What's Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness

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Abstract With great interest, employers in the United States are using wellness programs to reduce insurance costs and monitor the health of their employees. While these programs are often embraced as benign in their assessments and positive in their outcomes, this perspective fails to consider the discriminatory effects on people with disabilities. The case of *Seff v. Broward County* in 2012 addressed the question of whether wellness programs violated the Americans with Disabilities Act (ADA). Finding a safe harbor in the ADA for bona fide insurance plans, the court concluded that the initiative did not violate the act, even though employees were penalized monetarily. This article argues that wellness programs institutionalize disability bias and a false perception of health attainability. People with substantial physical or mental impairments will not be able to control many aspects of their health, even with concerted efforts. Embedded in this approach is the notion of responsibility for and control over all aspects of one's health, including disability. This kind of orientation further perpetuates a neoliberal approach to society where autonomy trumps community-based supports and acceptance of differences.

Introduction

Wellness programs increasingly are gaining traction in American workplaces, as well as internationally. Towers Watson (2012), a human resources consulting firm, estimates that over 65 percent of multinational employers have some wellness initiatives, with wellness initiatives being more robust in the United States. These initiatives can range from developing an on-site gym for all employees to requiring health screening for obesity. Employers are also moving more in the direction of tying both rewards and penalties

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to participation and biometric goal achievement in wellness programs. The recent passage of the Patient Protection and Affordable Care Act (ACA) enables employers to offer incentives to employees that could be as much as 30 percent of the total cost of health insurance, with exceptions allowed for some employers to move to 50 percent as needed (EBSA 2012). A primary motivation of these programs is cost savings in health care, but also important is the often overlooked nexus with personal responsibility arguments.

By tracing both the separate histories of the wellness and disability rights movements, this article explores the shift toward a wellness orientation in health discourse that also tracks a rise in neoliberal policy and ethical orientations in the United States (Prasad 2006). But what exactly is neoliberalism, and how does it relate to employers' wellness programs? At the core, neoliberalism "proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade" (Harvey 2007: 2). State intervention is kept to a bare minimum unless it supports these goals. Inevitably, neoliberalism "seeks to bring all human action into the domain of the market" (ibid.: 3).

Under these conditions, ethical problems become economic ones, and what is best for society, however measured, is whatever serves the advancement of the economy and increases autonomy. As David Harvey (2007) has noted, neoliberalism supports a rise in individual politics and movements such as civil rights and feminism while concentrating class power in elites and removing social supports. Neoliberalism transforms the concept of autonomy in some ways to produce independently functioning citizens who are now in charge of their rights. Society works as long as the market is working and the market—and access to it as both a producer and a consumer—guarantees individual freedoms. Reaching these goals is only possible through "responsibilization," where the best members of society are the ones who are able to regulate themselves and act in service to the market and its values (Rose 1999).

Neoliberalism thus disadvantages certain groups, and this disadvantage seems to be multiplied by preexisting financial marginalization: those on the economic fringe become less valuable and less likely to meet the new norms (Ewig 2010). A clear example of this combination of disadvantage is people with disabilities, a minority group that reflects high levels of unemployment, undesirable health status, and a perception of social and economic drain on the greater system. People with disabilities make an excellent lens through which to consider the potential discriminatory effects and intents of wellness for several reasons. In the midst of a discussion of bodily optimization and personal choice, they can be the perceived “outliers,” the exceptional cases for whom wellness and individual responsibility might not work. People with disabilities, however, constitute about 19 percent of the overall population, and many are already present in the workforce, just to a lesser degree than nondisabled people, reflecting a social history of discrimination (Brault 2012). Further, disabled workers are living barometers of some of the insurmountable deficits of a market-driven approach to social and legal improvement. Even after the enactment of the Americans with Disabilities Act (ADA), which was designed to combat discrimination, they face greater unemployment rates than people without disabilities (Bagenstos 2000). If wellness, and the neoliberalism that undergirds it, both reinforces and reifies a pick-yourself-up-by-your-bootstraps mentality, then people with disabilities and other minority groups with limited access to resources for health and safety will continue to struggle as the healthiest of workers receive the best benefits and privileges.

Harvey (2007), in his exploration of neoliberalism, suggests that the solution might lie in crafting an alternative model of rights that shifts away from the individual to what communities might expect in the way of protections and support. As I argue in this article, the disability rights movement, unlike the wellness movement, provides the first inklings of what that discourse might look like and where it will place acceptance and interdependence as values. Indeed, workers with disabilities provide greater insights beyond their own population into the problems of wellness for other marginalized segments of the population. They offer a mirror for a critique of wellness as neoliberalism by exposing the flaws in its arguments about behavioral control, personal responsibility, and bodily optimization—as well as the limits of identity politics and individual rights discourses.

In part 1 of the article, I provide an overview of the common facets of modern employer wellness programs. Then, in part 2, I highlight the tensions between the wellness and disability rights movements by tracing their respective histories and current trajectories, tying wellness to neoliberal societal trends. Finally, in part 3, I chronicle the philosophical and practical fallout for people with disabilities and other marginalized populations that come from neoliberal wellness approaches.

1. Modern Wellness Programs: A Brief Introduction

A. Definition and Approaches

One difficulty surrounding wellness scholarship has been defining what wellness programs are. For purposes of this article, I define wellness programs as efforts by employers, often in concert with their insurance companies and external consultants, to reduce health care costs by inducing employees to be "healthier" in their behaviors and lifestyle choices. In this section, I also look to current trends by examining both how courts have interpreted wellness and what the state of the art is in implementation.

How courts are defining wellness can be telling. Both the district and appellate courts in *Seff v. Broward County* in 2012 addressed the function of wellness programs in considering an ADA discrimination claim made by employees who declined to participate in a health questionnaire and biometric screening associated with the employer's wellness program. These employees incurred a biweekly $20 charge for their refusal (Order Granting Defendant's Motion for Summary Judgment of 2011, *Seff v. Broward County*, No. 10-61437-Civ. (S.D. Fla. Apr. 11, 2011) [hereafter cited as Order Granting Defendant's Motion for Summary Judgment]). Both courts found in favor of the employer. The record at the district court level, in particular, illuminates how cost and risk considerations guide the creation of these programs. The *Seff* district court framed wellness programs as based on a theory that "encouraging employees to get involved in their own healthcare leads to a more healthy population that costs less to insure" (Order Granting Defendant's Motion for Summary Judgment: 6). The court fully acknowledged that the approach was based on "assessing risks" because Broward County had been "saddled with an aging workforce" (Order Granting Defendant's Motion for Summary Judgment: 2, 7). It disagreed with the employer's claims of "altruism" and "some independent desire for a healthy workforce" (Order Granting Defendant's Motion for Summary Judgment: 8).

Wellness efforts, even united by a common thread of risk management and risk reduction, can take many forms—from highly structured health interventions with concomitant rewards and punishments to simply improving the nutritional value of cafeteria food. These initiatives can be as active as individualized health coaching to as passive as placing exercise equipment in the workplace without any directives or educational campaigns (Mello and Rosenthal 2008). Incentives for participation can also be varied, including prizes (e.g., gift certificates, cash prizes, drawings); reduced premiums; waiver of health-related fees (e.g., co-pays, health club memberships);

employee education; and structural changes in the workplace (e.g., ergonomic furniture, meditation space, flexible schedules to accommodate exercise or stress reduction).

As wellness programs have grown in the United States, so have awards for the ones with the best features (WELCOA 2012). These exemplar programs give us insights into current trends in the field. One of the most recognized wellness awards, the C. Everett Koop National Health Award, gave top honors to the State of Nebraska and L.L.Bean in 2012 for their wellness programs. L.L.Bean's program includes on-site fitness centers, walking trails, health education classes, healthy food offerings, and the Healthy Lifestyles Program (HLP). According to the company, the HLP is "a comprehensive Health Risk Appraisal program linked to the company's health insurance plan. Employees and spouses/domestic partners who choose to participate in the programs pay significantly less for their health insurance premiums (up to $2,900 less/year)" (Koop National Health Awards 2012a). Participants in the HLP complete an annual health-risk assessment, a biometric health assessment in alternate years, and an employee self-survey of "modifiable risks." They are then sorted into three risk categories for tailored coaching (high risk, moderate risk, and low risk).[1] L.L.Bean has seen the greatest returns through its smoking cessation program and its transition to tobacco-free work environments, dropping the employee smoking rate from 24 percent in 1985 to 5.6 percent in 2011 (ibid.). These dramatic reductions could be attributed to a range of factors, such as the employer providing free nicotine patches and gum, making the L.L.Bean campus smoke-free, and offering regular smoking cessation support. L.L.Bean's statistics also take into consideration a period of twenty-six years, in which smoking rates were also declining in the United States to a current level of about 20 percent (Saad 2012).

The state of Nebraska, also a 2012 Koop Award winner, began its "wellnessoptions" program in 2009, in response to increasing health care costs. Through "wellnessoptions," Nebraska offers its employees "web-based resources, health risk assessments, onsite biometric screenings, health coaching, and more" (Koop National Health Awards 2012c). Nebraska was one of the first state employers to integrate its health insurance with its wellness program. Nebraska heralds its "targeted messaging" approach as contributing to the successful launch of the program and its sustainability.

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[1] People grouped in these three risk categories receive different levels of telephone coaching to increase their wellness, ranging from unlimited outreach by the coach and unlimited coaching session requests for the high-risk participants, to one outreach session by the coach and unlimited coaching session requests by the low-risk participants (Koop National Health Awards 2012a).

Program directors increase compliance by sending home mailings (more than 146,000 reminders in just a one-year period) and making other forms of contact to remind employees of screenings that are due, inform them about the insurance coverage that will be provided, and offer resources for addressing those health issues. The state, in its employer role, uses data from health care claims to monitor employee compliance with these health recommendations (Koop National Health Awards 2012b). Nebraska counts among its successes reductions in prescription use, emergency room visits, hospital admissions, and lengths of stay (ibid.). The employer attributes these reductions to increased use of preventative screenings and interventions. Before the program, Nebraska's health care costs were rising at double-digit rates, but after the program, they have been less than 1 percent (ibid.).

Both of these programs are useful examples of the state of the art in wellness initiatives; they provide examples of the models to which other employer programs might aspire. They combine employer-led efforts with integration and support from insurance companies, as well as wellness professionals. Additionally, they do more than provide passive wellness resources for their employees; they take active, hands-on approaches to reduce undesirable costs and the behaviors associated with them. In both of these aspects, they represent current approaches to innovations in employer wellness initiatives and also provide the contours for the complexities and limitations these programs pose.

B. The Legal Limits of Wellness Programs

Even post-*Seff*, intervening in employees' health, whether by passively offering resources or by collecting actual data and tying benefits to it, implicates a complicated web of federal and state laws and regulations—among them the Health Insurance Portability and Accountability Act (HIPAA), the Employee Retirement Income Security Act (ERISA), the Genetic Information Nondiscrimination Act (GINA), the Age Discrimination in Employment Act (ADEA), the Pregnancy Discrimination Act (PDA), and the ADA. Other contributors to this special issue (see Madison, Schmidt, and Volpp 2014) have provided a rich analysis of some of these statutes and their effects on wellness programs, but an abbreviated version of the legal limitations on wellness programs is in order here, as well. My focus is on the legal potential for discrimination in wellness programs, as well as de facto discrimination that can occur from employers having so much access to information and control over its implications.

In the context of disability as the lens, focusing on HIPAA and the ADA is the most useful project for understanding the legal limits of wellness programs as they currently exist.

By way of overview, Michelle M. Mello and Meredith B. Rosenthal, writing in the *New England Journal of Medicine* (2008), have provided a useful introduction to the nondiscrimination issues raised by wellness programs—an issue central to this article and the remainder of my discussion. Mello and Rosenthal's approach is broad, as they attempt to provide the reader with the overall contours of these legal limits on information gathering and behavioral intervention.

In examining HIPAA compliance, Mello and Rosenthal distinguish between two kinds of programs that trigger differing levels of scrutiny to ensure protection from discrimination based on health status or information. The first is where rewards are based solely on program participation (e.g., gym membership, reimbursement for entering smoking cessation programs, prizes for taking care of annual diagnostic testing—regardless of outcome). Mello and Rosenthal flag these programs as voluntary and "automatically permissible," contrasting them with the second kind of wellness program where rewards are based on the attainment of certain health standards, such as cholesterol targets, a certain body mass index (BMI), or proof of smoking cessation. These programs, according to the authors, are acceptable with certain limitations, including the need for an alternative standard in the wellness program (Mello and Rosenthal 2008). For example, if reduced health insurance premiums were tied to achieving an LDL cholesterol number of below 100 mg/dL through diet and exercise and an employee was genetically predisposed to have high cholesterol, perhaps because of his or her genetic makeup or ethnic heritage, the employee could be given another path to reducing his or her insurance premium or allowed to reduce the premium by taking cholesterol-lowering statins. Similarly, if employees are given $100 gift cards to an online retailer for losing twenty pounds in three months through the wellness program, and a wheelchair user with fragile bones would not be a good candidate for such weight loss or high-impact exercise, that employee should be provided with an alternative standard, such as logging daily physical activity or setting a more modest weight-loss goal, even if the final BMI number was not the employer's ideal target.

While HIPAA provides for this alternative standard, its original regulations did not provide many specifics on what compliance or noncompliance looked like aside from requiring that the employer, through its health care plan, disclose that a reasonable alternative standard or the waiver of an otherwise applicable standard is available (ACA, 45 C.F.R. § 146.121, "Prohibiting Discrimination against Participants and Beneficiaries Based on a Health Factor" (2006)). New rules to take effect in 2014 offer some additional guidance, most notably by breaking down "health-contingent wellness programs" into two types: "activity-only" and "outcome-based" programs that trigger different reasonable alternative requirements (Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158–33,192 (2013)). For "activity-only programs," a reasonable alternative standard to receive the reward must be provided to any person for whom achieving the standard is medically difficult or inadvisable (Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,158). In contrast, outcome-based programs that provide rewards on whether an individual has reached a certain biometric, or health outcome, must build reasonable alternative standard access for all people who did not meet the original health standard. For the first set of programs, employers and their wellness programs can request documentation from employees' personal physicians. For the second set of programs, employees do not have to provide such documentation to access reasonable alternatives (Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,158).

Reasonable alternative standards do not need to be anticipated or crafted in advance; they can be created as the need arises, taking into consideration the facts and circumstances of the employee's limitations and the "reasonable design" of the program itself (Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,158, 33,163). Changes in standards should also come with appropriate adjustments in time to achieve those health standards, the new rules suggest. The rules provide some additional examples of whether a reasonable alternative standard has been met:

- If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable.
- If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

- If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness (Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,158, 33,163–33,164).

These initial contours for compliance will be helpful to employers and their insurance plans, but they could go farther in laying out what a model process for the request might look like, as well as when an employee has a claim for noncompliance and what the remedies will be. Mello and Rosenthal do not explore the significance of this lack of follow-through on regulatory guidance. For a provision to be meaningful, such as this alternative standard, employers need to know how to achieve compliance in a timely manner and what the sanctions will be for their failure.

Mello and Rosenthal's treatment of discrimination issues in wellness programs focuses less on disability discrimination than perhaps it should. The ADA is an important yet underexplored set of legal limits for these programs. While it contains no provisions with specific language for wellness programs, Title I of the ADA prohibits discrimination against employees with disabilities in hiring, firing, advancement, benefits, and other aspects of employment (ADA, as amended, Pub. L. 110-325, 42 U.S.C. 12101 (2011)). Clearly, wellness programs would be a benefit in the workplace, subject to ADA compliance. For example, if an employer provided a gym to its employees as part of its wellness outreach yet failed to provide it in a physically accessible location within the building or refused to offer adaptive exercise equipment when an employee with a disability requested it, then the employer could be in violation of the ADA.

Title III of the ADA provides equal access to public accommodations, such as requiring membership-based gyms to provide ADA-compliant doorways and toilets, doctors to provide interpreters to deaf and hard-of-hearing patients, and insurance companies to provide materials in alternative formats for low-vision and blind readers. The broad definition of public accommodations extends to insurance, but some courts have read a safe harbor provision in the ADA that allows insurers to be protected when it comes to different pricing systems for people with disabilities, if their health conditions increase their risk of incurring increased medical expenses (*Seff v. Broward County*, No. 11-12217 (11th Cir. 2012)).

Essentially, the courts have deferred to actuarial tests of risk to allow employers to defend against claims of disability discrimination while requiring other health-oriented resources to achieve ADA compliance.

Finally, the ADA also protects employees' health information, providing rules for the confidential storage and limited dissemination of those data, and also requires that health inquiries be job related and consistent with business necessity (EEOC 2011). If a wellness program is voluntary and not tied to the achievement of a certain biometric standard, however, employers can treat employees with disabilities similarly to nondisabled employees by using carrot-and-stick methods of assuring participation and compliance, such as reduced insurance premiums, prizes, and peer pressure (EEOC 2000). The Equal Employment Opportunity Commission (EEOC) has warned in two 2009 opinion letters that employers should worry about health-risk assessment questions that are simply covers for disability-related inquiries and medical examinations, particularly where securing health coverage was dependent on employees' responding to those queries (EEOC 2009). Employers may not use "standards, criteria, or methods of administration" that "have the effect of discrimination" based on disability (ADA, as amended, § 12112(3) (2011)). Employers implementing wellness programs, therefore, should be concerned if their metrics have the potential to generate categories that could be viewed as proxies for a disability or different kinds of disabilities. Wellness initiatives cannot become subterfuges, intentionally or not, for policies and practices that result in discrimination against people with disabilities (Rubenstein 2009).

Accessing health information triggers the ADA's privacy and confidentiality provisions, as well. Employers are allowed access to such data only under limited circumstances, such as to evaluate candidates with or without disabilities to see if they can perform the essential functions of the job or to recertify employees for safe return to work after accidents or illness-related absences (EEOC 2000). Even when employers do get access to medical information or are able to conduct medical inquiries, the scope of their inquiries must be such that it does not result in unnecessary bias against people with disabilities and the proliferation of unemployment among people with disabilities because of stereotypes and misperceptions about disability (ibid.). The ADA drafters recognized that unconscious bias could enter the hiring, retention, and promotion processes when applicants and employees with disabilities are subject to wide-reaching medical scrutiny irrelevant to job performance (ADA, as amended (2011)). Medical inquiries must be narrowly tailored and serve a legitimate employment purpose, such as the ability to perform the job's essential functions or concerns about whether the employee poses a direct threat to the safety of the workplace (EEOC 2000).

Wellness programs, in sum, can pose legal and regulatory complexities. Successful implementation can be difficult and should be weighed against the actual return on investment, considered along with not only the legal costs but also the potential effects for discrimination. While Mello and Rosenthal have briefly addressed disability discrimination in the context of wellness programs, their analyses do not reach the most important issues regarding the philosophical underpinnings of these programs and the practical fallout. These last pieces of the argument are my focus for the remainder of this article.

2. Histories, Principles, and Tensions: Disability and Wellness

To understand the actual implications of wellness programs and the relationship with disability rights, one needs to first understand the philosophical underpinnings of each movement. The wellness and disability rights movements evolved around the same time and in much of the same cultural milieu, yet their orientations and goals are strikingly different. One of the fundamental tensions between wellness and disability is that of how people should regard their physical and mental states. Disability rights, through a long history of concerns about stereotypes and bias based on physical and mental differences, encourages a view of acceptance of such diversity, while wellness embraces maximized improvements wherever possible (Altman 2001). Some historical context is helpful to show the divergences and conflicts between these approaches, both through rights-based and philosophical lenses.

A. The Disability Rights Movement: Disability Concerns as Civil Rights

The rise of production systems made the physical and mental impairments of people with disabilities salient social categories; those who could not work became less valuable in an industrializing society, while those who could had the promise of greater access to independence and autonomy (Kimberlin 2009). In some ways, people with disabilities were experiencing the beginning strains of neoliberalism before there was even a label for it. At first glance, this kind of insight into disability rights' roots is essentially Marxist (ibid.). However, the eventual valuation of labor participation erected cultural and social barriers that both moralized the experience of disability and further excluded people with disabilities—eventually spurring activism in the form of a civil rights movement focused on empowerment (ibid.).

While awareness about disability issues also gained traction in American society from industrialism and the disabilities that it created, as well as the return of veterans with newly acquired injuries from the two world wars, the history of a self-governing independence movement is much shorter (O'Brien 2001). The civil rights movement for people with disabilities traces its origins in the United States to the 1970s, when students with disabilities at the University of California, Berkeley, began to organize themselves for greater access within the university and expanded their advocacy to the surrounding community (DRILM 2004). They galvanized for independent living for people with disabilities and challenged paternalistic decision making that left people with disabilities at the mercy of parents, doctors, and government. These students were informed and inspired by concurrent and recent civil rights movements that focused on women, people of color, and sexual liberation (Kimberlin 2009). Within disability rights, the galvanizing experience among people with disparate impairments was shared discrimination. As a new social movement, disability rights attempted to transform both material rights and consciousness (ibid.). Other scholars have argued that disability rights has gone farther than that in its goals and should be recognized as a form of liberation because of the vast changes it has brought to both the political, financial, and social lives of people with disabilities (Shakespeare 1993). Regardless of its characterization, the movement has been successful in part because it has leveraged coalition building across the political spectrum and in concert with other minority groups (Kimberlin 2009).

Unlike some other civil rights movements, however, disability rights could not succeed based on autonomy arguments alone. The kind of assistance needed in removing physical barriers in the built environment, for example, or providing pathways to work for some members of the community, while keeping social benefits strong for others who could not work, made both support and interdependence core values of the effort. Expanding employment opportunity and workforce integration was a key component of the movement. Advocates for this new wave of empowerment recognized the need for people with disabilities to have access to financial independence but not at the risk of dismantling valuable community-based services and government benefits. Navigating this path of perceived divergent interests was tricky, but it meant that disability rights as a movement adopted tenets that focused on including the voices of people with disabilities in the creation of policies, bolstering autonomy in decision making, and changing attitudes about people with disabilities as passive recipients of other people's decision making. Rather than eliminate the differences posed by nonconforming minds and bodies, disability rights embraced a rights-based approach that was grounded in acceptance of bodily impairments and rallied against artificial barriers that were constructed that prevented people with disabilities from engaging in civil society or participating in the workforce (Kimberlin 2009).

The combined advocacy efforts led to the passage of the Rehabilitation Act, an attempt to eliminate disability discrimination in government and federally funded programs, and the eventual passage of the ADA of 1990 (DRILM 2004). The ADA's provisions have been described as "broad-sweeping"—from nondiscrimination in employment to places of public accommodation (Befort and Thomas 1999: 71).

With support for the ADA also came backlash, the latter grounded in a perception that legislators and people with disabilities themselves had suddenly put additional, cumbersome burdens on businesses and employers with the ADA's integration and accommodation mandate (Lindsay 1989). The reasonable accommodation provisions of the ADA are indeed an example of how civil rights for people with disabilities might differ from protections for other historically disadvantaged groups. People, largely non-disabled, must take affirmative steps to change policies, practices, and even building facades to enable people with disabilities to travel freely, take advantage of consumer goods and services, and work alongside people without disabilities (Mayerson and Yee 2001). These changes, unlike purely attitudinal ones, can carry tangible costs and manifestations. However, as many disability scholars have noted, the attitudinal changes have been among the most difficult to achieve in the years following the ADA's passage (Bagenstos 2000). As I argue in this article, a rise in neoliberal practices has not helped this situation but has rather reinforced the idea that the only valued form of participation is one that is autonomous.

The "social model" of disability was at the core of the advocacy of the disability rights movement, recognizing that people with disabilities were limited not by their physical or mental differences as much as by the barriers that society had erected to integration and independence (Davis 1995). The social model recognizes that interdependence is at the heart of inclusion; members of society do not function alone, but they depend on others for the fulfillment of their rights and access on a daily basis. For example, while a person using a wheelchair has tangible physical limitations, maneuvering through the world with assistive equipment would be less of an impediment if sidewalks, entryways, and doors were designed with universal access in mind. Those same curb cuts provide access to nondisabled parents with children in strollers, mail carriers with heavy carts of items to deliver, and able-bodied children too small to navigate high curbs. Yet the fix, the accommodation, is seen as something extra for a population that contributes little to the economy.

While people with disabilities are still engaged in an emerging civil rights movement, the group's experience of discrimination runs deep—from so-called ugly laws of the early twentieth century that prevented people with physical and mental differences from being on public streets to the sterilization of people with disabilities in the United States and around the world (Schweik 2009). Disability rights advocates have sought to untangle a long history of assumptions that people with disabilities are dependent on the charitable acts of others, not suitable for work, and offer very little to the economy and society (O'Brien 2001). It has also attempted to unravel a message of deservedness for disability—that somehow moral or personal failings have led to an undesirable health state that can then be used to judge the character and worth of the disabled person (Evans 2004).

One critical goal of self-advocates in empowering people with disabilities through legal change was ensuring that their talents would be engaged fully in the economy and society. As the rate of disability unemployment remains two to three times higher than that of nondisabled people, work takes on increasing concern because of its links to integration and economic self-sufficiency (ODEP 2012).[2] The ADA challenged workplaces to be flexible and adaptive in their thinking—and to be disability aware and difference respectful in creating new programs and policies. Fundamental to the ADA and disability advocates' visions is the concept that disability should not be stigmatized and penalized—as a perceived choice, individual failing, or uncomfortable difference (Hahn 2000).

This civil rights approach was influenced by, and also affected, a larger cultural critique of approaches to disability. One dominant thread of this work is how people with disabilities are penalized for not appearing normal, in their bodies or behaviors. Disability studies scholar Rosemarie Garland-Thomson argues in her writings on staring that the initial social evaluations that people make based on another person's appearance, and its

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[2] In September 2012, the ODEP reported that labor force participation was 21.9 percent for people with disabilities, compared with 69.3 percent for people without disabilities. The comparative unemployment rate was 13.5 percent for people with disabilities and 7.3 percent for people without disabilities.

conformity to what is considered to be "normal," become embedded with moral evaluation as well. These appearance-driven evaluations become proxies for social and individual worth, disadvantaging people who look different. Visual assessments go beyond metaphors to be viewed as tangible data about the person. In much the way that "good people" are those who stand up and are morally upstanding, so, too, do seated people in wheelchairs seem to exude sloth or dependency (Garland-Thomson 2009). In a neoliberal society that values contributions to the market, these perceptions do little to serve the advancement of people with disabilities.

Intertwined with these cultural narratives about the appearance of disability as a proxy for moral worth are social imperatives to move beyond disability, through bodily enhancement and optimization. The disability studies scholar and ethicist Gregor Wolbring (2008) suggests, for example, that ableism be defined not so narrowly to just be discrimination against people with disabilities but to recognize the ways in which society values some forms of functioning and certain abilities over others. He warns that science and technology are not the panacea to eradicating disability, but rather they have vast potential to multiply disabilities by suggesting that all persons can enhance themselves or be a better and improved form of themselves (ibid.). As we continue to remove physical and mental limitations through these advancements, the people who do not choose to take part in the improvements, or simply cannot access them, will become the new class of disabled people (ibid.).

Another thread of moral judgment that runs through the lives of people with disabilities involves separating out those individuals with the will to enjoy a "normal" and productive "pace of life" from those who do not seem to want it or are unable to achieve it (Wendell 1996: 37). The disability and feminist studies scholar Susan Wendell has described the ways that disabled people are encouraged to live beyond their bodies, ignoring any emotional or physical pain and limitations, to keep up with the "pace of life." This pace is constructed from able-bodied norms and is hardly questioned beyond disability studies for the ways that it creates and exacerbates the social status of disability. Further, the "pace of life" renders people who are experiencing pain as undesirable and to be avoided because seeing the disability struggle reminds nondisabled people about their own weaknesses and frailties. Therefore, this notion of the pace of life serves several functions, among them to distance and judge people who cannot keep up and to avoid recognizing how normalizing judgments about bodies and the message to overcome—the "myth of control"—create disabling social categories (ibid.: 111). Wendell argues that to accept disability as difference means to give up the idea that people can and should always control their bodies and, therefore, to dispense with the notion that they are responsible for their lack of compliance (ibid.).

B. The Wellness Movement: A Model for Improved Health

Over the past four decades, employers in the United States, in particular, have developed strong interests in wellness; this timeline runs parallel to the expansion of disability civil rights (Reardon 1998). Employer wellness programs, too, share significant influence from the two world wars, in which advances in technology and medicine changed the health needs of the population, introduced new ones (such as from returning veterans), and shifted the focus of health (Miller and Foster 2010). In 1959 Halbert L. Dunn introduced a working definition of wellness—"maximization of health through an integrated method of functioning, keeping in consideration an individual's environment" (Miller and Foster 2010: 5). Providing an extensive overview of the wellness literature, Gord Miller and Leslie T. Foster have noted that, over time, "chronic and lifestyle illnesses (e.g., heart disease, diabetes, cancer), associated with numerous stressors in life and the workplace, became the primary health concern" (ibid.). Wellness expanded to include the elimination of disease and disability, particularly those illnesses viewed as lifestyle-driven.

Scholars trace the evolution of wellness as a health concept to something of concern to employers by noting (a) employers' growing concerns about cost containment, (b) the influence of the occupational safety and health movement of the 1970s, and (c) the worksite health promotion movement of the same era (Reardon 1998). At first glance, these origins, particularly those focused on eliminating or reducing workplace injuries, do not seem so far afield from the disability rights movement's principles of dignity, acceptance, and respect. Workers should be provided with environments that do not exacerbate or introduce new forms of disability. Viewing employees as whole persons also can lead to programs that emphasize the importance of work-life balance, family needs, job satisfaction, and emotional well-being. This kind of view of wellness tracks the World Health Organization's (WHO 1999) current definition of health—"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Articulated through workplace-based programs, however, wellness takes on a different meaning than this relational well-being perspective. The wellness literature and wellness programs characterize disability as what is to be eliminated. For example, MediFit (2012), a corporate wellness program consultant and manager, offers that its services will allow employers to have lower disability costs and happier employees who are also healthier.

One wellness initiative, through New York University's Langone Medical Center, is specifically designed for women with physical disabilities and unconnected to an employer program. This program offers hairstyling services at its medical campus because "wellness is coupled with inner beauty and outer beauty" (NYU Langone Medical Center 2013). These programs are just a few examples of how wellness implicates personal responsibility, choice, and optimization.

The achievement of wellness, and a plan for it, becomes intertwined with fundamental definitions of health that are measurable in terms of insurance costs and other numbers, such as sick days and productivity levels. The very definition of health shifts. Felicity Bishop and Lucy Yardley (2010) have summarized three dominant, contemporary approaches to health—health as something one is, as something one has, and as something one does. All three approaches are grounded in an understanding that health means the absence of disease, sometimes because you are simply "healthy," you have overcome an illness, or you make healthy choices and practice behaviors that reduce disease and chronic conditions. These three approaches are themes in employer wellness programs, too, and the perspectives they offer are significant because they reflect increasing levels of deservedness for health or illness. They classify and separate people rather than see health as varied and diverse, cyclical and across the lifespan.

These modern definitions of wellness would frame disability as the problem or the undesirable difference, rather than see it as a neutral state of being. In a recent announcement for a workplace wellness discussion targeted at "aging academics," for example, effective wellness initiatives were linked in the same sentence to "retirement counseling" (University of Iowa 2012). In yet another context—a blog for benefits professionals—older employees are singled out, along with other "vulnerable populations," for a failure to take responsibility for one's health (McGrory-Dixon 2011). Indeed, the dominant approach to wellness is that of "health choices." This concentration on behaviors and decisions leaves the issues of chronic, persistent disease and disabilities estranged from wellness orientation in many ways, as if people who are sick or disabled are not trying enough or have made the wrong choices (Reardon 1998). Even under flexible wellness approaches that offer a more individualized approach to wellness—wellness as defined in the context of that person—the focus on wellness makes a statement about the undesirability of certain ways of being in the world. It pushes for individual responsibility and ascribed models of being that do not fit everyone and are not even possible in many situations because of constrained resources and energy. The wellness imperative also shifts the attention from societal barriers to health, discrimination based on perceived unhealthy states, and inequitable resource allocation to personal improvement and paternalistic intervention.

C. The Neoliberal Narrative of Wellness

This shift from wellness as a holistic focus on health to a personal responsibility narrative in the employment context is rooted in concerns about cost containment that are neoliberal in their tendencies and also give greater insight into current societal tensions in values (Ericson, Barry, and Doyle 2000). Wellness neoliberalism empowers certain actors to be monitors or gatekeepers of measuring health, primarily employers, human resources professionals, and insurance companies, rather than government agencies, sick individuals, and public health nonprofits. Healthy individuals, in contrast, are rewarded with independence as long as they uphold the social contract of reducing and constraining their health care costs. If neoliberalism is concerned about reducing the infrastructure of the state and placing the onus of responsibility on citizens to be efficient and productive, then wellness is a compelling example of neoliberalism in action as we see a scaling down of resources for a spectrum of health and wellness and, in their places, a focus on market intervention and individual failing.

The wellness paradigm is decidedly one of personal responsibility and accountability: health is within a person's control and a matter of *choice*. Self-improvement, measured in terms of absence of disease, should be the goal, and actions toward it reflect a commitment to the social good by respecting the economic drain that disease creates. Poor behaviors or choices lead to the undesirable state of illness, but they, like the market, can be corrected. With appropriate education and modifications, people will be able to become "healthier"—if only they exercise more, eliminate smoking, reduce alcohol consumption, improve their mental health, tackle stress, and achieve a desirable BMI (Fuerstenberg, Fleury, and Connolly 2011). The assumption of choice ignores resource allocation and lack of access as a source of health inequity. These resource issues range from food and water safety to work stress and pressures, disability-inaccessible medical examination tables to culturally dated attitudes toward health care delivery to minority populations. The choice-and-control narrative also makes health the responsibility of the individual, rendering the failure to achieve it something for which the individual could be judged and punished financially or socially (Gray 2009).

Similarly, the citizen in the neoliberal state must constrain and conform his or her behaviors to best serve reductions in services and resources provided by the state. Neoliberalism assumes, like its offshoot wellness, that most people will be able to do so to some extent—at least to keep the state as efficient and productive as possible. It also treats one's behavior as a commodity, making a person more or less desirable in the community and in the workforce based on this ability to exercise personal responsibility and autonomy. This framing of citizens as having a call to duty to be healthy puts everyone on the same playing field of responsibility and punishes them for noncompliance. As Richard Ericson, Dean Barry, and Aaron Doyle (2000) note in their critique of the neoliberal tenets of the insurance industry, not all people will be able to comply with the neoliberal state's demands of them, but those people are easily disregarded from the calculus. The state provides no extra supports for them, and they are simply seen as a deficit that cannot be overcome. These "deficient people" are notably people with disabilities or other limited means and marginal health because they simply cannot prevail over the real physical and economic constraints that guide their lives. A market approach, in this regard, is inflexible, providing no safety net. If the most disadvantaged people cannot surmount their barriers, they will be unable to participate in the financial rewards that the competitive marketplace and workplace offer them.

Worth noting is that disadvantaged people can sometimes surmount barriers—a core value of neoliberalism—and that through personal accountability and resilience, even the weakest can rise to higher positions. As Jon Binnie (2013: 1) notes in his work on queer politics, for example, neoliberalism can be both "generative and hostile"—making space for individual rights movements and democratizing the promise of equality but privileging people within marginalized groups who are able to achieve self-regulation and normalcy. For example, for the few people with disabilities who can make normalized wellness targets, that accomplishment further divides them from others with disabilities who cannot—and moralizes the failure of the latter while privileging the conformity of the former. The focus shifts again to the individual instead of a change in values and systems that could support the overall health of communities, such as recognizing interdependence and care as ethics worth preserving.

3. Neoliberal Wellness versus Disability Rights: The Philosophical and Practical Fallout

I have already argued that wellness programs are neoliberal at their core, expecting the free market and the autonomy of individuals to create a system of health in the United States. At the heart of the system is a commitment to the most efficient and productive members of the market, even if this value excludes people who are vulnerable or disadvantaged (Ericson, Barry, and Doyle 2000). Neoliberalism is more than a set of ideologies, however; its application creates fallout for people with disabilities. That fallout is not as neatly categorized as one might hope.

People with disabilities exist in a contemporary societal space that is neoliberal in its internal and external conflicts. They may often have to choose between systems—gainful employment and disability benefits, trying to figure out which path allows them the greatest potential to live independently and be included in the community. While to rally against all that neoliberalism has seemed to bring in its dismantling of social services and supplemental income programs is easy enough, it has also carried along messages of independence and autonomy (Harvey 2007). Like other civil rights movements, disability rights has heard this call. A neoliberal obsession with individual rights made room for identity politics, nongovernmental organizations, even awareness of equity in health care, but just as readily it switched those foci back to what the individual could do to overcome the obstacles (ibid.). And that is where people with disabilities, particularly as a poor minority group, have struggled with neoliberalism because they simply do not fit with a model of autonomy or wealth accumulation (ibid.). In this section, I highlight the tensions between current neoliberal wellness and disability rights approaches by identifying disability-grounded approaches to wellness and contrasting them with the neoliberal perspective inherent to employer wellness programs.

A. Questioning Health's Desirability and Meanings

Perhaps the most fundamental conflict between disability and wellness is around what health is, what it means, and how much one should want it. Disability rights recognizes that some people will, in fact, never be healthy or vigorous and that the best efforts are spent not on trying to change the impossible but in removing the social and economic barriers that stigmatize illness. While disability rights advocates are pushing for views of wellness and individual worth that are inclusive of disability and less obsessed with physical and mental differences, the wellness approach tends to coalesce around some universal standards of health that are supposedly desirable and achievable for all or most. The disability rights perspective has been criticized in other contexts for focusing too much on the social aspect of disability and less on actual, tangible limitations, such as chronic health conditions, out of fear that acknowledging physical and mental impairments will undermine the social, liberatory approach to disability (Wendell 2001), but scholars such as Tom Shakespeare (2014) have suggested that the power of the movement can be recognizing the tangible and societal effects of impairments. The wellness paradigm embraces impairment, too, but attempts to move entire groups of employees toward more homogeneous pursuits of health and its desirability.

This conflict is no surprise: people with disabilities have long been left out of public health approaches to health and wellness (Lollar 2002). Disability has been the undesirable state, with only recent changes coming through health care reform and its greater inclusion of disability as a minority health experience worthy of investigation (Pendo 2011). While disability advocates have challenged the normative message of health (Wendell 1996), and worked toward developing acceptance of disability as part of the spectrum of natural human differences (Schriner and Scotch 2001), wellness advocates are working toward enhancement and optimization—the seeming future of health as Wolbring (2008) has described.

Practically speaking, people with disabilities will be unable to keep up with health norms that are rapidly shifting toward greater optimization and normalization. If the transformative power of disability rights was to question normalcy, then all wellness does is undermine those decades of efforts. Wellness-oriented definitions of health also legitimize discrimination based on disability because these definitions are heralded as generally accepted standards of what it takes to be a valued member of society. At a time when people with disabilities continue to combat social exclusion, further stigma about their health differences, or simply a desire that they be “better” through a “cureism” approach, devalues their lives and perspectives (Herndon 2002; Lukin 2013).

B. The Futile Pursuit of the Well State

Wellness programs can be adapted to meet the needs of people with disabilities in certain situations, but a disability rights perspective asks why we should even bother with a futile pursuit of wellness. Disability confronts wellness as further avoidance of accepting the reality of health—that we will all be sick and disabled at some point, if we live long enough, and that experience does not degrade our worth as humans. In essence, the pursuit of a well state, as a community or for an individual, is simply temporary. No one will escape death. We will never eliminate disease completely. Resources are limited, and rather than appropriate them to further benefit the already healthy, they should be shifted toward the inclusion of outliers, such as people with disabilities. Instead of mainstreaming people with disabilities toward a homogenized definition of health, advocates should dismantle current definitions and replace them with ones that are nuanced and inclusive, less hierarchical, and free from paternalistic assumptions (McRuer 2011–12). Health as defined by WHO, as already discussed, is one such starting point, but "being well" and the desirability of wellness need to be informed by marginalized perspectives, such as those of people with disabilities.

Some of the greatest insights that the disability rights perspective offers are questioning which health goals are attainable, who is in charge of creating and validating them, and to whom these goals should extend. They may not be appropriate for everyone; indeed, they are not. One hears a dominant thread among the wellness-oriented: "Of course, health is desirable. Many things can be fixed about health and should be." This model of fixing is what early disability rights advocates resisted and labeled as the "medical model" and what they attempted to replace with a civil rights or social model of disability to dismantle the destructive fallout of personal or moral responsibility for disability differences (Meekosha 2010).

Even if the philosophical differences between wellness and disability scholars could be resolved around this question of what it means to be "healthy" and how that privileges some groups and not others—advocates and researchers are still left to grapple with the reality that wellness will not be advisable or possible for some people. Functional limitations, health restrictions, resource deprivation, and medication interactions, for example, limit the ability of people to strive to be their "better selves" and instead privilege able bodies (Puar 2009). Sometimes health is a state of continual decline rather than advancement, and while people should be as comfortable and supported as possible, they do not need to be encouraged to feel better. Furthermore, neoliberal approaches to removing social safety nets actually guarantee that the sick will not feel better; rather, they will be without access to support in the community.

Greater attention should be focused on why barriers to health equity exist before assuming them away and crafting programs that further divide healthy and sick people (Coburn 2000). Wellness must be viewed from a resource allocation perspective to understand how its emerging dominance as a perspective affects people with chronic health conditions. If resources are simply shifted from people who are ill to those who “want” to get better—or to the healthiest—then we have created a system where the sick get sicker and the stronger rule. Commitments to this perspective have emerged already in state approaches to wellness, such as in Laramie, Wyoming, where to take advantage of insurance premiums that differ by $1,600 in cost, government employees must pay a $110 health coaching fee upfront (Families USA 2012).

C. Employees, Not Employers, Know Best

While the autonomy narratives of neoliberalism make way for more people with disabilities to enter work, to take control of their “financial destinies,” and to rise to greater class status, they also expect that people with disabilities will either become able-bodied in doing so or succumb to the substituted decision making of employers. Most employees with disabilities will not be able to normalize themselves, and therefore wellness will inevitably privilege the employer to assume responsibility for minimizing health costs and the drain of sickness. Under a regime of responsibilization, someone has to take charge of containment.

The wellness model approaches health and disability issues through a cost-benefit model, emphasizing the financial burdens that have shifted to employers, as employees have required more costly health care. This perspective is highly neoliberal because it reduces employment to merely quantitative, economic modeling inquiries outside nondiscrimination mandates and employment equity. With neoliberalism comes a form of paternalism and fear that will affect people with disabilities by never making them desirable hires if they are always matched against a healthier hire (Soss, Fording, and Schram 2009). A cost-benefit analysis model generally disadvantages the most marginalized workers, particularly those with health issues, and it erroneously shifts the discussion from the proper role of employers in a government-business-individual model of health care to the elimination of the most costly plan members (ibid.). It reinforces the pre-ADA fear that employees with disabilities place ever-expanding burdens on the budget because of accommodation and health care costs (Fuerstenberg, Fleury, and Connolly 2011).

Wellness, therefore, becomes a guise for cost shifting and pricing the sickly out of the employers’ plans within the United States (Elliott, Bernstein, and Bowman 2014 [this issue]). Employers take on paternalistic, sleuthing roles that ferret out the sickest, leaving them even sicker with less access to the best insurance plans and increasing employers' roles in the lives of people with disabilities. In the context of fatness as a disability and workplace accommodation, Anna Kirkland (2006) has identified similar actions by employers, which she has called "managerial individualism." Under managerial individualism, societal outliers lose some of their transformative potential by being swept into a system that merely governs and regulates their differences (ibid.).

Placing employers in this managerial, paternalistic role also runs afoul of the ADA in using standards or criteria that have the effect of discrimination. The ADA, as previously discussed, also puts tangible privacy and confidentiality constraints on employers. Taking the narrow relevance of such health information seriously, the ADA limits how far that information can be shared. Managers, supervisors, and human resources personnel might need access to the information to make safety assessments or to provide reasonable accommodations to a worker with disabilities, but the information is not to be shared beyond those who must act on it to assist the situation (EEOC 2000). This notion of limits extends to how the information is gathered and stored, attempting to ensure that fears about an employee's disability will not result in a string of negative employment decisions (Feldblum 1991). These provisions also reflect a greater desire to reinforce the supremacy of people with disabilities in managing and acting on their health information as autonomous, capable individuals.

As constructed in the United States, a wellness approach, however, suggests that employers can, and should be, in the business of monitoring and regulating their employees' health (Berry and Mirabito 2011). It advances the argument that they have an interest in, and perhaps even a right to, broad information *and* that employers (and their wellness contractors) know best in creating wellness programs (ibid.). The strongest arguments proposed for wellness are economic ones—that employers pay increasing health care and insurance costs for their employees, particularly where they are self-insurers, and that employee illness leads to lost productivity in the form of more days off and quality issues when less-than-optimally-healthy employees are at work (Baicker, Cutler, and Song 2010).

However, a recent review of the current wellness program literature sponsored by the US Department of Labor and the US Department of Health and Human Services found that the actual returns on investment and effects of workplace wellness programs are unclear in most areas (Mattke, Schnyer, and Van Busum 2012). The goals of the study were to examine "the current state of workplace wellness programs in the United States . . . ;

assess current uptake among U.S. employers; review the evidence for program impact; and evaluate the current use and the impact of incentives to promote employee engagement" (ibid.: 5). The authors noted that while wellness programs are widely available, program participation rates are not as high, with only about 20 percent of eligible employees involved (ibid.). In analyzing program impact, the team selected thirty-three peer-reviewed scientific articles that met their "standards for methodological rigor," finding "evidence for positive effects on diet, exercise, smoking, alcohol use, physiologic markers, and health care costs, but limited evidence for effects on absenteeism and mental health" (ibid.: 6). They noted that "positive results found in this and other studies should be interpreted with caution, as many of these programs were not evaluated with a rigorous approach, and published results may not be representative of the typical experience of a U.S. employer" (ibid.). Finally, in looking at wellness program incentives, the authors note that their function is poorly understood. In offering a conclusion to their study, Soeren Mattke, Christopher Schnyer, and Kristin R. Van Busum suggest that while wellness programs are increasingly popular in the United States, they found "insufficient objective evidence to definitively assess the impact of workplace wellness on health outcomes and cost" and "no data on potential unintended effects, such as discrimination against employees based on their health" (ibid.: 7).

This recent study points to the pervasive gaps in knowledge about wellness programs' positive and detrimental effects. Even if greater objective data were possible and workplace wellness programs proved successful in reducing national health care expenditures, is that argument enough to justify employers having a stake in employees' bodies? Such an interest is one that overrides their privacy and autonomy when it comes to health concerns that affect employers financially. The neoliberal promise of autonomy here is different for the nondisabled employee than for the healthy employee; it comes with punishments.

Wellness neoliberalism is based on the same kinds of arguments that have marginalized people with disabilities historically and made them undesirable hires and retentions. They substitute paternalistic decision making for the capable decision making of the disabled person (Daniels 2003). The form of these arguments—the cost of sick workers, the accountability of ill people for their state of being, the burden of disability—was what propelled the ADA's antidiscrimination mandate. Now people with disabilities find themselves in tension with the neoliberal values of autonomy and economic stability that guided their paths into employment and made way for an individual rights movement while dismantling the supports that were critical to its advancement.

The subtleties of disability employment discrimination in this wellness-driven context merely are conduits for not wanting people with disabilities at work. Even if employers are "suffering" from having sick workers, respect for antidiscrimination principles and equity should outweigh neoliberal preoccupation with cost savings and risk avoidance. Rather, systemic problems call for a shift away from an approach that individualizes responsibility and point in the direction of government intervention, community-based programs, and stricter scrutiny of health inquiries made at work.

Conclusion

The fundamental tension between wellness and disability rights remains that of bodily enhancement and perfection versus acceptance and inclusion. As Harvey (2007) has suggested, neoliberalism has set the stage for these movements but also especially limited the reach and transformation of civil rights by having a narrow view of what values are important. The way out is to recognize alternative principles (ibid.). The disability rights model is grounded in meeting people where they are in terms of their physical and mental states. It also recognizes the myriad ways that attitudinal barriers toward disability, primarily those of aversion, pity, disgust, and normalization, exclude people with disabilities from full participation in society. By embracing the values of interdependence, community, and acceptance, disability can be transformed from the state of being that is least desirable to an acceptance of the spectrum of health states that all people experience throughout their lives. This acceptance, under a disability rights orientation, comes without moralistic judgment or condemnation for health differences, even ones that pose serious limitations and impairments. It asks for no concerted efforts for people to be more normal or healthy. Wellness, in contrast, pushes people to try harder and be better and makes calculations and calibrations based on the failures of individuals to reach more desirable states because they, in turn, burden the economy—the most important part of a neoliberal society.

Thus far, efforts to critique wellness from a disability perspective have only perpetuated wellness as the desirable model and asserted the need for it to be more inclusive (Call, Gerdes, and Robinson 2009). They have failed to address how wellness is not always the best value or ideal to hold. In a recent report on workplace wellness programs and the inclusion of employees with disabilities, the Department of Labor's Office of Disability Employment Policy (ODEP 2009: 15) recommended that "corporate culture needs to change to encourage more employees with disabilities to participate in workplace wellness programs." Promising an analysis that would critique whether or not workplace wellness programs had been adapted to or could be modified to meet the needs of employees with disabilities, the report and its accompanying employer tool kit for implementation fall far short of their goals (Call, Gerdes, and Robinson 2009) by spending energies on discussing the "altruistic benefit" of workplace wellness rather than offering a thoughtful critique of one of the central research questions that the authors pose: "What is/should be the role of employers in promoting the health and productivity of workers with disabilities?" (ibid.: 2–3). The authors discuss the ways in which people with disabilities do not engage in physical activity, and then they focus on access to wellness, rather than question its tenets. In doing so, they reinforce a central message of workplace wellness literature—that employees with disabilities should improve, too, and they would like wellness if they only had the chance to try it.

The solution is not to include people with disabilities in workplace wellness but to question reductionist thinking that assumes that disability is the product of poor choices and attitudes, as much as health is the demonstration of positive ones (Willitts 2012). Much of the wellness literature, in fact, suggests that health is attainable only if employees try harder to reach biometric and medical goals. It also frames discrimination as a failure to be included within wellness programs, as Mello and Rosenthal touch on in their work. This perception of choice and control is troublesome when it comes to people with disabilities, and other marginalized groups, such as low-income people, racial and ethnic minorities, and multiple part-time jobholders. These populations, in particular, might find that workplace wellness programs pose discriminatory incentives and hurdles to health insurance access while reinforcing a message that optimum health is possible for all and disability and difference are undesirable.

The failure by even the agencies charged with disability advocacy to be thorough and critical in examining the conflicts between wellness and disability rights approaches does more than a disservice to people with disabilities in the workplace. It provides a blanket approval of wellness approaches with very little in the way of careful analysis of their impact on anyone with serious health conditions or limitations in access to quality, respectful health care. Personal responsibility arguments, gone unquestioned, pose penalties within the legal and regulatory systems. These penalties extend beyond issues of disability discrimination to further divides in resources and access for many communities.

Wellness programs construct an image that further marginalizes people with disabilities and others existing in social and economic liminality by putting forth an ideal self-image and expecting them, through the expression of the values of personal responsibility and autonomy, to reach it. The disability rights movement and the activists behind it have already addressed this question of how to reach this accomplishment. The answer is to simply accept who you are and to be able to rely on principles of community and interdependence to find support for your needs and strengths.

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