Wellness as a Worldwide Phenomenon?

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Abstract This article examines the concept of wellness through a comparative political economy and legal framework. It asks whether *wellness*, an increasingly defined term within US federal and state legislative instruments including, for example, the Patient Protection and Affordable Care Act, is primarily a US-centric phenomenon. Or is wellness, in its various different guises, a worldwide phenomenon? By focusing on three distinctly different jurisdictions—the United States, Germany, and Australia—this article examines wellness through the lens of employers, the health care system, employment and tort law, and the greater political economy. It notes that while improving employee health, well-being, and productivity is common across the three countries and their respective cultures, the focus on wellness as a distinct legal concept is unique to the United States.

Introduction

Wellness is a rather complex and imprecise word. The term may be employed differently depending on the framework or lens being used: sociology, political science, economics, and law, for example. More importantly, as this special issue has sought to highlight, *wellness* has been reframed in the United States from a term with broad application to one more closely associated with corporate wellness. Each framing influences our ability to understand the term and, more importantly, the concepts underpinning it when used in the public health context. Establishing a shared understanding, or at least appreciation, is essential to being able to answer questions such as whether employee wellness programs are

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effective as well as cost-effective. And also important, for the purposes of this article, is whether the increasing focus on wellness in the context of employee programs exists beyond the United States. If the wellness phenomenon is more than a US-centric model, employed to reduce costs associated with health care and increase return on investment by employers, then what are the key drivers for implementing such programs beyond the United States?

To begin to answer these questions, this article examines the nature of wellness, and wellness programs in particular, in three distinct jurisdictions: the United States, Germany, and Australia. These three countries differ in terms of their cultural, political, legal, and historical contexts; the structure of their health care systems, and how they are funded, operate, and engage with citizens, is similarly diverse. As such, the way they perceive health and health care provision in relation to their citizens also differs across the three countries. The purpose of our analysis is not to draw generalizations, and indeed we cannot, but rather to create a preliminary sketch of wellness in a global context.

As others in this special issue have sought to illustrate, wellness in the United States, at least in the recent past, has been driven largely by the establishment of workplace wellness programs (corporate wellness). The legal basis for these programs comes from the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and while wellness itself is not defined within HIPAA, it has emerged as an employer-driven program with the aim of reducing employer health care costs through interventions such as medical screenings, on-site fitness programs, and health education. In contrast, German wellness schemes are driven primary by the state, rather than by private employers. The structure of the health care system and the shared decision-making power between Germany's sixteen states (*Länder*), the federal government, and the corporatist organizations of payers and providers create an interesting mix of incentives and disincentives within German wellness schemes. The Australian case also proves interesting in that wellness incentives are rooted in state financing of health care. Unlike in the United States, wellness incentives have not been institutionalized by employers as part of workplace wellness programs; rather, they are rooted within the macrofinancing of the health care system. Wellness incentives and programs can, however, be found throughout the public and private sectors, with employers offering employees extra benefits such as free fruit and gym memberships.

Wellness in the United States

The US health care system exists as a patchwork of publicly and privately funded health insurance. Historically, Americans have relied on their employers to provide health coverage for themselves and their families. While employment-based health coverage remains the most common form of health coverage in the United States, it has been eroding significantly over the past few decades. In 2011 55.1 percent of the population had employment-based health benefits, down from 62.6 percent in 2001 (Mills 2002: 2; DeNavas-Walt, Proctor, and Smith 2012: 21). How the Patient Protection and Affordable Care Act (ACA) of 2010 will affect Americans' source of health coverage has led to much speculation. Even with pending changes and the current state of flux in the US health insurance market (Kaiser Health News 2013), employers will remain an important and significant player in the health insurance market.

Concern over rising health care spending and the resulting effects on the cost of health coverage is widespread. The share of the gross domestic product (GDP) devoted to health care spending, both public and private, grew from 7.2 percent in 1970 to 17.9 percent in 2010. Private health insurance expenditures totaled $896.3 billion in 2011 and accounted for 45.7 percent of all health insurance expenditures (CMS 2012). By the year 2020, the Centers for Medicare and Medicaid Services (CMS) estimate that all national health spending will account for nearly one-fifth of the GDP (Kaiser Family Foundation 2012). Increased health care premiums translate into higher costs for both employers and employees. Employers appear to see wellness programs mainly as a tool to reduce the increasing burden of health care costs on their bottom line (Kaiser Family Foundation / Health Research Education Trust 2007; see, e.g., Reardon 1998; Merrill et al. 2011; Merrill, Anderson, and Thygerson 2011). Under federal law, employers can shift some of this burden onto employees by offering financial incentives for employee participation in workplace wellness programs.

The federal legal framework for workplace wellness programs stems from a small provision in HIPAA. The law states that no language in the bill will be construed "to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention." The Departments of Health and Human Services, Labor, and the Treasury issued final regulations on the HIPAA group health wellness plan rules, which applied to plan years after July 1,

2007 (Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75014 (Dec. 13, 2006)).

The regulations divide wellness programs into two general categories: participatory and health contingent. Participatory wellness programs typically work one of two ways. Either they do not require an enrolled individual to meet a standard related to a health factor in order to obtain a reward, or they do not offer a reward at all ("positive wellness," as defined by Greer and Fannion in this issue).

Participatory wellness programs comply with the HIPAA nondiscrimination requirements without having to satisfy any additional standards if participation in the program is made available to all similarly situated individuals. The financial incentives for participatory wellness programs have no limit.

Examples of participatory wellness programs in the 2006 regulations are highly varied. They include a fitness center reimbursement program, a diagnostic testing program that does not base any reward on test outcomes, a program that waives cost sharing for prenatal or well-baby visits, a program that reimburses employees for the costs of smoking cessation programs (regardless of whether the employee quits smoking), and a program that provides rewards for attending a free health education seminar.

Health-contingent wellness programs do require individuals to satisfy a standard related to a health factor in order to obtain a reward (see Greer and Fannion 2014 [this issue], in relation to their discussion of "negative wellness"). To obtain a reward, health-contingent wellness programs require an individual to attain or maintain a certain health outcome, such as smoking cessation, obtaining a certain body mass index (BMI), or meeting exercise targets. Plans and issuers may vary employee benefits, premiums, or contributions on the basis of whether an individual has met the standards of a wellness program that satisfies certain requirements:

- The total reward for satisfying a program condition offered by a plan sponsor does not exceed 20 percent of the total cost of coverage under the plan.
- The program is reasonably designed to promote health or prevent disease, meaning that it must have a reasonable chance of improving health or preventing disease, not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method.
- The program gives eligible individuals an opportunity to qualify for the reward at least once per year.

- The reward is available to all similarly situated individuals, and a reasonable alternative standard or waiver of the standard must be made available to any individual for whom it is unreasonably difficult or medically inadvisable because of a medical condition to satisfy the applicable standard during that period.
- In all plan materials describing the terms of the program, the availability of a reasonable alternative standard or waiver is disclosed.

In 2010 the ACA revised the HIPAA wellness provisions, and proposed regulations were released in November 2012. Final regulations were issued in 2013 and are effective for plan years beginning on or after January 1, 2014. The new regulations divide health-contingent wellness programs into two categories: activity-only and outcome-based. Activity-only programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward. For example, these include diet and exercise programs. Outcome-based programs require an individual to attain or maintain a specific health outcome to receive a reward. For example, these include programs that require attainment of a certain BMI or reward nonsmokers. Both activity-only programs and outcome-based programs are subject to the five requirements listed above.

Additionally, the regulations increase the maximum permissible reward under a health-contingent wellness program from 20 percent to 30 percent of the cost of coverage. The regulations further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. The regulations also include other clarifications regarding the reasonable design of health-contingent wellness programs and the reasonable alternatives they must offer to avoid prohibited discrimination. The regulations also extend the nondiscrimination protections to the individual insurance market, meaning that individuals who purchase insurance on the individual market cannot be denied eligibility for benefits, including rewards obtained through a wellness program, or be charged more for coverage because of any health factor (US Department of Labor, n.d.). But HIPAA currently provides discretion to group health plans to charge one group health plan more than another because the group is less healthy overall. How this discretion will translate into an individual market made up of disparate individuals is unclear.

Wellness is not defined anywhere within HIPAA, the ACA, or federal regulation. What constitutes a workplace wellness program is vaguely outlined through examples and restrictions, rather than a formal definition. A generally accepted definition of workplace wellness programs has yet

to emerge in the United States. We would argue that such an agreed-on definition is unlikely to be adopted anytime soon. Employers define, structure, and manage their programs differently. Doing so is to their advantage. Nevertheless, certain key components have become common across programs, including health-risk assessments, clinical/biometric screenings, lifestyle and risk factor management, disease management programs, and structural improvements (Mattke, Schnyer, and Van Busum 2012: 13–14). A wellness program can consist of elements such as health fairs, health education, medical screenings, health coaching, on-site fitness programs, or online health education programs. The common thread in most workplace wellness programs is an aim to achieve increased physical or mental well-being and to decrease employer health care expenses.

The goal of dividing workplace wellness programs into two categories was to account for the possible discriminatory effect that disability or medical inability would have on reward attainment. But these divisions do not prevent the possible coercive nature of workplace wellness programs. Though the regulations define the financial incentive as a reward, the concern is that such a financial incentive may actually be a penalty to those unable to meet the requirements of a workplace wellness program. Even though HIPAA requires alternative standards for those who cannot or should not participate because of medical inability, this category is narrowly defined and does not account for other factors that could affect attainment of targets, such as health disparities based on income. Failing to meet reward targets would disproportionately hurt low-paid employees, who are usually less healthy and have less access to resources, such as gym equipment or healthy foods, compared with their higher-paid counterparts (Schmidt, Voigt, and Wikler 2010).

State workplace wellness laws were exclusively passed after the release of the final regulations on the HIPAA group health wellness plan rules in 2006. State legislation can be divided into two main categories. First, eleven states have adopted laws that provide safe harbor protections from state insurance discrimination, rebate prohibition, or unfair practice laws to any HIPAA compliant workplace wellness program that offers insurance premium discounts, rebates, or incentives (Alaska Stat § 21.36.110 (2009); Colo. Rev. Stat. § 10-16-136 (2009); Ga. Act 462 (2008); Ga. Act 463 (2008); Ga. Act 548 (2010); Ind. Pub. L. 136 (2006); La. Rev. Stat. § 22:1016 (2010); Md. Ch. No. 591 (2007); Md. 12 Ann. Code § 15-509 (2009); Mich. Pub. Act No. 413 (2006); N.Y. Ch. No. 592 (2008); Tex. HB 2252 (2007); Utah 13 Code Ann. § 31A-22-724 (2009); Wis. Stat. § 628.34 (13) (2010)). Second, nine states have adopted laws that allow insurance carriers providing

individual and/or group health coverage to provide incentives, including premium discounts or rebates, modifications to co-payment, deductible and coinsurance amounts, to individuals or employers that participate in workplace wellness programs (Ala. Pub. Act No. 2008-80 (2008); Colo. Rev. Stat. § 19 10-16-136 (2009); Iowa Ch. No. 2007-57 (2007); Iowa Ch. No. 2008-1188 (2008); Md. Ch. No. 600 (2007); Mich. Ch. No. 20 412 (2006); N.H. Ch. No. 56 (2008); Ore. Ch. No. 389 (2007); Va. Code § 38.2-3540.2 (2010); Wash. Ch. No. 257 (2007); Rev. 21 Code of Wash. § 48.30.140 (2009)). These state laws are aimed at bringing state law in line with federal law to ensure that employers can take advantage of the possible cost savings offered through workplace wellness programs. One state, Indiana, has provided an additional financial incentive for workplace wellness programs. Its Small Employer Wellness Tax Credit program allows employers with between two and one hundred employees to receive a tax credit for 50 percent of the costs incurred in a given year for providing qualified wellness programs to their employees (Ind. Pub. L. 218 (2007)).

The Hybrid Case: German Wellness Schemes

To understand wellness schemes in Germany, one must understand the many unique facets of the German health care system. Richard Freeman (2000: 53), who undertook an extensive study on the comparative health politics and institutions of Western Europe, noted that the German health care system is the "archetypal social insurance system." Solidarity is one of the key elements of the health care system, as is the unique independence of financing and provider institutions from the federal government. Originally, the Bismarck model of health care, characterized by a mix of public and private providers, was seen as a path to social integration (Weindling 1989: 157–58) and was constructed as an entitlement program that was largely associated with labor status (Göpffarth and Henke 2013). In the 1880s, health was assessed no longer in terms of the individual but as a way to achieve social integration through the collective responsibility for a healthy society. These values can be seen in Germany's present-day health care system, a compulsory insurance system composed of sickness funds (SFs) that cover the majority of Germany's population. The values that helped create the Bismarck model of health care are largely still present in the German health care system, and they have also provided the backbone for the types of wellness schemes that exist in Germany today.

As with incentive programs in the United States, a strong legal basis exists in Germany for similar programs. Many of these incentive programs

are offered through the German Statutory Health Insurance system and are bound by the provisions in the Social Security Code (Sozialgesetzbuch V, or SGB V) (Schmidt, Gerber, and Stock 2009). Wellness schemes in Germany are run by the state rather than by private employers, owing primarily to the structural design and funding of the German health care system. Health care financing in Germany is characterized by a pluralistic funding system between the *Länder* and the federal government, as well as societal organizations (Busse and Riesberg 2004). The German health care system can be seen as an extension of the broader German political system insofar as decision-making power is shared between the *Länder* and the federal government.

The most well-known scheme, and indeed the scheme most relevant to the discussion of wellness, is the public statutory health insurance (SHI) program. At the federal level, all SHI schemes are regulated through the SGB, specifically SGB V. While the SHI program is often cited as the most important statutory health insurance scheme, other schemes do exist such as accident, retirement, and long-term care insurance programs. The *Länder* are responsible for maintaining hospital infrastructure, public health services, and undergraduate medical, dental, and pharmaceutical education. In addition, the *Länder* also supervise the regional physicians' association(s) and the SFs operating in that *Land* (state) (Weindling 1989). In 2003 over 88 percent of the German public was insured through the SHI program (ibid.). Health insurance in the SHI scheme is provided by competing SFs, autonomous institutions that are organized on a regional and/or federal basis (ibid.). These nonprofit entities compete for members, as well as negotiate prices with other corporatist actors, such as physicians. In 2004 292 statutory SFs insured approximately 72 million people (ibid.). Important to note is that membership in certain SFs depends on attributes of the individual. For example, in 2004 37 percent of all SHI members were insured with one of the 17 regional SFs (known as the Allgemeine Ortskrankenkasse, or AOK), 21 percent of those insured were covered by one of the 229 company-based SFs (referred to as the Betriebskrankenkassen, or BKK), and 6 percent were covered by one of the 20 guild funds (Innungskrankenkassen, or IKK) (ibid.: 350–62; Tulchinsky and Varavikova 2009: 492).

Given the description above, one could easily assume that societal actors, such as employers, would be involved in the provision of corporate wellness programs. And while some employers do offer wellness-type programs and benefits, as noted above, the legal and practical implementation of

wellness programs rests with the SFs and governmental institutions. Why is that the case? In some sense, for one to assume that German employers would have an incentive to invest in the health and well-being of their workforce is logical. If, for example, workforce turnover is relatively low, then employers that invest in the health of their workforce have a greater chance of capturing a return on their investment. The key to comprehending Germany's wellness schemes is having a solid legal and cultural understanding of the country. Unlike in the United States, the wellness schemes in Germany are better integrated into the health care system and are not directly for the benefit of employers.

Wellness schemes lie primarily at the interface between Germany's SHI system and the broader European Union (EU) member state social security systems (Stock et al. 2010) and, as such, are subject to the politics and dynamics of both. Many of the social security systems in the EU are currently faced with the economic reality of an aging population, fiscal challenges, and an increase in health care costs. Germany is certainly no exception (ibid.). With an estimated 40 percent of the German population diagnosed with at least one chronic condition (ibid.: 52), the question of how to finance an influx of health care needs is relevant and timely. Under the assumption that an up-front investment in prevention programs will lower health care costs over time, the Advisory Council of the Ministry of Health recommended that health care in Germany incorporate prevention programs (ibid.). These include programs aimed at encouraging healthy behaviors such as exercise and the consumption of nutritious foods and seeking appropriate counseling and screening sessions for chronic diseases such as cancer.

As mentioned above, health and wellness schemes have been embedded in the SGB V since 1998 (Schmidt 2007: 242). The key to understanding the incentives behind these regulations is the concept of solidarity in German statutory health insurance. The concept of solidarity is codified in the SGB in three main ways (ibid.):

- Contributions and expenditures are pooled without knowing the individual or sex-specific risk assessments. Therefore, people who are younger, healthier, and able to work support those who are older, less healthy, or unable to work within the insurance schemes.
- Contributions are means-tested in the German insurance schemes, meaning that those participants who are more well-off end up supporting those who are less well-off.
- Participants with dependents are supported by those who have none.

The concept of solidarity in health care is set out in Article 1 of the SGB V. According to Schmidt (2007: 242–43), Article 1 states that citizens have the "'co-responsibility' for their health and should therefore 'lead a health-conscious lifestyle' while taking part in preventative measures to 'avoid sickness and disability.' " This healthier lifestyle can be achieved by participating in preventative health measures and in medical treatments and rehabilitation, which may reduce disease burden and disability within the population (ibid.). To this end, the German state was able to incentivize participation in primary and secondary prevention efforts through the use of bonus programs, introduced in the SGB V in 2004 (Stock et al. 2010: 52).

The rationale for such a move can be understood through a largely sociological paradigm: reducing one's claim on the overall health care system is seen as responsible individual behavior, which in turn reduces the overall costs to the greater community (ibid.). The four main incentives schemes introduced to reduce health care costs through wellness and health programs are the following: engaging in healthy behaviors, screening for early detection and treatment of chronic diseases, completing dental checkups, and minimizing the use of health care services.

Drawing on the body of work published by Harald Schmidt (2007) and colleagues, each scheme is discussed in detail below. Important to note is that while the features of the bonus programs vary by SF, each fund has similar programs and incentive schemes. The schemes below have been implemented by Barmer Ersatzkasse, one of Germany's largest SFs, which ensures roughly 10 percent of the German population (Schmidt, Stock, and Doran 2012: 2).[1] The German programs that encourage people to engage in healthier behaviors are one aspect of the German wellness movement that is similar to that in the United States. Germany's SFs offer a variety of different reward schemes for engaging in health promotion, screening, and checkup programs. However, as we highlight below, many of the German wellness schemes are markedly different from the corporate wellness programs found in the US market.

Bicycle Helmets and Yoga Mats: Healthy Behaviors and Wellness

Barmer Ersatzkasse rewards its members, for example, for engaging in health-conscious behaviors through providing cash bonuses, reductions in

1. The information concerning specific incentive schemes pulls heavily from the excellent work of Schmidt, Gerber, and Stock 2009 and Schmidt 2007. Where other information was used, it is noted in the text.

insurance contributions, and gifts such as bicycle helmets and sports watches. In the case of Barmer Ersatzkasse, participants can earn reward points through seventeen different activities. These include, for example, interventions such as vaccinations (100 reward points per year) and checkups for chronic diseases as required by law. Others include nutrition classes (150 reward points per year) and licensed exercise classes (100–150 reward points per program, per year), which are provided to encourage insured persons to engage in healthier lifestyle choices. Participants' earned rewards are tracked and then signed off on. Participants earning five hundred or more points over the course of two years are eligible to redeem their points for a variety of items such as backpacks, helmets, or cash benefits. Barmer Ersatzkasse also allows its members to reduce their insurance contribution if they engage in preventative screenings and checkup programs. Participants are able to use a Web-based calculator to see how their monthly contributions can be altered by their scores on common health metrics such as BMI, blood pressure, and cholesterol (Schmidt 2007: 244). A caveat applies, however, to the above incentive program. All bonuses given to and collected by members have to be financed through the savings that are directly attributable to the wellness programs (Schmidt, Stock, and Doran 2012: 2). The reason is that all bonuses are funded through a form of gain sharing that comes from the reduction in health care costs of people who are enrolled and participate in wellness programs. The absence of savings within the programs translates into a lack of a bonus payment for participants.

Mammograms and Colonoscopies: Chronic Disease Incentives

German wellness incentives also extend to patients who have chronic disease and cancer diagnoses. As opposed to the healthy behaviors schemes, incentives that are part of the early detection and treatment of chronic disease schemes have more of a "stick" element to them than one might think. This element can be seen in the co-payments that these patients are required to pay. As Schmidt, Andreas Gerber, and Stephanie Stock (2009: 725) note, SGB V (Article 62) specified that those who participate in counseling sessions for cervical, bowel, and breast cancer, and who then do not refuse treatment if diagnosed with one of these illnesses, are able to reduce their co-payments from a maximum of 2 percent of their income, down to 1 percent of their gross annual income. While an age inclusion criterion is associated with this regulation, patients who comply with current treatment and counseling guidelines will not have to pay as much for their care.

This particular incentive scheme is ripe with ethical and moral dilemmas. Should people who are unable to comply with current guidelines, for whatever reason, be charged more? What if people are unable to understand or participate in counseling sessions because of a disability or other factors? What is the role of physicians in policing these activities? Many of these questions have already been raised and, indeed, were brought up when Article 62 passed. When this regulation was introduced, the German government's justification was that patients who receive expensive medical care and are part of an SF do have personal responsibilities above and beyond the average user of the system (Schmidt 2007; Bundesregierung 2006: 304). What is clear is that the incentives surrounding chronic diseases and cancer go back to the idea of a solidaristic health insurance scheme, where each participant has the responsibility to act in the most prudent way to avoid an increase in health care use.

Gingivitis, Tooth Decay, and Floss: Dental Wellness Incentives

Unlike in the United States, German SFs offer wellness incentive packages for dental checkups. Barmer Ersatzkasse, for example, offers such an incentive package. As a baseline, the SF covers 50 percent of the costs associated with dental treatment, and the patient covers the remaining 50 percent. In the dental health incentive scheme, the SFs increase their contribution to 70 percent of the total costs if adults participate in annual checkup programs for over five years. Additionally, if each adult completes a dental checkup regularly over ten years, with no gaps in service, each fund will increase its contribution to the cost of dental care to 80 percent. If, however, a patient has a gap of more than a year between checkups, the patient will return to paying 50 percent of the costs of treatment.

Twinkies, Bear Claws, and Hostess No More: Minimizing the Use of Health Care Services

In line with the concept of a solidaristic health care community, incentives to decrease the use of health care services have been built into the SGB V and many of the health bonus schemes. As illustrated above, Barmer Ersatzkasse, and indeed the majority of other SFs, offer reduced contributions, or at times lower co-payments, to those participants who agree to take part in prevention and screening efforts and engage in healthy behaviors (as deemed by the funds). For example, Barmer Ersatzkasse has offered two schemes since 2007 (both have binding three-year contracts).

The first scheme offered that participants could reclaim €80–€200 each year if they were not admitted to the hospital or if they did not have an appointment with a general care practitioner that led to a prescription. The second scheme (which comprised nine different schemes) enabled participants to annual rebates if they agreed to pay a certain percentage of their health care costs for the year. Rebates were typically between €80 and €500. Important to note, however, is that the funds are not trying to reduce all health care use. An effort is being made to have participants take part in prevention activities, screenings, dental checkups, and other services that the funds assume will lower health care costs.

The question remains, however, of whether these programs are effective in meeting their overall objectives. Are participants any healthier, and have health care costs decreased? Some studies suggest mixed results, with some participants who had no health care costs at baseline exhibiting significantly higher costs by 2006, compared with those who did not participate in wellness/bonus programs and who had no health care costs at baseline (Schmidt, Stock, and Doran 2012: 5–6). Or has not enough time accrued for such questions to be appropriately answered? If not, then how much time must lapse before studies can possibly determine whether the overarching objective and monetary savings have been realized?

That being said, we note the importance of the fact that regardless of who is participating in these programs and whether health care savings have been realized or not, these programs present an interesting hybrid approach of the US and German approaches to wellness. While the carrot-and-stick approach is not necessarily overt in the German case, these health and wellness schemes provide both incentives and disincentives to participants.

The underlying concept of the German wellness schemes and incentives appears to be based on solidarity (Schmidt 2007: 242). Individuals are expected to exhibit an appropriate degree of personal responsibility for their health, while continuing to contribute to the financial health of the German SFs (Stock et al. 2010). While many of the incentives described above can be seen as policies that reward certain types of behaviors, some of these do contain disincentives, such as an increase in co-payments for individuals who do not comply with certain disease-related screening and preventative measures (Schmidt 2007). As in many other countries, wellness programs are embedded in the statutory framework of the SGB V and the SFs. While employers may be making an effort in Germany to provide some form of a wellness program for employees, these types of schemes are firmly embedded, both historically and practically, in the health care insurance system.

What, then, does this mean for the health of Germans? Do these interventions count as wellness programs even though these activities could be considered prevention? Are wellness programs and prevention programs different? As others have noted in this special issue (Kirkland 2014b), they are indeed different. But the lines are not as clear-cut in Germany. From a US context, an easy assumption is that wellness programs constitute health fairs and fruit in lunchrooms. We are able to make this distinction because wellness programs in the United States are largely a corporate and employer-based phenomenon. Our case study of Germany shows that its approach differs. German wellness programs appear to be more comprehensively embedded in incentives for a healthier life, which includes dental checkups and screening of chronic diseases. These types of programs look much more like prevention programs than they do wellness programs. These incentives are built and offered in an effort to lower health care spending and to ensure that duplicative and inefficient health care services are reduced. While this approach may be considered German-style wellness, it does not resemble the goal of individual betterment that is characteristic of US-style corporate wellness.

Wellness as Part of the Australian Landscape

To examine the extent or nature of wellness initiatives in Australia, one must first understand the nature of the country's health care system and the broader social policy backdrop. As in the United States and Germany, the health care system in Australia is dynamic in nature, having undergone significant structural reforms over the past four decades (Palmer and Short 2000). Arguably, the most significant of these reforms was the introduction by the then Labor government of the Medibank system—a federal universal tax-based insurance system that came into effect in 1975.[2] The system's overarching objective was to provide universal health care to all Australian residents. Funding of the scheme was to be drawn from general Commonwealth revenue (Duckett 1984: 960; Najman and Western 1984: 951).

This scheme, in its original form, was short-lived. This duration was in part due to the dismissal of the (then) government. A revised scheme, Medicare, superseded the initial scheme in 1984. Under Medicare, universal coverage is funded by a flat income tax levy—the "Medicare levy," which is currently set at 1.5 percent of taxable income with exemptions for

2. As established by the Health Insurance Act 1973 (Cth).

low-income individuals (Klumpes 2001: 178)[3]—and general revenue. Universal health care is viewed today by the Australian population as both a social enterprise and a fundamental right. The federally funded scheme ensures that "all Australians have access to free or low-cost medical, optometric and hospital care while being free to choose private health services and, in special circumstances, allied health services" (AIHW 2012: 37). In 2010–11 22.5 million Australian residents were enrolled under the scheme, at a cost of approximately $A16.3 billion (ibid.). Services covered under the scheme include both prevention (i.e., annual eye examinations and certain screening tests and procedures) and treatment of illnesses and injuries. This coverage includes hospital care as a public patient within the public hospital system.

Legislative and regulatory power within the public health system is shared between the federal, state/territory, and local governments. Each plays a major role in the financing, operating, and delivery of health services to the public.[4] The public system is supplemented by a private health care system, the funding for which is generated through individual member premiums and federal government rebates (ibid.).

In 2009 health spending as a proportion of GDP in Australia was estimated at 8.7 percent (OECD 2011).[5] By way of comparison, this figure was 17.4 percent for the United States and 11.6 percent for Germany (ibid.). Average health spending across the Organisation for Economic Co-operation and Development (OECD) was 9.6 percent of GDP (ibid.). As with the United States and Germany, Australia similarly faces the challenge of an aging population and increasing health care expenditure.

Universal health care, paid for by the public-at-large, arguably creates different incentives around the notion of wellness. And more importantly in the context of this article, it does so for workplace wellness initiatives. Unlike in the United States, where such initiatives have been institutionalized by employers as part of coercive employment conditions and benefits (as discussed, e.g., by Kirkland [2014a] and Madison, Schmidt, and Volpp [2014] in this issue), such arrangements do not exist in Australia's

3. At the time of its introduction in 1984, the levy was set at 1 percent; this rate has been indexed over time.

4. As the Australian Institute of Health and Welfare notes: "Of the total health funding of $121.4 billion in 2009–10, the Australian Government contributed 44% and state, territory and local governments 26%. The non-government sector funded the remaining 30%" (AIHW 2012: 473). See also OECD 2011.

5. The OECD figure, however, underrepresents Australia's health spending as a proportion of GDP, as noted by the AIHW. In its words, "Australia's ratio does not include spending on long-term care outside hospitals, unlike many other OECD countries" (AIHW 2012: 473).

labor market. In short, Australia does not have the same need for firms to provide health insurance to their employees to manage health care costs, since Australian firms do not fill this health insurance provider role. As such, the incentive structure to make a workplace healthier and thereby reduce health insurance premiums simply does not exist in the Australia employment context. Such incentives, arguably, instead lie at the macro-level given the role that the state plays in financing health care.

The burden of higher costs associated with health insurance in Australia is borne by those who are most likely able to afford to do so. As noted above, the Medicare levy is a 1.5 percent flat tax on income; those who fall within the definition of "low income" are exempt from paying the tax. As set out by the Australian Taxation Office (2012), in 2011–12 individuals less than sixty-five years of age, with a taxable income of less than $A19,404 per annum, were considered of "low income" and exempt from paying the Medicare levy. Individuals earning between $A19,404 and $A22,828 were only required to pay a part of the levy.

Since 1997, those defined as high-income individuals *without* private patient hospital coverage have been required to pay the Medicare levy and a 1 percent surcharge. The introduction of the Fairer Private Health Insurance Incentives Act 2012 (Cth) further entrenched this requirement. As summarized by the Australian Institute of Health and Welfare (AIHW 2012: 474): "Individuals earning between $A93,001 and $A124,000 in 2011–12 will pay a 1.25% surcharge, and those earning $A124,001 or more will pay 1.5%. The equivalent thresholds for families are $A186,001 and $A248,001." After much debate, in March 2013 the federal government passed the National Disability Insurance Scheme Act 2013 (Cth). As set out in section 3, the objective of the act is to "provide for the National Disability Insurance Scheme in Australia." The first stage of the scheme began in July 2013 and provides an additional layer of targeted support within the Australian welfare system. The scheme will be paid for, in part, through an increase in the Medicare levy. As of July 1, 2014, the Medicare levy will increase to 2 percent of gross income; high-income earners who do not take out private patient hospital coverage will continue to incur an additional surcharge.

Income level, in combination with an individual's express decision not to engage with the private health insurance market, is the trigger to the higher premium. It is not, importantly, the individual's BMI, blood glucose levels, smoking history, or employment terms that give rise to this financial cost.

That is not to say, however, that wellness initiatives do not exist in the Australian context. They do. And many of the programs have been

designed by the very same companies or firms that have been institutional in developing and implementing the programs now seen in the United States. But we would argue that they are generally framed in the form of—to quote Anna Kirkland (2014a: 975)—"corporate citizenship and employee satisfaction." Or, simply, they are nice extras associated with employment. Such programs can be found throughout the public and private sector with employers offering, for example, free gym memberships, reduced rates for yoga and Pilates classes and free fresh fruit, flu shots and nutritious snacks, and general lifestyle benefit programs (Allens, n.d.; TressCox, n.d.; Ernst and Young, Australia, n.d.; Macquarie Group 2013). Such programs are likely to offer a wide range of benefits and gains to the employee and the employer. But the motivation behind their implementation would appear to be different from those observed in the US context. Such programs may be viewed as analogous to the participatory wellness programs seen in the United States. They are not health-containment wellness programs, designed to satisfy a certain physiological standard or health outcome.

Corporate health/wellness programs are part of Australia's private health insurance landscape. Here we see evidence of the same sorts of promissory language of "increased productivity" and "reduced absenteeism" as used in the United States. However, even the providers note that such initiatives are also associated with employer satisfaction, with one insurance provider noting, for example, that such programs "make a positive contribution to their organisation's culture—including the attraction and retention of talented employees" (NIB, n.d.). Such programs are not ubiquitous in nature, nor are they defined by the carrot-and-stick approach of their US counterparts.

Discussion and Conclusions

In an era of aging populations, increasing health expenditure costs, and economic instability, not surprisingly the public and private sectors alike are actively engaged in promoting programs that focus on prevention rather than on treatment. Increased up-front expenditure on prevention, or programs that promote physical and mental wellness, should translate to reductions in health care costs. Yet the incentive or motivation to invest in wellness is likely to be tempered by a firm's (albeit public or private) ability to realize a return on this investment, however the firm may measure this payoff. Logically, then, governments in jurisdictions with universal health care systems, such as Germany and Australia, will arguably be more

inclined to invest in programs designed around medicalized prevention programs—including, for example, health screening programs and annual eye examinations—than in those that do not. Their role of providing a health care safety net to their citizens is fundamental to their role as government, and such services are considered to be a right of all. In this context, the state does not have to engage in complex calculation of employee retention and movement patterns in order to determine whether such up-front investment will result in a longer-term payoff that they will realize (as opposed to another employer in the US context).

Our analysis suggests that wellness is a worldwide phenomenon. However, the way it is framed or delivered in terms of programs and benefits differs notably across the three jurisdictions considered in this article. In the United States, health care is decentralized, while in Germany decentralization does not adequately describe the health care system or the German style of federalism. While the different levels of government control certain elements of the health care system, two of the most distinguishable characteristics of the German health care system are the delegation of state power to corporatist actors and the privatization of aspects of the system. These two countries differ from Australia in that universal health care is very much perceived as a basic public right and should be delivered by the federal government in partnership with the state/territory governments. Private coverage is perceived to operate above and beyond this fundamental safety net, with the system structured in such a way as to push, or coerce, those who are considered to be higher earners—and thus more able to pay—into the private system. Wellness in this context is seen in part in the state's role in investing up front in prevention, rather than being a consumer of only health treatment. Whether this approach is beneficial to the government's bottom line is beyond the scope of this article.

The above case studies highlight the differences between wellness programs but also tap into broader cultural and historical legacies. The United States, Germany, and Australia all have different governmental structures, legal systems, health care systems, and domestic institutions. Despite these differences, all three countries are faced with aging populations, increased public-sector spending on medical services, and pressure to cut costs. Wellness programs may be one way to promote a healthier society and rethink how public and private money is allocated within these systems. While US-style wellness programs, and indeed wellness programs in the wider European Commonwealth, are typically marketed as solidaristic in nature, in practice these programs are quite different, most notably in the institutional structure in which they are embedded. Could US wellness

programs possibly incorporate the solidaristic culture of German wellness programs or move toward a more centralized provision of these programs, as is the case with Australia? These changes seem unlikely given how employer-centric and corporatized wellness programs have become in the United States. Additionally, the notion of solidarity has not been incorporated into health care financing or provision institutions in the United States. A radical change in how the United States conceptualizes, provides, and finances health care would be needed to even approach a form of solidarity in practice. Learning from other jurisdictions will be important in determining what a wellness program is, what it should look like, and what incentives—if any—are associated with the programs.

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