Making Health the CFO's Business

FINDINGS FROM THE INTEGRATED BENEFITS INSTITUTE'S 2011 CFO SURVEY

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Executive Summary

The Integrated Benefits Institute (IBI) has conducted three surveys on the attitudes, beliefs and experiences of senior financial officers (CFOs) over the past decade concerning the employers' role in managing health, absence, productivity and disability. This survey of CFOs investigates how benefits managers and others can best suggest to financial executives that health initiatives should be viewed as an investment. What factors regarding health-related outcomes must be included? What types of information are likely to be most helpful and credible, and where will they come from? What are the most likely pathways that CFOs see—from poor health to financial performance? How can health-related productivity best be defined and measured?

More than two-thirds of the 313 CFOs surveyed agree that health is a cultural or financial priority in their organizations. Responses highlight a subset of what we call in this report "Health + Productivity Leaders" (H+P Leaders), who demonstrate an especially strong perspective on the importance of workforce health to their businesses. The report examines factors associated with that viewpoint, including how best to communicate with H+P Leaders concerning health decisions. Findings also demonstrate that CFOs view the impact of health on financial performance in both conventional (e.g., healthcare expenses and sick-day absences) and less conventional ways—with H+P Leaders exhibiting a broader understanding of those drivers.

Finally, the results suggest specific approaches that CFOs, and those seeking their partnership, can take to foster an understanding of the full potential for health and health interventions as an investment in improved productivity and business performance.

IBI and CFO Research Services (the research arm of CFO Publishing LLC) collaborated to develop and field the survey via e-mail. IBI performed the analysis. Participation by CFO Research Services was funded by Novartis.

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Integrated Benefits Institute
February 2012

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Principal Findings

- **CFOs are key participants in benefits decisions.** Eight in 10 CFOs report that finance professionals play a role in their organizations' healthcare benefits decisions, usually in collaboration with human resources (HR) and executive leadership and often with operations.

- **Health is an organizational priority.** More than two-thirds of CFOs report health as a cultural or financial priority in their organizations. However, the patterns of their responses indicate the existence of a subset of CFOs from organizations with an especially strong perspective on the importance of workforce health to the business. In this report, we term these "Health + Productivity Leaders" (H+P Leaders). About one in three CFO respondents is identified as an H+P Leader.

- **Productivity is critical to the bottom line, but the role of health is less clear.** CFOs tend to view productivity as an important direct contributor to the bottom line and as an indirect contributor through meeting customer and market needs. However, they view employee health as a less important driver of workforce productivity than other factors such as employee training and retention. H+P Leaders are among the most likely to describe employee health as important to productivity.

- **CFOs understand that health impacts financial performance.** CFOs view health as having an impact on financial performance in both conventional (e.g., healthcare expenses and sick-day absences) and less conventional ways (e.g., opportunity costs and requirements for larger-than-optimal staffs). H+P Leaders are more likely than others to recognize the impact of poor health on important—but difficult to measure—concepts such as opportunity costs and health-related turnover. *Days absent* emerges as an important health and productivity measure for CFOs.

- **Internal information is the most credible to guide action.** Generally, CFOs find information from their own organizations (such as claims costs, employee surveys and program results) to be more credible than external sources of information, modeled estimates or recommendations from suppliers or consultants. CFOs who receive benefits program results in terms of their own strategic financial goals assign more credibility to supplier/consultant recommendations than do other CFOs. They also are more likely to link the health of the workforce with the financial performance of the organization.

- **Critical information is lacking.** CFOs have ample access to some types of helpful information when making decisions about improving the health of the workforce—such as benefits costs, sick-leave days and measures of employee satisfaction and productivity—but face substantial information deficits in areas they view as helpful, such as for return-on-investment (ROI) analysis from health interventions and for the impact of health on work performance or quality. Information deficits tend to be self-inflicted, however, because the availability of helpful information is one of the distinguishing characteristics of H+P Leaders. H+P Leaders have an information advantage with regard to the impact of health on work performance, workforce health risks, employee satisfaction and ROI from health interventions.

- **CFOs suggest ways to measure lost productivity.** CFOs made several suggestions about "the best way" to measure health-related lost productivity. The most commonly suggested measures were the cost of absence days followed by more-conventional productivity metrics (e.g., output to labor input).

Introduction: A Broader View of Health

The research literature demonstrating the link between workforce health and business productivity is large and well established.[1] Researchers consistently find that employees with health conditions such as depression, diabetes and obesity have more sick-day and disability absences and worse job performance than their healthier peers.[2] There is also ample evidence that employees who engage in healthier behaviors—such as exercise, avoiding tobacco and maintaining healthy cholesterol, blood sugar and triglycerides—have better productivity outcomes.[3]

To the extent that productivity contributes to an organization's capacity to accomplish its missions and meet its financial goals, workforce health and organizational performance are linked by definition, even if only indirectly. The business "opportunity costs" of each lost work day—in missed sales and deliverables, overtime and extra staffing costs—are estimated to be in the range of 26% to 41% of daily wages and benefits.[4]

Researchers are not the only ones who recognize this connection between the health of a company's workforce and how well it performs. In a recent IBI study, benefits managers and HR professionals cited reducing health-related lost productivity as a primary or secondary goal of their health promotion, disease management and return-to-work programs nearly as often as they cited reducing medical and pharmacy costs.[5]

The business case for workforce health as an investment in productivity is clear to researchers and benefits professionals. However, the challenge of making that case in terms that resonate with senior management in a climate of economic uncertainty remains daunting.

To better understand how CFOs currently perceive the health of the workforce as a human capital resource, and factors influencing this perception, IBI partnered with CFO Research Services, a unit of CFO Publishing LLC, to survey more than 300 CFOs, controllers, directors, vice presidents (VPs) of finance and treasurers at firms of a variety of sizes across a range of industries.[6] We label respondents generically as CFOs for the remainder of this document.

[1] For a general overview of the approaches and findings of this literature, see Kessler RC and Stang PE, eds. *Health and Work Productivity.* Chicago: University of Chicago Press; 2006. Also see Green GM and Baker F. *Work, Health, and Productivity.* New York: Oxford University Press; 1991.

[2] Kessler RC, Barber C, Birnbaum HG et al. Depression in the workplace: effects on short-term disability. *Health Affairs.* 1991;18(5):163–171; Integrated Benefits Institute. "Diabetes—How Employers Can Defuse a Looming Time Bomb in Their Workforce." November 2011. *<http://ibiweb.org/do/PublicAccess?documentId=1165>;* Finkelstein EA, Dibonaventura MD, Burgess SM et al. The costs of obesity in the workplace. *Journal of Occupational and Environmental Medicine.* 2010;52(10):971–76; and Loeppke R, Taitel M, Haufle V et al. Health and productivity as a business strategy: a multiemployer study. *Journal of Occupational and Environmental Medicine.* 2009;51(4):411–28.

[3] Laaksonen M, Piha K, Martikainen P et al. Health-related behaviours and sickness absence from work. *Journal of Occupational and Environmental Medicine.* 2009;66:840–47; and Goetzel RZ, Carls GS, Wang S et al. The relationship between modifiable health risk factors and medical expenditures, absenteeism, short-term disability, and presenteeism among employees at Novartis. *Journal of Occupational and Environmental Medicine.* 2009;51(4):487–99.

[4] Nicholson S, Pauly M and Polsky, D. Measuring the effects of work loss on productivity with team production. *Health Economics.* 2006;15:111–23; and Nicholson S, Pauly M and Polsky D et al. How to present the business case for health quality to employers. *Applied Economic Health Policy.* 2005;4(4):209–18.

[5] Gifford B, Molmen W and Parry T. *More than Health Promotion: How Employers Manage Health and Productivity.* San Francisco: Integrated Benefits Institute; 2010.

[6] See the Appendix for a summary description of the sample respondents.

For this study, we focused on CFOs' responses to several broad question areas:

- **How do CFOs view workforce health as a priority in their organizations?** We are particularly interested in whether patterns can indicate a strong "culture of health" that might foster a greater recognition of the impact of health on the bottom line and a greater openness to information demonstrating that link.
- **How do CFOs view the relationship between the health of employees and the health of the bottom line?** Are CFOs in companies with a strong culture of health more likely than others to make this connection? When CFOs recognize that health plays a role in business performance, what particular aspects seem to matter most?
- **What types and sources of information do CFOs find credible in assessing the link between health and organizational performance?** This question is crucial because demonstrating the potential to improve business performance through investments in the health of human capital stands to be much more effective when CFOs are understood as consumers of information with a particular (financial) worldview. To that end, we further explore whether presenting information in terms that reflect a firm's financial goals increases its credibility and whether information is given more credibility by CFOs in companies with a strong culture of health.
- **Given the information that CFOs find credible, we address what information they would like to have when making decisions about investments in workforce heath but that currently is unavailable in the organization.** A subset of CFOs also suggests how they ideally would measure health-related lost productivity.

We conclude the study by summarizing the results and suggesting how advocates for initiatives that contribute to a healthier workforce—including researchers, benefits and wellness managers, and healthcare and wellness suppliers—can best make a convincing case for why a healthier workforce is an investment that pays off in more than just reduced medical and pharmacy costs.

Workforce Health as Seen from the C-Suite

There is no shortage of evidence suggesting that employers stand to gain a great deal by ensuring that their workers are healthy enough to show up for work consistently and work at their peak capabilities—and that employers have much to lose when they neglect the health status of the workforce.

Translating the weight of that evidence into practical action, however, requires getting information into the hands of organizational stakeholders who value it and who are in a position to act on it. With that in mind, we directed our survey toward CFOs for two important reasons. First, as principals in their organizations, CFOs are likely to have an enterprise-wide view that provides a bottom-line context to questions about investments in human capital. Second, because CFOs are responsible for how financial resources are used, we expect that they will play a role in making decisions about the design and the financing of health benefits and programs.

Our survey results bear out this second point. The vast majority of respondents (more than eight in 10) indicate that finance personnel are involved in determining health-related employee benefits. They are almost never the sole decision-makers (only about 2% play this role); rather, they make decisions about health-related benefits in collaboration with an average of three other departments, most frequently human resources and executive management and often with operations (which is critical to the delivery of products and services to the marketplace).

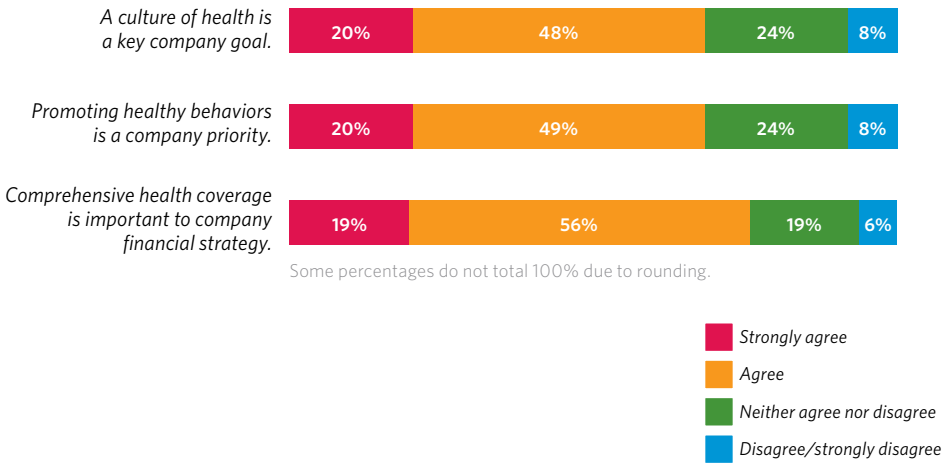
How do CFOs view health as a priority in their organizations?

Results suggest that CFOs are receptive to the positive message about the impact of health on productivity. Almost seven in 10 respondents agree that promoting healthy behaviors and building a culture of health is a priority within the company, and only a handful (fewer than one in 10) disagree with these statements. The belief that providing health benefits is important for their company's financial strategy is stronger still (about three of four respondents agreed).

Given the correspondence in responses to these three questions, it is reasonable to view them together as a measure of how CFOs perceive the importance of a health-focused culture in their companies. This is confirmed through a statistical technique called "factor analysis."[7] While we find that CFOs broadly agree to each of the health-culture questions, if we treat the responses numerically (*strongly agree* = 5; *agree* = 4; *neither agree nor disagree* = 3; *disagree* = 2; and *strongly disagree* = 1), about one in three CFOs has average responses that indicate agreement or strong agreement with all three items (i.e., an average score above 4.0 on the combined health-culture scale).[8]

We refer to these high-scoring CFOs and their organizations as H+P Leaders. To the extent that they share the values of their corporate culture of health, we expect that these CFOs are the most likely to perceive the link between health, productivity and financial performance and to be the most discriminating consumers of health and productivity concepts and information. Importantly, we find that no single type of organization dominates H+P Leadership: being a leader does not depend on company characteristics that are unlikely to markedly change, such as industry, workforce size or corporate revenue.

HEALTH AS A CORPORATE PRIORITY



Some percentages do not total 100% due to rounding.

[7] In general, factor analysis takes into account how answers to particular survey questions correspond with one another, on the assumption that the patterns reflect some underlying—but not easily observable—beliefs or points of view. It is frequently used in survey research because it allows questions with high correspondence to be meaningfully combined into a scale. This is useful because it allows for the analysis of a smaller number of questions without losing the richness of the data and because responses to multiple questions often are a better gauge of an overall viewpoint than the response to a single question. For a deeper introduction to factor analysis, see Kim JO and Mueller CW, *Introduction to Factor Analysis: What Is It and How to Do It*, London: SAGE Publications, 1978. We employ factor analysis to create scales from corresponding questions throughout this study, and we report responses for scales and individual questions where appropriate. In creating scales, we take the average scores across the questions and round the result so that the scale reproduces the original response category values.

[8] Arithmetically, a CFO could be considered an H+P Leader by responding *strongly agree* to two questions and *neither agree nor disagree* to one question. Only three H+P Leaders responded in this way.

How do CFOs see the relationship between health and the bottom line?

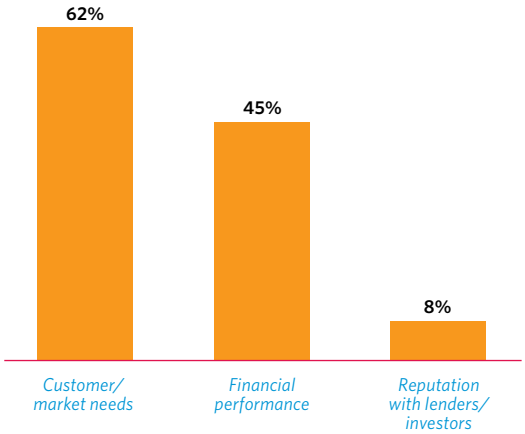
Considering that many of the CFOs we surveyed work in companies that broadly acknowledge the importance of health as a corporate value or financial strategy, we next examine how they view the role of productivity (whether health-related or not) as a contributor to financial performance (again using factor analysis to develop scales from several survey questions).

CFOs understand that workforce productivity is critical to the bottom line, directly as well as indirectly through aspects such as customer satisfaction, effective delivery of products and services, and corporate reputation. Almost half the respondents report that productivity is one of the most important drivers of financial performance. This compares well with how CFOs link productivity to their ability to meet customers' or market needs (six in 10 responded that productivity was "one of the most important factors")[9] and greatly exceeds the perceived link between productivity and the company's reputation with lenders and investors (one in 12 responded that productivity was "one of the most important factors").[10]

But what of health's role in productivity? Per the graph on page 8, more than nine in 10 cite health as at least *moderately important* to productivity (30% say it is *very important*). At the same time, one may not expect CFOs to rate the impact of employee health as highly as some of the more conventional and better-established indicators, such as skill level, headcount and (in these turbulent economic times) downsizing and the need to do more with less.

Although health is at least moderately important, CFOs rank other items above health in productivity

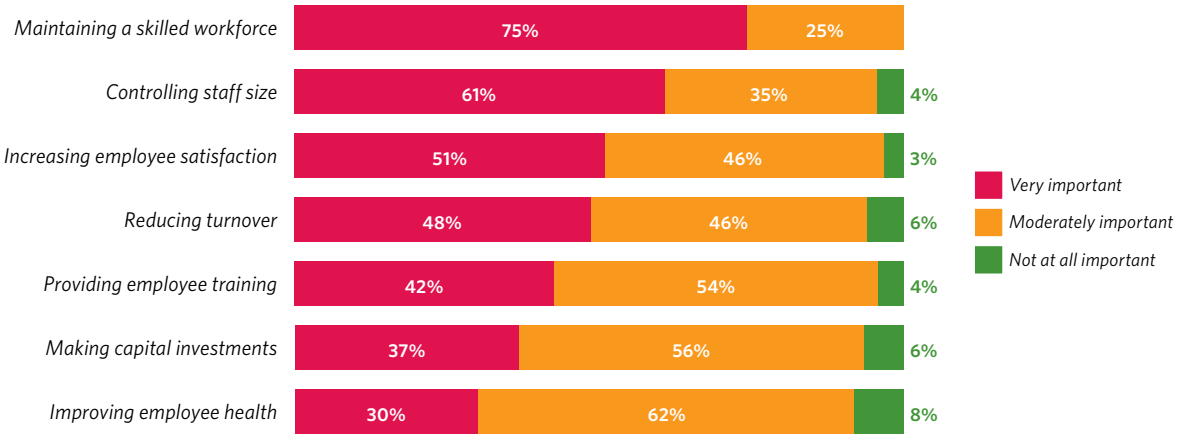
WORKFORCE PRODUCTIVITY AS ONE OF THE MOST IMPORTANT FACTORS FOR...



[9] As indicated by average responses to questions about "customer satisfaction" and "product or service delivery."

[10] As indicated by average responses to questions about "credit rating" and "market valuation."

IMPORTANCE TO WORKFORCE PRODUCTIVITY OF...



Some percentages do not total 100% due to rounding.

impact. Two "human capital factors"—skilled workers and staff size—are identified at the top of the CFO list as productivity drivers. Four items—employee work satisfaction, turnover, employee training and capital investments—all are ranked above health.

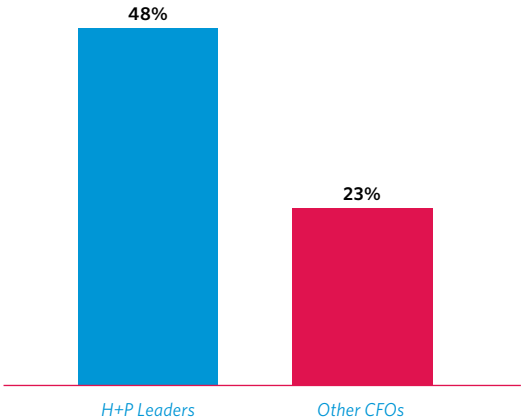
Rather than be discouraged by this finding, benefits professionals may see an opportunity. CFOs recognize the importance of assembling a qualified, trained, satisfied and efficient workforce but need convincing as to how health is integral to sustaining the productivity of those employees. There are at least three encouraging points relating to the potential for success in these efforts.

First, because the productivity impact of improving workforce health is relatively under-recognized, there is still a competitive advantage to be gained by early-adopting organizations. By contrast, productivity practices such as investing in skills and promoting job satisfaction have become standard in most fields, to the point where they are essential for being in business at all. Generally speaking, firms can be better or worse on these dimensions, but, from a competitive standpoint, any practice that is universally adopted will sooner or later reach a point of diminishing returns.

Second, despite the comparatively low rating of health as a productivity driver compared with more-traditional measures, results from the factor analysis suggest that CFOs consider employee health an element of an underlying concept we describe as "human capital investments," which includes other items such as employee training, satisfaction and retention. The fact that these other elements of human capital have become widely recognized for their productivity impact bodes well for health, as part of the underlying concept, to be similarly recognized. In addition, ratings for the human capital investment scale, including improving health, average higher than for other capital investments such as technology, facilities and machinery.

Finally, some CFOs in our sample are more likely to get the message about health and productivity. We found that CFOs in H+P Leader organizations are twice as likely to consider employee health a *very important* contributor to workforce productivity. This suggests that any trends toward the promotion of health as a corporate social value—whether driven by the changes in the larger culture or out of the financial imperative to slow or reduce rates of growth in medical and pharmacy costs—could bring greater recognition to its bottom-line value as well.

PERCENTAGE WHO SAY THAT IMPROVING EMPLOYEE HEALTH IS VERY IMPORTANT TO WORKFORCE PRODUCTIVITY



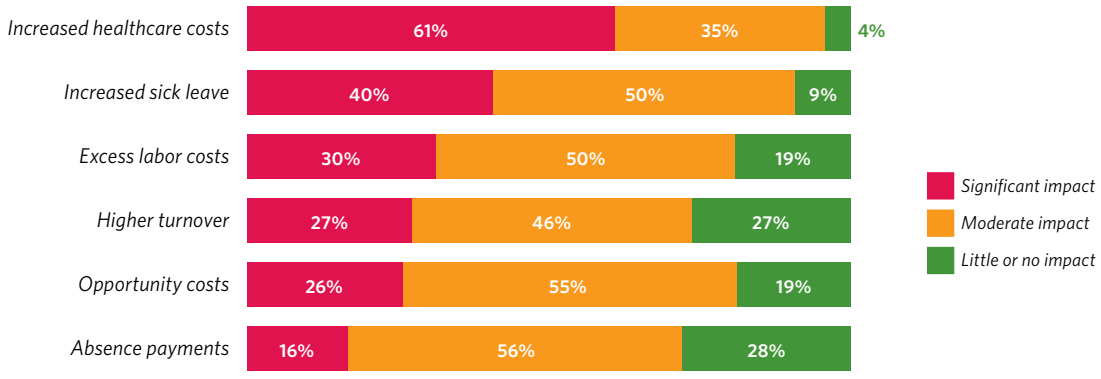
What is it about health that seems to matter?

As the research literature describes, there is no single way in which health impacts productivity, and we expect that CFOs would recognize a variety of pathways through which poor workforce health translates into financial performance. We therefore asked CFOs to describe the various ways in which poor health in the workforce impacts the company's financial success, and we then reduced the number of survey items by creating scales based on the results of the factor analysis.

Overall, CFOs most frequently cited tangible, directly measurable pathways from poor health to financial performance. Six in 10 CFOs indicate that poor health in the workforce significantly impacts financial performance through increased healthcare costs, while four in 10 cite a significant impact through increased sick days.

Yet, CFOs also are relatively willing to ascribe a significant role to less "direct" effects. For example, three in 10 believe that poor health has a significant impact on their financial success by imposing excess labor costs (for example, by requiring a larger workforce than they would otherwise need or increasing their reliance on overtime and extra hours). A similar proportion of CFOs views poor health as contributing to business "opportunity costs" incurred through such channels as missed revenue opportunities, reduced quality of products and services, and reduced employee satisfaction. Turnover related to health is also seen as detrimental to financial performance.

PATHWAYS OF POOR HEALTH TO FINANCIAL PERFORMANCE



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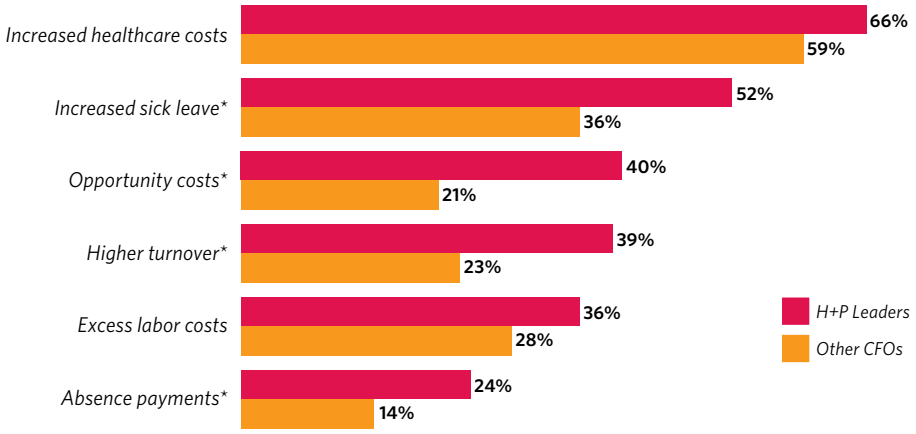
PATHWAYS OF POOR HEALTH TO FINANCIAL PERFORMANCE:
H+P LEADERS vs. OTHER CFOs



Percentage of CFOs indicating a *significant* impact on financial success

**Statistically significant differences*

A Role for H+P Leaders

Yet again, H+P Leaders are more likely to recognize the important role of health on the bottom line than are other CFOs. Perhaps more interestingly, the gap in that recognition increases as the impact of health on financial performance becomes less measurable in financial terms.

For example, there is no statistically significant difference between the 66% of H+P Leaders who cite healthcare expenses as having a significant impact on financial performance and other CFOs (59%). In effect, CFOs from both types of organizations recognize that health in the workforce drives healthcare costs. The 12% difference is likely due to chance in survey sampling.[11] The same can be said of the 29% gap in how CFOs perceive the impact of excess labor costs attributable to poor health.

For several other factors, the gap grows as the factor is perceived to be less measurable in financial terms. This appears most strongly for business opportunity costs, where H+P Leaders are 90% more likely than other CFOs to see the significant impact of poor health (40% of H+P Leaders compared with 21% of other CFOs). The differences between the two groups of CFOs for higher turnover and sick leave are also relatively large (70% and 44%, respectively) and statistically significant.

A possible exception to this pattern (the gap widening as the factors are perceived to be less measurable) relates to wage replacements paid to absent workers. There is a statistically significant 71% gap in the way that H+P Leaders and other CFOs view this impact from poor health. Though wage replacements could conceivably be measured, perhaps non-leader CFOs simply haven't asked for it. Or they may believe that they would be paying absent workers their wages anyway, whether at work or not, without regard to the employee replacement costs they undoubtedly pay to get the absent employee's job done.

[11] That is, the differences in the percentages across the H+P Leaders are not statistically significant at the commonly accepted level of significance (0.05). This means that if there is, in fact, no difference between how CFOs in organizations with strong and weaker health cultures view the link between poor workforce health and healthcare expenses, we would still expect to see a difference this large in about 5% of survey samples purely due to chance.

What types of information do CFOs find credible in assessing the link between health and organizational performance?

We know that CFOs view productivity as an important contributor to the bottom line but view employee health as a less important driver of workforce productivity than other factors, such as training and retention. At the same time, large proportions of CFOs in our sample describe poor health as having a significant impact on financial performance through factors that influence productivity (for example, opportunity costs, sick leave and turnover).

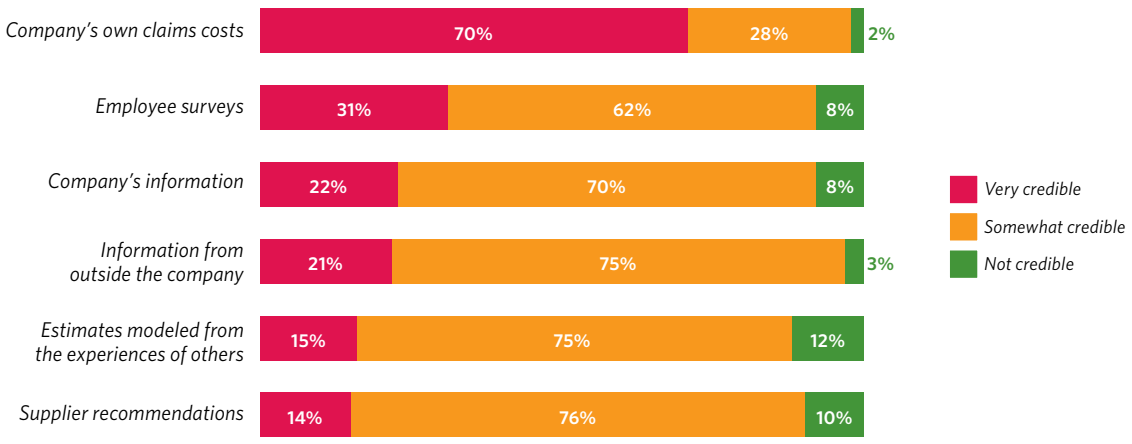
CFOs as a group appear poised to recognize the established links between workforce health, productivity and financial performance in more-direct and concrete terms. Yet, making the case for these links still will likely require the presentation of evidence (whether on a company-by-company basis, in the trade publications, at professional conferences or in the national media) in ways that resonate with financial executives.

To facilitate this effort, we asked CFOs to describe the credibility of various information sources they might be presented when making decisions about improving workforce health. We then used factor analysis to group information types based on the correspondence among the responses. The final list of information sources is shown in the graph below.

With some notable exceptions, very few CFOs describe any information sources as *not credible*. However, by at least a two-to-one margin, CFOs give the highest credibility to results from their own claims experiences; seven in 10 find this information *very credible* (as opposed to only *somewhat credible* or *not credible*), and there was near-unanimity that claims data are at worst *somewhat credible*. Employee surveys are also given relatively high credibility, as are other internal sources of information generated from a company's own experiences (such as from pilot programs, medical screening and recommendations from an internal benefits professional).

While giving highest priority to company claims costs, surveys and internal information, CFOs' responses nonetheless suggest an openness to external sources of information (in fact, in a separate survey item, only one in three CFOs would consider *only* objective measures from within the company when assessing the need for health improvement). One in five CFOs considers as *very credible* information sources from outside the company (such as information on best

CREDIBILITY OF INFORMATION IN MAKING DECISIONS ABOUT IMPROVING WORKFORCE HEALTH



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practices, external research and results from competitors' health improvement initiatives), but only 3% find these to be *not credible*.

The least credible are estimates modeled from the experiences of other organizations and recommendations from benefits suppliers and consultants. In each of these categories, between one in 10 and one in eight CFOs found the information *not credible*, nearly the same portion that saw them as *very credible*.

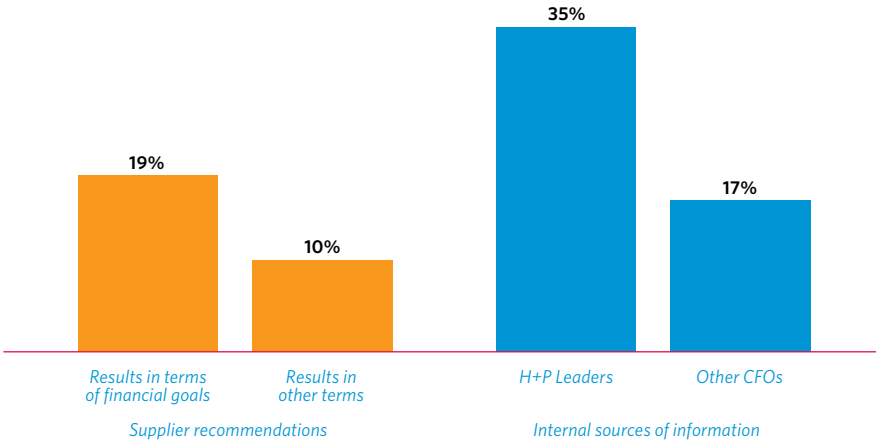
These may be unsurprising findings: Modeled outcomes can be couched in terms of esoteric statistical techniques that may be viewed with suspicion; and CFOs may be understandably wary of advice from supplier entities they perceive to have a financial interest in decisions about improving employee health.

At the same time, the relative rankings of credibility may reflect the manner in which the information is presented to CFOs. For modeled outcomes and outside recommendations (or any other type of information), presenting information in ways that reflect CFOs' financial worldview may enhance that information's credibility. As a proxy for how CFOs typically receive information on health improvements, we asked if they agreed that benefits managers reported program results in terms of importance to the CFO's strategic financial goals. Only about two in five CFOs responded affirmatively.

We find that CFOs who received reports on health programs in terms that resonated with the firm's strategic goals assign significantly higher[12] credibility to supplier recommendations by nearly a two-to-one margin. For example, 19% of CFOs who receive reports in terms of their strategic financial goals find supplier recommendations *very credible* compared with 10% of other CFOs. For other types of information, there were no discernible differences in credibility.

Nor do we find that CFOs in H+P Leader organizations generally assign credibility to information differently than do other CFOs, with one notable exception: H+P Leaders are twice as likely as other CFOs to rate information from their own companies' experiences as *very credible* (35% compared with 17%).

PERCENTAGE OF CFOs DESCRIBING A SOURCE OF INFORMATION AS VERY CREDIBLE



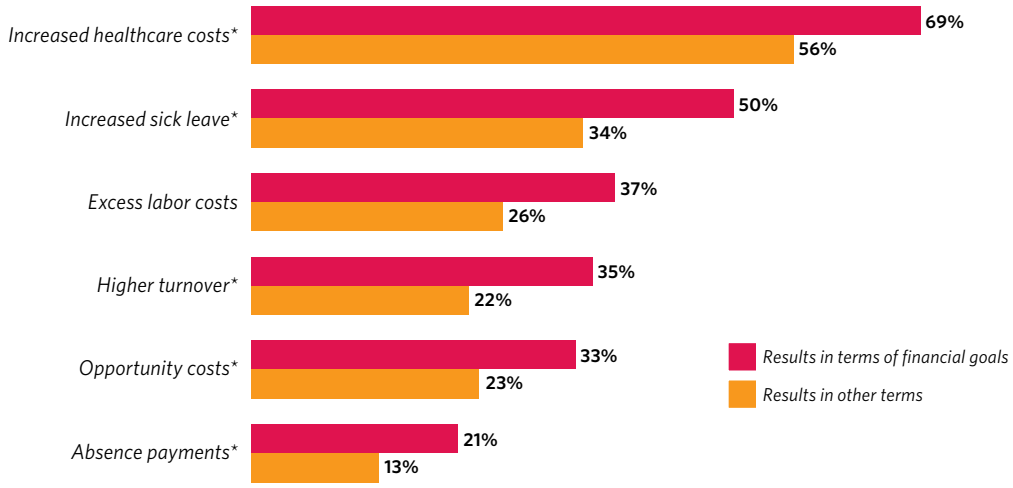
[12] The results are significant at the 0.10 level rather than the stricter 0.05 level.

Nonetheless, receiving program results in the CFO's own financial terms also seems to characterize a stronger tendency to believe that health has a "significant impact" on financial performance through various factors.

This is most apparent with absence payments and higher turnover. In each case, CFOs who received information in financial terms were roughly 60% more likely to agree that poor health impacted their financial success through these pathways. That tendency was also strong for opportunity costs (43% higher among CFOs who received information in their own financial terms) and sick leave (47% higher).

These results are consistent. For every category, CFOs who receive program results in their financial terms are more likely than other CFOs to perceive a significant impact of health on financial performance. For only one category are the differences likely due to chance in the sample: excess labor costs—a scale measuring agreement about the impact of poor health on financial success by requiring a larger workforce than they would otherwise need or increasing their reliance on overtime and extra hours.

PATHWAYS OF POOR HEALTH TO FINANCIAL PERFORMANCE:
RESULTS IN TERMS OF FINANCIAL GOALS vs. OTHER TERMS



Percentage of CFOs indicating a *significant* impact on financial success

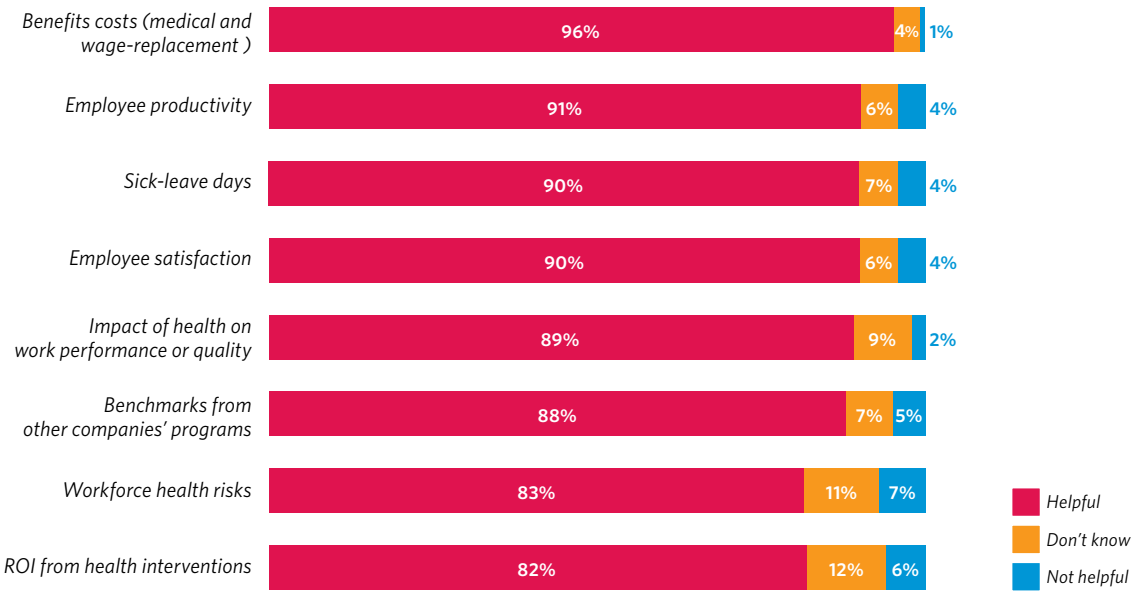
**Statistically significant differences*

What kinds of information would CFOs like but are unable to get?

We asked CFOs about the helpfulness and the availability of various types of information in making decisions about improving the health of their workforce. For the most part, CFOs saw utility in each type of information, but the availability of key information is problematic.

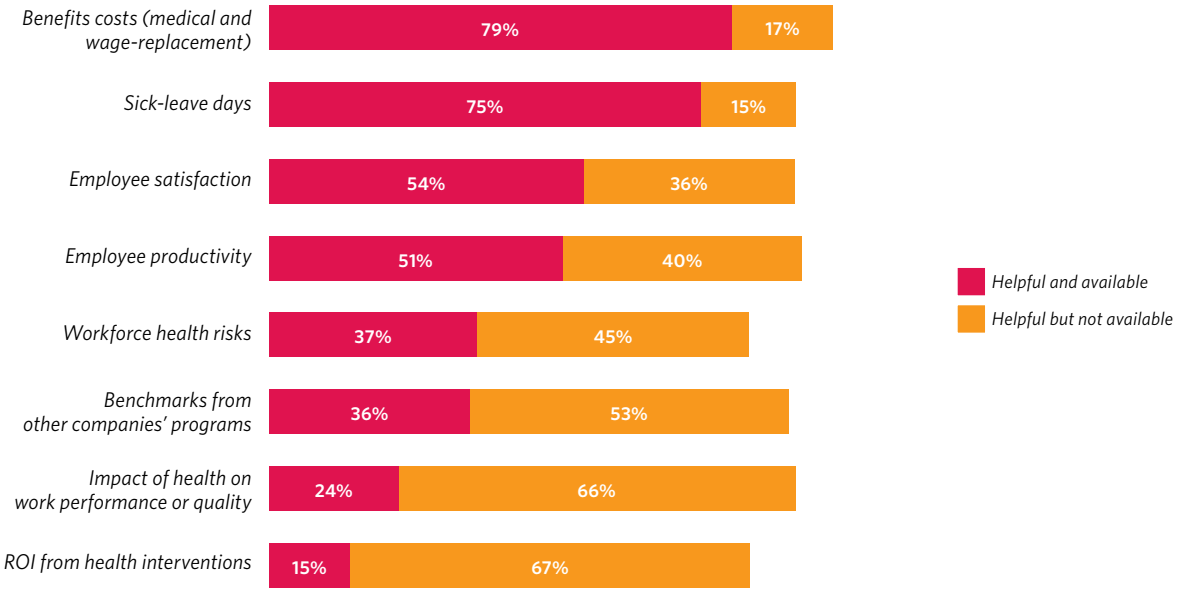
On each of the eight information dimensions surveyed, a large majority of the CFOs report that the information would be helpful in making decisions about improvements in workforce health. For four of the sources, at least nine in 10 find them helpful: benefits costs (medical and wage-replacement), employee productivity, sick-leave days and employee satisfaction. Between eight and nine find the other four sources helpful: impact of health on work performance, benchmarks from other companies' programs, workforce health risks and ROI analysis.

HELPFULNESS OF INFORMATION



Some percentages do not total 100% due to rounding.

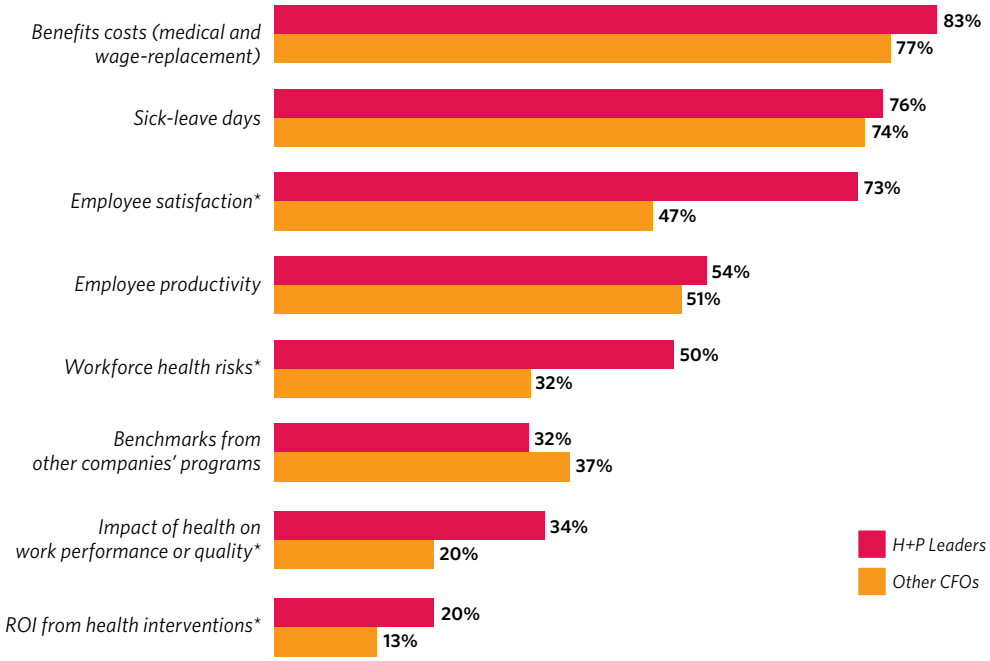
AVAILABILITY OF HELPFUL INFORMATION



Some percentages may not total the *Helpful* percentages shown on page 14 due to rounding.

However, not all of this helpful information is available to CFOs. Not surprisingly, information on benefits costs (medical and wage-replacement) is most available. Interestingly, a majority of CFOs report that information on sick-leave days is also available. The four most challenging areas of "helpful information" by order of unavailability: ROI from health interventions, the impact of health on work performance or quality, benchmarks from other companies' programs, and workforce health risks. These types of information are available only to a minority of CFOs who believe they would be helpful.

AVAILABILITY OF HELPFUL INFORMATION IN MAKING WORKFORCE HEALTH IMPROVEMENT DECISIONS: H+P LEADERS vs. OTHER CFOs



*Statistically significant differences

The availability of helpful information is yet another of the distinguishing characteristics of H+P Leaders. With the exception of benchmarks from other companies' programs, H+P Leaders are more likely than other CFOs to report greater availability of all types of helpful information. The greatest information advantage is observed for the impact of health on work performance or quality, where H+P Leaders are about 70% more likely than other CFOs to have information available (34% compared with 20%). The information advantages for ROI from health interventions, workforce health risks and employee satisfaction are similar to one another, with H+P Leaders about 50% more likely than other CFOs to have information available (although the difference in ROI availability is significant at the 0.10 level rather than the stricter 0.05 level). The differences observed for all other measures are likely due to chance in the sample.

It may be, of course, that the H+P Leaders simply have obtained such information in accord with their greater interest in the business impact of health. Much of this information is available in the marketplace, particularly through tools that capture employee self-reported information.[13] The challenge remains in determining the ROI from health interventions. Without well-designed randomized control studies of such interventions, conclusions about individual strategies are very difficult to assess.

[13] *Workforce Health and Productivity: How Employers Measure, Benchmark and Use Productivity Outcomes.* Jointly developed by Riedel & Associates Consultants, Inc. and the Integrated Benefits Institute. August 2011. Accessed January 20, 2012, at *http://www.ibiweb.org/research_toolcasestudies.*

What do CFOs suggest as the best way to quantify health-related lost productivity?

In drafting our survey questions, we recognized that it would be impractical to present respondents with an exhaustive list of different ways to assess the impact of health on their business operations and, ultimately, financial success. The survey therefore included an open-ended question inviting CFOs to offer their opinions on the best way to quantify health-related lost productivity. About 70% of respondents offered suggestions. We analyzed these responses and organized them into thematic categories based on the inclusion of specific concepts or keywords.[14] The most common categories are shown in the graph below.

By far the most common suggestion is to quantify the cost of absence days. The next most common suggestion was a ratio of some measure of output (such as sales or items produced) per labor input (typically per healthy person). Expressing productivity results using absence days and some sort of output ratio would address measures suggested by nearly two of three respondents.

[14] Some respondents suggested more than one measure, and some measures touched on more than one theme; in either case, these responses are counted as many times as is appropriate.

Conclusion

What makes an H+P Leader?

We've shown how the attitudes and the beliefs held by Health + Productivity Leaders differ from those of other CFOs, but is a "Leader" designation simply capturing other immutable attributes of CFOs and their companies?

We find this not to be the case.

Being an H+P Leader does not depend on characteristics of an organization that are unlikely to markedly change, such as industry, revenue and workforce size. None of these characteristics independently impacted the likelihood of a CFO's being an H+P Leader. CFOs who recognize the impact of health on the bottom line can be differentiated for that very reason and are found across a variety of organizations.

CFOs share basic perspectives on decision-making information.

We have established that there exists a caliber of CFO who sees stronger connections between employee health and the bottom line and has greater access to helpful information when making decisions about workforce health improvements. At the same time, H+P Leaders and CFOs are generally in agreement on the relative credibility of different types of information.

How benefits professionals report information to CFOs is critical.

Despite similarities in how H+P Leaders and other CFOs rank the credibility of information, the framing of results and information matters a great deal. Putting benefits program results in the proper context—in terms important to the CFO's strategic financial goals—can help guide CFOs toward a broader understanding of how health impacts financial performance and how important benefits investments can be to their businesses.

Lessons Learned

The research suggests a variety of practical steps both for CFOs and the benefits professionals who work with them.

For CFOs new to the concept of health and productivity:

- Credible information and methods for measuring health risks and outcomes beyond medical and pharmacy costs—such as lost time, health-related performance and lost-productivity impacts—are available in the marketplace. If you see a gap between the helpfulness and the availability of such information at your organization, reach out and make specific requests of your benefits managers and supplier partners. More than likely, the metrics and the sources you seek (with the possible exception of consensus measures of ROI from health interventions) are obtainable and already being used by CFOs at leading organizations to better understand the full impacts of health interventions.
- Partner with those in your organization who manage health and lost time to ensure that they understand your financial goals and are able to translate their information into your terms. Insist on setting program goals that are relevant to your firm's financial strategy and be sure that your benefits teams are capturing the right data.

For benefits professionals and policymakers trying to demonstrate the business case to CFOs:

- Keep in mind that the business case for health and productivity is solid (as evidenced by the research literature). Do your homework and understand the likelihood that program impacts go beyond medical and pharmacy expenses.[15]
- Advocate a culture of health and bring the need for change to senior management. Look to other leading employers for the best strategies. Try to convince senior managers to walk the talk. Change is most effective when strongly supported from the top.
- Start by maximizing the available resources and information within an organization in making a business case for health investments. While claims costs tell only part of the story, they also represent "low-hanging fruit" to initiate conversations and get the CFO's attention.
- Learn CFOs' strategic financial goals, focus on a set of metrics that correspond to those goals and measure outcomes in those terms.
- Strive to understand the organization's and the CFO's views pertaining to a culture of health and health's connections to business performance. Determine the extent to which you are working with an H+P Leader.

[15] Fendrick A, Jinnett K, Parry T. Synergies at Work: *Realizing the Full Value of Health Investments.* Center for Value-based Insurance Design and Integrated Benefits Institute. February 2011. Accessed January 20, 2012, at *http://www.ibiweb.org/partnerresearch_synergiesatwork.*

Appendix

The Integrated Benefits Institute and CFO Research Services (the research arm of CFO Publishing LLC) collaborated to develop and field a survey among senior finance executives in June 2011.

The survey instrument was distributed by e-mail to more than 10,000 finance executives from U.S. companies. Responses were solicited from members of the CFO Publishing community, including subscribers to *CFO* magazine, registrants on CFO.com and members of CFO's Research Panel. Responses from 313 senior finance executives from companies with more than $100 million in annual revenues were accepted in June 2011. The response rate is appropriate for surveys distributed by e-mail and is typical for surveys conducted by CFO Research Services.

Respondent Characteristics

Industry	
Auto/industrial/manufacturing	17.9%
Financial services/real estate/insurance	16.3%
Healthcare	9.6%
Wholesale/retail trade	9.3%
Business/professional services	6.1%
Food/beverages/consumer packaged goods	6.1%
Chemicals/energy/utilities	4.8%
Media/entertainment/travel/leisure	4.8%
Public sector/nonprofit	3.8%
Construction	2.9%
Pharmaceuticals/biotechnology/life sciences	2.6%
Telecommunications	2.2%
Transportation/warehousing	2.2%
Aerospace/defense	1.9%
Hardware/software/networking	1.3%
Other	8.3%

Respondent Title	
Chief financial officer	32.9%
Controller	19.2%
Director of finance	16.9%
VP of finance	16.0%
EVP or SVP of finance	6.7%
Treasurer	1.9%
Other	6.4%

Some percentages do not total 100% due to rounding.

Ownership Type	
For-profit, private	44.2%
For-profit, public	39.7%
Nonprofit	10.9%
State or local government	2.6%
Federal government	1.0%
Other	1.6%

Organization Revenues	
$100M–$250M	31.1%
$250M–$1B	26.6%
$1B–$2B	10.6%
$2B–$5B	8.3%
$5B–$10B	5.4%
More than $10B	17.9%

Organization Size (Headcount)	
Fewer than 100	4.2%
100–500	18.3%
501–1,000	15.4%
1,001–2,500	15.4%
2,501–5,000	11.5%
More than 5,000	35.3%

Employees Under Age 35	
Fewer than 33% of workers	67.2%
34% to 66% of workers	30.0%
More than 66% of workers	2.8%

Employees Age 35 to 49	
Fewer than 33% of workers	25.8%
34% to 66% of workers	70.7%
More than 66% of workers	3.5%

Employees Over Age 49	
Fewer than 33% of workers	74.6%
34% to 66% of workers	25.0%
More than 66% of workers	0.4%

White-Collar Workers	
Fewer than 33% of workers	47.3%
34% to 66% of workers	19.9%
More than 66% of workers	32.9%

Male Employees	
Fewer than 33% of workers	6.7%
34% to 66% of workers	66.4%
More than 66% of workers	26.9%

Unionized Employees	
Fewer than 33% of workers	81.5%
34% to 66% of workers	12.0%
More than 66% of workers	6.5%

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The **Integrated Benefits Institute** (IBI) is a national, not-for-profit, member-directed organization established in 1995. IBI is the health and productivity industry's premier private, not-for-profit research organization. In addition, IBI offers an unequaled suite of health and productivity measurement and benchmarking tools to fit any company's needs regardless of budget, data availability and staff resources. Each year, IBI offers scores of integrated health and productivity educational forums.

IBI's mission, program and activities are determined by its members, representing hundreds of corporate entities, more than 85% of which are employers. IBI's membership also includes consultants, insurers, healthcare providers, third-party administrators, pharmaceutical companies, disease management firms and others having an interest in health, productivity and absence/disability management.

For more information about IBI's programs and membership, go to **IBIWEB.ORG**.