Neoliberal Solutions to Chronic Disease: Workplace Wellness and the Myth of Personal Responsibility

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HS 679HB
Special Honors in the Department of Health and Society
May 2020

Abstract

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The University of Texas at Austin (2021)

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Workplace wellness programs have increased in popularity in recent decades. While extensive research has been conducted to find ways to improve the efficacy of these programs, there is little research critiquing the principles on which these programs are founded. In this thesis I critique the manifestations of neoliberalism in the American healthcare system, and specifically in corporate wellness programs which promote the principle of personal responsibility without examining social determinants of health. Wellness programs use financial rewards and punishments to incentivize certain healthy behaviors and to attempt to eliminate chronic disease risk factors. However, because they fail to address systemic problems that often accompany chronic disease risk factors, the programs risk further cementing disparities in health between those of lower and higher socioeconomic status. I use Foucault's theory of the panopticon to demonstrate how these programs can be seen as a microcosm of neoliberal ideology in which people internalize the values of personal responsibility and police themselves in accordance. I use wellness programs as a means to explore how neoliberal ideology compromises equitable

healthcare by ignoring systemic causes of bad health and shifting the responsibility of care away from the government and onto its citizens.

TABLE OF CONTENTS

INTRODUCTION

Workplace wellness programs have significantly grown in popularity over the past decade. Stemming in part from a rise in health care costs for employers, wellness programs seek to reduce the effects of chronic disease by exerting influence on the health behaviors of their employees. Rates of chronic disease are rising in the United States, and some research indicates that a large proportion of healthcare expenditures are related to treating and managing chronic disease. In this sense, employers have an incentive to curb the effects of chronic illness to save on health care spending in their workforce. In this paper I will challenge the efficacy of these programs and explore ways in which corporate wellness programs may inadvertently exacerbate existing health disparities in the United States. In chapter one I explore the concept of wellness and how it has been introduced into the workplace in the form of corporate wellness programs. In chapter two I will critique the efficacy of workplace wellness and discuss possible ulterior motives of these programs. In the third chapter I examine workplace wellness as a microcosm of a culture of growing individualism and self-surveillance, and finally in chapter four I will examine the U.S. healthcare system at large and suggest a more upstream and systemic solution to poor health outcomes in the United States.

Corporate wellness programs emphasize personal health decision-making and operate under the assumption that individuals have considerable power to determine their health through their own behaviors and choices. I will examine values of individualism and personal responsibility both in the contexts of wellness programs and a neoliberal society at large. Just as the neoliberal value of personal responsibility maintains that people are largely responsible for their economic and social circumstances, workplace wellness programs erase sociopolitical

context, reducing chronic disease to “bad choices.” In this paper I will demonstrate that workplace wellness programs are a microcosm of a larger culture of individualism, where we accept the ideal of personal responsibility and police ourselves in accordance with the values of our given society.

CHAPTER ONE

The Adoption of Wellness Dogma

The Rise of Wellness

The term "wellness" has come to dominate the media in recent decades, reflecting a cultural shift in conversations about health. Google trends shows that the word wellness peaked in 2017 and has been on the rise again in conjunction with the COVID-19 pandemic along with the term "self-care," which is commonly associated with wellness. The concept of wellness has been influential with doctors, mental health providers, celebrities, motivational speakers, and even hotel companies, all preaching its benefits. Because of the expansiveness of the concept of wellness, it is difficult to produce a singular definition of the word. The National Wellness Institute vaguely defined wellness in 1976 as "an active process through which people become aware of, and make choices toward, a more successful existence" (National Wellness Institute 2020). It goes on to illustrate six dimensions of wellness including occupational, social, physical, intellectual, spiritual, and emotional wellness (National Wellness Institute 2020). The pharmaceutical company Pfizer offers a similar definition, defining wellness as "the act of practicing healthy habits on a daily basis to attain better physical and mental health outcomes, so that instead of just surviving, you're *thriving*" (Pappadopulos).

Different definitions of wellness seem to share the belief that wellness involves moving beyond a status of simply being disease free towards an even healthier and subsequently more successful life. Practicing wellness encompasses a vast range of expectations and tasks pertaining to one's personal maintenance that one must undertake to be considered healthy including managing levels of stress, engaging in "clean eating," and getting a host of screenings

and check-ups testing for multitudes of diseases and disorders. Merely being without illness is a passive state that many can expect to inhabit for part of their lives. *Wellness* however is dynamic, encompassing a certain degree of personal responsibility. Wellness is a practice. One will never reach a state of achieving wellness. Instead, it is something to be constantly working at yet remains perpetually out of reach.

The vague and dynamic nature of the term makes wellness ripe for commodification. Celebrities have become proponents of wellness, preaching their own self-care tips and selling teas and supplements to their fans. Gwyneth Paltrow's Netflix series *The Goop Lab* explores eccentric wellness practices like jumping into freezing lakes, reiki healing, and tripping on psychedelic mushrooms. Paltrow profits from the wellness trend in other ways as well, selling wellness-themed items from vitamins promising to give women a metabolism similar to their high school selves, to a thousand-dollar gemstone mat that is intended to increase mindfulness. Other celebrities like Kate Hudson, Beyoncé, and Cindy Lauper have joined the wellness crusade, using it to market a variety of athletic clothing and teas designed for weight loss and appetite suppression. Some of these marketing schemes have brought controversy onto the practice of wellness, with some critics calling it a rebranding of the diet industry (Knoll 2019). Regardless, this commodification has created a trillion-dollar industry that does not appear to be slowing (McIntyre et al 2017:59). The Global Wellness Institute themselves admits that "wellness is becoming a selling point for all kinds of products and services – from food and vitamins to real estate and vacation packages, and from gym memberships and healthcare plans to meditation apps and DNA testing kits." (Batarags 2021).

While wellness is commonly associated with marketing ploys, there is evidence to suggest that a more well-rounded approach to health is beneficial. Recent years have shown a

dramatic increase in mental health issues with suicide rates drastically increasing between the years 1999 and 2018 (Hedegaard et al 2020). Frequent use of social media has been shown to increase feelings of depression and isolation. The sharpest incline of suicide rates in the United States took place after 2006, a year when social media use was becoming much more common and the year prior to the release of the first iPhone which came on the market in 2007. It seems obvious today, with suicide in the top ten causes of death in the United States, that an approach to health that includes one's mental wellbeing is necessary (CDC 2019). Wellness seems to embody that approach, moving beyond one's physical health and recognizing the importance of overall well-being, representing a more holistic and comprehensive outlook on healthcare.

The idea that one's health is determined by a wide variety of factors including one's social relationships and emotional wellbeing is widely accepted by healthcare professionals. In 2005 the World Health Organization (WHO) began exploring the concept of social determinants of health (WHO 2005). It now lists social connection, physical environment, and access to health services as key factors in one's health outcomes (WHO 2017). Doctors' offices have utilized the language of wellness, calling check-ups "wellness checks" and gynecological exams "well woman exams." Today it is more common for doctors to ask patients about healthy eating habits, drug use, and stress levels instead of simply treating patients when they become sick (Medical Associates of Northwest Arkansas). College campuses have incorporated the idea of wellness into their health centers too. The University of Texas has recently launched a Wellness Center that has initiatives including promoting a positive body image, helping students maintain healthy sleep habits, and working to end sexual assault on campus (Longhorn Wellness Center). The growing expansiveness of wellness indicates an understanding that one's well-being is influenced by more than just our physical health, and wellness successfully conceptualizes this feeling.

Wellness in the Workplace

Employers too are increasingly seeing the benefits of a more holistic approach to health care, likely due to the understanding that one's behavior and surroundings directly influence their health. It is now common for employers to encourage employees to adopt healthy practices such as a good diet, regular exercise, and engaging in medical screenings. Today, many companies go well beyond providing traditional health insurance benefits, offering an array of wellness initiatives that can include things like enrollment in weight loss programs, smoking cessation programs, and screening for certain diseases (McIntyre et al 2017:65). In fact, in the United States, 80% of companies with over 200 employees have some sort of wellness initiative that employees are encouraged to participate in (McIntyre et al 2017:61). These initiatives add up. Workplace wellness programs are so widespread that they comprise a six billion dollar per-year industry in the United States (McIntyre et al:59).

One explanation for the sudden boom in workplace wellness programs has to do with concerns over rapidly increasing healthcare costs. Health care spending increased "by 4.6% in 2019 to $3.8 trillion or $11,582 per capita" (American Medical Association 2020). Today, 90% of health expenditures in the United States are related to chronic disease management, making chronic disease treatment one of the most expensive aspects of the country's entire healthcare apparatus. Because many receive their healthcare from their workplace, chronic disease represents a significant cost for employers as well (CDC 2021). The rising costs of healthcare in the United States have created an undeniable incentive for employers to have a vested interest in the health of their employees. Under our current healthcare system, the workplace is largely

tasked with managing the distribution and costs of healthcare. Because of this, measures to curb health expenditures are often led by employers themselves.

Chronic disease poses other financial problems to employers as well. Employees with chronic disease are more likely to have higher rates of absenteeism than employees without chronic disease, as well as reduced productivity at work. Some studies suggest that the revenue losses from absenteeism and reduced productivity are even greater than the healthcare expenditures related to treating the chronic diseases themselves (McIntyre et al 2017:62). Chronic disease, unlike acute illness, develops slowly over time and is generally long lasting. There is a myriad of risk factors that can increase the likelihood of developing certain chronic diseases or that can worsen the effects of the diseases when they present. Because many chronic diseases such as diabetes, obesity, and many cancers have risk factors strongly related to behavioral and lifestyle choices, there is a clear motivation for workplaces to attempt to influence and discourage risky behavior in their employees. Almost paradoxically, workplace wellness programs were born out of a desire to curb the costs of spending on health care in the workplace.

Wellness initiatives can be analyzed as follows: They are typically categorized as either primary interventions, secondary interventions, or screenings, and are either reward-based or punishment-based. Screenings and examinations are the most common elements of wellness programs. Screenings are often used to determine what kind of wellness initiatives employees will be sorted into, but some wellness programs offer only screenings without follow up strategies. Wellness initiatives that focus on primary interventions are often called “lifestyle management” programs and work to promote a healthier lifestyle among employees, hoping to target behavior that is associated with chronic disease. Excluding screenings, lifestyle

management programs are the most prevalent form of wellness programs. Most commonly, lifestyle management programs will promote nutrition, weight loss, exercise, and smoking cessation. Smoking cessation is one of the most popular interventions, found in 70% of lifestyle management programs. Lifestyle management programs, unlike secondary interventions, are typically open to the entire workforce and are not contingent on the presence of disease, risk factors, or results of screenings (McIntyre et al 2017:60).

Secondary interventions, often called disease management programs, target employees that are already affected by chronic conditions. These programs mostly "aim to improve health through better medication adherence and bolstered patient self-care knowledge and ability." (McIntyre et al 2017:60). Wellness programs can also be categorized as either rewards-based or punishment based. Rewards-based, or participatory programs, will reward employees for participation or for reaching certain health related goals or milestones. Contrastingly, punishment-based programs, or "health-contingent" programs will penalize employees who fail to reach certain indicators of good health. For example, employees may be penalized for failing to keep their blood pressure at a healthy level, exercising an insufficient amount as deemed by their boss, or by failing to participate in the program at large (McIntyre et al 2017:63). However, it is common for health contingent programs to be organized so as to appear to reward those who achieve certain health goals instead of punishing those who do not. This is largely a matter of framing, as the financial outcome is essentially identical between the two models. Those who don't receive the monetary "reward" experience the same financial loss as they would if they were being financially penalized. While employers cannot make wellness programs mandatory for their workforce, financial incentives can heavily influence people's choice whether or not to

participate. Because of this, these programs can be seen as towing the line between voluntary and mandatory (McIntyre et al 2017:64).

While rewards-based programs on the surface do not appear to discriminate against ill employees, health contingent programs more clearly complicate this rule. Discrimination on the basis of one's health or disability status used to be widespread in American workplaces, but major strides have been made to reduce discrimination for sick and disabled employees in past decades. While employers were once able to refuse jobs to people with disabilities, in 1990 the Americans with Disabilities Act expressly prohibited this practice. Additionally, the Affordable Care Act ended the practice of charging higher rates of healthcare for sick customers and customers with "preexisting conditions" (Guo et al 2017). Current HIPAA regulations and years of legislation strongly suggest that American lawmakers value the elimination of discrimination against workers on the basis of their health status. However, the introduction of wellness programs and their inclusion in the Affordable Care Act calls this value into question, as wellness programs explicitly allow employers to charge employees with risk factors for chronic disease higher premiums. Nevertheless, the Affordable Care Act encourages workplace wellness programs despite this complication by allowing health contingent programs so long as they do not violate other non-discrimination stipulations. In fact, Congress had to specifically exempt health contingent programs from this regulation in order to allow them (McIntyre et al.). Because of this exemption, workplaces essentially have the power to financially reward or penalize employees on the basis of their health status so long as these measures operate within the program and remain officially voluntary.

Safeway and the Normalization of Workplace Wellness

The financial benefits of corporate wellness programs drew national attention when the grocery store chain Safeway boasted that they were able to keep healthcare costs steady between the years 2005 and 2009. They claimed that a wellness program incentivizing employees to engage in healthier lifestyles allowed the company to maintain lower costs. Safeway incentivized healthier lifestyle choices in its employees by making employee's health care premiums contingent on adopting certain healthy behaviors such as eliminating tobacco use and maintaining healthy cholesterol levels and weight. This success story drew so much media attention that it generated fervor for more wellness programs and was praised by both Republicans and Democrats in Congress. Safeway was even explicitly identified in the Affordable Care Act under a clause informally known as the "Safeway Amendment." This section allows for a larger portion of employee's premiums to be contingent on participation in wellness programs or on the achievement of certain health goals met within a wellness initiative. Prior to the Affordable Care Act, under President Bush healthcare premiums could be up to 20% contingent on employees meeting certain health standards. Because of the widespread belief that Safeway was able to substantially reduce healthcare expenditures by influencing employee behavior, it was decided that incentives to increase healthy behaviors in employees were beneficial. In response, the Affordable Care Act allowed for 30% of employees' health care premiums to be contingent on meeting health requirements. For instance, if an employee fails to exercise sufficiently or maintain desired cholesterol levels, they may be penalized by paying a larger portion of their premiums out of pocket that would normally be covered by their employer. For smokers, their share of premiums can be even higher. The Affordable Care Act technically allows for employers to make employees shoulder the cost of 50% of their premiums if they are

smokers and fail to complete smoking cessation (McIntyre et al, 64). In chapter two I will discuss some of the ethical implications of these practices, but regardless, journalists later discovered that Safeway's wellness program was not the reason for the declining costs of healthcare in the first place. In reality, Safeway was able to curb costs by overhauling their benefits in 2006 which was three years before the instatement of their wellness program. Costs began to climb again shortly after 2006, revealing that it was the overhaul of benefits, not the implementation of their wellness program that made costs initially fall (McIntyre et al 2017:61). Despite some reporting on this misconception at the time, Safeway's practices were normalized with their inclusion in the Affordable Care Act.

Safeway's supposed success story and the subsequent support of workplace wellness programs in the Affordable Care Act have effectively codified corporate wellness programs into law. Today, corporate wellness programs are commonly used as a primary means to cut costs of healthcare at many companies. These programs are widespread and rarely challenged. Most of the existing research on corporate wellness initiatives is focused on ways to improve the existing structure of the programs, but the idea of these programs is rarely called into question. However, most research that does investigate the effectiveness of these programs indicates that the impact of wellness initiatives like these are mild at best.

CHAPTER TWO

Managing Workers Through Wellness

Mechanics of Wellness Programs

There are many explanations for the growing rates of chronic disease in the United States from an aging population, to a shift towards more sedentary lifestyles. Still, it is undeniable that the prevalence of chronic disease creates a heavy economic burden shouldered both by those affected by chronic illness and the healthcare systems that are treating them. According to the American Action Forum, patients with chronic disease have annual healthcare costs five times those of patients without chronic disease (Hayes 2020). The indisputable link between chronic illness and rising healthcare costs gives employers, who are tasked with providing the healthcare of the majority of Americans, an understandable financial incentive to try to curb the effects of chronic illness in their workforce (Tikkanen et al 2020). By minimizing the consequences of chronic disease, employers can hope to decrease healthcare expenditures, decrease absenteeism, and increase productivity among employees at work. Wellness programs are intended to help employers achieve these objectives.

With the goals of curbing chronic disease and their associated costs in mind, a study conducted by Jill R. Horwitz, Brenna D. Kelly, and John E. DiNardo conceptualized three major assumptions that wellness programs must meet in order to be considered effective. These assumptions are as follows. First, employees with behavioral risk factors must be shown to be "worthy targets for incentives." (Horwitz et al 2013:471). Secondly, financial incentives must be able to both prompt employees to change their health behaviors, and thirdly, must subsequently

generate savings for the employer (Horowitz et al 2013:471). While lifestyle management programs must meet all three assumptions, disease management programs must only meet the last two because they do not attempt to identify employees with risk factors but work solely with employees already living with chronic disease.

Evaluating the Efficacy of Workplace Wellness

The first assumption asserts that lifestyle management programs, in order to be successful, must be able to not only identify employees with health risks, but ensure that those employees are "worthy targets of incentives" (Horowitz et al 2013:471). As discussed in chapter one, the practice of screening is broadly promoted as an important form of preventative health care, and the use of screenings and tests in wellness programs is frequently used to identify at risk employees. While screenings are beneficial to the early detection and treatment of certain diseases, they can be overused, often resulting in expensive and unnecessary treatment and stress. A common example of over-diagnosis due to screenings is the overuse of mammography or testing to detect breast cancer. Some doctors recommend that women begin screening for breast cancer in their 40s, but many research studies point out that overdiagnosis is common among younger women, and the expansion of mammograms in recent years has not significantly decreased the mortality rate of breast cancer (Pruthi, 2019) (Kramer and Croswell 2009:127). A study published by the American College of Physicians estimates that rates of overdiagnosis from mammograms could be as high as 54% (Nelson et al 2016).

Overdiagnosis and over medicalization are common problems in the healthcare systems of high-income countries. An Italian study concerning the rapidly rising rates of thyroid cancer among women in high income nations estimated that 70-80% of thyroid cancer diagnoses in the

United States, France, Italy, and Australia were likely to have been misdiagnosed between the years of 1998 and 2007 (Salvatore et al 2016). Most screening services have recommended ages in which it is medically advisable to begin screening for certain conditions, and it is most likely that consulting with a doctor individually is the best means to determine if one should be tested for certain chronic diseases. While there is an obvious case to be made that it is better to over-screen than potentially miss life-threatening diseases from a lack of testing, over-testing and false diagnoses also carry their own health risks. People who receive a false positive diagnosis are likely to report higher levels of anxiety and distress. Additionally, testing and follow up procedures can be expensive and lead to unnecessary medical interventions that carry their own adverse health risks. In the case of screenings in the workplace, "screening an entire workforce can be costly and inefficient, generating false positives" (Horowitz et al 2013:472).

Simply being able to identify at risk employees does not guarantee that programs will be able to change employee behavior, prohibit the development of chronic disease, or save on healthcare expenditures. The RAND corporation conducted a large study collecting data from 100 companies over 10 years concerning their wellness programs and found that the average return on investment (ROI) per employee was $1.50 per dollar spent. While that number seems promising, 87% of those savings can be attributed to disease management programs, not lifestyle management programs. Most of the savings attributed to disease management programs came from reductions in hospital stays among employees with chronic illness. In contrast, lifestyle management programs represented only a $.50 return on investment for every dollar spent. Furthermore, lifestyle management programs are much more extensive despite their limited savings as they generally target a larger portion of the workforce. The RAND study found that 87% of people participated in lifestyle management programs versus the 13% participating in

disease management programs (Mattke et al 2014). In light of these findings, it seems much more cost effective to implement disease management programs that focus on caring for those already living with chronic illness than working to prevent it in other employees.

While certain risk factors like frequent use of tobacco products, obesity, high cholesterol, and high glucose levels are considered to be risk factors for chronic disease, employees with these risk factors do not necessarily cost their employers more on healthcare expenditures. A meta-analysis that examined the healthcare costs of working age people with certain risk factors for chronic disease found that while some risk factors lead to higher spending, many do not. Of the studies analyzed in the meta-analysis, many found that people with obesity or higher glucose levels do tend to have higher healthcare costs, although a large minority of studies found that there is no significant difference in spending between those with these risk factors and those without. Furthermore, a majority of the studies that were included found that tobacco use, high blood pressure, high cholesterol, and receiving little physical exercise are unlikely to make a difference in health expenditures among working age adults (Horowitz et al 2013:471). Although these studies do not provide a possible explanation for these findings, one possible interpretation is that chronic disease tends to set in over an extended period of time, and risk factors are less likely to cause major harm to one's health early in life. While it is undeniable that using tobacco, for instance, is likely to cause some deleterious health outcomes, these outcomes may not present until a person is no longer of working age. This is an important point considering that tobacco users in particular can face much higher healthcare premiums than their non-smoking counterparts under the assumption that they represent a larger cost burden on the employer healthcare system than non-smokers.

This potentially false assumption is even written into law. As I discussed in chapter one, the Affordable Care Act allows companies to charge smokers up to 50% higher on their premiums, an additional 20% more than other employees with identifiable risk factors for chronic disease. The notion that smokers may not cost workplaces more than their non-smoking counterparts represents a very serious challenge to the validity of the assumption that those who tend to cost the healthcare system more should have to pay more, which is an idea that is foundational to workplace wellness.

The studies examined in the meta-analysis also found that workers experiencing high levels of stress are likely to be considerably more expensive than those without chronic stress. This is ironic considering that the most common causes of stress are related to one's job and finances, and workplace wellness initiatives rarely address stress as a risk factor for chronic disease (Scott 2020). Earlier, I demonstrated that identifying "at risk" employees through screening and testing and ensuring that the employees identified are good candidates to curb healthcare costs is only marginally beneficial at best.

One way to improve the efficacy of lifestyle management programs would be to only focus on eliminating risk factors that are proven to be expensive. For instance, employers could only target those with obesity, high glucose levels, and chronic stress because those risk factors are more clearly associated with higher costs. However, this is unlikely to happen for a few reasons. Primarily, targeting only some employees with chronic disease risk factors and neglecting the rest would undermine the narrative that workplace wellness programs exist to benefit employees. Additionally, if employers cared to curb the levels of stress in their workforce, they could potentially do so by providing their employees with a higher salary or increased time off, but that approach is likely to be at odds with companies' profit motives. It is

estimated that more expensive workplace wellness programs can cost around 2,000$ per employee (Zirke 2020). If this money were to be put into employees' salaries instead of spent on wellness programs, that money could represent a significant raise for many employees and potentially alleviate some stress caused by finances.

I have demonstrated that workplace wellness programs are not necessarily the best means by which to identify employees at risk of chronic disease and curb costs associated with those risk factors. Still, it is important to assess whether or not these programs are able to improve employees' overall health. Although many studies promoting the use of workplace wellness programs boast that employees generally adopt healthier lifestyles due to their implementation, in reality these findings are more complicated than the studies suggest.

A meta-analysis of studies concerning the efficacy of workplace wellness programs found that most often financial incentives through workplace wellness do little to change employee's health behaviors. Some studies showed that employees in weight loss programs or smoking cessation programs were initially able to lose weight or quit smoking, but most eventually gained the weight back and resumed their tobacco usage (Horowitz et al 2013:471). Earlier I mentioned that the average ROI for lifestyle management programs is .50 cents for every dollar spent. The fact that these programs are managing to generate some savings despite the fact that employee health seems not to significantly change is problematic. This indicates that savings may be coming not from improved employee health but from charging employees with chronic disease risk factors a larger share of the overall healthcare costs. Furthermore, addressing one risk factor carries the possibility of causing negative health outcomes in other areas. The authors of the meta-analysis point to the growing body of evidence that diabetes treatment can cause rapid weight gain and hypoglycemia. Similarly, patients in smoking cessation are found to

gain on average over 20 pounds which comes with its own associated health risks (Horwitz et al, 472).

An intense focus on one's health, nutrition, and weight can also cause serious mental health issues. The term "orthorexia" was coined in 1996 to describe an unhealthy obsession with nutrition and healthy eating, and it is estimated that 9% of the U.S. population will suffer from some form of eating disorder at one point in their life (Petre 2020) (ANAD). The prevalence of eating disorders is a serious problem in the United States representing the second deadliest mental illness after opioid abuse (ANAD). In light of these findings, it seems most responsible to recruit the help of medical professionals that can work individually with patients before advising that they implement a significant change in their lifestyle. Furthermore, overemphasizing health, weight, and nutrition has the potential to create a hostile work environment for employees who are overweight, mentally ill, or otherwise outside of the boundaries of wellness' desired bodies.

Corporatizing Upstream Solutions to Health

The ineffectiveness of these programs to promote adequate behavioral health changes shouldn't be surprising considering that many people with chronic disease risk factors such as obesity or tobacco use already face considerable outside pressures to change their behavior. Both of these aforementioned risk factors carry considerable stigma, and there is already existing societal incentive to be thin, non-smoking, and healthy (Horwitz et al, 471). Tobacco use has become heavily stigmatized in recent decades, and today is strongly correlated with lower socioeconomic status, lower education levels, and the presence of mental illness (CDC). Drug use is also very stigmatized, but persists, likely due to other abject circumstances.

While many consider drug use to be the cause of problems like homelessness and poverty, in many cases the reverse is true. Some research, for instance, indicates that the rates of drug use among homeless women are much higher among homeless women who had previously endured sexual assault. The implication of this finding is that women experiencing homelessness may use drugs to cope with the trauma that they live with from being sexually assaulted, not that their drug use has caused their status as houseless (Wenzel et al 2000). Similarly, we can interpret high smoking rates among lower income groups to be related to enduring the stress of financial instability, and in fact many people who use tobacco report that they smoke to alleviate stress and anxiety. People who served in the U.S. military have higher rates of tobacco use than civilians, and a possible explanation for this is that smoking is in part a coping mechanism for resulting anxiety or trauma (CDC).

In light of these findings, it is not surprising that workplace wellness programs that seek to disincentivize smoking without addressing underlying problems fail to succeed. Nearly all of the risk factors targeted in workplace wellness programs have risk factors themselves which are largely systemic. These systemic factors are similar across different chronic disease risk factors, indicating that systemic inequalities play a significant role in public health. Obesity, low physical activity, and tobacco use are all positively correlated with both lower levels of education and lower socioeconomic status (Lantz et al 1998:1705). Moreover, marginalized groups are already overrepresented in populations with lower levels of income and education. It has been well documented that Black, Hispanic, and indigenous Americans have on average lower income levels as well as lower levels of education than their white counterparts (Pew Research Center 2016). Additionally, LGBTQ+ people tend to have higher rates of poverty, with bisexual and transgender people experiencing a poverty rate of almost 30% (Badgett 2019:2). While

substantial research showing major health disparities associated with income and economic attainment helps to explain some of the health disparities between white Americans and Black and indigenous Americans, a growing body of evidence suggests that discrimination itself could be exacerbating the existing health disparities between these groups.

Some research indicates that the daily stress of racial discrimination is causing Black women to have rates of breast cancer higher than that of white women (Telatia et al 2007:51). Additionally, racism can be a factor contributing to high blood pressure, a major risk factor associated with heart disease, in Black men (Din-Dzietham et al 2003:453). Furthermore, health behaviors are heavily influenced by one's socioeconomic circumstances. Access to healthy food, a safe environment, and the time required to adopt a healthy lifestyle plays a considerable role in rates of obesity which are subsequently correlated with these same trends of inequality, being overrepresented in marginalized groups.

Public health officials often use the terms “upstream” and “downstream” to refer to systemic public health efforts and targeted, individualized efforts respectively. For instance, a downstream health intervention could be helping a patient with high cholesterol adopt a healthier lifestyle or find a medication to reduce their cholesterol levels and prevent heart disease. An upstream approach would involve examining the factors that lead people to have high cholesterol in the first place. At first glance, workplace wellness programs appear to be upstream, by attempting to target risk factors and prevent chronic disease before it presents. However, these methods fail to address the risk factors of the risk factors (Link and Phelan 1995). Without addressing systemic problems like income inequality, educational disparities between the rich and poor, and discrimination against people of color and queer people, only limited strides in chronic disease prevention can be made.

The workplace does yield considerable influence in these realms. However, it is arguable that a workplace wellness program is an inefficient mechanism for addressing these problems. In fact, workplace wellness may exacerbate existing health and income disparities because those with risk factors for chronic disease are likely to have to shoulder more of the cost of healthcare. If these individuals are already more likely to be of lower socioeconomic status or from otherwise marginalized groups, as I have argued, then these programs have the potential to exacerbate both financial and health disparities instead of solving them. Alternatively, workplaces could ensure that they are providing their workforce with sufficient wages, grant their employees paid sick leave or paid time off for new parents, and take measures to limit both wage discrimination and racism in the workplace.

The Wellness Industrial Complex

Despite the growing evidence that workplace wellness initiatives are at the very least limited in their effectiveness, they have expanded rapidly over the past decade. "The global corporate wellness market size was valued at USD 52.8 billion in 2020 and is expected to expand at a compound annual growth rate (CAGR) of 7.0% from 2021 to 2028" (Grand View Research 2021). In the United States alone there are over 550 corporate wellness programs that offer their services to employers. Despite this dramatic increase in the scope of these programs, this same report indicates that "costs related to lost productivity due to absenteeism related to illnesses are expected to cross USD 150 billion in the coming years" (Grand View Research 2021). Corporate wellness programs, like the companies that employ them, operate with a business model. In this sense, the fact that rates of chronic disease, absenteeism, and reduced productivity in the American workforce are rising, not falling, with the introduction of these wellness programs is

not necessarily a concern to their business model. On the contrary, the presence of chronic disease will benefit these companies that produce wellness solutions, so long as workplaces continue to employ them on wider and wider scales.

In this sense, a wellness industrial complex has been created, in which big players have little financial incentive to improve population health, and instead become trapped in a business model that promotes practices that are antithetical to their purported goals in order to maintain their relevance. According to Open Secrets, the top organization tasked with tracking lobbying in government, ComPsych, a major workplace wellness corporation, donated $5,000 to Senator Josh Hawley from Missouri who supported the overturn of the Affordable Care Act in 2018, and opposed the implementation of mask mandates in his state in light of the COVID-19 pandemic. Similarly, Cigna, another major corporate wellness company has a political action committee that donates to candidates such as Representatives Kevin McCarthy and Steve Scalise who have similarly opposed the Affordable Care Act and have been critical of covid public health measures as well (Cigna 2015) (Goodkind 2019). These findings undermine the idea that these companies exist to improve people's health and lower rates of chronic disease, which calls into question the general efficacy of using a business model to promote health and wellbeing at all.

In this chapter I demonstrated that the foundational logic of workplace wellness programs is flawed at best. The corporate wellness model maintains that employees with risk factors for chronic disease are likely to cost the company more in healthcare spending. As a result, they conclude that it is reasonable to attempt to modify employee behavior to promote better health and charge higher premiums for employees who fail to adopt a healthier lifestyle. While these conclusions seem logical on the surface, much of this reasoning is problematic. In reality, it is much more difficult to determine which employees are likely to cost more in health

expenditures, creating the potential of erroneously charging certain employees higher healthcare premiums. Furthermore, financially penalizing employees based on the presence of chronic disease risk factors is likely to inadvertently intensify existing economic disparities between those with and without chronic illness.

CHAPTER THREE

Personal Responsibility and the Wellness Panopticon

The Metaphor of the Panopticon

I have demonstrated that there is an incentive for workplaces to attempt to control employee health behavior, but it is easy to imagine that there are incentives to control employees that extend well beyond the realm of health. Arguably, the workplace has an incentive to control many aspects of workers lives in order to reach maximum productivity for the lowest possible cost. In light of this, many gains from labor movements throughout history have surrounded increasing the rights and autonomy of workers to, for instance, receive sick leave, compensation if they become injured at work, and freedom from physical coercion and punishment. Workers are controlled by managers who have the power to dictate what workers do, and reprimand or fire them if they fail to obey orders. The act of management allows for employers to ensure that their employees are generally acting within the best interest of their company. Foucault introduced the metaphor of the panopticon in the late 1970s. Deriving from a physical structure, the panopticon represents ways that individuals internalize rules and authority (Foucault, 1977).

The panopticon itself is a prison that is constructed so that all of the cells surround a guard tower. The prison cells are visible to the guards in the tower who can monitor the prisoners at all times, but the prisoners cannot see the guards through the small obscured windows of the tower. This creates the impression amongst the prisoners that they are being monitored at all items regardless of whether or not any guards are present. The idea of the panopticon was created in the 18th century by philosopher Jeremy Bentham, who maintained that society would

improve if it was under constant observation. Writers like Shoshanna Zuboff have been more critical of panoptical surveillance, arguing that it can be used to exploit people under capitalist economies. This idea translates easily into the workplace where workers are more likely to "straighten up and work harder" in the presence of their boss (The ethics center 2017). Foucault discusses the panopticon and its psychological implications throughout much of his work, but a major idea is that the panopticon is successful regardless of whether or not one is actually being watched. In the example of the literal panopticon, its success is not contingent on whether or not there are guards present in the tower because prisoners will adjust their behavior as if they are being constantly surveilled. This same technique can be applied in workplaces where workers are subjected to surveillance or investigation by management regardless of their physical presence.

Worker Control Under the Ford Sociological Department

Owners of businesses and corporations have obvious incentives to implement some sort of control over their workforce, and tactics to influence and control employees are well documented throughout modern history. In 1913, Henry Ford, the founder of Ford Motor Company, created the Ford Sociological Department. The Sociological Department founded programs that existed to instill company values onto Ford's employees, and workers were incentivized to join with a promise of a dramatic pay raise. The minimum wage for employees who chose to participate in the Department's program rose from $2.70, to 5 dollars per day (Loizides 2004:60). The raise was implemented by enacting a form of wage sharing for employees who became involved. In other words, all employees were entitled to the company's $2.70 per-day minimum wage, but members of the Sociological Department's program were promised an additional $2.30 in company profits so long as they complied with the program

(Loizides 2004:55). Participants in the program were subjected to home and neighborhood inspections, as well as scrutiny into their personal habits. “The Ford Motor Company promoted a particular constellation of social values to its workers that it considered as representative of “middle-class” values, including thrift, temperance, diligence, loyalty, Americanism, and family values” (Loizides 2004:6). If workers were not sufficiently compliant with the norms implemented by Ford and the Sociological Department, they risked expulsion from the program which resulted in a severe pay cut. The value of “thrift,” meaning careful or conservative budgeting, was heavily emphasized in part to decrease the necessity of sick leave and reliance on retirement pensions (Loizides 2004:63). Investigators in the Sociological Department were tasked with ensuring that employees were spending their income in ways that the company deemed responsible, checking for “life insurance and bank savings” (Loizides 2004: 142). The Sociological Department theorized that if they could control the budgeting of their workforce, they would be less likely to have to provide large pensions to retired workers. Similar to modern workplace wellness initiatives, there was a financial motive that underlined the Ford Sociological Department that was implemented by increased worker control.

That being said, not every aspect of the program was related to cost savings. Much of the plan revolved heavily around “Americanizing” Ford’s employees which, at the time consisted largely of eastern European immigrants and Black Americans relocated to the North after the great migration. This demonstrates that the program was intended to mold workers into socially desirable employees in a specific cultural context.

Eventually, the paternalistic nature of this program became unfavorable to employees and the program adapted, limiting the number of investigations that were conducted and changing its name from the sociological department to the educational department in 1916 (Loizides

2004:60). The investigators who were tasked with neighborhood and housing inspections were subsequently renamed advisors, implying a more passive and supportive presence as opposed to the imposing presence of the investigators under the Sociological Department. Similar to wellness programs today, the Sociological Department framed its motivations as altruistic, intending to help employees make good decisions for themselves). In fact, the Sociological Department grew out of Ford's Medical Department in part to curb absenteeism, a major motivation for many of today's corporate wellness initiatives (Loizides 2004:60).
Ultimately, the Ford Sociological Department was not successful in fostering savings in its employees. While the 5 dollar per day wage was much higher than most companies at the inception of the program in 1914, by 1921 it became standard if not low in comparison to most workplaces due to inflation. By 1926 there were a disproportionate number of Ford employees relying on charity to sustain themselves, despite the purported advantages and mission of the Sociological Department's program (Loizides 2004:65).

While wellness initiatives today do not implement many of the draconian rules put in place under Ford such as the banning of talking, whistling, or sitting down at work, the paternalism of the Sociological Department is still in existence, and may be on the rise in the form of workplace wellness programs (Loizides 2004:61). In a way, the Sociological Department's program had a panoptical element to it. Workers knew that they would be subjected to inspections from their managers to ensure that they were living in accordance with the values ascribed by Henry Ford. The workers then might have internalized these values and adjusted their way of life due to both the perceived and real surveillance by Ford's investigators. Wellness programs are similar to this. As put by David McGillivray "wellness seems to indicate

the presence of an increasingly omnipresent gaze over the conduct of individuals' lives" (McGillivray 2005:133).

Workers enrolled in wellness programs take on goals ascribed by their employers, and work to execute these goals even outside of the office, internalizing the health and fitness objectives of others and policing their behaviors in accordance to them. In this sense, the workplace is extended into the private lives of employees. For instance, employees enrolled in a workplace sponsored smoking cessation program are in a way still being monitored by their workplace as they work to make changes in their lifestyles even when they physically leave the office. The gaze of wellness, in this case wellness imposed by the workplace, continues to govern the actions of employees both in and out of the physical workplace.

Neoliberalism and Internalized Authority

The illusion of the panopticon is not only relevant to the control of workers, but according to Foucault, is also used by the government to control its citizenry in a society committed to neoliberal principles (McGillivray 2005:331). The term "neoliberalism" has many definitions and can be used to describe different systems at play. Generally speaking, neoliberalism refers to a system of government and economics that values individual liberty and free market capitalism. Neoliberal governments will emphasize personal responsibility and shift the responsibility of governance from the government to the citizens themselves (McGillivray 2005:327). The implementation of neoliberalism often involves the cutting back of social welfare programs under the presumption that people should take responsibility for their own socioeconomic circumstances.

The value of personal responsibility can be viewed as a form of internalized authority. Foucault uses the term "biopower" to describe the "dispersed regulation of bodies, which encourage individual self-regulation of the internal processes of body and mind. In neoliberal manifestations of biopower, notions of agency, personal responsibility, and self-esteem are emphasized to such an extent that systemic, structural, and personal conditions are all but ignored" (Hepworth 2019:327). In other words, neoliberalism presumes that all people are operating with equal ability and ignores any extenuating factors that may put certain people at a disadvantage. The metaphor of the panopticon is central to Foucault's theory of self-governance. Citizens internalize the government's authority and begin to govern themselves in accordance with the values of their legal or economic systems. Under a neoliberal society, citizens internalize the idea of personal responsibility.

We experience the panopticon from things like security cameras, police patrolling, and data collection. For instance, we may stop at stop signs regardless of whether or not a police officer, or even other cars, are present. Wellness has introduced a new kind of self-surveillance in the form of health and fitness monitors. Scholar Dr. Katherine Hepworth describes a sort of panoptic relationship that she shares with her FitBit. Hepworth is aware that while she has access to only a small segment of her data collected from the device for a short period of time, the company FitBit perpetually has access to the totality of the data collected from the device. This creates a power imbalance where presumably some people working for FitBit have access to much more of her data than she will ever see, but these people remain anonymous to her. Also similar to the panopticon, she adjusts her health behavior to meet the goals set by her device.

Privacy Concerns and Data Mining in Wellness Programs

The collection of employee data in workplace wellness initiatives has been a contentious element of these programs. Biometric screenings, data collection from products like FitBit, and occasionally even genetic testing are often included in these wellness initiatives, and many employees are unaware that the data collected will be owned by the companies that administer the testing. In some cases, these companies are even able to sell the health data collected from employees to advertising companies. Importantly, while information collected from wellness programs that are a component of employee health insurance remain protected by HIPAA regulations, workplace wellness programs that operate independently from insurance programs are not bound by these restrictions and are able to sell data collected from employees (Ajunwa 2017). While employers themselves are not entitled to the personal health data of their employees, companies can anonymize the data of a workforce and "provide aggregated data on the number of employees found to be at risk for a given condition" (Silverman 2016). In one case, a wellness program was able to predict which employees were trying to get pregnant by tracking whether or not employees were refiling their birth control prescriptions (Silverman 2016). Many women felt that these practices were a breach of privacy stating that the subsequent messages they received prompting them to find an obstetrician or start taking prenatal vitamins were "creepy" (Wisenberg Brin 2016).

While the United States has laws against workplace discrimination based on health status or pregnancy, the possibility of employers having access to data showing that some employees are likely to become pregnant or ill could lead to discrimination if these laws are eroded or if workplaces choose to ignore them. Dr. Hepworth even mentions risks surrounding data collection from technologies like FitBit in workplace wellness programs in her writing,

mentioning that workplace wellness programs have provided a large new market to the company. The data collected by FitBit is not necessarily secure and has the potential to be bought by outside parties. She even maintained that "Recent investigative reporting has uncovered substantial evidence of the data from personal trackers offered through such programs being used by health insurance companies not only to monitor participants but also to penalize wearers whose data does not correspond with predetermined behavioral ideals" (Hepworth 2019:337). The metaphor of the panopticon is even more salient here. The introduction of fitness tracking technologies in workplace wellness adds another component of self-surveillance. Like the original metaphor of the FitBit as a panopticon, not only does FitBit have access to the totality of the data that it collects, but the workplace is able to monitor your data as well.

Surveillance of the Self

There is an obvious difference between the panopticon in its original sense, and the panoptical metaphors that I have used throughout this chapter. While the prisoners in the original panopticon are being physically forced to live under constant surveillance, we, at least in part, choose to be surveilled. While one could argue that participants of workplace wellness programs are coerced into participation by the financial incentives offered by their employers, the programs exist in part to attract new employees (Mcgillivray 2005:132). This indicates that a significant number of employees value and enjoy the idea of these programs despite their questionable efficacy, tendency to exacerbate inequalities, and privacy issues.

This should not necessarily be surprising considering the fact that products like the FitBit, Apple Watch, and Amazon Halo are immensely popular despite the fact that most research indicates that the data derived from these products is often inaccurate with a high margin of

error, and we have little knowledge or control of where the data collected from the devices ends up (Hepworth 2019:333). Data can also be portrayed in misleading ways that prompt people to draw inaccurate and unfair comparisons between themselves and others. Dr. Hepworth wrote about monitoring her sleep with her FitBit, finding that the device not only provides you with data concerning your sleep, but compares the quality of your sleep to others of your same sex and age range. However, sex and age are only two factors among many that determine the quality of one's sleep "including medications, medical conditions, shift work, and stress" among many other factors. (Hepworth 2019:333). She goes on to say that

> "In so doing, it presents a perfect neoliberal governance tool of self-regulation; if the goal is presented as attainable, but is not actually so, the activities undertaken to strive for it can be continuous, exhausting, and expensive. Absorbed in striving to optimize my activities as compared with fictional norms, I become a predictable, docile, and consumptive subject" (Hepsworth, 333).

In line with neoliberal ideology, the FitBit presumes that all women in her age group have equal ability to get good sleep and prompts a sort of competition amongst the customers. Dr. Hepworth even admitted, despite understanding the imprecise and unfair nature of these categorizations, that she wanted to obtain better sleep than the other women of her age group. Similar to the goals of wellness programs, this kind of data monitoring and person-to-person comparison prompts people to see their wellness as something that is entirely their own responsibility, regardless of circumstances that may make aspects of wellness unattainable. People become their own authorities and monitors, internalizing the ideals of the workplace or the government and imposing them onto themselves.

In accordance with Foucault's theory of self-governance, people's notions of what "good health" means is likely stem from the values of their own government and society. In neoliberal societies, good health can correspond to an ability to be productive under a capitalist economic system. This can be seen in the case of workplaces attempting to fix behaviors like smoking and obesity, which inhibit productivity while ignoring the deleterious effects of stress.

Stigma, Personal Responsibility, and Care

In chapter two I discussed the stigmatization of tobacco use. Scholars Link and Phelan define stigma as "a resource that allows" people to keep certain groups "down, in or away" (Link and Phelan 2014). Stigma surrounding tobacco use is widespread, and it is not just the act of smoking that is stigmatized, but illnesses that could feasibly be connected to tobacco use are stigmatized as well. A study exploring stigma experienced by different cancer patients found that lung cancer carried the most stigma (Marlow et al 2015). The stigma associated with smoking even presents itself in encounters with medical professionals. Smokers report facing stigma in medical settings, and doctors themselves confirm these reports. "A US study (Barr et al., 2005) found that 83% of physicians thought that COPD was a "self-inflicted" disease and a significant minority were nihilistic about the treatment of patients who continued to smoke" (Bell et al 2010).

The stigmatization of smoking can also inhibit people who smoke from seeking help. Many report keeping their status as a smoker a secret from their healthcare provider. Some doctors claim that they are hesitant to pose smoking cessation to known smokers due to fear that it will damage the doctor patient relationship if the patient senses judgement from the doctor due to the intense stigma surrounding this issue (Bell et al 2010). In light of this, it is unsurprising

that workplace wellness programs are unlikely to substantially influence certain behaviors that are already heavily stigmatized.

Because lung cancer is associated with smoking, a behavior widely known for its adverse health effects, there is a sense that patients with lung cancer are responsible for their condition. In chapter two I discussed the complex reasons that may lead people to smoke, illustrating that behavioral health choices are often results of other extenuating life circumstances such as stress, poverty, lack of education, or even the experience of discrimination or other forms of stigma. However, the pervasive idea that we are in control of our own health outcomes makes it so that certain illnesses and behavioral health choices are highly stigmatized, and often prevents us from examining social determinants of health.

The stigma associated with tobacco use is even considered to be good by many, and indeed is likely to have played a large role in the sudden decrease of smoking prevalence in the United States. “De-normalization" strategies focused on removing tobacco use from the mainstream by eliminating smoking indoors and in the workplace, as well as underlining the poor health effects caused by smoking. Notably, there has been much less of a concerted effort to de-normalize the tobacco *industry* and their political influence. While there has been a push to destigmatize issues like drug addiction and mental illness, the same push for de-stigmatization is much less present surrounding tobacco use. This discrepancy is likely due to the fact that because tobacco use has limited legal parameters, the public discouragement of tobacco use has relied in part on this very stigma. However, the stigmatization of tobacco has seemed to only work on certain groups.

Today, smokers are overwhelmingly working class. Additionally, LGBTQ+ people, indigenous people, disabled people, people with mental health issues, and those with lower

education levels are overrepresented in the population of current smokers (CDC). A study examining the stigmatization of smoking has hypothesized that some of the stigmatization of tobacco use can be attributed to the association of tobacco with a lower socioeconomic status and otherwise marginalized groups (Bell et al 2020). It is reasonable to assume that the association of smoking with LGBTQ+ people, non-white people, the mentally ill, and other groups that already face a certain degree of stigma and discrimination aid in the further stigmatization of smoking. Given this, it is unsurprising that the stigmatization of tobacco use as a public health initiative is ineffective among these groups who are already living with the stigma of being poor, queer, disabled, less educated, or mentally ill.

In the metaphor of the panopticon, we internalize authority and police ourselves in accordance with the laws and norms of our society. Stigmatization causes us to recognize certain behaviors as socially unacceptable, which results in feelings of shame when we fail to comply with societal norms and values. Similar to the use of real or perceived surveillance as a tool to maintain social order, shame is the punishment of failing to live in accordance with the ascribed values of one's society. The neoliberal tenet of personal responsibility makes people feel as though they have complete responsibility for their health, resulting in a sense that if someone becomes ill, it must be their fault, leading to feelings of shame and judgement.

In chronic diseases, where many of the risk factors are behavioral, these attitudes are even more pronounced. The idea that we are responsible for our own bad health is essentially the model of workplace wellness programs which charge employees higher premiums who make bad health "choices." In this belief system, healthcare is treated as something that is earned by good behavior, and if people fail to practice good behavior then they should bear the physical and financial consequences of their actions.

The belief that others should not have to pay for one's poor choices is widespread in neoliberal societies, and there is evidence that this belief extends beyond its rational application. For instance, one study prompted participants to distribute heart transplants amongst a group of fictional patients with a variety of different "controversial health behaviors (eating high fat diets against doctors' advice, cigarette smoking, or intravenous drug use)" (Ubel, Baron 1999:57). The participants were much less likely to distribute the heart transplants to intravenous drug users, despite the fact that these patients had "better transplant outcomes than other patients" (Ubel, Baron, 1999:58). A similar phenomenon exists in workplace wellness programs where employees with behavioral risk factors for chronic disease are forced to pay higher premiums regardless of whether or not they actually have higher healthcare expenditures. This indicates that there is a societal perception that some are unworthy of healthcare due to their lifestyle choices, even if those choices are not directly related to the healthcare they are seeking.

Ultimately, the entire system of healthcare exists under the presumption that everyone, at some point in their lives, is going to require care that is given simply because they need it. Care ethics is a philosophical framework that captures this idea, rejecting the application of a universal theory of ethics. Instead of focusing on equations and logic to determine what is morally or ethically correct, care ethics emphasizes actively responding to those in need instead of imposing a black and white moral framework. Care ethics recognizes that people are interdependent and are likely to both give and receive care at different times in their lives (Gilligan, 2011). The practice of medicine in its purest form seems to follow this philosophy. Doctors should care for the sick not because they are worthy of care, but because they are sick. Wellness programs, while they satisfy our urge to monitor, judge, and control our bodies, fail to recognize the complex reasons underlying people's health-related choices. Instead of working to

address the underlying causes of bad health and chronic illness, workplace wellness programs pervert healthcare into something that is *earned* rather than something that is *deserved* on the basis of being a person that requires care.

CHAPTER FOUR

Workplace Wellness as a Substitute for Universal Healthcare

Shortcomings of American Healthcare System

Today, the United States remains the only OECD[1] (Organization for Economic Co-operation and Development) country that does not guarantee healthcare for all of its citizens. Instead, the United States healthcare system is a patchwork of public and private entities with most Americans receiving healthcare from their employers. Low income individuals may be eligible for Medicaid, a federal healthcare plan, and others can purchase a plan on the market. However, many who are ineligible for Medicaid are left without insurance (Tikkanen et al 2020). As of 2020, 12.5% of Americans adults were uninsured, and 43.4% of adults were "inadequately" insured. The term "inadequately insured" describes U.S. adults who are either uninsured, experienced a gap in their insurance coverage, or who were insured but had extremely high deductibles or out of pocket costs (Collins et al 2020).

Even for those with health insurance, high costs of medical care present a major issue. "Nearly half of Americans say they have delayed or skipped medical care because of the cost" (Cutler 2020). High costs of care can be very dangerous to patients who are likely to be "diagnosed with cancer at later stages of the disease and take fewer medications" (Cutler 2020). Even patients who are very ill tend to cut back on their intake of prescribed medicine if they feel that they are unable to afford the high costs. According to a Gallup Poll survey, as of 2019 "more

[1] The Organization for Economic Co-Operation and development is comprised of 37 countries that are largely high income with relatively high Human Development Indexes. The OECD works to improve global economic relations and promote democracy.

than 13% of American adults -- or about 34 million people -- report knowing of at least one friend or family member in the past five years who died after not receiving needed medical treatment because they were unable to pay for it" (Witters 2019). The United States has by far the most expensive healthcare system out of its OECD counterparts, and despite drastically higher expenditures, has worse health outcomes. As of 2019 the United States had the highest chronic disease rate, obesity rate, suicide rate, and hospitalizations from preventable causes (Tikkanen, Abrams).

Throughout this thesis I have maintained that chronic disease is a major contributor to high healthcare expenditures. This is undeniable considering that an estimated 90% of healthcare expenditures are related to chronic disease management (CDC 2021). However, the framing of chronic disease itself as the major contributor to high healthcare costs in the United States is misleading. While costs associated with treating chronic disease make up a large portion of health care spending, prescription medication used to manage and treat chronic disease is much more expensive in the United States than in any other OECD country. The average cost of prescription drugs among 11 comparable nations (the United Kingdom (UK), Japan, Ontario, Australia, Portugal, France, the Netherlands, Germany, Denmark, Sweden, and Switzerland) is only 27% of the average cost of drugs in the United States. The United States has drug costs twice as high as Denmark, which has the second highest drug costs in the group, and nearly seven times as much as Japan which has the lowest (Ways and Means Committee Staff 2019:15). In 2018, the cost of Humira, a drug used to treat inflammatory conditions such as arthritis, psoriasis, and Crohn's Disease was 500% more expensive in the United States than in the other countries compared (Ways and Means Committee Staff 2019:18). Similarly, "insulin averaged $34.75 per dose in the U.S., which is 247 percent of the $10.58 price in other countries" (Ways

and Means Committee Staff 2019:20). In other words, the price of insulin in the United States is more than twice the price of insulin in comparable nations.

While there is truth to the claim that chronic disease is, in a sense, responsible for a large proportion of our healthcare expenditures, framing chronic disease as the reason that costs are high is misleading when the costs of treatment for chronic disease are vastly higher in the United States than in all other high-income nations. In this sense, cutting the costs of the drugs themselves would likely generate much more savings than attempting to change the health behaviors of individuals with risk factors for chronic disease.

In fact, chronic disease is not even listed as one of the top three most expensive components of the American healthcare apparatus. The most expensive aspect of our healthcare system is actually the administration, which is estimated to consume a third of funds allocated for health care. The next most costly components are higher prices for drugs and medical services and "higher utilization" of medical technologies, respectively. (Cutler 2020). Both of these components are similarly unrelated to population health trends. Because the United States has a complex patchwork of interconnecting healthcare systems, the general management of our healthcare system represents a very significant labor industry. According to the Census Bureau, healthcare represents the largest employment sector in the United States (Dowell 2020).

In chapter one I discussed the expansiveness of the wellness industry. In a sense, the U.S. healthcare apparatus as a whole faces similar challenges to Wellness Programs. In both cases the systems have been found to be relatively ineffective in achieving their intended goals. In chapter two I explored the ways in which wellness programs often fail to curb chronic disease risk factors and may exacerbate existing inequities in health. Similarly, health disparities in the United States have been growing over the past decade (Zimmerman and Anderson 2019).

Despite higher spending, the United States healthcare system is simultaneously more expensive and less effective at curbing chronic disease, preventable deaths and hospitalizations, and suicides than the healthcare systems of other OECD countries. However, both workplace wellness programs and the American healthcare system at large represent such extensive industries that generate large profits and jobs that, characteristic of industrial complexes, grow regardless of their lack of success. This is likely because, similar to the wellness industry, the American healthcare system operates on a business model, so growth, not good health, becomes the primary objective of the system.

It is clear that our healthcare system is failing to adequately care for us. According to a survey conducted by the American Association of Retired Persons (AARP) approximately 28% of Americans are not taking their medications as prescribed because of cost, and in some geographic regions this percentage is much higher. In Texas this number is 36%, and in Mississippi it is as high as 41% (Bunis 2019). A poll by the National Opinion Research Center indicates similar problems, reporting in 2018 that "about 40 percent of Americans report skipping a recommended medical test or treatment and 44 percent say they didn't go to a doctor when they were sick or injured in the last year because of cost" (NORC 2018).

Political Opposition to Medicare-for-all

While the subject of Universal healthcare is often presented as controversial by mainstream media outlets, a majority of Americans report that they would prefer "Medicare-for-all" to the system that we have now. A survey conducted by Reuters shows that 70% of Americans that were polled are in favor of Medicare-for-all, as well as 84.5% of registered democrats that were polled (Stein et al 2018). It's worth noting that it is possible that when some

say they are in favor of "Medicare-for-all" they are not referring to a single payer system but are expressing a desire for universal healthcare in general. Even still, according to the Pew Research Center a majority of democrats actually favor a single payer health care system similar to the United Kingdom's National Health Service. (Jones 2020).

Despite these statistics, a policy proposing a single payer plan, let alone universal healthcare is rarely suggested in mainstream politics. Of the 21 candidates in the 2020 Democratic primary, only two supported Medicare-for-all as a part of their platform (Kurtzleben et al 2019). While most politicians in the democratic primary claimed to support universal healthcare, the majority did not have plans to implement a healthcare system that would guarantee this. In the debates during the democratic primaries, a policy of Medicare-for-all was framed as unreasonable, expensive, and unlikely. President Biden and Speaker of the House Nancy Pelosi have expressed similar sentiments regarding Medicare-for-all and other progressive policies, dismissing their proponents as "four people" who "don't have any following" (Hasan 2019). In the months leading up to the primary results, Joe Biden claimed that Americans "don't want a revolution," implying a loyalty to the status quo (Gregorian 2020).

Despite political rhetoric framing healthcare reform as expensive and unnecessary, evidence suggests that a dramatic change in our healthcare system would be much less expensive than our current system. A Yale study indicates that Medicare-for-all would reduce healthcare costs by 13% and save 458 billion dollars per year. In addition, the study projected that a shift to Medicare-for-all has the potential to save over 68,500 lives per year (Galvani et al 2020). Even more conservative estimates indicate that a single payer system would generate major savings. A research study conducted by Mercatus, a conservative think tank funded by the Koch brothers,

estimated that Medicare-for-all would save close to 2 trillion dollars in overall healthcare expenditures over the course of 10 years (Blahous 2018:4).

While dramatic changes to our healthcare system seem politically difficult, they are possible. In *The Healing of America: A global quest for better, cheaper, and fairer health care*, T.R. Reid wrote about the adoption of Universal healthcare in both Switzerland and Taiwan, that, similar to the United States, were characterized by intense political partisanship, influential insurance industries opposed to change, and a deeply capitalist economy (Reid, 166). The pharmaceutical industry, popularly dubbed "Big Pharma" wields considerable influence in American politics. Open Secrets, the top research group studying and tracking lobbying in American politics, indicates that the pharmaceutical industry is the most influential lobbying group in Washington. This creates a large incentive for politicians to limit the extent to which they reform healthcare and regulate the pharmaceutical industry. Even democratic politicians whose constituents overwhelmingly favor universal health care and largely favor a single player plan are beholden to "big pharma." In fact, in 2020, democrats actually received more in campaign contributions from the pharmaceutical industry than republicans.

Neoliberalism in Healthcare and the Myth of Choice

Corporate wellness programs exist in part to manage the costs of expensive care in the United States which explains in part why their existence is much more prevalent in the U.S. than it is in other countries. Corporate wellness presents the problem of high healthcare costs as primarily driven by chronic disease, which is influenced by individuals' behavior and choices. Instead of assigning blame to unchecked pharmaceutical companies for the high prices of drugs, the problem becomes cast as "the prevalence of chronic disease." Instead of chronic disease

being attributed to lack of access to health care, growing income inequality, limited access to healthy food among lower income groups, and the stressors of things like poverty, racism, and discrimination, it is attributed to the poor choices of individuals.

The illusion of “choice” is central to neoliberal ideology. Just as neoliberalism frames chronic disease as a result of poor health choices, it equates privatization and unregulated markets as freedom, and people are expected to exercise their freedom of choice with money. This rhetoric was used in the debate surrounding Medicare-for-all by claiming that a single payer system would limit people's freedom to choose their own insurance providers. This rhetoric ignores the fact that the majority of people’s health insurance is chosen for them by their workplace, which can change their insurance at any time. Furthermore, employees are perpetually at risk of being kicked off of their insurance if they quit or lose their job. Corporate Wellness programs exploit this false idea of choice in order to justify charging people more likely to develop chronic disease with higher premiums.

CONCLUSION

Corporate Wellness programs exist to mitigate the costs of our extraordinarily expensive health care system. By trying to combat chronic disease instead of targeting high drug prices and excessive administrative costs, wellness programs act as a band-aid solution to the problem of rising costs of care. Substantially reducing the costs of our health care system would take much more than addressing chronic disease risk factors. Instead it would involve fundamentally reshaping health care in the United States so that it covered every American and drastically limited the cost of care.

In chapter one I presented different definitions of wellness. Wellness encompasses more than just one's physical health, capturing things like spiritual, emotional, and social wellbeing. Although wellness is often presented in a hyper individualized manner, in a way the understanding of social determinants of health presents a related concept. Social determinants of health recognize that health is influenced by much more than exposure to germs, highlighting the importance of social connectedness, education, and access to important resources. Workplace wellness programs, similar to celebrity weight loss teas and hotel sponsored wellness retreats, pervert the original meaning of wellness offering instead a commodified, distorted, and hyper individualized version of the concept.

In chapter two I analyzed many of the shortcomings of wellness programs critiquing their means of identifying at risk employees and successfully encouraging them to adopt a healthier lifestyle. Instead, wellness programs often erroneously target employees with risk factors of chronic disease, charging them higher premiums without evidence that they are actually costing the system more money. I demonstrated that workplace wellness programs ignore social determinants of health. Instead of examining underlying causes of chronic disease risk factors,

wellness initiatives assume that people who have risk factors for chronic disease should either adjust their behavior or shoulder a larger portion of the cost of health insurance.

At first glance, the logic of corporate wellness programs seems reasonable. People who make bad choices concerning their health should have to take responsibility for their actions. Furthermore, people who make *good* decisions shouldn't have to pay for those who make *bad* decisions. In reality however, many "bad health decisions" are the result of other more systemic problems like poverty, stress, discrimination, and lack of access to important resources like healthcare and a quality education. In chapter three I explored the ways in which stigma surrounding "bad health choices" ignores systemic problems that cause people to adopt unhealthy behaviors. Corporate wellness programs can be seen as a microcosm of a neoliberal society that promotes individualism over collectivism and personal responsibility over interdependence and care. Neoliberalism erases systemic problems and reduces health disparities to be the result of bad choices.

Our intense cultural fixation on personal responsibility inhibits us from recognizing that a healthcare system that operates under a business model is bad for the majority of Americans. In chapter four I discuss why Americans need universal healthcare. The notion that wellness programs will be able to make up the costs of a healthcare system that profits off of extremely high costs of care is false. In the tradition of neoliberalism, workplace wellness prompts individuals to take on the responsibility of lowering healthcare costs instead of addressing the exploitative practices that make costs high to begin with.

The notion of wellness is valuable in a larger discussion of health, but we should move away from the hyper-individualized conception of wellness that corporate wellness programs promote. According to the World Health Organization, social determinants of health have more

influence over one's health than their lifestyle or their healthcare. Wellness should recognize systemic barriers to good health instead of promoting the ideals of personal responsibility. Instead of outsourcing our wellness, like our health, to corporations and employer-sponsored programs, we should promote an upstream version of wellness that emphasizes the well-being of the collective over the individual. It is tempting to internalize the dogma of individualism and personal responsibility because the thought that we have complete control over our health, our finances, or lives at large is very comforting, but unfortunately this is not the case. If anything, the pandemic that we have lived under for the past year demonstrates that in reality we have very little control of much of our circumstances. An effective society should recognize that fact and work to care for its members instead of punishing them for its own shortcomings.

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