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The Health & Productivity Institute of Australia

SUBMISSION TO THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION REVIEW OF THE AUSTRALIAN HEALTH SYSTEM

FROM
AEGIS CONSULTING AUSTRALIA
ON BEHALF OF THE
HEALTH AND PRODUCTIVITY INSTITUTE OF AUSTRALIA

"USING THE WORKPLACE TO PREVENT CHRONIC DISEASE"

MAY 2008

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1. BACKGROUND TO THIS SUBMISSION

Aegis Consulting Australia has been commissioned to prepare this submission by the Health and Productivity Institute of Australia (HAPIA), which represents the nation's providers of employee health and wellness programs.

Eliminating risk factors for chronic disease to reduce employee absenteeism and enhance the productivity of the working population is the HAPIA mission. To achieve this, HAPIA members deliver health screening and assessments as well as health care interventions and advice within the Australian business and government sectors.

Currently over 1500 corporate and government employers provide health assessment and intervention programs for over 400,000 employees.

Previously health and wellness programs in the workplace were predominately viewed as tools for recruitment. However over the last five years employers have increasingly chosen such programs because of the financial, economic and social benefits associated with a healthier workforce. These benefits include reduced absenteeism, improved productivity and lower workers compensation claims.

2. EXECUTIVE SUMMARY

2.1 Objectives

This submission proposes that because of the financial, economic and social benefits that health screening and interventions (workplace health programs) provide, such programs should be considered as a part of the total health care system in two ways:

- As a form of primary care like the network of general practitioners and community based care; and

- As a key tool and often first step in the primary prevention of chronic disease.

The workplace should be viewed in this way because workplace health programs can identify, prevent and manage chronic disease risks to an extent that reduces clinical treatment costs in the health system and improves overall economic output. National and international data consistently demonstrate that investment in workplace health programs delivers a rate of return on investment or cost/benefit ratio of about 1:5.

The current review being conducted by the National Health and Hospitals Reform Commission (NNHHRC) and the development of a national preventative health strategy by the National Preventative Health Taskforce (NPHT) provide an opportunity to properly entrench the workplace as a part of the health care system, especially to achieve primary prevention outcomes.

Traditionally health policy and funding in Australia has been concentrated on the clinical practices and opportunities in GP clinics, specialist rooms, hospitals, community care facilities and aged care facilities. Equally primary health care has long been considered the dominion of general practitioners.

All of these components of health care have one common characteristic – they are places that people only tend to visit when they're already ill, not when they're seeking to avoid disease altogether. Thus while the traditional locations of health care practice play an obviously vital role in secondary prevention, it is uncertain that they can and should have the sole responsibility for primary prevention.

Public health programs aimed at primary prevention have tended to be delivered through education campaigns marketed via general media or schools, with the workplace largely ignored. This is despite the fact that over 10 million people spend at least 7 hours per day at their place of work absorbing and responding to information and engaging in a participatory way.

It is also despite the fact that national and international data conclusively demonstrates the financial, economic and social benefits of workplace health programs in terms of reduced absenteeism, improved productivity and lower workers compensation costs.

Under the terms of its review the NHHRC has a perfect opportunity to rectify this oversight in health care policy and recommend that the workplace be regarded as integral in the design and funding of policy programs aimed at improving primary prevention, especially for chronic disease.

In May 2008 the NHHRC recommended that the Commonwealth Government have sole responsibility for primary care to ensure better accountability for health spending on primary care programs.

If primary prevention of chronic disease through the workplace is considered a form of primary care then, based on the recommendation of the NHHRC, it follows that the Federal Government should play a leading role in funding or other regulatory options that serve to increase the take up of workplace health programs.

2.2 Proposed Options to Increase the Use of Workplace Health Programs

This submission proposes a range of ways the Commonwealth Government can fund and promote workplace health programs. These are:

- Subsidies delivered through Medicare, funding under the next Health Care Agreement, or direct grants to employers; and/or
- Changes to the *Fringe Benefits Tax Assessment Act* and *Income Tax Assessment Act* to provide clear incentives for employers; and/or
- Changes to the Private Health Insurance Act 2007 and *Private Health Insurance (Business Insurance) Rules 2007* to improve the capacity of employers and private health insurance firms.

In conjunction with any of these options or as a separate exercise it is also proposed that the Commonwealth Government consider establishing a National Health Prevention body tasked with developing a consistent national standard to measure and inform policy and market

responses to chronic disease risks. This body could be a Commonwealth agency, State/Federal body, or government/private sector body.

A key role of this body should be the annual survey of population health for the purposes of establishing a National Well Being Index. The aim of the index would be collect comprehensive data on population health to inform the development of national health benchmarks.

These proposed options are discussed in more detail in Chapter 5. Some of these options, like changes to tax, private health insurance legislation and the establishment of a National Health Prevention body and Well Being Index are short term solutions and require minimal funding from government.

Other options like Medicare payments, Health Care Agreement funding and direct subsidies to employers may be medium – long term solutions unless budget decisions and the political will of government enables their more immediate consideration and implementation.

3. EARLY INTERVENTION IMPROVES HEALTH OUTCOMES

When considering the proper role of the workplace in the health care system, a threshold issue is the importance that health policy does and should give to early intervention, particularly to combat chronic disease.

The concept of early intervention is not foreign to Australian health policy thinking and has been given significant importance by various governments and the NHHRC itself.

3.1 Australian Governments Agree on Early Intervention for Primary Prevention

3.1.1 Council of Australian Governments

The national social and economic benefits of reducing chronic disease through early intervention were recognised by the Council of Australian Governments (COAG) in February 2006. COAG agreed that health promotion, prevention and early intervention strategies and investment are required to reduce the incidence of chronic disease, and improve overall health outcomes. According to COAG:[1]

"Good health underpins the wellbeing and quality of life of Australians. Preventing ill health and improving physical and mental health helps people to participate in work and makes them more productive when they do so.

Reducing the incidence of chronic disease (such as diabetes, cancer and mental illness) means fewer people not working due to illness, injury and disability.

Risk factors such as poor diet, physical inactivity, smoking, alcohol misuse and excess weight contribute to chronic disease."

As a result, COAG approved a four year $500M plan called *Better Health for All Australians*, which was underpinned by a series of programs to promote good health, prevention and early intervention.[2]

Under the plan which commenced from 1 July 2006, jurisdictions agreed to:[3]

- **Promote healthy lifestyles** through a number of initiatives targeting alcohol use, nutrition, smoking and physical activity. This includes aligning actions by jurisdictions for early intervention to prevent chronic disease.
- **Support early detection of lifestyle risks and chronic disease** through a *Well Person's Health Check* available nationally to people 45-49 years of age.
- **Support lifestyle and risk modification** through clinical assessment and referral services for people wanting to make changes to their lifestyle.

[1] COAG, Communiqué, 10 February 2006
[2] Ibid, Attachment D
[3] Ibid

- **Encouraging active patient self-management of chronic disease** through services such as counseling.

- **Improving the integration and co-ordination of care** through a range of measures including incentive funding for all medical services.

3.1.2 Federal Government

The Federal Government has very clearly stated that in its view two of the four main challenges facing the Australian health system are the increasing prevalence of chronic disease and health services which fail to intervene early or comprehensively to maximise people's productivity and workforce participation.[4]

To address these issues the Government has committed to incorporate preventative health care into a new Australian Health Care Agreement.[5]

Underpinning this is a desire by the Government to "reduce avoidable hospitalisations and re-admissions to hospital." [6]

3.1.3 Victorian Government

The Victorian Government has moved a great deal beyond simply noting the need for preventative health through early intervention. It has made the sensible and practical link between the need for prevention and the ideal capacity of the workplace to host and deliver early intervention.

In March 2008, the Victorian Government responded to the research and analysis accumulated under the COAG human capital reform process about the costs of chronic disease by committing to early intervention programs through the workplace.[7]

Claiming a world first in policy design that connects chronic disease and workplace injury, the Government has committed to subsidise health screenings for every Victorian worker using its WorkSafe Authority's surplus funds. The aim of the WorkHealth Initiative is to identify workers at risk of chronic disease and prevent the onset of that disease. [8]

Under the first stage of the WorkHealth Initiative the Government has committed: [9]

- $60 million to enable WorkHealth to visit regional centres and Victoria's small and medium sized businesses to deliver advice and facilitate the free on-site screening services;

[4] Rudd K and Roxon N, New Directions for Australian Health, Australian Labor Party, August 2007, p2
[5] Ibid, p5
[6] Ibid, p6
[7] John Brumby, Premier of Victoria, Media Release, 18 March 2008
[8] Ibid
[9] Ibid

- $28 million for dollar for dollar grants for larger employers (up to $30 per worker) with payrolls over $10 million to cover the cost of screening and to provide advisory services and lifestyle programs at their worksite; and

- $130 million for prevention programs for those workers most at risk, including the lifestyle change program to encourage workers to lose weight, increase their physical activity and adopt healthier eating habits, as well as an education campaign.

3.1.4 National Health and Hospitals Reform Commission

In May 2008 the Commission released its first report titled *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*.

The report confirms a series of service design principles that the Commission believes should shape the future health system, including 'strengthening prevention and wellness.'[10]

The Commission recommends that these principles should inform the negotiation of the next health care agreements.[11]

The report also indicates that a key factor in determining the future framework of the health system is the 'changes and investments needed to enhance health promotion and wellness.'[12]

In responding to this issue appropriately the Commission has outlined twelve critical challenges which include 'investing in prevention' and 'redesigning care for those with chronic and complex conditions'.[13] As part of any investment in prevention the Commission considers that it will be important to build partnerships with various industry sectors and workplaces.[14]

The Commission recommends that in a future health system the Commonwealth could take sole responsibility for primary care which it defines to include "care in the community, primary medical care and community care".[15]

In our view the Commission's conclusions support the further consideration of workplace health screening and intervention as part of the primary health care system and Commonwealth Government investment to deliver and promote this.

3.2 The Benefits of Early Health Intervention

There are three primary reasons for the commitments that Australian governments have made to the use of early intervention to reduce chronic disease. These are the:

[10] Health and Hospitals Reform Commission, Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements, May 2008,p10
[11] Ibid
[12], p11
[13] Ibid,p13
[14] Ibid
[15] Ibid,p4

- Health of Australia's workforce;
- Economic cost of an unhealthy workforce; and
- Economic benefits of early intervention.

3.2.1 Australia's Workforce Health

The health of Australian workers can be considered in terms of chronic disease (long term conditions) and the risky behaviour that can contribute to chronic disease and other medical conditions requiring treatment or days away from work.

Classic chronic diseases include arthritis, asthma, diabetes, heart disease, stroke and vascular diseases and mental and behavioural problems. Some of these such as asthma and diabetes may not have a long term effect on a person's capacity to work or work effectively, but can be debilitating on their productivity over short periods.

Other conditions such as mental or behavioural problems may be devastating to a person's long term capacity to secure employment or be productive at work consistent with levels expected by employers.

Chronic Disease

The table below illustrates the latest national research by the Australian Bureau of Statistics (ABS), on the extent of chronic disease amongst the working age population and persons actually employed. [16]

Table 1: Rates of Chronic Disease Amongst Australian Workers

Category	Arthritis %	Asthma %	Diabetes %	Heart, stroke and vascular disease %	Mental and behavioural problems %
Working age population (18-64)	14.4	9.9	2.9	2.4	12.3
Persons employed	11	9.3	2.1	1.4	8.2

Of the total number of people in Australia with chronic disease 21.8% claim that their conditions are work related.[17]

Risky Behaviour

Lifestyle behaviour that contributes to chronic disease and other conditions includes smoking, high alcohol consumption, being sedentary or having low levels of exercise, being overweight/obese, consuming less than two serves of fruit and/or five serves of vegetables per day.

[16] National Health Survey 2004-05, Summary of Results: Paper No 4364, p16, 25
[17] Ibid, p30

In clinical terms a person's likelihood of developing a chronic disease increases with the number of risk behaviours they have. Research indicates that on average Australian's have four risk factors for chronic disease. [18]

The table below illustrates the extent of risk behaviours in the working population, and the relative incidence of these behaviours in people with chronic disease.[19]

Table 2: Risk Behaviour Amongst Australians of Working Age and Australians with Chronic Disease

Category	Current daily smoker %	High alcohol risk %	Sedentary/low exercise level %	Overweight /obese %	1 or less serves of fruit per day%	4 or less serves of vegetables per day %
Working age population (18-64)	24	14.6	69.4	49.5	48.3	86.3
Arthritis	17.9	13.1	75.1	57.1	40.6	82
Asthma	23.6	12.6	71.9	51.9	50.7	84.9
Diabetes	12.2	7.7	77.6	68.5	37.3	82.2
Heart, stroke and vascular disease	14.5	8.8	77.2	59.6	41.4	82.2
Mental and behavioural problems	31.8	15.2	76.2	48.7	52.6	87.3

The ABS survey illustrates a common pattern that chronic disease sufferers have low levels of exercise, are overweight and have poor diets.

The private health insurance industry has undertaken significant research to understand the relationship between risk factors for chronic disease and the impact on health insurance claims.

The graph below demonstrates that risk factors are more important than age in determining claims experience. Thus it is logical and sensible for health care policy to focus a great deal on reducing the population's risk profile.

[18] Health and Productivity Institute research results 2008
[19] National Health Survey 2004-05, Summary of Results: Paper No 4364, p16, 26

Graph 1: Relationship Between Chronic Disease Risk Factors and Private Health Insurance Claims Experience

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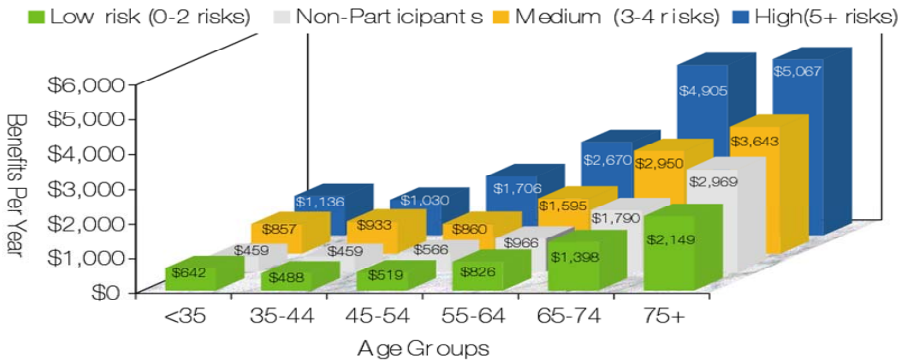
2005/06 AHM Research, Higher Risk = Higher Claims

- The number of risk factors is more important than age in determining claims experience



Source: AHM Senate Community Affairs submission (2006)

3.2.2 Economic Cost of an Unhealthy Workforce

Poor workforce health has a number of direct and indirect economic impacts. It:

- Increases health system costs.
- Increases workers compensation claims.
- Increases absenteeism.
- Reduces employee performance (productivity).

Health System Costs

In 2006/07 total health expenditure was $90 billion of which the Commonwealth Government spent $42 billion.[20] The Australian Treasury estimates that Commonwealth health funding in 2006/07 amounts to $1,858 per person and that based on the ageing of the population and all factors being equal, Commonwealth spending would rise to $6,458 per person by 2046/47. [21]

It is widely accepted that Commonwealth expenditure is mainly on pharmaceutical and medical services to treat the symptoms and/or effects of chronic disease and unhealthy lifestyles. [22]

[20] Rudd K and Roxon N, New Directions for Australian Health, Australian Labor Party, August 2007, p13
[21] Australian Treasury, Intergenerational Report 2007, April 2007
[22] Australian Institute of Health and Welfare (AIHW), Australia's Health 2003-04

It is estimated that a range of diseases and conditions that can be prevented or whose impact can be minimised through prevention strategies, represent a significant cost to the health system and economy generally. For example it is estimated that: [23]

- The annual financial cost of cardiovascular disease is $14.2 billion, which includes lost productivity.
- The total cost of obesity in 2005 was $21 billion, including lost productivity.
- The total cost of diabetes is about $21 billion, including lost productivity.

According to the Australian Health Management Group (AHMG), if the health care costs of people with low risk behaviour (estimated to be $377 per person) are used as a baseline, the health care costs of people with high risk behaviour (estimated to be $661 per person) represent excess costs to the health system worth 13.5% of total health expenditures. [24]

Workers Compensation Costs

In 2003/04 workers compensation insurers funded claims worth $1.1 billion.[25] As demonstrated by Table 1 there is a range of chronic diseases that may contribute to the national pool of workers compensation claims, particularly as 21.8% of people claim their conditions are work related. The high rates of risky but preventable behaviour amongst people of working age with chronic disease (as illustrated in Table 2) arguably contribute to the level of workers compensation claims.

An emerging trend that contributes significantly to workers compensation costs is stress, often underpinned by mental and behavioural problems. It is estimated that there were 8000 mental stress claims nationally in 2004 (up by 14% since 2001) and that this costs employers $200M annually.[26]

In the Commonwealth Government's Comcare scheme it is reported that in 2004 mental stress claims made up 5.9% of claims but 22% of costs with the average claim being $80,000.[27]

The high rates of mental and behavioural problems illustrated in Tables 1 and 2 provide a clue to why stress claims can be as high as reported. Another factor is the long term nature of such illnesses and their treatment.

[23] Access Economics, The Shifting Burden of Cardiovascular Disease in Australia 2005 and The Economic Costs of Obesity, October 2006
[24] Shirley Musich, Dan Hook, Tracey Barnett and Dee W Edington, 'The Association Between Health Risk Status and Health Care Costs Among the Membership On An Australian Health Plan' Health Promotional International, Oxford University Press, Vol 18 No 1 2003, p57
[25] Australian Institute of Health and Welfare
[26] National Workers Compensation Database and Medibank Private, The Health of Australia's Workforce, November 2005
[27] Business Review Weekly 25 January 2006

Absenteeism and Productivity

The ABS survey referred to in this submission recorded that in the two weeks prior to participating in the survey 8.2% of people of working age had days away from work/study and 10.9% had reduced productivity because of illness.[28]

Industry estimates are that Australians are absent from work an average 8.5 days per year. Of these absences 71% are estimated to be linked to physical or mental illness.[29] It is estimated that absenteeism resulting from sickness costs the national economy $2700 per employee per annum.[30]

The Federal Government recognizes that poor health is linked with low productivity because unhealthy workers tend to perform below their best at work.[31]

According to the AHMG:[32]

"Stress, obesity, smoking, depression, backache, heavy medication use, diabetes and dissatisfaction with life and job are all factors in making employees less productive.

"..workers with one to two ailments are about 6 per cent less productive, those with three to four are about 14 per cent less effective and the so called high risk employees with five or more illnesses are around 25 per cent less productive".

Both absenteeism and productivity have an impact on workforce participation rates. The Productivity Commission confirms that in its calculation workforce participation rates are lower for people with chronic disease and higher for healthy workers.[33]

Recent studies indicate that the productivity rates of Australian workers do not compare well to the rest of world and in fact have worsened between 2003 and 2005.[34] While there are various factors contributing to low productivity, the work of the Productivity Commission confirms that poor health and chronic disease is an important contributor.

The table below illustrates the average percentage of unproductive time spent by Australian workers compared to the rest of the world between 2003 and 2005.

[28] ABS, National Health Survey 2004-05, Summary of Results: Paper No 4364, p16
[29] Direct Health Solutions, National Health and Absence Survey, 2006.
[30] Ibid. Based on an average annual full time salary of $53,500.
[31] Rudd K and Roxon N, New Directions for Australian Health, Australian Labor Party, August 2007, p22
[32] Dan Hook, CEO of AMHG, quoted and referenced in the article' Cost-benefits of a flab-less workforce', Australian Financial Review Special Report, 23 February 2006, p12
[33] Productivity Commission, Effects of Health and Education on Labour Force Participation, Staff Working Paper, 2007 and Potential Benefits of the National Reform Agenda 2007
[34] Proudfoot Consulting 2007

Table 3: Unproductive Time Spent by Australian Workers Compared to the Rest of the World

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Average Percentage of Unproductive Time

	All 3 years	2003	2004	2005
Asia	41.6	37.8	46.4	39.0
Australia	32.3	24.9	32.1	39.0
France	30.8	27.0	32.0	37.0
Germany	35.8	38.7	37.6	31.9
Rest of Europe	27.6	23.4	31.6	35.7
South Africa	34.3	33.3	39.2	26.0
UK	36.6	39.9	37.5	31.5
USA	32.9	31.3	37.2	28.8
Whole Sample	33.9	32.5	37.9	30.2

Source: The Proudfoot Report 2007

Health industry research further demonstrates the view of the Productivity Commission that unhealthy workers perform poorly while at work.

The graph below indicates that workers who rank highly in terms of health and well being have the highest performance at work while those who are least healthy rank very poorly in terms of work performance. [35]

Graph 2: Relationship Between Worker Health and Work Performance

Unhealthy workers don't work much!

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Source: Medibank Private; 2006

[35] Medibank Private research 2006

3.2.3 Economic Benefits of Early Intervention

The economic benefits of early intervention rely on the notion that in many cases investing in preventative health programs is a more efficient allocation of resources than hospitalisation.

For example, in NSW the fact that emergency departments respond to incidents that can be dealt with in the general practitioner network is estimated to add $110M per annum to the cost of the health system. The comparable cost to the Medicare Benefits Scheme if those incidents were dealt with by GPs is $30M per year.[36] Thus allocating resources to support primary care through GPs has the potential to save $70M in NSW less the cost of the investment.

The allocative efficiency benefits of early intervention are proved by the outcomes of anti-smoking campaigns promoted by Australian governments. The investment in these campaigns is estimated to have reduced the smoking rate in the population to less than 20% and saved $12.3 billion in costs to the economy associated with the health effects of smoking. [37]

Even more recently, the Productivity Commission estimates that small investments in health prevention programs can either reduce the likelihood of chronic disease or reduce the impact of chronic disease on a person's capacity to work.

It suggests that health promotion programs can help to avoid 100 000 deaths resulting in 175 000 extra people in the workforce by 2030.[38] The Commission considers that adding this volume of additional workers represents about a 0.6 per cent increase in the workforce participation rate which is of significant assistance in addressing skill shortages in the economy.[39]

More specifically, over the last 30 years more than 600 international studies have been undertaken on the economic benefits of early intervention through workplace health programs alone.

The table below illustrates the results of some of these studies.[40]

Table 4: The Economic Benefits of Employer Based Health Programs

Productivity – 58 studies	▪ **53 show significant increases** ▪ 5 show no change
Absenteeism – 88 studies	▪ **84 show significant decreases** ▪ 4 show no change
Medical costs – 51 studies	▪ **47 show decreases by an average of $392** per person ▪ 4 show no change

[36] NSW Independent Pricing and Regulatory Tribunal, NSW Health: Focusing on Patient Care, August 2003
[37] Access Economics and AIHW as referenced in the Sydney Morning Herald, 2 March 2006,p11
[38] Productivity Commission, Potential Benefits of the National Reform Agenda 2007
[39] Ibid
[40] Good Health Solutions, 2006

Lifestyle change - 68 studies	▪ **66 show positive changes** ▪ 2 show no change
Industrial injuries – 34 studies	▪ **31 show lower number/cost of injuries** ▪ 3 show no change
Cost/Benefit – 29 studies	▪ **27 show net benefit averaging 2.92** ▪ 2 show no change

There are a range of individual examples that support the generic conclusions of these studies about the benefits of early intervention.

For example, health intervention and well being programs of 32 United States financial institutions is estimated to have delivered an average:[41]

- 27.8% reduction in workers compensation costs.
- 34.4% reduction in disability costs.
- 24.8% reduction in injuries.

Furthermore, a survey of 3600 Australian employees demonstrates that the healthiest employees in the sample survey are 3 times more productive than the least healthy.[42] The same survey concludes that employees with poor health take an average of 18 days sick leave annually compared to 2 days for healthy employees (a ratio of 9:1).

In addition, ANZ's health and wellbeing program has improved its rate of work time lost from employee poor health and injury by 23% over 2 years.[43]

[41] Good Health Solutions meta analysis
[42] Medibank Private, The Health of Australia's Workforce, November 2005
[43] ANZ, 2006

4. WHY WORKPLACE HEALTH PROGRAMS ARE INTEGRAL TO CHRONIC DISEASE PREVENTION

Workplace health programs are primary prevention tools because they make participants aware of the consequences of risky behaviour and underlying or latent symptoms that are indicators of the presence or potential, of chronic disease. With this knowledge participants have the capacity to make lifestyle changes necessary to minimise health risks at an early stage before they require hospitalisation or other health system treatment.

The number of published studies from around the world which document the benefits of worksite health programs has now risen to over 600.

Since the landmark publication of Roy Shepherd[44] in 1982, such luminaries as Kenneth Pelletier, Dee Edington and Larry Chapman have undertaken and published various "Meta-Analyses" which document the now irrefutable finding that investing in employee health delivers a solid rate of return (ROI).

A discussed, workplace health programs can produce a range of benefits such as:

- Decreased Illness/Absence
- Improved Productivity/Decreased Presenteeism
- Reduction in Occupational Injury/WorkCover Claims
- Attraction/Retention, Turnover

Based on these factors national and international studies demonstrate that the rate of return from investing in workplace health programs averages about 5:1. Studies also suggest that this ratio continues to improve as programs identify risk and intervene more effectively.

4.1 Cost/Benefit Data and Analysis

The accumulation of literature from around the world continues to affirm the integral relationship between employee wellbeing and key business metrics such as absence and productivity.

For instance, recent studies have shown that:

- Alcohol consumption by Australian employees amounts to an overall productivity loss of around 4% per employee.[45]
- Allergies and Hay fever cause a 7% drop in performance.[46]
- Inactivity can diminish productivity by 7%.[47]
- Smoking diminishes productivity by approximately 10%.[48]
- Stress/Anxiety/Depression average 13% in terms of the resultant performance deficit.[49]

[44] Shepherd, R, Medicine and Science in Sports and Exercise, 1982
[45] National Centre for Education and Training on Addiction 2006
[46] Current Medical Research and Opinion, Vol 22, No 6, 2006, p,1203-1210
[47] Chenworth et al, Governors Council, Michigan Fitness Foundation, 2003
[48] Burton et al, Journal of Occupational and Environmental Medicine, Vol 41, 1999, p,863-877
[49] Ibid

- Obesity results in an average work impairment of around 14%.[50]
- Neck and Back Pain result in a 20% productivity drop.[51]
- Lack of sleep impairs work performance by up to 30%.[52]
- Headaches/Migraines can diminish performance by up to 41%.[53]

The AHM study referred to in this submission shows that the work impairment for those with 0-2 risk factors is 14.5%. At 3-4 risks this rises to 23.7% and at 5 or more risks to 32.7%.

As the majority of Australian workers suffer at least 4-5 of these conditions,[54] there is little doubt that a health promotion program which helps employees to identify, prevent and/or manage them will produce positive outcomes for employers, the health system, and the economy, especially in terms of reduced health incidents and improved workforce productivity.

The information below contains a representative sample of the Australian and International literature which documents the benefits which accompany an investment in the health of employees.[55]

Australian Data

Over the past few years evidence from Medibank Private, Australian Health Management and workplace health program providers such as Good Health Solutions has demonstrated that:

- High risk employees (5+ Risks) are at work but not productive 32.7% of the time compared to low risk employees (0-2 Risks) who are not productive 14.5% of the time. The productivity difference between healthy and unhealthy employees is therefore 18.2% or 45 days per annum.[56]

- High risk employees average 5.1 hours/month absence versus 2.4 hours/month for low risk employees. This amounts to 32.4 hours (over 4 days) days per annum.[57]

- Healthy employees average 1-2 sick days per annum versus 18 days for those in the lowest health and well-being category.[58]

- The unhealthiest employees are productive for only about 49 hours out of each month compared to around 140 hours/month for the most healthy.[59]

[50] Ibid
[51] Allen et al, Journal of Occupational and Environmental Medicine, 2005
[52] Sarkis K, Occupational Hazards, May 2000
[53] Vo Korff M, et al, Neurology, 50:1741-1745, 1998
[54] Health and Productivity Institute of Australia research.
[55] It should be noted that US literature will often have medical cost reduction included in their ROI arising from employee health benefit schemes provided by employers. These cost reductions are not directly relevant to the Australian context.
[56] Musich S, et al, AJHP, 20(5): 353-363, 2006
[57] Ibid
[58] Medibank Private/Vie Life Report, 2007
[59] Ibid

- Poor health can account for an average 5% loss in productivity across the entire Australian workforce with the unhealthiest group reporting a 13% drop in productivity. About half this is related to chronic conditions such as headaches, hay fever and neck/back pain, whilst half can be accounted for by lifestyle factors such as inactivity, smoking, obesity etc.[60]

The conclusion from this research is that unhealthy employees represent an unmanaged risk to their employers, the health system and the economy. The literature is quite definitive that this risk can be mitigated to the financial advantage of all three sectors through early identification via workplace screening and subsequent preventative intervention.

In the example below, a starting group of 100 employees participate in a workplace health program resulting in a net movement of 12 people into the low risk group from the medium and high risk groups.

As these people now have higher assumed productivity levels, there is a net gain of 2,928 hours of productive time per annum compared to their pre-intervention values.

At an assumed wage of $60Kpa and program costs of $150pppa, the net saving is $87K for a $15K investment giving an ROI of 5.86 to 1 – similar to results achieved in many national and international programs.

Table 5: Example of Rate of Return Ratio for a Workplace Health Program

Starting Cohort (100 Employees)				
	Low Risk	**Med Risk**	**High Risk**	**Total**
	(0-2)	(3-4)	(5+)	
Before intervention (# of employees)	50	30	20	100
After Intervention (# of employees)	62	22	16	100
Productive hours per year/person	1,710	1,526	1,346	4,582
Productive hours before intervention	85,500	45,780	26,920	158,200
Productive hours after intervention	106,020	33,572	21,536	161,128
Difference (hrs/yr)	**20,520**	**-12,208**	**-5,384**	**2,928**
Assumed average annual wage ($)	$ 60,000.00			
Hourly rate	$ 30.00			
Value of Benefit	**$ 87,840.00**	(2,928 hours at $30/hr)		
Cost of Program at $150 pppa	**$ 15,000.00**			
Cost:Benefit Ratio	**5.86 to 1**			

[60] Lang J, Good Health Solutions, Absence and Productivity Survey, IHPM Conference, 2007

International Data

In Larry Chapman's 2007 update on the cost/benefit ratio's obtained from employee health promotion programs, 60 studies were reviewed involving over half a million employees totalling 226 years of observation.[61] The average cost benefit ratio was found to be 1:5.81. Importantly, all of the anticipated factors (smoking, inactivity, weight, stress etc.) contributed to the result. Table 6 illustrates the results of the Chapman analysis.

Table 6: 2007 Analysis of Cost Benefit Ratio of Workplace Health Screening and Intervention in 60 Studies Covering 500 000 Employees

Study Parameter	**Average and Totals (N=60)**
Average study duration (years)	3.77
Years of Observation	226.3
Number of Subjects	552,339
Number of Control Subjects	200,259
Average number of Health Risks Targeted	5.1
Change in Sick Leave	-25.3%
Change in Health Care Costs	-26.5%
Change in Workers Comp Costs	-40.7%
Change in Disability Management Costs	-24.2%
C/B Ratio	**5.81 to 1**

Reviews performed by Pelletier, Shepherd and Chapman have yielded similar results. The reviews, spanning over 600 articles and almost three decades, testify to the advantages of investing in early intervention programs, particularly through the workplace.[62]

A range of case studies are included in Appendix A.

Factors Affecting ROI

One of the most critical elements impacting program ROI is the participation rate.

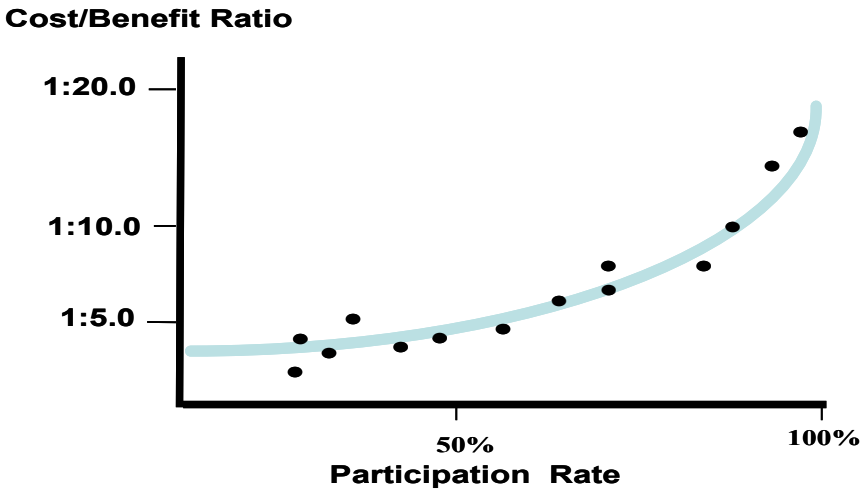
One might expect that the relationship between participation and ROI is linear, but due to the fact that the least healthy employees are also the least likely to attend/participate in workplace health programs, increasing participation rates draws more higher risk people into the program.

It is these people that generate the best ROI if their risks are managed effectively.

Graph 3 illustrates this result.

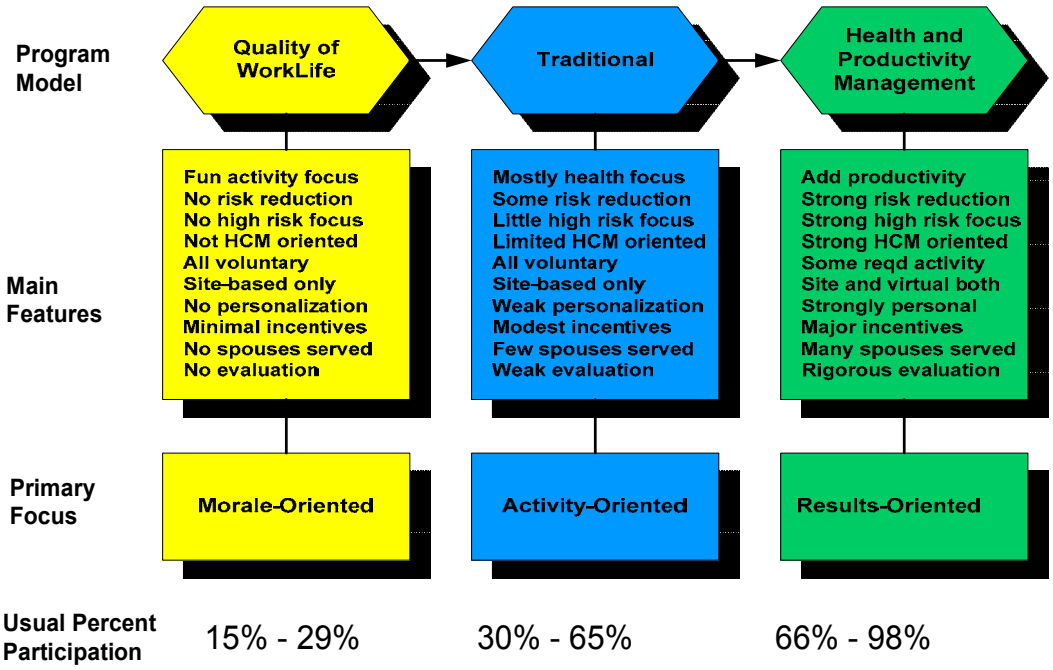
[61] Chapman L, Proof Positive: An Analysis of the Cost-Effectiveness of Worksite Wellness, Sixth Ed, 2007
[62] Pelletier, American Journal of Health Promotion, Vol 5(4), pp 311-315, 1991; Vol 8(1), pp 50-56,1993, Vol 10(5), pp 380 -388, 1996; Vol 13(6), pp 333-345, 1999; Vol 10(2), pp 107-116, 2001 and Chapman L, American Journal of Health Promotion, July-August, pp 1-14, 2005.

Graph 3: Cost Benefit Ratio Relationship To Participation in Workplace Health Programs[63]



The increasing use of an economic and financial results-oriented framework has underpinned the improved outcomes delivered by workplace health programs.

The graphic below demonstrates how workplace health programs can embrace a strong Human Capital Management (HCM) framework which is highly personalised, more results oriented, has higher participation and more robust evaluation criteria.



[63] Chapman, L., Proof Positive: An Analysis of the Cost-Effectiveness of Worksite Wellness, Summex Health Management, Sixth Edition, 2006.

5. HOW CAN GOVERNMENT PROMOTE WORKPLACE HEALTH PROGRAMS?

There are various ways the Commonwealth Government can support and promote the use of workplace health screening and intervention as part of the primary care network.

We have focused the discussion below on the options for the Commonwealth Government support because the NHHRC has recommended that the Commonwealth Government should be responsible for primary care.

The fundamental purpose of government support for workplace health programs should be to increase the take up and use of health screening and intervention by employers and employees. This is particularly where the Government considers that the cost of such support is worth the benefits to the health system and economy as demonstrated by available research.

We consider that the underlying principle guiding the form and substance of any support should be that government, employers and private health insurance providers should all contribute to the cost of workplace health programs.

This is because all these parties benefit from health improvement through the workplace, whether those benefits are in the form of more productive workers or lower health system costs. Therefore all these parties should have 'skin in the game' when it comes to funding prevention.

Where one of these parties assumes the whole or major responsibility for prevention through the workplace, it increases the risk that other parties will not have the incentives to contribute to prevention outcomes over the long term. This can serve to undermine the effectiveness and take up of workplace health programs.

We have discussed below some of the options for government to act to increase the take up of workplace health programs. They are:

- Subsidies delivered through Medicare, funding under the next Health Care Agreement, or direct grants to employers for health screening and interventions; and/or
- Changes to the *Fringe Benefits Tax Assessment Act* and *Income Tax Assessment Act* to provide clear incentives for employers to offer health screening and interventions; and/or
- Changes to the Private Health Insurance Act 2007 and *Private Health Insurance (Business Insurance) Rules 2007* to enable employers and private health insurance firms to provide health screening; and/or
- Benchmarking chronic disease risks by establishing a National Health Prevention body and Well Being Index.

It is recommended that the NHHRC consider all of these options when preparing its advice to government on the future design of the Australian health care system.

Option 1 – Commonwealth Government Subsidies

There are three obvious ways that the Commonwealth Government could provide subsidies for workplace health programs to increase their take up and use. These are:

- Payments through the Medicare system
- Funding through the next Health Care Agreements
- Direct subsidies to employers

5.1 Medicare Payments

5.1.1 Current Legislation Does Not Support Workplace Health Programs

The *Health Insurance Act 1973* (HIA) defines and governs the payment of Medicare Benefits and the services that are covered under this benefit scheme.

Under the HIA Medicare Benefits are only payable for professional services performed by medical practitioners, dentists, optometrists and pathology and diagnostic services undertaken on behalf of a medical practitioner.

Section 19 of the HIA indicates that unless the Minister directs otherwise, Medicare Benefits are not payable for:

- Professional services provided to a person where the cost is incurred by the employer of that person;
- Professional services provided to a person employed in an industrial undertaking for a purpose related to that undertaking;
- Professional services provided to conduct mass immunization; and
- Professional services provided in respect of a health screening that is not reasonably required to manage a medical condition of a patient.

Under the Act, the Minister has the discretion to direct Medicare Benefits to be paid in relation to workplace health programs. This avoids the need for legislative amendments.

5.1.2 How Could This Option Work?

Under this approach, eligible providers of workplace health programs would have to be provided with a Medicare Provider Number.

Eligibility for an MPN would need to be determined according to strict accreditation and quality assurance criteria developed by government and the industry. Employers wishing to outsource the design, delivery and/or management of their workplace health programs would have to ensure the providers they use have an MPN.

The proposed **key features** of such a system are as follows:

- The Government would need to determine the level of Medicare rebate payable in relation to a person who participates in a workplace health program and is entitled to Medicare.

- Employers would need to be liable for the cost of the workplace heath program not covered by a Medicare rebate.

- Providers of workplace health programs would need to collect the Medicare numbers of employees participating in such programs like General Practitioners do now.

- Providers of workplace health programs would need to invoice the employer for the employer's share of the cost of a program and seek a Medicare rebate for the Government's share of the cost.

- Employers would be liable for the full cost of the workplace health program for employees who are not entitled to Medicare.

The **advantages** of promoting workplace health programs through the Medicare system include:

- Enabling the Government to keep track of the health improvement and management programs a person may access over time, and the impact this has on their use of the health system.

- Supporting policy that seeks to link funding more directly to the care of patients as they journey through the health system.

- Giving people more control and choice about when, where and how they wish to address their health needs.

- Giving people more access to and increasing awareness about the benefits of prevention and early intervention. This can decrease the cost of other primary and acute care services.

The **disadvantages** of using the Medicare system for workplace health programs largely relate to the potential cost to Government, particularly where funding is use based and open ended.

5.1.3 Ways to Limit the Cost

Having regard to fiscal policy the Government may wish to limit the cost of a Medicare rebate scheme applying to workplace health programs. There are various ways it could accomplish this. These include:

- Confining the rebate to employees over a certain age. For example, the previous Commonwealth Government limited its Medicare funding of GP performed wellness checks to identify diabetes and other chronic disease to persons 45-49 years of age. In relation to workplace health programs the Government could retain this age threshold or set it lower to obtain a balance between the need to identify the health risks of employees at an earlier stage and the fact that the population is ageing.

- Confining the rebate to health risk assessments (screening) only or actual interventions only. The Government's decision about this would need to be influenced by the relative benefits to the health system and economy of risk assessments and interventions.

- Protocols and rules to avoid duplication of cost. For example the Government would want to manage against situations where an employee received a subsidised health risk assessment or the same intervention within one year or any other time period defined as appropriate. The risk of this occurs where an employee moves from one employment situation to another that both offer workplace health programs or takes the opportunity to have a health assessment and/or intervention through their work and GP.

- Use of health professionals other than GP's. The prevention, early detection and management of lifestyle related risks can be performed extremely well by qualified exercise physiologists and nutritionists. In fact the majority of preventive programs operating in the Australian corporate sector are delivered by these specialists with great success. These professionals are significantly cheaper than GPs and often more focused on prevention and lifestyle. In fact they should be considered part of the "front line" in the preventative focus of the Australian Health Care system.

5.2 Health Care Agreement Funding

The Health Care Agreements have traditionally been confined to allocating Commonwealth funding to State governments for the operation of hospitals and related medical services. The Federal Government has indicated publicly that it wants the next Agreement to also support spending on prevention programs to reduce avoidable hospitalisations.

5.2.1 How Could this Option Work?

This option envisages specific funding for workplace health programs through the future Health Care Agreements. The **features** of this approach are as follows.

- The Commonwealth Government could define a take up target for workplace health programs across the economy and the subsidies necessary to achieve this target.

- The target could include the number of employees the Government wants to undertake health screening and/or interventions through the workplace and the time period in which it wants to achieve the target. For example, industry data demonstrates that currently only about 400 000 employees participate in health screening and intervention programs out of a working population of about 10 million.

- To enable workplace program providers and employers to respond to a target the Government may need to stage the delivery of any targets it wants to set and the provision of related subsidies. Staging targets would also assist to identify and manage costs over the term of the Health Care Agreement.

- The Commonwealth could deliver subsidies to the market through State based health prevention programs. The Commonwealth may need to identify benchmarks to govern the need for and outcomes of funding used by State Governments.

The table below illustrates this approach in more detail for health screening only.

Stage	Years of Health Care Agreement	Target Number of Employees[64]	Average cost of Health Risk Assessment Per Employee[65]	Total Estimated Cost to Commonwealth Government
1	1-2	1.5 million	$100	$ 150 million
2	2-4	3 million	$104	$ 312 million
3	4-5	5.5 million	$108	$ 594 million
Total	**5**	**10 million**		**$ 1056 million**

The **advantages** of this approach are that:

- The Commonwealth can use it to influence and motivate State based health improvement programs which assist to deliver the Commonwealth's broader agenda with respect to reducing avoidable hospitalisations and re-admissions.

Possible **problems** with this approach include the following:

- Including funding of this kind in a fixed term Agreement reduces the flexibility of the Commonwealth to respond quickly to policy and market dynamics affecting workplace health programs and prevention generally.
- The Commonwealth would have to set benchmarks to govern how State Governments distributed funding for workplace programs in their markets.
- Delivery to the market through State Governments may reduce the connection between the targets the Commonwealth wants to achieve and actual outcomes. It may also add administration costs.
- It may be difficult for the Commonwealth Government to ensure that the funding is accessible to all employers.
- It may be difficult to avoid duplication in the use of workplace health programs by employees, particularly in relation to employers who transcend state borders.
- It may be difficult to link the use of funding to support continuous patient management and care.
- The approach is not consistent with the NHHRC recommendation that the Commonwealth Government should take sole responsibility for primary care.

[64] This assumes that each employee has one government funded health screening and assessment within the 5 year term of the Agreement.
[65] This cost is based on current industry averages. It assumes a 4 per cent inflation rate at each stage of the health screening program during the term of the Agreement.

5.3 Direct Subsidies to Employers

5.3.1 How Could This Option Work?

This is the approach adopted by the Victorian Government under its WorkSafe Initiative.

The **features** of this option include:

- The Commonwealth Government could define a take up target for workplace health programs across the economy and the subsidies necessary to achieve this target. The target could include the number of employees it wants to undertake health screening and/or interventions through the workplace and the time period in which it wants to achieve the target.

- The Commonwealth Government could provide different levels of funding for large, medium and small employers similar to the approach taken by the Victorian Government.

- Employers across the economy would need to apply for Commonwealth subsidies for their workplace health programs.

- To be eligible for Commonwealth funding, employers proposed workplace health programs and/or the providers engaged to deliver such programs would need to be accredited by the government or relevant industry bodies like HAPIA.

The **advantages** of this approach are as follows.

- It is consistent with the NHHRC recommendation that the Commonwealth Government could take sole responsibility for primary care.

- The Commonwealth Government has direct regulatory control over how its subsidies are used to promote the take up of workplace health programs.

- The Commonwealth Government has direct access to the data accumulated through workplace health programs to assist with the design of continuous patient centered chronic disease prevention and care.

- A direct relationship between one layer of government (the Commonwealth) and the market increases the opportunities for innovative and continuously improving market responses that assist the cost-effectiveness of the subsidies for workplace health programs.

- It has been examined and deployed already in one State and can therefore be leveraged Australia wide more easily that Option 2.

The **disadvantages** of this approach include the following:

- Where the direct subsidy is too high it may reduce the long term commitment of employers and private health insurers to contribute to the cost of health prevention.

- It may be difficult to sustain equitable subsidies for small, medium and large employers to the extent necessary to make a real difference to chronic disease prevention through the workplace.

Option 2 – Tax Incentives for Employers

The Commonwealth Government could clarify a range of existing tax measures to provide definite incentives for employers to implement workplace health programs. These are chiefly in relation to the operation of:

- Fringe Benefits Tax Exemptions
- Tax Deductibility

Currently employers and workplace health program providers are required to seek private rulings from the Commissioner of Taxation to ascertain whether fringe benefits tax exemptions and tax deductibility apply to workplace health programs in any particular case. This hinders market activity and the take up of workplace health programs. It all creates business uncertainty because private rulings can usually be withdrawn at any time.

It would be more effective for the relevant legislation to clearly provide that workplace health programs are exempt from fringe benefits tax, are tax deductible and GST free.

Requirements that workplace health programs must be controlled by medical practitioners in order to qualify for fringe benefits tax exemptions creates barriers to entry that restrict competition and therefore reduce the capacity of employers to take up and providers to offer and deliver workplace health programs. This approach also increases they cost of such programs and often diminished their preventative focus. Quality assurance issues can be satisfied through alternative regulatory means.

5.4 Fringe Benefits Tax Changes

The provision of workplace health programs to identify and prevent chronic disease involves services in the following key categories:

- Health consultancy services – defining a workplace health program
- Health risk assessments – screening
- Targeted health interventions
- General health interventions – workplace counseling

The *Fringe Benefits Tax Assessment Act (FBTAA) 1987* deals with all of these categories in different ways and therefore there is scope for Government to legislate to ensure a consistent approach that serves to promote health prevention to tackle general and/or specific chronic disease through the workplace.

5.4.1 Health Consultancy Services

Health consultancy services are generally those services that an employer seeks to guide the development, objectives, options and shape of a workplace program suitable for its employees and workplace.

There is uncertainty about whether health consultancy services are an exempt benefit under the FBTAA.

On one construction these services may be a fringe benefit within the definition of section 136 of the FBTAA as they could be considered a 'benefit provided to an employee or an associate of an employee'.

On the other hand if health consultancy services are considered as general services provided to an employer as a preliminary step towards a more tailored workplace health program for an employer they may not be a fringe benefit.

The Federal Court has determined that to fall within the definition of fringe benefit in the FBTAA, a benefit must be provided to a particular employee who is identifiable.[66] On the basis of the Federal Court's interpretation the provision of general health consultancy services is not a fringe benefit.

Following the Federal Court decision the Commissioner of Taxation withdrew Tax Ruling TR 1999/5 which had a contrary view that a benefit was a fringe benefit even where it was not provided to a particular person.

Nevertheless uncertainty surrounds this issue which is fundamental to the provision of workplace health programs and legislative clarification would be useful.

5.4.2 Health Risk Assessments

Health risk assessments are primarily the evaluation of an employee's risk status in areas such as weight/height (BMI), nutrition, blood pressure, cholesterol, smoking, inactivity, stress/depression, blood glucose and alcohol consumption. These assessments can be delivered online, paper based or as a face to face service at the workplace.

In relation to health risk assessments the FBTAA indicates that "work related medical screening" is an exempt benefit if it:

- Involves an examination that is wholly or principally for the purpose of ascertaining an employee's risk of work related trauma.
- Involves an examination carried out by, or on behalf of, an audiometrist or a legally qualified medical practitioner, nurse, dentist or optometrist; and
- Is available to all employees who are at risk of developing a particular work related trauma in similar employment.

Work Related Trauma

Section 136 of the FBTAA defines 'work related trauma' as injuries and conditions that must relate to the employment of the employee.

It is debatable whether this definition is broad enough to include health risk assessments that seek to identify an employer's general chronic disease risk as part of a primary care

[66] Commissioner of Taxation v Indooroopilly Children's Services (Qld) Pty Ltd 2007 FCAFC 16

health initiative. This is particularly where the assessment is not linked to injuries or illness an employee may experience because of work.

One view may be that because the factors examined in general health risk assessments include pathology such as cholesterol levels, cardiovascular risks, weight and nutrition, a general assessment can be viewed as affecting and being affected by an employee's work. Accordingly health risk assessments may fall within the definition of medical screening for the purposes of ascertaining work related trauma.

On the other hand the notion of work related trauma may be viewed as applying only to injuries and conditions that are generated or accelerated by work. In this case the legislation can be interpreted more narrowly as mandating that the purpose of medical screening is to only identify trauma caused by work. This means that health risk assessments aimed at identifying an employee's general chronic disease risk, rather than specific risk of work related trauma would not be an exempt benefit.

As the FBTAA and rulings by the tax Commissioner are silent on this issue, there is scope to clarify the legislation to define the purpose of medical screening more broadly to promote health prevention even if there is no connection to 'work related trauma'. This would be necessary to promote the take up of workplace health programs.

Persons Carrying Out Work Related Medical Screening

Section 136 of the FBTAA requires that a work related medical screening is only an exempt benefit if it is conducted by or on behalf of an audiometrist or a legally qualified medical practitioner, nurse, dentist or optometrist.

This requirement creates barriers to entry for other allied health professionals such as dieticians, physiotherapists, and exercise physiologists in conducting health screening in the workplace, unless they are acting on behalf of the kinds of professionals indicated in s.136.

While the legislation itself does not define the meaning of 'acting on behalf of' the Commissioner of Taxation considers that the "relationship need not be formal as in principal and agent of master and servant". However the relationship must be one where "one party acts in place of or for the benefit of the other". [67]

On one hand it is a public good that medical screening can only be conducted by qualified professionals. The restriction supports quality assurance and the standards that should be demanded in relation to health advice.

Equally however, the restriction can serve to unnecessarily drive up the cost of health risk assessments for employees. In the current marketplace there are a range of allied health professionals able to perform basic health assessments to provide employees with information on their weight, lifestyle, nutrition, related risks of chronic disease and options to mitigate these risks.

[67] Commissioner of Taxation, Private Biding Ruling Number 27571

Permitting these professionals to be able to compete on equal footing in the market may not of itself compromise the expected standard of health (as distinct from medical) advice required in the delivery of health risk assessments. This may particularly be the case where government and industry bodies such as HAPIA agree on accreditation and quality assurance standards governing health risks assessments.

Reducing the barriers to entry to increase competition in the market for health risk assessments, without compromising standards, may make such assessments available to more employers and their employees and therefore increase the take up of workplace health programs without the need for Government subsidies. It may also be reasonably argued that such professionals are better equipped from a preventive standpoint as most of their training, expertise and skill revolves around lifestyle related issues rather than diagnostic and curative medicine as is the case with GP's.

5.4.3 Targeted Health Interventions

Targeted health interventions include exercise, diet, smoking, stress and lifestyle modification programs aimed at reducing the chronic disease risks of a particular employee. Such programs are usually deployed in relation to employees with a moderate to high risk of chronic disease identified through a health risk assessment.

Under s.136 of the FBTAA "work related preventative healthcare" is an exempt benefit if it:

- Involves healthcare for the whole or principal purpose of preventing an employee from suffering from an injury or illness related to the employee's employment;
- Involves healthcare carried out by or on behalf of a legally qualified medical practitioner, nurse, dentist or optometrist; and
- Is available to all employees who are at risk of developing a particular work related trauma.

These requirements raise similar issues to those discussed in relation to 'work related medical screening' chiefly:

- The definition of the purpose of preventative healthcare is not broad enough to capture workplace health programs that are related to an employee's general chronic disease risk, but not related to injuries or illness that an employee may experience because of their workplace.

- The requirement that preventative healthcare must be conducted by or on behalf of a legally qualified medical practitioner, nurse, dentist or optometrist may create barriers to entry that are not needed to maintain standards of health advice, particularly where such advice is provided by other qualified allied health professionals within quality assured systems.

Similarly to the discussion in relation to health risks assessments there is scope for the FBTAA to be amended to broaden definitions that reflect the modern importance and potential of the workplace in preventing chronic disease generally.

5.4.4 General Health Interventions

General health interventions include general education and information services and products provided to employees to assist their understanding and awareness of chronic disease risks.

This may include seminars, telephone counselling, and on-line counselling and information services.

Section 136 of the FBTAA provides that general intervention services will be an exempt benefit where they are a form of "work related counselling". The FBT exemption applies if:

- There is a counselling session offered;
- The counselling is attended by an employee;
- The counselling is directed towards improving/maintaining the employee in the context of their employment duties or for the purpose of preparing the employee for his/her retirement; and
- The counselling is not provided wholly or principally as a reward for the employee's employment services.

The FBTAA defines counselling as "the giving of advice or information in a seminar".

This of itself may exclude non-group or technological means to deliver information or advice, such as telephone or on-line counselling.

There is no guidance in the FBTAA or rulings by the Commissioner of Taxation about whether counselling can include modern non- group based activities that employer use to disseminate information to their employees.

Accordingly this is another area where there is scope for the legislation to be amended to ensure that it clearly supports promotion of preventative health programs to identify and tackle chronic disease through the workplace.

5.5 Tax Deductibility

To encourage employers to deploy workplace health programs as part of the primary care network, the Commonwealth Government will need to consider whether it should enable employers to claim tax deductions for the cost of workplace health programs where programs benefit employee health but do not assist the profitability of the employer's business (although we have presented copious data that improved employee health provides a demonstrable benefit to business through illness, absence and productivity improvements).

Currently a business expense is an allowable expense for the purposes of a tax deduction if:

- The expense is actually incurred;
- The expense satisfies the requirements under section 8-1 of the Income Tax Assessment Act 1997 (ITAA); and
- The taxpayer satisfies the substantiation rules where applicable.

Whether an expense has been incurred and the taxpayer can satisfy the substantiation rules are questions of fact to be determined on a case by case basis.

Satisfying the requirements of section 8-1 of ITAA depends on a range of matters. The section states that:

(1) You can deduct for your assessable income any loss or outgoing to the extent that:

(a) It is incurred in gaining or producing your assessable income; or
(b) It is necessarily incurred in carrying on a business for the purpose of gaining or producing your assessable income.

(2) However, you cannot deduct a loss or outgoing under this section to the extent that:

(a) It is a loss or outgoing of capital, or of a capital nature;
(b) It is a loss of a private or domestic nature;
(c) It is incurred or produced in relation to gaining or producing your exempt income; and
(d) A provision of this Act prevents you from deducting it.

Given these provisions, for a workplace health program to be a tax deductible item it must be:

- Directly related to generating an Employer's business revenue or necessary to the successful operation of a successful business;
- An expense that follows the advantage of incurring the expense; or
- An expense for the purpose of improving the profitability of the Employer's business.

This suite of requirements means that there is no tax incentive to invest in workplace health programs for employers where doing so has no direct revenue or profit benefit. Many small to medium businesses will be in this situation.

To alleviate this issue and promote the take up of workplace health programs for all employers, there would be merit in reviewing the operation of section 8-1 of the ITAA in relation to health prevention through the workplace.

Options to ensure that tax incentives operate to generate a widespread and increased market take up of workplace health programs include amending the ITAA provisions to include special treatment for such programs or the allocation of tax rebates for employers who choose such programs.

Option 3 – Changes to Private Health Insurance Rules to Promote Health Screening

Private health insurance is governed by the *Private Health Insurance Act 2007* (PHIA) and Private Health Insurance (Health Insurance Business) Rules 2007.

In his speech to introduce the 2nd reading of the Private Health Insurance 2007 Bill in Parliament on 7 December 2006, Tony Abbott, the former Minister for Health and Ageing, said:

"Broader health cover will also allow health insurers to work with a wide range of service providers to develop more flexible and innovative products that reflect modern clinical practice and consumer expectations. Health insurers will be able to better assist consumers to manage and prevent acute and chronic conditions. ***Many people can benefit from tailored programs that support and sustain healthy lifestyles, services such as personalised health checks, dietary guidance, exercise supervision, and support to quit smoking."***

However in direct contradiction to the Minister's statement, the PHIA and accompanying Rules, specifically exclude any screening programs designed to detect early health and chronic disease risks.

To alleviate this contradiction and maximise the market opportunities for preventative health through the workplace, the Commonwealth Government could amend the PHIA and accompanying Rules to include health screening at the workplace.

5.6 How the Current Legislation Works Against Health Screening in Workplaces

The PHIA governs the provision of private health insurance products, the conduct of private health insurance business and incentives for people to take out private health insurance, such as allowable discounts on insurance policy premiums for people over 65.

5.6.1 Community Rating

Under division 55 of the Act private health insurers must provide insurance products that are community rated. This means they must not discriminate against people when determining to provide insurance cover on grounds of their health or any other matter.

5.6.2 General Treatment and Hospital Substitute Treatment

Section 121.10 of the Act defines the meaning of general treatment to be goods and services that are:

- Not intended to manage or prevent a disease, injury or condition; and
- Not hospital treatment.

Under section 69.10 of the Act private health insurance can be provided for hospital substitute treatment, meaning general treatment that:

- Substitutes for an episode of hospital treatment; and
- Is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
- Is not excluded by the Private Health Insurance (Complying Product) Rules.

5.6.3 Employee Benefit Schemes

Section 121.15 of the Act permits private health insurance to be delivered through employee benefit schemes. The Act stipulates that an arrangement is an employee benefit scheme if:

- The arrangement provides for an employer to arrange payment in respect of the whole or part of the fees and charges that an employee of, or a person providing services to, the employer incurred in relation to hospital treatment or general treatment.

An arrangement of this kind:

- Can include the business of undertaking liability by way of insurance;
- Can be a minor or incidental part of the employer's business;
- Does not require the employee, or person providing services, to pay any contributions;
- Does not require the employee, or person providing services, to pay contributions that reflect the value of the benefits that the employer is providing under the arrangement;
- Can provide for the employer to make payments in relation to hospital treatment, or general treatment, provided to a person other than the employee or person providing services; or
- Can confer on the employer or another person the discretion whether to make payments.

However, an arrangement:

(a) Is not an employee health benefits scheme merely because, under the arrangement, the employer will pay, or will reimburse employees, or persons providing services, for payment of, one or both of the following:

(i) the premiums payable by them for complying health insurance policies;

(ii) the difference between benefits payable to them under policies, and amounts that they are liable to pay, for health services provided to them or members of their families; and

(b) Is not an employee health benefits scheme if the Private Health Insurance (Health Insurance Business) Rules provide that:

(i) it is not an employee health benefits scheme; or

(ii) arrangements of a class in which it is included are not employee health benefits schemes.

5.6.4 Private Health Insurance (Health Insurance Business) Rules 2007

These rules are made under the PHIA and further define the kinds of treatments included and excluded from private health insurance cover.

It specifically excludes health screening to identify chronic disease from the definitions of general and hospital treatment in the PHIA.

Section 8 of the Rules indicates that the PHIA does not cover preventive chronic disease management programs for people with identified multiple risk factors undertaken as part of hospital treatment. This is because hospital treatment is defined as that "intended to manage a disease, injury or condition and does not cover prevention". [68]

Section 11 of the Rules indicates that general treatment under the Act can include a chronic disease management or health management program if the programs have been approved by a private health insurer.

Section 11(2) defines a health management program as a program that is intended to ameliorate a person's specific health condition or conditions. This implies that to fall within the meaning intended by the Act, a health management program must relate to a diagnosed condition.

The Private Health Insurance Information Circular 78-06 provided by the Department of Health and Ageing on 15 December 2006 (after the 2nd reading of the Bill) for comment by industry affirmed this interpretation by defining general treatment as treatment:

- to reduce complications in people with (pre-diagnosed) chronic disease; and
- to prevent or delay the onset of chronic disease for people with (pre-determined) multiple risk factors.

Accordingly, it indicates that "CDMPs *[chronic disease management plans]* do not include the diagnosis of chronic disease or the identification of risk factors. These activities are separate to the CDMP, in much the same way that diagnosis of a condition precedes the decision about treatment and, for example with elective surgery the timing of admission to hospital for treatment."

Section 12 of the Rules defines chronic disease management programs to mean a program intended to either:

- Reduce complications in a person with a diagnosed chronic disease; or
- Prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

In relation to programs to prevent or delay the onset of chronic disease, section 12 indicates that these programs can only be general, not hospital treatment. [69]

Section 12 defines chronic disease to include a "disease that has been or is likely to be, present for at least 6 months, including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis and a musculoskeletal condition".

[68] See Note to section 8(d)
[69] See Note to section 12(1)(a)(ii)

The section also defines that risk factors for chronic disease include, but are not limited to:

- Lifestyle factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and
- Biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and
- Family history of a chronic disease.

The section indicates that chronic disease management plans for the purposes of the Act can be prepared and implemented by allied health professionals who are eligible to claim a Medicare rebate for the service they have provided. These include diabetes educators, dieticians, and exercise physiologists. [70]

Accordingly, if the Commonwealth Government amended the PHIA and accompanying Rules to include health screening and assessment, the current Act supports these programs being conducted by a range of professionals. This would promote competition and reduce the cost of such programs within an accreditation and quality assurance program.

Option 4 – Benchmarking Chronic Disease Risks

5.7 National Health Prevention Body and Well Being Index

Option 4 can be pursued in conjunction with options 1, 2 or 3, or as a stand alone approach.

Currently health prevention programs are pursued separately by Commonwealth and State governments. Co-ordination can occur through the COAG process but is usually confined to outcomes that governments can agree upon within their respective funding, policy and resourcing priorities. Government action is also often constrained by a lack of consistent and regular measuring, analysis and reporting of population health risks beyond particular chronic disease that capture the immediate attention of health policy makers and providers.

At the same time workplace health providers, the medical profession, research organisations, like the Australian Institute for Health and Welfare, and other interested groups measure health risks for their particular purposes in different ways.

Measuring health risks in a consistent manner across the nation to inform policy and market responses is a fundamental step in tackling chronic disease in an effective and co-ordinated manner.

To achieve this it is proposed that the Commonwealth Government consider establishing a **National Health Prevention body** tasked with developing a consistent national standard to measure and inform responses to chronic disease risks. This body could be a Commonwealth agency, State/Federal body, or government/private sector body.

A key role of this body should be the annual survey of population health for the purposes of establishing a **National Well Being Index**. The aim of the index would be collect comprehensive data on population health to inform the development of national health

[70] See section 12(2)

benchmarks. Such benchmarks would enable medical professionals, corporate health providers, hospitals, community care providers and any other bodies involved in the prevention of chronic disease to design consistent responses and strategies. It would also assist governments to link funding for prevention with benchmark goals and target high risk groups with special interventions in a scientific and cost-effective way.

A useful example of the success of this kind of approach is found in the State of Colorado in the United States. Nationally, the extent of population obesity in the United States has increased dramatically between 1985 and 2004.

In 1985, 10-14% of the population in eight States was considered to be obese. However by 2004 only four states had populations where less than 20% of people were considered obese. Ten states had populations where over 25% of people were considered obese. [71]

Against this trend of increasing obesity Colorado has maintained the lowest level of obesity in the United States. This is partly because it has gathers and maintains the most sophisticated data on the well being of its population giving it the capacity to direct resources to the most high risk groups or activities.[72]

Workplace health programs can be used to collect the kind of data required to maintain a Well Being Index and develop benchmarks.

In the marketplace benchmarks can be used to encourage competition between employers to provide successful and leading edge wellness programs. This would be much like the way companies with work/life balance programs seek affirmation from the market and bodies like the Commonwealth's Equal Opportunity for Women in the Workplace Agency as employers of choice.

This would link benchmarks not only to policy design for government but also to employers' corporate social responsibility agendas, and thereby promote a holistic approach to chronic disease prevention.

[71] United States Centre for Disease Control 2007
[72] HAPIA research

Appendix A

Examples of the Return on Investment (ROI) for Worksite Wellness Programs at Selected Companies

Australian Health Management – Participants who completed a HRA claimed $50 less in hospital claims per annum. Those who completed the HRA and undertook health coaching claimed almost $500 less per annum.
Source: AHM Senate Community Affairs submission (2006) and AHPM (2006)

Good Health Solutions
A company with over 10,000 employees demonstrated an ROI of 4.11 to 1 as a result of a program which offered health assessments, seminars, activities and other support for improved health.
Source: GHS internal data (2008)

Northeast Utilities – The company's Well Aware Program demonstrated a $1.4 million decrease in behavioral claims,
31% decrease in smoking, 29% decrease in inactivity, 16% decrease in mental health risk, and 11% decrease in cholesterol risk. The ROI was 6:1.
Source: U.S. Dept. of Health and Human Services, Prevention Makes Common Cents, 2003.

Motorola – Program participants experienced an increase of only 2.4% in health care costs whereas non-participants experienced an 18% increase in health care costs. The ROI was $3.93:1.
Source: U.S. Dept. of Health and Human Services, Prevention Makes Common Cents, 2003.

Union Pacific Railroad – The company's wellness program produced a $53 million reduction in health care costs in one year.
Source: U.S. Dept. of Health and Human Services, Prevention Makes Common Cents, 2003.

Wisconsin Educational Insurance Group – A medical self-care program and health education materials produced an ROI of $4.75:1.

Caterpillar – Participants in the Healthy Balance Program who completed the HRA reduced their doctor visits by 17% and hospital days by 28%.
Source: Wellness Councils of America, The Cost Benefit of Worksite Wellness, 2002.

Dupont – A study involving 45,000 blue collar workers found that absences from non-job related illness decreased 41% at locations where a worksite wellness program was offered compared with a 5.8% decline at 19 sites where it was not. The ROI was $1.42:1.
Source: Wellness Councils of America, The Cost Benefit of Worksite Wellness, 2002.

Johnson & Johnson – The results of a 4 year worksite wellness program involving 18,331 employees demonstrated an overall savings of $8.5 million annually
due to reduced health care costs. This amounted to a savings of $225 per employee per year.
Source: Journal of Occupational and Environmental Medicine, January 2002, 44(1):21-29.

Florida Power & Light – After an employee wellness program, total health care costs were reduced by 35%, workers compensation costs were reduced by 38% per claim, and 82% of employees reported personal health improvements.
Source: Wellness Councils of America, The Cost Benefit of Worksite Wellness, 2002.

Xerox Corporation – A worksite wellness program revealed a drop in the frequency of workers' compensation claims and the average cost per injury. 5.6% of wellness participants filed claims with an average cost of $6,506 per injury. 8.9% of non-wellness participants filed claims with an average cost of $9,482 per injury.
Source: University of Michigan Health Management Research Center, 2001.

Citibank – A comprehensive health management program showed a $4.56:1 ROI in reduced total health care costs.
Source: Journal of Occupational and Environmental Medicine, 1999, 14(1):5131-43.

Washoe County School District – Wellness program participants averaged 3 fewer missed workdays than those who did not participate in the program. The decrease in absenteeism produced an ROI of $15.60:1.
Source: Preventive Medicine, 2000; 40:131-7.

Manufacturing Company – A 6 year wellness program including 2,596 participants saved $623,040 due to
reductions in disability absence days. This resulted in an ROI of $2.30:1.
Source: Journal of Occupational and Environmental Medicine, 2002; 44:776-80.

Large Company – A worksite wellness program compared 13,048 participants who filled out a Health Risk Appraisal
with 13,363 non-participants. Overall, the HRA participants cost an average of $212 less medical costs than non-participants.
Source: Journal of Occupational and Environmental Medicine, 2003; 45:1196-2