

Parallel Lines Do Intersect: Interactions between the Workers' Compensation and Provincial Publicly Financed Healthcare Systems in Canada

Quand les lignes parallèles se croisent :
interaction entre les commissions des accidents
du travail et les systèmes de santé provinciaux
au Canada



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Abstract

The authors of this paper use a case study approach to document and analyze the interactions that arise between two healthcare payers in Canada: the provincial public healthcare insurance plans and the provincial workers' compensation boards. Through a documentary review and semi-structured key-respondent interviews, the study identified a set of policy events and decisions undertaken by each payer that had consequences for the other. These events, which included changes to governance, funding and service delivery within each system, generated interactions transmitted through the political, institutional and economic environments (primarily through competition for the same resources) and cross-system learning. The two payers currently lack a formalized process by which to consider such spillover effects and to coordinate policy between them. These interactions, and their associated consequences for both payers, raise important policy challenges and, more generally, provide insight into the dynamics of parallel systems of healthcare financing.

Résumé

Les auteurs du présent article ont recours à l'étude de cas pour documenter et analyser l'interaction entre deux payeurs de services de santé au Canada : les régimes provinciaux d'assurance pour les services de santé et les commissions provinciales des accidents du travail. Les entrevues semi-structurées menées auprès de répondants clés et l'analyse documentaire ont permis de dégager un ensemble de décisions et de démarches politiques dont la mise en place, par l'une des entités, a des conséquences sur l'autre. Ces activités, notamment les changements en matière de gouvernance, de financement ou de prestation des services, favorisent une interaction, qui emprunte les

canaux politiques, institutionnels et économiques (principalement par la compétition pour accéder aux mêmes ressources), et l'apprentissage entre les systèmes. Il y a présentement absence de processus permettant d'examiner les effets de telles retombées ou de coordonner les politiques entre les deux entités. Les interactions et leurs conséquences pour les deux payeurs, mettent au jour d'importants enjeux politiques et, de façon plus générale, donnent un aperçu des dynamiques associées au financement d'un système de santé parallèle.

IT IS COMMONLY BELIEVED THAT CANADA HAS ONLY A SINGLE PAYER FOR medically necessary physician and hospital services: provincial public insurance plans. This belief, in fact, is false: Canada has several parallel payers for these services. The federal government, for instance, finances healthcare services for aboriginal peoples, the RCMP, the military and federal prisoners (who, along with visitors to Canada, are excluded from the Canada Health Act's [CHA] definition of insured persons); workers' compensation boards finance healthcare required to treat workplace-related injuries and illness (which are excluded from the CHA's definition of insured services); and automobile insurers finance healthcare needed to treat injuries associated with motor vehicle accidents (also excluded from CHA's definition of insured services). These payers provide their beneficiaries access to healthcare services on terms and conditions different from those offered to individuals by provincial health insurance plans. The existence of distinct, parallel payers alongside the provincial insurance plans raises a number of important policy issues, foremost of which is the nature of the interactions between the parallel payers.

This paper examines the interactions that arise between the provincial public health insurance plans and one of Canada's parallel payers: workers' compensation boards (WCBs). Our goal is both to document and to clarify the nature of interactions between parallel systems, interactions that can be both beneficial and harmful and that can range from the purely political to those that affect the care received by individuals. The WCBs present an interesting case study of parallelism because the 13.1 million workers covered by workers' compensation are simultaneously eligible for healthcare through provincial public plans and, if injured in the workplace or ill as a result of an occupational disease, through the WCBs. The payer depends only on whether the illness or injury is work-related.

Workers' compensation in Canada long predates medicare. It was established in the early part of the 20th century as a system of social insurance, financed by employers (currently through risk-rated premiums to encourage workplace safety) as part of a "historic compromise" in which workers gave up the right to sue employers for workplace-related injuries and illness in return for defined levels of no-fault benefits (Ison 1989).

WCBs finance or provide three types of services and benefits to individuals who suffer a work-related injury or illness: healthcare – the focus of this analysis – which aims to restore an injured worker’s functional capabilities as much as possible and allow a “timely and safe return to work”; vocational rehabilitation, which assists injured workers in finding alternative employment when necessary; and disability benefits, which compensate a worker (temporarily or permanently) for lost income and, in the case of permanent impairment, for pain, suffering and loss of enjoyment of life. WCBs ensure workers’ access to needed healthcare services through a variety of arrangements, including direct provision at WCB facilities and contractual arrangements with both public and private providers. Although WCB healthcare spending is small relative to total healthcare spending in Canada (in 2003, workers’ compensation health spending equaled approximately 1.5% of total provincial healthcare spending, or about 3.8% of provincial healthcare spending on the working-age population (CIHI 2005)), it is concentrated in areas of particular policy concern, such as orthopaedic services and diagnostic imaging.

Methods

For this case study, we gathered data through a documentary review followed by semi-structured interviews with key informants. The documentary review identified events and policy decisions emanating from either the WCB or the provincial healthcare system that would likely have generated spillover effects for the other payer. The review was conducted using the LexisNexis Academic database. All identified newspaper and newswire articles were assessed for relevance in terms of potential for creating important cross-payer effects, and relevant articles were used to construct, for each province, a policy timeline from 1990 to the present that included events and decisions that potentially created interaction between the WCB and the provincial plan.

The semi-structured, key-informant interviews, conducted by telephone between September 2006 and February 2007, were designed to provide an in-depth understanding of the nature of the interactions between the two systems. The interviews were limited to four provinces – British Columbia, Alberta, Manitoba and Ontario – chosen on the basis of the richness of the set of events identified through the documentary review. Twenty-two key-informants were interviewed, with 8, 6, 3 and 5 individuals from British Columbia, Alberta, Manitoba and Ontario, respectively (see Table 1). The key informants were identified through multiple sources, including media reports of selected policy events, research team knowledge of individuals with current or past policy participation in either the workers’ compensation or provincial healthcare sectors in the provinces under study and the key informants themselves. The key informants included past or current members of provincial WCBs (14), provincial ministries of health (1), regional health authorities (4), researchers (2) and a hospital administrator (1). (Some key informants had held multiple professional roles in their careers and could speak to

issues from more than one perspective.) All interviews were audio-recorded, transcribed and checked for accuracy; each key informant had the opportunity to review his or her transcript prior to coding and to review draft study papers.

TABLE 1. Interview subjects

Characteristics	Province				
	ON	BC	MB	AB	Overall
WCB	4	6		4	14
Health ministry		1			1
Regional health authority		1	2	1	4
Researcher			1	1	2
Hospital sector	1				1
Physician					
Total sample	5	8	3	6	22

The interviews varied from 30 to 90 minutes in duration and were divided into two parts. Key informants first reviewed the list of policy events identified for their province through the documentary review, commented on the accuracy and completeness of the listing and identified any missing events. In the second part, key informants selected two events or policy decisions from the list provided or based on their own experience and answered a series of questions regarding the rationale, goals, implementation and consequences (intended and unintended) of each event, as well as its implications for both systems. All transcripts were independently reviewed and coded by the research coordinator (DP) and the principal investigator (JH) and then discussed by the full research team at study meetings.

Results: Interactions between the WCB and the Publicly Financed System

Policy events and decisions identified by respondents

Table 2 lists the policy events and decisions judged by key informants to be associated with important interactions between the WCB health systems and the provincial healthcare systems. Some events were identified by multiple respondents. The events vary along a number of dimensions. Although most were WCB initiatives, they also include actions undertaken by the federal government, provincial governments, regional health authorities and medical associations. They include changes in governance,

Parallel Lines Do Intersect

especially the change to regionalized systems of governance, changes to the methods and levels of healthcare funding and changes in delivery arrangements (Lavis et al. 2004). Many of the events are linked. Funding cutbacks to the provincial plans in the mid-1990s, for instance, and the associated growth in wait times, was one catalyst that impelled WCBs to develop new funding and delivery relationships with providers.

TABLE 2. Respondent-identified policy events and decisions that create interactions between WCBs and the public provincial health insurance plans

	Governance	Funding, payment policies and financial incentives	Delivery arrangements	Other
BC	<ul style="list-style-type: none"> Provincial public plan establishes regionalized system of governance 	<ul style="list-style-type: none"> WCB in 1990s takes a more proactive, independent (from provincial health plan negotiations) approach to negotiations with BCMA Lack of a fee schedule based on a validated relative value scale Federal government decreasing transfers to provinces for healthcare in 1980s WCB offers physicians incentive payment to expedite care for workers 	<ul style="list-style-type: none"> WCB implements novel delivery arrangements, including in-house delivery and visiting clinics, to expedite care for injured workers 	<ul style="list-style-type: none"> WCB establishes a relationship with UBC Centre for Health Services and Policy Research regarding integration of WCB claims data with BC linked database to facilitate research
AB	<ul style="list-style-type: none"> Provincial government passes legislation to allow care provision in non-hospital surgical facilities 	<ul style="list-style-type: none"> Provincial government cuts funding to provincial health plan in 1990s WCB establishes its own fee schedule and begins direct negotiation with Alberta Medical Association WCB uses a combination of financial incentives and standards of care to expedite care for workers 	<ul style="list-style-type: none"> WCB explores alternative service delivery models to expedite care for injured workers Private interests establish private, for-profit MRI clinics Selected Regional Health Authorities create separate, expedited care streams for WCB clients WCB establishes contractual arrangements with healthcare professionals and facilities to define standards of business (e.g., accreditation) practice and standards of care through preferred provider relationships 	

TABLE 2. Continued

MN		<ul style="list-style-type: none"> • WCB begins direct negotiations with Manitoba Medical Association • WCB pays financial incentives to private clinics for expedited care 	<ul style="list-style-type: none"> • WCB establishes contractual arrangement with (public) Pan Am Clinic for expedited care 	
ON	<ul style="list-style-type: none"> • Historical exclusion of WCB from <i>Canada Health Act</i> • Lack of independence of WCB from political process • Provincial government passes the 1991 <i>Regulated Health Professions Act</i> 		<ul style="list-style-type: none"> • WCB establishes new service delivery models to facilitate early access and treatment for workers • WCB, in collaboration with health professionals, introduces "Programs of Care," which provide evidence-based treatment plans for various worker injuries • WCB introduces nurse practitioner-based case management program to ensure timely, appropriate care for workers • WCB devolves care from WCB Downsview Rehabilitation Centre to community-based clinics through contractual relationships 	<ul style="list-style-type: none"> • Workplace Safety and Insurance Board establishes the Institute for Work and Health to provide independent research evidence

Key types of interaction between the WCBs and provincial plans

Interactions between the WCBs and the provincial public plans arose most often because actions by one affected the broader environment in which both payers operate. Interactions generally work through the political environment, the institutional environment, the economic environment (especially in the competition for shared resources) and cross-payer learning. Interactions in each of these dimensions arose in each province, though the specific events that generated them often varied across provinces.

INTERACTIONS IN THE POLITICAL ENVIRONMENT

A recurring theme in the interviews was that the “politics of medicare” imposed constraints on WCBs’ ability to act in ways that were legal but perceived by government to have unacceptable political ramifications. One respondent noted, for example:

But [the WCB is] artificially restrained from doing that [providing appropri-

ate healthcare at the right time for the best possible recovery for injured workers] because of the public image or the politics around the public healthcare system. ... they [governments] don't want contrasting systems.

The WCB initiatives of most concern were strategies to expedite care for workers by sending patients out of province (including to the United States), contracting with private for-profit clinics and contracting for "excess" capacity within the publicly funded infrastructure. Such initiatives had political impacts because they implied that Canada has "two-tier" healthcare. Faster care for workers also served as a reminder that the public system was not delivering timely care. This perception not only creates political difficulties for a provincial government but, some argued, could more generally erode support for publicly financed healthcare:

... when they [WCB] started to manoeuvre some of their clients through the system quicker ... a bit of a black cloud was going to hang over the organized system for the rest of the population. ... a number of commentators went to great lengths to flag this as a mark of the deteriorating capacity of the public system and the great advantages [of] this semi-privatization model

The political responses to these concerns range from moral suasion – quietly asking WCBs not to pursue such strategies – to limiting the nature of certain contractual relationships between public facilities and WCBs, to outright prohibition. The Ontario WCB, for instance, was prevented from transferring orthopaedic surgical services to specialty clinics located in community-based teaching hospitals because the services were sufficiently similar to those obtained (after extended wait) by the general public and, as such, would invite direct comparison:

when you start dealing with cartilage operations on knees or things like that, it has a direct, comparable issue with general public healthcare ... [whereas with] the hand program or the prosthetic program and other things, nobody saw a direct parallel very clearly.

INTERACTIONS THROUGH THE INSTITUTIONAL ENVIRONMENT

Changes to institutional arrangements for governance, funding and delivery in one system can have consequences for the other system. Because of its more dominant role, changes to governance, funding or delivery by the provincial public plan more often had consequences for the WCBs. The change to regionalized governance within the provincial healthcare systems, for example, reduced transaction costs for the WCB and led to greater consistency and coherence of policy across hospital sites by dramatically

reducing the number of organizations with which the WCB had to contract:

We [the WCB] had been interacting essentially with each individual entity in the province. And what's begun since 1997 ... is us moving to interacting with just the six health authorities or processes ... trying to rationalize things through the six health authorities instead of going through two hundred hospitals and god knows how many long-term and short-term clinics and centres.

Changes to the regulatory framework and delivery systems can similarly generate spillover effects. The *Regulated Health Professions Act* (RHPA) in Ontario, for example, facilitated WCB contracting by defining recognized health professions and thereby delineating the providers eligible for WCB reimbursement. Bill 11 in Alberta, which for the first time allowed non-hospital overnight-stay facilities, expanded the range of services for which the WCB could contract with private clinics. Primary care reform within provincial plans, and in particular the creation of larger, multi-professional primary care practice funded through blended arrangements, can benefit the WCB by providing greater scope for interested family physicians to develop occupational health specializations.

INTERACTIONS IN THE ECONOMIC ENVIRONMENT: COMPETITION AMONG PAYERS

Competition among payers for the same scarce resources is one of the most-debated aspects of parallel arrangements. WCB initiatives to expedite care for injured workers, such as incentive payments for physicians to treat injured workers more quickly, contracting with private for-profit clinics and contracting with hospitals for after-hours use, are of particular concern in this respect (see Hurley et al. 2008 for a detailed discussion of these strategies). Supporters argue that WCB initiatives to expedite care for workers can increase access to services in the provincial plan by injecting additional funding into the system and removing WCB cases from queues in the provincial plans. Detractors counter that such initiatives often simply divert resources from the provincial plan, resulting in the same number of cases being treated but with preferential access for workers. The ultimate impact depends on several factors, including the most binding resource constraint among the resources required to produce a service. Even if a surgeon has operating time available for treating patients outside the provincial plan, if another input is in short supply it can still have consequences:

... we have private centres using local resources, so using anaesthetists who work here, it's been a diversion of resources from the public and into the private sector. ... we've had an anaesthesiologist shortage which at least has been exacerbated by the existence of those private efforts.

WCB revenue is increasingly attractive to cash-strapped hospitals. In providing services to WCB cases, hospitals allocate treatment and management resources towards WCB cases:

If there's a scarce resource, hospitals, if they had the choice of having the physios or OTs work in a revenue-generating or a non-revenue-generating area, you can imagine which one they'd choose. ... that might be true too about MRI/CAT scans. ... hospitals certainly have the financial incentive to make sure that their scarce resource of radiology technologists do the paid work

Competition between WCBs and the provincial plans for the same resources puts upward pressure on resource prices, reducing the real ability of each system to provide services with a given budget. The potential for WCB bonuses and incentives for physicians to exert upward pressure on fees in the provincial system was recognized by respondents from both WCBs and ministries of health:

With orthopaedic surgeons, we [WCB] pay a significant premium ... and so that may cause the government some grief. We have to work closely with them to ensure that we're not setting them up to be levered by our fee structure into raising their rates generally.

The docs, as is their wont ... began their negotiation season by doing a deal with the WCB in which WCB paid 10% above our going rate, which put a lot of pressure on us.

The impact of WCBs' private contracting initiatives can also extend beyond the specific services purchased by the WCB. WCB contracts can increase the financial viability of private clinics for which the individual private-payer market alone is insufficient or too risky. Larger-volume WCB contracts can cover the fixed costs, creating a platform from which a clinic can enter the individual private-pay market.

CROSS-SYSTEM LEARNING

Cross-system learning, whereby innovation in one system is adopted by the other, can arise at both the managerial and clinical levels. At the managerial level, for instance, some of British Columbia's regional health authorities built on the WCB contracting experience to introduce their own form of contracting with the private clinics in an effort to reduce wait times in the provincial plan. The Ontario WCB hoped that Ontario's provincial plan might adopt a variation on a WCB nurse-based "pathway" management program designed to help an injured worker navigate the complexities

of the healthcare system to obtain appropriate services. The Alberta WCB's quality initiatives embodied in its preferred provider arrangements can potentially generate changes in practice that benefit all patients of these providers. More generally, because many providers treat both WCB-financed injured workers and public patients, clinical initiatives such as evidence-based practice guidelines in one system can have spillover effects on the other. Finally, initiatives such as the integration of WCB claims into the BC Linked Database and the research of work-related institutes such as the Institute for Work and Health can enhance cross-system learning (Brown et al. 2007).

THE MISSING INTERACTION: LACK OF FORMAL POLICY COORDINATION ACROSS THE TWO SYSTEMS

One of the most striking findings was the absence of mechanisms through which to consider spillover effects or to coordinate policy development between WCBs and ministries of health. While regular communication occurs at the operational level where the two systems share infrastructure (e.g., the billing system), and ad hoc communication takes place at a higher political level between WCB CEOs and ministers of health (this factor tended to depend on personal relationships between individuals), we consistently found gaps in planning and coordination at the deputy minister, assistant deputy minister and director levels. The following comment with respect to WCB initiatives to expedite care typifies what we heard throughout the interviews:

I recall no discourse at all in the planning. ... there was no formalized way of communication. ... all [discussions have] been directly with the institutions themselves. Even now we have very little direct contact with the Ministry.

Discussion and Conclusions

Interaction between parallel systems is inevitable when they draw on the same pool of resources. Interactions arise at all levels, from high-level political concerns down to the activities of individual clinicians and patients. Some interactions depend on the relative sizes of the parallel systems, but many do not. From a political perspective, for instance, the mere existence of even a small parallel payer creates political challenges because it invites comparison. Whether such comparisons are fair or appropriate is often immaterial because such details become lost in the public debate. A small system's effects can also be disproportionately large when its activity is concentrated in selected areas, as is the case for WCBs, and when that activity is leveraged by other system stakeholders, as private clinics have done with WCB contract work.

Health system stakeholders, and providers in particular, will inevitably exploit the presence of parallel payers to pursue their objectives. For example, in recent years physi-

cians have increased their income opportunities through new fees, higher fees and new service opportunities with the WCBs. Unfortunately, some of the very conditions necessary for sound management of a publicly financed healthcare system – a keen eye on costs, accountability, adoption of evidence-informed practices – are precisely the conditions that make a parallel payer attractive to providers and provider organizations.

Parallel systems inevitably generate both efficiency and equity effects. Parallel systems, for example, can compromise efficiency by reducing the overall health generated with society's limited health resources and increase transaction costs for patients and providers as people navigate back and forth across and within the systems. Transaction costs associated with adjudication costs, appeal costs and establishing and maintaining a claim may be particularly important in the workers' compensation system. Parallel payers, some argue, can foster greater innovation and, especially in the case of workers' compensation, increase efficiency of the broader economy by improving productivity. The full set of potential efficiency effects is too complex and subtle to explicate here, but their consideration is central to an assessment of parallel finance.

The equity effects of parallel finance are transparent: individuals accessing care through one system are seen more quickly or receive care of different quality than an identical individual accessing care through the other. Who gets preferential access depends on the nature of the parallel system. In the case of WCBs, the distinction rests solely with the place of injury or cause of illness: if it occurs at work or can be linked to work, then access is through WCBs; if not, patients must rely on the provincial plan. The preferential treatment of workers is increasingly questioned by some (Commission of the Future of Health Care in Canada 2002; Office of the Auditor General of Ontario 2006). Within the current legislative framework, of course, WCB strategies to expedite care for injured workers are fully legal and, indeed, WCBs have a legal obligation to employers and workers to obtain the care necessary to return a worker to work as quickly and safely as possible. (They also have financial incentive to do so because they must pay benefits to a worker who is off work owing to an injury.) A policy review, therefore, would have to confront the more fundamental question of whether there continues to be a convincing policy rationale for the exclusion of workers' compensation from medicare's regulatory framework.

Finally, although the WCBs and the provincial plans are distinct, both serve the public interest, and there appear to be unrealized opportunities to improve policy and practice in both systems through better coordination and communication. Fragmented policy making by multiple payers each considering only its own interests leads to "ricochet effects" – unanticipated effects on other payers active in the same arena – that can ultimately harm the interests of both payers (Gildiner 2001). Better policy coordination between the WCBs and the provincial plans, however, requires creation of institutional structures through which to carry out this all-important work.

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