Introduction

What Is Wellness Now?

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Wellness as Buzzword

Wellness is a popular buzzword these days. One finds wellness programs, wellness centers, wellness contests, wellness conferences, wellness journals, wellness administrators, wellness awards, wellness tourism, and even a Wellness brand cat and dog food (complete with its own blog and website asking, "What is true wellness?"). Like "intersectionality" in feminist scholarship (Davis 2008), the rise of "diversity" over affirmative action (Kelly and Dobbin 1998; Edelman, Fuller, and Mara-Drita 2001), "sustainability" in approaches to the natural world and its use and development (Scoones 2007), and "sexual health" in place of panic over sexually transmitted infections (Epstein and Mamo 2011), the hegemony of the buzzword *wellness* signals its usefulness for framing consensus in contemporary American society. That consensus is that health is more than just the absence of disease, that health promotion and prevention of disease should be a top governmental and personal priority, and that each individual can and should strive to achieve a state of optimal functioning. But in

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typical buzzword fashion, the appeal of the term comes from its ability to float above thorny and contested details and to mean different things to different stakeholders so that it becomes viewed as an uncontroverted good.

The aim in this special issue is to pull wellness down from its buzzword height and to draw out all the political, legal, ethical, and practical controversies contained within it. The contributing authors define its variations with precision and locate them within the competing professions (the medical profession versus the alternative remedy world), domains of expertise (insurer or wellness coach), nations (the United States and other countries with different health care systems), and moral systems (holistic or pointedly individualistic and punitive) in which the term now proliferates. The articles focus on wellness as it is institutionalized and professionalized in the workplace. While much of the discussion throughout this issue addresses the economic rationale for wellness programs in profit-making private firms, the contributing authors understand the workplace to include the public sector (as municipalities have also taken up wellness and wellness programs) as well as organizations like colleges and universities, nonprofits, and other groups whose leaders understand them to have a stake in the health of their members or employees.

While wellness is not new or unstudied, we are at a uniquely critical point in the institutional and legal position of wellness in the health economy of the United States. The Patient Protection and Affordable Care Act established grants and technical assistance for small businesses to develop wellness programs and set up new regulations that increase the incentives employers can tie to employees' achievements of certain health benchmarks. Currently, workplace wellness programs are common and rapidly expanding, especially among larger employers, and they are generally voluntary rather than punitive (Mattke et al. 2013). That status may soon be changing, however. As a new survey by Aon Hewitt found, 83 percent of businesses surveyed offer incentives for employees to participate in wellness activities, but 58 percent reported that they planned to add penalties in the next few years for employees who "did not take appropriate actions" to improve their health (Mihelich 2013). The contributing authors argue that workplace wellness is the currently dominant variation of wellness in the United States, simultaneously more narrow and more powerful than its more holistic predecessors because of its tightened connection to economic interests. These collected articles explore what this new wellness regime will mean for law, culture, and justice and raise new questions for further research.

The Idea of Wellness over Time

Words become buzzwords because they capture something particularly salient about a culture at a moment in time and come to stand in for wide agreement about how something should be characterized. Wellness captures the sense that the era of combating diseases has given way to a more complex problem of success in modernity: living well, since so many more of us live long lives, entirely avoiding the diseases and accidents that killed our ancestors. Its emergence in the form we still know it today coincides with the rise of the notion that "health behaviors" were a large part of the explanation for health and disease, an idea that medical sociologist David Armstrong (2009) argues arose in the late 1950s and early 1960s in the United States and the United Kingdom. Today we would speak of *health behaviors* or *risk factors*, but these are simply the current terms for individualized explanations for health outcomes, ideas that have been with us a long time. The term *wellness* first came into usage in the post–World War II United States, but the roots of the concept extend far back into the history of American ideas about health, morality, and responsibility. In the nineteenth-century United States, religious and spiritual movements such as New Thought and Christian Science were founded on the idea that individuals' bodily health derives from their own achievement of a proper state of mind, usually understood as morally virtuous and often explicitly religious, not from outside medical intervention (Miller 2005). Christian religious ideas about sin and morality no longer have the central role in ordering American society that they did when early health movements began (Morone 1997, 2003), but the strong tie between proper attitude, correct practice, and individual responsibility for health remains a central part of wellness.

Halbert L. Dunn's 1959 article "High-Level Wellness for Man and Society" (the basis of his better-known 1961 book *High-Level Wellness*) first introduced the term, and his argument that health is about much more than the absence of disease remains a cornerstone concept of wellness today. Dunn (1959: 787) explained the need for this new turn to wellness as arising out of four features of modern life: interconnectedness through communications technologies, population boom and crowding, aging of the population, and rising tensions because of the "tempo of modern life." Dunn's concept of wellness was designed to evaluate and prepare people and societies for a cacophonous, tense, and demanding new world in which everyone would be tied more closely together for longer lives. His concept was explicitly hierarchical: there were lower levels of wellness and higher

ones, and the aim was to move everyone up from where they started to high-level wellness. Dunn's sense of a crowded, aging society is less prominent in wellness discourses today in those precise terms, but the sense that we have somehow gotten ahead of ourselves in modernity and cannot quite handle it all is still part of the turn to wellness. Now health professionals are more likely to point out that chronic diseases have become the biggest health problems, since we have improved so much in our abilities to combat infections and accidents.

Dunn (1961: 4–5) defined wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable." Dunn's sense of individual striving from a certain starting point within a hierarchy of health possibilities is still salient in wellness discourses today. Donald B. Ardell's work in the 1970s and early 1980s clearly echoed Dunn's terms, but Ardell (1982: 17) defined wellness somewhat more individualistically though still holistically as "self-responsibility, nutritional awareness, physical fitness, stress management, and environmental sensitivity." Definitions of wellness continued to vary somewhat but retained the form of roughly five dimensions covering vast areas of personal and social life. The *Berkeley Wellness Letter*, in print since 1984, defines it as "optimal physical, mental and emotional well-being, a preventive way of living that reduces—sometimes even eliminates—the need for remedies. It emphasizes personal responsibility for making the lifestyle choices and self-care decisions that will improve the quality of your life" (BerkeleyWellness.com 2013). Psychologists describing the "wheel of wellness" in 1991 outlined its "five life tasks of spirituality, self-regulation, work, love, and friendship" that "dynamically interact with the life forces of family, community, religion, education, government, media, and business/industry" (Sweeney and Witmer 1991: 529). Spirituality is at the center of the visual depiction of the wheel of wellness, and while physical fitness and nutrition appear as one component of the wheel's axes, moderate body weight is mentioned only in passing after much discussion of other elements such as humor, creativity, sense of worth, and emotional responsiveness. *Health promotion* and *optimal health* are terms often used interchangeably with *wellness*, as in Michael O'Donnell's (2009: iv) definition of optimal health as "dynamic balance of physical, emotional, social, spiritual, and intellectual health." Gallup surveys several hundred thousand Americans nationwide each year (and will expand worldwide in 2014) to gauge well-being using its Healthways Well-Being Index Composite Score, assessing six domains: life evaluation,

emotional health, physical health, healthy behavior, work environment, and basic access (Gallup-Healthways 2013).

An emphasis on preventing diseases rather than waiting for them to strike has always been central to wellness. But a close look at the intersections of prevention and wellness shows that not all prevention counts as wellness, and these points of dissociation are revealing. What are called disease management (DM) and medication management are certainly preventative, but they are usually situated in medical and pharmaceutical practice, controlled by experts, and administered as part of a larger bureaucratic program. Prevention controlled by outside experts loses the aspects of wellness that center individual responsibility for one's own striving and correct attitudes and thus may explain why wellness and prevention have not collapsed into each other and become synonymous. Value-based insurance design (VBID), for example, is a model of health insurance provision that attempts to change behaviors to both save money and spend it in acquiring the most health-promoting treatments for patients and that is also focused on prevention in a highly expert-driven, behind-the-curtain fashion (Chernew, Rosen, and Fendrick 2007). For certain categories of patients who already have medical problems, these programs have very specific goals, such as managing diabetes and avoiding an amputation or keeping an elderly person on his or her medication after release from the hospital. They target the person with risk factors and constitute him or her in a much more medical and actuarial frame than much wellness discourse does in its focus on the holistic person striving for self-improvement on his or her own, without expert intervention and highly technical guidance.

Wellness is prevention, but not the curing or treatment of any acute condition or specific health event. It is not associated with the design of complex actuarial schemes to shift population-level human behavior, such as in a new form of insurance design. It is the ongoing prevention of chronic diseases, aging, and disability at the site of an individual's body and is conducted in a self-aware manner by that individual starting well in advance of any particular medical problem. The sense of time here is critical—it must be a sustained effort of small actions and omissions that is descriptive of a lifestyle, not a highly medicalized or expert-driven management of a condition, no matter how much money it saves. This distinction is likely part of the heritage of wellness within the alternative medical community, with its emphasis on distance from doctors and diseases. (Recall the *Berkeley Wellness Letter*'s definition, under which perhaps no use of remedies would be needed after wellness is embraced.)

So why, then, has accident prevention not been part of wellness discourse? It is personal, nonexpert-driven, and part of individual responsibility for health. (In the workplace context, preventing industrial accidents predates any wellness concerns and would be considered already addressed with other policies.) Storing firearms separately from ammunition and in a locked gun safe is not part of wellness, for example, nor is learning to swim or taking a defensive driving course. Accident prevention is too distant from the body and too isolated and abruptly temporal to count as wellness. Wearing a life jacket while boating or refraining from texting while driving are not lifestyles. A cynic might say that it is not wellness unless its achievement also advances one's ability to appear physically as an elite member of our society—thin, toned, and energetic at any age. I am interested in watching the direction of wellness in the future: Will it merge with techniques for cost saving and improvement of care such as VBID and become just a way of monitoring employees for the presence, emergence, and worsening of risk factors, or will it hold on to its more individualistic, holistic, and moralistic features? One conjecture is that it will do both within the corporate workplace, with the aspects that help with cost saving becoming firmly placed within systems of medical surveillance, while the workplace culture celebrates the parts of wellness that are employee perks (an on-site gym, for example) and which communicate striving, physically energetic individualism as a necessary part of being a good worker.

If the period of wellness blossoming from the 1960s to the managed care of the 1990s was the era of the five dimensions including aspects of the spiritual, intellectual, or emotional alongside the physical, the five data points of the current workplace wellness era would be body mass index (BMI), smoking status, glucose and cholesterol levels, and blood pressure. Wellness in the United States has become more focused on the attainment of specific biometric goals at the same time as it has become highly managerialized within the business world as employers seek to lower their health care costs. Even the Gallup yearly study on community wellness mentioned above focuses outside the workplace through a household telephone survey of individuals all over the world and is then used by its corporate partner, Healthways, to inform business clients who purchase its wellness programs aimed at those populations. This new version of workplace wellness is not a transformation but rather a paring down of some aspects of the definition that do not fit so well within the regimes of standardization that businesses use to measure wellness or which do not have a clear relationship to business goals. It is easy to measure employees' BMI and blood pressure, but not so easy to standardize the proper type and

amount of their spirituality, nor articulate why an employer would care about it. The list of sessions at the 2013 National Wellness Conference (a meeting held yearly since 1977 in North America, organized by the National Wellness Institute [2013]) still contained panels on mindfulness and meditation, suggesting that they remain part of wellness discourses, but they were far overwhelmed by sessions on how to bring wellness programs into the business context, how to motivate and coach, and how to get a job in wellness administration.

As wellness programs have gone corporate, a big question has been whether they would yield much return on investment (ROI) for employers. Studies report that wellness programs can indeed return investments of about $3.00 for every $1.00 spent (Baicker, Cutler, and Song 2010). But many evaluation studies of wellness programs compare employees who enrolled in the program to those who did not, and consequently such studies suffer from significant selection bias (since healthier employees are much more likely to join and receive rewards for what they are already doing anyway). The trick is to show that wellness programs do more than just reward the already healthy or prompt improvements that will yield benefits only after the employee has moved on to another job. In a review of thirty-three wellness evaluation studies performed since 2000 on sites in the United States, random controlled trial designs showed that wellness programs produced positive effects (measured by a wide range of outcomes) about half the time, while the more biased observational designs claimed that three-fourths of programs had positive effects (Osilla et al. 2012). In addition, some of the studies had very short follow-up periods and small numbers of employees enrolled, and positive effects were small (especially for diet and exercise outcomes).

In short, a company or wellness program vendor could easily put together claims that a program is working well by comparing the health and expenditures of the signed-up group to those who did not join in, following them for just a year or two, and capturing just a few dozen or a few hundred workers. But this type of study design would not be considered strong enough to permit any causal inferences to be drawn in other scholarly areas, and so, not surprisingly, positive claims have not settled the question of the worth of wellness programs. One study of the long-standing (thirty-year-old) wellness program at Johnson and Johnson used propensity score matching to improve on this problem, comparing health outcomes and costs of Johnson and Johnson employees to similar employees at other companies with less well-established wellness programs. The researchers concluded that the Johnson and Johnson program returned an estimated

$1.88–$3.92 for every dollar spent on the program as well as kept the company's health care costs lower (Henke et al. 2011). (I wondered whether such a strong health culture also draws health-conscious employees over time or drives out or bars unhealthy ones.) Longtime wellness researcher Dee Edington (2009, 2012) advocates taking a broader cultural and environmental approach in implementing a wellness program, looking to simply maintain health and prevent decline in employees, and resisting big claims about ROI. One question will be whether the distinction between wellness and other potentially cost-saving disease management programs will really hold up much longer, since they are likely to be pulled together by the employer's interest in saving money.

The New Wellness? Interrogating Wellness under the Affordable Care Act and Beyond

In my own contribution to this issue, "Critical Perspectives on Wellness," I open up the question of what wellness programs do from the more commonly asked efficacy question (do they return on investment?) to the broader question of how they will operate in law, in organizational culture, and as a basis for social norms. The large majority of companies implement wellness programs without any plans to evaluate their effectiveness (i.e., their ROI in health care savings) (ADP Research Institute 2012: 6). Perhaps wellness is worth having (from the perspective of those implementing the policy, of course) regardless of its economic payoffs. So, then, what does wellness do that is so important? What kind of wellness do companies want? I consider three main criticisms of what wellness, or certain forms of it, may do: (1) promote a conservative, individualistic health ideology, thereby undercutting communal, structural, redistributive, and sympathetic approaches to health; (2) promote workplace discrimination in programs as actually implemented within firms and organizations; and (3) promote homogeneity and prescribe one specific way of life for everyone, thus creating a problematic trend in a diverse democratic society. What the new workplace wellness means in practice will be influenced by the particular sites and people involved in implementing it, and wellness culture will surely have many positive features for some people. Nonetheless, I argue that some theoretical features of wellness ideology are troubling and that some predictable organizational paths it might travel along could produce undesirable consequences.

The next contribution in this special issue, "I'll Be Gone, You'll Be Gone: Why American Employers Underinvest in Health," by Scott L. Greer and

Robert D. Fannion, takes up the question of wellness programs from the perspective of the employer. Greer and Fannion first make the case that wellness can be viewed as an investment by the employer in the employee. Thinking about wellness as an investment helps illuminate many of the perplexing features of wellness spending (such as why it would be worthwhile to spend money extending an employee's lifespan when he or she will likely only work for the company for five years), and placing it within the scholarly literature on the level and variability of American employers' investment in their workforces allows Greer and Fannion to offer new explanations for these features. They introduce the terms *positive wellness* and *negative wellness* to capture the differences between investment (positive) and actuarial underwriting that raises insurance costs for at-risk employees (negative, and the type that the Affordable Care Act expands in 2014). The investment perspective is not encouraging for wellness as a positive investment. Greer and Fannion argue that public health, like most other forms of human capital in the United States such as education, is really only jointly produced by individuals and the state, with employers having no real incentive to invest much in producing it as well. They predict that employers will instead prefer to institute more symbolic forms of positive wellness as public relations and human resources tools while using negative wellness to save money.

The Affordable Care Act expanded the power of employers to incentivize participation in workplace wellness in order to promote health and preserve affordability while preventing discrimination. In "Using Reporting Requirements to Improve Employer Wellness Incentives and Their Regulation," Kristin Madison, Harald Schmidt, and Kevin G. Volpp examine the regulation of workplace wellness programs and their use of incentives, focusing in particular on the improved evidence base needed for effective regulation. The first set of regulations from 2006 allowed for significant flexibility in program design and made no provision for systematic oversight. With the increasing popularity of incentive programs, however, perhaps the time has come to revisit these regulations. Do incentive programs work to improve health while avoiding discrimination and, if so, in what precise forms and for what kinds of people? Will data suggest that incentives differ in their effectiveness or that effects vary across groups of employees? What are the implications for fair treatment? The Affordable Care Act's provisions and new proposed regulations in 2012 allowing more intensive use of financial incentives provide an opportunity to do so. Madison, Schmidt, and Volpp describe how incentives are regulated and then detail the many unanswered questions about incentive program

effects, at least some of which might have implications for regulatory design. They then identify ways to expand the body of knowledge about these programs through reporting requirements, describing the potential functions of reporting, discussing who should have access to reported data, and considering what data elements might be reported.

Perhaps the greatest point of tension in antidiscrimination law and wellness law is in the treatment of disability. Sick and unhealthy employees, such as those with chronic conditions, diseases such as cancer, or a history of having had such conditions, are protected from workplace discrimination under the Americans with Disabilities Act. Disability rights movements question whether health should be assumed to be so central to one's worth or happiness. Wellness programs hope to create healthy employees, or at least make each of them healthier, and the idea of a group of workers defined and protected by their unhealthy status would seem to be anathema to wellness goals. In "What's Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness," Carrie Griffin Basas uses disability as a lens to explore the conflicts between the disability rights and wellness movements, tracing both their histories and their current intersections. Disability is a helpful perspective from which to critique wellness because it surfaces the underlying neoliberal tenets of wellness, for example, that health is within one's control, that it is a matter of behavioral choice and reform, and that the costs of illness should be borne by individuals, not the government or employers. One mission of the disability rights movement has been to describe health as a flexible, fluid state for everyone and to remove social stigma and moral reprimand for sickness. Wellness initiatives, however, can further marginalize people on the basis of health status by creating new categories of difference and inferiority and reifying old ones that are economically and socially disabling. They do this by vesting employers with new powers to regulate the private health information and decisions of their employees and to cast judgment with financial fallout that separates the healthy from the sick, the desirable from the unemployable.

If *wellness* is indeed a defining buzzword that captures so much about our relationships to health and personal responsibility, we should also ask how far the term has spread. Is it meaningful mostly in the US context of employer-sponsored health care, or does its neoliberal valence and lifestyle description travel well in other nations? In "Wellness as a Worldwide Phenomenon?" Heather Elliott, Jennifer Bernstein, and Diana M. Bowman focus on three distinctly different jurisdictions—the United States, Germany, and Australia—and examine wellness through the lens of employers,

the health care system, employment and tort law, and the greater political economy. While the authors note that improving employee health, well-being, and productivity is common across the three countries and their respective cultures, they conclude that the focus on wellness as a distinct legal concept is unique to the United States.

Directions for Further Research

Refusing to use *wellness* as a buzzword means pressing for what its current meanings really are and asking how it is arranging power relations in specific settings. The contributors suggest a set of meanings and hierarchies in their essays, but more work needs to be done. One direction would be to continue work on evaluating the economic and health effects of wellness programs as they expand and perhaps take on more punitive forms under new regulations of the Affordable Care Act. Madison, Schmidt, and Volpp have pointed out many uses of regulatory information on wellness programs, and researchers could both independently gather and analyze some of that information as well as continue to direct policy makers about what exactly we need to know about how wellness actually operates and to point out persisting gaps.

Many of the essays collected here suggest that in its details and in its application, wellness will be discriminatory. The aim of contributors has been to lay out exactly why wellness is incompatible or at least in tension with equality norms and the exercise of personal freedoms and to point out where discriminatory practices are likely to be seen. A second area for new work will be to continue the ethical and moral arguments that treating people differently based on their health is indeed discriminatory. What counts as discrimination is highly contested, of course, and simple differential (and worse) treatment is certainly not always unlawful or unethical and is sometimes legally or ethically required. Some areas of US law stipulate that treating people differently based on their genes or health status may be illegal, but employment statutes generally only mention traits like race, sex, national origin, religion, ethnicity, disability, and perhaps sexual orientation. That mere measurement at an unacceptable level on a biometric screening constitutes a legally protected disability is unlikely, and weight discrimination is perfectly legal across nearly the entire United States except in Michigan and a few liberal cities such as San Francisco.

A third potential direction for further research on the discrimination question is to find out exactly how prevalent wellness-driven discrimination is, what forms it takes, and what its effects are. If business surveys are

correct, workplace wellness programs under the Affordable Care Act are about to become even more common and much more punitive. Since most wellness programs up until now have been only participatory and not punitive, legal requirements for running a punitive wellness program has not been tested or extensively litigated. Health discrimination claims, either as disability discrimination claims or as claims about mistreatment under wellness incentives and punishments, could become a major site of employee dissatisfaction and litigation. The contributors to this special issue suggest that the law as written is not well poised to absorb these tensions, and it will be important for scholars to track and evaluate the new world of legal disputes over wellness.

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