Wellness in the Work Place: Potentials and Pitfalls of Work-site Health Promotion

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IN THE PAST DECADE WORK-SITE HEALTH PROMOTION or "wellness" emerged as a manifestation of the growing national interest in disease prevention and health promotion. For many companies it has become an active part of their corporate health care policies. This article examines the potentials and pitfalls of work-site health promotion.

Work-site health promotion is "a combination of educational, organizational and environmental activities designed to support behavior conducive to the health of employees and their families" (Parkinson et al. 1982, 13). In effect, work-site health promotion consists of health education, screening, and/or intervention designed to change employees' behavior in order to achieve better health and reduce the associated health risks.

These programs range from single interventions (such as hypertension screening) to comprehensive health and fitness programs. An increasing number of companies are introducing more comprehensive work-site wellness programs that may include hypertension screening, aerobic exercise and fitness, nutrition and weight control, stress management, smoking cessation, healthy back care, cancer-risk screening and reduction, drug and alcohol abuse prevention, accident prevention, self-care and health information. Many programs use some type of health-risk appraisal (HRA) to determine employees' health risks and to help them develop a regimen to reduce their risks and improve their health.

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Work-site health promotion has captured the imagination of many health educators and corporate policy makers. Workers spend more than 30 percent of their waking hours at the work site, making it an attractive place for health education and promotion. Corporate people are attracted by the broad claims made for work-site health promotion (see O'Donnell 1984). For example:

> Benefits of worksite health promotion have included improvements in productivity, such as decreased absenteeism, increased employee morale, improved ability to perform and the development of high quality staff; reduction in benefit costs, such as decreases in health, life and workers compensation insurance; reduction in human resource development costs, such as decreased turnover and greater employee satisfaction; and improved image for the corporation (Rosen 1984, 1).

If these benefits are valid, probably no company would want to be without a wellness program.

Many major corporations have already developed work-site health promotion programs, including Lockheed, Johnson and Johnson, Campbell Soup, Kimberly-Clark, Blue Cross-Blue Shield of Indiana, Tenneco, AT&T, IBM, Metropolitan Life, CIGNA Insurance, Control Data, Pepsico, and the Ford Motor Company. Nearly all the programs have upbeat names like "Live for Life," "Healthsteps," "Lifestyle," "Total Life Concept," and "Staywell."

The programs' specific characteristics vary in terms of whether they are on- or off-site, company or vendor run, on or off company time, inclusive (all employees eligible) or exclusive, at some or no cost to employees, emphasize health or fitness, year-round classes or periodic modules, have special facilities, and are available to employees only or families as well. All programs are voluntary, although some companies use incentives (from T-shirts to cash) to encourage participation. In general, employees participate on their own time (before and after work or during lunchtime). The typical program is on site, with modest facilities (e.g., shower and exercise room), operating off company time, at a minimal cost to participants and managed by a part-time or full-time health and fitness director.

The number of work-site wellness programs is growing; studies report 21.1 percent (Fielding and Breslow 1983), 23 percent (Davis et al. 1984), 29 percent (Reza-Forouzesh and Ratzker 1984–1985),

and 37.6 percent (Business Roundtable Task Force on Health 1985) of surveyed companies had some type of health-promotion program. It is difficult to interpret these figures. Not only are there serious definitional problems as to what counts as a program, but many may yet be only pilot programs and not available to all employees and at all corporate sites. Estimated employee participation rates range from 20 to 40 percent for on-site to 10 to 20 percent for off-site programs (Fielding 1984), but accurate data are very scarce (Conrad 1987a).

Work-site health promotion as a widespread corporate phenomenon only began to emerge in the 1970s and has developed largely outside of the medical care system with little participation by physicians. The dominant stated rationale for work-site health promotion has been containing health care costs by improving employee health. Business and industry pays a large portion (estimated at over 30 percent) of the American national health care bill, and its health insurance costs have been increasing rapidly. By the late 1970s corporate health costs were rising as much as 20 to 30 percent a year (Stein 1985, 14). This has become a corporate concern. In an effort to reduce these costs, corporations have redesigned benefit plans to include more employee "cost-sharing," less coverage of ambulatory surgery, mandated second opinions, increased health care options and alternative delivery plans (e.g., health maintenance organizations and preferred provider organizations), as well as work-site health promotion programs. Although wellness programs are only a piece of a multipronged cost-containment strategy, they may be especially important as a symbolic exchange for employer cost shifting and reductions in other health benefits. They are moderate in cost and very popular with employees.

Corporations are restructuring their benefit packages to shift more cost responsibility to employees in the form of deductibles, cost sharing, and the like. A national survey of over a thousand businesses found that 52 percent of companies provided free coverage to their employees in 1980; by 1984 only 39 percent did so. In 1980 only 5 percent had deductibles over $100; four years later 40 percent had such deductibles (Allegrante and Sloan 1986).

Cost containment may be the most commonly stated goal of wellness programs, but it is not the only one. Reducing absenteeism, improving employee morale, and increasing productivity are also important corporate rationales for work-site health promotion (Herzlinger and Calkins 1986, 74; Davis et al. 1984, 542). "Hidden" absenteeism can be

very costly, especially when skilled labor is involved (Clement and Gibbs 1983). Improved morale is expected to reduce turnover, increase company loyalty, and improve work-force productivity (Bellingham, Johnson, and McCauley 1985). The morale-loyalty-absenteeism-productivity issue may be as important as health costs in the development of work-site wellness. The competitive international economic situation in the 1980s makes the productivity of American workers a critical issue for corporations.

Despite the broad claims for work-site health promotion, the scientific data available to evaluate them are very limited. While more scientific data could better enable us to assess the claims of the promoters of work-site wellness, it is not necessarily helpful for addressing some of the difficult social and health policy issues raised by work-site health promotion. To examine these more policy-oriented dimensions, it is useful to distinguish between potentials and pitfalls—potentials roughly aligning with the claims made for work-site programs, the pitfalls with less-discussed sociopolitical implications. These distinctions are for analytic purposes and are somewhat arbitrary; there may be downsides to potentials as well as upsides to pitfalls. This framework, however, provides us with a vehicle for examining work-site health promotion that includes yet goes beyond the dominant corporate/medical concerns of reducing individual health risks and containing costs.

Potentials

The Worksite Locale

More people are in the "public" (i.e., nonhome or farm) work force today than ever before—estimated to be 85 million in the United States. Roughly one-third of workers' waking hours are spent in the work place. Work sites are potentially the single most accessible and efficient site for reaching adults for health education. From an employee's perspective, on-site wellness programs may be convenient and inexpensive, thus increasing the opportunities for participation in health promotion. The work site has potentially indigenous social support for difficult undertakings such as quitting smoking, exercising regularly, or losing weight. Work-site programs may raise the level of discourse and concern about health matters, when employees begin to "talk

health" with each other. And since corporations pay such a large share of health costs, there is a built-in incentive for corporations to promote health and healthier workers.

One of the most underdeveloped potentials of the work site is possible modification of the "corporate culture." When the term "corporate culture" is used by the health promotion advocates, they generally mean improved health changes in the orgnaizational culture and physical environment. Some also include changing company norms or the creation of the healthy organization (Bellingham 1985), often meaning making healthy behavior a desirable value among employees and management. Such goals, however noble, are vague and difficult to assess. In practice, changing the corporate culture has meant introducing more concrete interventions like company smoking policies (Walsh 1984), "healthy" choices and caloric labeling in cafeterias and vending machines, fruit instead of donuts in meetings, and developing on-site fitness facilities. Very rarely, however, have proposed wellness interventions in the corporate culture included alterations in work organization, such as stressful management styles or the content of boring work, or even shop floor noise.

Health Enhancement

Screening and intervention for risk factors are the most common vehicles for enhancing employee health. Medical screening includes tests for potential physiological problems; interventions are preventive or treatment measures for the putative problem. Medical screening at the work site, including chest X-rays, sophisticated serological (blood) testing, blood pressure and health risk appraisals (HRAs), can identify latent health problems at a presymptomatic stage. To achieve an improvement in health, however, work-site screening must also include appropriate behavioral intervention, medical referral, and back-up when necessary. Thus far, hypertension screening has produced scientific evidence supporting positive work-site results (Foote and Erfurt 1983).

The scientific evidence available to support specific work-site interventions is also, as yet, limited. Examining the extant literature on specific interventions, Fielding (1982) found good evidence for the health effectiveness of work-site hypertension control and smoke-cessation programs. He concluded that the data on physical fitness and weight-

reduction were not yet available. Hallet (1986), on the other hand, argued that well-controlled studies of work-place smoking intervention are not yet available. The evidence for physical fitness is still contentious (e.g., Paffenbarger et al. 1984; Solomon 1984) although the health effects of 30 minutes of vigorous exercise three times a week are probably positive, at least for cardiovascular health. There are reports of using work-place competitions (Brownell et al. 1984) or incentives (Forster et al. 1985) for increasing weight reduction, but the studies are short term and lack follow-up.

In the past few years large research projects to study the effects of work-site health promotion were initiated at AT&T (Spilman et al. 1986), Johnson and Johnson (Blair et al. 1986a) and Blue Cross-Blue Shield of Indiana (Reed et al. 1985). Most of the results currently available are from pilot programs or one or two years of work-site health promotion activity (except the Blue Cross-Blue Shield of Indiana study, which is a five year evaluation). In general, these studies show health improvements in terms of exercise (Blair et al. 1986a), reduced blood pressure and cholesterol (Spilman et al. 1986), although the findings are not entirely consistent. The 5-year Blue Cross-Blue Shield of Indiana study also found that interventions led to a significant reduction in serum cholesterol and high blood pressure and a lesser reduction in cigarette smoking (Reed et al. 1985). These reductions in risk factors are positive signs of health enhancement, but the studies are too short term to measure actual effect on disease. Limited scientific evidence aside, the interventions are at worst benign, since few appear harmful (save infrequent exercise-related injuries) and likely health effects seem between mildly and moderately positive.

Cost Containment

The effect of work-site health promotion on health costs, while highly touted, is difficult to measure and has engendered little rigorous research. Most companies do not keep records of their health claims in a fashion that is easy for researchers to assess. Since most research in this area tends to be short-term, and cost-containment benefits may be long-term (say five to ten years), the long time frame makes rigorous research on this topic unattractive to corporations and expensive for investigators. Finally, it is difficult to ascertain which, if any, work-site wellness interventions effected any changes in corporate

health costs. Many studies of health promotion "project" potential cost savings from reductions in risk, which while unsatisfactory for scientific evaluation often satisfy the corporate sponsors.

There are a few studies of cost benefits that report promising findings. A national survey of 1,500 of the largest United States employers conducted by Health Research Institute found that health care costs for employers with wellness programs in place for 4 years was $1,311 per employee compared to $1,868 for companies without such programs (*Blue Cross-Blue Shield Consumer Exchange* 1986, 3). Such cross-sectional surveys, however, do not adequately control for confounding variables (e.g., different employee populations or benefit plans) that certainly affect health costs. Blue Cross-Blue Shield of California initiated a single intervention—a self-care program—through 22 California employers, that reduced outpatient visits, especially among households with first dollar coverage (Lorig et al. 1985, 1044). The authors don't calculate the estimated cost savings, but since the cost of the intervention was small, the cost-savings potential is high.

The most compelling cost-containment data to date come from the Blue Cross-Blue Shield of Indiana (Reed et al. 1985; Gibbs et al. 1985) and Johnson and Johnson (Bly, Jones, and Richardson 1986) studies. The Blue Cross-Blue Shield study tracked and compared claims data for participants and nonparticipants (N = 2,400) in a comprehensive wellness program for 5 years. They found that although participants submitted more claims than nonparticipants (i.e., had a higher utilization), the average payment per participant was *lower* throughout the course of the study. When payments were adjusted in 1982 dollars, the mean annual health cost of participants was $227.38 compared to $286.73 for nonparticipants. For 5 years, the average "savings" per employee was $143.60 compared to the program cost of $98.60 per person, giving a savings to cost ratio of 1.45. A possible selection bias in terms of who is attracted to the program could have affected the results. Overall, the 5-year cost of the program was $867,000, with a saving of $1,450,000 in paid claims and an additional $180,000 saved in absence due to illness. The savings is estimated to be 8 to 10 percent of total claims (Mulvaney et al. 1985).

The Johnson and Johnson study compares health care costs and utilization of employees over a 5-year period at work sites with or without a health-promotion program (Bly, Jones, and Richardson 1986). Adjusting for differences among the sites, the investigators

found that the mean annual per capita inpatient cost increased $42 and $43 at the two sites with the wellness program as opposed to $76 at the sites without one. Health-promotion sites also had lower increases in hospital days and admissions, although there were no significant differences in outpatient or other health costs. The investigators calculate a cost savings of $980,316 for the study period. What is interesting is that this study was based on *all* employees at a work site. The suggestion here is that a work-site wellness program may produce a cost-containing effect on the entire cohort, not just on participants. The "Live for Life" program is an exemplary and unique program in terms of Johnson and Johnson's corporate investment in wellness; the effect of health promotion on an entire employee cohort needs to be replicated in other work-site settings.

Without further prospective studies, cost containment remains a promising but unproven benefit of work-site health promotion. Changes in health status—which are more easily measurable—do not automatically translate into health cost savings. It is often difficult to quantify health effect and subsequent cost savings. High employee turnover, discovery of new conditions, and other factors may affect actual cost benefits. On the other hand, the usual calculations do not take into account the cost of replacing key employees due to sickness or death. As Clement and Gibbs (1983, 51–52) note, the cost savings may be affected by characteristics of the company:

> For example, more benefits would be achieved by firms with highly compensated, high-risk employees, where turnover is low, recruitment and training costs are high, benefit provisions are generous and employees are likely to participate.

If corporations are serious about using health promotion to contain health costs, programs may need to be reconceptualized and expanded beyond their current scope. An important reality is that roughly *two-thirds* of corporate health costs are paid for spouses and dependents, who are not part of most work-site wellness programs, and that a large portion of health costs is expended for psychiatric care, which may only most indirectly be affected by wellness programs.

Cost containment is an overriding concern for some managers and program evaluators, especially in terms of "cost-benefit ratios." It may be that the current corporate political climate demands such bottom-

line rhetoric for the implementation of work-site health promotion, but very few programs have been closed down due to lack of cost effectiveness.

Improving Morale and Productivity

The effects of work-site health promotion on morale and productivity are more difficult to measure than health effects. Participating in wellness activities, especially exercise classes, has several potentially morale-enhancing by-products. Current evidence is only anecdotal, but is generally in a consistent direction. First, there is the "fun" element. In the course of a year's observations at one corporate wellness program, I regularly observed banter, joking, and camaraderie among participants during program activities. There is a sense of people working together to improve their health. Programs that are open to all employees may create a leveling effect; often employees from varying company levels participate in the same classes and corporate hierarchical distinctions make little difference in sweatsuits and gym shorts. As one participant told me, "We all sweat together, including some of the higher ups." But rigorous studies on the effect of the programs on job satisfaction are not yet available.

Despite a legion of claims, virtually no one has even attempted to measure increased productivity as a result of work-site health promotion. Although changes in productivity are difficult to assess, there are two productivity-related effects about which we have some information. Several studies have found a reduction in absenteeism among wellness-program participants (Reed et al. 1985; Baun, Bernacki, and Tsai 1986; Blair et al. 1986b). It is generally believed that a reduction in absenteeism can lead to an increase in overall productivity. Second, several observers have noted that participants often say they "feel" more energetic and productive from participating regularly in the program, especially in terms of exercising (Spilman et al. 1986, 289; Conrad 1987b). This kind of "subjective positivity" that results from wellness participation may be related to improved morale and productivity, although we are not likely to obtain "hard" measures.

The symbolic effects of offering a work-site wellness program should not be underestimated. Work-site health-promotion programs are often among the most visible and popular employee benefits. The mere existence of a program may be interpreted by employees as tangible

evidence that the company cares about the health of its workers, and as contributing to company loyalty and morale. Programs are also a plus in recruiting new employees in a competitive marketplace.

Individual Empowerment

Work-site health promotion presents a positive orientation toward health. Its orientation is promotive and preventative rather than restorative and rehabilitative and provides a general strategy aimed at *all* potential beneficiaries, not only those with problems ("deviants," or troubled or sick employees). This makes participation in wellness nonstigmatizing; in fact, the opposite is possible—participants may be seen as self-actualizing and exemplary.

The ideology of health promotion suggests that people are responsible for their health, that they are or ought to be able to do something about it. This may convey a sense of agency to people's relation with health, by seeing it as something over which individuals can have some personal control. Positive experience with these kinds of activities can be empowering and imbue employees with a sense that they are able to effect changes in their lives.

Pitfalls

In their enthusiasm for the positive potentials of work-site health promotion, the promoters and purveyors of wellness programs usually neglect to consider the subtler, more problematic issues surrounding work-site health promotion. In this section I want to examine some of the limitations and potential unintended consequences of promoting health in the work place.

The Limitations of Prevention

Many wellness activities, such as smoking cessation, hypertension control, and cholesterol reduction, are more accurately seen as prevention of disease than promotion of health. Disease prevention may be useful, but these interventions are not specific to the mission of health promotion (i.e., enhancing positive health).

Research within the lifestyle or "risk factor" paradigm has unearthed

convincing evidence that a variety of life "habits" are detrimental to our health (e.g., Breslow 1978; U.S. Department of Health, Education, and Welfare 1979), but it is not always clear that this translates directly to health enhancement. Promoters of health promotion have frequently oversold the benefits of intervention (Goodman and Goodman 1986), which are not always well established (Morris 1982), and have ignored such equivocal evidence as the MRFIT study (Multiple Risk Factor Intervention Trial Group 1982). Moreover, just because a behavior or condition is a "risk factor" does not mean automatically that a change (e.g., a reduction) will lead to a corresponding change in health. In addition, clinicians and social scientists do not yet know very well how to change people's habits—witness the mixed results of various smoking-cessation programs or the high failure rate in diet and weight reduction.

In terms of modifying health risks, over what do people actually have control? Surely, there are some behavioral risk factors, but what about the effects of social structure, the environment, heredity, or simple chance? Clearly, the individual is not solely responsible for the development of disease, yet this is precisely what many work-site health-promotion efforts assume (Allegrante and Sloan 1986).

The overwhelming focus of work-site health promotion on individual lifestyle as the unit of intervention muddles the reality of social behavior. The social reality, including class, gender, and race—all known to affect health as well as lifestyle—is collapsed into handy individual risk factors that can be remedied by changing personal habits. This approach takes behavior out of its context and assumes "that personal habits are discrete and independently modifiable, and that individuals can voluntarily choose to alter such behaviors" (Coriel, Levin, and Jaco 1986, 428). At best this is deceptive; at worst it is misguided and useless.

It is often assumed that prevention is more cost effective than treatment and "cure." As Louise Russell (1986) has persuasively shown, for some diseases prevention may actually add to medical costs, especially when interventions are directed to large numbers of people, only a few of whom would have gotten sick without them. She concludes that prevention and health promotion may be beneficial in their own right, but in general should not be seen as a solution for medical expenditures. Ironically, for corporations for whom cost containment is a major goal, there is an additional problem in that if employees

are healthier and live longer (by no means yet proven), corporations will have to pay higher retirement benefits. In any case, prevention seems a limited vehicle for medical cost containment. To the extent that controlling health costs is a major rationale, work-site wellness may seem peripheral when the results are limited.

Blurring the Occupational Health Focus

Work-site health promotion's target for intervention is the individual rather than the organization or environment. While the history of the occupational health and safety movement is replete with examples of corporate denial of responsibility for workers' health and individual interpretations of fault (e.g., "accident prone worker") (Bale 1986), by the 1970s a strong measure was established to change the work environment to protect individual workers from disease and disability. This was both symbolized and in part realized by the existence of the Occupational Safety and Health Administration (OSHA). But the promulgators of wellness are uninterested in the traditional concerns of occupational health and safety and turn attention from the environment to the individual. One virtually never hears wellness people discussing occupational disease or hazardous working conditions. Whether they view it as someone else's domain or as simply too downbeat for upbeat wellness programs is difficult to know. But this may in part explain why work-site health promotion has been greeted with skepticism by occupational health veterans.

The ideology of work-site wellness includes a limited definition of what constitutes health promotion. For example, it does not include improvement of working conditions. As noted earlier, wellness advocates neglect evaluating the work environment and conceptualize "corporate cultures" in a limited way. In fact, the individual lifestyle focus deflects attention away from seriously examining the effects of corporate cultures or the work environment. Little attention is given to how the work-place organization itself might be made more health enhancing. Perhaps it is feared that organizational changes to improve health may conflict with certain corporate priorities. For example, by focusing on individual stress reduction rather than altering a stressful working environment, work-site health promotion may be helping people "adapt" to unhealthy environments.

Moralizing Health Concerns

The ideology of health promotion is creating a "new health morality," based on individual responsibility for health, by which character and moral worth are judged (Becker 1986, 19). This responsibility inevitably creates new "health deviants" and stigmatizes individuals for certain unhealthy lifestyles. While this process is similar to medicalization (Conrad and Schneider 1980) in that it focuses on definitions and interventions on the individual level and fuses medical and moral concerns, it is better thought of as a type of "healthicization." With medicalization we see medical definitions and treatments for previously social problems (e.g., alcoholism, drug addiction) or natural events (e.g., menopause); with healthicization, behavioral and social definitions and treatments are offered for previously biomedically defined events (e.g., heart disease). Medicalization proposes biomedical causes and interventions; healthicization proposes lifestyle and behavioral causes and interventions. One turns the moral into the medical; the other turns health into the moral.

The work-site wellness focus on individual responsibility can be overstated and leads to a certain kind of moralizing. For example, although personal responsibility is undeniably an issue with cigarette smoking, social factors like class, stress, and advertising also must be implicated. With other cases like high blood pressure, cholesterol, and stress, attribution of responsibility is even more murky. But when individuals are deemed causally responsible for their health, it facilitates their easily slipping into victim-blaming responses (Crawford 1979). Employees who smoke, are overweight, exhibit "Type A" behaviors, have high blood pressure, and so forth are blamed, usually implicitly, for their condition. Not only does this absolve the organization, society, and even medical care from responsibility for the problem, it creates a moral dilemma for the individual. With the existence of a corporate wellness program, employees may be blamed both for the condition and for not doing something about it. This may be especially true for "high risk" individuals who choose not to participate. And even relatively healthy people may feel uneasy for not working harder to raise their health behavior to the new standards. Thus, work-site health promotion may unwittingly contribute to stigmatizing certain lifestyles and creating new forms of personal guilt.

In a sense, health promotion is engendering a shift in morality in

the work place and elsewhere; we need to, at least, raise questions about what value structure is being promoted in the name of health and what consequences might obtain from taking the position that one lifestyle is preferable to another. While it is assumed that work-site wellness is in everyone's interest—I've heard it termed a "win-win" situation—it is important to examine what we are jeopardizing as well as what is gained (cf. Gillick 1984).

Enhancing the Relatively Healthy

In several ways work-site wellness focuses its attention on relatively healthy individuals. Were we to consider the major global or national health problems from a public health perspective, workers would not be listed among the most needy of intervention. Research for decades has pointed out that lower social class (Syme and Berkman 1976) and social deprivation (Morris 1982), in general, are among the most important contributors to poor health. Workers in spite of having real health problems are a relatively healthy population. Occupational groups have generally lower rates of morbidity and mortality than the rest of the population. This so-called "healthy worker effect" implies that the labor force selects for healthier individuals who are sufficiently healthy to obtain and hold employment (Sterling and Weinkam 1986). There is, furthermore, some evidence suggesting that unemployment may have a detrimental effect on individual health (Liem 1981). The main target of work-site health promotion is a relatively healthy one.

Even within the work-site context, who is it that comes to wellness programs? Although data are limited, a recent review suggests some self-selection occurs:

> Overall, it appears participants are likely to be nonsmokers, more concerned with health matters, perceive themselves in better health, and be more interested in physical activities, especially aerobic exercise, then nonparticipants. There is also some evidence that participants may use less health services and be somewhat younger than nonparticipants (Conrad 1987a, 319).

In general, the data suggest that participants coming to work-site wellness programs may be healthier than nonparticipants (see also Baun, Bernacki, and Tsai 1986).

Finally, the whole health-promotion concept has a middle-class bias (Minkler 1985). Wellness advocates ignore issues like social deprivation and social class, which may have health effects independent of individual behavior (Slater and Carlton 1985), when advocating stress reduction or health enhancement. The health-promotion message itself may have a differential effect on different social classes. As Morris (1982) points out, in 1960 there was little class difference between smokers; by 1980 there were only 21 percent smokers in class I while there were 57 percent smokers in class V. And what little evidence we have suggests that overwhelmingly the participants in work-site wellness programs are management and white-collar workers (Conrad 1987a). For a variety of reasons—including scheduling, time off, and priority setting, blue-collar workers have been less likely to participate (see Pechter 1986). Thus, work-site health-promotion programs may generally be serving the already converted.

Expanding the Boundaries of Corporate Jurisdiction

The boundaries of private and work life are shifting, particularly as to what can legitimately be encompassed under corporate jurisdiction. Work-site programs that screen for drugs, AIDS, or genetic make-up are more obvious manifestations of this, but work-site wellness programs also represent a shift in private corporate boundaries.

Work-site health-promotion programs, with their focus on smoking, exercise, diet, blood pressure, and the like, are entering the domain of what has long been considered private life. Corporations are now increasingly concerned with what employees are doing in off-company time. We have not yet reached a point where corporate paternalism has launched off-site surveillance programs (and this is, of course, highly unlikely), but employers are more concerned about private "habits," even if they do not occur in the work place. These behaviors can be deemed to affect work performance indirectly through a lack of wellness. This raises the question of how far corporations may go when a behavior (e.g., off-hours drug use) or condition (e.g., overweight) does not *directly* affect others or employee job performance. Yet, screening and intervention programs are bringing such concerns into the corporate realm.

With the advent of health insurance, especially when paid for by employers, the boundaries between public and private become less

distinct. That is, health-risk behavior potentially becomes a financial burden to others. The interesting question is, however, why are we seeing an increased blurring of boundaries and corporate expansion in the 1980s? The danger of this boundary shift is that it increases the potential for coercion. The current ideology of work-site wellness is one of voluntaryism; programs are open to employees who want to participate. But voluntaryism needs to be seen in context.

> Bureaucracies are not democracies, and any so-called "voluntary" behavior in organizational settings is likely to be open to challenge. Unlike the community setting, the employer has a fairly long-term contractual relationship with most employees, which in many cases is dynamic with the possibility of raises, promotions, as well as overt and covert demotions. This may result in deliberate or inadvertent impressions that participation in a particular active preventive program is normative and expected (Roman 1981, 40).

Employers and their representatives may now coax employees into participation or lifestyle change, but it is also likely that employers will begin to use incentives (such as higher insurance premiums for employees who smoke or are overweight) to increase health promotion. At some point companies could make wellness a condition of employment or promotion. This raises the spectre of new types of job discrimination based on lifestyle and attributed wellness.

In a sense, what we are discussing here is the other side of the "responsible corporation" that cares about the health and well-being of its employees. The crucial question is, are corporations able to represent the individual's authentic interests in work and private life?

Conclusion

Work-site health promotion is largely an American phenomenon. Few similar programs exist in Europe or other advanced industrial nations. Work-site wellness is a response to a particular set of circumstances found in the United States: the American cultural preoccupation with health and wellness; the corporate incentive due to the employer-paid health insurance; and the policy concern with spiraling health costs. Its growth is related to a disenchantment with government as a source of health improvement and a retrenchment in the financing of medical

services. Its expansion is fueled by the commercialization of health and fitness and the marketing of health-promotion and cost-management strategies (cf. Evans 1982). Moreover, work-site wellness aligns well with the fashion in the 1980s for private-sector "corporate" approaches to health policy.

In their enthusiasm, the promoters of work-site health promotion make excessive claims for its efficacy. The work-site wellness movement has gained momentum, although it may still turn out to be a passing fad rather than a lasting innovation. It seems clear that work-site wellness programs have some potential for improving individual employees' health and will perhaps contribute to reduce the rate of rise in corporate health costs. The scientific data on program effects, however, are by no means in and to a large extent corporations are operating on faith. The actual results are likely to be more modest than the current claims. How much data are necessary for policy implementation is an open question. For despite the rhetoric of cost containment, corporate concern over health costs may be more of a trigger than a drive toward wellness programs. Concern about morale, loyalty, and productivity—corporate competitiveness in the marketplace—may be of greater import than health.

Rigorous scientific evaluation will enable better evaluation of the potentials of work-site health promotion for improving employee health, reducing costs, and improving morale and productivity. But such data remain largely irrelevant for assessing the more sociopolitical pitfalls of work-site wellness. These can be only adequately evaluated in the context of the social organization of the work place, the relation between employers and employees, and as part of an overall health policy strategy. They cannot be simply counted in terms of reduced employee risk factors or saved corporate health dollars.

Work-site health promotion has the appearance of corporate benevolence. Health is a value like motherhood and apple pie. In modern society, health is deemed a gateway to progress, salvation, and productivity. Despite the pitfalls discussed in this article, work-site health promotion does not appear to be an overt extension of corporate control, at least not in terms of so-called technical or bureaucratic control (Edwards 1979). In fact, on the surface work-site wellness appears as more of a throwback to the largely abandoned policies of "welfare capitalism" (Edwards 1979). Whether work-site health promotion is a valuable health innovation, the harbinger of a new type

of worker control, or an insignificant footnote in the history of workers' health remains to be seen.

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