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## Bad Bosses and Broken Hearts

You may have jokingly said at some point that your boss was going to give you a heart attack. Turns out, that could be true. A new Swedish study suggests that managers who score better on standardized leadership testing are associated with a lower risk of heart disease among their employees. Plus, the longer an employee works in the same place, the stronger the link.

The study looked at the risk of 3,122 men for incidence of ischaemic heart disease (IHD, defined as heart attacks, angina, or related deaths) between baseline measurement in 1992 – 95 and the end of 2003 (mean, 9.7 years). Each person surveyed had at least four years exposure in that workplace, and women were excluded only because they had so few (N=12) incidents of IHD. The men were generally better educated than average, fewer smoked, and they averaged 42 years of age.

Health-related data were objectively measured, except for smoking behaviour. Income and tenure data were from government sources. Ten management behaviours, broadly defined as the “leadership climate”, were surveyed. There were 74 incidents of IHD over the study period. The strongest predictors of IHD were communication, managing change, goal clarity, job control, and career development.

The researchers acknowledged that the employee survey responses could arise from different perceptions of leadership among the participants, as well as actual behaviours of managers. Adjustments for education, smoking, exercise, and heart-related biometric measures (e.g., blood pressure, cholesterol) did not affect the results. While the findings do not prove that bad bosses cause IHD, the association certainly indicates that improving the work environment and management behaviours are likely to improve heart health as well.

**Source:** Nyberg A, L Alfredsson, T Theorell, H Westerlund, J Vahtera, M Kivimäki, 2009. Managerial leadership and ischaemic heart disease among employees: The Swedish WOLF study. *Journal of Occupational and Environmental Medicine* 66(1): 51-55.

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## Insight on Incentives

An American survey of 500 large corporations looked at the use of incentives and disincentives to affect employee health decisions. The first key finding was that incentives were “widespread”. Over half of respondents targeted outcomes, two-thirds (65%) aimed at behaviour change, and over 80% rewarded participation. About one in 5 used a disincentive – typically cash-based or benefits-related – to change behaviour.

Noting that incentive use was relatively new, the report was critical of the haphazard approach to changing behaviour. Not enough employers set specific goals for their incentives, and few measured results. Many companies did not target effectiveness: only one of the five most frequently used incentives was among the most effective as ranked by an expert panel of employers. Further, significant money was being invested; about half had incentives or disincentives valued at over US\$200 per person per year, and over 20% totalled \$400 or more. Greater accountability for these investments will be required.

The report provided many tips, particularly towards targeting and integrating incentives and disincentives, and tying them closely to benefit plan design, member education, and HR-related communication. These tactics should be deliberately aligned with organizational culture and goals. Not mentioned in this study, but supported by research, is that all these “extrinsic” incentives and disincentives need to be eventually replaced by “intrinsic” (personal) motivation in order to create successful long-term behaviour change.

The study included one very important reminder: “Too often a health and productivity program may be perceived as a Benefits Department initiative simply aimed at saving health plan costs.” Instead, an incentive program “...must be seen as part of your corporate culture of health for it to be recognized as a serious and permanent part of your organization.”

**Source:** Employer Incentives for Workforce Health and Productivity: Actions for American Business Today. *Integrated Benefits Institute*, 2008. Available at: [www.ibiweb.org](http://www.ibiweb.org).

## Disability Benefits – Challenging the Status Quo

Many employers provide income protection plans for absence, short term disability (STD), and long term disability (LTD). A 2007 paper reports about half of Canadian employees have access to LTD. In 2001, 166,000 LTD benefit recipients received \$4.5 billion in payments. Employers also fund Workers' Compensation (WCB) plans, and contribute to the Canada Pension Plan for retirement and disability [CPP(D)] benefits. Provincial welfare programs and automobile insurers also provide disability benefits. Almost 400,000 working age Canadians say they are disabled, essentially unemployed, and receive no disability-related benefits from any source.

These plans vary in their definitions of disability, eligibility, duration, and return to work orientation and provisions. For example, the CPP(D) has a very stringent view of disability ('severe and prolonged'), relative to most employer plans that typically have two-year “own occupation” and then “any occupation” protection to age 65. Private LTD and most WCB plans offset CPP(D) awards, and some claimants receive benefits from multiple sources. Employment-related plans aggressively pursue return to work for most claimants, but CPP(D) assumes re-employment is all but impossible.

These disability plans must be better integrated. Between ages 55 and 64, over one in 10 (11%, or 407,000) Canadians receive a disability benefit, twice the rate of all working age Canadians (5.1%, or over 1 million people aged 15-64). Despite the wide impact and huge importance of these benefits, there is no integrated, national approach or standards related to disability. There are very few data available to create benchmarks or assess changes over time, and no forum to coordinate expertise in social and workplace disability programs. A focus on prevention would yield huge savings in financing and human costs.

Since disability rates rise with age, the problems will grow. Wouldn't it be great if these issues were addressed before we need them?

**Source:** Mustard CA, C Dickie, S Chan, 2007. Disability Income Security Benefits for Working-Age Canadians. *Institute for Work & Health*. Available at: [www.iwh.on.ca](http://www.iwh.on.ca). Population data from 2006 Census, available at [www.statcan.gc.ca](http://www.statcan.gc.ca).

## Generic Drugs Generate Challenge

The federal Competition Bureau released a study in 2007 that stated Canadian generic drug prices were high relative to other countries. A second report was released in November 2008 to look at ways Canadians could realize lower generic drug prices.

The Bureau noted that when the Ontario Drug Benefit Plans (ODBP) limited most generic drug prices to 50% of the brand-name price, there was a 21% reduction in the cost of older generic drugs, but only for the ODBP. Other payers, public and private, continue to pay more for the old drugs, and new generic drug prices have jumped to 70-75% of the brand-name price.

Ontario is continuing to push with a Competitive Agreements process that targets the price of three popular generic drugs. According to IMS Health, Germany now has 68% of its generic drug sales covered by similar payer contracts.

The latest Bureau report said Canadians could save up to \$800 million annually – 20% of the \$4 billion Canadian generic drug market – with 70% of that potential (\$540 mm) resting in the private market. Private payer savings could grow another \$300 million as a result of the loss of patent protection for \$2.8 billion in brand-name drug sales by 2012. To get these savings, it said:

“...[private] plan sponsors and beneficiaries will be required to accept and demand changes in the manner in which drug plans have traditionally been delivered.”

But it also cautioned payers that choose to exercise their “countervailing bargaining power” to do so in ways that respect the Competition Act.

Clearly, these are strange and interesting times when a government agency feels the need to encourage private industry to chase significant savings for its customers.

**Source:** Benefiting from Generic Drug Competition in Canada: The Way Forward. *The Competition Bureau Canada*, 2008. Available at: [www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/home](http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/home). IMS Health comment from News Releases, December 10, 2008, available at: [www.imshealth.com](http://www.imshealth.com).

## Drug Plan Management – Dancing in the Dark

A new review of published Canadian literature suggests drug plan managers tend to rely on intuition and aim for financial expediency. That’s because there are few studies that carefully document cost or utilization, and even less that examine medical outcomes. No research has assessed patient satisfaction, quality of life, or functional status. All these are important considerations in changing drug plan design and coverage.

Starting with over 1,200 potentially relevant studies, just 35 met the study parameters, and most of those addressed seniors (71%). Only two included changes to a private drug plan.

The good news is that most studies (25 of 35, including one private plan study) reported the plan change had the intended effect; it reduced cost or utilization of the drug plan. Some (N=4) showed no change, and four showed mixed effects. Two did not look at this dimension.

Just thirteen studies looked at the effects of those drug plan changes on the cost or use of medical care, and the results were mixed and sometimes had temporary effects. Six studies evaluated clinical outcomes – the medical events resulting from the drug plan change. Four of these found no measurable change, and the other two reported both positive and negative effects.

Even with resource constraints, it is important to consider all the major potential impacts of drug plan changes. To do that, we need insurers, pharmacy benefit managers, and consulting firms to work with academics and health professionals to provide solid, actionable research on private drug plans. A recession will push plan managers to further control operating costs, and they need high quality guidance on what works, and for whom.

**Source:** Morrison A., MacKinnon NJ, Hartnell NR, McCaffrey KJ, 2008. Impact of drug plan management policies in Canada: A systematic review. *Canadian Pharmacists Journal*, 141(6).

### COMMENTS AND QUESTIONS TO THE EDITOR:

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