# Health Care Privatization and the Workers' Compensation System in Canada[1]

Paper prepared for presentation at
The Canadian Political Science Association meetings
Saskatoon, June 1, 2007
Comments Welcome

*Teresa Healy, Senior Researcher*

*Social and Economic Policy Department,*
*Canadian Labour Congress*
thealy@clc-ctc.ca

Canadian Labour Congress
Congrès du travail du Canada

In late August 2006, the Canadian Medical Association (CMA) confirmed that Orthopaedic surgeon Dr. Brian Day, owner of the private, for-profit Cambie Surgery Centre, and founder of the Canadian Independent Medical Clinics Association, would become the organization's new president-elect. Dr. Day is the largest partner in a for-profit surgical hospital in British Columbia, and is a major provider of services to WorkSafe BC, the provincial workers' compensation board. With these public funds, the Cambie Surgery Centre has been able to establish and maintain a private hospital since 1996.[2]

With other advocates of private care, Dr. Day points out that governments allow injured workers to receive expedited medical services in both public hospitals and private clinics. He objects to the fact that private insurance companies and employers, paying long-term disability costs for patients not injured on the job, are not allowed to pay to have their patients "jump-the-queue". This leads him to his central argument: If third party insurance for health care is permitted for injured workers, then why is it not available for everyone else? Why is it wrong, he asks, for Canadians, and their insurance companies, to spend their own money on health care in private facilities? [3]

The simple answer to this question is that Canada's public health care system is built upon a commitment to equality. Medicare was established explicitly to avoid privileged access to medical care based on ability to pay. The more complicated answer requires us to understand: i) what makes our public health care system "public"; ii) what is the relationship between public health insurance and public health service delivery; iii) how do the public health care and workers' compensation systems intersect with one another; and iv) how is that relationship challenged by the introduction of markets, profits and competition.

In working to reduce their expenses due to workplace injury or illness, employers' interests dove-tail with those of private insurance companies and private clinic owner-investors. As employers send injured workers to "jump the queue" in the public health facilities, they create longer wait times for other patients and undermine the public health care system. To the extent that employers pay a premium through workers' compensation to have workers treated quickly at private clinics, they are creating a market where none previously existed, thus exacerbating the more general problems associated with private clinics. Finally, in fueling market-based solutions to the problem of excessive "wait times", employers use the workers' compensation system to

legitimize private solutions based on ability to pay, undermine the legitimacy of the Canada Health Act, and challenge the concept of single-payer insurance.

I will elaborate this argument by looking first at the emergence of the workers' compensation system in Canada, followed by a review of the emergence of the public health care system. I will then explore the turn to neo-liberalism in workers' compensation, and continue with a discussion of the "wait times" debate. The paper will conclude with a discussion of ways to bring these two public services into a more cooperative and sustainable relationship.

## The historic compromise in employers' liability for workers' compensation

In Canada, laws regarding the liability of employers to compensate employees for injury and workplace-related disease were developed at the provincial level. What became known as the workers' compensation *system* in Canada was heavily influenced by the work of Sir William Meredith who, in 1910-13 led a Commission of inquiry and produced draft legislation for the Ontario government. Meredith's report articulates the key principles of workers' compensation as it developed across the country.[4]

Meredith's proposals challenged many of the prevailing liberal ideas of common law. Before Meredith's principles became entrenched in provincial laws, the 'assumption of risk' rule declared that workers were essentially 'free' to work or not to work, and were responsible for ensuring their wages were adequate to cover the risk of injury or death. Meredith also challenged the concept of 'joint negligence' which had relieved employers of their liabilities by suggesting workers should be blamed for their own injuries and illnesses.

Meredith agreed with the representatives of 'the workingmen' who argued that a just law would provide compensation for injured workers, as well as those suffering from industrial diseases. He agreed that these risks should be considered as risks of industries and, as such, compensation should be paid by the industries themselves. Meredith proposed the law follow the example of the German system of "collective responsibility" and publicly administered mutual insurance, instead of the principle of individual responsibility, established in British law. In Britain, small employers were sometimes bankrupted by the costs of compensation. Workers were often left without any recourse if employers

were unable to meet their responsibilities. Compensation, in Meredith's view, was expressly for the purpose of ensuring that injured workers and dependents would not become a burden for their friends, family or the broader community. Thus, he argued, it was imperative that the insurance for workers be compulsory.

He recommended that a non-partisan Board should collect and administer funds, as well as ensure reserves to meet present and future needs. The Board would be responsible to determine the assessment rates according to the hazards of various industries, and to add to the list of industrial diseases over time. This meant that the workers' compensation system would be administered publicly. Finally, and significantly, Meredith's bill proposed that workers would surrender their right to sue for damages under common law in return for a fair system of compensation in the event of injury or industrial disease. This was to become the heart of the "historic compromise."

"Workmans'" compensation boards were set up to administer public insurance in provincial and territorial jurisdictions across Canada beginning in the early part of the twentieth century. Each Board was established by the broad terms of provincial legislation, and is governed according to the specifics of its own policies. Each board is completely funded by employers. Provincial and territorial Workers' Compensation Boards (WCBs) assess claims for compensation, and reimburse doctors and hospitals for providing medically necessary services to claimants. Apart from wage replacement and medical services, Boards also provide training for workers who cannot return to their jobs. Boards have procedures through which health care professionals from a broad number of fields are approved.

As Roy Romanow reminded us in his 2002 Royal Commission report, workers' compensation boards and agencies are part of the *social security system* of the country:

> Social security funds are social insurance programs that are imposed and controlled by a government authority. They generally involve compulsory contributions by employees and employers, and the government authority determines the terms on which benefits are paid to recipients. In Canada, social security funds include the health care spending by workers' compensation boards and agencies, and the drug insurance fund component of the Quebec drug subsidy program. Health spending for workers' compensation

includes what is commonly referred to by provincial workers' compensation agencies as medical aid.[5]

Workers' compensation lies within the jurisdiction of provincial and territorial social security systems. It is compulsory for workers to be covered, although there are industries excluded from the system. Otherwise, there is no right of employers or workers to opt out. Excluded employers, however, may apply to opt in.[6] Workers' compensation boards are funded entirely by assessments levied on employers and the assessment level is reviewed depending on the health and safety record of the industrial sub-group the employer is assigned to by the Board. Assessments are based on annual estimates of how much will be needed to pay the claims of that sub-group. It is generally the case that employers will be rated according to their health and safety record. With "experience rating" employers are assessed above or below the standard rate of their sub-group.[7]

Benefits for workplace related illness or injury are paid out of these common funds. A provincial/territorial public corporation, known in most instances as the Workers' Compensation Board (WCB), both administers and adjudicates claims. Benefits are paid without regard to who was at fault in causing the injury or illness.[8] Compensation, however, can only be paid "for injuries arising out of and in the course of employment".[9]

WCB benefits are broadly defined. *Medical Aid* benefits generally include hospital services, rehabilitation, physician services and other specialty services provided by dentists, podiatrists, chiropractors or physiotherapists, among others. Medical Aid also includes pharmaceutical drugs and medical equipment or prosthetic devices.[10] Other types of benefits, such as wage loss replacement and payments for permanent disability and death, as well as rehabilitation services, touch on themes beyond the scope of this paper.

Provincial and territorial legislation confer upon WCBs the power to set the conditions under which health care (medical aid) benefits are extended to injured workers. For example, in British Columbia, the Workers' Compensation Act gives a great deal of power to the Boards:

> 21 (6) Health care furnished or provided under any of the preceding subsections of this section must at all times be subject to the direction, supervision and control of the Board; and the Board may contract with physicians, nurses

> or other persons authorized to treat human ailments, hospitals and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care; and all questions as to the necessity, character and sufficiency of health care to be furnished must be determined by the Board. [11]

There are an equal number of worker and employer representatives on each Board, ranging from 1 each in British Columbia, to 7 each in Quebec. In some cases, representatives from the "general public" are also appointed. Policy making tends to be quite a closed process, in contrast to the requirement that consultations be held before the adoption of provincial regulations.[12]

## History of the Public Health Care System in Canada

The public health care system in Canada was developed in the context of relentless political battles over the relative merits of public and private insurance. Although attempts to reach agreement in federal-provincial negotiations over health insurance collapsed in 1946, the issue remained alive throughout the early post-war years. In 1948, the federal government, under the direction of Health Minister Paul Martin, announced a series of national health grants for hospital construction and planning, as well as annual grants for a few priority health issues.[13] Prime Minister Mackenzie King argued that this was the first stage in the development of a comprehensive health insurance plan.

The Canadian Medical Association (CMA), together with hospital associations, the insurance industry and the Chamber of Commerce worked to convince provincial and federal politicians that a public alternative was not necessary. In fact, they argued, the already existing doctor-sponsored prepayment plans and private commercial insurance could adequately cover the needs of the majority of the population. They argued that only the “medically indigent” would require government assistance in paying their premiums.[14] A federal government survey in 1951, however, suggested that the voluntary system was not working well. Low-income people were not receiving as much physician care as those with higher income, and there was a definite inequality in the ability of provinces to provide health services.[15]

In Parliament, the CCF continuously pressed the issue. Stanley Knowles called the Liberal Party to task for its inaction on its own

policies: "… the Liberal Party is already committed, and has been across the years, to the proposition that if we are going to have a proper program of health insurance it must be administered in the name of all the people by their government."[16] In its first brief to government in 1957, the Canadian Labour Congress called for a comprehensive health care program led by the federal government, lending support to the idea that the only way to ensure equality in the delivery of health services was for the federal government to help finance the costs of provincially-delivered, universal health care.

The federal government, taking into consideration the public health care initiatives in four provinces, as well as the constitutional division of powers, proposed to transfer grants to provinces under certain conditions. Those provinces with a plan for ensuring universal hospital insurance would receive 50 percent of the average costs of providing diagnostic services and hospital care.[17] A majority of the provinces were required to agree to the arrangement before the federal legislation was passed. Provinces, originally wary of federal incursion into their jurisdiction, were convinced both by the size of the transfers, and the need for the federal government to assist provinces and regions in establishing equal access in a country where there were significant regional economic inequalities. After twelve years of debate, reports, proposals and federal-provincial negotiations, Parliament unanimously passed the Hospital Insurance and Diagnostic Services Act in 1957. By 1961, all the provinces had signed on and virtually the whole Canadian population was covered.[18]

It took another decade before the battle for public insurance for medical services came to a conclusion. The Canadian Medical Association and the insurance industry maintained their position that the government should only step in to cover or subsidize the premiums of low-income people. In their view, the premiums should be paid to the voluntary plans. The Canadian Labour Congress (CLC) argued that the issue should not be limited to a debate about insurance. The CLC argued that health care should be seen as a public service that was "comprehensive in scope, universally available without regard to means, equitably financed, free of co-insurance, deductibles or other financial deterrents, and having a(n)… administration precluding control or undue influence by any interest group."[19]

In 1960, the Conservative government of John Diefenbaker called a Royal Commission on Health Services. The Commission recommended the adoption of a Health Charter, and a Federal-Provincial Health

Conference to forge an agreement. The Hall Commission recommended that the federal government support provinces and territories which had committed to comprehensive, universal coverage of health care services upon uniform terms and conditions. The Commission concluded that the option promoted by private insurers and the medical profession which required a means test was both undemocratic and inefficient.[20] Commissioners recommended the program should include medical services, some dental services, prescription drugs, optical services, prosthetics and home-care.

The Commission further recommended that the federal government subsidize provincial insurance plans, rather than individuals, since means testing would be cumbersome and inefficient. Hall argued that a compulsory program would be accepted in a democratic society as long as people were free to choose their physician and hospital, and free to seek private insurance for other items. He further suggested that health insurance funds should be administered by one agency for the sake of efficiency.

The Hall report was issued in the midst of a shift in federal-provincial relations during which the likelihood of the federal government imposing conditions grew less and less.[21] At the federal level, conditional grants-in-aid were being changed to shared-cost program financing. When hospital insurance was first introduced in 1957, it was possible for the federal government to audit provincial accounts and impose national standards. This was not the case by the late 1960s.

Finally, after long-term negotiations with the provinces, the federal Liberals introduced a Medicare bill into Parliament. Ten provincial programs would receive federal financing covering 50% of the average national per capita cost, but to qualify, each plan would have to implement four principles.[22] The Medicare bill passed in December 1966 after intense debate within the minority Liberal caucus. The program began on July 1, 1968, but it took until 1972 before every province and territory qualified.

## The Canada Health Act

Canada's public health insurance is run by provinces and territories, but a federal law, the *Canada Health Act (CHA),* governs the plans. The CHA of 1984 replaced the Hospital Insurance and Diagnostics Act of 1957, and the Medical Care Act of 1968. The requirements

underlying the CHA represent the values of Canada's health care system and the conditions provinces and territories must meet in order to receive federal transfers.[23] The CHA states that every province and territory "must ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service." Insured services include hospital and physician and some dental care if delivered in a hospital.

The Canada Health Act asserts five criteria which provinces and territories must meet in order to qualify for federal funding. Health insurance must be administered on a non-profit basis by a public authority. This is the criterion for *public administration*. The health care insurance plan of a province or territory must cover all insured health services provided by a hospital, medical doctor, surgical-dental care delivered in a hospital, and other services as determined by the province. This is the criterion for *comprehensiveness*. All insured residents must be entitled to insured health services on uniform terms and conditions. This is what is meant by *universality*. Insured residents moving from one province or territory to another must be covered by their home province for the duration of the waiting period. This is the *portability* criterion. Finally, insured persons must have reasonable access to services on uniform terms and conditions which is not to be impeded by extra charges and or discrimination. This establishes the criterion of *accessibility*. [24]

Provinces must report to the federal government each year and must acknowledge the financial contribution of the federal government. Finally, regulations state that there are to be no user-fees and no extra-billing. Insured persons must not be charged facility fees in order to receive treatment. In addition, provinces and territories are free to provide services other than medically necessary hospital and physician services on their own terms and conditions - e.g. pharmacare, ambulance services, optometric services. These are called *non-insured health benefits.*

There are services excluded from the provisions of the Canada Health Act. These include services delivered to those individuals covered under Workers' Compensation Systems; the Armed Forces; the Royal Canadian Mounted Police; inmates in Federal penitentiaries and those not eligible for residency. As the Act states,

> "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a

person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;[25]

**Neo-liberal WCB reforms and the pressure to privatize**

Not only does the system of workers' compensation predate the emergence of the public health care system, but it has a different legislative basis. Health services provided by workers' compensation boards are specifically excluded from the definition of insured health services under the CHA. Consequently, the criteria of the Canada Health Act do not apply to WCB.[26] Boards are funded by a completely different statutory body than provincial and territorial health insurance plans, which are paid for in taxes. Employers pay the whole cost of WCB, but it is not a private system. The WCB system is clearly part of the public social security system in that it is a universal insurance system, publicly administered and set up to protect the rights of workers.[27]

All employers and all workers in British Columbia are covered by workers' compensation, unless explicitly exempted by the Board with the result that in 2005, 92.5% of workers in British Columbia were covered.[28] Coverage is higher than the national average of 81.1%. [29] Most employers pay an assessment based on their "experience-rating" as a percentage of payroll, but some are self-insured, which leaves them responsible for paying the costs of compensation out of their own funds.

It has historically been the case that injured workers were treated in hospitals and by health care professionals in much the same way as other patients. Although they have historically had their own rehabilitation centres and assessment clinics, WCBs have always paid hospitals and health care professionals for services. WCB funds continue to be a welcome source of revenue for hospitals. Recently and increasingly, however, WCBs have privatized their rehabilitation centres and, instead, will pay premiums to hospitals and health care professionals for expedited services.[30] Along with recent efforts, on the part of employers, to reduce their experience ratings and lower their assessments, "queue-jumping" is one of a number of neo-liberal reforms that are driven by the desire of employers to get workers off wage-replacement and back to work quickly.

In the 2002 Report of the Commission on the Future of Health Care in Canada, Roy Romanow addressed the issue of fast-tracking

workers ahead of residents in the public health system. Romanow recognized the generally accepted belief that workers who are ill or injured should get back to work quickly. He asks, however, why people who have job related injuries and illnesses should be given preference in getting access to diagnostic or other health care services, over those whose illness or injury is not work related, or who may not be formally employed. (p.8) According to Romanow:

> … many would agree with one physician's assessment that today this preferential access amounts to "officially sanctioned queue-jumping in the public system" (quoted in LeBourdais 1999, 859). Indeed, the vast majority believe that all Canadians are equally entitled to timely service, regardless of their employment status. The elderly and children, for example, are just as deserving of prompt diagnosis as injured workers. For the same reasons that private payment for diagnostic services is contrary to the basic principle of medicare, this "public" form of queue-jumping should be redressed in a modernized Canada Health Act." [31]

Romanow likened the practice of some workers' compensation agencies of contracting with private producers to deliver fast-track diagnostic services to claimants, as being similar to the growth of private MRI clinics. In these clinics, individuals can purchase faster service and then use the results to jump the queue for treatment in the public system. Romanow saw this as being "incompatible with the 'equality of access' principle at the heart of medicare" [32] and recommended that governments must both define diagnostic tests as "medically necessary" insured services and invest sufficiently in the public system to make timely access to diagnostic services a reality.

The amounts of money spent on health care and vocational rehabilitation benefits are not inconsequential. In 2005, WorkSafe BC spent $249.7 million for health care and vocational rehabilitation benefits. Across the country, workers' compensation boards spent $1.67 billion on health care and vocational rehabilitation in 2005.[33] This does not include the money spent on income support, administration, or other benefits.

The system of workers' compensation was set up with the assumption that Boards would "bring revenue into line with expenditures, not *vice versa*."[34] This has meant that assessments must

be adjusted to meet the needs of injured workers and workers facing occupational illnesses. Employers, however, have been circumventing this principle by pressuring Boards to restructure, reduce expenditures and off-load responsibilities onto the public health care system. Employers, who pay the whole cost of workplace injuries and illness, can keep their expenses down if their experience-rating is low.

One could safely assume that if employers worked harder to create healthy and safe work environments, they would have an easier time raising revenue in line with expenditures. In 2005, across Canada, there were 1,097 workers killed on the job and 337,930 injuries accepted by WCB. [35] A focus on prevention would be in the interests of workers, but in the case of British Columbia, a province where 189 workers died in 2005, only 3% of the Board's budget was applied to the prevention of workplace illness, injury and disease in that year.[36]

Increasingly, workers report being pressured not to report workplace accidents to the WCB. To the extent that claims that are not accepted by WCB, they will be treated in the health care system rather than in the workers' compensation system. To the extent that stress, cancer, musculo-skeletal injuries are under-reported or under-compensated, the costs of these injuries are off-loaded onto the public health care system, or in the case of drug costs, to group insurance plans. In British Columbia, for example, WorkSafe BC has, in its own words, "aggressive" targets to reduce the average short-term claim duration. To the extent that workers are pressured into returning to work too quickly, the costs of workers' compensation will be eventually transferred to the public health system. To the extent that the full cost of private care, for example, air flights, are not accounted for in "health care" statistics, the costs of bringing patients to private clinics in metropolitan areas is not fully evident.[37]

A series of neo-liberal reforms to the organization of workers' compensation across the country has meant that we now face a blurring of the lines between public and private service provision. As employers attempt to reduce their costs, some provincial governments have permitted employers interests to tilt WCB towards a private sector model of service delivery. In this way, WCB has become a tool used by employers and governments to open up more of our public services to privatization. As government cut-backs in the 1990s led hospitals to decreasing numbers of beds and out-patient rehab services, employers increased pressure on the Boards to seek out private sector service delivery options. The effects of cost-cutting are seen most dramatically in

the medical aid service of WCB, with the effect of shifting the burden of ongoing treatment to the public health system and group health insurance plans.

**The Wait Times Debate**

Romanow's point about wait times and equal access has become particularly important since the highly controversial and split decision of the Supreme Court struck down Quebec's prohibition on private insurance for publicly insured health services. Since the *Chaouilli* decision in June 2005, advocates for for-profit care have not so much argued that private insurance for publicly insured services and private delivery of services are inevitable. Rather they have argued that "care guarantees" are inevitable.[38] The implication is that governments will guarantee to provide service within a certain time period.

Quebec has responded to the Chaouilli decision with Bill 33 which does permit private insurance for certain targeted procedures (radiotherapy, cancer care, advanced cardiac care) within provincially-mandated time-frames. If the procedures cannot be provided on these terms, the government will pay for the service to be delivered by the private sector in specialised clinics, or in other jurisdictions. The government will also lift the ban on private insurance for patients who wish to see physicians not participating in the medicare system. To begin with, private insurance will be allowed for only only those procedures subject to an access guarantee (cataracts, knee and hip surgery). Over time, the government will add other procedures to this list.

The Charest government argues its plan will support the public system, operate on the basis of universality and not on ability-to-pay, and will lead to greater efficiencies and cost-controls. Private specialty clinics will be considered new partners in the health care system. The clinics will be constructed, equipped and managed by private partners and will affiliate with a public institution. Patients will not be charged for the services they receive. Quebec will maintain the barrier between participating and non-participating doctors and will also maintain legislative tools limiting the number of doctors who do not participate in the system.[39]

As well, the Conservative federal government has taken up "care guarantees" as the solution to wait times in the public health care system. Since the election campaign late in 2005, the minority

Conservatives have been introducing Canadians to the idea of “Patient Wait-Times Guarantees”. If patients are unable to receive treatment in a timely manner, Conservatives argue, the public health system should pay for treatment “at another hospital or clinic, even outside of their home province.”[40] As these treatments will be paid for by public funds, this policy mimics municipal government contracting-out and “alternative service delivery” strategies; i.e. the service remains publicly funded, individuals do not pay out of pocket, but the service is delivered by private, for-profit corporations.

The central problem with “care guarantees” is that they will not guarantee health care services will be delivered in the public system. This policy requires public funds to support the emergence of for-profit specialty clinics and hospitals to meet the demand for specifically targeted medical procedures. Rather than seek public solutions in better wait list management, a thoughtful health human resources strategy and primary care reform, the federal government seeding the ground for private networks of clinics and hospitals to become established. Health care workers will obviously be needed to staff these new entities, with the danger of siphoning-off workers from the public system. Without dealing with the staffing crises in the health care sector, this strategy will lead to more shortages and more difficult jobs for those who remain in the public system. At the same time, the federal government is using the excuse of labour shortages to encourage the active recruitment of internationally trained health care workers from countries of the global South, facing staggering public health care challenges of their own. Migrant and immigrant workers of colour in Canada are recruited only to find themselves in jobs where their skills and experiences are not recognised, and where their human rights are not guaranteed.

The restructured workers' compensation system thus introduces another dimension to the "wait times" debate. For example, WorkSafeBC will expedite service for injured workers in three ways. It will permit expedited consultation by a specialist within 20 working days of the referral. It will arrange for elective surgery to be performed by a specialist within 20 working days of the date of booking, and it will also expedite diagnostic imaging. The Board argues that it "will not displace members of the general public who are currently on waiting lists." Instead, it will use public clinics during hours they are usually closed, as well as private clinics, and it will pay a premium for this service.[41]

In fact, this strategy does undermine the public health care system in a number of ways. First of all, workers' compensation contracts

provide the public resources necessary for private clinics to exist. The viability of these private clinics depends on the workers' compensation system, but these clinics are not simply privatized replacements for the old WCB rehab centres. They blur the lines between the social security and health care systems and bring into being a potential parallel consultative, diagnostic and surgical alternative infrastructure and this new infrastructure is proposed as a private solution to the wait times issue in the public health care system.

At a March 2006 Roundtable organized by the Canadian Medical Association and the Centre for the Study of Living Standards, economists suggested that medical standards were not the only way to evaluate wait times. Instead, a cost-benefit analysis could justify the reallocation of resources to reach shorter wait times. This analysis suggested that the costs of waiting will increase for those with highest wages and highest productivity.[42] It is possible to see how such analyses could be used to justify special access to health care for those who are considered more economically valuable.[43]

As stated in WorkSafe BC's 2005 Annual Report, getting workers back to work more quickly "... is better for the worker, better for the employer, and more cost-effective for the entire workers' compensation system."[44] While this might indeed be true, it is no less true for any other injured or ill resident of British Columbia, or any worker injured while not on the job. If WCBs are permitted to purchase expedited services, then this draws resources away from the public system, and increases wait-times for everyone else. By expediting services, propping up private clinic alternatives and drawing resources away from the public system, it is the interests of employers, and for-profit producers that are expressed through the institution of workers' compensation. This clearly undermines the public health care system and workers' interests in general.

As well, by paying a premium for expedited services, WCBs are strengthening the legitimacy of the argument linking timeliness of service with extra-billing. This argument is being used forcefully by those who would challenge the Canada Health Act in respect of public health care. WCBs cannot justify this by saying they are outside of the public health care system, when they use its services, all the while challenging its fundamental legislative basis.

Finally, there are the health human resources issue which lie unacknowledged within the strategy. Given the staffing crises in public

health care, market forces will draw professionals out of the health care system if they are paid a premium for workers' compensation cases.[45] Even if the WCB system pays for expedited treatment in public facilities on off hours, it is the same health care professionals who normally work for the health care system who will do the WCB treatments on over-time, or for a premium. It would be much preferable for governments to face the wait times issue for all residents with solutions that build-up, rather than erode the public system. This would include wait-times management strategies that take into account a fair and integrated approach to the needs of patients who are and are not covered by the Canada Health Act.

These arguments reflect the extent to which traditional opponents of universal public health care have become emboldened by years of neo-liberalism. Instead of working to defend the public system and employ public solutions to wait times, those with a direct interest in private for-profit health care have re-articulated their traditional opposition to public health insurance and are working to establish a parallel private health care system subsidized by public funds. The private sector challenge to the Canada Health Act comes out of a political context in which a decade of cut backs to health care spending, together with spiralling costs of pharmaceuticals have led to huge pressures on the public health care system. Currently, the issue of “wait times” has been moved to the centre of public discourse about Canada's health care system, but the debate is being conducted in such a way as to undermine public confidence in the ability of Medicare to meet the needs of Canada's residents. An alternative approach would celebrate the innovations that have been made, and may still be made in the public system when physicians work in teams with other health care workers, and when wait lists are managed on a regional basis.[46]

## Fair is Fair: The need to protect and defend public services

Workers' compensation acts do not require medical services to be delivered publicly. Nor do the Acts protect the public health care system by disallowing expedited treatments. These Acts need to be reformed in order to protect both the public character of workers' compensation and health care. In general, provincial and territorial legislation permits Boards to establish policies and programs in relation to compensation and benefits, including the review and approval of operating policies. If the Act encourages Board members to view their responsibilities narrowly in terms of the efficacy of the Workers' Compensation system,

then it is the responsibility of the Province or Territory to take a broader view and ensure the compatibility of both public systems; including establishing the measures necessary to protect Medicare from privatization.

Provincial governments should not permit WCB to become an ideological wedge undermining the legitimacy of the public health care system. Neither should workers' compensation justify an argument for private insurance to pave the way for private insurance companies to pay for expedited treatment for individuals who were not injured at work, but are out on short or long-term disability. Employers should not be able to insist that injured workers get faster treatment than anyone else, and, as public insurance institutions, workers' compensation boards should be brought into compliance with the principles of the Canada Health Act. One public service should not be a vehicle driven by employers to undermine another.[47]

For its part, it is the responsibility of the federal government to work to ensure that in no way is the Canada Health Act undermined, thwarted or contravened. The exclusion from the CHA of insured services delivered under workers' compensation should be dropped. Similarly, the federal government should bring health care services for RCMP, Armed Forces, inmates in federal penitentiaries into conformity with the principles of the CHA. Furthermore, the federal government could act to coordinate with other governments to deal with wait times in the public system. The real solution is to bring public health care resources on-stream with better wait list management. This would mean guaranteeing health care shall be delivered in public facilities. In addition, the federal government could move public solutions to the wait times issue forward by establishing comprehensive support for post-secondary education, training for health care workers and recognition of the experience and skills of immigrant health care workers.

Instead of working to find public solutions to the problems facing the public health care system in Canada, it would seem that private sector interests continue to seek refuge in the ideological arguments used to undermine hospital insurance and Medicare since their inception.[48] The attack on public health care, however, is not simply ideological and there are very clear material interests tied up in the privatization of health care. In the end, if we are to have a health care system that meets the needs of the population, it will be necessary not only to maintain the scope of the Canada Health Act, but to expand it as well. In the medium term, however, given the strength of the right-wing

attack on public insurance at present, we will have to think very carefully about when and how to advocate a reform of the Canada Health Act.

Across Canada, injured workers have direct experience of the negative impacts of neo-liberalism in the workplace. As if that wasn't enough, they must now contend with a dangerous turn towards privatization and de-regulation of the very institutions they must rely on while receiving treatment. The labour movement is opposed to practices in which a worker injured on the job would receive special access, while the same worker injured off the job would not. Workers who deliver WCB services are also intimately aware of the negative impact of privatization in the system and have joined together to sign the "Standhope Manifesto on Workers' Compensation".[49] Among other things, the Declaration calls for workers' compensation to:

- Be publicly delivered
- Be administered in a not-for-profit system, collectively-controlled through legislation; and
- Receive appropriate support from provincial governments.

Given the high incidence of workplace illness and injury rates, and the number of workers and families affected, workers' compensation is something the labour movement cares very deeply about. At the same time, the labour movement has always defended Medicare. At their last Convention, affiliates of the Canadian Labour Congress re-affirmed their long-standing commitments and resolved to "continue to make protecting and improving publicly delivered, not-for-profit health care a top priority worthy of continued national campaigning."[50]

The ongoing defence of public health care and public workers' compensation will require concerted action at the federal, provincial/territorial and local levels based on cooperation between unions, health and safety activists, organizations of injured workers, labour and community advocates of public health care, as well as labour activists employed in the workers' compensation system. Because First Nations governments have their own health care struggles with the government of Canada on health care issues outside of the Canada Health Act, it would be fruitful to establish a dialogue with aboriginal communities about ways to support equal access in a public system. The Canadian labour movement actively supports the Canadian Health Coalition, and provincial and territorial coalitions which work together to defend public health care.

All defenders of public health care are very concerned about the trend towards privatization and there is potential for a strong coalitional response to this problem. Both workers' compensation and health care are part of the rich heritage of public services and need to be defended by Canadian social movements. Privatization, after all, can and should be countered by democratization.

TH:sh\cope225\G:\TH\Papers\2007\Health Care Reform and WCB-Final-May 22.doc

[1] The author would like to thank David Bennett, Andrew Jackson, Irene Jansen, Tom Juravich and Natalie Mehra for comments on an earlier draft.
[2] Cambie Surgerie Centre, "The History" Retrieved May 17, 2007 http://www.csc-surgery.com/history.php
[3] Dr. Brian Day, Evidence, Government of Canada, Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology, First Session Thirty-seventh Parliament, 2001, Thursday October 18, 2001,
[4] Hon. Sir William Ralph Meredith, C.J.O, Commissioner, *Final Report on Laws Relating to the Liability of employers to make compensation to their employees for injuries received in the course of their employment which are in force in other countries, and as to how far such laws are found to work satisfactorily"* Legislative Assembly of Ontario (LK Cameron, Printer to the King's Most Excellent Majesty: Toronto, 1913) as found on the WorkSafeBC website: www.worksafebc.com/publications/reports/historical_reports/meredith_report/default.asp
[5] Roy J. Romanow, Commissioner, *Commission on the Future of Health Care in Canada* (Ottawa: Government of Canada, 2002), p.349.
[6] Ison, *Workers' Compensation in Canada* p.8
[7] Ison, *Workers' Compensation in Canada, p.130.*
[8] Terence Ison, *Workers' Compensation in Canada*, (Toronto: Butterworths, 1983), p.2
[9] Ison, *Workers' Compensation in Canada* p.19.
[10] Ison, *Workers' Compensation in Canada* p.49.
[11] Workers' Compensation Act RSBC 1996 Chapter 492 http://www.qp.gov.bc.ca/statreg/stat/W/96492_01.htm#section21
[12] Steve Hunt, Interview with author, United Steelworkers -Métallos, Director District 3, Ottawa April 19, 2007
[13] These included public health, venereal disease control, mental health, tuberculosis control, cancer control, crippled children, professional training, and public health research. Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), pp.161-164
[14] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p. 170-172, 189-191.
[15] G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), 173-176.
[16] House of Commons *Debates*, June 20, 1951, p.4386-87 as cited in Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p 197.
[17] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p,217
[18] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p.234.
[19] Canadian Labour Congress, Submission to the Royal Commission on Health Services, May 1962 as cited in Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p. 358.
[20] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p.347.
[21] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), pp 0361-362
[22] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), p.362.and p. 365
[23] Health Canada, "Overview of the Canada Health Act" 13 October 2005. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html
[24] Health Canada, "Overview of the Canada Health Act" 13 October 2005. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html
[25] *C-6 Canada Health Act* Section 2 - Interpretation "Insured Health Services" http://www.canlii.org/ca/sta/c-6/whole.html
[26] This exclusion also existed in the two pieces of legislation that the CHA replaced. Correspondence with Melynda Kurucz, Research Analyst, Health Canada, September 18, 2006.
[27] Interview with Steve Hunt, United Steelworkers -Métallos, Director District 3, Ottawa April 19, 2007
[28] Association of Workers' Compensation Boards of Canada, "Key Statistical Measures 2005" http://www.awcbc.org/english/board_pdfs/2005KSMs.pdf
[29] The Board has granted exemptions to: homeowners who employ an individual in or around a private residence for short periods of time; spouses involved in an unincorporated business; businesses in the trucking industry not incorporated in BC and with other limitations; professional competitors and athletes; financial holding company under certain conditions; consulates and trade delegations from visiting countries; as well as flight crews from outside BC. Workers' Compensation

Board of British Columbia, *Assessment Manual*, Exemptions from Coverage, AP1-2-1 January 1, 2003. www.worksafebc.com/publications/policy_manuals/assessment_policy_manual/Assets/PDF/assessment_manual.pdf

[30] Fuller, p.169-170

[31] Romanow, p.65

[32] Romanow p.xxi

[33] Association of Workers' Compensation Boards of Canada, Key Statistical Measures 2005, 5.1.1 Health Care and Vocational Rehabilitation Payments for All Years Paid During the Year for Assessable Employers. http://www.awcbc.org/english/board_pdfs/2005KSMs.pdf

[34] Ison, *Workers' Compensation in Canada, p.129.*

[35] Association of Workers' Compensation Boards of Canada, National Work Injury/Disease and Fatality Statistics Program. Table 14. Number of Fatalities, by Jurisdiction, 1993 – 2005 and Table 1 Number of Accepted Time-loss injuries by jurisdiction 1982-2005.

[36] WorkSafeBC, "From Awareness to Action: 2005 Annual Report and 2006-08 Service Plan" iii

[37] Interview with Steve Hunt, United Steelworkers -Métallos, Director District 3, Ottawa April 19, 2007

[38] Patrick J. Monahan*, "Chaoulli v.* Quebec *and the Future of Canadian Healthcare: Patient Accountability as the "Sixth Principle" of the Canada Health Act ,* 15th Annual C.D. Howe Institute Benefactors Lecture,(November 2006). 30 pp http://www.cdhowe.org/pdf/PressReleases/english/benefactor_lecture_2006_pr.pdf

[39] Garantir l'accès : un défi d'équité, d'efficience et de qualité Le premier ministre Jean Charest et le Ministre Phillipe Couillard tracent un bilan positif en matiere de sante et invitent les Quebecois a aller plus loin." February 16, 2006, Press release

[40] Government of Canada, Budget Plan 2006, p.143

[41] WorkSafeBC, "Health Care Providers" Expedited services: consultation, surgery and diagnostic imaging" www.worksafebc.com/health_care_providers/health_care_practitioners/medical_and_surgical_specialists/treating_injured_workers/default.asp

[42] Ernie Stokes and Robin Somervillw, "The Economic Costs of Wait Times in Canada" Centre for Spatial Economics, June, 2006 http://www.csls.ca/events/CMA-CSLS/BCMA-CMA-waittimes.pdf

[43] This point was made by Andrew Jackson, Canadian Labour Congress, at the Roundtable on Health Care and the Economy, March 7, 2006 Ottawa.

[44] WorkSafe BC, 2005 Annual Report, p 23.

[45] "We are not a unionized facility because if we were, we would have the same trouble getting nurses as the hospitals have. We pay our nurses 15 per cent higher than the highest level they can achieve after 12 years in the public system, because we need these nurses...Secretaries are not unionized. Similarly, the technical group would, in the hospitals, belong to the hospital employees union. The central sterile technicians who sterilize all the equipment, clean the equipment, are not unionized. Again, to attract those people, we have to pay higher than union wages. If we were unionised, the workers would have to take a cut in pay. We will never be unionized until public sector catches up with our wages." Dr. Brian Day, Evidence Government of Canada, Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology, First session Thirty-seventh Parliament, 2001, Thursday October 18, 2001,

[46] Alicia Priest, Michael Rachlis, Marcy Cohen, "Why Wait: Public Solutions to Cure Surgical Waitlists", Canadian Centre for Policy Alternatives, BC Office, May 2007.

[47] Further attention needs to given to the question of whether these principles should also be applied to federally-delivered health care. The federal government provides health care services to First Nations peoples living on reserve, Inuit, active members of the Royal Canadian Mounted Police and the Canadian Forces, as well as veterans, inmates in federal institutions and refugee claimants. Health Canada, "Canada's health care system: The Role of Government" http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-hcs-sss/role_e.html#1

[48] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. (Montreal: McGill-Queens University Press, 1978), pp.331-377.

[49] Stanhope Manifesto on Workers' Compensation , 2002, Canadian Union of Public Employees, National Union of Public and General Employees, Compensation Employees' Union. Letter from Paul Moist, CUPE to Ken Georgetti, CLC March 15, 2007.

[50] Canadian Labour Congress, Resolution on Public Health Care, 24th Constitutional Convention, June 2005, Montreal