



Rewarding Healthy Behaviors: Variation in Health Risk Across Industries Among American Workers

Introduction

Faced with an unsustainable growth in health care costs, both employers and policymakers have begun to consider the potential savings that might be achieved by investments in health promotion and better access to preventive care. There has also been public discussion about the potential of building financial incentives for healthy behaviors and the use of prevention services into health plans. Creating the right incentives is a challenge however, because experience is so limited and healthy behaviors among workers vary widely. To illustrate the range of differences, this issue brief specifically describes the variation among workers across large industry groups in these key areas: family income, health risk factors, education, language, and access to basic health care where preventive services are provided.

Very few employers have tried using financial incentives to achieve healthy behaviors. Just 10% of firms offering health benefits in 2008 gave their employees the option of completing a personal health assessment with only 12% of these firms offering a financial incentive to the worker to complete it.¹ Only a small share of all firms offer some type of wellness program to their employees—23% of firms offering health benefits offered gym membership discounts or on-site exercise facilities, 21% offered a smoking cessation program, and 15% offered a weight loss program in 2008—and these rates vary widely across different industries.

While wellness programs are not a mandated or optional benefit covered by state Medicaid programs, a few states have taken a new direction with programs designed to improve health behaviors. Florida and Idaho, for example, have implemented incentive programs where beneficiaries earn credits with healthy behavior that can be used towards state-approved health care products, and in Idaho, toward their share of Medicaid premiums.² West Virginia has taken a different approach by reducing benefits for parents and children, unless parents sign and adhere to an agreement that includes responsibilities such as participating in health education programs as directed and appropriate emergency room use.³ However, to date these evaluation findings suggest that programs have had limited impact on changing behavior and have been administratively complex to implement.⁴

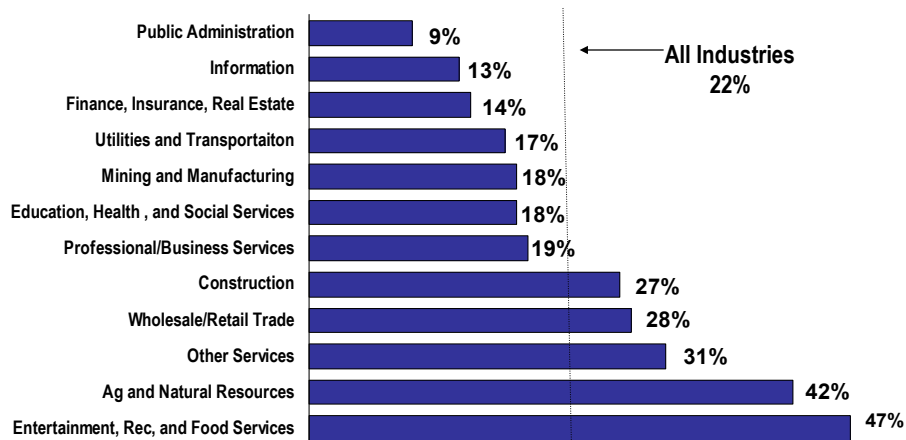
New health policy that would build financial incentives for healthy behavior into health plans may work for some, but not all, and could potentially widen economic disparities in health. Because a person's health status is closely tied to family income, these incentives also would likely affect businesses differently, depending on the number of low-wage workers they employ. In addition, differences across employers in their workers' health risk factors, education, health literacy, and access to basic health care will affect how useful financial incentives prove to be in reducing health care costs over time.

More than one in five workers comes from a low-income family—a group less likely to have the means to readily change health habits.

Certain industries have far more low-income employees than others. Nearly half of service jobs in the entertainment, recreation, and food industries are filled by low-income workers. In the combined industry group of agriculture/natural resources, 42% are low-income workers. Both the construction and trade sector have workforces with more than the average share of low-income workers as well. (Figure 1). As shown later, most all of the industry groups with an above average share of low-income workers, also have an above average share of workers with health risks and access barriers.

Figure 1

Percent of Industry’s Workers from Low-Income Families (<200% Poverty Level)

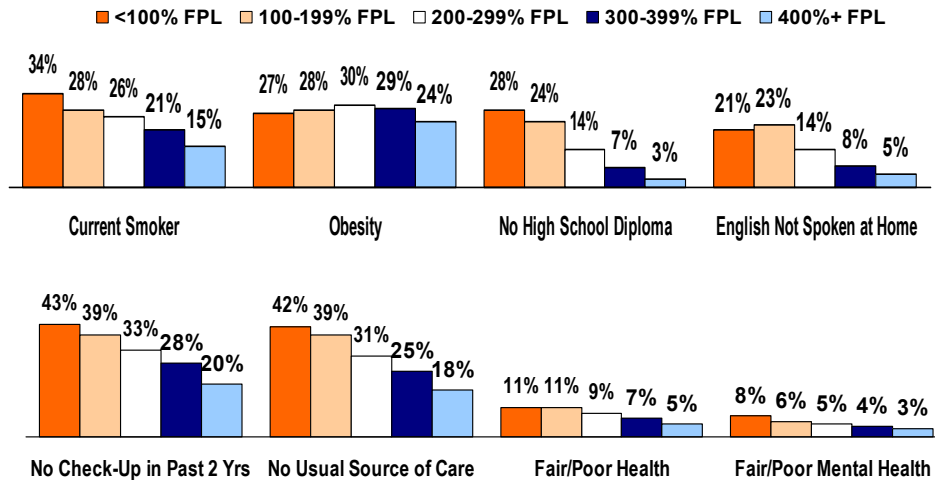


SOURCE: KCMU analysis of MEPS (3 pooled years 2004-2006).
Workers age 19-64

Family income factors strongly into individual health risk, the ability to obtain preventive care, and ultimately, how healthy people are. Across the measures studied here, with the only exception being obesity levels, there is a consistent gradient by poverty level: the lower a worker’s family income, the greater the worker’s health risk, and the poorer the worker’s access to basic care and general health status (Figure 2).

Figure 2

Health Risk Among Workers By Poverty Levels Income Matters -- Except in Weight Control



SOURCE: KCMU analysis of MEPS (3 pooled years 2004-2006).
Workers age 19-64

Health risk factors vary widely across industries (Table 1).

Smoking. About a fifth of workers are current smokers, but the rate ranges from a low of 14% in the education, health, and social services sector to 34% in the construction industry. Low-income workers are more likely to be smokers than others overall; particularly true in some industries. For example, among professional/business service workers, low-income workers are twice as likely as others to be current smokers (32% vs. 16%).

Obesity. Over a quarter (27%) of all workers are obese¹ and these rates do not vary as much across industries as other health risks and barriers—ranging from 22% in the entertainment/recreation/food service sector to 34% in public administration. In contrast to smoking risk, there are no income differences between low-income and higher income workers for the risk of being obese (comparing incomes <200% vs. ≥200% poverty level).² The same is true for workers’ rates of being overweight. Almost two-thirds of all workers are overweight (a body mass index of 25 or greater).

Basic barriers to changing health habits are greater in certain industries (Table 2).

Education. Only 11% of workers have less than a full high school education, which is often linked to lower health literacy and less knowledge of good health practices. Poor education varies widely

¹ The standard definition of obesity was used -- having a body mass index of 30 or greater.

² However, obesity and overweight prevalence among workers with incomes greater than 400% of poverty are significantly lower than others (obesity: 24.5% vs. 28.6%, p<.01; overweight: 62.0% vs. 63.2%, p<.05).

across industries, from just 2% of workers in the information sector to 32% of workers employed in agriculture/natural resources. In every industry group, low-income workers are at least twice as likely as others to have lower education levels. In agriculture/natural resources, 50% of low-income workers have less than a high school education compared to 19% of higher income workers.

English as a Second Language. About one in ten workers is not speaking English at home, suggesting English may be their second language (ESL)—which can be a barrier to understanding preventive health information, as well as following medical directions and treatments. Certain industries have fairly high levels of ESL workers, for example, in the agriculture/natural resources sector a quarter of all workers and 46% of low-income workers are not speaking English at home. In every sector, except for the information industry, low-income workers are far more likely than others to be ESL adults.

Access to basic health care varies across industries (Table 2).

No Health Check-Up in Past Two Years. Over a quarter of workers have not had a health check-up in the past two years and low-income workers are far more likely not to have had a check-up than higher income workers—in every industry. The rates are particularly high in the construction (46%) and agriculture/natural resources sectors (50%). Visits to health care providers that focus on health screening and preventive counseling are key to staying healthy. However, for many workers the costs of even routine care and not having a usual source of care are real barriers to health prevention.

No Usual Source of Care. A quarter (26%) of all workers, and 40% of low-income workers, report not having a regular provider, i.e., a usual source of care for themselves. This access barrier ranges from 14% among workers in public administration jobs to 39% among construction workers. Having a regular health provider and being insured are closely linked so industries where employees are less likely to have health coverage are more likely to have employees that have not established a regular physician or provider for themselves.

In summary, industries where health risk factors, education, language, and access to care barriers tend to be lower than average include:

- Finance, Insurance, Real Estate
- Education, Health and Social Services
- Information
- Public Administration

Industries where the prevalence of these factors are generally higher than average include:

- Agriculture, Natural Resources
- Construction
- Mining and Manufacturing
- Entertainment, Recreation, and Food Services
- Other Services

Conclusion

Most health reform proposals currently on the table support new investments in public health measures, health promotion, and improved access to preventive services. A few proposals go further and would provide financial incentives in the form of premium discounts for healthy behavior.

Health risk factors, as well as basic barriers to changing health habits and behavior vary widely, even among adults healthy enough to be working. Blue-collar industries tend to have:

- more workers with health risk factors (smoking and obesity),
- more workers who are poorly prepared to make health changes given less education and language barriers, and
- more workers who have poor access to basic primary and preventive care.

By nature, these same industries have more low-income workers than other sectors—workers who are less likely to have the financial means to pay for behavioral health programs, gym memberships, or co-payments for preventive visits and screening tests.

Little information on the effectiveness of financial incentives to achieve healthy behaviors currently exists, in either private or public health plans. Nor do we know whether these kinds of incentives work better or worse across socioeconomic groups. What is known is that both the availability and affordability of wellness programs, exercise facilities, nutritional counseling, smoking cessation programs, etc., as well as the costs of regular check-ups and prevention screening, are real barriers to changing health habits.

Methods

Three years of Medical Expenditure Panel Survey (MEPS) data (2004, 2005, and 2006) were pooled together for this analysis to ensure reliable estimates of smaller subgroups among workers age 19 to 64. Industry classifications were assigned in accordance with the Bureau of Labor Statistics' CPS Industry Classification; self-employed workers were included, while workers in the armed forces or in unknown/unclassified industries were excluded. Poverty thresholds were calculated based on Health Insurance Eligibility Units rather than families.

This issue brief was prepared by Catherine Hoffman and Anthony Damico of the Kaiser Family Foundation.

Endnotes

¹ Kaiser Family Foundation and Health Research and Educational Trust. 2008. Employer Health Benefits, Annual Survey. Chapter 12.

² Barth, J and J Greene. 2007. "Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho." Center for Health Care Strategies, Inc. Issue Brief, July. Green, J. 2007 "Medicaid Efforts to Incentivize Healthy Behaviors." Center for Health Care Strategies, Inc. Issue Brief, July.

³ Kaiser Commission on Medicaid and the Uninsured. 2006. "West Virginia Medicaid State Plan Amendment: Key Program Changes and Questions." Fact Sheet available at <http://www.kff.org/medicaid/7529.cfm>.

⁴ Artiga, S. 2008 Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status. Kaiser Commission on Medicaid and the Uninsured Policy Brief available at <http://www.kff.org/medicaid/upload/7823.pdf>.

Table 1
Health Risk Factors, by Industry and Income Level
Among Workers, age 19-64

	Number	FPL		Obesity		Current Smoker		
		<200%	200%+	<200%	200%+	All	<200%	200%+
All Workers	135,137,813	22%	78%	27%	27%	21%	30%	19% *
Industry -- Range across Industries		9-47%	53-91%	22-34%	23-39%	14-34%	19-39%	12-32%
Agriculture, Natural Resources	1,587,461	42%	58%	28%	31%	19%	19%	19%
Construction	10,756,615	27%	73%	26%	24%	34%	39%	32%
Finance, Insurance, Real Estate	9,311,336	14%	86%	25%	28%	15%	23%	14% *
Education, Health and Soc. Services	29,532,305	18%	82%	27%	33%	14%	24%	12% *
Information	3,517,271	13%	87%	25%	25%	19%	28%	17%
Mining and Manufacturing	16,613,416	18%	82%	29%	29%	24%	30%	22%
Public Administration	6,973,547	9%	91%	34%	39%	17%	30%	16% *
Professional and Business Services	15,486,041	19%	81%	25%	28%	19%	32%	16% *
Entertainment, Rec, and Food Services	10,733,968	47%	53%	22%	23%	29%	34%	24%
Other Services	6,074,194	31%	69%	26%	26%	23%	27%	22%
Utilities and Transportation	6,961,478	17%	83%	30%	26%	25%	33%	23% *
Wholesale/Retail Trade	17,590,181	28%	72%	27%	26%	25%	31%	23%

FPL = Federal Poverty Levels

* Smoking risk is statistically different between workers with family incomes <200% FPL vs. 200% + FPL (p<.05) in this row. Income differences in both obesity and smoking risk were tested statistically, but only differences in smoking risk were found to be significant. Estimates in the highlighted table cells are based on a sample size <50.

All workers includes the self-employed. Excluded workers: military, those whose industry was unknown or in an unclassified industry

Data: MEPS (3 pooled years 2004-2006)

Table 2
Health Access Barriers, by Industry and Income Level
Among Workers, age 19-64

	Less Than High School Education		English Not Spoken at Home		No Check-Up Past 2 Years		No Usual Source of Health Care			
	All	<200%+ 200%+	All	<200%+ 200%+	All	<200%+ 200%+	All	<200%+ 200%+		
All Workers	11%	25% 6% *	11%	22%	7% *	28%	40%	26%	40%	22% *
Industry -- Range across Industries	2-32%	7-50%	1-19%	3-26%	8-46%	2-15%	17-50%	24-62%	16-43%	14-33%
Agriculture, Natural Resources	32%	50% 19% *	26%	46%	11% *	50%	60%	35%	47%	27% *
Construction	24%	46% 16% *	17%	36%	10% *	46%	62%	39%	57%	33% *
Finance, Insurance, Real Estate	3%	10% 2% *	6%	14%	5% *	25%	34%	23%	35%	21% *
Education, Health and Soc. Services	5%	13% 3% *	6%	12%	5% *	19%	25%	18%	25%	16% *
Information	2%	7% 2% *	7%	8%	7%	26%	41%	22%	36%	20% *
Mining and Manufacturing	13%	34% 9% *	14%	31%	10% *	30%	42%	25%	39%	22% *
Public Administration	2%	12% 1% *	3%	12%	2% *	17%	24%	14%	23%	14% *
Professional and Business Services	8%	25% 4% *	12%	24%	9% *	29%	38%	30%	40%	28% *
Entertainment, Rec. and Food Services	21%	28% 14% *	20%	25%	15% *	37%	45%	36%	44%	29% *
Other Services	16%	29% 10% *	15%	26%	11% *	32%	39%	33%	46%	27% *
Utilities and Transportation	10%	22% 7% *	7%	17%	6% *	22%	35%	26%	39%	24% *
Wholesale/Retail Trade	11%	22% 7% *	10%	17%	7% *	33%	42%	29%	41%	24% *

FPL = Federal Poverty Levels

* <200% vs. 200%+ FPL are statistically different, p<.05. Estimates in the highlighted table cells are based on a sample size <50.

All workers includes the self-employed. Excluded workers: military, those whose industry was unknown or in an unclassified industry

Data: MEPS (3 pooled years 2004-2006)



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