TOWERS WATSON

The Business Value of a Healthy Workforce

A Global Perspective

Health issues and their effect on the workforce have become a global priority for employers. The continued increase in preventable chronic diseases such as cardiovascular disease and type 2 diabetes has expanded beyond Western countries to become a growing problem — and in some instances a more urgent one — in countries with an emerging middle class. As a result, the number of companies providing health and productivity (H&P) programs has increased in many markets around the world, and includes multinationals as well as local and regional organizations.

To explore H&P strategies and programs globally, our North America Staying@Work Survey was expanded this year to cover organizations in 15 key markets around the world. (For further details, see page 10.) The global survey uncovers several similarities across regions and some important differences.

A shift in focus to health as an organizational strategy

While most companies globally do not currently have an articulated H&P strategy that differentiates them from competitors and helps attract and retain talent, many recognize the need for such a strategy to gain key organizational benefits, link to the employee value proposition (EVP), and provide a motivation for employees to join and stay with the organization. With Europe as a notable exception, most organizations around the world plan to develop an H&P strategy within the next three years *(Figure 1).* Although there is growing recognition in Europe of the links between well-being, and broader engagement and productivity issues, there is perhaps still more focus on tactical interventions linked to occupational health and safety measures.

Figure 1. Which of the following steps have you taken in your H&P strategy to date, and what do you expect to accomplish in the next three years?

	No strategy		Adopt strategy		Communicate and deliver		Differentiate H&P strategy			
	Offered various programs but have not articulated an H&P strategy		**Articulated an H&P strategy** with stated objectives and goals for each program		**Effectively communicated the value proposition** behind the H&P program and delivered on its promises		**Customized for critical workforce segments** to compete for talent and used organizational analytics to test program effectiveness		None	
	Today	In 3 years	Today	In 3 years	Today	In 3 years	Today	In 3 years	Today	In 3 years
Brazil	48%	3%	9%	18%	15%	21%	24%	53%	4%	6%
Canada	63%	5%	10%	18%	13%	25%	6%	45%	7%	7%
Mexico	49%	19%	15%	19%	17%	14%	8%	40%	10%	9%
U.S.	50%	3%	18%	14%	16%	21%	14%	59%	2%	3%
Europe	47%	18%	17%	20%	13%	26%	8%	33%	16%	3%
China	61%	13%	5%	27%	19%	10%	9%	47%	6%	3%
India	59%	8%	9%	10%	19%	25%	8%	54%	5%	3%
Southeast Asia	49%	6%	12%	18%	14%	15%	11%	53%	14%	9%

Improved H&P is a business priority in all countries studied, and the majority of respondents expect to increase support for these programs over the next two to three years.

With surprising consistency, around half of respondents in each country indicated they offer various employee programs but do not have a formally articulated H&P strategy that is aligned to business priorities, while between 10% and 15% in each market have an articulated strategy with stated objectives and goals. Another 15% have effectively communicated the strategy and delivered on its promises, and 10% or less indicate they have differentiated their H&P program from other organizations as they compete for talent.

However, employers clearly understand that they must step up their game, and they plan to do so. Half of respondents said that, within the next three years, they expect to adopt an H&P strategy that will help them compete for talent by customizing for critical workforce segments, and using analytics to test program effectiveness and links to business value. The main outlier was Brazil, where higher percentages of participants said they already effectively communicate and differentiate their strategy.

Top health risks

Employers globally rank stress, lack of physical exercise and obesity as the top health risks faced by their employees. Stress was identified as the number one health risk factor in nearly all surveyed countries *(Figure 2)*. The multifaceted issues particularly related to stress are driving the need for broader organizational commitment that extends beyond the physical and mental health to encompass the work environment, culture and interpersonal relationships that connect employees to the mission and goals of the organization. The Towers Watson Global Benefits Attitudes Survey highlights the fact that the main sources of stress for employees around the globe are tied to the work experience — inadequate staffing, low pay increases and conflicting job expectations.

"Employers globally rank stress, lack of physical exercise and obesity as the top health risks faced by their employees."

Figure 2. Lifestyle risk factors that are a workforce issue

	Tobacco use	Lack of physical activity	Obesity	Poor nutrition	Stress	Substance abuse	Presenteeism
Brazil	7	2	3	5	1	4	6
Canada	6	2	3	4	1	7	5
Mexico	6	2	3	4	1	7	5
U.S.	5	3	2	4	1	7	6
Europe	2	3	4	7	1	6	5
China	3	1	4	7	2	5	6
India	4	2	3	6	1	7	5
Southeast Asia	5	2	3	6	1	7	4

Mixed success in managing health risks

Employers' ability to impact modifiable health risks, chronic disease, and related absence and disability varies widely by country, probably due to the complex interrelationships among employee health habits, access and availability of quality health services, and the vendors to assist with corporate wellness initiatives.

Components of an H&P strategy

More than 60% of respondents' H&P strategies include medical benefits, occupational health, and onsite medical and wellness services. They are less likely to offer pandemic preparedness or absence and disability management *(Figure 3).*

Most companies across the globe offer a range of H&P programs, although there is little consistency across countries and regions (*Figure 4,* page 4). After the U.S., Canada was second, followed by Brazil and Mexico in the percentage of companies offering various programs. The high percentages of companies in Mexico and Brazil providing onsite health most likely reflect regulations in those countries.

Employee participation rates in H&P programs also vary considerably by country. Participation rates generally run between 15% and 60%, depending on the program (*Figure 5,* page 5). However, the participation statistics quoted in some countries are higher than those seen on the ground in our client experience, giving rise to some speculation that they may be due to some initial excitement around programs. As Figure 5 shows, rates in some countries are reported to be as high if not higher than the more mature markets such as the U.S. and will be difficult to sustain without follow-up mechanisms — on both the employer and the employee side — to keep the momentum going.

Strategic priorities

Respondents across all markets have a surprisingly consistent set of priorities for their H&P strategy (*Figure 6,* page 5). One key theme across markets was the need to create a workplace culture of health and improve employees' engagement in their health. Chinese respondents were one outlier. They indicated improving employees' stress and anxiety as their top priority, followed by employee health engagement and physical health.

Figure 3. Core components of H&P strategies

	Americas					Asia Pacific		
	Brazil	Canada	Mexico	U.S.	Europe	China	India	Southeast Asia
Medical benefits	91%	96%	71%	97%	88%	84%	95%	99%
Onsite medical and wellness services	77%	46%	62%	50%	36%	45%	59%	53%
Occupational health	96%	79%	71%	64%	88%	72%	55%	58%
Wellness/health management programs	83%	79%	74%	93%	65%	48%	66%	76%
Pandemic preparedness	55%	68%	57%	50%	43%	36%	50%	53%
Absence and disability management	62%	88%	41%	76%	35%	39%	26%	23%
Reputational risks/branding	60%	46%	30%	46%	45%	25%	38%	28%
All of the above	30%	22%	13%	22%	13%	11%	15%	11%
None of the above	2%	0%	0%	0%	0%	1%	0%	0%

Figure 4. H&P programs in place in 2013

	Americas					Asia Pacific		
	Brazil	Canada	Mexico	U.S.	Europe	China	India	Southeast Asia
Wellness screening								
Health risk assessment/appraisal	57%	45%	52%	84%	53%	30%	44%	60%
Biometric screening (e.g., BMI, blood pressure, cholesterol)	74%	38%	61%	76%	42%	92%	50%	67%
Preventive screening (e.g., skin, mammography)	53%	9%	37%	70%	42%	45%	32%	46%
Worksite								
Vaccinations (e.g., flu, hepatitis B)	89%	79%	83%	89%	62%	30%	21%	55%
Onsite or near-site health center	66%	30%	65%	40%	59%	23%	46%	52%
Onsite health coaching and condition management	21%	28%	53%	37%	37%	25%	32%	29%
Onsite or subsidized fitness facilities (e.g., gym)	50%	68%	19%	69%	41%	41%	49%	39%
Worksite diet/exercise activities (e.g., yoga, walking programs, fitness challenges, nutrition education)	55%	61%	33%	76%	25%	55%	42%	51%
Lifestyle change and health management								
Lifestyle behavior coaching programs (telephonic)	13%	46%	14%	73%	12%	16%	18%	13%
Weight management programs	57%	44%	58%	85%	13%	5%	14%	22%
Tobacco-cessation programs	45%	52%	26%	90%	21%	9%	16%	12%
Stress or resilience management	23%	42%	26%	62%	35%	23%	32%	27%
Chronic condition (disease) management programs	59%	21%	19%	83%	11%	8%	10%	16%
Maternity support (pre- and post-delivery, child care resources)	49%	38%	31%	72%	29%	36%	46%	34%
Decision support and tools								
Treatment/health decision support	53%	30%	34%	63%	18%	15%	27%	20%
Web-based health information tools	28%	65%	35%	85%	31%	20%	29%	22%
Price/quality transparency tools (U.S. only)	—	—	—	54%	—	—	—	—
Telemedicine for professional consultations (U.S. only)	—	—	—	21%	—	—	—	—
Employee assistance program (EAP)	41%	99%	32%	—	36%	26%	48%	29%
Drug/alcohol treatment programs	30%	49%	11%	—	8%	5%	9%	11%

Note: Based on companies offering the program and excludes "Don't know"

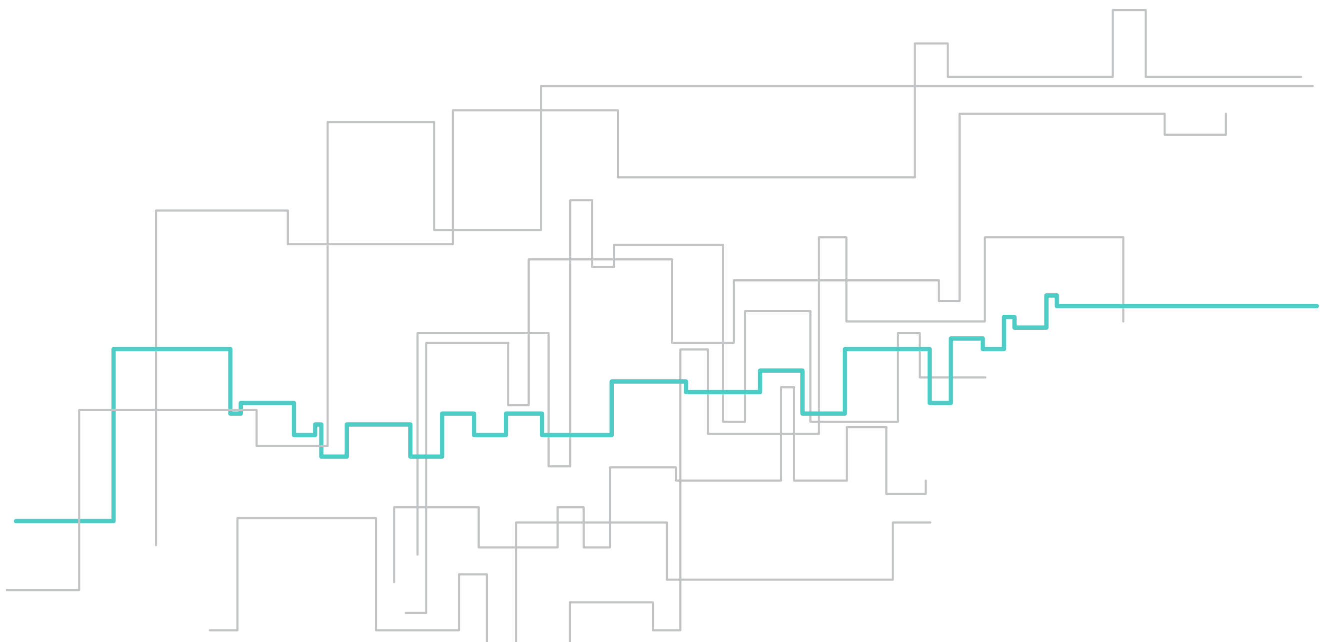


Figure 5. H&P programs — Average participation rates

	Americas				Europe	Asia Pacific		
	Brazil	Canada	Mexico	U.S.		China	India	Southeast Asia
Wellness screening								
Health risk assessment/appraisal	68%	24%	59%	50%	56%	79%	55%	62%
Biometric screening (e.g., BMI, blood pressure, cholesterol)	70%	25%	58%	49%	55%	91%	61%	62%
Preventive screening (e.g., skin, mammography)	49%	16%	56%	41%	42%	80%	40%	50%
Worksite								
Vaccinations (e.g., flu, hepatitis B)	74%	24%	60%	46%	36%	64%	48%	51%
Onsite or near-site health center	75%	38%	70%	40%	55%	72%	49%	73%
Onsite health coaching and condition management	35%	25%	59%	21%	50%	58%	40%	62%
Onsite or subsidized fitness facilities (e.g., gym)	26%	30%	32%	22%	31%	52%	25%	36%
Worksite diet/exercise activities (e.g., yoga, walking programs, fitness challenges, nutrition education)	35%	22%	31%	22%	17%	63%	37%	32%
Lifestyle change and health management								
Lifestyle behavior coaching programs (telephonic)	32%	13%	38%	13%	13%	48%	46%	30%
Weight management programs	29%	12%	41%	10%	25%	53%	50%	32%
Tobacco-cessation programs	33%	8%	42%	10%	4%	38%	49%	29%
Stress or resilience management	23%	17%	44%	12%	36%	54%	42%	32%
Chronic condition (disease) management programs	37%	21%	48%	13%	4%	78%	53%	40%
Maternity support (pre- and post-delivery, child care resources)	55%	13%	32%	17%	53%	64%	40%	55%
Decision support and tools								
Treatment/health decision support	56%	15%	52%	13%	45%	72%	61%	56%
Web-based health information tools	57%	21%	53%	27%	48%	58%	62%	62%
Price/quality transparency tools (U.S. only)	—	—	—	16%	—	—	—	—
Telemedicine for professional consultations (U.S. only)	—	—	—	9%	—	—	—	—
EAP	36%	21%	35%	—	25%	50%	31%	34%
Drug/alcohol treatment programs	23%	6%	21%	—	22%	8%	27%	28%

Note: Based on companies offering the program and excludes "Don't know"

Figure 6. Top priorities of H&P program (by rank)

	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Brazil	Health Engagement	Workplace Health Culture	Safety	Awareness	Stress/Anxiety
Canada	Workplace Health Culture	Stress/Anxiety	Health Engagement	Awareness	Manager Awareness
Mexico	Workplace Health Culture	Health Engagement	Stress/Anxiety	Awareness	Safety
U.S.	Workplace Health Culture	Health Engagement	Educate Employees	Awareness	Physical Health
Europe	Safety	Stress/Anxiety	Health Engagement	Workplace Health Culture	Attraction/Retention
China	Stress/Anxiety	Health Engagement	Physical Health	Safety	Awareness
India	Workplace Health Culture	Health Engagement	Stress/Anxiety	Awareness	Safety
Southeast Asia	Workplace Health Culture	Health Engagement	Stress/Anxiety	Attraction/Retention	Awareness

Note: Respondents could select up to three options.

In Europe, safety concerns were top of mind, partly driven by statutory requirements that exist in many European countries.

In the U.S., as well as Brazil and Mexico to some extent, H&P issues are inextricably linked to the increasing cost of health care for both employers and employees, so the focus of these respondents on creating a workplace culture of health — and the cost management aspects of a healthy workforce, along with concerns about health engagement and employee education — is not surprising. It is notable that stress and anxiety are not among the top priorities for an H&P program in the U.S., although stress is the top lifestyle risk. It's possible that U.S. employers underestimate the importance of stress reduction to H&P or that the high costs of health care in the U.S. eclipse all other concerns.

In nearly all other countries, employer health care costs are far lower, and therefore are not a leading business issue. In Europe, for example, company reputation, customer satisfaction and the potential for labor disputes tend to be of more concern than employee wellness, with social responsibility being a more typical focus than productivity.

Although the priorities across much of Asia fairly consistently follow those of the Americas, the underlying drivers do differ. Productivity and absenteeism are certainly key issues, but attraction and retention of talent are perennial employer concerns in Asia's rapidly growing markets.

In short, drawing employees into healthy lifestyles through more programs is not enough. The key themes across markets are the need to create a workplace culture of health, improve employees' engagement in their health and better manage employee stress.

Biggest obstacles to changing employee behavior

Lack of employees' engagement in their own health is a top obstacle to changing employee behavior in most countries *(Figure 7)*. However, lack of evidence of best practices ranked highly as an obstacle in most of Asia, as did available budget to spend on wellness programs. Budgets were also an issue in Europe and Brazil. Lack of evidence and budget are closely related, since inability to point to effectiveness can often result in management reluctance to put money into programs.

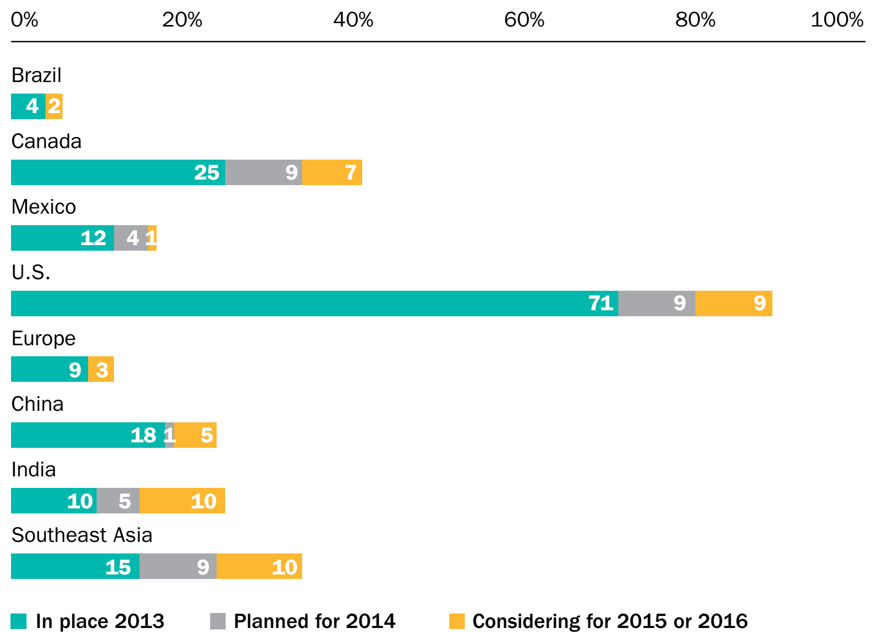
Figure 7. Biggest obstacles to changing employee behavior (by rank)

	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Brazil	Health Engagement	Financial Incentives	Senior Leaders	Organizational Structure	Budget
Canada	Health Engagement	Budget	Financial Incentives	Evidence of Returns	Senior Leaders
Mexico	Health Engagement	Budget	Evidence of Returns	Evidence of Best Practices	Organizational Structure
U.S.	Health Engagement	Evidence of Returns	Budget	Financial Incentives	Senior Leaders
Europe	Budget	Health Engagement	Evidence of Returns	Regulatory	Financial Incentives
China	Budget	Evidence of Returns	Senior Leaders	Health Engagement	Evidence of Best Practices
India	Health Engagement	Evidence of Best Practices	Financial Incentives	Evidence of Returns	Actionable Data
Southeast Asia	Health Engagement	Evidence of Best Practices	Budget	Financial Incentives	Evidence of Returns

Note: Respondents could select up to three options.

Incentives for participation in programs or for achieving health-related goals are predominantly a U.S. feature, where 71% of respondents currently have a program and 18% plan to implement in 2014, or are considering implementing one for 2015 or 2016. Canadian companies also use incentives, but to a significantly lesser degree *(Figure 8)*. However, interest in incentives in Canada and Asia is growing somewhat, as evidenced by the percentage of companies in those countries that are considering implementation over the next three years. Outside the U.S., incentives most often take the form of cash or gift certificates. Within the U.S., incentives are generally in the form of reductions to health costs.

Figure 8. Use of financial rewards



Data collection

How companies collect and measure data varies considerably across markets, most likely due to data availability and quality, and regulatory constraints governing their use. Many organizations that do collect data do not integrate and analyze them for corporate decision making. This represents a significant opportunity for organizations to develop effective population H&P programs.

Lack of consistent data indicates that companies are likely underutilizing data as a measurement tool. In essence, there is considerable room for improvement, but the availability of certain kinds of data may be a baseline challenge in a number of countries outside the U.S. (*Figure 9,* page 8).

Overall program success

Less than half of survey participants in all countries rank any aspect of their H&P program as successful (*Figure 10,* page 8). The success of certain key goals — including reduction of costs and frequency of lost work time, and reduction of chronic disease and lifestyle-related risks in the employee and dependent population — is extremely low everywhere except Brazil. Brazilian companies reported relatively high rates of success overall, although there is room for improvement.

Lack of program success could be due in part to a lack of a clearly articulated strategy. In addition, it can be extremely difficult to achieve key H&P outcomes such as a reduction of costs and lost work time, and reduction of chronic disease and lifestyle-related risks. Companies just starting to address these concerns may not see measurable returns for some time.

> "Lack of consistent data indicates that companies are likely underutilizing data as a measurement tool."

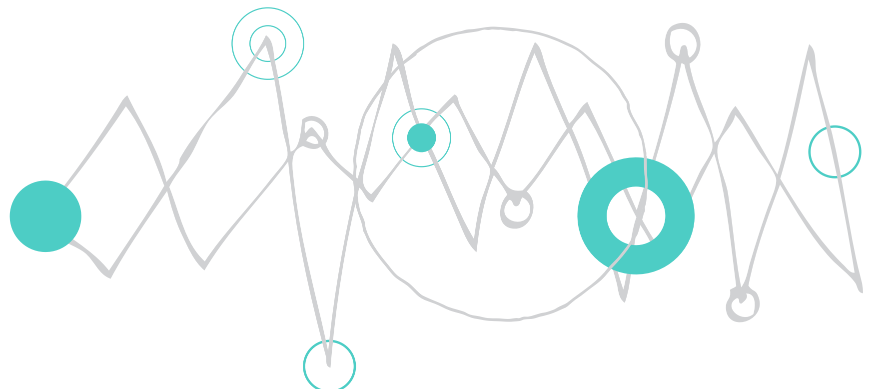


Figure 9. Percentage of companies analyzing or collecting data

	Brazil	Canada	Mexico	U.S.	Europe	India	China	Southeast Asia
Preventive care utilization (e.g., annual physical, age-appropriate screenings, designated primary care physician)	78%	26%	49%	88%	46%	54%	45%	60%
Pharmacy claim data (e.g., adherence rates, generic utilization)	36%	81%	83%	94%	7%	32%	22%	40%
Disability program data (short and long term)	81%	95%	66%	86%	41%	29%	29%	27%
Workers compensation data	65%	77%	85%	69%	59%	54%	36%	56%
Biometric information (e.g., blood pressure, cholesterol, BMI)	76%	30%	61%	73%	31%	49%	60%	50%
Lifestyle-related risk reduction data (e.g., health risk appraisal data)	58%	32%	46%	70%	30%	31%	17%	35%
Employee participation in wellness and lifestyle programs	74%	61%	57%	78%	44%	52%	29%	58%
Disease management data	73%	29%	48%	80%	65%	30%	24%	24%
Data on reduced performance at work (i.e., presenteeism)	43%	25%	39%	22%	47%	44%	36%	36%
Unplanned absence data (e.g., number of leave of absence or sick days, reasons for absence)	70%	68%	60%	36%	77%	70%	47%	72%
Onsite or near-site health center data	61%	13%	55%	28%	23%	42%	19%	38%
Employee satisfaction with H&P programs	62%	50%	49%	46%	38%	60%	28%	48%
Employee engagement (i.e., work attitudes, employee commitment)	64%	74%	44%	58%	56%	69%	59%	68%
Medical claim data	64%	92%	95%	—	77%	92%	80%	90%
EAP utilization	41%	97%	28%	—	47%	49%	20%	27%
Pregnancy care utilization	50%	8%	32%	—	24%	52%	9%	29%

Figure 10. Health program effectiveness

Extent your organization has been effective in each of the following areas

	Brazil	Canada	Mexico	U.S.	Europe	India	China	Southeast Asia
Integrating the delivery of benefits and vendor/provider programs	41%	41%	30%	44%	28%	35%	38%	26%
Making employees aware of their health risks/status and current benefits	47%	25%	22%	44%	28%	36%	54%	28%
Encouraging employees to participate in healthy lifestyle programs	42%	26%	32%	32%	21%	24%	49%	27%
Encouraging employees to use onsite services like a medical clinic or health coaching	45%	22%	36%	29%	20%	32%	39%	25%
Creating a corporate culture of health and well-being in your organization	47%	19%	28%	27%	25%	27%	54%	26%
Improving overall employee performance at work	37%	25%	31%	25%	38%	41%	51%	34%
Using data to measure the impact of H&P programs	29%	21%	14%	22%	14%	30%	26%	16%
Making employees responsible/accountable for their health	34%	11%	19%	19%	21%	26%	48%	30%
Generating positive financial return from investing in H&P programs	34%	9%	11%	16%	12%	26%	26%	11%
Reducing lifestyle-related health risks in your employee and dependent population	45%	10%	22%	13%	14%	21%	26%	13%
Managing the cost or frequency of all lost time	24%	26%	7%	12%	18%	24%	34%	17%
Reducing the impact of chronic disease in your employee and dependent population	39%	7%	18%	11%	8%	24%	19%	13%

Summary

Globally, companies face similar challenges in addressing lifestyle choices that contribute to chronic disease and disability. However, they continue to make significant investments in H&P programs, and they recognize that a defined H&P strategy is needed for success.

Broadly, companies with high overall H&P effectiveness scores (see sidebar) use a holistic approach to H&P that takes advantage of the following strategies:

- Leadership actively supports and communicates the importance of H&P goals that are connected to the EVP.
- H&P is defined broadly to include the physical, psychological and emotional aspects of health.
- Employee engagement in H&P is part of the company's business priorities and linked to overall business value.
- Measurement of program effectiveness is holistic, and includes employee satisfaction and process- and results-oriented metrics.
- Continuous improvement is emphasized, using an evidence-based approach that aligns local experience and culture with product and service innovations.
- The organization aligns and assimilates worksite programs and activities into the local culture to support H&P goals.
- H&P programs are customized to meet individual needs, with the goal of optimizing recovery and promoting an efficient return to work.
- Certain population segments are targeted for intervention to assure support is integrated with overall benefits and employer services.
- The organization uses multiple channels to communicate regularly with employees, spouses and dependents about the H&P programs and services.
- The organization actively manages and integrates business partner services, communication and performance objectives.

Effectiveness Methodology

To evaluate program effectiveness across the respondent group, we created an overall score by adding an equally weighted value of responses for each of the 18 H&P items. This score captures all facets of an effective H&P framework in a single summary variable. Responding companies are divided into three equal groups based on their H&P effectiveness scores, and companies with the highest values are deemed to have the most effective programs. We examine differences in human capital and financial outcomes by the high-, medium- and low-effectiveness companies in the section "Conclusion: How High-Effectiveness Organizations Are Finding a Better Way to Build a Culture of Health" from the *Towers Watson 2013/2014 U.S. Staying@Work Survey.* These differences show that high-effectiveness companies reap significant financial rewards for their H&P investments.

To provide an in-depth look at the characteristics of effective programs, Towers Watson also developed the H&P Scorecard, which inventories the programs and policies of companies in each of the three effectiveness groups. Using best practices as the standard, the survey asks 220 questions about the tactics and programs companies have in place in 2013. These items are separated into two primary categories: health programs and workforce effectiveness.

Both categories are defined by three key components (pillars) and further broken down into 21 sub-elements (subpillars). Organizations receive a score of 0 to 5 for each metric, with 0 indicating no best practices in place and 5 indicating all best practices in place. Overall scores represent the weighted average of the individual respondents' scores within each category. A combination of factor analysis and regression analysis of the factor scores against overall H&P effectiveness is used to develop relative weights for allocating the values across the subpillars, and determine the scores for the Health and Productivity Scorecard.

About the Survey

The 2013/2014 Towers Watson Staying@Work Survey was conducted between May and July 2013 in North America, Latin America (Brazil and Mexico), Europe (France, Italy, the Netherlands, Spain and the U.K.) and Asia (China, Hong Kong, India, Malaysia, the Philippines and Singapore). In the U.S., the survey was jointly sponsored by Towers Watson and the National Business Group on Health, as it has been for more than a decade. The responses reflect the strategy, tactics and experience of each company in the local market. The primary target for the survey was the most senior benefit manager, or H&P expert, in the country. However, the survey asked for information that may have required expertise in other departments (e.g., external and internal communication). Respondents were encouraged to ask the most appropriate individuals in their company to assist in completing designated sections of the survey.

Across all 15 countries/markets, the data include responses from 892 HR and/or health benefit managers *(Figure 11)*. There were 199 participants in the U.S., representing all major industries *(Figure 12)*. Fifty-nine percent of U.S. responding organizations are publicly held; 22% are private, and 19% are nonprofit or government agencies.

Figure 11. Number of full-time workers employed by respondents

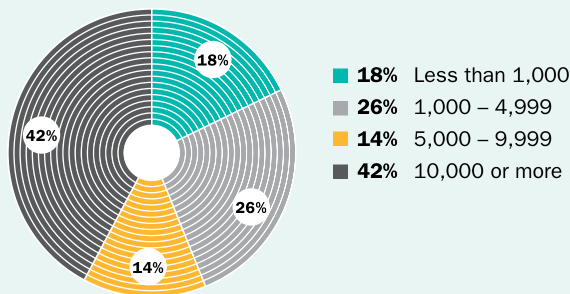
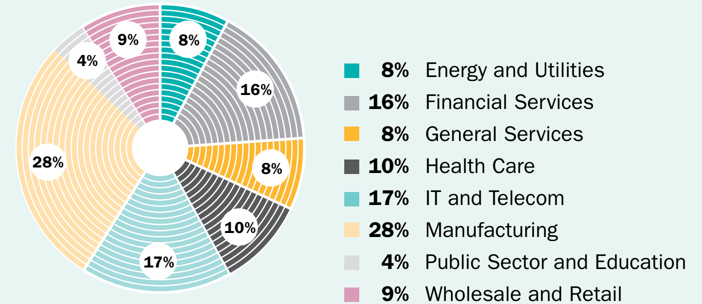


Figure 12. Industry groups



About Towers Watson

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With more than 14,000 associates around the world, we offer consulting, technology and solutions in the areas of benefits, talent management, rewards, and risk and capital management.

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