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SA BOARD FOR
PEOPLE PRACTICES
Setting HR standards

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FACT SHEET

EMPLOYEE WELLNESS SCREENING

1. INTRODUCTION - WHAT IS WELLNESS SCREENING?

Wellness screening is part of what you do when you go for a health check-up at a healthcare provider. You may think you are totally healthy, or you may know or suspect otherwise, but you go to your doctor or clinic for a defined number of screening tests which might include blood, urine and maybe other tests which are based on current best practice evidence, such as an intra-ocular pressure test to screen for glaucoma in the eye. The healthcare practitioner may ask you further questions on your life-style, measure your height and weight to determine your BMI (body mass index) and your family medical history for relevant genetic disease patterns such as early heart disease or certain cancers such as breast cancer.

Some employers arrange for their executives to have their health checked up so they can act timeously and not lose a key executive due to, for example, an untimely heart attack or some form of cancer. Some medical schemes may encourage you to have such tests at a pharmacy clinic or other healthcare practitioner. Often when you buy new life assurance the insurer requires a healthcare practitioner to conduct tests to ensure that you pay a life insurance premium according to your health risk or they may refuse you insurance if you are a high risk case. These are all forms of health screenings. The purpose of all of them is to know your health status, and given the outcome thereof to advise you of your health risks and what you can do to avoid serious illness or worse.

The purpose of this Fact Sheet is to provide the facts why it has become vital for everyone to know his or her health status and then to act responsibly with that knowledge and understanding how to manage their health risks appropriately.

2. SCREENING IS THE ESSENTIAL FIRST STEP IN DEALING WITH EPIDEMICS - TAKE NOTE OF HOW THE HIV / AIDS EPIDEMIC GOT TACKLED

It is well recognised that one of the key success factors in combatting the HIV / AIDS epidemic is for each member of the community to know his or her HIV status (implying whether or not he or she is HIV positive or negative). We also know that intense counselling should be organised before the screening test is done on the individual and if the outcome of the test is bad news, further counselling is needed and assistance to embark on the treatment, which initially might require only close monitoring. Much of the counselling has to do with empowering the individual with knowledge about the disease, its impact on a person and those around him or her, how to prevent it and how to treat it. Given that knowledge, the onus is so much more on the individual to take the step of getting to know his or her status. The HIV test and everything around it is a perfect example of a type of health screening.

Through the experiences of the HIV/AIDS epidemic it was, despite serious knowledge dissemination, an uphill battle to get people to take the test to get to know their status. Employers, who also stood to lose seriously through the impact of the epidemic on their employees, embarked on large scale and innovative incentive programmes to have employees (and their dependants) tested.

3. SOUTH AFRICA'S QUADRUPLE BURDEN OF DISEASE EPIDEMICS

The quadruple burden of disease that South Africa is experiencing refers to the four epidemics of

- HIV and AIDS;
- Injuries, crime related and other;
- Other communicable diseases (transmittable diseases); and
- Non-communicable diseases (non-transmittable diseases or diseases of life-style).

Combined, these four team up to progress to a disaster, if not a catastrophe, for the current generation, of healthcare treatment needs that will overwhelm the available resources, leaving untreated, suffering and untimely dying patients in its wake. Much of the burden is a result of people developing life-styles, either by choice or by being forced into it by socio economic circumstances, that make them more prone to illness. Life-style in this regard has mostly to do with people's socio-economic circumstances, but even within these environments, physical activity or lack thereof, eating habits and patterns and state of mind – consciously or unconsciously – hugely impact one's health status.

South Africa is not well positioned to deal with this quadruple burden of disease. It has a dichotomy of healthcare services and finances. On the one hand there is the private sector that caters for the more affluent and on the other the public sector for the less affluent. The progression of the current system will inevitably result in less and less people being able to afford private healthcare. More and more people have no other option but to access the public healthcare system which is already over-burdened the way it is currently managed. The key problem in private healthcare is a classic economic theory one of continuing increase in demand which meets limited supply so the price goes up. Even worse, we experience supplier induced demand and private providers are understandably often driven by the profit motive and supported by best quality arguments.

The fact is that in both the public and private sectors, the healthcare financing and delivery system developed into a hospital-centric one with neglect of preventative and primary healthcare. In the public sector, initiatives are afoot to re-engineer primary health care to community oriented primary healthcare, but this will take years if not decades to start to have an impact at large. The private sector is increasingly dominated by healthcare delivery through hospitals and specialists particularly through the regulation and administration of medical schemes, with little preventative and primary healthcare incentives. For example the Prescribed Minimum Benefits regulation of medical schemes is considered by commentators to have added to the cost escalation without necessarily improving healthcare outcomes.

The Competition Commissioner is busy with an inquiry into the (private) healthcare system – the outcome of which is likely to recognise the complexity of the system, not the least being the huge number of role players with varied interests. It would be most interesting to see what they would come up with as practically implementable steps to create a turnaround that will work soon. South Africa's Minister of Health has commendably come out with very strong policy measures to address the absolute shortage of preventative and primary healthcare and thereby reduce the demand on the public hospital services.

Government has many ways to really impact wellness and prevent disease. As such, not many commentators have acknowledged that the government's anti-smoking laws have arguably been the single biggest and most successful wellness campaign in the country.

4. THE FACTS OF HEALTHCARE COST ESCALATION AND IMPACT ON EMPLOYERS' BOTTOM LINES

As revealed in the latest annual reports of the Council for Medical Schemes, medical scheme contribution rates in general escalate at roughly double the rate of consumer price inflation and this has been the case for decades. We know that general salary escalation tends to equal or might marginally exceed CPI inflation.

The result is that the more affluent people, who are employees that can afford to belong to medical schemes (about 25% of income earning citizens), experience a reduction in their take-home pay in real terms as a result of medical scheme contribution inflation. Alternatively they downgrade to cheaper benefit options with lesser benefits. These cheaper options typically entail less primary care benefits. To compromise on primary healthcare simply means fuelling the vicious spiral of escalating hospital and specialists costs (i.e. so-called tertiary healthcare). As many informed healthcare commentators have said, "we need to keep people away from the hospitals and specialists". To do that requires effective preventative and primary healthcare.

To put this impact into perspective, salary negotiations between employers and labour very often hinge on an increase of a fraction of a percentage. By contrast, the impact that better employee health through effective preventative and primary healthcare can have on direct costs of employee health for the organisation runs into a multiple of percentages year after year. This is because the direct cost of employee health for employers is in the order of 20% to 30% of payroll, of which medical scheme contributions make up the bulk. Thus, any intervention to reduce the escalation in this large cost will yield a large return on investment.

Furthermore, a well-designed and implemented integrated employee health, wellness and productivity strategy will further improve the effect on the organisation's financial bottom line – and obviously also its social bottom line. Recent commentary even refers to this as the fourth bottom line in addition to the triple bottom line of the Global Reporting Initiative. This is one of the reasons why employee wellness cannot be relegated to being only or merely an "HR matter" – it is a matter of both profitability and long-term sustainability for the organisation and requires authority, responsibility and accountability at the highest executive levels including that of the board of directors.

5. LESSONS TO BE TAKEN FROM THE HIV / AIDS ANALOGY

In the same way as knowing your status is critical to successfully manage the HIV / AIDS disease, so it applies with healthcare in general. Each one of us needs to know what our health status is with respect to any disease. If we could break down the stigma associated with HIV / AIDS, it is surely achievable practically speaking with all diseases. This is what wellness screening is about – to regularly and appropriately have each member of the community tested (screened) so that he or she would know what his or her health status is in regard to many existing, latent or potential preventable and or manageable diseases where routine screening or surveillance and timeous treatment have proven to be cost effective.

6. HEALTH SCREENINGS ARE NECESSARY SIMPLY TO KNOW YOUR HEALTH STATUS

The table below shows recent statistics of around 1,000 employees of a certain industrial company. Note that health screenings are done for early identification of the major risks for the majority of the community (community in this case being an employee group). The extent of diseases covered through the health screenings evolves and improves over time through technology advances. There are certain tests (think of DNA analysis and whole body scanning) that are still exorbitantly expensive, so these will not routinely be conducted at this stage. For the largest part, identification of the major contributors to the existence and development of disease involve life-style and hereditary diseases and are relatively easy and cheap to identify. What is not easy, is to encourage those affected or infected to adapt life-styles for the better and this is again where the lessons learnt through managing HIV / AIDS in counselling and incentivising behaviour change can fruitfully be adapted and adopted.

Percentage of employees that present HIGH RISK on account of stated health screenings (from a real case)	
Body mass index (being overweight)	29%
High blood pressure	31%
Bad cholesterol	16%
Glucose	4%

The importance of the contents of the table above is:

- firstly that these results are known;
- secondly that the results indicate serious health threats amongst these employees;
- thirdly that the results indicate potential large costs to the employer.

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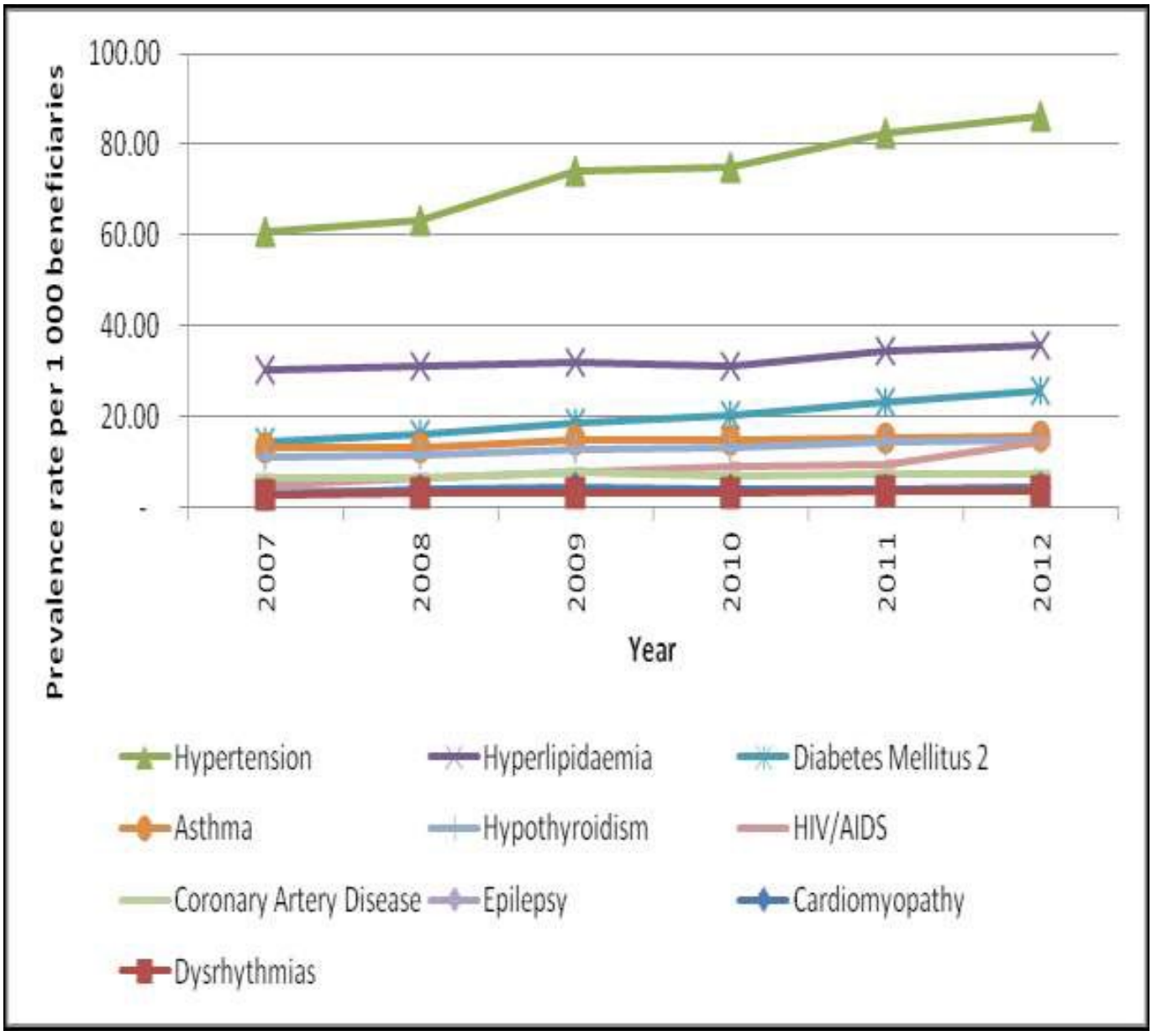
7. HEALTH MANAGEMENT FOLLOWING KNOWN HEALTH STATUS

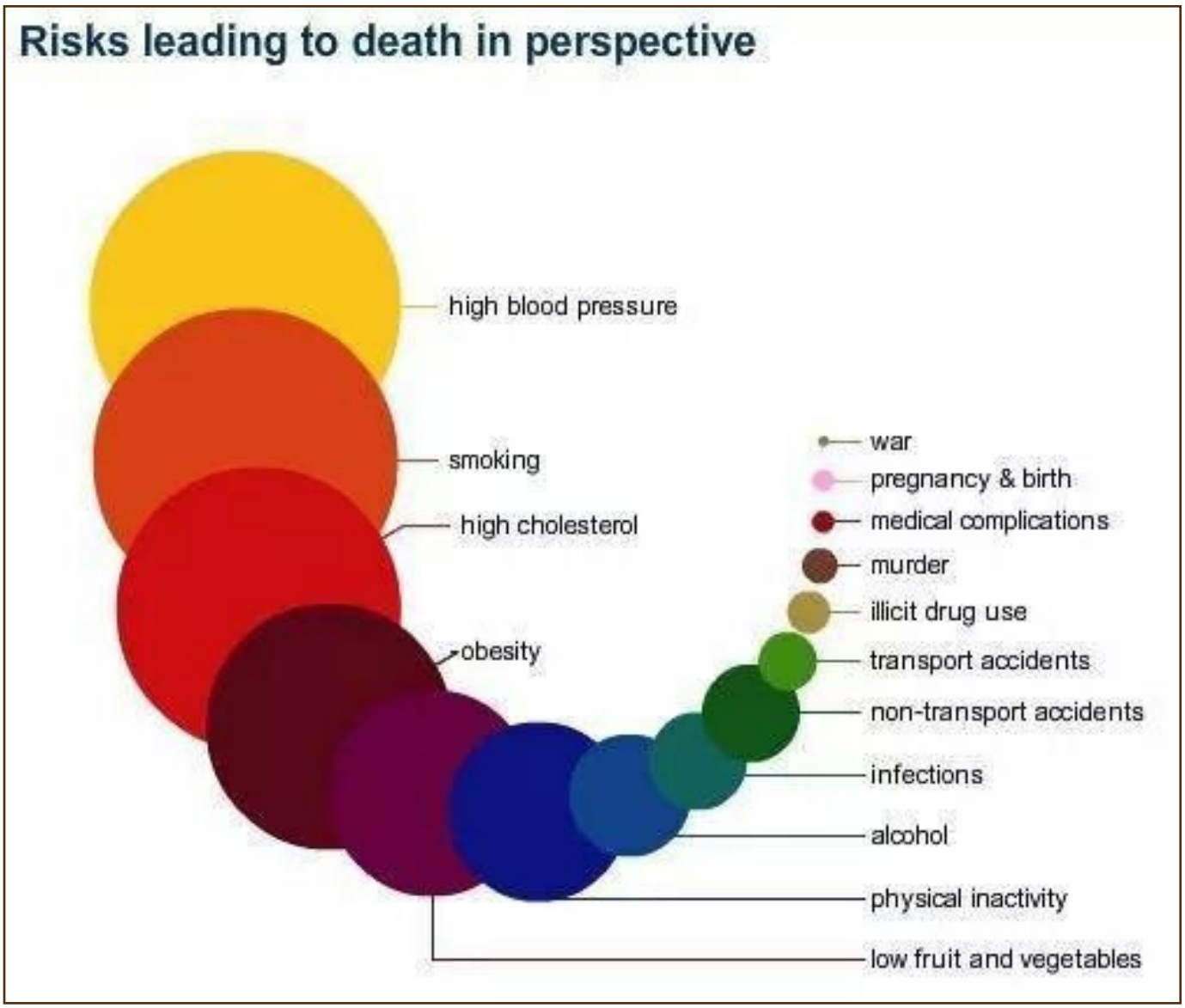
The high risk employees reflected in the table above all belong to medical schemes since this is a condition of employment at this particular employer. Despite this, health management of these high risk employees is generally speaking not forthcoming from their medical schemes.

The statistics from the medical scheme industry reflect that the top ten chronic diseases are as follows:



Hypertension is clearly the most prevalent disease yet only around 8% of medical scheme beneficiaries are treated for this. Other statistics, such as the one on the employer case stated above, show that the actual hypertension (high blood pressure) prevalence revealed by screening is likely to be 3 to 5 times the extent to which medical schemes actively manage the disease.

The following picture emanating from US figures also puts perspective on disease – particularly life-style related diseases.



One can deduce from the SA medical scheme statistics that healthcare management of high risk cases is generally speaking inadequate or not forthcoming. What is even more startling is that management of a disease such as hypertension need not be complicated or expensive for the vast majority of those suffering from it. Although the easy solution is simply to use relatively inexpensive medication, indications are also that a large part of those who take the drugs to manage their condition, in fact could do away with the medication were they to simply eat right and exercise regularly. However, the latter requires a life-style change which is often very difficult for an individual. Therefore it is crucial that the individual understands the consequences, both in terms of personal suffering as well as the financial impact, of not managing his or her health appropriately. One should also make use of programmes and services that exist to receive support and assistance in how to effect and maintain the required life-style changes. Again, the testimonies and outcomes of HIV positive persons being in denial are stark reminders of the consequences of ignorance and non-action.

8. HEALTH SCREENINGS AT THE WORKPLACE FOR THE WORKPLACE

However unpopular it may be from employees' or employers' viewpoints to have health screenings done at the workplace, the facts of the situation as explained above clearly indicate need for a new paradigm. There is indeed opportunity or threat for better employee health and hence productivity and business sustainability if health screenings are done or not done for all employees regardless of the level of employment. Furthermore, if the health screenings can be extended to family members of the employees, it is even better.

The impression one gets is that management is often loathe to attempt to intervene when it comes to employee health matters. Often the argument is, like in the motor industry, "we do cars we don't do health", but the evidence coming from the United States, where healthcare seems to pose even more challenges than in South Africa, is clear that employers are taking charge of their employees' health and it is for the better.

9. CONCLUSION

Apart from HIV/AIDS and tuberculosis, it is apparent that the biggest impact financially and in terms of health and productivity outcomes for employee groups and therefore for employers will be in early identification and interventions through large scale health screenings in the following diseases:

- Hypertension
- Hyperlipidaemia
- Diabetes
- Asthma and
- Mental illness.

However, the health consciousness and other benefits created by such large scale health screenings will also contribute to better management of the more rare yet very disruptive, debilitating and costly physical illnesses such as chronic renal failure. It is alarming that it has been mentioned that the disaster of the suicidal Germanwings Airline pilot could have been avoided through better workplace health screenings.

This fact sheet has been prepared by George Marx (Healthcare Actuary and MD of Wellnicity (Pty) Ltd – gmarx@wellnicity.co.za), with the kind assistance of EOH Health's Prof Sam Fehrsen and Drs Adriaan Combrinck and Thys Kruger.

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