The sanofi-aventis Healthcare Survey 2009

Turn ideas into action

How Canadian plan members view access to healthcare and engage in their own health

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Because health matters

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Turn Ideas Into Action

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Welcome to the twelfth edition of *The sanofi-aventis Healthcare Survey*. How things have changed since the last edition! In 2008, the Canadian economy slid from "steady," according to Statistics Canada, into an official recession in the beginning of 2009. Negative growth was reported by Statistics Canada for seven of the 12 months of 2008.[1] The Toronto Stock Exchange shed a third of its value. Building permits were down by one-fifth. Unemployment crept up over the year, and the only job gains were in part-time work.[2] And another federal election came and went, which almost completely ignored healthcare as an issue—even though a poll taken just before the October 14 vote showed it remained the second most important issue for Canadians at 19%, following the economy at 26%.[3]

Despite these difficult times, sanofi-aventis is committed to facilitating the healthcare debate with solutions and tools to better understand the needs of Canadians. This is why we are pleased to be able to present again this year, *The sanofi-aventis Healthcare Survey*. As always, we have polled Canadian benefit plan members on their thoughts and attitudes toward their health and benefit plans. The report is a valuable tool, not only to help employers gauge the success and the perceived value of their current programs, but also to pave the way for future improvements in employee benefits and engagement. The 2009 edition of *The sanofi-aventis Healthcare Survey* delves into Canadian plan members' perceptions about health access, engagement in their personal health and in their health benefit plan, the value of employee health benefits, the public healthcare system, and the work environment.

One ongoing issue for Canadians and their governments has been access to health services. In its "10-Year Plan," the federal government pledged $4.5 billion in the Wait Times Reduction Fund between 2004 and 2010. The focus has been on five areas: cancer, heart, diagnostic imaging, joint replacement, and cataract surgery. Despite the efforts, the results have been mixed, hampered by a lack of comparable data. But access concerns more than these five targeted areas. Access to primary care, physicians, emergency services, long-term care, prescription medicines, and rehabilitation are all critically important.

The economic crisis has also increased our collective stress levels, and the finances of governments, employers, and families are under considerable strain. This mindset has no doubt affected the health-related choices, preferences, and attitudes of employees toward their health benefits. Employers will be challenged to balance the need for an engaged, healthy, loyal, and productive workforce with the need to control short-term costs.

This year we have upgraded the data collection of the survey by doing most of it online for the first time. Not only has this new methodology allowed us to increase the scope of the survey, but it has also allowed us to reach more plan members; we've increased the national sample of primary plan holders to 2,090, up from 1,500 in 2008.

Access to healthcare services and providers, and employee engagement in their own health, are key issues in today's work environment. This report clarifies the perceptions of Canadian employees on these and other prominent topics, and provides key action items.

We are very excited about the findings in the 2009 edition of *The sanofi-aventis Healthcare Survey*. We at sanofi-aventis Canada Inc. hope that you will take the results of this year's report and turn ideas into action.

1. Real Gross Domestic Product (Statistics Canada, data available at: http://www.canadianeconomy.gc.ca/english/economy/gdp.cfm; 2. Statistics Canada, 2009. Latest Release from the Labour Force Survey, January 9, 2009. Available at: http://www.statcan.gc.ca/subjects-sujets/labour-travail/lfs-epa/lfs-epa-eng.htm. Accessed 29 January 2009; 3. News release: Ipsos-Reid, for Canwest News Service and Global Television, 2008. As Markets Decline, Economy (26%) Rising in Importance in Campaign. See: www.ipsos-na.com/news/pressrelease.cfm?id=4082.

Advisory Board

The *sanofi-aventis Healthcare Survey* would not be possible without the participation of the Advisory Board. The members of the Advisory Board dedicate their time to reviewing, discussing, and adding insight to the results of the survey. They are the most highly esteemed professionals in the Canadian health benefits industry, and each member represents an essential industry stakeholder, including health benefit plan sponsors, healthcare service providers, insurers, and consultants. Every year, Advisory Board members bring their understanding, knowledge, and practical experience to the analysis of the employee benefit plan member research. This is the 12th edition of *The sanofi-aventis Healthcare Survey*, and as the survey continues to expand and evolve, so does the enthusiasm and analysis of the Advisory Board members.

Sanofi-aventis and the members of the Advisory Board would like to thank
GINETTE DAVID *for her many years of hard work and dedication to this project.*

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ANTHONY MAY *was a valued member of* The sanofi-aventis Healthcare Survey *Advisory Board for many years. He is greatly missed and fondly remembered.*

Employers and the Workplace

Summary

Ensuring that employees have access to high-quality, well-received health benefit plans while still managing costs is an ongoing challenge for many employers. The 2009 edition of *The sanofi-aventis Healthcare Survey* found that access to a variety of benefits remains good for most employees, but there are issues in certain groups. Perceived plan quality is high, but is under some pressure. Certain employer characteristics, such as size and type of employer, are associated with higher quality. As well, responses indicate interesting correlations between communication, wellness programs, plan quality, and job satisfaction scores. The Survey also reveals challenges plan sponsors have with effective communication and member understanding of health benefit plans — again, areas of traditional strength that may now need review.

Access to Health Benefits

Access to physicians, diagnostic procedures, and surgery has been perhaps the dominant issue for the public and the government-funded health system in recent years. A majority of plan member respondents say they have access to drug plans (91%), basic dental plans (80%), paramedical practitioners (78%), vision care (75%), and semi-private hospital coverage (72%). Major dental plans (57%) continue to be considered a prime benefit, offered at a substantial cost to employees. It is also interesting to note that just under half (48%) get paid time off for occasional absences.

Younger men (aged 18–34) are less likely to report having coverage of each of their benefits than all other segments, including women of the same age and those with the lowest range of household income. "Still, I've been surprised at the feedback from young people in their first jobs," says Sarah Beech, Managing Principal, Consulting Canada, Hewitt Associates, in Toronto, Ontario. "They're talking about the health program in a way we never did. They're putting value on other things beyond their pay."

There are also some interesting variations by province. Significantly more Quebec respondents report they have paramedical benefits (83%), but fewer report basic dental coverage (64%), vision care (56%), and major dental coverage (44%) than the national average. Respondents in British Columbia are also less likely to report having access to drug plans (84%) and semi-private hospital coverage (53%) than those in other parts of the country.

In addition to the 9% of respondents who say they already had a health spending account (HSA), an additional 9% indicate that their employer added this benefit during the last year, doubling the proportion who report having this benefit. Twelve per cent don't know if they have an HSA. Younger employees (aged 18–34) are much more likely to be aware of a new

ACCESS TO BENEFITS FOR YOUNGER AND LOWER INCOME PLAN MEMBERS

	Drugs	Basic Dental Coverage	Paramedical Practitioners	Vision Care	Semi-private Hospital Coverage	Major Dental Coverage
All respondents	91%	80%	78%	75%	72%	57%
Men, Aged 18–34	76%	72%	57%	69%	47%	51%
Women, Aged 18–34	88%	79%	74%	76%	58%	58%
All, Income < $30,000	78%	64%	55%	65%	49%	29%

HSA (15% versus 9% overall), but also more likely to answer "don't know" (16% versus 12% overall). Respondents in Alberta (18%) and British Columbia (14%) are much more likely to report having an HSA added during the last year.

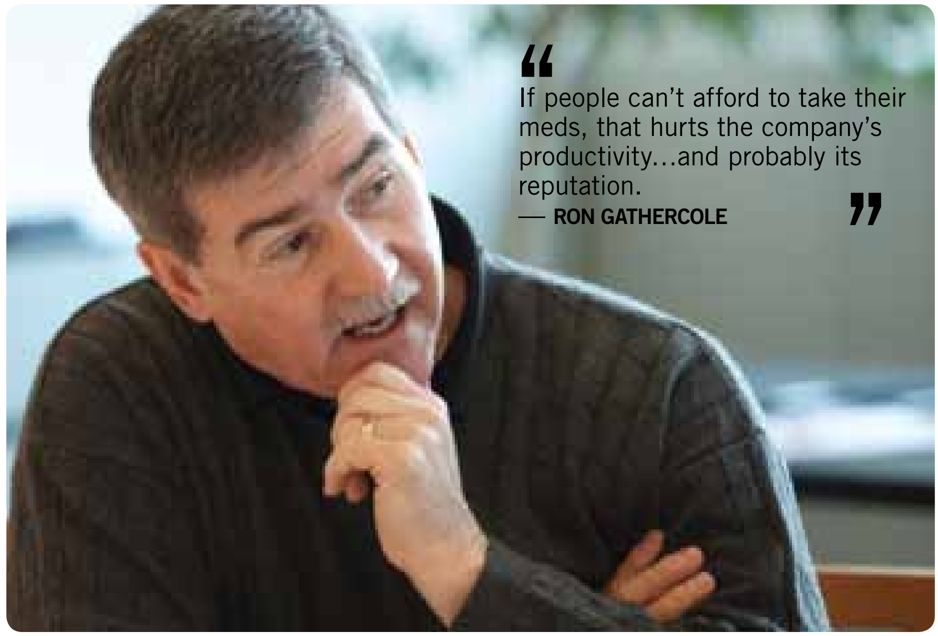
Health Benefit Plan Quality

For many years, respondents have repeatedly said they are highly satisfied with the quality of their health benefit plans. However, those giving their plans the top ratings of excellent or very good have been slowly declining, from 59% just four years ago, to 54% in 2009. Plan members who rate their plans as good have increased slightly during that time period to 38%, up from 36%. Those who say their health benefit plan is poor or very poor climbed to 8% this year, from 4% in 2006. Despite this trend, over half of respondents still assign very strong ratings.

Plans offered by larger employers are positively correlated with quality, meaning that as company size increases, perceived quality does as well. Large employers get significantly better health plan quality ratings than smaller employers — 43% of respondents in companies with less than 50 employees rate their plans excellent or very good compared to 59% of those in organizations with between 1,000 and just under 5,000 employees, and 62% for plan members in firms of 5,000 or more employees.

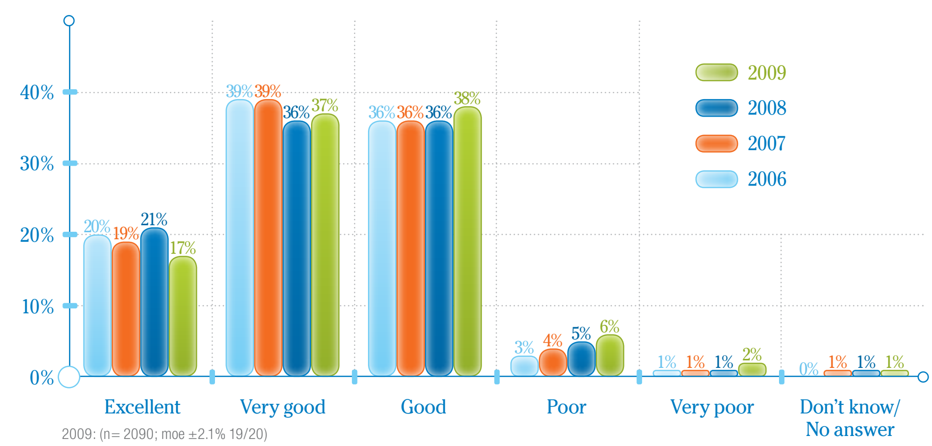
Public sector respondents rate their plans higher (57% say excellent or very good) than do their counterparts in the private sector (48%). Older respondents also rate their health benefit plans highly — 71% of plan members aged 65 and older say their health benefit plan is excellent or very good, as do 67% of those who are retired, compared to the national average of 54%.

Benefit plan quality is rated highly by those who say their employer does a very good job communicating plan information (84% versus 54% overall, and just 27% of those who say communication is poor or very poor). Plan members who understand their plans extremely or very well are also more likely to say plan quality is excellent or very good — 67% versus 54% overall, and just 19% for those who say they understand their plans not very well or not well at all.



QUALITY OF HEALTH BENEFIT PLANS

In general, how would you describe the quality of your employer-sponsored health benefit plan, that is, your health benefit plan that is provided by your employer? Would you say it is…



Plan quality is positively linked to employers that provide wellness programs, such as those focused on nutrition, exercise, stress management, weight management, and smoking cessation. Sixty-five per cent of plan members who have a workplace wellness program say their plan is excellent or very good, versus 46% of those who do not have one. Those who actually participate in their wellness program rate their plan quality even higher, at 73%.

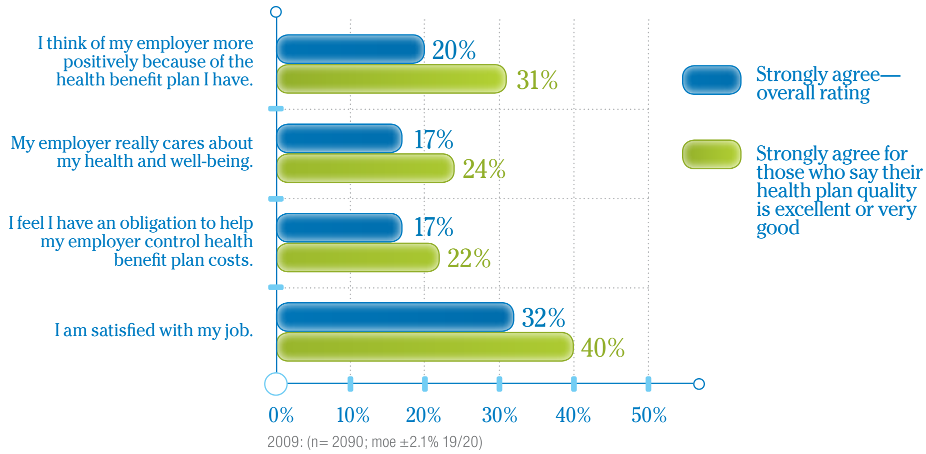
There are other factors that correlate with perceived plan quality. The chart on page 8 illustrates the linear relationships between excellent/very good benefit plans and four important statements describing the way employees think of their employer. For example, those who strongly agree their benefit plan is excellent or very good are more likely to think of their employer more positively than those who somewhat agree, somewhat disagree, or strongly disagree.

Employers and the Workplace

The combined effect of these correlations indicates that maintaining or improving benefit plan quality perception is likely to improve employee loyalty and accountability.

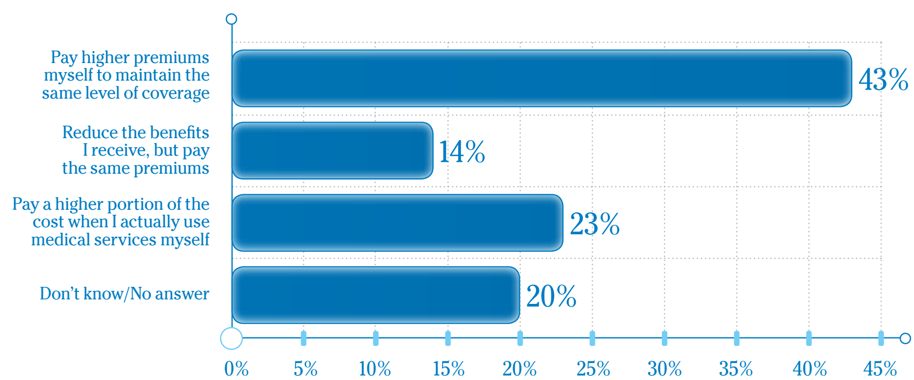
The Advisory Board felt strongly about the link between benefit plan quality and the relationship between employers and employees. There was concern among many that the recession could lead to plan cuts. John McGrath, a Principal with Mercer in Vancouver, British Columbia, believes employers should carefully consider the process for cost review. “Employers can certainly make changes, but there are things you can upset by looking at one silo and trying to manage it in isolation.” Sarah Beech, Hewitt Associates, agrees, “Even if the plans don’t change, what’s going on with people’s salaries will have an impact on their purchasing power, and their ability to access health services.” Ron Gathercole, an independent consultant from Moncton, New Brunswick, adds, “If you change your plan to add 20% coinsurance without an out-of-pocket cap, that will seriously affect the least healthy and the lowest paid. If you take five or six medicines, that 20% can really add up. If people can’t afford to take their meds, that hurts the company’s productivity…and probably its reputation.”

LINEAR RELATIONSHIPS BETWEEN EXCELLENT/VERY GOOD BENEFIT PLANS AND OTHER JOB FACTORS



2009: (n= 2090; moe ±2.1% 19/20)

IF EMPLOYER COULDN’T COVER INCREASE TO PLAN COSTS



2009: (n= 2065; moe ±2.1% 19/20)

Higher Premiums, Fewer Benefits?

For many years, *The sanofi-aventis Healthcare Survey* has tracked how plan members would respond to an increase in plan costs if their employer was unable or unwilling to pay. Since 2002, the portion that would pay higher premiums themselves to maintain their benefits has declined but appears to have stabilized and is now 43%. Respondents selecting this option are more likely to be in Atlantic Canada, at 57%. A minority, also stable at 14% this year, would reduce their benefit coverage in order to pay the same cost. This group is significantly more likely to be both men and women between the ages of 18 and 34 (21% versus 14% overall), an age group that is assumed to be the most healthy and use their plan the least.

Farouk Ratansi, Director, Employee Benefits and Retirement Services, Central 1 Credit Union, Vancouver, British Columbia, concluded, "The older generation seems to have more concern for their employer than do younger employees. The new Gen Y workforce may not show as much loyalty, and may feel a stronger sense of entitlement to benefits because they've grown up with having full coverage through both parents' health plans. Their perception may be limited to thinking, 'This is part of my compensation and it's not my responsibility to manage these costs.' Clearly, it is important for employers to make the link between unrestrained increases to benefit costs and less money available for cash compensation."

Digging deeper into the minds of the 14% who say they would reduce their coverage rather than pay more, 23% say

The Value of the Plan

Again in 2009, employees are placing a very high value on their health benefit plans. When asked a series of questions about which they would rather have, the majority of plan members said they would prefer their health benefit plan over other types of compensation. Fifty-two per cent would choose their health benefit plan over an additional cash compensation of $15,000 per year (versus 41% choosing the money), 92% would choose their plan over an extra week's vacation (versus 6% choosing the vacation), and 59% would choose health benefits over a more generous pension plan (versus 30% choosing the pension plan). Even when the cash was increased to $20,000 nearly half still would choose their health benefit plan (45% versus 47% choosing the money).

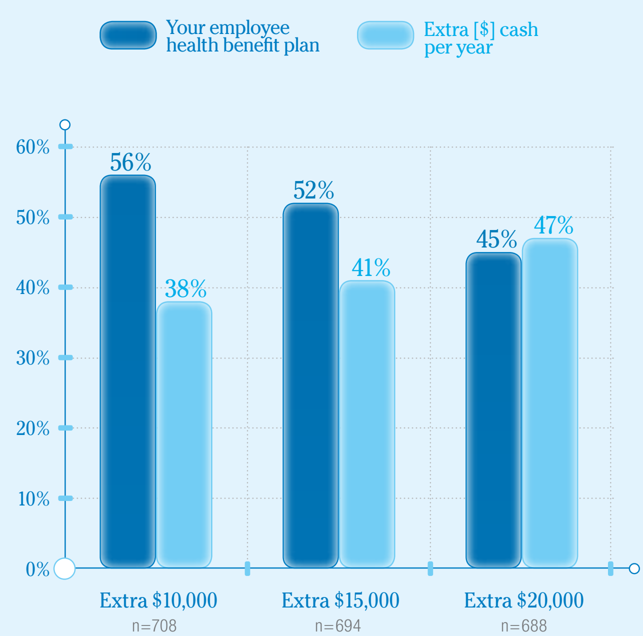
These numbers support our finding that most plan members appreciate their benefit plans for the value it brings them with everyday healthcare costs, which may be either affordable or avoidable. When asked which part of their health benefit plan they found most valuable, the majority of the respondents (64%) say coverage for day-to-day healthcare costs for themselves and their families. Only 29% say coverage for unexpected healthcare costs for themselves and their families is the most valuable part of the plan.

Younger plan members, aged 18–34, are more likely than their older counterparts to opt for the cash over their plans (65% would take the $20,000 versus 29% who opt for the benefit plan; 54% would take $15,000 versus 37% who choose their benefit plan). Interestingly, those in the lowest household income group are among the least likely to choose money over benefits (28% in this income group would choose $20,000 compared to 47% of plan members overall who would opt for the $20,000).

Regionally, there are some differences, with plan members in British Columbia being the most likely to choose their health benefit plan (58%) over an extra $20,000 cash per year (35%). Next door in Alberta the views are almost a mirror image, with 56% of plan members indicating they would choose $20,000 over their health benefit plan (36%). Respondents in Ontario are evenly divided (46% opt for their plan versus 46% who would choose the cash). It also seems that better understanding of the health benefit plan is linked to greater appreciation of its value. Respondents with the two highest levels of understanding are significantly more likely to choose their plan (49%) over $20,000 cash (43%), and their plan (59%) over $15,000 cash (35%).

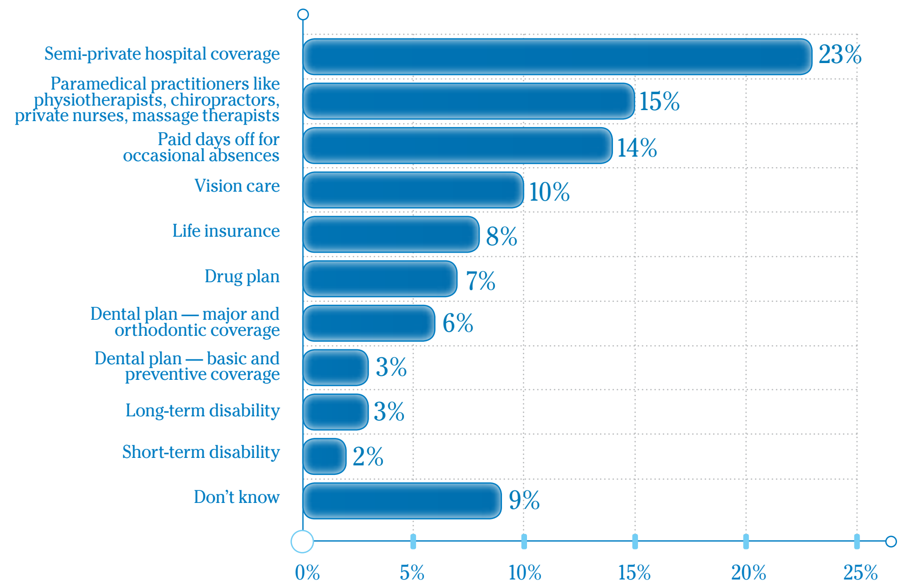
It is probably no surprise that plan members who view the quality of their health benefit plan as excellent or very good also clearly choose their plan (54%) over $20,000 (39%). In comparison, those who say the quality of their plan is poor or very poor would opt for the cash ($20,000: 62% versus 23% for the benefit plan).

VALUE OF HEALTH BENEFIT PLANS



they would cut their semi-private hospital coverage, 15% would allow their paramedical benefits to be taken away, 14% would give up paid days off for occasional absences, and 10% would leave their vision care behind. When asked what effect losing those benefits would have on them personally, over half (57%) of respondents say, "no effect" because they rarely use that part of the plan. Thirty-seven per cent indicate the lost benefit would have some effect, because they would then pay for that benefit themselves. Just 6% of respondents report they would no longer use that service.

SERVICES WILLING TO GIVE UP



2009: (n= 264; moe ±6.0% 19/20)

Relationships with the Workplace

This year's Survey included several attitudinal questions designed to demonstrate new insights into job satisfaction and perception of employers.

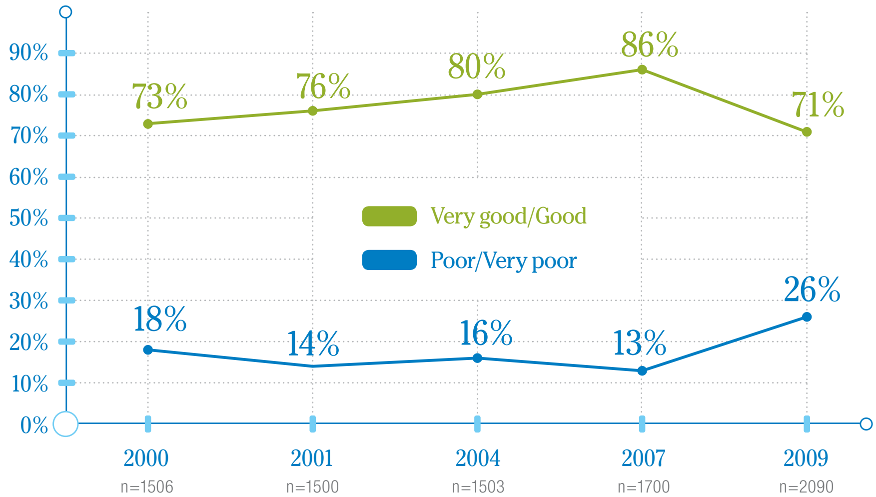
Nearly six in 10 (57%) respondents strongly or somewhat agree they have an obligation to help their employer control the cost of the benefit plan, with 17% of those strongly agreeing. Thirty-four per cent of plan members strongly or somewhat disagree with that statement and 10% say they don't know or have no answer. Here's an example where advancing age is a good thing: the percentage of those aged 55–64 (69%) and 65 and older (75%) who strongly or somewhat agree they have a responsibility is significantly higher than their younger colleagues, particularly those aged 18–34, at 43%. Consensus of the Advisory Board was that the economy has many people far more worried about their personal finances, and so protecting their employer's funds no longer matters as much.

Twenty per cent of plan members strongly agree that they think of their employer more positively because of the health benefit plan and 43% somewhat agree. Respondents from Quebec are significantly more likely to somewhat or strongly disagree, at 39% versus 27% overall. So are union members, at 34% versus 26% of non-union employees who think of their employer more positively because of the health benefit plan.

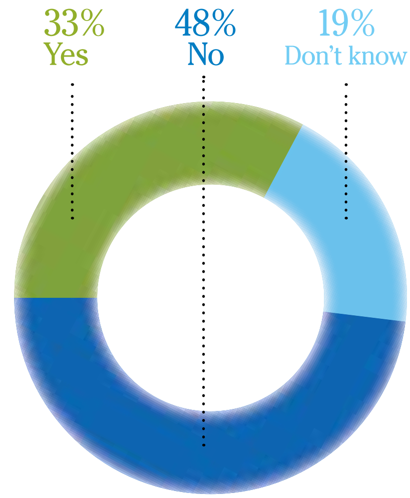
It appears that job satisfaction may be on the decline, with just 32% saying they strongly agree they are satisfied with their job, down from 57% in 2008 and 61% in 2007. Forty-five per cent somewhat agree versus 33% last year, and 14% strongly or somewhat disagree this year versus 8% in 2008.

Should employer communication change with the times? Advisory Board member Theresa Rose, Director, Group Product Management, Medavie Blue Cross in Moncton, New Brunswick, believes the economy dictates a change in approach. "With so much electronic communication, we've lost sight of spending time with employees and delivering messages face-to-face. With uncertain times, leaders need to be more visible to build employee engagement." She believes this will help reassure employees, create reasonable expectations, and help them see their role and place into the future.

PLAN COMMUNICATION



HEALTH EDUCATION PROVIDED



2009: (n= 2090; moe ±2.1% 19/20)

The percentage of respondents who agree their employer really cares about their health and well-being is at 59% (strongly agree at 17%), down from 74% in 2008. This is another of the areas where union membership makes a difference — at 52%, union members are significantly less likely to agree their employer cares versus 65% for non-union plan members. Regionally, plan members in Alberta (71%) are the most likely to agree with this position, while those in Quebec (47%) are least likely to share this view.

The answers to all these attitudinal questions are affected by health status: respondents in better health are more likely to agree with each statement. Each attitude is significantly and positively correlated to quality of the health benefit plan, coverage communication, plan understanding, and provision of a wellness program. Each attitudinal statement is similarly related to each other — those who agree with one are significantly more likely to agree with each of the other three.

Health Education and Health Plan Communication

This year, 33% of respondents report that their employer provided health education materials, which is not far off the 2003 mark, when 39% agreed. The 2009 edition of *The sanofi-aventis Healthcare Survey* found that almost half of plan members say they do not receive health information from their employer (48%) and a surprising 19% of respondents don't know. Only 25% of employers with 500 or fewer employees provide health information.

Relatively few respondents aged 65 and older say they receive employer health education (30% versus 33% overall), and they are far more likely to say they don't know (32% versus 19% overall). Since health costs rise with age, and begin to accelerate rapidly after about age 60,[4] older plan members would be a prime target for health education that could improve knowledge and encourage behaviour change.

Providing information is important, but having employees access it is even

better. Of those who receive health education from their employer, almost six in 10 (59%) say they have read health-related materials such as brochures or emails. About half (49%) of plan members report accessing online information, 48% say they have read newsletters, 47% say they have seen information that encourages physical fitness or used employer-provided access to fitness equipment, 40% say they have used healthcare facilities or healthcare staff, and 39% say they have used wellness programs.

The sanofi-aventis Healthcare Survey asked respondents about how well their employer communicated health benefit plan coverage information. Seven in 10 (71%) plan members say their employer did a very good or good job communicating this information, with 19% reporting they did a very good job. In 2007, when this question was last asked, 86% said very good (41%) or good (45%).

The percentage of respondents who say they understand their benefits extremely or very well is strong, at 59%. Thirty-four per cent say they understand them somewhat well, and still just a very small group (7%) say they understand them not very well, or not at all well.

Those aged 65 and older are significantly more likely to say their employer does a very good or good job communicating what is covered under their benefit plan (82% versus 71% overall), and this group understands their benefits much better too (77% versus 59% overall).

The sanofi-aventis Healthcare Survey indicates that very good or good benefits communication, and understanding the plan extremely or very well, are each statistically associated with having a higher opinion of the employer (71% communications and 70% understanding versus 63% overall), greater obligation to help the employer control plan cost (62% communications and 63% understanding versus 57% overall), higher rates of job satisfaction (82% communications and 82% understanding versus 77% overall), and a sense the employer really cares about their health (69% communications and 67% understanding versus 59% overall).

Leading employers are well beyond simply telling employees what's in their benefit plan. Deb Mayberry, Business Partner, Human Resources, City of Calgary, Alberta, explains: "Our communication strategy is not just about design, but where we want our plan to be, how we measure that, and how that compares to our competitors. The plan becomes part of our value proposition to the employee, not just an entitlement." Expanding the conversation allows the City of Calgary to "connect the dots" for employees, and position the plan as an integral part of their total compensation — a bigger, richer topic for both employer and employee.

Access to Useful Services

Respondents were given a list of things their employer could do and asked which ones would be useful to them. Ranking highest, 67% of plan members say education about the healthcare benefits available to them through their employee health benefit plan would be useful. Fifty-eight per cent cite an EAP to assist them and their families with work-life issues, 56% say the ability to purchase additional health benefit coverage, and half (50%) would find personalized health counselling that provides health-related information and available resources based on specific needs useful. Following closely behind, 47% say a health risk assessment and 45% say physician referral service would be useful things their employer could do.

Action Steps

1 Employers should sustain their investments in health promotion programs and high-quality health benefit plans, especially in this tough economy. The more employees understand and control their health risks, the more likely it is that employers will have lower long-term costs and create greater employee loyalty.

2 Employers need to review the cost of employee out-of-pocket co-pays, particularly for lower income employees, improving equity and access for those families. Ensure the company's health plan rules do not unnecessarily hinder people from access to lower cost regulated health professionals, e.g., dentist referrals to dental hygienists.

3 Evaluate benefit-related communication to ensure it is meeting plan member and company needs, and is clear, accurate, accessible (especially to families and retirees), and relevant.

4 To help ensure plan members have access to high-quality health information, employers can serve as the conduit to reputable websites, rather than the source of such information. Insurers, employee assistance plan (EAP) providers, and plan advisors can help, and can often attend employee meetings. Don't forget to include the family.

4. Canadian Institute for Health Information, 2008. National Health Expenditures Trends 1975–2008. Figure 25, page 39.

Plan Members and Their Practices

Summary

With a particular emphasis on employee engagement, the 2009 edition of *The sanofi-aventis Healthcare Survey* once again questioned plan members about their health issues and attitudes toward their health benefit plans, and what employers can do to help. Despite workplaces having a better understanding of the personal and organizational dimensions of stress, the problem remains. Many people are carrying more stress than they feel they can handle, and those in poor health are significantly worse off. Responses this year are likely affected by poor economic news; there is serious concern about personal finances. Employers have a number of options, including better communication and health promotion programs. However, success rests in the execution of these tactics, and this year, there is room for improvement. It seems that organizations — and employees — struggle with putting information into practice, and finding a way to bridge the gap between knowledge and execution.

Wellness Program Engagement

The sanofi-aventis Healthcare Survey has regularly tracked the number of employers that offer health promotion, or wellness programs at work, programs that address issues such as nutrition, exercise, stress management, weight management, and smoking cessation. There is considerable published evidence in Canada and many other countries that demonstrates the effectiveness of a comprehensive workplace health strategy aimed at preventing and managing disease in order to reduce health risks and costs.

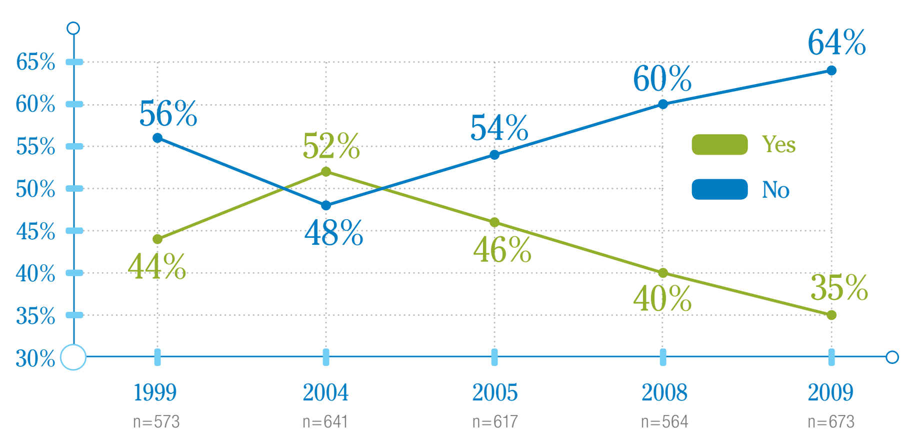
The 2009 results reveal that 31% of respondents have such programs, reduced from the peak of 43% reported in 2004 and 37% in 2008. This year, just under half (46%) indicate they don't have these programs, while almost one-quarter (23%) of respondents say they don't know.

Wellness programs are more popular in Atlantic Canada (37%), Ontario (34%), and British Columbia (33%), and less so in Quebec (28%), Alberta (24%), and Saskatchewan/Manitoba (24%).

Prevalence of health promotion programs increases with company size. Half (48%) of respondents in the largest companies (5,000 or more employees) say they have access to wellness programs, compared to just 14% of those in companies employing fewer than 50 workers. In general, the proportion who report having access to wellness programs increases with company size. One in five (22%) plan members in companies of between 50 to 249 employees report having wellness programs, while the number almost doubles (38%) for companies of between 250 and 999. Forty-seven per cent of respondents in organizations employing between 1,000 and 4,999 employees have programs. Of interest is that this linear relationship between size of company and availability of health promotion programs does not continue when actual participation is measured. As will be noted later on, the biggest companies, who tend to provide greater access, do not necessarily have the highest participant rates.

Union members are more likely to say they have wellness programs (38% versus 29% for non-union), as do those in the public sector (37% versus 28% for those in the private sector). Union members are also significantly more likely to regularly

PARTICIPATION IN WELLNESS PROGRAMS



participate than their non-union counterparts (41% versus 30%). Thirty-five per cent of plan members who say they are in excellent health also say they have access to these programs, versus 31% overall.

As in past years, companies that offer health promotion programs are significantly more likely to have their health benefit plans rated as excellent or very good (65% versus 54% overall), have very good benefits communication (80% versus 71% overall), and create better understanding of those plans (71% say they understand their plans extremely or very well versus 26% who say somewhat well, and just 4% of those who say not very or not at all well). It seems that employees believe that companies that provide high-quality health benefit plans also tend to invest in health promotion, provide good communication, and create better understanding.

Wellness programs also generate other positive returns in employee attitude. Employees who have programs are significantly more likely to be satisfied with their job (82% versus 77%), agree they think of their employer more positively because of their health benefit plan (75% versus 63% overall), feel an obligation to help control benefit costs (66% versus 57%), and agree their employer cares about their health (73% versus 59%).

Advisory Board member Farouk Ratansi, Director, Employee Benefits and Retirement Services, Central 1 Credit Union, Vancouver, British Columbia, believes that "Everyone seems to have a different view of what wellness means and what programs should deliver. If employers are uncertain, it's easy to understand why employees may become confused about their employer's expectations or doubt their commitment. To be effective, a wellness strategy has to be based on what employees need. Employers can start by looking at developing targeted, goal-oriented prevention strategies and fostering a culture that supports these objectives. Clarity and purpose matter."

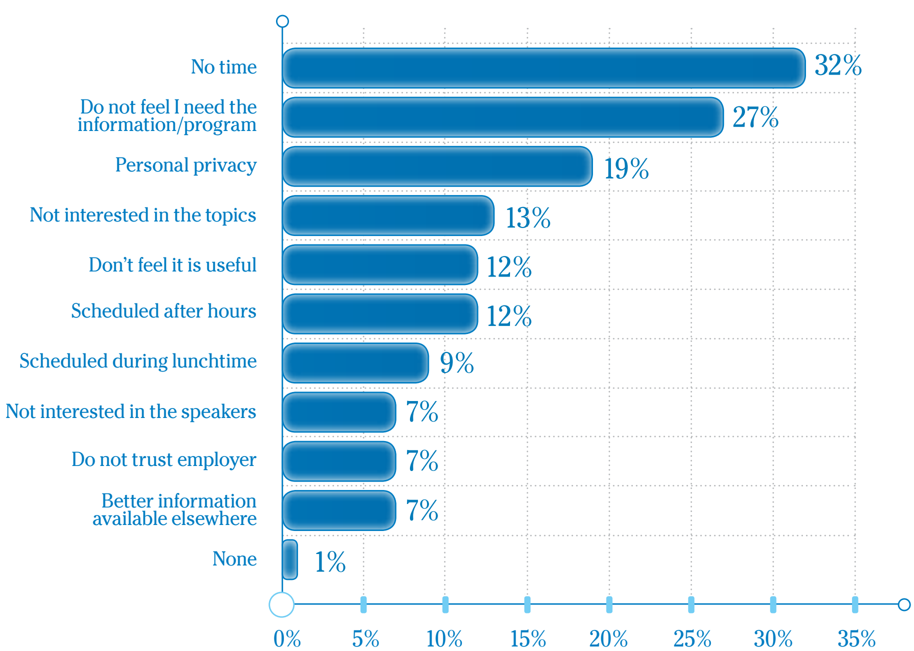
But, of course, offering these programs is just the beginning — employees must also participate in order to reap the benefits of better health. In response to a question about whether those who have access to wellness programs at work regularly participate, the response is discouraging. This year, 35% (versus 40% in 2008) say they use these programs, either definitely (11%), or "kind of" (24%). Program use is highest in British Columbia, with 50% participating. Programs are least popular in Alberta (21%) and Saskatchewan/Manitoba (22%).

Regular participants tend to be younger — generally aged 18–34 (46% versus 35% overall) — and with advanced education, with 48% of those who say they participate having graduate or post-graduate degrees. Looking more closely at the age bands, the cohort who reports the highest participation is males aged 18–34 (53%), but an above-average 38% of females in this age group also participate. Between ages 35 and 54, more women than men participate (35% versus 28% of men), and then things even out after age 55 with about three in 10 of both genders (men at 31% versus women at 29%) participating. These findings indicate that health promotion programs are very attractive for organizations with younger and better-educated workers.

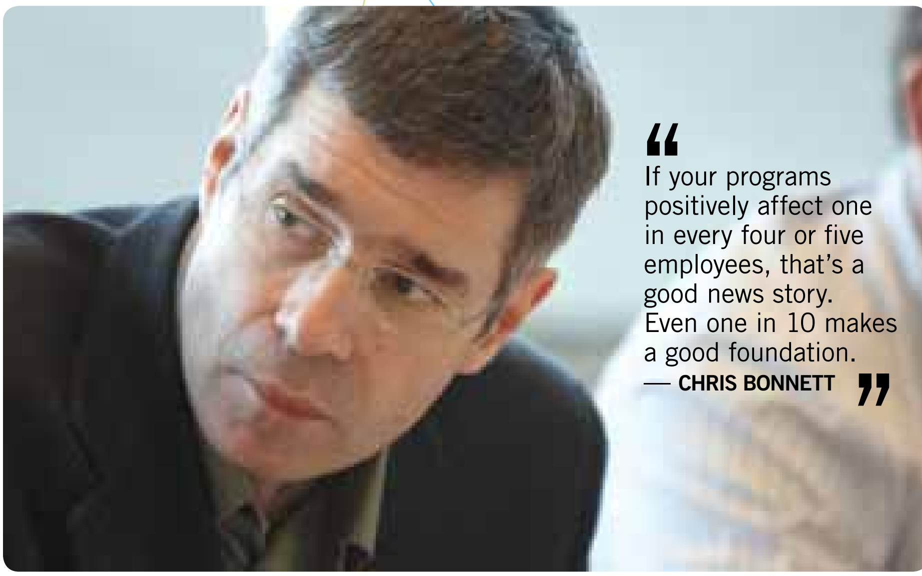
As was noted earlier, access to wellness programs increases with company size, however participation does not. Plan members in the largest organizations (5,000 or more employees: 33%) are no more likely to participate than those in the smallest companies (less than 50 employees: 33%) or respondents from companies with between 50 to 999 employees (50 to 249 employees: 33%; 250 to 999: 30%). Plan members in companies with between 1,000 and 4,999 employees (38%) are just slightly more likely to report participating in their wellness programs. In fact, the portion of employees who say they definitely participate (versus "kind of") is among the highest in the small organization group (15% versus 11% overall). Smaller organizations may be less likely to offer wellness programs, but when they do, committed participation tends to be better.

Are workplace health promotion programs only reaching those who are already healthy, or are they making people healthy? Forty-five per cent of respondents who say they are in excellent health participate in these programs versus 35% overall. Plan members who use the programs decline slightly amongst those in very good or good health (34% and 29%, respectively), but the numbers then climb for those in poor and very poor health (40%). Wellness programs may be most valued by plan members who wish to stay

BARRIERS TO PARTICIPATION IN EMPLOYER WELLNESS PROGRAMS



2009: (n= 673; moe ±3.8% 19/20)



in shape, but also for those who have had health issues and want to recover or at least hold their current level of health and functionality.

The reasons for not participating are no surprise — time is the dominant issue. In an open-ended question where more than one answer could be provided, almost one-third (32%) of respondents say they do not have time, 12% say they don't participate because programs are scheduled after [work] hours, and 9% say it is because wellness activities occur during lunchtime.

In addition, interest and perceived need are questioned. Over one-quarter (27%) of respondents say they don't feel they need the information or program, 13% say they are not interested in the topics or in the speakers (7%), and 12% say they feel the programs are not useful. Plan members who strongly agree their workplace stress has made them physically ill in the last year are more likely to use workplace health promotion programs (56% versus 35% overall, and 27% of those who strongly disagree).

Lack of time is most cited among employees aged 18–34 (39%), especially women (50% versus 29% for men aged 18–34, and 32% overall). Interest in the topics doesn't vary much by age, but interest in the speakers does — 16% of those aged 18–34 say this is an issue, versus 7% overall. So, even though *The sanofi-aventis Healthcare Survey* reports that the highest participation comes from this age group, this is also where the greatest resistance comes from in terms of time pressures, interest in speakers, and willingness to give up lunchtime (15%).

These findings also speak to the need to refresh and perhaps re-focus these programs. "Evaluate what people are using and ask if the money is being spent in the most appropriate way," says Chris Bonnett, H3 Consulting/businesshealth, Toronto, Ontario. "If your programs positively affect one in every four or five employees, that's a good news story. Even one in 10 makes a good foundation."

HEALTHCARE SERVICES FOR WHICH RESPONDENTS WOULD BE INTERESTED IN PURCHASING NEW OR ADDITIONAL COVERAGE, BY REGION

	Total	British Columbia	Alberta	Manitoba/ Saskatchewan	Ontario	Quebec	Atlantic Canada
Continued employee health benefit coverage into your retirement	62%	64%	57%	56%	58%	68%	69%
Critical illness insurance coverage, that is insurance that pays you a lump sum benefit to be used as you wish if you are diagnosed with a specific serious condition like cancer, heart attack, stroke, multiple sclerosis	46%	46%	42%	41%	43%	51%	57%
Dental coverage for high-cost procedures like bridges, crowns, or orthodontics	44%	45%	47%	32%	44%	48%	45%
Prescription drug coverage for expensive medications that are not included in your employee health benefit plan	41%	40%	32%	31%	38%	49%	48%
Long-term care in facilities like nursing homes	38%	43%	35%	24%	37%	41%	38%
Paramedical practitioners like physiotherapists, chiropractors, private nurses, optometrists, massage therapists, etc.	32%	34%	35%	26%	27%	37%	36%

Plan Members and Their Practices

Another answer might concern employers: almost one in five (19%) say they do not participate due to concern regarding personal privacy. Reinforcing that all health information — in policies, practices, and all relevant communication — will be kept private and confidential will help allay these fears.

Engaging Plan Members in Their Own Health

Only a minority of plan members are engaged in workplace health promotion programs, so it is important to know what employers could do to increase participation. About six in 10 plan members say they would be much or somewhat more likely to change their behaviour, exercise more frequently, or eat healthier foods if their employer subsidized an outside gym membership (62%), provided small incentives or gifts (61%), offered subsidized healthy food choices (56%), or if employers provided more flexible work hours (55%). Time at lunch or breaks for fitness activities (51%) and providing more health information and education programs (48%) all appealed to about half of those surveyed. Between approximately 30% to 40% of respondents (ranging from 27% for subsidized outside gym memberships to 41% regarding providing more health/wellness information/education programs) are essentially neutral about all these options, and approximately one in 20 say they would be less likely to change their behaviour if their employer provided these options.

Older employees (aged 55 and older) are significantly less likely than those aged 18–34 to be interested in many of these options (gym memberships 54% versus 67%, respectively; small financial incentives or gifts 51% versus 68%, respectively; healthier food choices 49% versus 61%, respectively; and time at lunch for fitness activities 45% versus 56%, respectively).

Given only moderate interest in workplace wellness programs, and the gap between good intentions and actual participation, employers need to be very strategic about what incentives are offered to help employees learn and practise healthier behaviours. A recent study of 500 American employers determined that incentives are widespread — used by up to 80% of those surveyed.[5]

Good Health

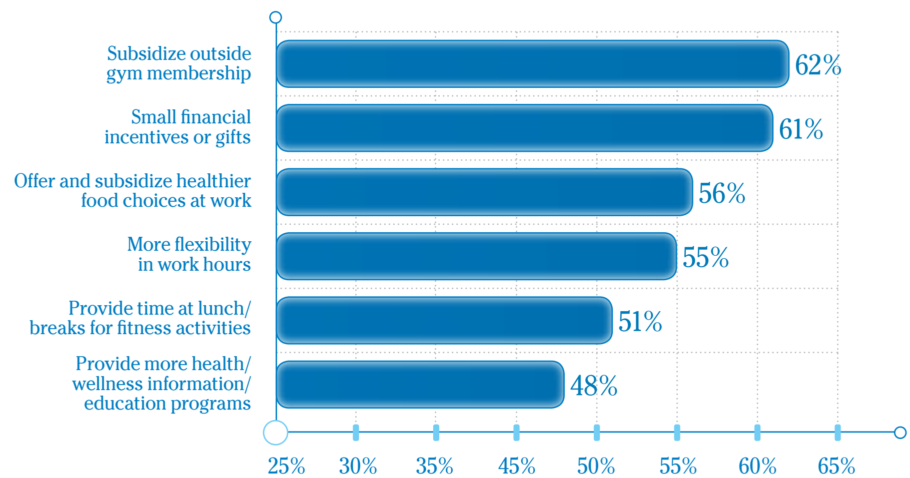
Almost half (47%) of respondents this year say they are in excellent (11%) or very good (36%) health. Ten per cent report their health as poor or very poor.

Plan members who are in excellent or very good health are more likely to describe healthcare system quality in the same way (43% versus 37% overall). The same story occurs for access — those in excellent or very good health are significantly more likely to describe access as excellent (39% versus 27% for those in poor or very poor health). So too are plan members who have personally or within their family had a serious illness or injury in the last two years are more likely to describe health system quality as excellent or very good (41% versus 37% overall), and health system access the same way (36% versus 31% overall).

The story is similar when health status and quality of the health benefit plan are assessed. Respondents in the best health rate benefit plan quality the highest (59% versus 54% overall). Health status and job satisfaction are also related; those in poor or very poor health are significantly more likely to strongly disagree they are satisfied with their job (15% versus 5% overall).

About one in four (27%) respondents or one of their family members has had a serious illness or injury in the last two years, such as cancer, heart disease, diabetes, or mental illness. Not surprisingly, this group is more likely to think of their employer more positively because of their health benefit plan (67% versus 61% for those who do not share this experience).

EMPLOYERS' INCENTIVES TO HEALTHIER BEHAVIOURS



2009: (n= 2090; moe ±2.1% 19/20)

Voluntary Coverage

The 2009 edition of *The sanofi-aventis Healthcare Survey* asked plan members if they would be willing to pay personally for new or additional insurance beyond their standard health benefit plan.

- 62% say they would pay to extend their health coverage into retirement;
- 46% say they would pay for critical illness coverage;
- 44% say they would pay for dental insurance for high-cost procedures like bridges, crowns, or orthodontics;
- 41% say they would pay for a top-up drug plan to cover expenses above those paid by their standard plan;

- 38% say they would pay for long-term care coverage; and
- 32% say they would pay for extra coverage for paramedical practitioners like physiotherapists, chiropractors, private nurses, and massage therapists.

Not surprisingly, the youngest group, aged 18–34, are significantly less likely to say they would pay extra for retiree health coverage (53% versus 62% overall, and 67% of those aged 55 and older). Plan members aged 55 and older are more willing to pay for extra insurance for prescription drugs (46% versus 41% overall) and for long-term care coverage (43% versus 38% overall). Interest in critical illness peaks in the mid-career years, respondents aged 35–54 (50% versus 41% for those aged 18–34, and 46% for those aged 55 and older). Overall, interest in paying for extra coverage is generally higher in Quebec and Atlantic Canada, and the lowest in Manitoba/Saskatchewan for all six categories.

Respondents who rate the quality of their health benefit plan as poor or very poor are less likely to say they would be willing to pay for extra prescription drug coverage (29% versus 41% overall). Plan members who strongly agree their employer really cares about their health are significantly more likely to say they would be willing to pay for extra prescription drug coverage (49% versus 41% overall), and a dental plan for major expenses (52% versus 44% overall). Those who strongly feel an obligation to control the cost of their health benefit plan are generally more likely than plan members overall to say they would be willing to pay extra for coverage into retirement (71% versus 62% overall), for critical illness protection (56% versus 46% overall), and for a better prescription drug plan (50% versus 41% overall).

Marilee Mark, Vice-President, Group Marketing with Manulife Financial in Waterloo, Ontario, believes the results reflect plan member concerns and priorities in this uncertain economy. "While plan members are generally more financially conservative, depending on their individual situation or stage of life, they have diverse priorities. Plan sponsors can respond by introducing more flexibility with optional benefits to allow members to select the coverage and price point that suit their current situation. Since more responsibility is shifting to plan members, it's even more important for insurers and benefit advisors to help employers educate employees to plan for their benefit needs before and following retirement."

These linkages suggest that employers who provide high-quality health plans, demonstrate care for their employees, and create a shared sense of responsibility for the financial viability of their health benefit plans are likely to be rewarded with plan members who will "do their part" and agree to pay personally for certain "extra" benefits.

Handling Stress

Modifying a question asked in both 2002 and 2008, the 2009 edition of *The sanofi-aventis Healthcare Survey* asked plan members if they had experienced workplace or personal stress that was so overwhelming that it had made them physically ill in the last year. Previous surveys had not specified a time limit. Even so, similar results were found. This year, 38% (versus 39% in 2008) of respondents agree they've experienced serious stress in the past twelve months at their workplace that made them physically ill, and 31% (versus 26% last year) agree stress in their home or personal life made them physically ill.

When asked who was responsible for stress, Jacques L'Espérance, of J. L'Espérance Actuariat Conseil Inc., Montreal, Quebec, said, "It's on everyone's mind. Obviously, high stress can be from personal sources, and from work. If it's only work, maybe you can safely download it to your family or friends, but if it's from both places, it's dangerous."

Women report significantly more high stress (scores 7–10 on a 0 to 10 scale) in the last year (54% versus 42% for men). Overall, plan members aged 35–44 are more likely to face high stress (59% versus 48% overall).

When asked about a number of different potential stressors, personal finances or meeting personal financial responsibilities is the top issue, with a total of 43% of respondents rating it high on the stress scale (7–10 on a 10-point scale). Despite such gloomy times, scores for all but one of the stressors that was also asked in 2000 were the same or lower than when that year's survey was undertaken.

Job insecurity is the biggest concern to respondents with the lowest incomes (27% for those with household incomes below $30,000 versus 21% overall). Personal finances are of greatest concern to those

with family incomes less than $60,000; they are most likely to report very high stress, meaning scores of 8–10 on a 10-point scale, 1 meaning does not cause any stress to 10 meaning causes a great deal of stress (27% versus 21% for those with family incomes of $100,000 or more, and 28% overall). Residents of Alberta (33%) and Ontario (32%) are more likely to report very high stress over their finances than those in other regions of the country. Ontarians are also feeling the highest level of job insecurity (20% versus 15% overall). To put this in context, Statistics Canada reported that Canada shed 129,000 jobs in January 2009, a bigger monthly drop than any downturn in the 1980s and 1990s. Further, 101,000 of those jobs were in manufacturing, and over half (71,000) were in Ontario.[7]

Looking at the causes of stress, younger employees, those aged 18–34, are more likely to have very high stress than others due to personal finances (37% versus 28% overall). Plan members in mid-career, aged 35–54, are significantly more likely to experience high stress from workload (26% versus 21% overall) and interaction with their direct manager (15% versus 12% for those younger or older). Plan members aged 55 and older are more likely to report low stress (scores 1–3 on a 10-point scale) than all other ages on almost all measures. Growing older appears to have its benefits, but the impact of the recession may change this trend for these benefit plan members.

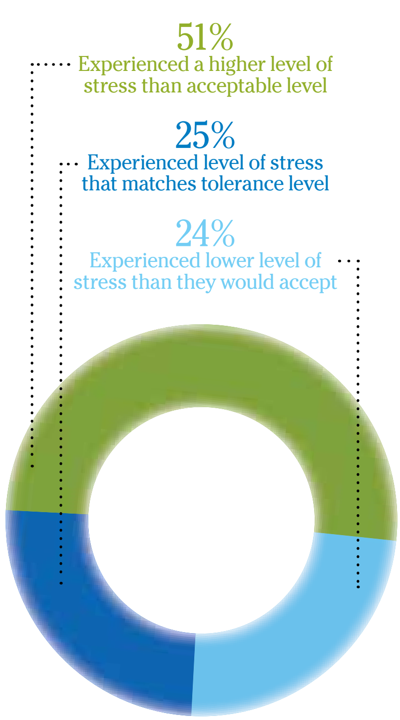
Most (77%) respondents say they can handle a moderate level of stress (50% say, "some," and 27% say, "little to no" stress). Almost half (48%) say they have experienced high stress in the last year, but only about one-quarter (24%) say this is acceptable. Half (51%) of respondents report they experienced a higher level of stress than they consider acceptable during the past year.

Presenteeism should be a concern for employers, with more than one in four (28%) respondents saying that they did not get much work done when experiencing stress. Nearly as many (26%) called in sick for a couple days when feeling stressed.

Chris Bonnett, President, H3 Consulting and Editor of businesshealth, Toronto, Ontario, wonders why more progress

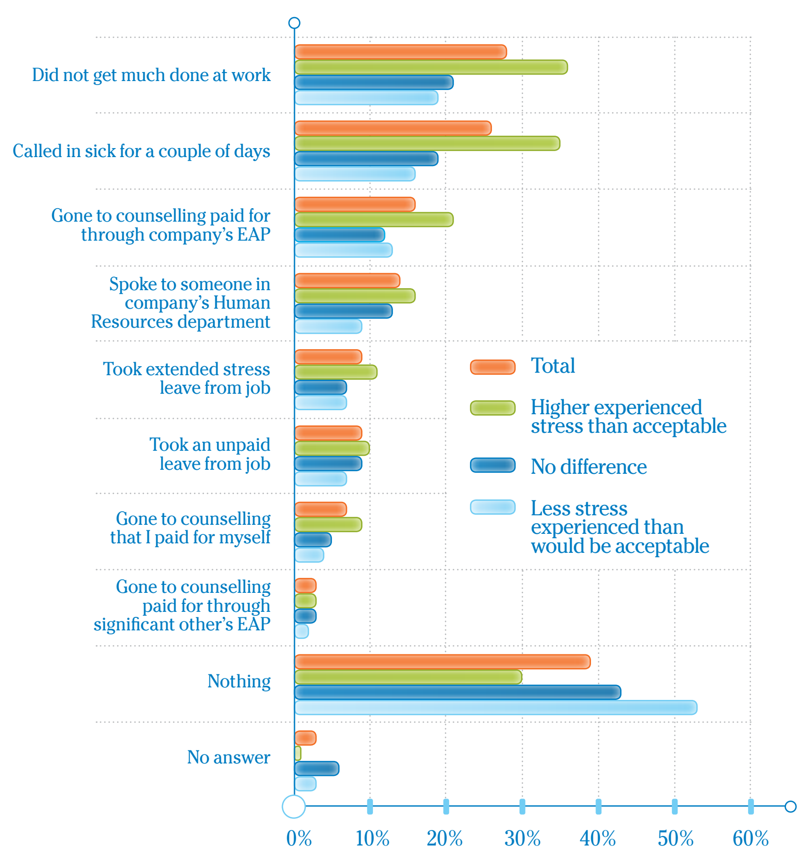
Statistics Canada recently reported that **28%** of working women and **20%** of working men say they have a high-strain job. **One-third** of women surveyed felt quite a bit, or extremely, stressed most days at work, compared with **29%** of men. These employees were almost twice as likely as people with low-strain jobs to report reduced work activities (odds ratio for men, 1.7; for women, 1.6).[6]

EXPERIENCED STRESS VERSUS ACCEPTABLE STRESS



2009: (n= 2090; moe ±2.1% 19/20)

ACTIONS OF PLAN MEMBERS TO DEAL WITH STRESS



2009: (n= 2090; moe ±2.1% 19/20)

hasn't been made against workplace stress. "In good economic times and bad, the Survey shows too many suffer, and employees, families, and employers all lose. Especially in today's economy, it will take more than an EAP or a time management course to set things right. The companies that get it right will be best positioned for success, and their employees won't forget."

Companies are losing 9% of their stressed plan members to unpaid leaves, and/or to extended stress leaves (9%). These figures are significantly higher among public sector plan members than those in the private sector — 31% of public sector respondents say they called in sick for a couple of days versus 25% of private sector, and 13% of public sector employees took an extended stress leave, almost twice the percentage of private sector plan members (7%). These are significant drains on productivity and not well measured by most employers.

Plan members who are strongly dissatisfied with their job are at least twice as likely to agree they are experiencing very high levels of stress from each of the 10 listed factors (workplace environment 57%; personal finances 51%; meeting personal financial responsibilities 46%; workload 42%; job insecurity 41%; interaction with direct manager 40%; work/life balance 25%; interaction with colleagues 21%; work commute 19%; and new workplace technology 10%).

"At work, employers can ensure demands are reasonable, that employees are well trained, and that they have enough control over the pace and type of work."
— **ANDREW CAMERON**

Employers can do their part. "It comes down to looking at what's causing the stress," says Andrew Cameron, Director, Global Benefits and Employee Wellness, Air Canada in Montreal, Quebec. "At work, employers can ensure demands are reasonable, that employees are well trained, and that they have enough control over the pace and type of work. They need enough authority to make decisions. If we can do these things, and provide meaningful and motivating rewards and recognition, then we've made a big difference."

Almost four in 10 (39%) of all respondents say they did nothing in response to periods of stress. Fortunately, it is those experiencing low levels of stress who are more likely to do nothing (54% versus 43% for those with some stress, and 29% for those in high-stress situations).

Action Steps

1. A recession that includes job losses, job-sharing, higher debt, and much uncertainty will most likely continue to increase stress levels for many employees. Given the impact on productivity and health, consider how your organization either creates or mitigates stress among its employees. Specifically and comprehensively address this issue. Assess workload, degree of control, effort, autonomy, and cross-training for those who remain.

2. Organizational leaders can help dispel uncertainty and reduce stress with more frequent, open and personal, one-on-one communication with employees. Lead by example. In the long term, trust and engagement are crucially important.

3. Since personal finances are the biggest source of stress, employers may arrange access to high quality financial and retirement planning through their insurers or benefit advisors.

4. Review and adjust EAPs to improve value. Educate and encourage company executives to promote these services to employees, especially to those facing more stress than they can handle.

5. Reduced access and lower participation means health management programs need to be evaluated for objectives, value for money, and relevancy to employees. Consider adding appropriate incentives for participation, progress towards personal health goals, and outcomes.

6. A proportion of plan members are interested in buying new or extended health insurance, especially coverage in retirement and for critical illness. Offering this will create minimal administrative cost for employers, but will be immediately appreciated by many employees and provide more affordable protection from important risks.

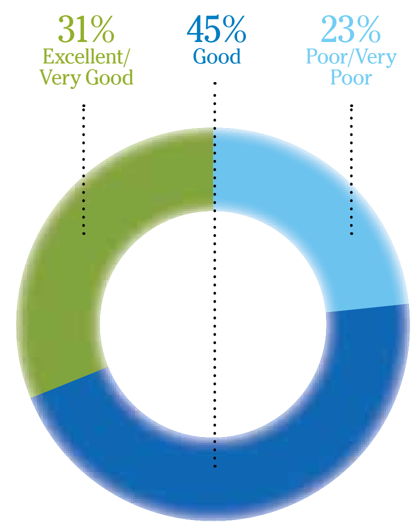
5. Integrated Benefits Institute, 2008. Employer Incentives for Workforce Health and Productivity: Actions for American Business Today. Available at: www.ibiweb.org.
6. Statistics Canada, 2007. Work stress and job performance, Perspectives on Labour and Income, 8(12), December.
7. Statistics Canada, 2009. The Daily, February 6: Latest release from the Labour Force Survey. Available at: www.statcan.gc.ca.

Governments and the Healthcare System

Summary

While Canadians take great pride in their publicly funded health system, there has been mounting concern that access has been reduced as governments strain to rein in costs that are rising at a rate much higher than that of the consumer price index. The Wait Times Strategy has allowed important gains in many provinces, but it is narrow in scope and there are many other ways in which waiting can occur and frustrate access to necessary health services. The 2009 edition of *The sanofi-aventis Healthcare Survey* examined access in different areas, notably primary care, diagnostics, and prescription medicines. As in past years, health system quality was also surveyed by benefit plan members, with some good news.

ACCESS TO HEALTHCARE



2009: (n= 2090; moe ±2.1% 19/20)

Access to the Public System

Respondents were asked to rate their overall access to healthcare services. Most (45%) described it as good, with more saying very good (24%) than poor (17%). Just 7% described access as excellent, and 6% as very poor.

Younger males (aged 18–34), who it is assumed tend to use the system relatively rarely, are significantly more likely to rate access as excellent or very good (43%). Further, the problems in access do not appear to be with seniors, who it is generally believed tend to use the system more frequently than others (just 16% of those aged 65 and older say access is poor or very poor), but with respondents in the prime child-raising years of 35–54 (27%) and among women aged 35–54 (31% who say access is poor or very poor).

Most healthcare services are provincially organized and funded. Access is rated most highly (excellent or very good) in Atlantic Canada (43%) and British Columbia (40%). It is rated lowest in Quebec, at just 18%, with 35% in that province rating access as poor or very poor.

According to Advisory Board member Alain Sanche, Account Executive for Sun Life in Montreal, “In Quebec, wait times

Prescription Medication Access

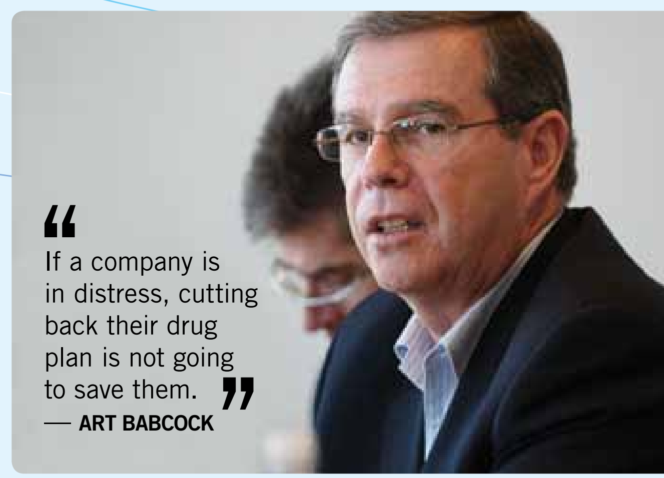
PLAN MEMBERS WERE ASKED ABOUT A SERIES OF ACCESS SITUATIONS RELATED TO DRUG PLANS. A MAJORITY (57%) OF RESPONDENTS INDICATE THEY HAVE EXPERIENCED AT LEAST ONE OF THESE CIRCUMSTANCES IN THE PAST TWO YEARS.

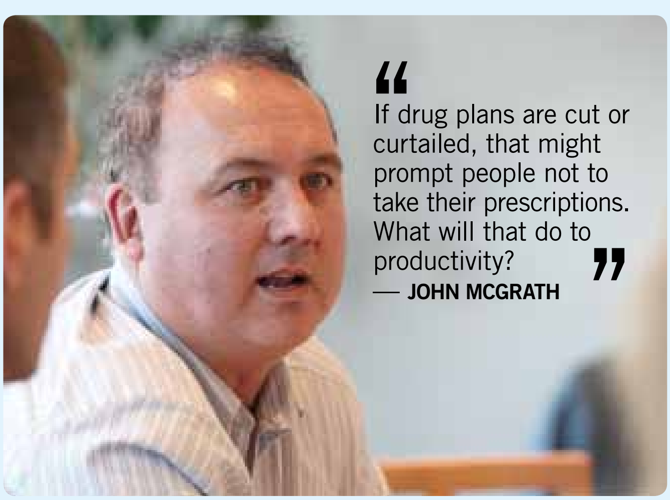
Almost four in 10 (38%) respondents say in some instances a pharmacist substituted a generic drug for the brand-name product ordered by their physician. Respondents in Manitoba and Saskatchewan reported significantly less generic substitution (25%) than those in other sections of the country.

Almost three in 10 (28%) report their doctors asked them if they had a private drug plan before writing a prescription. There are many potential reasons for why physicians might ask about the existence of private drug plans: generally because private plans effectively have better coverage than provincial plans, the affordability of the preferred drug, or it may mean the physician wants to recommend a drug not covered by the provincial drug plan.

Almost one in six (17%) report their physician had to fill out paperwork in order to receive coverage for a prescription. This practice was significantly less common in Quebec (10%) than anywhere else in Canada.

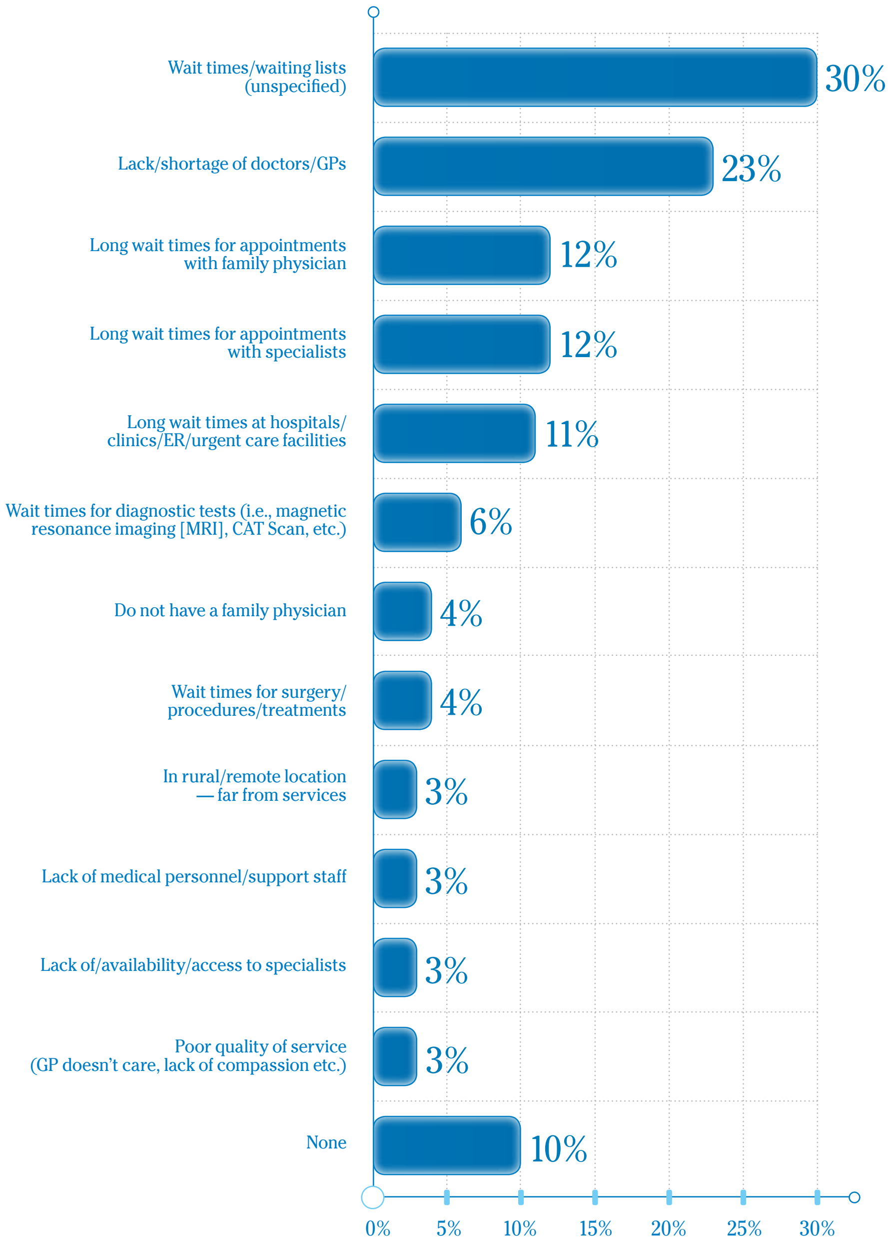
Fewer than one in 10 (9%) respondents report the drug originally prescribed was ineligible under their plan. This was significantly more common in union and public sector plans (12% each) than non-union (8%) or private sector plans (7%). One in 12 (8%) said they did not buy the drug prescribed because it was not covered under their health benefit plan. John McGrath, Principal, Mercer, Vancouver, British Columbia, is concerned. "Many employers are now dealing with layoffs, but I suspect the next cost centre to be targeted will be benefits. If drug plans are cut or curtailed, that might prompt people not to take their prescriptions. What will that do to productivity?" Art Babcock, Vice-President, Aon Consulting, Edmonton, Alberta, agrees, "If a company is in distress, cutting back their drug plan is not going to save them."





Respondents with household incomes below $30,000 report higher rates of experiencing all the drug-related situations discussed. For example, having a physician fill out paperwork to receive coverage for a prescription is reported by 26% of those with the lowest level of family income versus 17% overall, and taking a drug other than the one first prescribed because the first one is not covered is reported by 22% of low household income respondents versus 9% overall. Eighteen per cent of those with family incomes under $30,000 say they did not buy the prescribed drug because it wasn't covered versus 8% overall. More equitable approaches to drug coverage are needed to ensure low income does not keep people from necessary treatments.

BARRIERS TO PUBLIC HEALTHCARE SERVICES



2009: (n= 1435; moe ±2.6% 19/20)

and difficulties accessing healthcare are very common topics of discussion politically and in the media, so most people are sensitive and aware of the situation. With this shortage of family doctors, people tend to use the emergency room as a first point of access and this of course contributes to creating even longer wait times at the hospital."

Respondents who believe the quality of the healthcare system is excellent or very good are more likely to also rate access highly, at 84% and 62%, respectively, versus the 31% overall who rate access excellent or very good. Clearly access and quality are closely associated.

However, access and general health status are negatively correlated. Those who say they are in poor or very poor health are more likely to find access lacking (31% say it is poor or very poor versus 23% overall), relative to those in good health (27%), very good health (19%), or excellent health (16%). However, respondents who have personally suffered a serious illness or accident in the last two years rate access highly (39% say excellent or very good versus 31% overall). It may be concluded that while access needs to be improved generally, those in greatest need are likely to be well attended.

The sanofi-aventis Healthcare Survey allowed respondents who describe their healthcare access as good, poor, or very poor, to identify the barriers they personally face in accessing health services. Multiple factors could be named. Wait times were the dominant theme, either generally (ranked first at 30%), or with respect to waiting for family or specialist physicians (each named by 12% of respondents), or at hospitals, clinics, or other healthcare facilities (11%). Waiting for diagnostic tests (6%) and surgery (4%) was also an issue for a smaller number of plan members. The only other major issue reported was a shortage of physicians,

According to data from Statistics Canada's 2007 Canadian Community Health Survey, **15%** of Canadians aged 12 and older do not have a regular physician, either because they can't find one or because they have not looked. Fortunately, almost **80%** of those people have another option, mostly a walk-in clinic, a hospital emergency department, or community health centre, depending on province and location. For rural Canadians, the alternative is generally the local emergency department.[8]

ranked second overall by 23%. Only 10% could not name a barrier.

In Quebec, it appears that wait times in general (39% versus 30% overall) and waiting for family physician appointments (20% versus 12% nationally) were worse.

Access to Healthcare Providers

Having a family physician is an important factor in accessing health services. While many health problems can be resolved by a family doctor, he or she is also the gatekeeper for many pharmaceuticals, referrals to specialist physicians and other health practitioners, as well as diagnostic tests. Fourteen per cent indicate they do not currently have a family doctor.

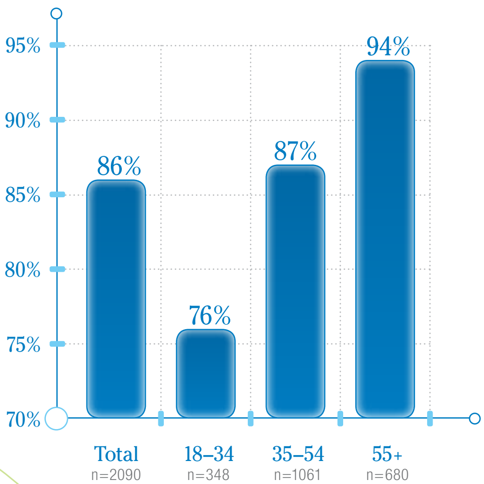
With new physicians taking 10 years or more to train, shortages are not going to be solved quickly. That's why a number of provinces have implemented changes in the scope of practice of other professionals, such as nurses and pharmacists. Dr. Steven Semelman, President, Gemini Pharma Consultants Ltd., Oakville, Ontario, notes that an expanded role for pharmacists is being considered for Ontario, following recent changes made to allow selective prescribing first in Alberta, and then in British Columbia, Manitoba, and New Brunswick in the last two years. "These changes reflect the times, the advanced skills of qualified pharmacists, and the needs of patients for better access. It will also free up physicians to focus on more complex care and move routine drug issues out of rural emergency rooms."

"These changes reflect the times, the advanced skills of qualified pharmacists, and the needs of patients for better access."
— STEVEN SEMELMAN

The 2009 edition of *The sanofi-aventis Healthcare Survey* indicates that those aged 18–34 are significantly more likely to report not having a family doctor, at 24% versus 14% overall. Overall, there is not much variation by region, although respondents in Quebec (24%) and Manitoba/Saskatchewan (17%) are above the national percentage. Ninety-two per cent of Atlantic Canadians report having a family doctor.

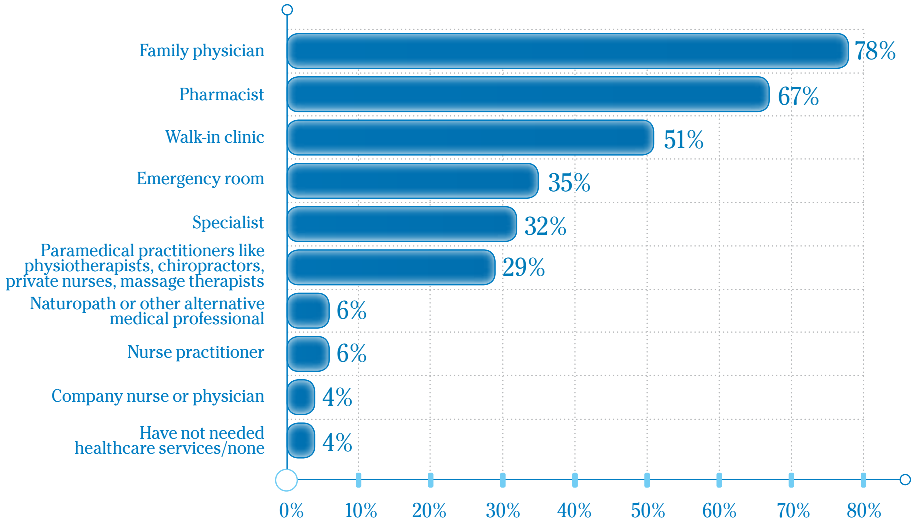
The sanofi-aventis Healthcare Survey asked plan members which of a series of health services they had accessed over the last year. The most common were family physicians (78%), pharmacists (67%), walk-in clinics (51%), emergency rooms (35%), specialist physicians (32%), and

HAVE A FAMILY PHYSICIAN



2009: (moe ±2.1% 19/20)

ACCESSED HEALTHCARE SERVICES IN LAST YEAR



Responses less than 3% not shown; 2009: (n= 2090; moe ±2.1% 19/20)

Sources of Health Information

We have many potential sources of health information, some better than others. A slight majority (53%) report they very or somewhat frequently (scores of 5–7 on a 7-point scale) get health information from their physician, 37% name their pharmacist, 32% say the Internet, and just 7% identify their employer as a frequent source. These figures are somewhat at odds with the type of healthcare services accessed in the last year. For example, though 78% report visiting their family physician in the last year, far fewer (53%) indicate they frequently receive health information from their doctor. Two-thirds (67%) report visiting a pharmacist, but only 37% say they frequently get health information from this source. Art Babcock, Aon Consulting, noted, “There's a disconnect between how many access the pharmacist relative to the number getting information from them. In Alberta, we're talking about the value of professional fees, and this speaks against it.” Deb Mayberry, Business Partner, Human Resources, City of Calgary, suggested, “With pharmacists getting more power to prescribe in some provinces, it's one to watch.”

Age has an important link to source. Younger plan members, those aged 18–34, are the most likely to get health information from the Internet (38%), a nurse or nurse practitioner (19%), a government toll-free health line (15%), and from their employer (11%). Older employees, those aged 55 and older, are most likely to look to their physician for information (57%).

Employees who describe their health benefit plans as excellent are somewhat more likely to report frequently receiving health information from their employers (11% versus 7% overall). This is also true for employers who are rated as very good in communicating their benefits (15%), and employers who offer wellness programs (12%).

paramedical practitioners such as physiotherapists, chiropractors, or massage therapists (29%).

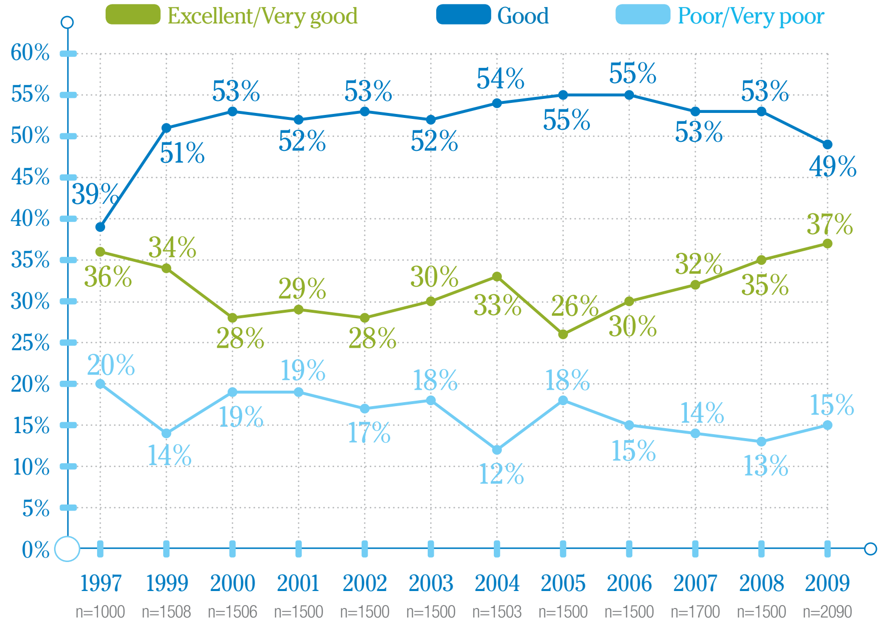
More respondents aged 18–34 visited a walk-in clinic (72%) than a family doctor (62%), the only age cohort where this is the case. This proportion visiting walk-in clinics is also significantly higher than for any other age band (those aged 35–54 at 49%, those aged 55 and older at 35%), as well as higher than for all plan members (51%). Younger plan members are also more likely than other age cohorts to visit a hospital emergency department (40% versus 35% overall). This behaviour has implications for employers, since an appointment made with a family physician in advance is likely to result in far less time away from work, particularly for those who resort to using emergency departments.

Respondents with family incomes below \$30,000 are also less likely to have seen a physician in the last year (69% versus 78% overall), a pharmacist (55% versus 67% overall), and are more likely to have visited an emergency department (43% versus 35% overall). Income appears to be an important access issue, even in Canada with publicly financed hospital and physician services, and among those employed and who have drug benefit plans.

Respondents were asked about their personal experience with four access situations in the last two years: trouble getting an appointment with a family physician, with a specialist, for a diagnostic test, or taking time off work to travel out of town to receive healthcare services. Half (51%) say they have experienced at least one of

Based on 2005 and 2007 Statistics Canada data published by the Ontario Hospital Association, **85.3%** of Canadians rated health services received as excellent or good, very similar to the **86%** who ranked the health system excellent, very good, or good in the 2009 edition of *The sanofi-aventis Healthcare Survey.*[9]

OVERALL QUALITY OF HEALTH SYSTEM IN CANADA



the four. Almost three in 10 say they had trouble getting a doctor's appointment, either with a family physician (29%) or a specialist (27%). Fifteen per cent had trouble getting a diagnostic test, and about one in eight (12%) had to travel out of town to receive healthcare services.

Health System Quality

One question that has been asked every year since the Survey was first published in 1998 concerns the overall quality of Canada's healthcare system. Over the twelve years, those ratings have risen and fallen. This year, 37% rank the system excellent or very good, slightly above where it was in the first year. Almost half (49%) rate system quality as good.

Fifteen per cent of respondents say the healthcare system is poor or very poor, just slightly below its 12-year average. This percentage has remained essentially unchanged despite massive funding increases. Between 1997 and 2008, Canada's spending on health services increased 118% from almost $79 billion to $172 billion.

Rating the quality of the healthcare system and access to it are highly correlated. Plan members who say access is excellent are much more likely to rate quality as excellent or very good (90% versus just 8% for those who rate quality as poor or very poor, and 37% overall).

Regionally, plan members in Alberta (31%) and Quebec (29%) are the least likely to rate the healthcare system excellent or very good. Compare this to members in Manitoba/Saskatchewan where just under half (46%) rate the system this highly.

Younger plan members, aged 18–34, and older members, aged 55 and older (41% and 38%, respectively) are more likely than those in between (aged 35–54: 31%) to rate the public healthcare system as excellent or very good. Similar to the numbers regarding access, it is young men aged 18–34 who are most likely to rate quality most positively (46% say excellent or very good). Advisory Board member Theresa Rose, Director, Group Product Management, Medavie Blue Cross in Moncton, New Brunswick, sums up the public healthcare findings. "Perception is reality. And for the users of Canada's healthcare system, their experience is the reality they've lived. Government has made significant investments in healthcare services, primarily for users. But when you look at the lower ratings for respondents aged 35–54, perhaps more needs to be done in the area of prevention and disease screening."

Action Steps

1. To fill access gaps and sustain private funding, governments need to engage employers and the private payer community in funding and policy decisions. Many business advocacy organizations regularly make health-related policy recommendations; get involved to help make that voice more powerful.

2. Barriers to timely, high-quality health services exist, and these reduce the capacity of employees to work. Particularly now, productivity matters. Employers may be able to work with insurers, Workers' Compensation Board organizations, or local business or healthcare organizations to find healthcare for those in greatest need.

3. Like Workers' Compensation Boards, employers need a policy to help them know when to assist their employees in getting faster access to diagnostics and health services, to ensure faster and safe return to work or full productivity.

8. See: http://www.statcan.gc.ca/daily-quotidien/080618/dq080618a-eng.htm
9. Source: Health System Facts and Figures, provided by the Ontario Hospital Association based on Statistics Canada data from 2005 and 2007. "Health services" includes hospitals, physician care, community care and telephone-based health services. Available at: www.healthsystemfacts.com.

The sanofi-aventis Healthcare Survey Respondents

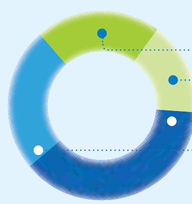
Between December 2nd and 22nd, 2008, Ipsos-Reid fielded the survey on behalf of Rogers Business and Professional Publishing using a mixed methodology of online (Internet) and telephone surveys. Identical questionnaires were used for both online and telephone data collection.

In total, a national sample of 2,090 primary holders of group health benefit plans completed the study. At the time of each interview, these adults were the primary holders of employee plans with a health benefits portion. The 2,036 online completes were conducted using a random sample drawn from the 240,000+ members of the Ipsos-Reid Canadian i-Say Panel. The 54 telephone interviews were completed with primary holders of group health benefit plans who do not have Internet access either at home or work and were recruited via Ipsos-Reid's national telephone omnibus.

We can say with a 95% certainty that the total results are within +/- 2.1% of what they would have been had the entire population of Canadian plan members been polled. It is important to note, though, that the margin of error is larger among sub-sample respondent groups. The data has been statistically weighted to ensure that the age, gender, and regional composition of the sample reflect those of the adult population according to the 2006 Census data. The figures on the right provide a demographic breakdown of this year's respondents. Additionally, some response categories in this report do not add up to 100%. This is due either to the rounding of numbers or questions that allowed plan members to provide multiple responses.

10% are with organizations employing fewer than 50
10% are with organizations employing 50 to fewer than 250
9% are with organizations employing between 250 and fewer than 1,000
11% are with organizations employing between 1,000 and fewer than 5,000
18% are with organizations employing 5,000 or more
43% did not know the size of their organization

16% hold administrative/clerical/secretarial positions
16% hold technical/trade positions
16% hold managerial/supervisory/executive positions
15% hold professional positions
13% hold sales/service positions
12% are retired/not currently working
4% hold teaching/academic positions
2% are self-employed

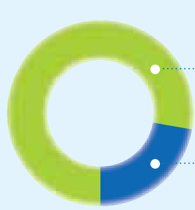


21% have a university degree or post-graduate degree
16% have some university
37% have a college education (some college or diploma)
24% have a high school education or less

5% have household incomes of less than $30,000
28% have household incomes of between $30,000 and $59,999
35% have household incomes of between $60,000 and $99,999
22% have household incomes of at least $100,000

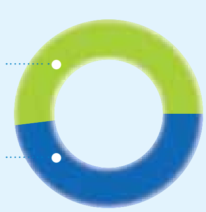
13% live in British Columbia
10% live in Alberta
7% live in Saskatchewan/Manitoba
38% live in Ontario
24% live in Quebec
7% live in Atlantic Canada

28% are aged 18 to 34
18% are aged 35 to 44
22% are aged 45 to 54
23% are aged 55 to 64
9% are aged 65 and older



78% of the surveys were conducted in English
22% of the surveys were conducted in French

52% are female
48% are male



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