

Viewpoint: Private employers and public health

David Satcher, MD, Surgeon General of the United States, believes employers can play a significant role in improving the health of America. In an interview with *Business & Health* Editor Rick Service and Contributing Editor Annmarie Geddes Lipold, Satcher, who began his four-year term in February 1998, explains how employers benefit from investing in their employees' health. Satcher also offers his views on mental health issues, makes suggestions for reducing fatal medical errors and shares his vision for covering the 42 million Americans who don't have health insurance.

BUSINESS & HEALTH: *There are many reasons why the workplace is a prime target for adult public health initiatives. But what's in it for employers?*

SURGEON GENERAL SATCHER: I think it's very clear that workplace lifestyle programs benefit the workplace. They lead to increased productivity among workers and also improve peer relationships in the workplace....

I've made it clear during my term here that I believe that wellness—if you will, a lifestyle—is not just the responsibility of individuals but the responsibility of communities and [health] professionals. The studies that we have suggest that when [wellness] programs are in place, they also improve retention and recruitment. Part of what we're saying in terms of benefit is that when you have these kinds of programs, it's likely you're going to maintain the people you want to maintain much longer than you would otherwise.

B&H: *What are the top health problems employers should address right now?*

SATCHER: Clearly, employers should address the health problems that relate to lifestyle such as smoking and obesity, which are major risk factors for heart disease, cancer and diabetes. Employers have an opportunity to address those problems in the workplace, and my argument is that it has both short-term and long-term benefits.

If you look at the major causes of death in this country—cardiovascular

disease, cancer, stroke, etc.—then the major risk factors are for the most part lifestyle. They are physical inactivity, smoking, and poor nutrition. Obviously, employers can also make sure that their employees engage in the appropriate screening programs, including cancer screening, immunization. That can save lives, by the way.

B&H: *What kind of concerns do you have about employers who are cutting back on health benefits because medical costs are going up and the economy is soft right now?*

SATCHER: I think a comprehensive health benefits program is a good investment for employers in the short run and long run. I would think twice before cutting back there.

I know there's a short-range temptation to cut back on those programs. I would probably recommend, in many cases, that those programs be modified to put more emphasis on the lifestyle areas.

I would have the physicians put much more emphasis on not just treating people when they get sick but on counseling people and prescribing lifestyle changes and talking to people about the early detection of diseases by screening programs and regular immunizations where they are indicated. Putting all these things together with traditional medical knowledge is a good investment.

B&H: *There is a trend among employers to shift more of the cost of health care on to employees. How do*

you think this increase in the financial responsibility that patients have for their health care might affect their buying behavior?

SATCHER: That's hard to answer, because we're talking about a shared commitment to good health and how it's shared or broken down between employer and employee. Some people have more disposable income than others, so the likelihood that a person would make a commitment to continue a program would depend upon the impact that cost had on that individual person and family.

One of the problems we have in this country is that of the 41 to 42 million people who are uninsured, the majority of them work every day. They don't necessarily have the income that allows them to buy health insurance. Any employer has to look at that and ask the impact on different segments of the employee population.

B&H: *What about prescription drugs? What if differentials in copays start to widen to \$50, say, instead of \$15?*

SATCHER: You're asking me about an economic model, and I don't lay claim to that expertise. I do know there are economists who could tell you what the risks would be—at each level—of losing a certain percentage of people. I do know that there's a level at which people are not going to choose health or health care over other essentials. It's a matter of people's values, especially when it comes to their family.

B&H: *What should be done about all these working people and their families who don't have health insurance?*

SATCHER: I believe, first and foremost, we as a nation should make a commitment to universal access to health care. We should bring the best minds we can find together to decide how best to reach that goal. To what extent do we do it through employers

and tax credits? To what extent do we have a "public program" that covers everybody up to a certain level and also allows other people to buy into it? Those are technical questions.

I think we should make a commitment to universal access and provide the necessary incentives for participation in that program and disincentives for not participating. I think we should take advantage of the workplace, but also making sure that there is "safety net" so that nobody gets left out or left behind. I'm not ready to give the details of what that system should be. The problem is we have not made the commitment to universal access. It has to be beyond politics . . .

B&H: *Turning to another issue, what kinds of carrots and sticks would you like to see applied to the whole problem of fatal errors in hospitals? Even if there are solutions you favor, what do you see as the obstacles to implementing them?*

SATCHER: We have available to us the technology to prevent many of those errors. We have not brought that technology to bear on our systems in the hospitals or even in physicians' offices. The technology is there to put in place systems that do not depend upon someone's memory or someone's handwriting or even somebody's communication with another person.

The question then becomes: "How do we make sure this happens?" In terms of the stick, I would say one of the first things we need to do is make sure that people have access to the information about medical errors. I think that in itself will be a tremendous incentive for a lot of people to reduce their error rate because they don't want it known, the nature and magnitude of the errors that take place every day. We have to make it clear that people are no longer going to be able to hide. That the information about what errors take place on a day-to-day basis on a year-to-year basis will be available for potential patients and clients to review.

B&H: *What's your assessment of the mental health of America and the problem of depression?*

SATCHER: I released the first ever Surgeon General's Report on Mental Health in December of 1999. And the response to that report has, in our opinion, been greater than any other report in recent years, since probably smoking and health.

In that report, we pointed out that one in five Americans suffer some form of mental illness each year. That was the thing that surprised so many people—talking about almost 45 million people suffering a diagnosable, known disorder.

But the good news in the report was that 80 to 90 percent of the time we have the ability to treat people and return them to productive lives and positive relationships. The bad news was that less than one half of the people who suffer mental illness even seek care, either because they don't understand that we have the ability to treat or because they're afraid of the stigma that surrounds mental illness that we're still struggling with in this country. We have about 31,000 suicides in this country every year, 81 every day—we have 500,000 attempted suicides that we treat in the emergency rooms.

On a day-to-day basis, for both children and adults, depression is a major cause of low productivity and poor relationships. Depression clearly interferes with individuals performing at their optimum—whether students in school or workers in the workplace. But between the mild depression and suicide, there's the depression that many people carry with them every day. They don't get treated, they don't seek treatment because they don't want to be labeled as mentally ill.

The workplace could help to solve that problem, by the way, because people are also afraid that if they list on their application that they have been treated for a mental illness that it's going to dramatically decrease their

chance of getting the job. They also believe it could interfere with promotion and job responsibility.

B&H: *In terms of mental health, are there equivalents to the lifestyle programs we talked about at the outset that have a direct impact of physical health?*

SATCHER: One of the things we said in the report was that, unfortunately, today we know more about mental illness and how to treat it than we know about mental health and how to promote it and prevent mental illness. We need more research. We're getting more and more of that research done. We do know, however, that physical activity is one approach to dealing with depression.

B&H: *What is an employer to do about an employee who has demonstrated the symptoms of depression?*

SATCHER: No. 1, they can make sure they create the kind of environment where people know that it's okay to seek treatment for depression and mental illness.

Every employer in this country can help to change the environment so that people feel comfortable and safe in seeking treatment for depression or any other mental illness.

I said employers, but if you're a supervisor with 20 people under you, you could get together to talk about [depression] or use videotapes. You can change the environment in your office. It doesn't have to be the whole plant.

Physicians who work in various worksites have a major responsibility, too, with their relationship to patients.

One of the problems we have is that so often physicians on the front line, even when they do see patients, don't recognize depression. A lot of patients go to physicians complaining of headaches and back pain, and unless the right questions are answered we miss [depression]. Seventy percent of the elderly who commit suicide have seen a physician within one month of that suicide, and in most cases not been diagnosed as being depressed.