WHITE PAPER · 2026

Why companies need a global health policy

The case for managing workforce health centrally: staying compliant in every country, keeping people fit for work and reducing cost. And how one record per employee makes it possible.



Dr. Laurent Bonnardot, Founder and CEO, MyC · October 2026

www.myc.care

Executive summary

81% of work-related deaths are caused by disease, not injury (WHO/ILO, 2021). Yet the health data that would show where that risk sits is most often still kept site by site, in the hands of each local medical team, and is not accessible to HSE, HR and management.

As a result, boards receive little to no reporting on employee health, although 83% of C-suite executives say that workforce well-being should be discussed at board level (Deloitte, 2023).

Since medical costs keep increasing, health data is also the strongest cost argument a medical director can make internally. The medical cost trend facing US employers is 9% in 2027 (PwC, 2026), and insurers project 10.3% worldwide for 2026 (WTW, 2026).

In Great Britain, workplace injury and new cases of work-related ill health cost £22.9 billion a year, and 72% of that comes from illness rather than injury (HSE, 2023/24). A health program built around recordable incidents only addresses the remaining 28%.

Where the £22.9 billion goes

Annual cost of workplace injury and new cases of work-related ill health, Great Britain



72%
ill health, mostly unmeasured on site

28%
injury, the part incident programs track

Figure 1. Source: HSE, 2023/24.

This paper looks into how to make health data usable across a company while keeping the medical details confidential. We'll cover why health data now matters to companies, why it is still scattered across sites and systems, what makes it compliant and usable, and what each function gains from it.

What health data covers

In the context of employee health, health data is usually understood as the clinical record, which is one reason it has been left to doctors. In practice, it includes every record of a health-related activity for every worker, both employees and contractors.

Each of these is recorded by different teams or providers, often in different tools, which is how one employee's health ends up scattered across sites and systems.

That breadth is also what makes the subject sensitive. The individual record is confidential and should stay with doctors. Yet without a shared system, medical information often circulates by email, especially when managing cases with external service providers, which is itself a breach of confidentiality.

01	**Primary care delivered on site**
02	**Occupational health follow-up** Fitness to work · exposure history · surveillance history · sick leaves · statutory reporting
03	**Prevention campaigns and vaccinations**
04	**Case management** Medical evacuation · referral · approval · hospitalization follow-up

What HR, HSE and executives need is the same data, but anonymized, aggregated and presented as shares, trends and comparisons, with no names attached.

Read this way, one dataset serves several departments at once. HR sees sick leave, HSE sees fitness-to-work, incidents and exposure groups, and finance sees the full cost of health, well beyond medical spend.

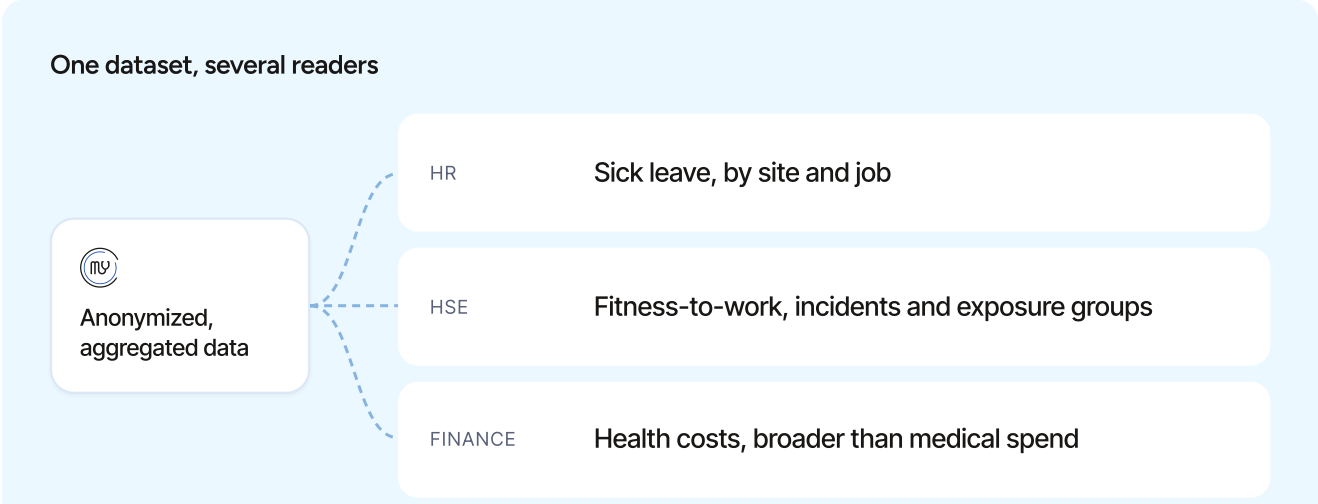


Figure 2. The same data, read by each function without names attached. Illustrative.

Contents

Employee health is a core part of business performance, and management should monitor it as such, without breaching medical confidentiality. This paper looks at the opportunity, why health data remains siloed, and the cultural change and tools that make it usable for every function.



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83% of C-suite executives say that workforce well-being should be discussed at board level.

Deloitte, 2023

01 CHAPTER

Why health data is now key for companies

01 Health keeps operations running

During the COVID-19 pandemic, a global energy company tasked Dr. Laurent Bonnardot, founder and CEO of MyC, with tracking cases among its workers in Uganda. A single cluster on a site would have cost millions in lost revenue. To prevent it, the company needed to know every day, across every site, who was sick, who had been exposed and who was fit to work. The pandemic made one thing concrete for executives: employee health keeps operations running, and it can stop them.

3.3%

of EU GDP lost each year to work-related illness and injury



02 Health data has to be secure and usable

Regulators set strict rules on how medical data is handled. In the EU, health data is a special category of personal data (GDPR, Art. 9). In the US, HIPAA applies to healthcare providers and health plans, but usually not to the health information an employer holds about its own employees (HHS), while OSHA requires employers to keep employee medical records for the length of employment plus 30 years (OSHA, 29 CFR 1910.1020).

Some rules also reach the systems themselves. In the Netherlands, care providers must run their information systems in line with the NEN 7510 security standard (Stb. 2017, 446). In the EU, electronic health record systems will need common interoperability and logging components, starting in 2029 (European Commission, EHDS).

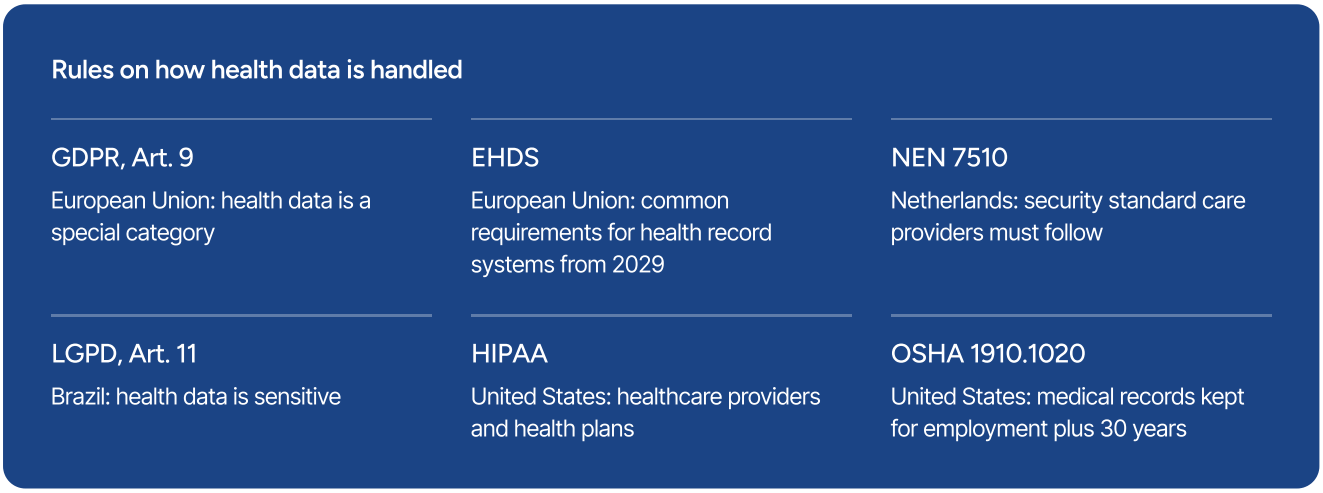


Figure 3. A selection of rules that apply to health data.

Compliance is only part of the question. A health record mixes clinical data, such as diagnoses and test results, with operational data, such as fitness-to-work decisions and sick leave. Recorded together, all of it falls under medical confidentiality, including the parts other teams could use. Separating data by type is what makes it secure and usable at the same time.

03 Regulators expect complete records

Regulators have also raised the stakes. In 2022, OSHA, the US workplace safety regulator, cited Amazon for 14 recordkeeping violations: injuries and illnesses not recorded, misclassified or recorded late, and records not produced on time. The proposed penalty was $29,008, small for a company of that size, but OSHA announced it in a national news release that affected the company's reputation (OSHA, 2022).

Publicity is a deliberate tool. When OSHA publicly names a company, other workplaces within about three miles record 73% fewer violations, without being inspected, and one press release prevents as many violations as 210 inspections (Johnson, American Economic Review, 2020).

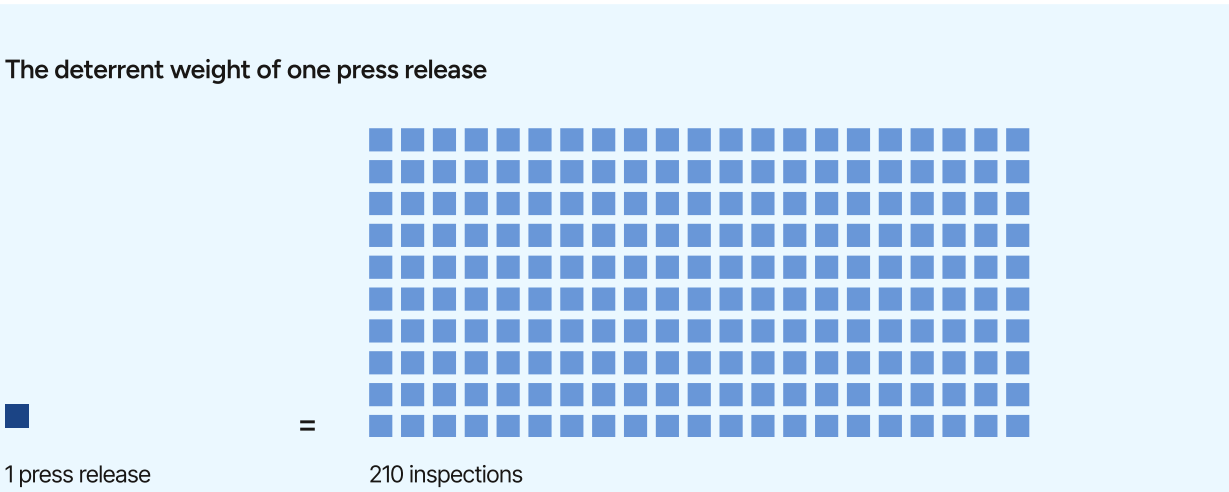


Figure 4. Source: Johnson, American Economic Review, 2020.

In the EU, large companies now have to publish their number of recordable cases of work-related ill health and the days lost to them (CSRD, ESRS S1). Both obligations assume records that are complete and available for every site.

04 Prevention pays

At the same time, employee health has started to show up in business performance. Fewer incidents and fewer sick leaves mean more people at work. In the EU, work-related illness and injury cost an estimated €476 billion a year, 3.3% of GDP (EU-OSHA and ILO, 2017). Prevention returns an estimated €2.20 for every euro spent (ISSA and DGUV, 2011).

To spend that money where it works, a company has to see where risk is building: which site, which job, which condition. Each of these depends on health data the company can read across its sites. In most companies, that data is still scattered across sites and providers, out of the company's reach, and the reasons go back to how occupational health has been organized.

02 CHAPTER

Health data is siloed by inheritance

Health data has stayed with medical teams for confidentiality reasons. It is some of the most private information a person shares, and they share it with a doctor in confidence.



Each site has also long worked with its own methods and tools: on paper, in spreadsheets, in software installed locally. Across a company's sites, there is usually no common standard for how health information is collected. A worker's record is complete only on the site where it was made.

Part of the picture sits outside the clinic altogether. HR records sick leaves. HSE records incidents. Both are health-related, but they are kept in systems separate from the medical record, so none of it can be read together.

From any single site, fragmentation rarely looks like a problem. Each site can be fully compliant with local rules. The gaps appear at group level. A missing entry at one site and a late one at another look minor on their own, but regulators add them up across sites, and a company holding its records in separate systems cannot.



The same sites, before and after

Site by site

Per-site access. Different formats and accuracy.

SITE A Paper files	SITE B Spreadsheets
SITE C PDFs	SITE D Emails

No group view

One global view

Role-based access with audit trail. Centralized data and analytics.

SITE A One record per worker	SITE B One record per worker
SITE C One record per worker	SITE D One record per worker

One group overview

Figure 5. The same sites, site by site and with one record per worker. Illustrative.

Local records are not comparable across sites or over time, and local systems were not built to give different people access to different parts of a record. Currently, most of the time, the data they hold cannot be used beyond the clinic without breaching confidentiality.

FOCUS

Exposure follows the worker, not the site

Exposure records have to outlive the site that created them. Occupational cancer causes more than 100,000 deaths a year in the EU, and nearly half of European workers have probably been exposed to at least one cancer risk factor (EU-OSHA). The disease usually appears about 20 years after exposure, sometimes 40 (EUROGIP). By then, the worker may have changed site, job or employer, and a record kept on one site, for one period, cannot connect the illness to its cause.

Occupational cancer latency against EU record retention

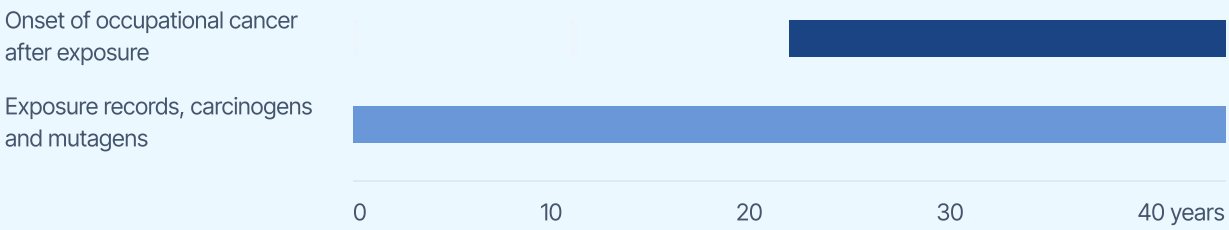


Figure 6. Occupational cancer usually appears about 20 years after exposure, sometimes 40. Sources: EUROGIP. Directive 2004/37/EC, Art. 15.

In the EU, records for carcinogens and mutagens must be kept for 40 years. Since the 2022 revision of the directive, reprotoxic substances are covered too, with records kept for five years (Directive (EU) 2022/431, amending Directive 2004/37/EC, Art. 15).

What it takes to measure one employee's exposure

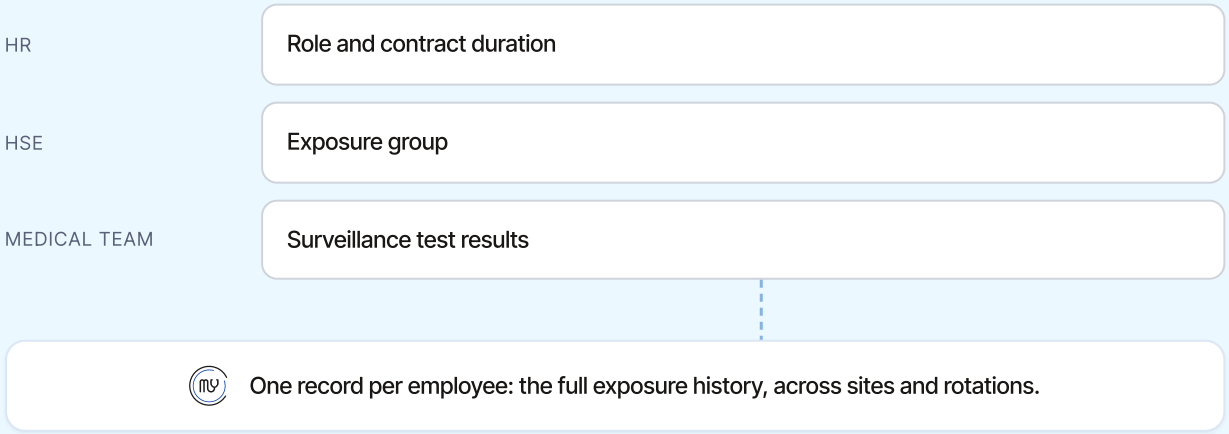


Figure 7. Schematic.

03 CHAPTER

Health data governance

Using health data beyond the clinic depends on the system that holds it. Collecting it the same way on every site and storing it centrally is a requirement for both compliance and accessibility.



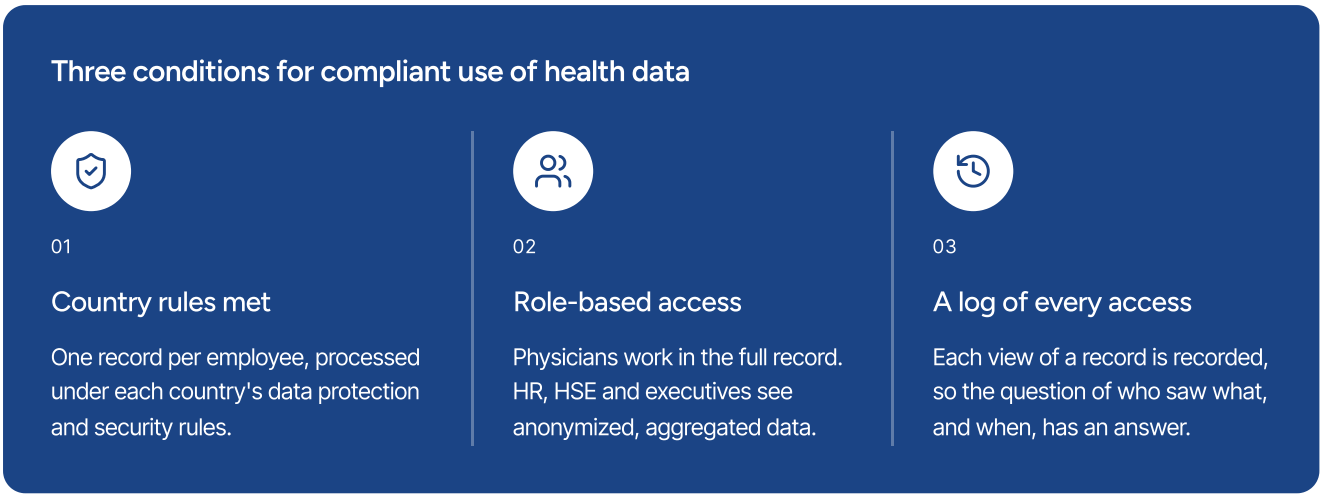


Figure 8.

What any analysis can find is decided when the data is entered. A record that is incomplete on the day of a consultation stays incomplete. Four requirements for usability:

01

Structured

Coded vocabularies such as ICD-10, and constrained fields wherever a value should be constrained. Free text can be analyzed with natural language processing, but only if it is written consistently. Structure also means fewer platforms, with health data kept in one system rather than spread across several.

02

Complete, and visibly incomplete when it is not

In primary care, clinically important information was missing in 13.6% of visits, about one in seven, and judged likely to harm the patient in 44% of those cases (Smith et al., JAMA, 2005).

03

Accurate at source

Each result goes through as few steps as possible, for example taken directly from the medical device that performed the test rather than retyped.

04

Consistent over time

Workers are often followed for decades, so testing techniques, equipment and interpretation have to stay the same over that period (ACOEM, JOEM, 2020).

The same rules have to apply on every site. With one record per employee, and medical activities recorded the same way everywhere, results can be compared across sites and over time. A baseline is only useful if everything measured after it was measured the same way.

Data that meets these conditions can be analyzed at a scale no single site could reach. A common reason AI projects fail is poor data quality: garbage in, garbage out. Consistent standards for data collection, across sites and over time, are a prerequisite for confidence in the reports.

AI research shows what's possible once data is clean and structured across many workplaces:

83,294

OSHA injury narratives used to train a deep learning model

The model predicted injury severity with 0.95 accuracy for hospitalization and 0.98 for amputation, and surfaced the causes described in the free text (Khairuddin et al., PeerJ Computer Science, 2024).

1.2 million

Ohio workers' compensation claims coded by machine learning

Industries were ranked by the claims that ergonomic or slip, trip and fall prevention could have avoided (JOEM, 2018).



04 CHAPTER

Benefits by role



01	Medical teams	Each result read against the worker's own history	Better quality of care
02	Chief medical officers	Global health policy steered and its impact monitored	Program coverage by site
03	Employees	Safer care and direct access to part of their own record	Safer care
04	HSE	Gaps against policy seen before they become incidents	Fewer incidents
05	HR	Sick leave read across sites, so absence is addressed early	Higher workforce availability
06	Executives	Health managed as a measure of performance	Lower cost of ill health

What each role gains, and its key result.

01 MEDICAL TEAMS

Better care through a longitudinal view

A result is read against the employee's own history since hire, across transfers and providers. In spirometry, comparing a worker to their own baseline detects excessive loss of lung function earlier than comparing a single test to population norms, and a decline of 15% or more from that baseline is a reason to refer (ACOEM, JOEM, 2020). Hearing works the same way: a standard threshold shift, an average change of 10 dB or more at 2,000, 3,000 and 4,000 Hz against the worker's baseline audiogram, can only be detected when that baseline follows the worker (OSHA, 29 CFR 1910.95).

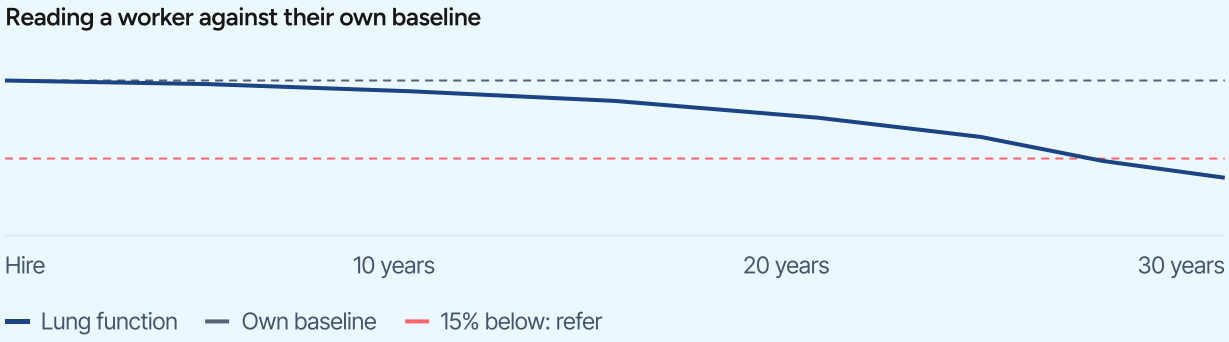


Figure 9. Schematic. Source: ACOEM, JOEM, 2020.

Continuity also changes outcomes: in a nationwide Danish cohort, patients who had fewer than 25% of their contacts with their usual provider had a mortality rate 2.6 times higher, and 49% more potentially inappropriate medication, than patients with full continuity (Prior et al., BMC Medicine, 2023).



02 CHIEF MEDICAL OFFICERS

Global health policy, steered from evidence

Coverage and testing status are current on any given day, on every site, so it is clear where a program is working and where it is not. Over time, policy can be set from evidence about the workforce, and care can move from reacting to cases to preventing them. Clinical detail stays with the physicians, and the access log shows who saw what, and when.

Who saw what, and when

ROLE	VIEW	LOGGED
Site physician	Full record	Yes
Chief medical officer	Coverage by site	Yes
HSE lead	Anonymized trends	Yes

Figure 10. Every access recorded, by role. Illustrative.

03 EMPLOYEES

Care is safer

Every physician who sees them decides on their full history rather than part of it. They no longer have to repeat the same information at each consultation. Their confidentiality is protected by how the system is built, and they can access part of their own record directly.

One record that follows the worker

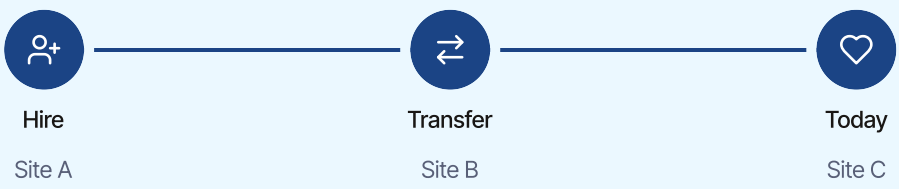


Figure 11. Schematic.

04 HSE

Fewer incidents, with prevention aimed at the gaps

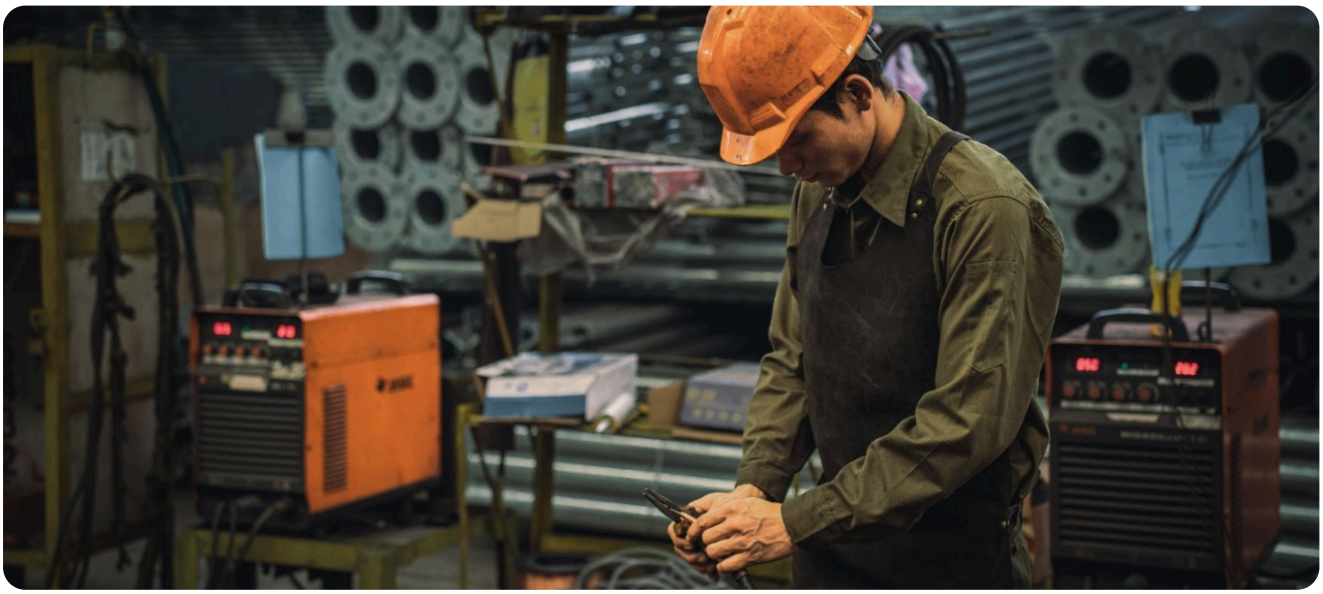
Many incidents start with a health condition that a physician knew about but the people organizing the work could not see. Aggregated across sites, the same data shows HSE where the workforce stands against its own policies and procedures: cardiovascular risk factors in roles with heavy physical load, reduced lung function among workers exposed to dust or fumes, hearing loss in high-noise areas.

Where the workforce stands against policy

INDICATOR	SITE A	SITE B	SITE C
Cardiovascular risk factors roles with heavy physical load	Within policy	Gap	Within policy
Reduced lung function dust and fume exposure groups	Gap	Within policy	Within policy
Hearing loss high-noise areas	Within policy	Within policy	Gap

Figure 12. Aggregated, anonymized view by site. Illustrative.

Individual decisions can also be shared without the diagnosis behind them. One approach is to separate the fitness-to-work outcome from its medical basis: HSE sees that a worker is fit with a restriction, such as no work at height, while the reason stays in the physician's record.



05 HR

Higher workforce availability

Anonymized sick leave trends by site and group of employees show where absence is building, so it can be addressed before it becomes long term. Early patterns matter: in a Danish register study of young employees, those with frequent short absences in their first year of full-time work had a higher risk of long-term sickness absence over the following two years (Sørensen et al., BMJ Public Health, 2025).



Figure 13. An early signal in routine sick leave data. Source: Sørensen et al., BMJ Public Health, 2025.

06 EXECUTIVES

Health becomes a measure of performance

Medical costs stop being a line that only goes up, because the company can see what drives them: incidents, sick leave, exposure. Health indicators can be managed centrally, the way financial data already is. Better employee health could generate $3.7 trillion to $11.7 trillion in global economic value, 4% to 12% of global GDP, with 54% to 77% of it coming from productivity (World Economic Forum and McKinsey Health Institute, 2025).

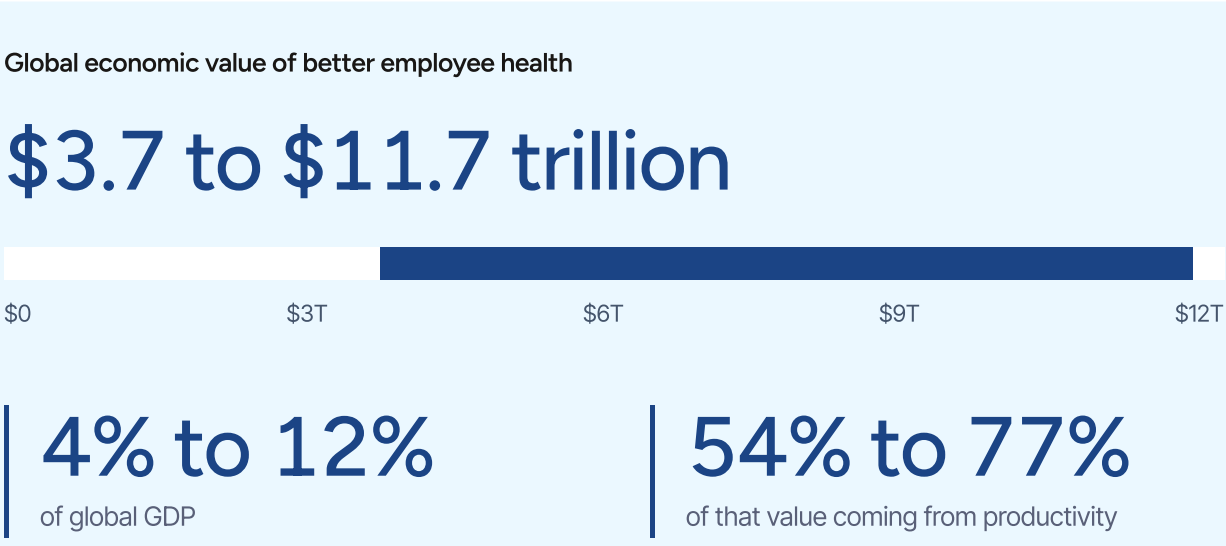


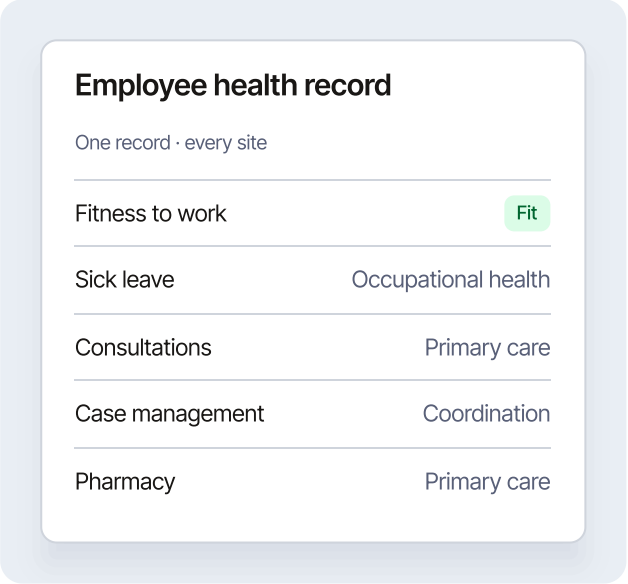
Figure 14. Source: World Economic Forum and McKinsey Health Institute, 2025.

Conclusion

Health data becomes usable when there is one record per employee, not one per site: collected in the doctor's hands and read across the company. That is the principle behind MyC, and it comes from practice.

Dr. Laurent Bonnardot spent more than twenty years practicing medicine in some of the world's most isolated places, and served as medical director for companies on remote industrial sites, before founding MyC.

MyC holds one health record per employee, covering occupational health and primary care: fitness to work, sick leave, consultations, case management and pharmacy. Medical teams work in the full record. HR, HSE and executives work from anonymized trends. The platform is certified to ISO 27001 and NEN 7510, and complies with HIPAA and the GDPR.



Because every activity is recorded the same way on every site, the data can be analyzed beyond reporting to identify early risks, such as:

- Sick leaves recurring in the same crew, an early sign of burnout
- Repeated consultations for the same symptoms on one site
- Fitness-to-work restrictions piling up in one job position

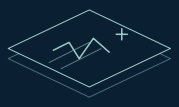
Certifications and compliance

ISO 27001 NEN 7510 HIPAA GDPR

The conditions described in this paper are rarely met all at once. Instead, it's a gradual evolution. The three levels below map where companies stand and what to work on next.

Three levels of maturity

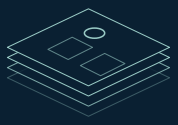
LEVEL 1



Fragmented

Health information and practices depend on individuals, local routines or scattered records. Start with a shared process and a consistent way to record information.

LEVEL 2



Structured

Repeatable processes and maintained records support your health program, but coordination or oversight still depends on manual work. Focus on shared visibility and consistent follow-through.

LEVEL 3



Governed

Shared information, clear responsibilities and regular reviews support decisions across sites. Sustain these practices and check that improvements lead to better outcomes.

The first level matches the situation described in chapter 2: records that depend on each doctor and each site. The second level is where data quality at entry starts to hold. The third is where health data is used across sites, and where prevention can be aimed at the risks that data shows.

Health Maturity Survey

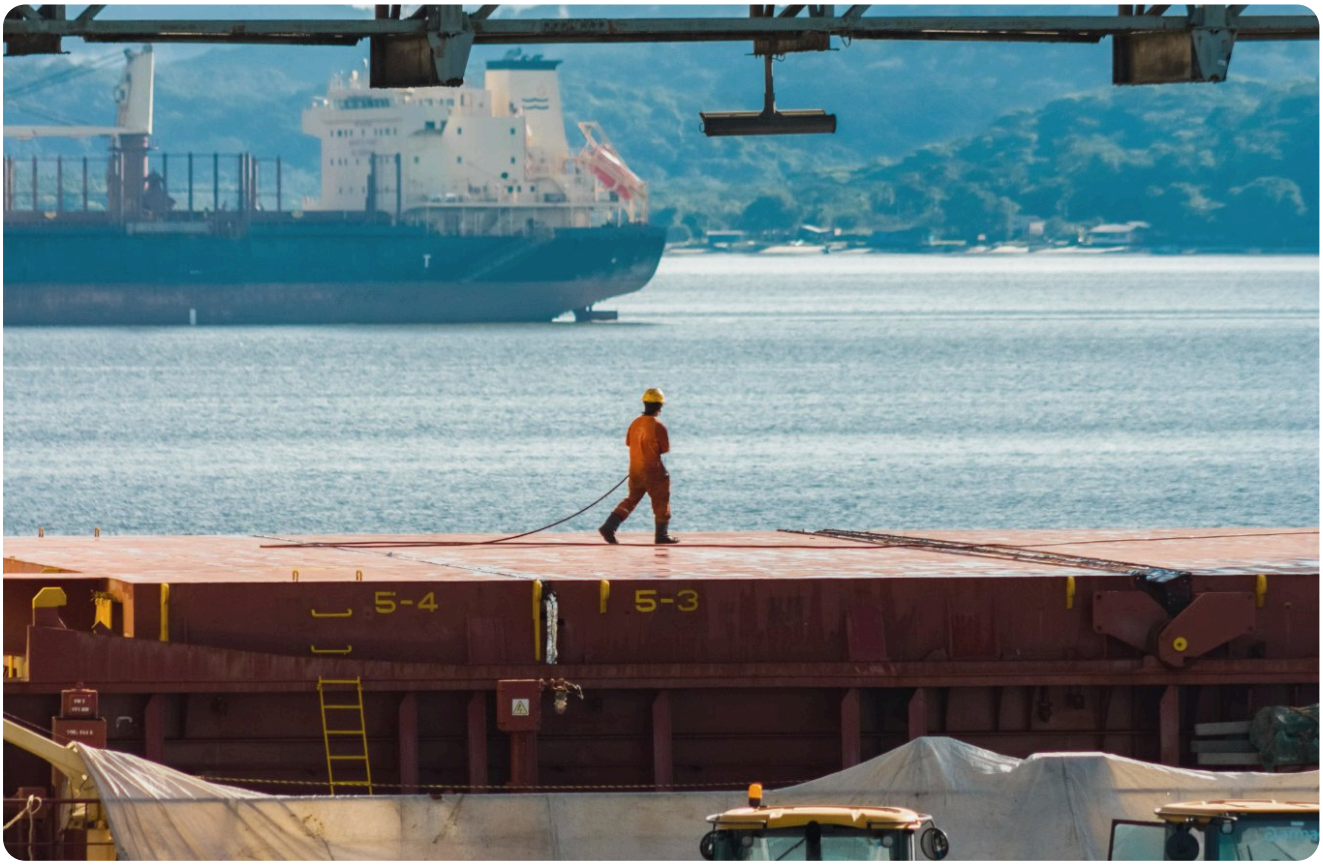
Where does your health program stand? 9 questions across 6 areas of health management, in 2 to 3 minutes. See which of the three levels your program has reached, and what to work on next.

www.myc.care/survey →

> **At that level, health data stops being a record of what has already happened to employees. It becomes a way to change what happens next.**

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About MyC

MyC is an employee health platform for large multi-site organizations. It provides a single health record per worker, with full access for medical teams and live trends for HSE, HR, and executives.

1M
Electronic Health Records managed

800
sites deployed across 67 countries

24/7
live support

Better health starts with better care

Book a demo at www.myc.care

Certified to ISO 27001 and NEN 7510. Complies with HIPAA and the GDPR.