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IN THE LITERATURE

Workplace Wellness Programs and Accessibility for All

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Griffin Basas C. What is bad about wellness? What the disability rights perspective offers about the limitations of wellness. *J Health Polit Policy Law*. 2014;39(5):1035-1066.

In recent decades, employee wellness programs have become widespread among large companies. A study by Rand showed that, in 2009, 92 percent of US employers with 200 or more employees offered [wellness programs](#) [1]. While on the surface, the goal of improving employee health seems benign at best, some worksite wellness programs are focused less on population health improvement and more on reducing corporate costs. This emphasis on corporate costs, combined with the fact that employers wield a lot of power over employees, can lead to a potentially coercive approach to wellness that feels obligatory and tied to job performance. In "What Is Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness" [2], Carrie Griffin Basas walks the reader through the wellness program philosophy of health as attainable through self-responsibility and modern workplace wellness programs, using court cases and the history of wellness and disability rights movements to suggest that these programs may be discriminatory and set up unrealistic expectations about health for all persons. Griffin Basas argues that the way these programs affect persons with disabilities provides "a mirror for a critique of wellness as neoliberalism by exposing the flaws in its arguments about behavioral control, personal responsibility, and bodily optimization" [3]. A brief working definition of neoliberalism can be helpful here. Briefly, neoliberalism characterizes a range of views that privilege self-reliance-based (rather than interdependence-based) and autonomy-oriented (rather than communitarian) ways of being in the world. Neoliberalism has been widely critiqued for rewarding traditionally privileged traits, such as male, white, able-bodied, and heterosexual [4].

Throughout her article, Griffin Basas argues that employee wellness programs and the wellness philosophy create a power divide that continues to grow between healthy workers and those with disabilities (as well as other minority groups with limited access to resources for health and safety); those who are healthy (and have access to resources) are rewarded for getting healthier, while other groups are unable to benefit and therefore drop further behind. She begins by discussing the 2012 court case *Seff vs. Broward County*, which highlights the opposing forces surrounding workplace wellness programs. In this case, employees who did not complete a health questionnaire and

biometric screening were [charged](#) \$20 every two weeks. Griffin Basas argues that this case simultaneously illustrates wellness programs' positive emphasis on supporting health and their negative aspects—depersonalizing employees and punishing employees who do not or cannot take part in “healthy behaviors” like exercise or achieve health-related goals like weight loss.

The structure of a wellness program, she explains, may make it difficult for persons with disabilities to take part. The author reviews Mello and Rosenthal's work on two types of wellness programs—one in which rewards are based on participation regardless of outcomes, and one in which rewards are based on attainment of goals such as a certain BMI or smoking cessation. For example, while some workplace wellness programs are focused on activities like joining a gym or filling out an annual survey on health behavior, others may focus on cholesterol targets or a specific body mass index (BMI) [5]. Both approaches can present barriers: it may be difficult for a person who needs to rely on public transportation to get to a gym that can accommodate a particular physical disability, and it may be unrealistic for a wheelchair user with fragile bones to take part in a weight loss program. Programs that fail to acknowledge these barriers are unethical if there are rewards tied to program participation or meeting targets, such as the reduction in insurance premiums L.L. Bean offered to its employees who took part in its Health Lifestyles Program [2].

The discussion then shifts to the origins of the workplace wellness movement. For employers, improving employee wellness contains costs—“encouraging employees to get involved in their own healthcare leads to a more healthy population that costs less to insure” [6]—and promotes occupational safety as well as an emphasis on work-life balance, job satisfaction, and emotional well-being. When these programs were introduced, persons with disabilities saw this emphasis on elimination of injury as positive, but, Griffin Basas argues, adoption of the wellness movement philosophy by corporations has led to some unintended consequences such as reinforcing a negative bias towards hiring persons with disabilities. With the passage of the Americans with Disabilities Act (ADA) came a backlash, the view that people with disabilities were putting a burden on businesses and employers to spend money by making accommodations that spurred reluctance to hire persons with disabilities. Griffin Basas argues that workplace wellness programs cast persons with disabilities as a liability on an organization's balance sheet.

It was not only people with disabilities who were viewed as burdensome to employers. Griffin Basas argues that the wellness movement has taken on a neoliberal bent, representing wellness as controllable through personal responsibility and choice. Health—an absence of illness or impairment—became defined as the result of choices, leading to an emphasis on prevention. This emphasis in turn has led to societal discrimination against those who supposedly “don't take responsibility for their health,”

including elders, or portrayal of them as villains. It is here that Griffin Basas points out that, one day even people without classical “disabilities” will also be part of a marginalized group viewed as a burden to employers.

Towards the end of the article, Griffin Basas provides a call to action to health and disability advocates:

Resources are limited, and rather than appropriate them to further benefit the already healthy, they should be shifted toward the inclusion of outliers, such as people with disabilities. Instead of mainstreaming people with disabilities toward a homogenized definition of health, advocates should dismantle current definitions and replace them with ones that are nuanced and inclusive, less hierarchical, and free from paternalistic assumptions [7].

Griffin Basas asks us to consider “why barriers to health equity exist” [7] before inadvertently creating any programs that divide healthy and sick people. The social model of disability argues that disability exists because of the way society is organized [8], challenging people to think through ways to remove barriers that restrict life choices for persons with disabilities. Worksite wellness programs that reward participants based on a decrease in weight or gym memberships are creating societal barriers and thus undermining equity.

Consistent with her larger argument that wellness programs provide a critique of the neoliberal emphasis on self-responsibility for health, Griffin Basas ends the article by showing that workplace wellness programs may not be the answer to improving population health, the impetus behind the wellness movement. In particular, she relies on Mattkey, Schnyer, and Van Busum’s 2012 literature review [1], which found that the returns on investment for these programs is unclear, most likely because so few eligible employees participate.

Response

If workplace health programs can perpetuate injustice, should we dispense with them altogether? As a public health practitioner, I say no. I fully support the wellness movement to reduce or eliminate diseases that are lifestyle-driven through education efforts and programs or techniques designed to increase readiness to adopt healthy behaviors. Workplace wellness programs can play a key role in the wellness movement because they employ two key strategies in public health: enlisting nontraditional health partners and influencing the social determinants of health.

Enlisting nontraditional partners in promoting public health. Healthy People 2020, a federal health promotion initiative, recognizes the importance of working with nontraditional

health partners to meet health goals [9]. Employers are a nontraditional health partner, and their involvement could increase the reach of health messages.

Increasing protective social determinants of health. The term “social determinants of health” is often used to refer to [nonmedical factors](#) influencing health [10], and the Centers for Disease Control and Prevention recognize that the work environment can be such a determinant, a risk factor that can lead to poor health or a protective factor that can lead to maintaining good health [11]. One could argue that employers who offer workplace wellness programs are creating a protective factor by providing external motivation for engaging in healthy behaviors as well as, depending on the program, resources such to teach healthy eating, track movement, and provide nicotine patches to help reduce smoking. However, it is important that these programs be delivered with an emphasis on improving an individual employee’s health rather than on just decreasing employer health care costs.

Accommodations: Reconciling Wellness with Respect for the Person

To reap the positive benefits of wellness programs without the discriminatory aspects Griffin Basas draws attention to, it is important that workplace wellness programs be accessible in a way that is useful to everyone. One way workplace wellness programs are encouraged to overcome this bias against those who cannot easily take part is to allow alternate paths to success—personalized health goals rather than standardized or required outcomes [5]. (This approach, too, though, can be ethically problematic if there are barriers to requesting permission for a more personalized approach. For example, some programs just require employees to let the employer know they need to set a different goal. Allowing requests is not the same, however, as ensuring that employees do not feel singled out for having to make them. Other programs require a physician recommendation for an accommodation, an additional hurdle for the employee.)

In my opinion, one way to achieve personalization is through accommodations, a requirement in Title I of the ADA [12]. The ADA states that employers must provide a reasonable accommodation to persons with disabilities who are employees unless to do so causes undue hardship. There are many examples of an accommodation for a person or a group of people benefitting many, even those without disabilities. Griffin Basas points to examples outside of the workplace, including accommodations made by cities and businesses to increase mobility such as power-operated doors and curb cuts; these accommodations are also helpful for large deliveries and parents pushing strollers [2]. Schur et al. found that making accommodations for all employees led to higher employee satisfaction. Finally, accessibility need not entail accommodations [13]; Griffin Basas notes examples of workplace wellness programs that offer programs that are individualized to fit the need of the employee.

I believe the key to decreasing the discrimination of workplace wellness programs is to allow alternate paths to success—personalized health goals rather than set health outcomes [5].

Ultimately, wellness, like disability, can take many forms. As Griffin Basas notes, “to accept disability as difference means to give up the idea that people can and should always control their bodies and, therefore, to dispense with the notion that they are responsible for their lack of compliance” with able-bodied norms of health [14]. Workplace wellness programs can look to other individualized health care approaches such as motivational interviewing and patient navigation for examples of systematic approaches to working with people in an individualized way that is responsive to their situation and their needs. Recognition of the person who is taking part in the program can help increase access (justice) and minimize maleficence (do no harm).

I feel it is important to create ways for everyone—regardless of race, socioeconomic status, and ability—to adopt healthy behaviors that minimize their risk of, or decrease the burden of, lifestyle-influenced diseases. One approach is to include nontraditional partners—including places of worship, community agencies like libraries or social service programs, and community health workers who go out into the community they serve—to help reach people and deliver health information or health programming [9]. Workplace wellness programs can play a vital role in wellness promotion and act as a protective factor as long as they can remain accessible and responsive to individual needs and goals. To achieve these aims, those who design workplace wellness programs need to work with all stakeholder groups, including persons with disabilities, to understand their needs as well as question reductionist thinking that assumes that disability is the product of poor choices and attitudes and health is a demonstration of positive ones. As Griffin Basas reminds us, ultimately, we will all be sick and disabled at some point. That does not degrade our worth as humans and does not take away from our desire to be as healthy as possible. We should not forget that the key to wellness is meeting persons where they are and allowing them to be part of the conversation about what wellness looks like for them.

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