THE CANADIAN COUNCIL ON INTEGRATED HEALTHCARE

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PRESENTS:

A DISCUSSION PAPER ON WORKPLACE HEALTH

Working Group Members:

Sharon Blaney
Chris Bonnett
Suzanne Caron
Shelley Kee
Anthony May
Jim Norton
John Yardley

With the writing assistance of:
Lisa Walters

And project support guidance from:
John Elliott

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EXECUTIVE SUMMARY

The Canadian Council on Integrated Healthcare (CCIH) is a national, multi-stakeholder health education group with a mission to help Canadians understand emerging healthcare changes. This paper on workplace health arose from several fundamental questions: Given the presence and impact of the workplace in most Canadians' lives, where does workplace health fit into the wider Canadian healthcare landscape? Should workplace health become more or less of a priority for Canada, and why?

In its consideration of these questions, the CCIH reviewed academic research on the topic of workplace health. This revealed that modern, and broader, definitions of health (that include psychosocial well-being along with physical health) have implications for notions such as health and safety in the workplace. Research points to the critical role played by government in enabling and encouraging healthy workplaces; it also suggests that, at the employer level, organizational "culture" can be a strong contributor or detractor to workplace health. Finally, research indicates that workplace stress is a growing problem for many Canadians. What research does not yet demonstrate (in large part due to the nature of the workplace itself as a test site) is that workplace health initiatives lead to positive performance or productivity-related work outcomes.

The CCIH next reviewed the statistics around employee illness and injury. This showed that the cost of ill health for employers is staggering: for example, the cost of employee absence alone is estimated to be $8.6 billion annually for Canadian employers. Furthermore, the numbers show that work-related mental and nervous disorders are rapidly becoming a major health concern, with serious cost implications.

Finally, the CCIH reviewed the current landscape, to determine who is doing what in terms of workplace health. This revealed that benefit plan sponsors and their members are responsible for a very significant portion of Canada's total direct expenditures on healthcare, and there is relatively little government leadership or assistance offered in relation to the promotion of health in the workplace. The CCIH also considered the major components of a healthy workplace.

The CCIH reached the following conclusion:

> **While public policy, employers, and unions have demonstrated varying degrees of commitment to the concept of workplace health in the past, all Canadians would benefit from the creation of a new and different environment – one that recognizes the need to develop a collaborative strategy for health in the workplace as a national priority.**

In particular, this paper puts forward the argument that there is a very real value proposition for employers who adopt a more proactive approach to workplace health: Given the costs of ill health, and pressing issues such as the serious challenge of an ageing workforce, there is a 'bottom line' incentive for employers to focus on a healthier workplace.

How can a new environment be created for workplace health? It is the contention of the CCIH that Canada must undertake this at two levels. First, strategic-level shifts in attitude must take place. Second, this attitude must be reflected in tactical (or program) level initiatives. Furthermore, such change requires an integrated approach involving both employers and public policy makers as well as other key players (such as employees, healthcare professionals, business leaders, unions, researchers, data custodians, to name a few).

At the strategic level, government needs to ensure that healthy workplace policy is set by senior bureaucrats and politicians so that it is a more permanent fixture on the Canadian economic landscape – and this paper presents actionable recommendations to achieve this. For their part, employers need to make important organizational ("cultural") changes that reflect a new attitude toward workplace health – again, this paper presents suggestions on how this can be achieved.

In terms of tactical changes, the CCIH recommends that the Canadian tax system be altered to incent employers towards workplace health, and also recommends what 'first steps' employers could take towards the goal of a healthier workplace. Recommendations (both strategic and tactical) for other key players are also presented.

Creating a new 'mindset' in Canada towards workplace health, and then taking the necessary practical steps to support and reflect that new outlook, are, in the view of the CCIH, essential to the overall health of our country. The goal of this paper is to spark discussion that will, ultimately, lead to change.

INTRODUCTION

Canada's overall healthcare system is under intense scrutiny. To date, however, relatively little attention has been paid to the potential contribution of workplace health to the larger Canadian healthcare landscape. This paper arises from the observation that while there are waves of interest, the concept of workplace health is not entrenched as a 'given' within the workplace or within Canadian public policy. And yet many of the pressing healthcare challenges that confront Canada have workplace connections – for example, the demographic reality is that Canada has a rapidly ageing workforce whose ongoing good health needs to become a priority[1]; and mental health or stress-related problems (which often have work-based origins[2]) are steadily on the rise.[3]

This paper takes the point of view that Canada needs to foster a positive environment -- to develop a new 'mindset'-- that encourages and promotes healthy workplaces. The first part of the paper makes the case for this particular point of view by:

- **reviewing the research** in the area of workplace health;
- **crunching the numbers** – presenting the arguments that suggest workplace health should matter to employers; and
- **assessing the current environment** of workplace health and determining 'who is doing what' – in particular, reviewing the public policy environment and its relationship to employers; and examining what makes or breaks a healthy workplace.

What will become clear from this initial section is that any changes in Canada's approach to workplace health must involve two major players – public policy makers and employers – as well as involvement and commitment from other key players such as private health plan sponsors (employers and unions), plan members, plan providers, healthcare providers, researchers, labour organizations, and non-governmental organizations (NGOs) such as the Canadian Centre for Occupational Health and Safety, the Association of Workers' Compensation Boards of Canada, the Canadian Institute for Health Information, the Canadian Life and Health Insurance Association, the Diabetes Association of Canada, and others.

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1 Presentation to the CCIH by David Baxter, Executive Director, Urban Futures Institute, Vancouver, in April 2002. See www.urbanfutures.com for more detail.

2 "The fastest growing health problem, indicative of increased pressures from workplace changes, is in the area of work stress and mental health": Chu, C. & Dwyer, S. (2002). *Employer role in integrative workplace health management: A new model in progress.* Disability Management and Health Outcomes, 10, 175-186.

3 The contributing role that work plays in creating stress-based illness is a thread that runs through this paper.

The second part of the paper moves toward action by presenting **recommendations** for how a new and more positive environment – one that fosters and encourages workplace health – can be created in Canada. This section will focus on:

- **broader, strategic changes** that need to take place both at the legislative/policy level (where leadership by the federal government, in particular, is required[4]), and at the corporate level (where changes in corporate culture and values are pivotal) so that thought processes around workplace health are altered; and
- **tactical, program-level changes** that support and reflect a new environment for workplace health. Specific opportunities for innovation, as well as specific challenges, will form part of this discussion.

What will emerge from both sets of recommendations is an actionable model for change.

As its name denotes, the Canadian Council on Integrated Healthcare (CCIH) is committed to the concept of integration within the healthcare system. This paper will show that an integrated approach – in particular, a partnership between governments and employers (and engaging other key players) – is essential if a truly proactive environment for workplace health is to be created. . . one that meets plan sponsor, plan member, and social policy goals as well.

The Council is also committed to fostering discussion among Canadians on topics of national importance within the healthcare field. The CCIH regards workplace health as such an issue. This paper is designed as an interpretive, solution-oriented, evidence-based, and constructively controversial document that will generate debate and deliberation among its readers.[5]

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[4] This focus on leadership correlates with one of the major focus areas of the CCIH submission made to the Commission on the Future of Health Care in Canada (headed by Roy Romanow) in November 2001. The CCIH was selected to present its paper to the Commission, and participated in a Roundtable Discussion in April 2002.

[5] In addition to its submission to the Romanow Commission, which similarly strives to prompt discussion through its series of recommendations, the Council has also produced another discussion paper titled "The Impact of Genomics on the Canadian Healthcare System" (September 2001). Both documents are available on the CCIH website at www.ccih.ca.

PART ONE

MAKING THE CASE: WHY SHOULD WORKPLACE HEALTH BECOME A CANADIAN PRIORITY?

A: The Research – Academic Studies on Workplace Health

What does current research have to say about workplace health? This is a complex question, mainly because the workplace itself is characterized by a set of complex processes, and therefore a myriad of potential factors can affect worker health, worker performance, and research findings. What is clear: a set of workplace health programs is likely to have only limited impact unless the organization has supportive policies, an enabling culture, and the initiatives are nurtured by organizational leaders as part of their strategic plan.

After providing a brief explanation of terms, this section of the paper will undertake a very broad overview of academic research on workplace health. In keeping with the overall emphasis of the paper, this section is not intended as an exhaustive summary, but rather an effort to identify some of the key issues and trends that emerge from an academic consideration of workplace health. Ultimately, this section will identify how certain aspects of academic research lend support to the argument that workplace health is worthy of more attention, exploration, and certainly more research. Key issues and trends will also lead directly to specific recommendations later in this paper.

Explanation of terms

Health: A complete state of physical, mental and social well-being, and not merely the absence of disease. (World Health Organization, 1948)[6]

Health Promotion: The science and art of helping people change their lifestyle to move toward a. . . balance of physical, emotional, social, spiritual and intellectual health.[7]

Both these definitions have at their core the notion that health is a positive concept that includes social and personal strength as well as physical capabilities; in other words, health is a "resource" to meet the needs of daily life, and not the objective of living.

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[6] Shah, C.P. (1998). Public Health and Preventative Medicine in Canada: 1.
[7] Cited in: O'Donnell, M. P. and Harris, J. S. (1994). Health Promotion in the Workplace: xi.

What is the significance of these expansive definitions of health to the workplace? Since daily life includes "work", paid and unpaid, health is an important component of meeting the demands of work. Hence it is meaningful to ask the kinds of questions that have prompted this paper, such as:

- "What is a 'healthy' workplace?";
- "What contributions can health make to helping meet the demands of our work life?";
- "How does work affect health?";
- "What should corporations, trade unions, and governments do to encourage 'health at work'?"

For the purpose of this paper, workplace health means strategies, policies, programs, and practices found in the workplace (some of which may be non-occupational in nature) that provide benefits that improve the total health of the individual – mental, physical, and psychosocial.

The bottom line is that once health is understood to be a multi-faceted state, initiatives to improve health in the workplace can no longer be based solely on health promotion programs. In terms of research, this new demand for a more comprehensive approach leads to commensurately greater (and more expensive) questions in terms of what works and under what circumstances, how might measurement occur, evaluations be performed, and outcomes improved.

The 'big questions': Academics reflect on strategic issues related to workplace health

There is much workplace-based research on the topic of health in the workplace, some of which will be discussed below. But the wider definition of health above has also been reflected in more broad-based or 'big picture' thinking about the future of the workplace and the workforce in Canada.

Some academics are focused on questions about the nature of work and how it can best be designed and managed to create "healthy work conditions." Lowe, for example, presents an expanded notion of work when he considers the future of work. [8] He states that the critical issue is not the end of work, or the end of traditional full-time jobs: "Rather, it is the kind of work we value and therefore want to create as a society" (p. 5). He then goes on to describe in great detail what types of jobs might be created in Canada, embracing the term "quality" to explain what a "good job" might look like. It is not mere coincidence that "good jobs" equate to "healthy jobs", since high quality jobs include consideration of physical, social, and psychological dimensions, i.e., they are consistent with the elements of a modern definition of health.

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[8] Lowe, G. (2000). The Quality of Work: A People Centred Agenda.

Another topic that interests many academics is the notion of "work-life" balance. While futurists, in the past, have speculated on the emergence of an easier, more leisurely, more balanced life in the New Millennium, there is ample evidence to indicate that the balancing of work and non-work life is no easier today, and in fact is worse than it has been previously. The most compelling Canadian study on this topic is by Duxbury and Higgins, where they relate the changes (or lack thereof) from their Canada-wide survey on the topic of work-life balance in 1991 versus 2001.[9] Duxbury and Higgins' report lends support to the argument that the workplace must be more responsive to the work-life balance needs of employees, and accommodative work practices should be part of a healthy and supportive work environment.[10]

It is important to note that the expanded definitions of work and health go well beyond the traditional domain of occupational health and safety, which is still clearly focused on hygiene, safety, and physical health and hazards. However, it is also important to note that change is afoot in the 'strategic' thinking of certain governments in this regard. Shain, for example, points out that the Government of Saskatchewan has broadened its view of occupational health and safety to require employers to actively promote physical, mental, and social well-being.[11]

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[9] Duxbury, L. and Higgins, C. (2001). *Work-Life Balance in the New Millennium: Where Are We? Where Do We Need to Go?* Work Network, Canadian Policy Research Networks, Inc.

[10] They found, for instance, that work-life conflict for Canadian workers had increased over the decade, and during the same period employees' mental health had declined and their attitudes toward work had deteriorated. They also found that employees spent more time at work in 2001 and there was more job stress, while there was less job satisfaction and less job commitment.

[11] Cited in Health Canada (2000). The Saskatchewan Occupational Health and Safety Act, S.S. 1993, states, for example, that employers shall engage in: "i. the promotion and maintenance of the highest degree of physical, mental and social well being of workers…;iv. the placing and maintenance of workers in working environments that are adapted to their individual physiological and psychological conditions; and v. the promotion and maintenance of a working environment that is free of harassment…." (p. 27). Shain himself further reflects on this trend in his report, *Investing in Comprehensive Workplace Health Promotion.* Health Canada (2001).

This movement to extend the meaning of health and safety in the workplace, furthermore, is occurring worldwide. Smallman provides a very comprehensive review of 55 empirically based, peer-reviewed, post-1990 health and safety publications from ten different countries.[12] His review shows that governments are starting to recognize, for example, that: "The health and safety system needs to do more than just prevent work-related harm. It must **promote better working environments** characterized by motivated workers and competent managers"[13]

What are the implications of this new approach to health and safety? If health is defined beyond the standard "occupational hygiene and safety" mandate to include the psychosocial health of individuals and the hazards of the organization, then there is a very powerful argument to be made for legislation and policy to support employers that do their part to promote healthier workplaces. Partnerships among different levels of government, and between governments and employers, are also integral to this new approach.

On a broader level (beyond simply the hygiene and safety aspects of workplace health), research more generally points to the critical role that government must play in enabling and encouraging workplace health promotion. Interviews conducted by the European Foundation (1997) with experts in the field of workplace health indicated "many were quite pessimistic about the prospects for its development in the absence of Government initiatives or real economic incentives."[14] While this finding reflects European expert opinion, it mirrors the need in Canada for government to take a central role in instigating workplace health initiatives and providing effective incentives. Presently, in Canada, there appears to be no single agency in any level of government that is taking the lead role in the support of nationwide workplace health promotion. In fact, there is a need to integrate today's fragmented approach within government departments, between departments, and between different levels of government. While constitutional and jurisdictional considerations would have to be taken into account, the goal would be to better coordinate Canada's overall approach to workplace health, so that various governments could consolidate their knowledge and budgets in this regard, and become more effective in their efforts.

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[12] US, UK, Canada, Norway, Australia, Sweden, Germany, Hong Kong, India, and Taiwan. From Smallman, C. (2001). *The Reality of Revitalizing Health and Safety*. Journal of Safety Research, 32, 391-439.

[13] From the British Government Health and Safety Commission report (2000), cited in Smallman, 2001, p. 401. Emphasis in the original.

[14] European Foundation for the Improvement of Living and Working Conditions (1997). *Workplace health promotion in Europe: Programme Summary*.

Nor is there any single professional association, or agency advocating on behalf of a certain group (such as unions or employers), that has taken a dominant or strong leadership role in the stimulation of workplace health in Canada, though the National Quality Institute (NQI) is closest to having attained this role. Further, there is no concerted collaboration currently being supported in the areas of workplace health education at the Community College or University level, or in the consulting industry. The time would appear to be ripe for leadership in all these areas.

Another 'strategic' or 'big picture' issue is that individual organizations exhibit their own "organizational culture".[15] A review of the literature shows that these micro-cultural differences *among* organizations have not been widely researched. It is not implausible to suggest that in Canada the differences among or within sectors of industry might be more important than regional or provincial differences. Most importantly, it raises the point that no one approach to workplace health will fit all organizations.

Research on workplace health

a. Overall considerations in conducting research in workplace health

Before looking at specific field-based research efforts in the area of workplace health, it is important to appreciate the particular challenges facing academics who focus on this subject area. First, nearly half of Canada's employed individuals are not in "standard" jobs, i.e., only 54% of Canadians are paid, permanent, full-time employees who have been in their job for at least six months and are not holding multiple jobs.[16] The flip side of this statistic is that nearly 46% of Canada's employed workforce is, therefore, not in "standard" types of employment. Therefore, any attempt to create a simple or "standard" approach to employment practices and policies related to the creation of a healthy workplace will need to take into account this diversity of work.

Second, the very nature of the workplace makes research design difficult. All research studies have to contend with threats to validity and reliability and no single study can rule out all threats, though strong experimental designs come closest to doing so.[17] Due to the nature of the workplace, and the potential

[15] The European Foundation for the Improvement of Living and Working Conditions (1997) also notes, on an international scale, that different country-based cultural styles may impact on approaches to workplace health promotion.

[16] Lowe, L. and Schellenberg, G. (2001). *What's a good job? The importance of employment relationships.* Study No. W/05, Changing Employment Series, Canadian Policy Research Networks, Inc.

[17] Campbell, D. and Stanley, J. C. (1963). Experimental and Quasi-Experimental Designs for Research.

for research to disrupt normal work processes with consequent productivity and economic consequences, there is very little experimental workplace health research. Consequently, workplace research suffers from a variety of methodological inadequacies such as measurement, design, and sampling issues. A brief survey of some of the challenges facing those who conduct research in workplace health is presented in Appendix A of this paper. Arising from that survey, the CCIH makes the following observations about the future of workplace health research:

- More research is needed: workplace health is an under-explored area, particularly workplace outcome-related research.
- Better measurements are needed, particularly productivity and performance measurements.
- Improved research designs are necessary: specifically, more longitudinal designs and quasi-experimental designs would be beneficial (where possible).
- Funding support is needed: in particular, deliberate earmarking of funds in the area of workplace health research is necessary; further, some of this funding needs to be multi-year in order to properly ascertain the long term effects of workplace interventions.
- The source of funding needs to be negotiated. Since it is the prime beneficiary of the research, it is reasonable to ask Canada's business community to pay at least part (though not all) of these costs. Such funding could possibly be correlated to health care savings and rebates through "public" channels (for example, Employment Insurance, or WCB).

b. Research related to mental health and stressors in the workplace

Given the expanded definition of health, discussed above, and its recognition that both social and mental well-being are integral to good health, it is no wonder that a major topic of interest to researchers today is the social-psychological elements of work. For instance, HR Reporter (November 19, 2001) featured an article on the fact that the WSIB in Ontario was considering redefining stress. As the article states, "A proposal to redefine mental stress in the workplace[18] has Ontario employers concerned they could be facing big compensation claims…. there is protracted debate over how responsible employers are for the mental health of their employees."

In terms of research in this area, some researchers have focused on the broader environment of the workplace, and how it impacts on the well-being of the employee.[19] In their recent landmark Canadian study, for example, Lowe and Schellenberg report on findings from the Canadian Policy Research

[18] A direction that Dr. M. Shain has taken in his report: *Best Advice on Stress Risk Management in the Workplace*. Health Canada, (2000).
[19] See for example: Duxbury and Higgins (2001) op cit; Health Canada (2000) op cit; Health Canada (2001) op cit; Lowe (2000) op cit; Shain, M. (1999).

Network's (CPRN) "Changing Employment Relationships (CER) Project".[20] They found that four "employment relationship" factors (trust, commitment, influence, and communication) were strongly predictive of a number of important workplace outcomes, including job satisfaction, turnover, and absenteeism. Moreover, they report that a "healthy and supportive work environment" was the single most important predictor for each of the employment relationship factors, and they conclude: "a **healthy and supportive work environment** is the crucial factor in creating robust employment relationships" (p. xii - bold in the original text).

Other researchers are focused more specifically on the issues of stress and mental health in the workplace. Attached as Appendix B to this paper is a brief survey of some of the major research in this area. Key points are as follows:

- Much research suggests that management must play a greater role in efforts to reduce the effects of stress, anger, and depression in the workplace. This finding reinforces the need for workplace health initiatives to be integrated into managerial responsibilities.
- Research suggests that workplace health promotion interventions should be better targeted, particularly aimed at those workers suffering from high levels of a stressor or disease, rather than more "general education" based types of interventions. Concerns about privacy are not insurmountable through good communication (trust; clearly stated intentions) and obtaining appropriate consent.
- Related to the above, comprehensive and intensive workplace health interventions are generally found to be more effective than simple, easy, and less costly approaches. Once again, the importance of managerial leadership is critical: given that such measures have the potential to cost more and be more disruptive of "normal" workplace routine, active support from leadership in the workplace is required to provide the resources to support such initiatives.
- While current research may lead to cautious conclusions about workplace stress management programs leading to demonstrable health outcomes, there is a lack of consistent, strong research that suggests positive performance or productivity-related work outcomes.
- In addition to overt (often written) contracts of employment, employees and employers also have psychological contracts, comprised of the beliefs held by employees about the reciprocal obligations between them and their employer. Research suggests that violations of the latter are usually not eligible for formal appeal to a higher authority such as a grievance process[21] and the impact on individual employees can include: decreased trust of the employer, reduced job and organizational satisfaction, feelings of less obligation and increased turnover intentions, and reductions in their contributions to their workplace. Given the potential impact that an employee in such a state can have on the organization, it is clear that the violation of psychological contracts is potentially a very important consideration for employers.

[20] Lowe and Schellenberg (2001), op cit.

[21] It should also be pointed out there is a very large segment of workers who do not have a formal grievance process available for *any* of their workplace problems, and must rely on the legislative framework, in most cases the Employment Standards Act of their respective province.

- Beyond looking at "stress" in the workplace, much research points to increasing levels of incivility and aggression at work. The vast majority of studies regarding aggression in the workplace focus on the more overt and physical forms of incivility. Studies indicate that the structure of work, manager-employee relations, and co-worker relations can all affect workplace violence and aggression. Significantly less attention has been given to the much more frequent but less observable forms of aggression such as rude comments or thoughtless acts. The concept of a 'spiral of incivility' (coined by researchers Andersson and Pearson) suggests that smaller transgressions, if left unattended, can lead to higher levels of aggression or harassment.[22]
- If a healthy workplace includes the notion that workers' perceptions, attitudes and feelings are causally related to their work performance behaviours, then these psychological elements are fundamental to creating a healthy worker and a healthy workplace. Employers concerned about prudent management, due diligence, and standards of care need, therefore, to understand that their responsibilities may well include "social" and "psychological" dimensions of workplace health, as much as they have previously been concerned about the "physical" dimensions.

c. Looking toward the future: models that arise from workplace health research

Canadian and international research clearly shows that in the vast majority of industrialized nations there has been a shift in the focus, and the understanding, of workplace health over the last two decades.[23] As discussed earlier, this shift is reflected in the call for workplaces to adopt health policies, procedures, and practices that go beyond mere compliance with legislation, such as national or provincial occupational health and safety requirements.[24]

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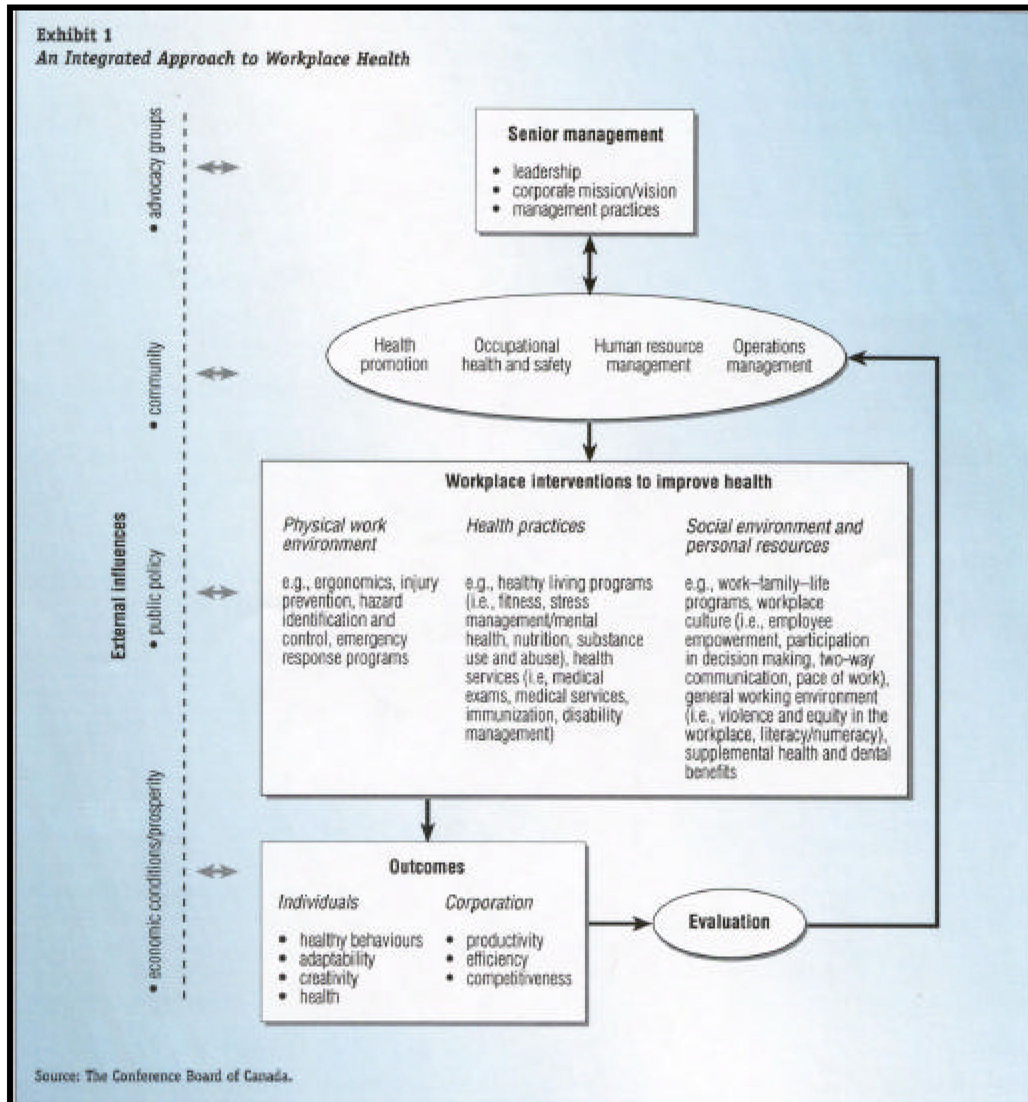
[22] Andersson, L. M., and Pearson, C. M. (1999). *Tit for tat? The spiraling effect of incivility in the workplace*. Academy of Management Review, 24, 452-471.

[23] See, for example: Bachmann, K. (2000). *More than just hard hats and safety boots: creating healthier work environments.* The Conference Board of Canada. Ottawa; Chu, C. & Dwyer, S. (2002). *Employer role in integrative workplace health management: A new model in progress*. Disability Management and Health Outcomes, 10, 175-186; Chu & Dwyer (2002); European Foundation for the Improvement of Living and Working Conditions (1997); Riedel, J. E., Lynch, W., Basse, C., Hymel, P., and Peterson, K. W. (2001). *The effect of disease prevention and health promotion on workplace productivity: A literature review*. American Journal of Health Promotion, 15, 167-191; Washington Business Group on Health (1998). *Investing in people for corporate growth and success: Health and productivity management*.

[24] For example, as discussed by Bachmann, K. (2000). *More than just hard hats and safety boots: creating healthier work environments*, op cit; European Foundation (1997).

These changes ask much of employers. Arising from the research to date, several theoretical models have been developed to suggest how employers could begin to undertake a more progressive approach to workplace health. One useful model is offered by Bachmann, wherein she sets out what is necessary for an employer to build a healthy workplace:



Reproduced with permission from: "*More than just hard hats and safety boots: Creating healthier work environments*", by K. Bachmann, The Conference Board of Canada, November 2000.

In the view of the CCIH, Bachmann's model provides a holistic, integrative, and comprehensive approach that provides a worthy foundation for building healthy workplaces in Canada, at least in terms of the employer. Research shows that too frequently in the past, workplace health promotion and health education have been presented to strategic management as an intervention that will lead to health and

productivity effects. Clearly, on their own, such interventions are limited in their effects.[25] Further, workplace health strategies are fundamentally human resource (HR) strategies, and Yardley and Campbell present a model outlining that HR strategies must be linked to business strategies in organizations.[26] Moreover, those linkages at the strategic planning level need to become part of managerial actions down and across the organization. In turn, such actions should be evaluated in terms of whether they have the intended consequences or outcomes, so that feedback will impact on management actions and strategic planning.

B: The Numbers – The Case for Workplace Health

As the previous section demonstrates, the complexities of the workplace make it very difficult to design research to explicitly determine whether there is a direct connection between a healthier workplace and increased productivity.

It is the contention of the CCIH, however, that there is a very strong case for employers and unions to support workplace health initiatives, and it can be found in the statistics around employee illness and injury. The National Quality Institute has recently produced a list of Canadian organizations that have achieved compelling results from evaluation of their comprehensive workplace health promotion initiatives. Please refer to Appendix C.[27]

A brief review of these numbers provides convincing proof that commitment to and investment in a healthier workplace can significantly and positively impact on both the workplace and the nation.

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[25] See, for instance; Pelletier, K.R. (1993). *A review and analysis of the health and cost-effective outcome studies of comprehensive health promotion and disease management programs at the worksite: 1991-1993 Update*. American Journal of Health Promotion, 8, 50-62; Pelletier, K.R. (1996). *A review and analysis of the health and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: 1993-1995 Update.* American Journal of Health Promotion, 10, 380-388; Pelletier, K.R. (1999). *A review and analysis of the clinical and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: 1995-1998 Update (IV)*. American Journal of Health Promotion, 13, 333-345; Shephard, R.J. (2002). *Issues in worksite health promotion: A personal viewpoint*. Quest, 54, 67-82.

[26] Yardley, J. K., and Campbell, K. C. (2001). *Employees: A key feedback resource. Just ask them!* Excellence, Winter, pp. 11-13.

[27] McKeown, G (2002). *Healthy Workplace: A Sound Business Strategy and a Good Investment: The Four-Step Guide to Building a Compelling Business Case for Your Organization*. National Quality Institute (in press).

The statistics

The following is a brief summary of recent statistics and studies related to the cost of ill health for employers:

- Members of the Canadian Life and Health Insurance Association (CLHIA) made health benefit payments in Canada (including drugs, other medical/hospital, disability, dental and AD&D[28]) of $12.5 billion in 2000. In 1990, these costs were $5.9 billion.[29] (Blue Cross and other not-for-profit providers are excluded, and would add many hundreds of millions of dollars to this total.) Insurance for drug, other medical/hospital, and dental components totaled $7.8 billion, about 29% of total private healthcare spending in 2000. Note: *Premium and claim costs are often shared with employees; employee contributions are not included above.*[30]
- The CLHIA estimates its members (excludes Blue Cross and other not-for-profit companies) cover about 8.3 million Canadians for group disability plans, 15.7 million for group dental, and 23.5 million people for extended health (medicare supplement) plans. Some employers also fund benefits for retirees, although given the new accrual funding requirements, discussed later in the paper, these plans are unlikely to become more popular with employers.[31]
- Statistics Canada recently published updated information on absence in Canada.[32] Absence increased to 8.5 days per year for each full-time worker in 2001, up from 7.4 days five years earlier. Excluding vacation and maternity leaves, Canada lost 85.2 million workdays for personal reasons in 2001, up from 65.6 million workdays five years ago. Using an average weekly pay rate of $663.17 (Statistics Canada for June 2001), and a daily rate of $133, the cost was about $11.3 billion in 2001. Approximately 75% of time lost for personal reasons, or about $8.5 billion, was lost for illness or disability.[33]
- A survey of 41 major Canadian employers by Mercer Human Resource Consulting in 2000, showed these organizations spent between 2 and 8 percent of payroll on staff who are absent for one reason or another. (The figures do not include casual absences, or the cost of replacement workers.) Increasing age, and higher stress levels were expected to drive these figures higher in the future. Importantly, the author pointed out employers could reduce these absences "by taking active measures to improve their work environment, by making early interventions [when employees were absent], and providing flexible solutions to get employees back to work…"[34]

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[28] Accidental Death and Disability.
[29] Canadian Life and Health Insurance Facts, 2001: 18. Viewed online at www.clhia.ca, August 2002.
[30] Canadian Institute for Health Information (2001), National Health Expenditure Trends, 1975-2001.
[31] Canadian Life and Health Insurance Facts, 2001.
[32] News release: *Canadians missing more work*. Viewed July 4, 2002 on globeandmail.com
[33] "Full-time workers rack up 'little absences' each week", Globe and Mail, February 27, 2002, B1 and B8.
[34] "Working Life – Absences Can Cost Firms More Than They Think: Study." Globe & Mail, February 3, 2000, B12.

- The follow-up study by Mercer covered 86 large public and private Canadian employers. "The Benchmarking Study of Absence Costs", showed short-term disability costs were more than double the cost of long-term disability and Workers' Compensation costs combined. More than 75% of the cost was for non-occupational absences. Additionally, within each industry group, there were significant variances in costs, for example, the median cost of absences was 3.5% of payroll, but this ranged from < 1% of payroll to > 10%. Some employers were doing much better than their peer group, and creating a competitive advantage. The authors stated:

  Absence is not about personal illness as much as it is about employee well-being and commitment to work…Employers should not view absence as solely a disability or health issue. These are BUSINESS issues that require MANAGEMENT action.[35]

- Watson Wyatt's 2000/2001 "Staying@Work" survey of 281 Canadian employers representing 700,000 employees, showed a direct costs of absenteeism and disability of 7.1% of payroll. Including indirect costs for overtime and replacement workers (6.2%) and lost productivity (almost 4%), the total came to 17% of payroll.[36]

- Employers contribute corporate taxes, a portion of which is allocated to healthcare in many provinces. In Québec, corporate taxes of 2-3% of salaries go towards funding healthcare.[37] Likewise, in Manitoba a payroll tax is used towards health and postsecondary studies.[38] In Ontario, the $3.6 billion Employer Health Tax supports healthcare services.[39] Newfoundland has a tax similar to the one in Manitoba.[40]

- The Association of Workers' Compensation Boards of Canada reported that in 2000, there were 392,502 new lost time claims, with current year benefit costs exceeding $4 billion.[41]

- The Canada Pension Plan reported Disability Benefits, paid to contributors and their children, represent 9.5% of the total number of CPP benefits paid and 14.9% (about $2.8 billion) of the total benefit dollars paid out by the CPP in 1999-2000. Note: *C/QPP premiums are shared by employers and employees.*[42]

- Up to 15 weeks of Employment Insurance (EI) benefits are available for sickness and injury. A premium reduction is available to employers who offer a disability plan with at least equal provisions to that of the EI plan – essentially a benefit of at least 55% of salary, payable after no more than 14 days following illness or injury, for a period of 15 weeks. Note: *EI premiums are shared by employers and employees*.

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[35] Remarks from the prepared notes of M. Gaul and A. Nicoll, consultants with Mercer Human Resource Consulting, during a seminar presenting the study on March 14, 2001. Emphasis in the original.

[36] *Staying@Work 2000/2001, The Dollars and Sense of Effective Disability Management*. Watson Wyatt Worldwide. Survey synopsis can be viewed online at: www.benefitsworld.com

[37] The Quebec contribution fund is titled the "Fonds des services de Santé". The rate varies from 2.7% of payroll for employers that have less than $1 million to 4.26% when payroll exceeds $5 million.

[38] In Manitoba, the first million of payroll is exempt from tax, the next million is taxed at 4.3% of payroll, and above that the tax rate is 2.15%.

[39] In Ontario, the rate varies from 0.98% to 1.95% of payroll, depending on the size of the employer's total payroll. The 2001 provincial budget forecasted EHT revenue of $3.62 billion in 2001-02.

[40] The rate, however, is 2% of payroll if the employer has an annual payroll exceeding $500,000.

[41] Viewed online, April 2002: www.awcbc.ca/english/board_data-key.asp.

[42] Viewed online, April 2002: www.hrdc-drhc.gc.ca/isp/cpp/report/9900/toc_e.shtml.

The following chart summarizes some of the workplace-related health burden referenced above.

Value of Canadian Workplace Health Burden		
Item	**Source**	**Amount ($billion)**
Private health insurance payments	Canadian Life & Health Insurance Association (CLHIA)	12.5
Personal absence	Statistics Canada/CCIH	8.5 (est.)
Workers Compensation	Association of Workers' Compensation Boards of Canada	> 4.0
Payroll taxes	Government of ON QC MB NF	3.6 N/A N/A N/A
CPP Disability Benefits	Human Resources Development Canada	2.8
Sales Taxes – ON, QC	CLHIA	0.78
Premium Taxes	CLHIA	0.27
Employment Insurance – Sickness Benefits		N/A
Total Workplace Health Burden		***$32.5 billion***

Beyond these elements, the provision of various health promotion and disability management programs, and Employee Assistance plans are tangible expressions by employers of their interest in the health of their employees, families, and communities. In addition, employers often subsidize or offset the cost of provincial health premiums in Alberta and British Columbia. These totaled $0.68 billion (2002-03 estimate), and $0.15 billion (2001/02, Medical Services Plan only) respectively.

A look at one organizational cost: Workplace stress

As discussed in relation to research on workplace health, stress and mental health are rapidly becoming major issues in the workplace and in Canadian society. Statistics show that workplace stress is steadily increasing and that there are significant cost implications related to this growing organizational concern.

A recent discussion paper developed for the National Social Worker Initiative[43] included the following facts:

- A recent study by Health Canada described mental illness as a $14 billion health issue in Canada, even before including the cost of absence, company long-term disability plans, or untreated illness.[44]
- A recent Canadian study showed claimants using anti-depressants had the second-largest share of drug costs - 25% of the total spent was for claimants using anti-depressant medications.[45]

According to Statistics Canada[46], in 1998-99:

- About 1.5 million Canadians aged 12 or older contacted a health care professional (MD, Social Worker, or Psychologist) regarding mental health issues. Most of these were in the 25 to 44 age band.
- The average number of visits to an MD, Social Worker, or Psychologist for patients with these mental or emotional problems was 9-10.
- The most recent national population health survey (1994-95), noted 35% of Canadian women and 28% of men experienced high personal stress.

Additionally:

- According to the CLHIA, depression costs $300 million per year in long-term disability payments. The World Health Organization predicts it will become the second-leading cause of disability – trailing heart disease – by 2020.[47]
- BCE Emergis lists prescriptions used to treat depression as the largest drug category in its 2001 listing of the 20 most expensive disease states (8.7% of paid claims, or $94.8 million). Other mental disorders took the 20th spot (1% of paid claims, or $10 million).
  Mental and nervous disorders have now replaced musculoskeletal conditions as the top condition causing long-term disability. They now represent close to 50% of short and long-term disability claims, compared with 30% in 1990 and 15% in 1980.[48]
- According to an internal study produced by Desjardins in 1997, 50% of people suffering with depression are undiagnosed.[49]

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[43] *Registered Social Workers – Good Therapy for Business*, February 2002. Used by permission, Ontario Association of Social Workers.
[44] Stephens T. and Joubert, N. (2001). *The Economic Burden of Mental Health Problems in Canada.* Chronic Diseases in Canada, 22(1).
[45] The Merck Frosst Handbook on Private Drug Plans 1997-2000 (2002). Table 6.1.
[46] Statistics Canada (2001). Health Reports: How healthy are Canadians? Annual Report 2001. p. 35
[47] Felix, S. (2002) *Combatting Depression.* The Canadian Healthcare Manager, August 2002.
[48] From "Journal de L'Assurance" [The Insurance Journal], May 2001. Quote by Bernard Dalbec, President, Solareh, Inc.
[49] Ibid. In her article, Felix (2002) also notes that the Canadian Mental Health Association estimates that more than half of people with depression don't go for treatment.

- Data released by SSQ Life, a Québec-based company that specializes in group insurance, indicates that the duration for claims related to mental and nervous disorders increased by 20% in six years, from 66 days to 78 days. The incidence also went up from 17% in 1994 to 23% in 1999.[50]
- In the 2002 Aventis Healthcare Survey[51], 51% of Canadian employees say they experience a great deal of stress at work. Roughly 25% of these employees say that their workplace stress has been so overwhelming that it made them physically ill at times. More than half of the employees surveyed say they worry that the stress they experience at work could cause more serious long-term illness. When asked if their employer is doing enough to help them manage their stress at work, 44% of respondents said "no".

Workplace health as a value proposition

Why invest in workplace health?

Interestingly, most employers do not consider their support of health programs as a core or strategic offering, one that protects their business viability. They also generally avoid any health-related practices or programs that may intrude on the privacy of an employee or their family members. Most view benefit programs as a tax-effective form of total compensation. However, unlike governments that have reduced the scope of their coverage to control their budgets, employer plans remain mostly generous by any standard, and often not closely managed to control cost.[52] Given this situation, why should employers be interested in promoting healthy work environments? Why should governments create supportive policy for a largely complacent audience?

The first reason addresses health services utilization, and reinforces the adage of 'measurement before management'. Employers need to analyze their costs, including benefit plan utilization, Employee Assistance plan usage rates, short and long-term disability claims incidence and duration, workers' compensation benefits, workplace accidents, absenteeism, and even life claims. Such an assessment would reveal costs of sufficient magnitude to encourage employers to make the cultural and financial steps necessary to move their organizations toward healthier workplace practices and policies.

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[50] From Journal de L'Assurance, May 2001, citation from Carl Laflamme, Vice-President, Group Sales and Marketing, Solareh.
[51] Available from Aventis Pharma, 1-800-265-7927.
[52] In Health Canada's "Canadians' Access to Insurance for Prescription Medicines" study (Health Transition Fund project NA202), only 20% of private plans were described as "managed".

Secondly, the CCIH believes the statistics presented earlier paint a stark picture, one that points to a broad impact on our health and social support system. Health issues in the workplace cost not only the employer money (and increase stress for remaining employees, creating a vicious cycle), but sick employees impact on families, communities, and the healthcare system. The boundaries of the workplace are permeable, and costs are easily transferred to other elements of society.[53] It is for these reasons that workplace health must become a priority for governments, and not just for employers, unions, and plan members.

Paradoxically, the workplace has become an environment that both contributes to employee ill health while simultaneously offering the most potential for improving overall employee health and well-being.

The long-term view of costs

What should employers expect if they make workplace health a priority? Canadian employers should see a dollar spent on employee health and well-being today provide them with compounding returns over several years, but seldom beginning before three years has passed. There is, in other words, an incubation period. Communication and general awareness initiatives can pay some earlier dividends, but these effects are even harder to objectively measure. Higher cost trends for health and disability plans (as well as the increasing rates of absenteeism, and usage of Employee Assistance plan benefits, etc.) over the next five to ten years can be positively impacted by implementing healthy workplace practices now.

Indeed, appreciation of the "long-term" picture has recently become more important, given the requirement for private sector Canadian employers that offer post-retirement life and health care to accrue these costs, effective January 2000. They were formerly funded on a pay-as-you-go basis, like today's medicare programs.

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[53] Shain, M. and Suurvali, H. (2001). *Investing in Comprehensive Workplace Health Promotion*, published by the National Quality Institute.

So in addition to the cash-flow cost of benefits for active employees, employers extending coverage to retirees must now recognize, and manage, these huge balance sheet costs. A review of a small number of Canadian corporate reports showed the following numbers:

Post-Retirement Non-Pension Health Liabilities (latest fiscal year, ending in 2001)				
	Recorded Liability (millions)	Net Income (millions)	Assumed Trend Factor	Effect of 1% Increase in Trend (millions)
George Weston	$229	$582	7.5%	N/A
Imperial Oil	$323	$1,244	5%	$26
INCO	US$480	US$305	8% sliding	US$92
Royal Bank Financial	$693	$2,411	7.25%	$103
Sun Life Financial	$186	$882	8.5%	$26

Source: Company annual reports available on websites: www.weston.ca; www.imperialoil.com; www.inco.com; www.rbc.com; www.sunlife.com

These figures are an estimate of the present-value cost for the commitment to offer benefits over the expected life of all retired employees, now and in the future ("post-retirement liabilities"). The liabilities are sourced from Retained Earnings, and include health, dental, and life insurance benefits, if offered. Present accounting standards do not require these liabilities be funded, but they must be actuarially determined each year. The recorded liabilities may be understated, given current insurer healthcare trend factors (a combination of increased inflation and utilization) of 15-17%. They also appear to be highly leveraged (see far right column): if projected trend factors are inadequate (i.e., lower than actual), the post-retirement liabilities will increase significantly with every one percent increase in trend. If the health plan performance worsens over time, the post-retirement liabilities will also increase. Further, while liability recognition is now a practice, funding is undoubtedly the next step to bring the security of these benefits on par with pension liabilities.

However, there is a silver lining: if active employees are in better health, they are likely to incur lower costs and delay costs, thereby lowering the post-retirement liability. (However, to the degree they also live *longer* lives, some of this advantage will be offset because improved longevity will increase the cost of the benefit.)

The bottom line is that this accounting principle is a significant liability for those employers that offer post-retirement benefits, and serves to raise the stakes of those employers' involvement in the health of their active and retired workforce. They also speak to a long-term commitment by private health plan sponsors that serves to keep these liabilities off the public ledger. Governments and public policymakers must either be prepared to take on these liabilities themselves, or take steps to support employers who have agreed to carry the burden.

Signs of change

There are signs that the connection between workplace health and employer finances is being made. The Bank of Montréal stated: "We have statistically correlated a healthy organizational climate to profitability, productivity, customer loyalty and employee turnover." Executive leadership, a willingness to invest in research, and access to good quality data allowed the Bank to identify 2-3 year leading indicators of financial results.[54] This expanded on the findings reported by Sears executives in the US who explained how a 5% increase in employee satisfaction resulted in a 1.3% improvement in "customer impression", and a 0.8% revenue increase.[55] Neither of these studies was done to explicitly improve the health of employees, but both demonstrate the positive impacts of strong, progressive management on both business and health outcomes.

A study conducted in Halifax[56], Nova Scotia, in 1999/2000 *did* demonstrate a positive return on investment (ROI) for employers wanting to assist employees whose risk factors for cardiovascular disease could pose serious health issues in the future. Project Impact, a partnership project between Aventis Pharma, Atlantic Blue Cross Care and the Atlantic Health and Wellness Institute, involved a pre-screening process of 2,700 employees where information was collected about each individual, and a cardiac score identified that individual's risk for cardiovascular disease. Employees with two or more modifiable risks for cardiovascular disease (smoking, obesity, high blood pressure, high cholesterol and lack of physical activity) were invited to take part in the study.

[54] See: Gonzalez, M. (1999). *Shifting the Performance Curve*. Ivey Business Journal, July/August 1999.
[55] Rucci AJ, Kirn SP, Quinn RT (1998). *The Employee-Customer-Profit Chain at Sears.* Harvard Business Review, January-February: 83-97.
[56] Study results released in 2001 by Aventis Pharma Inc., Atlantic Blue Cross Care and Atlantic Health and Wellness Institute.

Of the 600 employees who volunteered, half were placed in the Intervention group, the other half in the Control group (which did not receive any intervention whatsoever). Following an intense, three-month intervention program (featuring a smoking cessation program, an individualized physical fitness program, nutrition counselling, and stress management sessions), researchers measured the impact of the Intervention program on participants' risk factors for cardiovascular disease, compared with baseline results before entering the program. In addition, Intervention participants' results were compared with their Control group counterparts.

The results were very encouraging. Overall, the Intervention group participants reduced all risk factors, and showed sustained improvement in their cardiac health. ROI calculations ranged from $1.64:1 (for every dollar spent, the employer received a ROI of $1.64) to $3.98:1 (for employees in blue-collar occupations). This study is the first of its kind in Canada, one that may assist Canadian employers to support health promotion in the workplace.

In essence, healthy employees and health-positive organizations may be a foundation for higher job satisfaction, more loyal customers, and better financial results.

The bottom line

There is, it would seem, a 'bottom line' reason to promote and pursue a healthy workplace. *Not* doing so can actually cost employers more money in the long run and have far-reaching impact on society as a whole. "Costs related to absenteeism, temporary workers, employee replacement, not to mention the opportunity cost of missed revenues and compromised quality resulting from an under-functioning workforce. . . percolate throughout the organization, the healthcare system and society at large."[57]

In summary, while employers do not often see the management of health issues in their workplaces as part of their corporate responsibility, there is increasingly strong evidence that the cost of doing nothing on this front exceeds the cost of thoughtful strategies to create a healthy organizational climate.

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[57] Quotation from D. Pratt, author of *The Healthy Scorecard* (Trafford, 2001). From a discussion paper titled, "Think", a regular publication of *Canadian Healthcare Manager* magazine, sponsored by GlaxoSmithKline, October 2001, Volume 8 (5), p. 24.

C: The Current Environment for Workplace Health

From a "numbers" perspective, the CCIH has concluded there is a strong case to be made for an increased emphasis on workplace health. In other words, Canada's approach to workplace health needs to change. The recommendations of the CCIH in this regard make up the second half of this paper.

But suggestions for change must be built on an understanding of what is currently in place. This section of the paper looks at the current environment in Canada for workplace health, from both a public policy and employer perspective (and the relationship between the two), and considering the critical role now played by private insurers. It also reviews current workplace health practices by employers, including a consideration of both the components of and the barriers to a healthy workplace.

Who's doing what: the current role of public policy, the employer, and the insurer in workplace health

Public-Private Coordination

In recent years, provincial governments across Canada responded to federal fiscal tightening by reducing their own role in financing healthcare, and consequently, the private role increased by default. The Canadian Institute for Health Information (CIHI) reported that from 1977 through 1996, growth in private expenditures outstripped public funding in all but four years. In 1991, the private share of funding was at 25.5%; it peaked at 29.8% in 1997, and was expected to drop to 27.4% for 2001.[58] Even though federal and provincial funding has increased significantly, various provincial governments continue to de-list needed services such as optometry and physiotherapy, and move very slowly to invest in mental health, home and community-based health services, adopt new technologies, and make even breakthrough medicines available to those in need. Private plan sponsors have little choice but to pay for these services, either delivered in Canada or the United States, in order to rehabilitate ill or injured employees and facilitate an early return to good health, along with a safe return to the workplace.

[58] Canadian Institute for Health Information, *National Health Expenditures Database Trends 1975-2001*. Tables A.2.1 and A.2.2.

Unfortunately, there is little coordination of payment for health services between governments and third-party plan sponsors. Employers are often making whole those working Canadians (and their families) who are not equitably served by provincial medicare plans. Unfortunately, not all Canadians can benefit from this generosity, and governments appear to be taking it for granted.

The Canada Customs and Revenue Agency (CCRA) does permit companies to write off the cost of their health benefits programs, including premiums for everything from Workers' Compensation to Employee Assistance plans. Benefits payable under these plans are not taxable in the hands of employees. Even so, the "numbers" associated with workplace health (and ill health) are daunting. All these costs, together, can easily exceed 15%, 20%, or more of payroll. Governments have also been reluctant to afford employers tax incentives to encourage investments in workplace disease prevention and health promotion.

In this scenario, private health plans are no longer "fringe benefits" to employees, or to Canadians in general. They play an important role in supporting Canada's public health system. The Employer Committee on Health Care Ontario (ECHCO) reports that research commissioned in 1994 showed employer plans provide about five percent of their beneficiaries with benefits of between $20,000 and $100,000 annually. As ECHCO said: "This is essential support to deal with serious health conditions."[59] A new research report, the "Merck Frosst Handbook on Private Drug Plans 1997-2000", reviewed a database of over 30 million prescription drug claims for working Canadians and their dependents, and found the 5% most expensive claimants accounted for 40% of the total cost. Each year, this minority submitted 40 claims, with total average drug costs of almost $2,700. Clearly, the employer investment in drug and other health plans takes a tremendous burden from public plans that patients would otherwise expect to pick up the cost.

Relative to private sector involvement in healthcare, it is important from a policy perspective to distinguish private funding (28% of all such spending in Canada), from private delivery of healthcare services. Over half of all private spending is out-of-pocket by consumers and patients. Most of the balance is through private insurance contracts. Insurers (either for-profit, or not-for-profit) sell "private health services plans" allowed by the Income Tax Act (Sec. 118.2) mostly to employers, but sometimes to unions, or joint labour-management welfare trusts, and sometimes to individuals. They supplement

[59] From ECHCO: *The Employer's Voice in Health Care Change*, November 1997. Viewed online: www.echco.org, Non-members, then Document Archive.

coverage offered by the provincial governments, and by law cannot compete with provincial health plans. More private insurance does *not* mean more privatization of healthcare services; such plans *do* improve access to needed health services for millions of Canadians.

In summary, plan sponsors and their members are shouldering a very significant portion of our total direct expenditures on health care. Except for legislated requirements concerning occupational health and safety, Canada's governments are providing inadequate incentives for employers or other plan sponsors to continue their role in creating healthier workplaces, and a healthier working population.

What makes a healthy workplace?

Research in many countries demonstrates that some workplaces have had significant, positive results from their approach to workplace health. The premise of this paper is that a wider, strategic commitment to workplace health needs to take place within Canada, both at the public policy and employer levels. In order to make relevant recommendations for change, there must be recognition of the key ingredients of a healthy workplace, along with potential barriers. In other words, knowing what to strive for or avoid is necessary in order to recommend concrete, actionable initiatives.

Drawing from the research reviewed, the CCIH would suggest that the following characteristics are some of the major hallmarks of a healthy workplace (this list is by no means exhaustive):

1. *The presence of a supportive environment/culture*

   Organizational culture is "created, reinforced and sustained by ongoing patterns of human relationships and communications that are known to have an important influence on mental and physical health."[60] The presence of a culture that is supportive of the health of the employee -- psychological, psychosocial, and physical -- is critical for a healthy workplace.[61] This should include:

   - Safe work practices and low risk work environments;
   - A culture that encourages social cohesion and the balance of work and personal time;
   - Supportive management policies, programs, and practices;

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[60] From *"Canadian Healthy Workplace Criteria",* published by the National Quality Institute, Health Canada

[61] In her chapter titled "Assessing the Organization" in <u>Occupational Health Nursing: Concepts and Practice</u> (W. B. Saunders, 1994), Dr. B. Rogers provides an "organizational culture checklist".

- Comprehensive health benefit programs; and
- Communication of the importance of families and communities.

A comprehensive human resource strategy is essential to a healthy workplace. This includes such things as design of workspace, flexible work time, ongoing training, injury and illness management, adapted job responsibilities, early intervention programs, effective communication, and the "duty to accommodate" an employee's return to work. The organization also requires an ability to effectively and meaningfully promote change when change is necessary.

2. *Program planning and evaluation*

To be healthy, a workplace needs to uncover issues affecting the organization and its employees, and determine the 'root cause' of these problems. This includes:

- The capacity to recognize the needs and priorities of a dysfunctional corporate environment;
- Having a plan/policies in place to avoid, mitigate, or at least quickly respond to,-problems and their root causes; and
- Managing the implementation of that plan, including an evaluation of whether the response is appropriate.

Certainly, the degree of program planning and evaluation within the workplace depends on the size of the organization and its culture, but within any healthy organization a continuum of problem solving and support needs to be in place.[62] Having a good understanding of the culture of the workplace and the role of HR can lead to better success for health promotion programs.[63]

3. *Reward systems*

An important element of psychosocial support/health in the workplace is whether there is both financial reward and praise (a value system) to recognize the good work that employees do.

[62] In 2001-02, the Canadian Labour and Business Centre examined a number of workplaces as part of a case study review of 'best practices' in the area of workplace health. Their report can be found at their website: www.clbc.ca.

[63] V. M. McNeil and M. A. Garcia discuss this in *Enhancing Program Management Through Cultural Organizational Assessment*, American Association of Occupational Health Nursing Update Series (4/6).

4. *Leadership*

There must be willingness on the part of management to make it a priority. Without demonstrated leadership and commitment (and an appreciation of how change needs to be implemented), workplace health initiatives simply will not move forward. The "Heartworks" health promotion program sponsored by the New Brunswick Heart and Stroke Foundation (1999) identifies that "wellness is linked to Corporate Culture. Understanding the prevailing Corporate Culture, its values, expectations, beliefs and the prevailing management structure is vital to developing a strategic vision for Workplace Health Promotion programming. Leadership must be readily committed and evident. Leadership must walk the talk." [64]

Furthermore, employers who are inconsistent in their approach to workplace health, and rely on ad hoc, non-strategic approaches, are less likely to achieve or sustain success.

5. *Management*

Most commonly, it is HR that takes responsibility for health benefits and organizes various health-related initiatives. In some plans, such as multi-employer benefit trusts, it is the trustees who must consider their role in health promotion. When HR departments see the issue of workplace health as low on their list of responsibilities,[65] basic questions need to be asked, such as:

- What is stopping HR or trustees from instituting workplace health initiatives?
- Is the organization ready to change?
- What qualities or precursors are necessary for an organization to try such initiatives?
- How can HR or trustees be brought on board so that they are part of the strategic change to a healthier workplace?

[64] From: "Heartworks Manual: A Workplace Health Promotion Program", New Brunswick Heart and Stroke Foundation (1999)
[65] This is discussed in a recent article by E. Buffet in Benefits Canada (February 2002).

In fairness, health is not a traditional responsibility of HR managers. They are not trained in health issues, and may not have ready access to an occupational nurse or physician. They have also struggled with threats to their own legitimacy – some large companies (e.g., CN, BCE) have out-sourced their HR departments, believing they are not "core". Others have reduced headcounts for much the same reason, and are left with only enough resources to administer and trouble-shoot. They rarely consider strategic issues and approaches to organizational development. This is where health must fit in – it must be positioned as an integral, crucial means to achieving the organization's strategic plan.

6. *Employee's knowledge/buy-in*

Employees must believe in and understand workplace health issues and initiatives, in order that they succeed. The "Heartworks" program mentioned above determined that not only is leadership critical, but "Employee Participation in the design process [of workplace health programming] is essential for success."[66]

The 2001 "Workplace Health Survey" (conducted jointly by Health Canada and the Canadian Council for Health and Active Living at Work) found that employee respondents identified their top three priorities for maintaining or improving their health: 69% said they wanted more physical activity; 53% said they wanted to lose weight; and 38% said they wanted to learn to cope with stress.

According to the survey, employers should:

- Communicate more openly with employees - 45%;
- Provide recreational or exercise facilities - 41%;
- Train supervisors/managers to be more sensitive to employees' concerns - 40%;
- Provide or support stress control programs - 40%; and,
- Encourage employees to improve their health - 39%.[67]

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[66] Heartworks Manual (1999).
[67] Further information about this survey can be found at www.activelivingatwork.com. See: "Supporting Material".

A news release announcing the launch of the Active Living website in March 2001, quoted Dr. Peter Katzmarzyk of York University's Faculty of Kinesiology and Health Sciences, who said:

> Our research, published in the November [2000] issue of the Canadian Medical Association Journal, concluded that illness due to physical inactivity is costing the Canadian health care system at least $2.1 billion annually in direct health care costs. Epidemiological data have established that physical inactivity increases the incidence of at least 17 unhealthy conditions, almost all of which are chronic diseases or considered risk factors for chronic diseases.

The Active Living initiative is a great example of a more proactive, coordinated, and employee-centred approach to health in the workplace, involving government, academic researchers, and employers.

7. *Evaluation and respect for privacy*

To assure value, it is important that workplace health programs are evaluated for need, implementation, operations, and outcomes. Presently, changes to privacy legislation both provincially and federally require a new level of responsibility and accountability for "custodians" of personal information. These new laws will make it more difficult to obtain accurate aggregate data to support workplace health programs, but this will be no less important. Plan sponsors must obtain informed consent, implied or express, for the collection, use and disclosure of personal information. While this can often be done using aggregated data, sometimes individual data will be required, e.g., for longitudinal outcomes studies, although it can be made anonymous for greater security: In this case, obtaining informed consent from individual employees is clearly paramount. Indeed, an employer's respect for individual employees' privacy is critical to establishing a workplace atmosphere characterized by trust.

8. *Competitive marketplace*

The issue of how workplace health fits into a competitive marketplace is a critical one. The Conference Board of Canada's paper "From Payer to Player: The Employer's Role in the Canadian Health Care System", describes the results of a forum of employers and pharmaceutical companies brought together to address changes to the role of the employer in Canada's

healthcare.[68] The forum arose out of the following observation: "The private share of health care financing is increasing, and questions remain as to the future of the system and the role of employers in it. This issue is critical for the competitiveness of Canadian business." The report states:

> The employers that engaged in this exercise see the link between good health and corporate, community and individual success. They realize that employers need to balance their social responsibilities with their need to ensure business competitiveness. They recognize that it is of strategic competitive importance for organizations to become more proactive in promoting health in their organizations and communities and to become involved in public policy discussions around health care.

The reluctance of an organization to commit to workplace health could have significant, negative repercussions on future competitiveness.

9. Labour relations

Unions and trustees in joint labour-management health plans can play a key role in encouraging their members and their families to lead safe and healthy lives. This should not be perceived as a trade-off: health is an important priority in bargaining, and more focus on health need not be at the expense of continued investments in safety, as is sometimes believed. Where good, constructive relationships exist between labour and management, stress at the workplace and the opportunities for injury and ill health are reduced.

[68] Conference Board of Canada – discussion paper 246-98, November 1998.

PART TWO

CHANGING THE CANADIAN ENVIRONMENT FOR WORKPLACE HEALTH: RECOMMENDATIONS FOR ACTION

In part one, the CCIH has sought to demonstrate that there are strong reasons to encourage and foster workplace health within Canada. Employers have the potential to positively affect their 'bottom line' by creating a healthier workplace. Such investments clearly benefit employees, their families, and the nation. Furthermore, as explained in the earlier "Who's doing what" section of the paper, employers are huge financial contributors to the bigger healthcare picture in this country, although they rarely raise their heads on health issues or policy to protect their contribution.[69] This despite important national concerns related to health services that have significant impact on their operations:

- An ageing population;
- Declining health status, sedentary lifestyles, and increased incidence of serious diseases;
- Unequal and inequitable medicare services depending on residency;
- More expensive diagnostics and treatments; and
- Earlier testing and medicinal interventions, etc.

Furthermore, research suggests there are many benefits Canada could derive from a generally healthier populace.

What emerges from the preceding discussions of research, numbers, and a review of the current landscape, is that improving Canada's approach to workplace health needs to take place at two levels: first, nothing significant will change without strategic-level shifts in attitude (the "mindset" towards workplace health); and second, this new mindset must find expression at the tactical (or "program") level. In addition, such change necessitates an integrated approach involving both employers and public policy makers (as well as other players, such as employees, insurers, healthcare providers, business groups, unions, and researchers.) There is, in other words, a role for all in this new approach: for this reason, many of the recommendations below speak to partnership initiatives between the various players.

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[69] A review of the 141 organizational submissions to the Commission on the Future of Health Care in Canada (www.healthcarecommission.ca) showed only nine came in the name of employers, including four hospitals, two pharmaceutical companies, a long-term care company, a medical equipment manufacturer, and a human resources consulting firm. However, many industry and professional associations made submissions on behalf of their members.

What also emerges very clearly is that if workplace health is to move forward as a national priority, changing the Canadian environment will require leadership by some players, and a sustained commitment by all.[70]

Strategic Recommendations: Public Policy

- Government needs to ensure that progressive healthy workplace policy is set by senior bureaucrats and politicians, in close consultation with employers and other stakeholders, so it is not subject to the whims of economy, but is a more permanent fixture on the Canadian economic landscape. One early step should be to consolidate all federal government initiatives in just one area, including policy, programs, and research sponsorship.
- Strengthen the mandate and resources of Health Canada's Occupational Health & Safety Agency to investigate, validate, and promote corporate "best practices" in workplace health management. Further, government needs to recognise and reward "good" employers. For example, a program styled after the successful "Imagine" campaign (recognising corporate philanthropy) could be developed to promote workplaces engaging in positive health-related initiatives. (The National Quality Institute's *Healthy Workplace Award* is another approach to recognising excellence.) This could be a joint public-private initiative, and involve both provincial and federal governments.
- A "scenario planning" exercise should be developed to illustrate the longer-run opportunity costs of ignoring health issues in the workplace. This is one step toward creating an environment where healthcare becomes an integral part of business thinking.
- Develop effective communication strategies related to workplace health issues and initiatives. In particular, focus on the economics/finances of workplace health and demonstrate how organizations benefit from healthy employees.
- Consider experience rating the employer health-related taxes in Ontario and Québec, in a manner similar to how premiums are set by Workers' Compensation Boards. (An alternative would be to dedicate such taxes to health-related expenditures, or to provide a rebate if an employer institutes a disease management program that meets certain strict, measurable, guidelines.)

[70] The CCIH focused on federal leadership as one of its key recommendations in its November 2001 submission to the Commission on the Future of Health Care in Canada.

- Remove the financial disincentives for employers to expand their healthcare funding activities. Repeal premium taxes and sales taxes on health programs that actually support the public interest, such as improved access to disability and long-term care products.
- Consider allowing plan sponsors to write off the cost of health promotion and disease prevention programs. This would also include broadening the Income Tax Act regulations to allow expanded coverage for health-positive services such as cognitive services by pharmacists, and qualifying social workers as eligible health care providers.
- Encourage more fundamental and applied workplace-related research on physical, mental, and psychosocial hazards through the Canadian Institutes for Health Research. Presently, none of the 13 member institutes are focused on the workplace. Research should focus on best practices, and establish the role that organizational culture, governance and management policies, particularly those of Human Resources, play in an individual's risk profile. Importantly, this research must include case studies of organizations that have undergone rapid change.
- Recognizing that employers need to see evidence on wellness and that the measurement of results is critical, government should compile and then provide information on inputs and outcomes: For example, the "Burden of Illness" study, as published by Health Canada in 1996, conservatively estimated the cost of absence and disability to the Canadian economy at $157 billion in 1993 dollars. It did not account for many billions of dollars in premiums and reserves from employer-sponsored Long Term Disability plans. The study has been followed up with one on Mental Health (May 2001), but needs to be refreshed on a regular basis, e.g., every five years.

Strategic Recommendations: Employers

- Many employers could benefit from changes to their organizational culture: they should start by focussing on corporate leadership in the area of workplace health.[71] Employers also need to hire and hone the skills needed to help employees manage workloads and work-family conflicts (including childcare and eldercare), and help create a culture in which demands are controlled and appropriately rewarded. For this, they will need to invest in a new set of integrated measurements to establish baseline conditions and evaluate changes.
- The roles of Human Resources and Occupational Health and Safety are of particular importance in managing workplace health policies and programs, and these two professions must be more closely linked to broaden their respective constituencies and demonstrate the "bigger picture" to organizational leaders. Health programs need to be nested in organizational human resources strategy in order to be sustained and effective. And employers and unions must encourage more flexibility in work design, shift arrangements, task organization, and advancement.
- The employer community, in conjunction with organized labour, needs to invest funds in research on how its policies, programs and practices affect the health or its workforce, and its communities. This research should seek answers to questions such as: What are the most cost-effective, workplace-centred approaches to promoting good health in Canadian workplaces?

Strategic Recommendations: Other Players

- There should be continued financial and logistical support for coordinating workplace health expertise and activities across Canada. Health Canada began this process in mid-2001, through a meeting of organizations interested in Canada's Healthy Workweek, an annual awareness building promotion staged in October each year. This group includes representatives of government, media, insurers, consultants, business groups, occupational health and safety organizations, academia, and several other organizations. Workers Compensation Boards and unions across Canada must also be engaged.

[71] When Magna International initiated their wellness program, they offered it to executives first to increase awareness and support, then went company-wide. Source: Discussion with Magna's occupational physician, Dr. Arif Bhimji, 2001.

Tactical Recommendations: Public Policy

- Private employers should be incented to adopt "best practices" in needs analysis, implementation, and outcomes evaluations, particularly those that focus on prevention, through the tax system and rebates from Workers' Compensation Boards across Canada. Public employers must lead by example. At the same time, their "duty to accommodate" absent workers who wish to return to their workplace must be clarified and reinforced. Government should also provide financial incentives and recognition for early adopters who strive for change, while recognizing that some organizations may legitimately start later and progress more slowly up the workplace health ladder.
- The two main private payers of health services in Canada (consumers and employers) should be courted by the federal and provincial governments. Together, their $28 billion contribution to health services is a crucial element of Canada's $102 billion system. Governments have assumed employers and unions will continue in their willingness to sponsor health plans, but do not include this community in their policy debates or decisions. The CCIH proposed a "Payers' Forum" in its submission to the Commission on the Future of Health Care in Canada.[72] This concept would fulfill the need for relationship building, good will, and ongoing consultation.
- The governments of Canada, and public sector unions, should lead in demonstrating progressive and collaborative management techniques. Both management and union need to understand that their relationship sets a tone in an organization, and "win-lose" approaches create far more losers – especially among those not at the table.

Tactical Recommendations: Employers

- Employers should focus on proactive measures within their control – for example, prevention measures such as free screening for disease or depression, rather than just reactive measures (for example, implementing an Employee Assistance program in response to high stress, absence, and disability incidence).

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[72] The CCIH recommended that the federal government: "Call a National Funders' Forum to explore the current and desired framework for funding and delivery of health services between various levels of government, consumers, private insurers, and employers."

- Employers could take a number of "first steps" towards improved workplace health:
  - Encourage good management practices in the workplace, such as:
    - Increasing employee control and flexibility over how their jobs are performed;
    - Selecting and adequately training employees for their jobs;
    - Ensuring demands are realistic, effort is reasonable, and rewards are adequate. (This includes ensuring that shift work arrangements and hours of work are not onerous and excessive.); and
    - ensuring that fairness is encouraged through a supportive workplace culture.
  - Support access to high quality and necessary health services through comprehensive health insurance plans.
  - Ensure safe and early return to work following illness or injury by accommodating employees' needs through proactive intervention initiatives.
  - Invest in occupational health and safety initiatives beyond the legislated minimums.
  - Obtain expert advice from occupational health specialists, peers, industry associations, or consultants in workplace health.
  - Support educational and active living initiatives focused on health promotion and disease prevention.

These steps may be different, or in a different order, depending on the specific workplace, e.g., for larger and smaller employers, for those in different industries, for office environments, for those located in urban centres or in rural locations, or according to demographic composition (gender, culture, or age), for government or private sector settings, etc. However, once started, employers will develop their own "roadmap" leading towards improved workplace health.

Tactical Recommendations: Other Players

- There is undoubtedly room for greater efficiency and coordination between private insurers, WCB organizations, and government programs, e.g., concerning drug program co-pays.
- Canada's next generation of labour is already in waiting, but health and business programs in universities and colleges seldom teach about the importance and role of health in the workplace. Work-life balance seems only to be learned the hard way, although today's student generation is reportedly more ready to accept this principle. Post-secondary institutions, supported by governments, should develop course content to improve the visibility of the topic for Canadian students.

- Plan members must see the value of investing time to become better educated about their own health, the value of prevention, disease warning signs, and the individual's responsibility to access the system only at points of need. This includes:
  - Continuing their partial financial responsibility for the costs they incur, especially when they choose a less cost-effective alternative form of care; and
  - Respecting family and community responsibilities, especially when they conflict with the workplace.

CONCLUSION

There must be improved recognition of the important role played by the workplace in determining the health of employees, their families, and our communities across Canada. It is clear that if Canada's approach to workplace health is to change, as the Canadian Council on Integrated Healthcare believes it should, this will not be a quick transformation, but will take several years. However, as the 'numbers' section of this paper suggests, the return on investment (in so many respects) will be significant. Healthier workplaces help create a healthier nation; Canada stands to benefit significantly both in the near and distant future.

The CCIH argues that this new approach rests on the shoulders (primarily, though certainly not exclusively) of two key groups. **Government** must support research and practical experiments that establish "best practices" in health management, and help develop health-positive policies and programs for the workplace (for example, through the tax system and/or the WSIB organizations in Canada). **Employers** must recognise their role and responsibility in contributing many billions of dollars for Canada's direct expenditures on health, and even more for disability. They must understand and improve their management practices that affect the health of employees, their communities, and their own long-term success. Labour must also join in this initiative for real progress to occur.

The CCIH calls on these two groups, and all other organizations or individuals involved with or concerned about workplace health issues, to carefully consider the facts and recommendations for change. By discussing the topic together, Canadians can make informed choices about how, when, and why change should take place in Canada's approach to workplace health.

APPENDIX A: ADEQUACY OF WORKPLACE HEALTH RESEARCH TO DATE

The following is a brief review of some of the academic writing on the subject of inadequacies and pitfalls in the area of workplace health research.

Riedel et al. (2001) indicates that "productivity", a term used often in workplace health research, is: infrequently defined clearly; frequently requires different measures based on job differences; and is often subjective in nature. Further, absence, a common performance measurement in workplace health measurement, is often unreliably measured, especially among white-collar workers. Much workplace productivity-related research, therefore, is suspect based on measurement issues alone.

Relatively few workplace health studies have the "experimental" or better "quasi-experimental" designs that allow strong causal inferences to be made (Pelletier, 1999; Riedel et al. 2001; Shephard, 1996). Most often studies are low level quasi-experimental designs or simply one-shot, cross-sectional projects, i.e., correlational in nature, which is the design least able to deal with "threats" to validity (Campbell and Stanley, 1963). As well, very infrequently have there been studies with sampling frames that allow generalization with any form of confidence, and often attrition of subjects from studies renders samples quite different from those originally selected (Pelletier, 1999). Consequently, the applicability of the majority of workplace health research is limited to narrow sectors of industry or simply to the company, or companies, within which the research took place and even that assumes the study sample adequately represents the organization.

Shephard (1996) and Dishman et al. (1998) conclude that strong experimental research (e.g., double blind, randomized, controlled experiments) is very difficult to organize in workplaces. Consequently, there is a high likelihood that there will continue to be reliance on less methodologically acceptable research designs for the development of workplace health knowledge base.

There is also a general lack of research indicating evidence of workplace health promotion effects leading to workplace productivity or performance improvements. Based on two citations, Riedel et al conclude: "Although a modest amount of evidence shows an association between DP/HP[73] efforts and corporate medical costs, little evidence exists showing associations between physical or mental health of workers

[73] DP/HP is a short form for Disease Prevention and Health Promotion.

and improved worker performance." (p. 167). There is a need to "prove" the value of workplace health programs and develop the business case: therefore, more research effort needs to be directed toward studies that specify performance and productivity outcomes. Pelletier (1999) reaches similar conclusions.

Shephard (2002) also challenges many of the findings purported to come from workplace health research and programs. Not the least of Shephard's commentary is his claim that the economic benefits of workplace health promotion programs have been over-sold (e.g., health impacts are frequently over-estimated), over-valued (e.g., economic benefits often exaggerated), and poorly evaluated (e.g., common design flaws and biases in evaluators). Such conclusions may be unflattering, but they signal the need for stronger and better research to be carried out in workplace health.

While the above assessments are relatively bleak, the body of workplace health research reflects what has been possible given the structure of work and the resources many researchers have been working with. Interestingly, in his efforts to provide ongoing evaluation of the effectiveness of workplace health promotion, Pelletier (1993) was willing to make the bold statement, "when anyone cavalierly dismisses 48 studies with glib dismissal of "there is no evidence," they are simply ignorant of more than 13 years of increasingly sophisticated research with documentation of both health and cost outcomes." (p. 51). Pelletier, in his two follow-up evaluations (Pelletier, 1995; Pelletier, 1999), augments his earlier findings with the demonstration of more positive evidence from improved research studies. Furthermore, much of the cited research by Shephard (2002) focused on physical activity interventions in the workplace. If anything, the lack of consistent strong empirical findings and the relatively small apparent payoff, health-wise and economically, strengthens the argument for workplaces to institute integrated, comprehensive health management interventions. That is, health promotion activities, particularly physical fitness promotion activities, on their own are but one quite small part of a much larger enterprise that should be undertaken in work organizations.

Consequently, readers should note that although workplace health research design and methodology improvements are definitely needed there is a considerable amount of positive workplace health research already done that provides a foundation for management and policy decisions and directions to be taken. This is particularly the case when the outcomes being considered are of employee health rather than workplace performance, productivity, or economic benefit.

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APPENDIX B: RESEARCH RELATED TO MENTAL HEALTH AND STRESS IN THE WORKPLACE

The following is a brief (and by no means exhaustive) survey of some of the research in the area of mental health and stress in the workplace:

Mental health and stress in the workplace - a growing concern

The first modern organizational literature, which used the term "Socio-Technical Systems", appeared in the early 1950's based on the mining studies of the Tavistock Institute (Katz & Kahn, 1978). Those early (and later) studies clearly indicated that though new technical systems can be very important contributors to improvements in productivity, unless work design and social elements are taken into consideration those improvements may not be obtained. In the interim period the role of the "social" and "design" aspects of work have waxed and waned. However, there is no doubting that there is a renewed interest in the social-psychological elements of work in very recent workplace literature, most notably under the guise of workplace health (see for example: Duxbury & Higgins, 2001; Health Canada, 2000; Health Canada, 2001; Lowe, 2000; Shain, 1999).

Sparks et al's (2001) review article indicates there have been widespread organizational and economic changes in western industrialized nations heightening perceptions of job insecurity, leading to increases in work hours, decreases in perceptions of job control, and increases in managerial stress levels.

Sparks et al. (2001) also indicates the long term costs to employee health and organizational performance associated with job insecurity are not known, though there are clear cross-sectional relationships with consequences such as increased employee absenteeism, lowered indicators of general health, and reduced commitment and motivation. Several times, Sparks et al. (2001) make the case for the need to demonstrate that cross-sectional findings are replicated in longitudinal studies. This is a frequent lament by other reviewers of workplace health research (e.g., Dishman et al, 1998; Pelletier, 1999; Shephard, 1996; Shephard, 2002).

Health Canada (2000) reports a number of studies suggesting evidence that extreme conditions of high demand/low control and high effort/low reward are associated with elevated levels of ill health usually in the order of two to three times the normal rates of ill-health. The ill health conditions range across a number of important health cost dimensions including: heart problems, back pain, cancers, mental health, workplace conflicts, injuries, and substance abuse.

<u>Stress and work – research on stress management programs in the workplace</u>

Dunnagan et al. (2001) studied the effects of a "traditional" worksite health promotion program and found that it had a limited role in reducing work-related mental health outcomes. The authors suggest that management must play a greater role in efforts to reduce the effects of stress, anger, and depression in the workplace. This finding reinforces the need for workplace health initiatives to be integrated into managerial responsibilities, a finding remarkably consistent with discoveries in other health promotion literature (e.g., Murphy, 1996; Pelletier, 1999; Shephard, 2002).

Murphy (1996) conducted an extensive literature review (64 studies) of research reporting on stress management programs in work settings over a 20-year period (1974-1994). Although there was some inconsistency in health outcome changes being affected by stress management programming, the majority of studies demonstrated positive changes in physiologic/biochemical, psychologic/cognitive, somatic, and job/organizational outcomes. The results were less conclusive when the findings were compared to control groups, which often demonstrated changes over the same period as the treatment groups, diluting the strength of the positive effects found in the treatment groups. On the other hand, the positive health effects were more consistently found for workers suffering from high levels of stress (i.e., treatment oriented) than for more global interventions (i.e., prevention programs given to all workers, regardless of their levels of stress). That particular finding supports the contention that workplace health promotion interventions should be better targeted, particularly aimed at those workers suffering from high levels of a stressor or disease, rather than the more "general" or "education" based types of interventions.

The issue of control or non-treatment groups demonstrating comparable~~,~~ or positive change~~,~~ at the same time as the treatment group is also found quite commonly in the workplace physical activity intervention research (e.g., see Dishman et al., 1998; Shephard, 2002) and the comprehensive workplace health research literature (see Pelletier, 1993 and 1999). The review findings of Murphy (1996) demonstrate that workplace stress management research suffers from the same methodological problems outlined elsewhere in this document for workplace health research efforts, in general.

However, Murphy (1996) cautiously reaches the conclusion that workplace stress management programs do have demonstrable effects, particularly if the technique is matched to the type of outcome, e.g., cognitive-behavioural interventions have strongest effects on psychologic outcomes and relatively lesser effects on physiologic outcomes. Importantly, Murphy (1996) suggests that "stronger" interventions, i.e., combinations of stress-management techniques, produced more consistent results than did individual techniques. This finding supports the need for workplaces to use strong workplace health interventions rather than simply opting for approaches that are simple, easy, and less costly. Clearly more comprehensive and intensive measures have the potential to cost more and to be more disruptive of "normal" workplace routine. Consequently, supportive work environment structures would be required to get such commitments, i.e., there would be a greater need for clear, demonstrable, active support from leadership in the workplace to provide the necessary resources (e.g., finance, human, management flexibility, etc.).

While current research may lead to cautious conclusions about workplace stress management programs leading to demonstrable health outcomes, there is a lack of consistent, strong research that suggests positive performance or productivity-related work outcomes. Murphy (1996) reports the ubiquitous "job satisfaction" as being the most frequently measured workplace outcome. However, for job satisfaction, and less so for absenteeism, individual techniques were not consistently able to demonstrate effects. This, as he also concludes, should not be surprising since stress management techniques do not address the root causes or the origin of the stressors so much as they provide coping techniques to individuals to reduce the effects of the stressors.

<u>Aggression in the workplace</u>

Beyond looking at "stress" in the workplace, much research points to increasing levels of incivility and aggression at work. The workplace was considered "by many to be one of the last bastions of civility. The relationship between coworkers was, for decades, characterized by formality yet friendliness, distance yet politeness" (Andersson & Pearson, 1999, p. 453). This last bastion of civility, however, appears to be disappearing as research reports escalating levels of incivility and aggression in the workplace (Andersson & Pearson,1999; Baron & Neuman, 1996). A large number of reasons are given for the increase, ranging from society in general being less civil to internal organization factors such as downsizing, autocratic work environments, and increased pressure to be productive. However, the vast majority of studies regarding aggression in the workplace focus on the more overt and physical forms of

incivility, whereas much less attention has been given to the much more frequent but less observable forms such as, "rude comments, thoughtless acts, or negative gestures" (Neuman & Baron, 1997 cited in Andersson & Pearson, 1999). These findings indicate that the structure of work, manager-employee relations, and co-worker relations can all affect workplace violence and aggression.

Douglas and Martinko (2001) found that a number of individual factors accounted for a large portion of self-reported incidences in workplace aggression. They suggest that organizational and other group level variables (e.g., teams or units) might interact with, or account for additional variance. While it is clear that aggression is an individual issue, it is also within the obvious purview of management since they can affect the dynamics of managing teams of people and the organization and structure of workplaces.

Calabrese (2000) concludes that there are a variety of organizational, team, and individual level characteristics that are possible causes for workplace anger. This conclusion supports, again, the notion that organization structures, managerial influences, and relationship management are important areas for intervention in workplace aggression.

Andersson and Pearson (1999) coin the phrase "incivility spiral" to posit that the lesser levels of incivility demonstrated by an instigator can, in turn, lead to higher levels of incivility by the target back at the instigator, which then leads to higher levels reflected by the instigator back to the target and so on. This escalation (or spiral) of conflict has been commonly described in the social conflict literature (e.g., Pruitt & Rubin, 1986) and demonstrates how relatively low levels of aggression or harassment can progress to higher and higher levels. Consequently, threatening and abusive comments or nonverbal interactions among people up, down, and across the workplace can result in emotional outburst, or worse, violence if appropriate levels of civility are not maintained. According to Andersson and Pearson, it is the processes that underlie incivility and, particularly, the less obvious gestures, upsets, and threats that need to be studied. If we can better understand the processes that cause incivility to spiral and explode into violence and physical harm, then interventions in workplaces can address causes, or precursors, before the greater harm is done or inflicted.

Psychological contracts are "made up of employee beliefs about the reciprocal obligations between them and their organization" (Morrison & Robinson, 1997). While violations of explicit contracts (i.e., those that are transactional in nature) are subject to clear appeal to higher authority such as grieving or legal recourse, violations of implicit or psychological contracts (i.e., those that are relational in nature) are less able to be handled by formal appeal and can result in a number of individual actions that can have profound effects on the individual and the organization.

Strebel (1996) suggests that employees and organizations have reciprocal obligations and mutual commitments. He says these "personal compacts" can be formal, psychological, and social. Strebel presents a series of questions – from the employee's perspective – designed to help the employee determine the degree of corporate commitment from the employer. His contention is that if a company does not live up to these commitments, conflicts occur and communication with employees breaks down. This can lead to a loss of credibility for management, from which it is very difficult to recover. Strebel also suggests that executives and employees view change differently, with managers often seeing it as an opportunity and employees often regarding it as disruptive and intrusive. He argues that if change is to be effective, the personal compacts that employees have with their employer have to alter, and this takes thoughtful leadership, careful implementation, and evaluation on the part of management.

Morrison and Robinson (1997) list a number of potential effects of such violations on employees: decreased trust of the work organization, reduced job and organizational satisfaction, feelings of less obligation and increased turnover intentions, and reductions in their contributions to their workplace. Given that productivity, turnover, and distancing from the organization are all very important to the stability and performance of an organization, it is clear that violating psychological contracts is potentially a very important consideration for organizations.

While such findings speak to productivity and psychological factors, Shain (2001) has indicated trust and promise-keeping (both explicit and implicit) are very much implicated in the health of employees. He argues that at the foundation of the employee-employer relationship are notions of fairness, justice, and equity. These factors are, potentially, at the very root of workers' perceptions of their work, their supervisors, and the organization as a whole. If a healthy workplace includes the notion that workers' perceptions, attitudes and feelings are causally related to their work performance and behaviours, then these psychological elements are fundamental to creating both healthy workers and workplaces.

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APPENDIX C: A SUMMARY OF CANADIAN ORGANIZATIONAL OUTCOMES

The following table is excerpted with permission from: *Healthy Workplace: A Sound Business Strategy and a Good Investment: A Four Step Guide to Building the Business Case for a Healthy Workplace,* by Geri McKeown. © 2002, National Quality Institute, Toronto, www.nqi.ca.

This table includes organizations that have won the NQI's *Healthy Workplace Award* on the basis of excellence in *comprehensive workplace health promotion*, i.e., opportunities for employees to take responsibility for healthy lifestyle practices supported by a healthy physical and social workplace environment. Details of all winners appear on the NQI website.

Organization	Outcomes
Amex (Canadian Regional Operating Centre), Markham, Ontario ▪ Over 2,000 employees ▪ Results reported for the year 2000 ▪ **2001, NQI Canada Awards for Excellence: Healthy Workplace Award winner**.	Non-experimental ▪ positive trend in employee satisfaction & favourable comparison with 50 Fortune 500 global companies ▪ positive trend in EAP usage ▪ negative trend in attrition rates (23% compared to the Call Centre industry average of 40%) ▪ on-site Fitness Centre at maximum capacity of 650 members ▪ fitness and health services were rated as 100% favourable by participants ▪ 21% of employees work alternative work arrangements ▪ 11 employees utilize the sabbatical program ▪ in 2000, $20,000 US provided through 32 employees to Global Volunteer Action Fund
Celestica International Inc. Toronto, Ontario ▪ 4,802 employees ▪ Results reported for 1998 ▪ **1999, NQI Canada Awards for Excellence: Healthy Workplace Award winner.**	Non-experimental ▪ # and severity of accidents consistently below industrial norm ▪ incidence and level of employee satisfaction with attracting and retaining people with the best qualifications, work/life balance and benefits program
Dofasco Inc. Hamilton, Ontario ▪ 7,300 employees ▪ Results reported in 2001, see the Canadian Labour and Business Centre web site www.clbc.ca for a description ▪ **2002, NQI Canada Awards for Excellence: Healthy Workplace Award winner**.	Non-Experimental ▪ an employee-driven, management supported culture contributed to positive trends in employee participation in lifestyle activities, e.g.,: o more than 3, 500 employees have participated in Back Power sessions o the average number of monthly visits to the company's in-plant fitness facilities increased from under 600 in 1997 to over 1, 500 in 2001 o employee participation in health screening for cholesterol, blood sugar and blood pressure increased from 1,052 in 2000 to 2,136 in 2001 o over 1,200 employees participated in the company's 2001 Active Living Challenge ▪ employee attrition rate remains below 1% (as reported from 1997 to 2001) ▪ for short term disabilities, days of work per claim have gone from an overall average of 95 in 1998 to 59.5 overall average in 2001, a 37% improvement

<table>
<tr><th>Organization</th><th>Outcomes</th></tr>
<tr><td></td><td>

occupational lost time injury frequency cut by more than half going from 7.0 per 200,000 hours worked in 1991 to 2.34 in 2001
occupational working time lost reduced by more than half, going from 1.4 hours per 100 hours worked in 1994 to 0.6 by 2001
decrease by almost half in non-occupational musculoskeletal injuries from 5 cases per 200,000 working hours in 1991 to 2.7 in 2001
company's payments to the Ontario Workplace Safety and Insurance Board dropped considerably (by 63%) from $4.71 per $100 of payroll in 1995 to $1.76 in 2001
from 1995 to 1998, the company's payments in total to WSIB were reduced by more than $6 million
implementing a team-based approach to production lead to increase in employee satisfaction, health and safety performance and overall performance at the manufacturing facility
company and employee charitable donations to civic, cultural, education, health, social services sectors were approximately $3 million in 2001
other awards include:

named one of the world's most sustainable companies by the Dow Jones Sustainability World Index for 4 consecutive years (1999-2002) – based on financial, social and environmental performance
profitable: ranked second in North America (NA) for cost per ton of steel, and near the top of all NA mills for earnings before interest & taxes
ranked second in NA among 30 steel suppliers in the 2002 Jacobson and Associates customer satisfaction survey
winner of the 2001 Canada's Climate Change Voluntary Challenge and Registry Inc. Leadership Award for being one of Canada's industrial leaders in greenhouse gasses reduction
2001, the 35 Best Companies to work for

</td></tr>
<tr><td>MDS Nordion
Kanata, Ontario

1,000 employees world-wide (~700 at Kanata site)
Results reported for 1998
1999, NQI Canada Awards for Excellence: Healthy Workplace Award winner.
</td><td>Non-experimental

turnover rate of 6% (industry norm ~10%)
annual sick day usage is ~4 days average per person per year (Canadian average 7.4)
lost time injuries at an all-time low of 0.25 injuries per 100 person-years
grievances average less than 5 per year (significantly less than in the early 1990's)
2002 Canada's top 100 employers
</td></tr>
<tr><td>NCR Canada Ltd.
Mississauga, Ontario

1,188 employees in Mississauga and 50 branch locations across Canada
Results reported in 2001 or 2002
2002, NQI Canada Awards for Excellence: Healthy Workplace Award winner.
</td><td>Non-experimental

turnover rate of 5% (industry norm ~10%)
overall improvement from 2001 to 2002 in employee satisfaction and commitment and with overall quality of life and how well NCR provides tools to support work/life balance
as a result of implementing the HealthFirst Program (a program designed to improve employee health and to ensure that employees that are injured or ill return to work healthy and productive) NCR Canada experienced a reduction in days lost per employee per year from 3.4 in 1998 to 2.39 in 2001 (Stats Canada average 9.1)
to generate a saving in 2001 of $194,981 in direct savings and $146,235 in indirect (productivity, administration & morale) savings for a total of $341,216
</td></tr>
</table>

Organization	Outcomes
	▪ on-site flu shots have reduced the number of respiratory cases from 22.7% in 1999 to 17.7% in 2001 ▪ Participation rates: o 25% of employees participated in the NCR Canadians Recognizing Canadians program that recognizes employees for their business excellence o 93% participation in the Wellness Program (a program that provides financial support for activities and items that encourage good health and well-being) o 99% of employees enrolled in a voluntary Savings Plan where NCR matches a certain amount per dollar of employee contribution o over 6000 courses offered through NCR's intranet system with a growth in employee usage that could exceed 20 million page requests by the end of 2002 ▪ other Awards include: o 2001, Benefits Canada – Benefits Communication Award for best newsletter "Future Focus" (financial education newsletter) o 2000, Award of Merit Newsletter publication and graphic design "Future Focus" (financial education) o 2000-2001, Benefits Canada – Progressive Software award for the Flex Benefit online re-enrolment tool o 2001, 35 Best Companies to work for o 2001 & 2002, Canada's Top 100 Employers
Telus BC (Corporate Health Services) Burnaby BC ▪ 25,000 employees ▪ Results reported for 1998 ▪ **1999, NQI Canada Awards for Excellence, Healthy Workplace Award winner.**	Non-experimental ▪ savings of $4,500,000, i.e., $3.00 for every dollar spent on the program ▪ in 1998, over 12,500 employees consulted with occupational health nurses, fitness membership neared 3,000, EAP counseled over 1,000 employees and family members, the ergonomics team completed over 1600 work station assessments, and the return-to-work program assisted 60 individuals in its pilot phase ▪ absenteeism in fitness members is 28% less than corporate average ▪ EAP average utilization greater than 10% for last 10 years (national average 4 - 6%) ▪ negative trend in overall absenteeism rate (12 days in 1995 to 9 days in 1998) ▪ absenteeism due to respiratory illness fell more than 7% following flu vaccination clinic ▪ ergonomics training resulted in 57% decrease in repetitive strain injury reports for Operator Services ▪ Telus BC, Operator Services, winner 1999, Canada Awards for Excellence, Quality Award

APPENDIX D: CONTACT INFORMATION AND CCIH MEMBERS

For further information or to learn more about the Canadian Council on Integrated Healthcare, please visit our website at www.ccih.ca, or contact:

Anthony May
Chair, Canadian Council on Integrated Healthcare
☎604-602-7909 / Anthony_may@maritimelife.ca

Members

Sharon Blaney, R.N., COHN(C), COHN-S
International Productivity Options, Surrey, BC

Chris Bonnett, MHSc
H3 Consulting, Toronto, ON

Suzanne Caron, F.S.A., F.C.I.A.
La Survivance, Montréal, QC

Wendy Graham, MD
Ontario Medical Association, North Bay, ON

Shelley A. Kee
Atlantic Blue Cross Care, Moncton, NB

Russell H.T. King, MD
Family Practitioner, Fredericton, NB

Jacques L'Espérance, F.S.A., F.C.I.A.
Buck Consultants, Montréal, QC

Yves Lorion, B.Com.
Aventis Pharma Inc., Laval, QC

Anthony E. May
Maritime Life Assurance Company, Vancouver, BC

Jim Norton
Toronto, ON

Dave Patterson
Ontario Labour Relations Board, Toronto, ON

Steven Semelman, B.Sc.Pharm., Pharm. D.
ESI Canada, Mississauga, ON

Cyril Theriault
Government of New Brunswick, Fredericton, NB

Kevin B. West
Rx Canada, Toronto, ON

Durhane Wong-Rieger, Ph.D.
Anemia Institute / Advocare, Toronto, ON

John Yardley, Ph.D.
Brock University, Workplace Health Research Unit, St. Catharines, ON

Observer

Denis Roch,
Canadian Medical Association, Ottawa, ON

Support

Ginette David (Administration)
Aventis Pharma, Laval, QC

John Elliott (Project Manager)
Aventis Pharma, Aurora, ON