Private Health Care Option In Disability Management

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The Debate

Timely access to healthcare has become a leading concern for many Canadians. Wait times for diagnostic procedures, medical specialists and surgical intervention have emerged as key points of debate for politicians, healthcare professionals and academics. At the centre of the debate lies the more volatile issue of whether some people should be encouraged to have their diagnostic procedures and surgeries done at private healthcare facilities rather than through the public system. Canadian employers are among those frustrated with long wait times and many are contemplating the option of providing access to private health care through their Disability Management programs.

Members of the Canadian workforce are among those affected by lengthy waits for medical intervention. At any given time, it is estimated that between 8 and 12% of the working population is off work due to a disability. (Dyck, 2000) In fact, the duration of a disability as a result of illness and non-occupational injury is often directly tied to how quickly the employee can access treatment. This seems difficult to achieve in light of the fact that a recent Statistics Canada (2006) report on access to health care suggests that of the 2.8 million Canadians who visited a medical specialist in 2005, a significant number had difficulty in accessing care, and if they were fortunate enough to get a specialist consultation, the wait time before seeing that specialist was significant.

Currently, wait times concerns are still at the forefront of debate despite a commitment made at the First Ministers conference in the fall of 2004. The Ministers stated that they would work toward "meaningful reductions in wait

times in priority areas such as cancer, heart, diagnostic imaging, joint replacement and sight restoration by March 31, 2007…" (Canadian Institute for Health Information, 2006, p.2). Since little progress has been made, Canadian employers are looking at alternative methods to assist employees in a speedier return to work. The economic cost of disability is staggering, and business competitiveness is affected when employees are off work because of a disability (Conference Board of Canada, 1998). Employers are aware of the business consequences of disability, and pro-active employers soon realize that investment in the health of their employees makes good business sense. One potential solution for employers would be to purchase medically necessary services such as diagnostic testing and surgery time from a private healthcare provider in order to expedite an employee's early return to work; much like what Worksafe BC is already doing with some of its claimants. However, the issue of whether a Canadian should be allowed to purchase medically necessary services privately when denied timely access through the public system is quite contentious (Hartt & Monaham, 2002). It would prove to be no less contentious for a company seeking health services from a private facility.

Without getting into a full analysis of the debate, it is important to note some key points. One side argues that private health care will create a two-tiered system that, by default, favours those who have money and status. In addition, opponents postulate that private healthcare violates the principles of the Canada Health Act, and undermines one of its core tenets that the provision of health care should be based on need rather than wealth or status. Conversely, those in favour

view private health care as a viable alternative that would help decrease wait times in the public system.

The employer's roles and responsibilities in the health of their employees has evolved dramatically over the last decade, moving from a strictly occupational health and safety focus to providing a comprehensive healthy work environment including programs for disability management, wellness and work/ life balance (Conference Board of Canada – 2000). Should this trend towards holistic workplace and workforce health include financing private surgery and diagnostic testing? How involved should employers be in the health of their employee's? This paper will examine whether financing private surgery is a viable option in disability management by analyzing some of the associated benefits and risks.

Disability Management

Disability management is described as: "a systematic goal-oriented process of actively minimizing the impact of impairment on the individual's capacity to participate competitively in the work environment, and maximizing the health of employees to prevent disability, or further deterioration when a disability exists." (Dyck, 2000, p.7). In practice, managing health by promoting healthy lifestyle and wellness initiatives cannot eliminate the likelihood that employees will develop, at some point in their life, illnesses and non-occupational injuries which will result in absences from work. This is when a structured disability management program is required. Over the years, employers have come a long way in the management of employee absences, moving from little or no involvement to sound and progressive disability management programs.

There is mounting evidence on the benefits that disability management programs offer, both for employers and their employees. For employers, a disability management program results in a healthier workforce, reduced absenteeism, improved productivity, lower disability costs, lower insurance premiums and rates (Dyck, 2000).

Benefits for employees are numerous and include the following: Dyck (2000):

- decrease/prevent feeling of loneliness and abandonment that reduce the employee's motivation to get well;
- avoid delays in the employee's obtaining appropriate health/rehabilitation services;
- avoid a run-around for the employee from health care professional to health care professional;
- help prevent the development of psychological problems such as the adoption of the "sick role" and related secondary gain;
- help with the physical, psychological, vocational, social and financial implications of a disability situation (p. 10).

One of the principles of disability management is early intervention. The disability community recognizes the importance of acting quickly at the onset of disability, not only to maintain occupational bonding but also to ensure a timely return to work as soon as medically feasible. However, there are several factors that can delay return to work and prolong disability despite many initiatives by employers to facilitate the return to work. These factors have been identified by

Krauss et al (2001). Specifically, seven categories are known to influence the duration of disability:

1. Workers' characteristics such as socio-demographics, psychological factors, attitudes and beliefs, health behaviours and clinical measures.

2. Injury descriptors such as disease category, injury or illness severity, body part injured compensability.

3. Medical and vocational rehabilitation such as acute, sub-acute and chronic disability phase including the medical case management.

4. Job task level, physical and psychological job characteristics.

5. Organizational level employer's factors such as: people oriented culture, pro-active in house return to work program, size of employer, unionization.

6. Employer or insurer based disability prevention program such as comprehensive programs, active monitoring of claimants by insurer; early contact of worker by workplace, modified work program .

7. Societal level; legislative, social policy and macro-economic factors such as: litigation, complexity of compensation system, high number of job benefits, high level of wage replacement benefits, etc. (pp. 470-475).

In the management of an employee's disability it is commonly accepted that all of the factors listed above can influence a successful outcome; however, in addition to these factors, it is important to note that timely access to health care must also be considered. Lengthy waits can influence the duration of disability and prevent timely return to work after an injury or non occupational injury. For instance, the Fraser Institute National waiting list survey (2006) indicates the

median wait time between referral by the General Practitioner (GP) and appointment with the specialist was 7.4 weeks in B.C. and the median wait time between referral by GP and appointment with specialist by specialty was 8.8 weeks (weighted median). Orthopaedic surgery was 16.2 weeks while neurosurgery was 21 weeks. The median wait between the appointment with the specialist and treatment was 4.9 weeks in B.C. overall. If, in the example above, it takes an average of 16.2 weeks to see an orthopaedic surgeon, plus almost 5 weeks for the treatment, a patient can expect to wait up to five months for treatment. The waiting time is not limited to surgery; similar problems occur for employees waiting for diagnostic tests such as magnetic resonance imaging (MRI), another area of concern identified by the 2004 First Ministers Conference. The Canadian Institute for Health (2006) indicates that outpatients can wait anywhere between 8 to 180 days between the time of their referral and the actual scan.

These wait times are of real concern to employers as stated by the President of Drug Benefit Consulting: "there is a time when employees become patients who need to rely upon the public healthcare system for medical treatment" (Benefit and Pension Monitor, 2007). As we know, while employees are waiting for treatment in the public system, they are away from work and unable to contribute to the success of the organization, affecting the bottom line and depriving a business of its human resources.

It is not the purpose of this paper to enter into the political debate around what constitutes "timely access" to health care since consensus is difficult to

reach even among medical practioners, but according to the Kirby Report on the Health of Canadians "timely access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practices guidelines to ensure that a patient's health is not negatively affected while waiting for care." (p. 99). Employers are not in a position to make a determination that an employee's health is affected while waiting for care; however, they can confirm that a lengthy wait influences the duration of disability and a timely return to work.

If the employee's return to work is delayed as a result of lengthy waits in the public sector, should the employer facilitate the recovery by ensuring the employee gets care as quickly as possible in the private sector? What are the benefits? What kind of diseases or injuries should be considered and why? These are some of the questions that employers will have to consider. On the other hand, what are the potential legal and ethical risks faced by employers? These are serious issues that need to be examined so that Canadian employers are not only considering this option from a business point of view but in the context of good corporate citizenship.

Economic Benefits:

The economic benefits of early return to work are obvious. Absenteeism costs Canadian employers about 1.75 to 2.5 times the employee's salary in direct and indirect costs, translating into 52.2 million hours of lost time at a cost of about $15 billion per year (Dyck, 2000). The Conference Board of Canada puts

the average costs of disability at $300/per day per employee not including loss of productivity, overtime pay for healthy workers, replacement staff and low morale (Benefits Canada, 2005). They further estimate that a single disability claim costs Canadian firms an average of $80,000. (Canadian HR Reporter, 2005). The Pharmaceutical Manufacturer Association of Canada recently commented that: "a focus on strategic health recognizes that poor health adds costs to labour. By managing health, organizations can better manage their true cost of labour.... labour cost is not simply a function of payroll and benefits, but a function that takes into account worker productivity, absenteeism, disability, worker's compensation and the unfunded liability for future health benefits." (Conference Board of Canada, 1998, p. 10) We also know that the longer an employee is off work, the less likely they will return to work which will significantly increase the costs of disability. For employers, the lack of timely treatment increases the cost of wage replacement indemnity the employee receives while waiting for treatment in the public system. Most employers in large companies have some form of wage replacement indemnity, typically 100% of wages for a set number of weeks and dropping to 60 to 70% of wages when on long-term disability.

For employees, the ability to access care in a private facility will not only reduce the risk of further deterioration and complications, but will also provide a speedier return to work. The C.D. Howe Institute (2002) indicates that: "the waiting period involved significant pain, loss of functionality, decreased quality of life and lost work time." (p. 15). There is also increased psychological impact

such as depression, anxiety and sleep disturbances." (Walker with Wilson, 2001, 7-8 in C.D. Howe Institute, p.15)

A recent article from the National Post Business (2002) on private health demonstrates the benefits. The reporter described the case of an RCMP officer off work for 4 months as a result of a sore hip. If he had been treated in the public system, he would have waited 19 weeks for an MRI and 18 weeks for surgery. The cost to the RCMP and its insurer, for long-term disability during the year he would have been off work, was $60,000. Having the ability to get care in the private health system allowed the officer to wait only one week for the MRI at a cost of $700.00 and only a few days for surgery. Cost of surgery was $4,000 for a total of $4,700. Total time off the job post-op was three weeks (National Post Business). Fortunately, RCMP service members, WCB recipients, members of the armed forces and prisoners in federal jails are exempt from the restrictions of the Canada Health Act and are able to receive care in private settings, which enabled this officer to return to work very quickly. The cost of the surgery and short recovery time was obviously cheaper for the employer than having this officer wait in the public system while on paid leave.

When patients are treated quickly, it minimizes the chance that their condition will deteriorate and result in an extension of the recuperation phase. Patients also benefit from reduced periods of pain and suffering and a quicker return to work and full wages instead of receiving wage replacement at a lower rate. In short, the benefits of being able to access private medical care provide a win-win situation for the employee and the employer.

According to Daphne Woolf (Managing Partner of the Collin Beer Group in Toronto), although nobody openly admits to it, perhaps because of the controversy, some employers are already paying for private care in Canada and the US on an informal, ad-hoc basis. (Canadian HR Reporter, 2005). Dr.Brian Day, founder of the Vancouver based Cambie Surgical Centre has said that as many as 50 Canadian companies sent up to 300 injured or disabled workers to his clinic for private treatment in 2005 (Canadian HR Reporter, 2005) According to Lynn Furlotte, Executive Director of the Specialist referral clinic in Vancouver (personal communication, April 13, 2007), more and more employers are sending their employees for private surgeries, primarily including orthopaedic surgery and general surgery such as hernia repairs and vascular surgery involving the spine and foot.

Another Side to the Benefits Equation

At first glance, the savings achieved on wage replacement combined with all the benefits of early return to work are attractive and make business sense. However, there is potential exposure on the benefits plan design. Health care costs for employers are on the rise, and according to the Towers Perrin Canadian Health Care Cost Survey (2006), employers in Canada are anticipating an 8% increase in combined medical and dental costs for active employees in 2006 and a 3% increase for retirees (Tower Perrin, HR Services). Factoring in these increases, the average plan cost per active employee in 2006 is expected to rise to $2,048 per year (medical and dental combined). In a recent survey, the Morneau Sobeco (2004) compensation trends and projections (as cited in Isaacs-Morell,

www.benefits.canada.com, 2005), 57% of employers who were canvassed indicated the increased costs of benefits are a key issue for them. Further, this same survey indicates that plan costs will likely continue to increase because of an aging workforce and the availability of more costly medical and dental treatment.

How private surgery comes into play in the benefits realm is a direct result of the Chaoulli decision (Chaoulli v.Quebec [Attorney General]). On June 9, 2005, the Supreme Court of Canada ruled that Quebec's prohibition on private health care insurance and the inability of its resident to buy privately delivered health care violated the Quebec Charter of Human Rights and Freedoms. While this decision is applicable in Quebec only, it is believed that it will have an impact across Canada.

The Chaoulli decision was the result of a patient who sued the Quebec government after a year long wait for hip replacement surgery. In a majority decision, the Court found "that waiting lists for health care services have resulted in deaths, have increased the length of time that patients have to be in pain and have impaired patients' ability to enjoy any real quality of life" (p. 27).

Employers have reason to be concerned about the potential impact this decision will have on their ability to curb their benefits cost. Experts believe that the Chaoulli decision will open the door to duplicate private health care insurance not only in Quebec, but in other provinces as well. Additionally, inquiries have been made as to who would be interested in purchasing duplicate private insurance and whether there is a potential for duplicate coverage to be provided

through employer-sponsored health care insurance (Madore, 2006). Employers are facing some exposure if they decide to pay for private surgery given that it will be seen as an additional benefit, setting the stage that this type of coverage should be provided as part of an employee's overall benefits package. Furthermore, consultants in the insurance business feel that: "as a result of the ruling, Unions and employees are expected to increase the pressure on Canadian employers to offer private care options for doctors, specialists, and hospital visits normally covered by the government. As we have seen, offering private health care options would enable employees to avoid the long waiting periods often associated with government-funded health services." (Business Insurance, 2005, p. 1)

The real dilemma for employers considering these options is determining which is the most cost effective. On the one hand, employers are looking at ways of reducing the cost of their benefits by moving away from traditional benefits plans toward flex benefits and/or health spending accounts. On the other hand, funding for private surgery and diagnostic testing might provide significant savings on the costs of short and long term disability plans, but could also trigger requests from employees and unions to include private care options as part of the overall benefits package. At the end of the day, companies will have to decide if the benefits of paying for private surgeries outweigh the potential risk of increasing the overall cost of their benefits plans. Employers considering this option would be wise to obtain professional cost/benefit advice from an economist or benefits specialist.

Disease Considerations

There are a wide range of diseases and conditions requiring different treatment and interventions that can affect employees. Obviously not all of them are suitable for private treatment given the complexity and type of care required for some conditions (e.g., cancer). However, one group of conditions with a significant toll both economically and occupationally are musculoskeletal disorders. There is extensive literature, studies and research devoted to musculoskeletal disorders and their impact in the workplace. The Director General of the World Health Organization (2003) Dr. Harlem Brundtland states that: "musculoskeletal or rheumatic disorders are the major cause of morbidity throughout the world, having a substantial influence on health and quality of life and inflicting an enormous burden of cost on health system" (p. 1).

Musculoskeletal disorders are particularly taxing in occupational settings given they are currently affecting the baby boom generation, the largest component of the workforce. The baby-boomers are people born between 1946 and 1965 who were between the age of 41 and 60 years old in 2006 (Statistic Canada, 2006 Census). According to Statistic Canada, one in three Canadians was a baby-boomer in 2006 and 3.7 million Canadians were between the ages of 55 to 65, a fact that helps to explain the explosive impact of musculoskeletal disorders in the workplace. The elimination of mandatory retirement in British Columbia effective January 1, 2008 may further exacerbate this effect.

Conditions included in the broad category of musculoskeletal disorders are osteoarthritis and osteoporosis, degenerative conditions associated with age, as

well as spinal disorders and rheumatoid arthritis. The World Health Organization (WHO) describes osteoarthritis as a condition characterized by focal areas of loss of articular cartilage within the synovial joints, associated with hypertrophy of the bone and tickering of the capsule (WHO, 2003). Osteoporosis is a disease characterized by low bone mass and deterioration of bone tissue which leads to increased bone fragility and risk of fracture, particularly of the hip, spine and wrist. According to Osteoporosis Canada, osteoporosis affects 1.4 million Canadians, an average of one in four women and one in eight men over the age of 50.The joints affected most by osteoarthritis are the hands, spine, knee, foot and hip, and these effects can be debilitating with respect to daily living activities, including work. People suffering from osteoarthritis are the most likely to undergo joint replacement surgery.

Other musculoskeletal conditions include spinal disorders (a range of specific and non-specific musculoskeletal disorders involving the spinal column and a range of maladies affecting the muscles nerves, inter-vertabrae discs, joints, cartilage, tendons and ligaments of the neck and back (WHO). According to the World Health Organization, non-specific musculoskeletal conditions are the most frequent causes of spinal disorders and have the greatest impact on individuals, health care systems and society as a whole.

Rheumatoid arthritis is an autoimmune disease which causes inflammation of the joints, mostly hands or feet. It affects 1 in 100 Canadians between the age of 25 and 50 (Arthritis Society, n.d.). A recent report from Health Canada (2003) on the challenges of arthritis and related conditions indicates that approximately 1

in 6 people age 15 and older are affected by arthritis and other rheumatic conditions. Two-thirds were women and nearly 3 of every 5 people were younger than 65 years of age, again confirming its devastating impact on the workforce. These diseases often hit employees during their most productive years, when their knowledge and experience reaches its peak. Employers are losing these valuable employees at a time when institutional knowledge needs to be transferred and when the baby boomers are needed to mentor the younger workforce.

Musculoskeletal Diseases and the Private Treatment Option

There are several reasons that musculoskeletal diseases may be particularly suitable for private surgery. The demographic of the population affected by these conditions is particularly significant in today's workforce given the large percentage of baby boomers. In addition, the economic cost of musculoskeletal disorders alone is staggering, having been estimated at $25.6 billion (in 1994 Canadian dollars) or 3.4% of the Canada's Gross Domestic Product (GPD; Coyte, Asche, Croxford, Chan, 1998) - direct and indirect costs were estimated at $7.5 billion and 18.1 billion, respectively. Hospital and physician costs represented the largest components of the direct costs of MSD at 42.1% and 27.2%, while musculoskeletal disorders accounted for 10.3% of direct health expenditures. Indirect costs were 2.4 times higher than direct costs. Under the baseline scenario, lost productivity due to disability was $13.9 billion or 54.3% of total musculoskeletal costs. Musculoskeletal disorders were the most costly disease group for women in Canada in 1998 ($8.2 billion) and the third most costly disease group for men ($8.1 billion) according to Health Canada

report on arthritis (2003). Morbidity costs due to long term disability accounted for 76.5% of arthritis costs, representing the largest cost components of arthritis at almost $3.4 billion (Health Canada). In addition to the economic burden, there is a significant price being paid by individuals suffering from musculoskeletal conditions. The reduction in quality of life because of pain, stiffness, loss of mobility of the joints, deformity, disability as well as loss of independence, reduced social interactions, and a decline in well being, needs to be taken into consideration as well (World Health Organization, 2003).

Wait times for musculoskeletal diseases

People suffering from musculoskeletal conditions are among those affected by long wait periods between diagnosis and intervention. For instance, the Joint Replacement Registry indicates that on average 40% of the wait time to see an orthopaedic surgeon is spent between referral to an orthopaedic specialist and the decision to proceed with surgery, while 60% is spent waiting for the surgery itself . The information provided by each province on joint-replacement wait times is measured from hospital booking to surgery. In British Columbia, for the three month period ending September 30, 2005, the estimated orthopaedic surgery wait was 51 days; the hip replacement wait estimate was 132 days, and the knee replacement wait was 175 days (Canadian Institute for health information, 2006). Moreover, these wait times do not include the timeline between diagnosis and actual surgery.

As we have seen, baby boomers are the most likely to be impacted by musculoskeletal disease. A recent Vancouver Sun article (October 27, 2007)

brings this point home. According to the article, active boomers do not want to live with a disability and repair or replacement of hip and knee joints is a growing trend amongst members of this generation. The article further suggests that the largest increase recorded over the last decade in knee and hip replacement is for patients between the ages of 45 and 54 years old. Hip replacement doubled in this age group over 10 years from 1,213 in 1994-95 to 2,664 in 2004-05, while knee replacements nearly quadrupled from 655 in 1994-95 to 2,529 in 2004-05. Dr. Paul Sabuston, orthopaedic surgeon interviewed for this article stated that: "they (baby boomers) are more active than their parents were. It's also a more demanding population (than the previous generation), they don't want to be waiting around forever, and they want to be fixed now"(p.A-4).

Legal and Ethical Risks Faced by Employers

Despite the advantages offered by access to the private system, one needs to examine carefully some of the potential risks for employers. There are two main issues: the potential for discrimination complaints under Human Rights legislation and ethical concerns.

Potential Discrimination Complaints

Both the British Columbia Human Rights Code and the Canadian Human Rights Code contain provisions prohibiting discrimination on a number of grounds including disability and age. Each of the prohibited grounds of discrimination applies in different settings such as denial of goods, services, facilities, accommodation and employment (R.S.B.C. 1996, c. 210 [as amended]).

In British Columbia, the purpose of the Code is defined in Section 3:

a) to foster a society in BC on which there are no impediments to full and free participation in the economic, social, political and cultural life of BC;

b) to promote a climate of understanding and mutual respect where all are equal in dignity and rights;

c) to prevent discrimination prohibited by this code;

d) to identify and eliminate persistent patterns of inequality associated with discrimination prohibited by this code;

e) to provide a means of redress for those persons who are discriminated against contrary to this code.

The Canadian Human Rights Act has similar provisions in Section 2.

Under the BC Human Rights Code discrimination in employment is described in Section 13 as follows:

(1) A person must not

a) refuse to employ or refuse to continue to employ a person, or

b) discriminate against a person regarding employment or any terms or conditions of employment

because of race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or because that person has been convicted of a criminal or summary conviction offence that is unrelated to the employment or the intended employment of that person.

Section (2) .....

The Canadian Human Rights Act outlines discriminatory practice in employment under Section 7 which states:

> It is a discriminatory practice to directly or indirectly
>
> a) to refuse to employ or continue to employ any individual or
>
> b) in the course of employment, to differentiate adversely in relation to an employee on a prohibited ground of discrimination.

One might ask how an employee could successfully file a Human Rights Complaint against his employer if the employer paid for private surgery to enable the employee to return to work sooner. Employees on disability could allege that the employer is providing differential treatment for disabled employees based on their disability or age. It would be particularly relevant in cases where two employees are off work and waiting in the public sector for much needed joint replacement and the employer provides private surgery for one, but not the other. The employee might be able to argue that he/she was treated differently by being denied access to funding for private surgery despite the fact that both employees required similar joint replacement. Having said that, let us examine the legal requirements for discrimination complaints.

The first step required by Human Rights legislation in determining whether an employee has been the subject of discrimination is to establish the existence of a prima facie case of discrimination (D'Andrea, 2005). The Supreme Court of Canada in a landmark case, Ontario (Human Rights Commission) v. Simpsons-Sears Ltd. (1985) 2 S.C.R. 536 (as cited in Matuszewski v.B.C. [Ministry of competition, science and enterprise]) described prima-facie as: "one

which covers the allegations made and which, if they are believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent-employer" (p. 49).

The employee has the onus of proving a prima facie case and must prove:

a) that he or she is disabled;

b) that the conduct that he or she complains about is prohibited;

c) that the employer's conduct was influenced by it having regard to the employee's disability or alternatively that the conduct had a negative effect on the employee and that;

d) the employee suffered harm in the employment context as a result of the discriminatory conduct (D'Andrea, 2005, p.4-9).

By way of contrast, Human Rights Tribunals sometimes limit themselves to three key questions:

1) Does the employee have a disability?

2) Has there been adverse treatment?

3) Was the disability a factor in the adverse treatment? (BCHRT – 2007-30)

According to D'Andrea (2005), the burden of proving a prima facie case is not heavy, given that tribunals and courts find that human rights legislation should be broadly interpreted to advance the remedial goals of the legislation.

In the examples cited throughout this paper, employees are off work as a result of a disability and employers are contemplating financing access to

private health care such as surgery or diagnostic tests to expedite the return to work. Both the BC Human Rights Code (BCHRC) and the Canadian Human Rights Act (CHRA) prohibit discrimination on the basis of mental and physical disability. As noted above, Human Rights tribunal have interpreted disability broadly to cover almost all medical conditions (MacNeil, 2007). Employees contemplating a discrimination complaint would not have difficulty meeting the first criteria, evidence of a disability. The second criteria would be to prove that the alleged discrimination is within one of the grounds upon which the employer may not discriminate under the Human Rights legislation (D'Andrea, 2005). Both the BCHRC and the CHRA prohibits discrimination in employment including hiring, discrimination during employment, and any term of employment. The author believes that disabled employees who are denied equal access to private health care would have a legitimate claim.

Justice McIntyre, in a Supreme Court of Canada decision in Law Society of British Columbia vs. Andrews (1989) 1 S.C.R.(as cited in Matuszewski v.Ministry of Competition, Science and Enterprise), defined discrimination as follows: "I would say then that discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society" (p. 143).

The last sentence is particularly relevant to our argument. Hypothetically, employees off work on disability as a result of a musculoskeletal disease or injury and waiting for some orthopaedic procedures would, in the writer's opinion, have a valid argument that providing payment on an ad hoc, or case by case, basis to certain employees "limits access to opportunities, benefits and advantages available to other members of society or alternatively, imposing burdens, obligations or disadvantages on such individual or group not imposed upon others" (p. 143). Either way, an employee who is not considered as a candidate for private surgery by his/her employer, or is not provided with this opportunity, may claim that the employer is imposing a disadvantage on the employee which is not imposed on others.

Human Rights tribunals have considered using the *Law Analysis* when determining if there has been discrimination contrary to the Code (Matuszewski v. BC [Ministry of Competition, Science and Enterprise] No.2, 2007, BCHRT 30). *Law* was a Supreme Court case based on a discrimination complaint filed under the Canadian Charter of Rights and Freedoms regarding the application of the Canada Pension Plan rules. Although the Charter is sometimes seen to apply primarily to the relationship between an individual and government, the Supreme Court of Canada has provided guidelines for analysis under s. 15 of the Charter that have been used in Human Rights complaints. They are:

A) Does the impugned law

(a) draw a formal distinction between the claimant others on the basis of one or more personal characteristics, or

b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?

B) Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds;

C) Does the differential treatment discriminate by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that individual is less capable or worthy of recognition or value as a human being or as a member of Canadian Society, equally deserving of concern, respect and consideration. (Law v. Canada [Minister of Employment and Immigration] , 1999, 1 S.C.R. 497).

The Supreme Court of Canada explains the comparative approach the claimant must follow by choosing the person, group, or groups with whom he or she wishes to be compared for the purpose of the discrimination inquiry. Some of these factors outlined by the Supreme Court of Canada are:

a) Pre-existing disadvantage, stereotyping, prejudice, or vulnerability experienced by the individual or group at issue;

b) the correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others.

c) the ameliorative purpose or effects of the impugned law upon a more disadvantage person or group in society.

d) the nature and scope of the interest affected by the impugned law.

When employers consider who amongst their disabled employees will be eligible for private diagnostic tests or private surgery, they will likely consider factors such as the medical condition of the employee, the position the individual has within the company, the cost/benefit analysis, the age of the employee and which disabled employee will most likely benefit from the procedure. In the B.C human rights decision on Matuszewski, the Tribunal member was relying on the *Law Analysis* and used the comparator group analysis outlined by the Supreme Court of Canada to render a decision on equal access to benefits - the benefit in this case being quicker access to treatment resulting in decreased pain and suffering while allowing the employee to return to work more quickly. In the Matuszewski case, the complainant was alleging discrimination on the basis of physical disability. Mr. Matuszeski was not accruing service seniority while on LTD. The Tribunal member completed a thorough analysis both under the traditional approach and the Law analysis and determined that the plaintiff had established a prima facie case of discrimination; therefore, it was up to the employer to establish a defence. In determining a proper comparator group for Mr. Matuszewski, the member drew upon the definition established by the Supreme Court of Canada in Hodge v. Canada (Ministry of Human Resources Development) 2004, S.C.C. 65 in Matuszwski which states:

> "the appropriate comparator group is one which mirrors the characteristics of the claimant (or claimant group) relevant to the benefit or advantage sought except that the statutory definition includes a personal characteristic that is offensive to the Charter or omits a personal characteristics in a way that is offensive to the Charter… the usual starting point is an analysis of the legislation (or state conduct) that denied the benefit or imposed the unwanted burden. (at para 23 and 24) in Matuszewski" (p.48).

If we apply the previous analysis to a potential discrimination complaint from employees denied the benefit of equal access to private surgery, the appropriate comparator group would be the group of employees on disability in that company who are on the public sector wait list for orthopaedic surgeries, or alternatively, the group of employees in that company on disability as a whole. If an employee was denied access to private surgery on the basis of age, an argument could be made that discrimination occurred as a result of age and the employee's treatment was different because of his age, a prohibited ground under Human Rights legislation.

Regardless of the approach used, the prima facie case or the *Law* framework, there are several circumstances that could give rise to scrutiny by the courts if one employee decided to challenge an employer who paid for private surgery for some employees and not for others.

The Ethical Dilemma

Another risk employers need to take into account when considering payment for private surgery is that presented by the ethical perspective. "Ethics is the philosophical study of morality; it is the systematic exploration of questions about what is morally right and morally wrong." (Keating & Smith, 2000 p. 13.) Rachels (2003), a teacher of philosophy at the University of Alabama at Birghinham, describes the minimum concept of morality as follows: "morality is, at the very least, the effort to guide one's conduct by reason – that is to do what there are the best reasons for doing – while giving equal weight to the interest of each individual who will be affected by what one does" (p. 14).

More and more companies are developing a business Code of Conduct to provide guidance to their employees on how to make the right business decisions, and how to behave in a manner that reflects high ethical standards. Typically, content within a code of business conduct includes items such as: respecting the right of others, obeying the law, conducting oneself appropriately in our relationship with government, community and customer (the previous is extracted from the author's own company manual). One area where ethics is particularly critical is around the employer-employee relationship. Employers must treat their employees with respect, dignity and fairness. The development of legislation on human rights, employment standards, labour relations codes and the Canadian Charter of Rights and Freedoms all contain provisions to protect employees from

discriminatory practices. It is the writer's opinion that the field of disability management is particularly vulnerable to ethical issues.

Employers that are currently paying for private surgeries, and those who are examining this option, may look at this like any other business decision. Business cases are prepared based on the following: identification of the problem or opportunity to be addressed, business and operational impact assessment, risk assessment, cost/benefit analysis, etc. If we apply these principles to the issue of determining under what circumstances an employer should pay for private surgery, companies will likely consider the following: cost of the surgery, cost of wage replacement while the employee is off work, relative importance of the employee's current position, job demands such as mobility requirements, age of the employee, overall health of the employee, which employees would benefit the most, and which employees would be most likely to return to work as a result of the surgery. These are all legitimate criteria from a business perspective.

In an effort to illustrate the underlying complexity of these types of decisions, let us examine the decision making process in the context of two employees who are off on disability as a result of osteoarthritis, both requiring hip replacement. Employee A is 45 year old who works in a physically demanding job; Employee B is 60 year old and works in an office environment. From a pure business perspective, the employer is more likely to fund surgery for Employee A, the 45 year old who needs his mobility in order to perform his job, and whose recovery may be quicker and who has several years of employment ahead of him. Both employees are incapacitated, in pain, and both are affected in their activity

of daily living. Is the 45 year old truly more deserving than the 60 year old? Is it right to pay for the younger employee because he has more working years ahead of him than the 60 year old? Is the 60 year old's welfare less important than the 45 year old's? In light of Rachel's definition of morality, have we considered the interests of the 60 year old when we decide as a company that it makes good fiscal sense to pay for the 45 year old but not for the 60 year old? Can we think in terms of our return on investment when we deal with employees on disability? As employers, are we not expected to treat employees with dignity and fairness by providing them with equal access to benefits and opportunities, and are we doing this by paying for some and not others? Can we hide behind the fact that the 60 year old employee will eventually receive treatment in the public system? Is this any different than employees on Worker's Compensation who are already jumping the public health queue with the blessing of the Canada Health Act? These are difficult questions that need to be asked, and therein lies the ethical dilemma for employers. What is the right thing to do? Should a company make these kinds of decisions? Should employers rely on an intermediary and let the employee's physician determine if going the private route is appropriate? Even in those circumstances, the employer may be faced with the dilemma of determining which cases makes business sense. What if the employee does not return to work following surgery because of unrelated health concerns? Answers to these questions are not yet clear, but as Disability Management practitioners, we should anticipate fielding these types of questions from senior management, or at the very least expect to be asked to make recommendations in similar circumstances.

Companies who are considering funding private health care alternatives might be wise to engage an ethics committee or ethics consultant who can examine each case on its merits and ensure that the final decision can withstand scrutiny from an ethical perspective. Such consultation may include guidance from ethical decision making models. For example, a decision making framework was developed by the Markkula Center for applied ethics at Santa Clara University (Velasquez, Moberg, Meyer, Shanks, McLean, DeCasse, Andre, 2001). It provides some useful guidelines to assist employers in dealing with ethical business dilemmas. First, the employer needs to recognize that that there is an ethical issue. Then all facts should be investigated and alternatives considered based on different ethical perspectives, i.e.:

1. the Utilitarian approach: the ethical action is the one that will produce the greatest balance of benefits over harms.
2. the Rights approach: the ethical action is the one that most dutifully respects the rights of all affected;
3. the Fairness or justice approach: the ethical action is the one that treats people equally, or if unequally, that treats people proportionately and fairly;
4. the Common good approach: the ethical action is the one that contributes most to the achievement of a quality common life together;
5. the Virtue approach: the ethical action is the one that embodies the habits and values of human at their best.

After examining all the potential impacts, the stakeholders should come to a consensus and decide on the best course of action for the company and the affected employees. This is not intended to be a philosophical paper, nor is the author an ethicist. However, the many questions raised make it clear that employers must carefully examine the potential dilemmas they will face when considering if the purchase of medically necessary services from private health care providers is a viable option under Disability Management. Additional investigation is needed to examine all legal and ethical ramifications for employers.

Conclusion

As we have seen, employers are facing more and more challenges in the field of disability management. The workforce is aging and despite the fact that baby boomers are healthier than previous generations, given their increased activity and life-span they are also more susceptible to degenerative diseases such as musculoskeletal disorders. The elimination of mandatory retirement in British Columbia further increases the risk as employees opt to work beyond age 65. This reality, combined with rising health care premiums, means employers have no choice but to look at ways of decreasing their disability costs. Paying for access to private health care and surgery might be one avenue. However, employers will need to balance disability cost savings against the increased cost of providing these services through benefit plans. To complicate matters further, the legal and ethical risks posed in managing such a program, to ensure fair and equitable access for all employees, requires careful consideration. In the absence

of well-defined case law and legal precedent, employers will need to tread carefully if they intend to explore these largely uncharted waters.

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