

Notes from the Editor-in-Chief

JEREMIAH HURLEY, DIANNA Pasic, John Lavis, Anthony Culyer, Cameron Mustard and William Gnam, all of whom are affiliated with McMaster University or the University of Toronto, have combined their enormous wealth of knowledge and experience to write this lead article on Workers' Compensation Boards (WCBs) in Canada.

The authors document the evolution of WCBs as parallel payers in Canada, with a particular focus on the last decade, during which they have adopted a range of strategies to expedite care for injured workers. The authors' analysis draws on a review of documents and interviews with individuals from WCBs, ministries of health, regional health authorities and medical associations in British Columbia, Alberta, Manitoba and Ontario. Their work was conducted as part of a larger project investigating interactions between WCBs and provincial health insurance plans. The authors describe how

WCBs employ two basic strategies to expedite care for injured workers: new service-delivery arrangements with providers, either in-house or on a contractual basis, and financial incentives for providers to treat injured or ill workers more quickly than other individuals. The specific mix and design of the strategies varies across the provinces depending on WCB management approaches, the broader political environments in which WCBs operate and the delivery options available in each province.

The workers' compensation system has funded health services since before medicare, but WCBs' recent innovations to

ensure timely access to care for workers have a number of implications for physicians, patients and governments. For physicians, for example, 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 provincial governments. For workers, these developments create better access to high-quality healthcare services. For patients, the authors indicate the implications are less clear. All patients may benefit from positive spillovers associated with greater WCB emphasis on evidence-informed practice, but non-worker patients may also experience longer wait times and reduced access in certain clinical areas as WCBs draw scarce resources toward injured or ill workers.

For governments, WCB-expedited services have always created headaches. They cloud the debate about access to Canada's public healthcare system and consequently provide challenges for governments in monitoring systems performance.

In concluding, the authors suggest policy makers recognize that WCBs are the "proverbial canaries in the coal mine." The public system is currently not meeting the expectations of many Canadians. WCBs have acted because they bear the substantial financial costs associated with waiting, costs borne by patients in the provincial plans. 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 payment for quicker access lowest.

The lead paper is clearly outstanding in identifying the issues around WCBs in Canada. However, we also have some very

interesting commentators from across the country who are not shy about presenting their own perspectives. François Béland, at the Université de Montréal, compares the effects of accelerated WCB services to those of the French railways in the 19th century. He refers to a concept of reverse subsidization, where the public system actually subsidizes parallel-system patients. As WCBs provide incentives for providers to process their patients faster, they may be causing delays in care to other patients.

Arif Bhimji, President of Medicentres Canada, in Alberta, describes how Medicentres contract with the Alberta WCB to provide expedited services for workers. Medicentre physicians earn enhanced fees for providing expedited comprehensive services, compared with their fees for “routine” services through an occupational injury clinic. Dr. Bimji disagrees with Hurley et al. in their view that the WCB system causes inequality and is therefore incompatible with the values inherent in the Canada Health Act. He takes the view that if Hurley et al.’s recommendations were followed, all care would be reduced to one common denominator – the public system.

Speaking from the experiences of British Columbia, Terry Bogyo describes the experiences of WorkSafeBC, the WCB for that province. He provides useful figures depicting how the different health services are paid for and funded. He concludes that work-related injury, illness, disease and death should not happen – it should be prevented, and WCBs offer a structural mechanism to do this.

Boris Kralj, Chief Economist for the Ontario Medical Association, reflects his own opinion by describing how the Ontario Wait Time Strategy has significantly improved wait times in Ontario for a number of injuries often taking place in the work environment. He points out that the Ontario Workplace

Safety and Insurance Board’s payment to physicians in 2006–7 was about \$33 million for medical services and almost the same amount for completing required WSIB paperwork and forms. As he indicates, this represents a very small proportion (about 2%) of total payments to physicians in the province as a whole. However, Alan Davidson at the University of British Columbia points out that this may sound minor at first glance, but WCBs are targeting diagnostic imaging and other diagnostic services, where demand is much higher than supply. Thus continues the debate on a potential two-tiered system and related inequalities.

Steven Lewis, Amy Zierler and Kira Leeb indicate that Canadians are probably “luckier” if their injury happens on the job than if they suffer the same injury elsewhere, especially if the injury is disabling but not life-threatening. They point out the importance of incentives and accountability in the WCBs system, attributes that are absent from the public system. They suggest ways to change the universal system to improve overall performance, including evidence-based care, improving patient flows and a first-class information system.

Finally, Carolyn Hughes Tuohy from the University of Toronto indicates that it is not a question of whether the approaches of WCBs are illegal – they are not governed by the Canada Health Act. More importantly, if they are providing essential care to a target population and no other patients are worse off because of it, is it a problem? As she indicates, more empirical evidence is needed.

This is an excellent set of informative readings and worth your while to read all the perspectives.

Peggy Leatt, PhD
Editor-in-Chief