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The Kids are *Not* Alright

In recent years, there have been sad tales concerning the health of Canadian children. Statistics Canada reported that 26% of our kids aged 2 to 17 were overweight or obese in 2004. Those results were attributed to low consumption of fruit and vegetables, and too much “screen time” (TV, gaming, and computer).

Now, the findings of a new StatsCan fitness study – The Canadian Health Measures Survey (CHMS) – have been released. While the report examines both adults and children, it is the latter group that is more worrisome.

Almost 2,100 Canadians aged 6 to 19 were surveyed and measured, and results were compared to the last federal survey conducted in 1981. The findings, in general: “Children are taller, heavier, fatter, and weaker than in 1981.” There may be a link to modern lifestyles: Canadian Old Order Amish and Mennonite kids have grip strength 50% higher than those measured in the CHMS.

One conclusion of this study echoes the oft-quoted New England Journal of Medicine article that predicted the current generation would not live as long as their parents. Specifically, the subjects aged 11 to 14 in this study are projected to be overweight by age 36, and likely to be less fit than their parents. Other research suggests such low childhood fitness levels are likely to signal faster onset of chronic disease, higher health costs, and reduced future productivity. The implications of these findings are very significant.

There is hope though. If we can find a way to encourage moderate to vigorous physical activity in our kids, the poor trends forecasted could slow or even reverse. Going one better, doing such activities with our kids could only help us parents too.

Source: Tremblay, MS, M Shields, M Laviolette, CL Craig, I Janssen, S Connor Gorber, 2010. Fitness of Canadian children and youth: Results from the 2007-2009 Canadian Health Measures Survey. *Health Reports*, 21(1).

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An Update on Changes to the Ontario Drug Programs

Last summer, key stakeholder groups were invited by the Ontario Ministry of Health and Long-Term Care to discuss changes to the provincial drug programs. (This was reported in the last e-news (5:3).) After a new Health Minister was appointed in October, the consultation process was put on hold until February. With a \$25 billion deficit forecast, the province is compelled to cut costs quickly and significantly.

A new meeting with the private payer community brought focus to the shared priorities of public and private plans. Pricing for generic drugs and pharmacy was extensively discussed, as was the balance between immediate regulation and the need for a much more competitive market. The government was told private insurers and employers strongly support a market-wide price ceiling on generic drugs. Uninsured individuals would also benefit, as would reimbursement plan customers who often pay significantly more as pharmacies shift costs to uncontrolled plans (see *Drug Pricing Discrepancies* below). Other issues tabled included pharmacies refusing to honour drug cards, and pharmacy balance-billing, where plan members pay the difference between their plan limit and the pharmacy's usual fee. (The public plan prohibits this practice, but private plans allow it.) Employer willingness to pay for new pharmacy-supplied health management services was also discussed.

In the meantime, Alberta's new Pharmaceutical Strategy has introduced regulatory changes for generic drug pricing that will benefit both public and private payers. The price of new generics dropped to 45% of the brand name drug price on October 1, 2009. On April 1, 2010 older products will be cut to 56% of the brand price, from 75%. Transitional allowances for pharmacy may actually boost their fees for the next three years.

With the first generic version of the blockbuster drug Lipitor® expected this summer, drug plan savings may start rolling in...at least in Alberta.

Drug Pricing Discrepancies

Maybe you've assumed there is little difference in the final price of a drug from one pharmacy to another. But over the last few years, the world has changed, and now drug ingredient costs, mark-ups, and dispensing fees vary significantly. The total eligible cost is the key, and it varies by insurer or pharmacy benefit manager, and by type of plan (reimbursement vs. pay-direct).

Plan sponsors with paper-based reimbursement plans are in the unenviable position of rarely having price controls. This allows pharmacies to charge whatever they like. Retail and wholesale mark-ups can be as high as 30-40% over the Manufacturer List Price (MLP). The dispensing fee can also vary significantly, but only pharmacies in Ontario and BC routinely reveal this cost. (Some pharmacies in Atlantic Canada also display their fee.) Though most pay-direct plans control prices, reimbursement plans generally do not.

Canadian pharmacies submit generic drug prices to PBMs that can now vary by up to 48%. Similarly, price differences of 7% to 11% have been seen on brand name drugs. The greatest cost discrepancies seem to be in Ontario, but they also occur in Atlantic Canada and Western Canada. In these two regions, the average cost varies from 20% to 25% for generic drugs, and from 7% to 9% for brand-name drugs.

For plan sponsors, it may be time to ask your plan advisor or insurer to tell you how much mark-up over the MLP they allow on your drug claims, and whether they use price files to control drug cost. If you have a reimbursement plan, ask if it's time to consider a switch to a pay-direct drug card.

Source: M. Sullivan, Cubic Health Inc. / www.cubichealth.ca.

Putting the Spotlight on Covert Coping

Coping can be described as the active and cognitive responses used to handle stressful events, such as those at work. Coping can be either open, or covert (avoiding conflict). In 2009, almost four in 10 (38%) Canadian benefit plan members said they had experienced stress so overwhelming that it made them physically ill in the last year.(1) “Internalizing” stress has been linked to coronary heart disease, hypertension, as well as higher illness-related absence.

A recent study looked at the association between covert coping with unfair treatment by a superior or peer at work, and heart attacks and cardiac-related death among 2,755 Swedish men.(2) Survey questions looked at several suspected factors, such as age, demographic and socioeconomic characteristics, and behavioural and biological risk factors. The survey addressed both immediate response, and the consequences of covert coping, i.e., feeling bad or having a reactive temper at home.

Income, decision latitude, education, supervisory status, job demands, and age were all statistically significantly related to covert coping. Those who sometimes or always avoided conflict were three times more likely to have a cardiac event than those who always confronted the unfair treatment. Only the immediate response was linked to the cardiac event. In this study, cardiac risk was also significantly associated with heavy drinking, diabetes, and elevated blood triglycerides.

At least for men, suppressing anger due to unfair treatment can be unhealthy. It is important to deal directly and constructively with treatment perceived as unfair. At work, policies and good practices about workload, conflict resolution, fairness, and respect can help reduce the opportunity for tension and aggression. Jobs should include as much autonomy as possible. Employers should consistently communicate expected behaviours and conduct. These steps will reduce the need for covert coping, and the serious health threats that can follow.

Source: (1) 2009 sanofi-aventis Healthcare Survey. (2) Leineweber C, H Westerlund, T Theorell, M Kivimäki, P Westerholm, L Alfredsson, 2009. Covert coping with unfair treatment at work and risk of incident myocardial infarction and cardiac death among men: prospective cohort study. *Journal of Epidemiology and Community Health*.

All You Never Wanted to Know about Stress

We noted above that “internalizing” stress has been linked to heart disease. Different than chronological aging (the passage of time), biological aging, or what researchers call “allostatic load”, is defined as the accumulated effects of strain on the body that can encourage disease.

Our stress response is driven by cortisol, insulin, and other hormones. Cortisol, perhaps the key stress hormone, has been linked to depression, and lower bone density in women. As we age, our bodies react less well to the effects of stress – we are slower to respond, have higher hormonal peaks, and the return to baseline hormonal levels is delayed. High, unrelenting stress, including work-related stress, is associated with insulin resistance, fat disposition (particularly in the abdomen), and obesity. In part, this is because stress encourages us to select foods high in fat, and motivates general overeating. Diabetes, the body’s response to inadequate insulin, may lead to earlier onset of some diseases of aging, such as dementia and frailty. More immediately, stress can also impair function (so-called “stress brain”) in the hippocampus, part of the brain with a high concentration of cortisol receptors, and concerned with verbal and contextual memory. In studies of older adults, allostatic load was associated with poorer physical and mental performance, the latter including memory, spatial abilities, and abstract reasoning.

So where do these studies leave us? The good news is that our health behaviours such as activity, diet, and sleep, shape our internal hormonal cocktail. All these things, done right, can help mitigate the effects of stress and allostatic load. All things being equal, we will also live longer. Clearly, stress isn’t, ever, just in your head.

Source: (1) Epel ES, 2009. Psychological and metabolic stress: A recipe for accelerated cellular aging? *Hormones* 8(1) 7-22. (2) McEwan BS, 1998. Protective and Damaging Effects of Stress Mediators. *New England Journal of Medicine* 338(3): 171-79. (3) Seeman TE, BH Singer, JW Rowe, RI Horwitz, BS McEwan, 1997. Price of Adaptation – Allostatic Load and Its Health Consequences. *Archives of Internal Medicine* 157: 2259-68.

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rpullman@businesshealth.ca

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