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Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers

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ABSTRACT

Canada's Workers' Compensation Boards (WCBs) finance health care for injured and ill workers in parallel to provincial health insurance plans. Parallel systems of health care finance can create preferred access for some. WCBs have in recent years pursued a number of strategies to expedite or improve the quality of care for injured or ill workers, including in-house provision in WCB-owned facilities, contracting with private, for-profit clinics, contracting with publicly funded hospitals and clinics for use of facilities "off-hours", and supporting specialized clinics within publicly funded hospitals. Many of these strategies incorporate incentive payments to physicians and facilities for treating WCB cases more quickly than patients covered by provincial plans. In this paper we both document the development of these strategies and discuss their implications for physicians, patients, government, and the provincial public insurance plans.

A parallel payer alongside provincial health insurance plans can create unequal access to insured services for those in equal need, the concern that lies at the heart of the Canadian debate over parallel private insurance (1). Although Canada *de facto* prohibits parallel private finance for insured physician and hospital services (principally by restricting physicians' and hospitals' ability to provide such services for private payment(1;2)), Canada does have parallel public payers purposefully excluded from the regulations of the Canada Health Act: the federal government, which finances care for aboriginals, the military, the RCMP, and federal prisoners (who are excluded from the CHA's definition of insured persons); and -- the focus of this paper -- provincial Workers' Compensation Boards (WCBs), which finance health care services needed by workers who suffer work-related injury or illness (such services are excluded from the CHA definition of insured services). WCBs are legally permitted to establish contractual arrangements with physicians and hospitals (as well as other providers and facilities) distinct from those established within the publicly financed provincial health insurance plans. WCBs have over time become increasingly sophisticated providers and purchasers of care emphasizing both timeliness and quality. At the same time, the WCBs as funders of health care services in parallel with provincial plans compete for access to health care providers and institutions. The policies and practices of the WCBs as health care payers, therefore, are of increasing importance to providers, patients and the provincial plans more generally. The activities of the WCBs also provide valuable insight into the dynamics of parallel systems of finance in general, and of small parallel payers alongside a large public payer in particular.

This paper documents the evolution of the WCBs as a parallel payer in Canada, with a particular focus on the last decade during which WCBs have adopted a range of strategies to expedite care for injured workers. The analysis draws on a documentary review and a set of key-informant interviews with individuals from WCBs, ministries of health, regional health authorities and medical associations in four provinces (British Columbia, Alberta, Manitoba and Ontario). The review and interviews were conducted as part of a larger project investigating interactions between the WCBs and the provincial health insurance plans (Hurley et al. (3) provides more detail regarding the study methods).

The Workers' Compensation System in Brief

Workers' compensation in Canada is a system of social insurance established in the early decades of the 1900s as part of an "historic compromise" between workers and employers whereby workers gave up the right to sue employers in return for defined levels of no-fault compensation for workplace injuries and illnesses (4). Each province and territory administers

its own Workers' Compensation Board (WCB), though they all share the principles of no-fault compensation, no worker right to litigation, full funding by employers, administration by public agency, and benefits linked to pre-injury income. WCBs finance or provide three types of services and benefits to individuals who suffer a work-related injury or illness: *health care*, 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 alternate employment when necessary; and *disability benefits*, which provide compensation to a worker for lost income (temporary or permanent) and, in the case of permanent impairment, compensation for pain, suffering, and loss of enjoyment of life. This analysis focuses solely on WCB health care benefits, though we will see below that WCB obligations with respect to disability benefits have been an important driver of its health care policies.

The workers' compensation system covers a full range of health care services, including diagnostic services, treatment, prescription drugs, prosthetic devices, medical appliances, physiotherapy and other rehabilitative treatment and care (and in some cases preventative services). WCB health care spending is small relative to total health care spending in Canada. In 2003, workers' compensation health spending equaled approximately 1.5% of total provincial health care spending and about 3.8% of provincial health care spending on the working-age population (5). WCB spending, however, is concentrated in some areas of particular policy concern such as orthopaedic surgery, musculo-skeletal treatment, rehabilitation and physiotherapy, and diagnostic imaging, making its potential impact in these fields disproportionate to its overall level.

WCB Approaches to Accessing Health Care Services for Injured and Ill Workers

WCBs employ a variety of approaches to ensure worker access to needed health care services, including direct provision through their own health care facilities and contractual arrangements with both public and private health care providers and institutions. The relative importance of these alternative approaches varies across service sectors and the provincial WCBs; it has also changed over time in response to changes in technology, evidence regarding treatment, policies of the provincial plans and expectations of workers regarding care. The discussion below emphasizes physician and hospital-based services since the introduction of Medicare.

During the 1970s and much of the 1980s WCBs direct provision of care in their own facilities constituted an important component of care provision. This was especially true for non-physician, rehabilitation services for injured workers. Examples of such facilities included the

Leslie R. Peterson Rehabilitation Centre and the Millard Rehabilitation Centre in Alberta, the Workers' Rehabilitation Centre in New Brunswick, the Richmond Rehabilitation Centre in British Columbia and the Downsview Rehabilitation Centre in Ontario.

For physician and acute hospital services, however, the WCB primarily relied on providers and facilities funded predominately through the provincial plans. That is, workers sought services from their family physician, who managed their care and made referrals to specialists as was appropriate, just as for any patient. WCB paid providers using the same fee schedule as the provincial plan and hospitals were reimbursed on a negotiated basis for services provided to injured workers. Where the WCB required a service not listed in the provincial plan's Schedule of Benefits (e.g., completing a report required for compensation claims), the WCB often paid a separately negotiated fee. By and large, however, injured workers received the same services on the same basis from the same providers as other individuals. The only difference was that the care was financed by WCB. In many cases, even this was not readily apparent. Providers often submitted claims to the provincial plan just as for other patients, and the provincial plan either paid the claim and was later reimbursed by the WCB or diverted the claim to the WCB, which then reimbursed the provider directly. The WCBs were, in many respects, passive, "silent" bill payers (6).

Beginning in the late-1980s but especially after the mid-1990s, WCBs began to explore alternative ways to ensure access to needed care for workers. This change was motivated by a number of factors. Like many health care payers at the time, WCB efforts to manage better the purchasing and provision of services were spurred in part by the combination of rising health care costs and increasing evidence of unnecessary, inappropriate or ineffective services. Workers also began to resist WCB delivery models that required them to travel long distances for specialized services provided in centralized WCB facilities. This prompted the WCBs to explore ways to contract for these services from community-based providers around a province. During the 1990s, however, the combination of three new factors pushed the WCBs to develop new arrangements to expedite care for workers.

The first was increasing delays for services in the provincial systems. In the mid-1990s the Canadian health care system underwent considerable retrenchment and upheaval; real per-capita public health care spending fell for the first time since data had been collected (5); cuts to hospital budgets reduced access relative to demand for many services; and the physician shortage worsened (7). Wait times for care mushroomed, especially in areas vital to the WCB such as orthopaedic surgery and diagnostic imaging. These delays imposed large financial

costs on the WCBs because every day of delayed care was another day that a WCB had to pay a worker wage-replacement.

Second, during this period research evidence increasingly documented that, other things equal, the longer a worker was off work, the greater the chance that they would never return to work (8-10). The implication for WCBs was clear: the overall costs of delayed care were substantially larger than previously thought. By stressing early return to work and maintaining a worker's link to their workplace during an episode of disability, the WCB could reduce the likelihood that a short-term disability would turn into a chronic disability and a life-time WCB pension.

Finally, WCBs were facing increasing pressures related to disability benefit costs. The WCBs in a number of provinces held large unfunded liabilities and they had to act to restore financial sustainability.

WCB Strategies to Expedite Care for Workers

The WCBs have pursued a number of strategies to expedite care for injured workers. The strategies fall roughly into those that create new service-delivery arrangements with providers, either in-house or on a contractual basis, and those that offer explicit financial incentive for providers to treat injured or ill workers more quickly than other individuals. Sometimes these are used in combination. The specific mix and design of approaches varies across the provinces depending on the management approaches of the WCBs themselves, the broader political environments in which WCBs operate, and the delivery options available in each province.

Alternative Delivery Arrangements

Ironically, just as many WCBs were closing down facilities through which they had directly provided services for decades in favour of community-based delivery, delays in the public system forced them to consider in-house delivery of services for which they had traditionally relied on other providers. In the early 1990s, for instance, the WCB in British Columbia hired upwards of 50 physicians to provide services in-house in WCB facilities. It also explored the possibility of purchasing (and very nearly did purchase) its own MRI for use in diagnosing injured or ill workers; it similarly explored the feasibility of building its own operating theatres. The WCBs in both BC and Ontario hired nurses or nurse practitioners to act as "pathway managers" whose primary role has been to assist workers in navigating the complexities of the

health care system, help ensure that they get the right treatments in a timely manner, and more generally improve the timeliness and appropriateness of care.

The WCB in BC found that its strategy of hiring physicians in-house was, for a variety of reasons, not as successful as hoped. It replaced this approach with a “visiting clinic” program in which the WCB contracts with specialists on a sessional basis to come to a WCB facility and assess injured workers on site. This enables the WCB to gain access to the varied expertise of community-based specialists, provides more flexible arrangements for both parties and still ensures quick assessment. The program has been highly successful and it currently involves nearly all the orthopaedic surgeons in the province.

More controversial are approaches based on contracting with private, for-profit surgical or imaging clinics. The extent of such contracting varies considerably across provinces, but in each of the four provinces studied the WCB has either explored or actively used this option. WCB contracts provide stable source of revenue for newly established clinics finding a place in the volatile, nascent private care market in Canada.

A common strategy undertaken in each province is to contract for “excess” capacity in the public system. Under these arrangements a WCB contracts with a hospital or a regional health authority to use a hospital’s MRI or operating theatre outside the hours funded by the provincial ministry of health. The WCB pays the hospital (or in some cases, free-standing clinic) a facility fee, as well as funding the physician and support personnel required to operate the service. WCB clients then have preferred access but in some settings if capacity remains after treating WCB clients, the physician is able to take on patients covered by the provincial plan. For hospitals these WCB contracts provide much-desired revenue to supplement the provincial global budget.

A closely related approach involves establishing specialty clinics within publicly funded hospitals to provide services (including some not-covered by the provincial plan) to injured workers. The Ontario WCB, for instance, transferred a number of specialized services from its Downsview Rehabilitation Centre to a series of clinics based in Toronto-area teaching hospitals. Access policies vary between clinics. In some cases, the clinic services are not available to provincially insured patients; in others, provincially insured patients may have access to insured services if capacity remains after treating WCB cases.

These alternative delivery arrangements are often complemented with a variety of financial incentives targeted at facilities, physicians and other health care workers to expedite care for WCB clients. Some WCBs, for instance, now have graduated fee schedules for some services whereby the fee paid to a physician is higher (often many times the provincial plan’s

fee) for seeing an injured or ill worker within a specified number of days. In addition to higher pay, the WCB can offer less stressful working conditions.

Do these initiatives to expedite care make a difference for a WCB? Yes. The WCB in British Columbia, for instance, estimated that the combination of its specialist visiting clinic program for assessments and contracts with private clinics for surgery reduced the treatment time from 6-9 months when relying on access through the provincial plan to less than 6 weeks, saving the WCB an estimated \$50,000 per client in wage-replacement costs alone.

Discussion

The workers compensation system has been a distinct funder of health care before the founding of Medicare, but the recent innovative approaches of the WCBs to ensuring timely access to care for workers have a number of implications for physicians, patients and governments.

For physicians, a more assertive alternative payer to the provincial plans, willing to pay a premium for quicker access, confers greater market power in their dealings with the provincial plans. Medical associations have recognized this and in a number of provinces they have sought greater independence in negotiating with WCBs over fees. The potential financial benefits to physicians of the new WCB approaches can even extend beyond WCB services. WCB contracts with private for-profit clinics can play a critical role in making such clinics financially viable at a time when demand in the individual private-pay market is thin. Hence, WCBs can play an important role in creating private-clinic options for physicians.

These developments, however, will also create challenges for physicians. WCB services are heavily concentrated in a small number of clinical areas, so physician specialties are not equally able to exploit these new opportunities.. This can create tensions within the profession. In addition, the development of expedited care has been part of a larger transformation of the WCB into a more sophisticated provider and purchaser of health care services for workers. As the WCBs gain experience and skills, they are scrutinizing the effectiveness of service provision more carefully, becoming more adept at writing, monitoring and enforcing contracts, setting quality standards for the delivery of care and at generating competition among physicians for access to injured and ill workers. In short, they are becoming a more discerning and demanding payer. This is evidenced, for instance, by the WCB preferred-provider network in Alberta, which is limited to physicians who meet defined timeliness and quality standards.

For workers, of course, these developments signal quicker access to high-quality health care services. The implications are less clear for patients in the provincial plans. While there are potential positive spillovers for the care of all patients (e.g., as a result of greater WCB

emphasis on evidence-informed practice), of particular concern is the possibility of longer wait times and reduced access in certain clinical areas as the WCBs draw scarce resources toward injured or ill workers.

For governments, these developments mostly create headaches. They challenge the credibility of the claim that Canada provides equal access to care for equal need for insured physician and hospital services, they muddy the debate about Canada's public health care system and, at least in some instances, they divert scarce resources from provincial plans, making it even harder to maintain their performance. Finally, provincial and federal governments will face increasing demands to justify why the treatments two citizens receive for the very same condition should depend on the cause of an illness or the setting in which the injury occurred (11-13).

Lastly, the strategies employed by the WCBs represent the kinds of initiatives we should expect any parallel payer to undertake, including private insurers (though private insurers would likely be less inclined than have the WCBs to work cooperatively with provincial plans). Furthermore, because WCBs must pay wage-replacement to an injured worker, their incentives closely match those individuals face in the presence of parallel private finance. Time off work is costly, and quicker access is most valuable to high-income individuals – those for whom the personal cost of delayed access is highest and the burden of any payment for quicker access the lowest. The WCBs initiatives therefore provide insight into what Canada can expect should it expand opportunities for parallel private finance for publicly insured services.

Reference List

- (1) Flood C, Roach K, Sossin L, (Eds). Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada. Toronto: University of Toronto Press, 2005.
- (2) Flood C, Archibald T. The Illegality of Private Health Care in Canada. Canadian Medical Association Journal 2001; 164(6):825-830.
- (3) Hurley J, Pasic D, Lavis J, Mustard C, Culyer AJ, Gnam W. Parallel Lines do Intersect: Interactions Between the Workers' Compensation and Provincial Public Health Care Insurance Systems in Canada. Hamilton, ON: Centre for Health Economics and Policy Analysis Working Paper No. 07-03, 2007.
- (4) Ison TG. Workers' Compensation in Canada. Toronto: Butterworths, 1989.
- (5) Canadian Institute for Health Information. National Health Expenditure Trends, 1975-2005. Ottawa: Canadian Institute for Health Information, 2005.
- (6) Campolieti M, Lavis J. The Silent Payer Speaks: Workers' Compensation Boards and Canadian Physicians. Canadian Medical Association Journal 2000; 162(8):1152-1153.
- (7) Chan B. From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s? Ottawa: Canadian Institute for Health Information, 2002.
- (8) Brooker AS, Cole DC, Hogg-Johnson S, Frank JW. Modified Work: Prevalence and Characteristics in a Sample of Workers with Soft-tissue Injuries. Journal of Occupational and Environmental Medicine 2001; 43(3):276-284.
- (9) Hogg-Johnson S, Cole DC. Early Prognostic Factors for Duration on Temporary Total Benefits in the First Year Among Workers with Compensated Occupational Soft Tissue Injuries. Occupational and Environmental Medicine 2003; 60(4):244-253.
- (10) Loisel P, Lemaire J, Poitras S, Durand MJ, Champagne F, Stock S et al. Cost-benefit and Cost-effectiveness Analysis of a Disability Prevention Model for Back Pain Management: A Six-year Follow Up Study. Occupational and Environmental Medicine 2002; 59(12):807-815.
- (11) Le Bourdais E. Preferential Treatment for WCB Patients Angers some MDs. Canadian Medical Association Journal 1999; 161(7):859.
- (12) Commission of the Future of Health Care in Canada. Building on Values: The Future of Health Care in Canada. 2002. Ottawa, National Library of Canada.
- (13) Office of the Auditor General of Ontario. 2006 Annual Report. 2006. Toronto, Queen's Printer for Ontario.