.

Choice architecture is a way of organizing choices in such a way that influences people’s decisions. Starting in 2014, employers can offer workers incentives worth up to 30% of their cost of health coverage for participating in a “wellness” program and achieving certain “health” benchmarks.

Such incentives are unfair because an individual’s health status is a result of a complex set of factors, not all of which are completely under an individual’s control. Most injuries and illnesses for which the employee would require care will not be prevented by wellness program interventions.

Behavioral economics could exacerbate health disparities and have a harmful, unfair impact on older workers and people who suffer from chronic diseases by making them pay more for their health care.

Genetics, predispositions; addictions

The scientific literature offers an abundance of empirical evidence regarding the bio-psycho-socio-economic determinants of health. Financial incentives don’t always work to change behavior. Requiring employees to

participate in order to receive an incentive without taking into account barriers to participation such as health status or other familial or work obligations could lead to even greater health disparities. Genetic predisposition plays a significant role in determining many health status factors including such attributes as excess weight, blood pressure, blood sugar, cholesterol levels, and chemical dependency.

Job stressors

According to the Centers for Disease Control and Prevention/National Occupational Safety and Health, stress is pervasive in the American workforce. Work-related stress is more strongly associated with health complaints than are financial or family problems. The National Institute for Occupational Safety and Health (NIOSH) defines job stress as “the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker.”

An impressive body of empirical research supports the link between job stress and problems in health and safety. Mood and sleep disturbances, stomach/digestive system disorders, headaches, and disrupted familial relationships are common in early manifestations of job stress.

In addition, rapidly accumulating evidence suggests that stress at work plays an important role in high blood pressure and elevated cholesterol levels,

cardiovascular disease, infectious and autoimmune diseases, anxiety and depression, and accidents and injuries.

Job stress is believed to account for approximately 50% of all workplace absences and for as much as 40% of employee turnover. Factors that have increased job stress among nurses in particular and other workers in general include budget cuts, increasing workload, and constant organizational changes.

Occupational safety and health researchers and practitioners agree that nurses are heavily exposed to a myriad of “psychosocial stressors” in their daily work. The term “psychosocial stressors” refers to stressful working conditions and/or job characteristics that relate to how tasks are designed and can also refer to the management style, interpersonal relationships and work roles that impact all workers in the employment setting.

Examples of these stressors include:

- Heavy workload
- Shift work
- Conflicting job demands
- Long work hours
- Understaffing
- Time constraints and pressure

- Increased productivity demands
- Lack of social support at work; especially from supervisors and higher management
- Exposure to hazardous substances
- Exposure to bullying and physical violence

Potential/Recognized adverse health effects of occupational stress:

- Psychological (irritability, job dissatisfaction, depression, burnout, PTSD)
- Behavioral (sleep problems, absenteeism)
- Physical (headache, upset stomach/digestive tract disorders, changes in blood pressure)
- Biochemical (Cortisol-secretion; elevated stress hormone associated with altered immune system response; obesity-weight gain/inability to regulate weight, achieve weight loss; heart disease; stroke; blood pressure/blood glucose control; memory impairment; reproductive endocrine, and growth processes; mood, motivation, and fear responses; insomnia; worsening of skin conditions-hives, shingles, eczema)

Poorly designed and implemented workplace “wellness” programs may have unintended consequences such as coercing and individual with a health

condition to participate in an activity without adequate professional medical supervision. Employers may create hostile work environments and induce the blame game as they use their “wellness’ programs to penalize employees who have medical needs, by reducing their health care benefits and increasing financial barriers to care. If employers are truly concerned about the well being of employees they should address workplace stressors and working conditions that have been shown to predispose workers to an illness and/or injury.

Disease and wellness screening should be provided privately, in an entirely separate primary care environment where the screening is part of a comprehensive, integrated health care program that belongs to the patient in collaboration with a licensed provider of their choice; not the employer or employer designated unlicensed “health” coaches/peer counselors.

This is yet one more reason why health coverage should be totally dissociated from employment. If we had an expanded and improved system of Medicare for all that covered everyone, health care access would be continuous throughout life. Barriers to health care should never be used to punish individuals unfortunate enough to have manifest or contracted medical problems.

Discrimination/backdoor redlining

Tying the cost of insurance to the ability to meet certain health status “goals” could discriminate against low-income individuals and racial/ethnic minorities. These individuals are more likely to have the health conditions that wellness programs target and they often face more difficult socio-economic barriers to health, such as unsafe neighborhoods; poor air quality; substandard/decaying housing; lack of access to affordable, healthy food; poor/no access to public transportation.

The ACA prohibits charging higher premiums based upon one’s health status. This is of critical importance to minority communities and persons with chronic conditions who are disproportionately affected by health disparities. Health disparities are the result of many socio-economic factors that may predispose an individual to illness or injury. Wellness programs do not account for or address these factors. Rather they shift the focus of managing one’s health onto the individual alone, creating the potential for discrimination through backdoor medical underwriting and redlining for individuals with pre-existing conditions or disabilities.

Privacy

Employer access to health data and information on employees has not been clearly addressed and is subject to interpretation. Electronic records can

be hacked, shared and distributed, possibly subjecting the victim to discrimination in hiring and employment practices, shame or humiliation.

Without the proper safeguards, wellness programs threaten individual privacy, especially if information is collected by employers who are not subject to federal and state healthcare privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA).

According to the Department of Health and Human Services/HIPAA Health Information Privacy website (HHS.gov):

[http://www.hhs.gov/ocr/privacy/hipaa/faq/public health uses and disclosures/301.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/public%20health%20uses%20and%20disclosures/301.html)

Employers and Health Information in the Workplace

The Privacy Rule controls how a health plan or covered health care provider discloses protected health information to an employer, including your manager or supervisor.

- **Employment Records:**

The Privacy Rule does not protect your employment records, even if the information in those records is health-related. Generally, the Privacy Rule also does not apply to the actions of an employer, including the actions of a manager in your workplace.

- **If you work for a health plan or covered health care provider:**

The Privacy Rule does not apply to your employment records.

The Rule *does* protect your medical or health plan records if you are a patient of the provider or a member of the health plan.

- Requests from your employer:

The Privacy Rule does not prevent your supervisor, human resources worker or others from asking you for a doctor's note or other information about your health if your employer needs the information to administer sick leave, workers' compensation, wellness programs, or health insurance.

What would an ideal Workplace Wellness Plan look like?

First, wellness programs should not increase the cost of healthcare for employees. Wellness programs should not link participation and performance in the program to employee co-pays, deductibles, premiums, or cost-sharing. Employer efforts to reduce healthcare costs through bribing employees to participate in wellness programs is destructive to the dignity and humanity of participating employees; during financially challenging times like the current economic crisis, employees trade self respect and autonomy for access to insurance and healthcare.

Wellness programs must address the needs of all employees in a particular workplace, without regard to gender, ethnicity, primary language, job description, physical or intellectual capacity, or socio-economic status. Workplace wellness programs must be culturally sensitive and inclusive to further social aims of a diverse and dignified workplace. Discrimination on any basis has no place when providing for health and well being.

Wellness programs must be voluntary, encouraging healthy lifestyles for every worker. Examples include an employer-sponsored Farmer's Market; a smoke-free worksite; walking trails, atriums, and meditation rooms for employees during break times; employer commitment to provide scheduled meals and breaks during the worker's shift; adoption of healthy human resource policies to prohibit mandatory overtime and offer paid sick leave and vacation time off; end punitive sick-leave/absence control policies so workers can stay home when they are ill to avoid infecting others.

Our ultimate goal is a national single-payer "Medicare for All" healthcare program. As we reach for and work toward universal healthcare, workplace wellness programs can have a place in national healthcare, provided the programs are carefully implemented and maintained.

Conclusion

The Patient Protection and Affordable Care Act of 2010 legislates financial advantages to some employees who pay premiums for employer-provided health insurance through participation in workplace wellness programs. Likewise, employers seek to reduce costs of healthcare for themselves, increase worker productivity, and reduce claims for workers' compensation by introducing wellness programs. Balanced against these purely financial interests are important individual and social considerations arising from workplace wellness programs. Potential pitfalls to these programs include: behavioral economics and cost shifting; genetics and predispositions to illness or disease; job stressors; discrimination; and privacy concerns.

Everyone should have access to a wide range of health benefits, a free choice of doctors and healthcare providers, and uninterrupted coverage when unemployed. Linking healthcare to employment means that those who become unable to work due to illness or injury lose their healthcare coverage at the time they need it most. If we are serious about providing high-quality, affordable, and humane healthcare as a right, not a privilege, the real solution to America's health care crisis is a Medicare-for-all, single-payer system. Until then, we will remain the only major nation that does not provide health care

for every man, woman and child as a right; free from interference or denial by reason of the commercial, economic, or fiscal interests of insurers or employers.

A single payer system controls costs without the necessity of imposing financial barriers such as higher premiums and high deductibles. For union members, a Medicare-for-All, single payer system would solve the problem of stalled or failed contract negotiations by taking health care issues off the bargaining table. The Nurses Care Plan to Heal America advocates for a change to policies that take care of patients first rather than policies that shift costs from employer or government budgets to individual patients.

Chapter 2

Wellness, When the BMI is Not Enough

By Faith Simon, RN, FNP

I am a family nurse practitioner in a rural northern California clinic. I spend many hours a week talking to adults, parents and children about health behaviors.

I ask about food choices, soda/juice intake, and family meal plans, cooking styles, grocery shopping and fast food. We talk about cigarettes, alcohol and other drugs. We talk about exercise habits. Overwhelmingly, my patients are aware of the “obesity epidemic”; they want their children to choose broccoli over potato chips, they are “rethinking their drinks” (the popular public health campaign) and choosing water over soda (or at least believe they should be). They worry about diabetes. Few defend trips to McDonalds. They want to be “well.” I have been doing this for years; and it’s far from new in my profession.

The recession drags on here; more, it’s always been a poor place. Still, it’s far from a food desert. Our local school has a splendid garden to table food program; it supplies the cafeteria with fresh produce and adds a highly

practical element to classroom health educational programs. We have community gardens and farmers markets. We have one of the best food banks in California (supplying people with some produce but also all too much high fructose corn syrup processed foods). We have of course our Safeway, plus a high end, locally owned supermarket. Both promote fruit, vegetables, and organics. We have two health food stores.

Poverty

It remains, however, a poor community, with poverty more than twenty percent. Seventy percent of the elementary students qualify for free breakfast and lunch school programs. And our family advocacy center currently prepares weekend grocery bags for 80 homeless students and their families.

One result of this: in the population I serve it is common to find children and adults with a BMI (Body Mass Index) of well over the “allowed” 25% mark.

The question is why? I don’t believe is just a matter of the absence of healthy alternatives (we also have a sensational new rec center here). I believe that behaviors considering food and exercise issues (as well as smoking and drinking/drugging) are not simply just bad decisions made by uniformed people; people without alternatives, though of course healthy

alternatives are always indispensable. Health behaviors are complicated and occur in social, political, cultural and biophysical settings (the ecosystems of our bodies). The answer, it seems to me, is to be found not just in diet and exercise (or lack thereof) but in our (and my patients) whole way of life. So this will include housing, employment safety and security, educational opportunities, environmental exposures, family dynamics and other stressors that are clearly more important to a plan for “wellness” than is one single biometric measure.

I have to say straight out that I believe the BMI is useless as a tool for helping people live healthier lives. It is a crude measure of body fat, the ratio of weight to height that has somehow been elevated to a position of prominence in “the war against the ‘obesity epidemic.’” (A concept that is itself quite suspect.)⁴ The BMI does not take into account skeletal mass, ethnicity, gender, visceral v. subcutaneous adiposity (where the body fat is located), or functional issues (activity). Moreover, BMI “standards” reflect changing cultural ideas of optimal sizes and “normals” that are always evolving. The BMI is not derived from clinical assessment of well-being but from a mathematical formula. Yet, I am required to measure BMI on all children who have state sponsored insurance (Medical, Healthy Families, etc.)

⁴ See Julie Guthman, *Weighing in, Obesity, Food Justice, and the Limits of Capitalism* (Berkeley: UC Press 2011).

and I will lose the reimbursement if I do not document this. In fact, there is currently a national program (school-based BMI-measurement programs initiated by the CDV and implemented in 13 states) to collect the BMI on *all* school children. The new Physician's Assistant in a nearby town has been hired with a primary task, to collect this data on every single student from Kindergarten to 12th grade.

Perhaps there is some utility in BMI as an epidemiological tool but it has little to offer as a tool for encouraging positive behavioral change. In fact it may do more harm than good.

Discrimination

Multiple studies, for example, have demonstrated systematic discrimination against people identified as “fat” in employment opportunity and advancement, in housing and in healthcare. Singling out “fat” people as the cause of rising healthcare costs can only discourage people from seeking care for what is itself a medical problem. Dr. Margot Waitz, a specialist in pediatric, adolescent eating disorders, has suggested that mass screening in schools for BMI may trigger eating disorders in students.⁵ And it is important

⁵ Margot Waitz, “Eating and Feeding Audio-Digest, Family Practice Vol. 58, Issue 36, September 28, 2010.

to note that no studies I know of have demonstrated improved *outcomes* as a result of BMI surveillance.

What, then, is a predictor of poor health? Well, poverty for a start; it has long been understood as the primary factor in understanding poor levels of health and longevity. The problem is that to consider poverty we must shift our gaze from the individual (and individual failings) to the society, and the BMI won't help us here.

Let me give you an example: I have a patient, a 15 year old girl who presents wondering about diabetes because she is fat. She is well-dressed, well-groomed and plays on her school volleyball team. Her family shares a two bedroom apartment with another family. Her father has been deported. Her mother works two jobs in local hotels; she is diabetic. Maria's food journal records frequent dinners of cereal and milk (easily accessible at the food bank). When her mom is not working she cooks traditional Mexican food, in abundance, greatly appreciated by all.

Helping people make healthy lifestyle decisions and acting upon them in conditions such as these is a very complicated business. (The County abandoned the field of affordable housing a decade ago). The fact is that everyone's life story is different, and that each human being is constantly changing biophysical social ecosystems in continuous interaction with the

environment. So two people may have the same BMI but completely different distribution of adipose tissue that may or may not represent a risk factor. This is about where the fat is on the body. Fat under the skin is generally harmless, whereas fat that surrounds internal organs can be a high risk factor for diabetes, stroke and heart disease. Some of my patients are on pharmaceutical products or have a pathology that leads to weight gain. I have families where parents are working 2 or 3 jobs (for altogether less than a living wage) and are *forced* by time and money to grab the quickest, easiest (high fructose) food for themselves and the children. I have parents who are farmworkers who have been exposed to estrogen disrupting chemicals in pesticides all their lives (chemicals known as obesogenic – causing weight gain). I have patients who have been sexually abused who may gain weight in a conscious or unconscious effort to protect themselves from further assault. Some of my patients overeat or eat the wrong food because they are lonely, or sad, or frustrated, especially those whose lives have been battered by trauma, racism, hopelessness and poverty.

I have to say, again, that none of this is really new. I have been grappling (as a primary care health provider) with these issues for 15 years. I have attended conferences, read articles, taken a university based certification program on how to treat obese children. I have recommended dietary

changes, cooking classes, Michael Pollan's guidebook to grocery store shopping, exercise classes, walking and dancing.⁶ Of course I will continue.

Limits

What I have learned is that there are limits to what can be done on an individual basis when we live in a system that produces nutritionally poor food (sometimes toxic food) industrially to be sold for profit to underpaid consumers who are then blamed people for eating it.

Workplace coaches are not equipped to deal with the complexities of eating behaviors; neither school yard peers. Monitoring BMIs whether in the workplace or the schools can't take the place of clinical medicine or laboratory science and ongoing holistic healthcare, including social psychological assessment. And holistic healthcare concerns not just the individual but the family and community as well, and here it is impossible not to notice that "Wellness Programs" are most often connected to cost-shifting in the context of a collapsing social safety net. Mental healthcare has been virtually abandoned in this County. "Wellness" is not a single faceted phenomenon that can be solved with financial incentives or worse punishment: 'Wellness programs' like other surveillance based health programs focus on individual

⁶ Michael Pollan, *Food Rules, An Eater's Manual* (Penguin Books: New York 2009).

behavior and choices. They ignore the broader political and economic situations in which these choices are made and we are paying the price for this.

Chapter 3

Employer Wellness Programs, The Good, the Bad, and the Ugly

By Lewis Maltby

Thousands of employers have created corporate wellness programs. These are presented to workers and the public as a “win-win”; employers reduce health care costs and employees get better health.

The reality, however, is often far different.

An Inconvenient Truth

The greatest problem with wellness programs is invisible; it lies in what they do not say. Virtually all employer wellness programs focus on the behavior of the individual employee. The goal is to get workers to stop smoking, exercise more, improve their diet and make other changes in their lives to improve their health.

But such programs ignore the damage to workers’ health caused by the employer. Many employees are injured on the job, either in accidents or by exposure to toxic substances. According to the Bureau of Labor Statistics, over 3 million workers were injured on the job in 2010.⁷ Almost 5,000 more

⁷ U.S. Bureau of Labor Statistics, October 20, 2011 News Release

workers were killed on the job.⁸ Many of these injuries and deaths were caused by employers violating safety rules. British Petroleum's Deepwater Horizon drilling platform had numerous safety hazards that were ignored by management; 11 workers died as a result.

Any serious workplace wellness program must begin with ensuring that the company is complying with all applicable safety rules. Management worrying about the damage to workers' health from poor diets while violating federal safety regulations would be funny if it were not so tragic.

Workplace Stress

Stress is more than unpleasant; it can kill you. Stress has been linked to heart disease, ulcers, diabetes, depression and many other medical problems. Some experts believe that stress is at least partially responsible for the majority of doctor's visits.⁹ Some amount of stress is unavoidable. But many employers increase stress with inflexible scheduling, excessive production requirements, electronic monitoring, and the lack of any system for responding to workers' concerns.

Workplace wellness programs need to examine sources of stress in the workplace and take steps to reduce it.

⁸ U.S. Bureau of Labor Statistics, www.bls.gov/iif/oshwc/cfoi_revised10.pdf

⁹ stress.about.com/od/stresshealth/a/stresshealth.htm

Carrots and Sticks

A wellness program that helps achieve goals set by workers themselves benefits everyone. Most of us are aware of our bad habits and would like to reduce them. The majority of smokers (69%) want to quit.¹⁰ Having the employer pay for smoking cessation programs and the cost of nicotine patches would be beneficial. Providing the program at the workplace during business hours would make it much easier for workers to participate at a modest cost to the employer.

Employers can also create exercise facilities, subsidize health club memberships, provide healthy food at discount prices in the cafeteria, and pay for voluntary consultations with medical wellness experts.

But many wellness programs are coercive. Workers who do not meet with a wellness coach are penalized by having to pay more to participate in the company medical plan. Employers claim that they are only providing a discount to employees who participate, but this is nothing more than word games. If a worker's paycheck is reduced if she does not participate in the wellness program, she has been penalized.

Often, participation alone is not enough. Workers are required to achieve results set for them by their wellness "coach". Those who do not

¹⁰ Smoking Cessation(tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm)

reduce their body mass index, reduce their cholesterol, stop smoking, or achieve other goals have their paychecks cut.

Personal Autonomy

Such programs give employers great control of workers' private lives. Virtually everything we do affects our health. The list of food with health effects is virtually endless. Alcohol, caffeine, sugar, and fat all affect health. So do our leisure activities. Skiing, scuba diving, and most other outdoor sports have a risk of injury. Even riding a bicycle creates risk. Someone with many sexual partners is at increased risk of contracting an STD. The most expensive thing workers can do is have children. Allowing employers to control health related behavior allows them to regulate our entire private life.

Privacy

Wellness programs with penalties also undermine workers' privacy. In order to impose penalties, the employer must know about the behavior in question. In some cases, such as smoking, there is little intrusion on privacy. For other behavior, the answer is quite different. Your employer cannot impose the penalty for excessive consumption of alcohol without knowing how much you drink, including drinking in your own home. For excessive fat consumption, the employer will need to know the worker's entire diet. For

STD risk, the employer will have to know how many sex partners you have, the identities of each, and what forms of sex you practice.

Employers argue that they should not be required to subsidize unhealthy behavior by charging workers with bad habits the same for health insurance as those who reduce their risks by healthy living. There is some logic to this claim. Life insurance companies charge higher premiums to smokers and sky divers; why shouldn't employers be able to do the same?

The ultimate solution to this conundrum is to get employers out of the health care business. The American model of providing health insurance is a historical accident of wage and price controls and tax policy. It also fails to provide health insurance to people who are unemployed. This model now creates financial incentives for employers to control workers' private lives. We need to provide health care through single payer or other system that is not employment based.

Until this occurs, we will be forced to argue about the relative importance of personal autonomy and health care cost control.

Even if employers are allowed to link workers' contribution to the cost of medical insurance, it must be done fairly.

Behavior not Outcome

Any program involving differential costs to workers must be based on behavior, not outcomes. A worker can control whether or not she smokes, eats healthy food, and exercises. But she cannot control the outcome of her behavior. Weight, cholesterol levels, and most other medical indicators are in part controlled by genetics. Some people can eat cheeseburgers every day and have low cholesterol. Others live on lettuce and still have high cholesterol. Penalizing workers for something beyond their control is unfair. Any financial incentives to workers should be based on their behavior.

Actual Cost

If a worker who smokes is required to pay more for the company medical plan because she has higher medical costs, the size of the penalty should be limited to the employer's additional cost.

This is not required by current law. Under HIPAA, employers can increase the worker's cost to participate in the medical by up to 20%. All that is required is that the penalty be "designed to promote good health". The employer is not required to demonstrate that the size of the penalty even approximates the increase in employer cost. Even if the worker can conclusively demonstrate that the penalty is much higher than the employer's increased cost the penalty is legal as long as it does not exceed 20%. This

allows employer to arbitrarily reduce the pay of any employee who engages in any unhealthy behavior.

This abuse will continue to grow when the penalty employers can charge without justification increases to 30%.

A Better Way

Wellness programs are a permanent fixture in employer provided health care. The cost of employer medical plans now exceeds \$15,000 a year for each employee.¹¹ Even a small employer with less than 100 employees now spends over \$1 million per year on health care. With costs of this magnitude, employers will continue to aggressively pursue all available methods of reducing them, including wellness programs. No action by workers, even those with a strong union, will eliminate wellness programs completely.

Nor is this a desirable goal. Workers benefit from better health, both financially and in the quality of their lives.

Our goal should be to develop wellness programs that address all threats to employee health, including those created by the employer. Any wellness program should begin by providing workers with tools for improving their health such as paying the cost of smoking cessation programs or exercise

¹¹ www.washingtonpost.com/blogs/ezra-klein/wp/2012/09/11

facilities. Plans that involve increasing workers' contribution to the cost of medical care should be the last option used only when necessary.

Even then, the employer should only penalize behavior, not outcomes that may be beyond the worker's control. The size of the penalty should be only what is needed to induce the worker to change the behavior and in no case should exceed the demonstrable cost to the employer.

Worker Involvement

A wellness program that meets these requirements cannot be designed by the employer alone. It is not in employers' interest to include workplace health risks in a wellness program.¹² Workers must have an equal voice for wellness programs to become the win-win strategy they are claimed to be.

While the specifics of each company's wellness program will be different, it would be very valuable to have a model wellness program designed by workers and worker advocates as a starting point. Without such a model, any discussion of workplace wellness will begin with a model designed to maximize employer profits, not workers' health.

¹² In some cases, it is in the employer's long-term interest to improve workplace safety because doing so reduces the cost of workers compensation claims. But in most cases the employer is better off financially focusing the program on worker behavior and taking a punitive approach.

Chapter 4

Mind Over of Matter. Corporate Health Care and the Bottom Line. Can Wellness Hurt You?*

By Jacqueline Hart, Ph.D.

I have been interested in the “Wellness Movement” since the nineties when I did a two-year study of the Wellness Department of a large corporation. I was interested in the wellness movement, what it meant and how it was being implemented, especially and increasingly in the workplace.

I’ll call it “Company X”, a global health services company, one of the top insurers in the US with a workplace wellness program which had then an annual budget of \$4 million and 29 full-time staff.

Along the way I had lots of conversations about individual responsibility for health and illness and the ways in which the worksite as an institution is really critical for putting a bite into wellness, something that sounded so warm and fuzzy. And these conversations became important for my understanding of what I call “wellness in action.”

*This chapter is adapted from Professor Hart’s presentation at the Berkeley conference.

An Appealing Movement

Wellness is widely understood to be supportive and friendly to us, something that feels good. It also plays a role in responding to what has, in many ways, been an important critique of western medicine. It has fit in with and been part of the New Age Movement in health with its increasing stress on mind over matter and the idea and that you are in control of your destiny, health above all. And this is an appealing movement especially in the context of the United States; especially in our American culture, of course, because we like to think that we can take control of our destiny, that we have control over things.

Wellness programs developed in the context of rapidly escalating healthcare costs. The way that all this typically was viewed was as an increasing health care cost burden for employers. A result of this, it was argued, was that it makes US workers more expensive and that this is it detrimental to the bottom line and compromised global US competitiveness.

So what could be the solution? Well, we can't really touch corporate interests and the structural arrangements of society, so let's focus on the individual. How do we do that? We can focus on individuals where they work and how they get their health insurance.

And, so it follows, let's respond to rising health costs by making people healthier. The road to hell, of course, is paved with good intentions, but, again, "wellness" sounds so fuzzy and warm and lovely, what could be better? We all win!

But, here's my question, what actually happens when the idea of "wellness" is applied in a setting like the workplace? How is it implemented there and what understandings must be in place there for it to take hold?

So I took these questions as the basis for my ethnographic investigation. I worked in the international headquarters for two years – in their Wellness Division.

"Winning" with Wellness

I want to focus on this program they called "Winning." The wellness ethic or ethos comes with a real bite when it's implemented in a company that's very self-assured and where employees are subject to its policies, around health and illness. That is, it's not just a nice idea, it comes with consequences.

Take "risk" for example. What about risk, and why is it so important in "wellness?" (And controlling costs?) Because risk is central to the wellness ethic, that is it is important to identify and control risk factors, through lifestyle and health behavior changes. But lot of the construction of the notion

of risk itself is wrong, because everyone is at risk and when we start thinking about pre-risk, we are talking about nothingness. We are all at risk for something. I think we need to be more critical about how public health data is being used in the name of “wellness” and risk control.

Back to “winning” and the question, are we “winning with wellness?” This program (at Corporation “X”) was new, it was considered to be cutting edge and it was focused on the reduction of short term disability costs. The goals were to get the employees back to work faster and at higher productivity levels and more generally to prevent the incidence of short term disability (STD) leave. Just briefly this plan was based on targeting six STD categories that were the highest cost categories: breast cancer, back pain and injury, respiratory illness/ asthma, diabetes, hypertension/ cardiac disease and STD repeaters (which become an illness, I guess). Then there were five tracks of behavior change. The understanding, as stated in an internal report, was that it is widely accepted that we can trace these STD diagnoses back to risk factors and therefore prevent these categories with behavior change: weight management, exercise, stress management, smoking cessation and cholesterol management.

So the program implemented these behavior change tracks in order to reduce STD costs. “Wellness” staff in turn became “coaches” and began by

calling people who had had been granted STD leave. So they were at home on STD when they were called, repeatedly, and “encouraged” to participate in this “voluntary” program.

I think a comment I need to make here is about how we move forward with a reasonably effective and fair “wellness” program in the workplace. It’s true that “voluntary” is necessary but voluntary means a lot of different things. How voluntary was this voluntary? When you’re sitting at the bargaining table voluntary is not enough. Because it’s a slippery slope when it rests on company definitions of what people should be doing.

Attitude Adjustment

The key findings that I’ll talk about today are that the program it became increasingly focused on attitude adjustment and it became increasingly standardized. And the implementation of wellness interventions also became quite standardized. One size fits all.

Now, to state the obvious, wellness and business in the US is a really lovely match. And why? Cost reduction and profit.

Illness in this process became quite delegitimized. This is all the more important because this is happening in the workplace, the place of your livelihood and, not coincidentally, where it’s tied to benefits and tied to employment and to assessments of productivity.

There is also a larger social comment we can make here about how it this erodes notions of the common good and social cohesion when we say that illness is not legitimate.

The focus of wellness instead becomes “attitude adjustment.” Essentially what I found in practice is that the body itself is sort of abandoned. The focus instead turns to attitude and someone’s willingness to take on responsibility in the company’s proscribed ways. Part of this is that definitions of the key terms in “wellness” are actually important. So when we talk about health and wellness and wellness programs, often what people really talk about is a sort of hyper health and healthiness (healthism). And it is centered really on an individual’s desire to be healthy and the ways in which they apply themselves to that.

There has been some talk about what we think might be different approaches toward being healthy. For example, would it be better for you and possibly much more effective to take a day off to rest when you’re tired because you’ve worked too many long days in a row?” No, this is not considered something that’s legitimate in pursuing your wellness.

This meant that the wellness program staff increasingly thought about health in terms of their role in doing character and attitude surveillance. They

aimed their training and their coaching on these behavior change tracks and toward adjusting behavior and attitude accordingly.

This, of course, provides an avenue deep into private lives when you're talking about attitude. This blurs the line between public and private domains. It's so deeply personal. But attitude equals your health and illness. One of the coaches on the wellness staff said something I heard many, many times: attitude plays the *biggest* part of your state of health. So, again, one size fits all. The idea is that wellness can provide a solution for people at any stage of any disease. So when we think about who can benefit, we conclude that everyone can benefit, no matter who you are, no matter where you live, no matter what your physical condition, because your attitude is what facilitates your participation. So then everyone can benefit from the same intervention. It gets us right back to classic Horatio Alger myth that we can all be equally successful. Again, wellness and business are a nice match.

Society and Structures

Wellness in this sense privatizes social problems and denies the social production of health. All this is all the more true when we are talking about wellness in the workplace, a very particular institutional context. We have to deal with that context. But I think that if we keep in mind the ways that health is socially determined, really socially determined, that we can find a way to

propose alternatives that make wellness positive and fair. We need to keep our eyes on that evidence as well, our society and structures, and production, where people are supposed to be producing.

In its wellness program, corporation “X” outlined the ideals of a valued employee. And they went beyond lifestyles. Through wellness, the company spelled out who it wanted, who it wanted on its team and who it didn’t. I did an interview with a vice president who described the philosophy of wellness within the corporation’s goals. *“It has to do with personal responsibility. It’s giving people the information they need to exercise their own responsibility towards themselves...That’s consistent with all the other values of this company anyway, to bear responsibility, to follow through, to do whatever it takes, to take advantage of the resources that are available.”*

Can Wellness Hurt Us?

So healthy people do their best. Healthiness is defined in this way, through attitude - and through the desire to do well, to volunteer, to participate. And, of course, healthy people are the good employees. One consequence of this is that illness and sick leave are delegitimized. Rather, there is a privileging of self-knowledge and self-help and “agency” - again, all the things that sound really nice. Who doesn’t want a sense of agency? Medical care is delegitimized. We already know that sick people have a bad attitude;

that's why, I was told by the director of the Wellness Division, they're repeat STDers.

The question then becomes, can Wellness hurt us? And the answer is "yes."

In corporation "X," gatekeepers were placed in front of gatekeepers, all to keep the consumer even farther away from the caregivers. Self-help first, then the wellness coach. I heard of one man who was told by his doctor to stay home. He called the Wellness Director and begged her to intervene. She did, the doctor relented and he went back to work. Why? I can't believe he wasn't first of all worrying about his job.

So can wellness hurt us? Yes, it directs attention to individuals and away from structural conditions. It can distance people from real healthcare by substituting coaches, ambassadors, and peers. It can offer incentives to not use medical care and it privileges personal knowledge of self over medical care and the places the desire to be well above the fact of wellness. And, then, above all, there is the business bottom line, the imperative of production.

Chapter 5

The Surrender of Oakland: The 2012 National Agreement between the Coalition of Kaiser Permanente Unions and Kaiser Permanente

By John Borsos

Introduction

In 1948, General Motors (GM) and the United Auto Workers (UAW) negotiated a path-breaking collective bargaining agreement that set the tone for labor relations in the United States for at least a generation. Dubbed by *Fortune* magazine at the time as “The Treaty of Detroit,” the GM/UAW agreement “proved a milestone from which there was no turning back,” according to Nelson Lichtenstein who has studied the UAW extensively and the author of a well-regarded biography of UAW president and architect of the agreement, Walter Reuther. [Lichtenstein, p. 280.]

The agreement allowed the giant automobile corporation to regain control of production and productivity in exchange for predictable annual wage increases, the further pegging of wages to increases in the cost of living as defined by the Bureau of Labor Statistics, and subsequently, corporate paid, rather the publicly provided, health insurance and pension. At the time,

Fortune noted “GM may have paid a billion for peace, but it got a bargain. General Motors regained control over one of the crucial management functions . . . long range schedule of production, model changes and tool and plant investment.” [Lichtenstein, p. 280.] Lichtenstein further quotes Frederick Harbison, a well-respected labor economist, on the treaty and its aftermath: “This kind of collective bargaining calls for intelligent trading rather than table-pounding, for diplomacy rather the belligerency, and for internal discipline rather than grass roots rank and file activity.”

[Lichtenstein, quotes are from p. 292]

Ultimately, the 1948 negotiations established the framework that continue to this day where the UAW became the junior partner of the Big Three automakers, unwilling to challenge the automakers on the issues that mattered most—production design, assembly-line speed, capitalization and investment. Indeed, it is that framework that locked the UAW into joining with Detroit’s auto makers in lobbying Congress to oppose increased fuel standards and other consumer-friendly legislation, for fear of disrupting Detroit’s profit-making capability.

But compared to the agreement recently negotiated by the Coalition of Kaiser Permanente Unions (CKPU), led by the Service Employees International Union (SEIU), on behalf of nearly 100,000 caregivers employed

by Kaiser Permanente, the Treaty of Detroit in retrospect appears like an unadulterated success. If *Fortune* magazine were covering labor relations today, like it did in the late 1940s, it might label the CKPU/Kaiser Permanente agreement “The Surrender of Oakland.” This puts a geographical marker on perhaps the most dramatic capitulation of a labor union to a corporation, “enshrining” Oakland because it is both the national headquarters of Kaiser and the headquarters of the largest single union in the CKPU, SEIU’s United Healthcare Workers West which represents approximately 47,000 of the roughly 100,000 coalition union members.

The new agreement not only cedes to Kaiser total control of production, in this case, how patient care is delivered, but it binds the union to full-scale embrace of Kaiser’s marketing campaign and corporate growth agenda. Finally, in a provision that smacks of the pre-UAW days in the automotive industry at Ford, when social workers on the Ford Motor Company payroll visited workers at home to ensure that they were living lifestyles befitting the puritanical prejudices of the company patriarch Henry Ford, the Kaiser-CKPU agreement includes an extensive, invasive “wellness” program that ties workers’ earnings to participation in company-supervised programs that measure and track workers’ body mass index, alcohol consumption, drug use,

sexual activities and other metrics that may indicate a less than healthy lifestyle.

In short, the Kaiser-CKPU national agreement represents the complete capitulation of labor to management—in production, in marketing and capitalization, and even by allowing the employer to invade Kaiser workers' lives outside the workplace. Rather than acting as defender of workers' class interests in relation to the nation's largest HMO and healthcare provider, CKPU establishes labor as a supplicant "partner" to Kaiser's corporate agenda. Finally, the agreement serves up SEIU and other coalition union members as guinea pigs. Offering the employees they represent as tools of management, SEIU and the CKPU are obligated to market Kaiser's long-term business plan by convincing other employers to enroll in Kaiser's cost-saving wellness program, marketed as "Total Health," that they themselves are now enrolled in.

Abdicating their role as patient advocates, the new agreement will have SEIU and other coalition unions offering the endorsement of "healthcare" workers in promoting programs that may not be in anyone's best interest except for employers trying to reduce healthcare costs.

1. The Background of Kaiser Permanente and Its Unions

Since its very inception in the 1940s, Kaiser Permanente has enjoyed a reputation as one of the most progressive, pro-union employers in the United States, not just in healthcare, but among all industries. Started by the industrialist Henry Kaiser to provide affordable, pre-paid health insurance for his employees who built the Grand Coulee Dam it then expanded to workers in the shipyards of Portland and the Bay Area. Pushed by the unions that represented workers in the shipyards, Kaiser extended medical coverage to include spouses and children at extremely affordable rates, leading it to be dubbed “the HMO that labor built.”

As summarized by Thomas Kochan and his co-authors in their recent study of the Labor-Management Partnership (LMP) at Kaiser Permanente, “Henry Kaiser did not invent prepaid medical plans but he was the first to build large scale an integrated model that included prepaid group health insurance and medical care provided by groups of physicians in the organizations own medical facilities and hospitals.” At the conclusion of the Second World War, enrollment in the health plan was opened to non-Kaiser employees and soon unions, particularly the International Labor and Warehousemen’s Union (ILWU) and other West Coast-based unions began negotiating the affordable health plan into their collective bargaining agreements, thereby increasing

Kaiser enrollees and its association with the labor movement. [Kochan, et al, pp. 26, 27, 30.]

As a business, Kaiser Permanente is a two-sided, multi-billion dollar corporation: on one side is the Kaiser Foundation Health Plan and Hospitals, a health maintenance organization (HMO) and the approximately thirty medical centers and hundreds of other healthcare facilities; and on the other side are the Permanente Medical Groups (PMGs) a series of regional for-profit entities of approximately 13,000 physicians who contract exclusively to provide medical services to the Kaiser Foundation Health Plan and Hospitals. The for-profit medical groups in turn created a number of other for-profit subsidiaries, including the Permanente Company that was designed to maximize its investment portfolio.

One for-profit subsidiary of the Permanente Company includes Kaiser Permanente Ventures, a venture capital company that invests in medical technologies and other medically related entities. Together they make up what is known as Kaiser Permanente, a hybrid not-for-profit and for-profit integrated health care delivery system and health maintenance organization that operates in several states including California, Colorado, Oregon, Washington, Hawaii, Ohio, Maryland, Virginia and Washington DC. It employs

approximately 130,000 people, making it one of the largest private sector employers in the United States. [Kochan, et al, pp. 25-30.]

The majority of unions that represent workers belong to the Coalition of Kaiser Permanente Unions, although several unions do not, including the most progressive unions that represent Kaiser workers--the California Nurses Association (CNA), Unite HERE! and the National Union of Healthcare Workers (NUHW). CKPU represents approximately 90,000 Kaiser workers, with SEIU the largest single union, with its local union in California representing 47,000 workers and SEIU locals in Oregon and Colorado representing an additional 5,000.

By virtue of its size, SEIU dominates the CKPU. The leadership of SEIU and its role in the CKPU has been the subject of intense controversy since the SEIU International leadership trustee UHW in January 2009 and removed its long-time, democratically elected leadership with a political appointee, Dave Regan, previously the head of small SEIU local in Ohio, with virtually no experience with large health systems, particularly Kaiser Permanente. [Early, esp. pp. 173-206.]

Under Regan's leadership, following the pro-corporatist model of his mentor, former SEIU president Andy Stern, SEIU-UHW has adopted a much more collaborative collective bargaining position with the industry. Indeed,

an NUHW analysis of SEIU-UHW contract settlement under Regan's leadership since the trusteeship has found that virtually every contract negotiated since January 2009 has included significant concessions to the industry, including the elimination of defined benefit pension plans at two major hospital employers, Catholic Healthcare West (now called Dignity Healthcare) and the Daughters of Charity Health Systems, as well as significant concessions in healthcare at a number of nursing home employers and Sutter Health, a dominant health system in Northern California.

At Catholic Healthcare West, the Daughters of Charity and Sutter Health, SEIU-UHW agreed to concessions that allow the employers to implement extensive "wellness" programs, including instances where employees who refuse to participate in the employers' wellness programs are forced to pay monthly premiums for health insurance, ending a standard that SEIU members had established dating to the 1960s, which provided for fully-employer paid health insurance for employees, spouses (and domestic partners) and dependents. The surrender in Oakland, therefore, is part of a larger pattern of SEIU concessionary bargaining, despite record profits by the healthcare providers in California.

The Kaiser Permanente/CKPU 2012 “Tentative” Agreement

In traditional collective bargaining, an employer and a union negotiate a “tentative agreement” that sets forth negotiated changes to a previously existing collective bargaining agreement. Such an agreement is “tentative” typically until the union gives its members the opportunity to ratify the agreement through a membership vote. Upon ratification, the agreement is no longer “tentative,” but then becomes the actual enforceable collective bargaining agreement or contract between the parties from the date of ratification until its agreed upon expiration date.

The Kaiser Permanente/CKPU 2012 Tentative Agreement defies tradition, and is highly unusual. In effect, it is a tentative agreement of a tentative agreement. Rather than clearly setting forth the specific contractual terms of the newly negotiated collective bargaining agreement, the 2012 Tentative Agreement leaves it to an unspecified “joint Contract Language Team [that] will develop specific contract language and recommendations, as appropriate, to effectuate these Tentative Agreements *at a later date.*”

(emphasis added, p. 1.) By approving the tentative agreements in the manner the leadership of CKPU presented them for ratification, Kaiser workers unwittingly gave union leaders a virtual blank check to develop unspecified contract language at an unspecified time and not subject at that point to

membership approval. [Kaiser Permanente and Coalition of Kaiser Permanente Unions, 2012 National Bargaining Tentative Agreements, 2012.]

So what did the parties agree to?

Unconditional Surrender

- a. “Total Health”: The linchpin of the agreement is the Total Health Program, which the agreement defines “as a long-term business strategy for KP. . . . To the extent that employees can model Total Health such personal leadership creates competitive advantage for KP.” According to the agreement, employees are given a collective, financial incentive to: “(1) Update biometric risk screenings; (2) Complete the Total Health Assessment; (3) Maintain or make steady improvements on key biometric risks (weight, smoking, blood pressure and cholesterol.” Significantly, even if employees’ overall health improves, Kaiser a financial incentive to employees, i.e. a bonus, “in accordance with the principles of the Partnership,” “is only paid out if there are mutually agreed upon savings in health care costs as the result of measureable improvements of the biometric risk indicators. . .” [p.7]

- b. Unit-Based Teams (UBTs): The method that Kaiser’s Total Health Program is implemented is through unit-based teams (UBTs). As the

name implies, unit-based teams consist of workers and their managers in a defined work area who are charged with improving productivity at the worksite. The performance of UBTs is measured by a number of Kaiser management-developed “metrics,” which are designed to measure across departments and regions the performance of each UBTs. The agreement requires the union to cooperate with Kaiser to guarantee that 85% of UBTs are ‘high performing’ by 2016. [p. 9.] The union leadership is contractually required to police the agreement and remove obstacles to performance improvement: “If local problem solving attempts to remove barriers and allocate resources are not successful, UBT sponsors will escalate to senior operational and union leadership.” [p. 8.] Translation: If a facility’s UBT is not performing, union leadership will be held accountable to bring rank-and-file caregivers in line.

Significantly, the new agreement requires the UBTs to enforce the performance requirements of the Total Health Program by creating “dedicated workplace leaders so that work teams can take ownership of employee health and wellness and integrate healthcare practices into the work unit.” The UBTs will be provided a jointly created “dashboard’

that reports and makes available to employees measurements in the areas of BMI [body mass index], smoking rates, cholesterol and blood pressure levels, and the incidence of workplace injury.” [p.6] In other words, not only are the UBTs required to help Kaiser improve its productivity, they are now further required to monitor the health and fitness of co-workers. Left unmentioned is how the invasive personal data that employees are expected to fill out as part of a Total Health Assessment survey—number of sexual partners, drug usage, drinking habits, feelings of depression, and so on—will be used and managed by the UBTs, a problem exacerbated by the fact that Kaiser Permanente is the health care provider for the supermajority of Kaiser employees.

A sample from the Total Health Assessment Survey includes the following questions:

- During the past four months, how much did your health problems affect your productivity while you were working?
- Have you ever had a total hysterectomy?
- How much do you weigh?
- Have you been actively trying to manage your weight?

- In the last month, how often have you felt nervous and stressed?
- In the last month, how often have you been angered because of things that were outside your control?
- Are you currently being treated for depression or bipolar disorder by a psychiatrist, psychologist or other health professional?
- During the past week. . . I felt lonely (yes or no)
- During the past week . . . I felt sad (yes or no)
- How many drinks containing alcohol do you have on a typical day when you are drinking?
- Have you ever used recreational drugs?
- Have you ever taken more of my prescription medication than was prescribed?
- How confident are you that you can improve in the following: Pain management? Weight management? Skin protection?

Furthermore, employees are “assured” that responses will be “kept confidential within Healthmedia, Inc. and ***Kaiser Permanente***.”

Healthmedia and Kaiser Permanente will not

Disclose this information without my permission ***unless permitted by***

law and as described in the privacy policy. [Emphasis added. The

privacy policy is not included. “Success,” Total Health Assessment

Questionnaire, 2011.] This fact is even more alarming when

considering that Kaiser’s primary incentive in developing this Total

Health Program is by demonstrating that it has reduced its own

employee health costs, so it can market similar programs to other

employers as part of its “core business strategy.” [p.6.]

- c. Marketing: As mentioned above, Total Health is more than controlling the healthcare costs of their employees, it is a “core business strategy,” and the agreement contractually obligates the union leadership to help KP succeed in its business strategy. The agreement requires the union to join Kaiser in marketing its employee health and wellness programs outside of Kaiser and even more than that it holds the Labor Management Partnership—both union and management—“accountable for KP growth activities.” The coalition unions are required to help

market Kaiser to retirees and to other employers with whom the union may bargain outside of Kaiser.

- d. Financing: To add insult to injury, for the privilege of ceding control of workplace to Kaiser and giving the employer the ability to control their personal lifestyle choices through the Total Health Program, all employees whose unions are part of the Coalition of Kaiser Permanente Unions are required to contribute nine cents (\$.09) of every hour worked to the Labor Management Partnership (LMP). [p.9.]

Conclusion

In its unconditional surrender to Kaiser Permanente, SEIU and the Coalition of Kaiser Unions do harm beyond the healthcare workers that they represent. By saddling themselves to marketing Kaiser's Total Health wellness to an unsuspecting public, CKPU provides a veneer of legitimacy and respectability to a program that workers should be very wary of. It is no surprise that employers across the country will gravitate toward any program that promises to significantly reduce their health care costs. But unions that represent health care workers who are saving peoples' lives every day have a higher level of responsibility to serve not just as an advocate for their members, but also for the patients who their members' serve.

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Appendix:

By JoAnn Volk and Sabrina Corlette

Premium Incentives to Drive Wellness in the Workplace: A Review of the Issues and Recommendations for Policymakers

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Executive Summary

Employers are increasingly turning to workplace wellness initiatives to curb rising health care costs and the growing prevalence of chronic conditions. Workplace wellness programs can take many different forms, from on-site flu shots and smoking cessation programs to programs that impose significant financial penalties on employees who do not participate or fail to meet health goals, such as employer-defined Body Mass Index, cholesterol, blood glucose or blood pressure levels. Recent changes enacted in the Affordable Care Act (ACA) allow employers to link greater financial incentives to the achievement of these and other clinical targets.

While wellness programs, if properly designed, hold the potential to improve health and encourage healthier behaviors, there is also limited evidence of what works. If poorly designed, workplace wellness programs can shift costs to those with the greatest health care needs; run afoul of federal anti-discrimination and privacy laws and the ACA's prohibition on health status rating; and potentially affect which workers remain in employer plans and which end up in the new health insurance exchanges, possibly with a federal subsidy.

As more and more employers implement wellness incentive programs for their workers, it will be important to establish standards at the state and

federal level for consumer protections to guard against those programs that inappropriately punish workers in poor health, are overly coercive, or create perverse financial incentives that result in poorer health outcomes. It is unclear how many wellness programs link financial incentives to health outcomes, but regulators should require these workplace wellness programs to include:

Health benefits that help pay for any required services such as nutrition counseling and disease management for targeted health conditions such as diabetes;

Multi-pronged programs that go beyond tying premiums to biometric measures and include support for improving behavior and health outcomes;

A reasonable time for participants to meet program goals, with incentives to make progress toward those goals;

Protections to ensure workers' premiums are not rendered unaffordable because they cannot satisfy the employer's health targets;

Safeguards to ensure such programs do not serve as a subterfuge for health status discrimination or result in adverse selection against insurance exchanges; and

Requirements for employers and vendors to report on incentives and other program elements, in order to identify best practices and any adverse consequences

For the entire report see <http://chir.georgetown.edu/publications.html>.

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