The silent payer speaks: workers' compensation boards and Canadian physicians

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Canadian physicians are remunerated for their services from several different sources, some with which they are familiar and others with which they are relatively unfamiliar. Provincial ministries of health probably represent the most visible source of income for most physicians, paying for the provision of all "medically necessary" (i.e., insured) services. Private insurance and direct payment by patients for uninsured services represent 2 other sources of payment. When the reason for seeking care is a workplace accident or an industrial disease, however, provincial workers' compensation boards (WCBs) pay for medical services. Compared with the other sources of payment, WCBs have been a relatively silent payer.

The WCBs of Canada form the foundation of the financial support system for workers who have been injured on the job or have acquired industrial diseases. The provincial WCBs pay for or provide 3 primary services: health care, vocational rehabilitation and indemnity benefits. The goal of the health care is to help injured workers achieve the point of maximum medical rehabilitation, restoring as much of their functional capabilities as possible. Once they have reached the point of maximum medical rehabilitation, the goal of the WCB is to return them to work. To facilitate this, WCBs provide vocational rehabilitation services to help workers reach a level of earnings similar to that before the injury. Indemnity benefits (awarded by a WCB adjudicator after reviewing the report filed by a claimant's physician) provide income support for injured workers unable to work and income supplements for those unable to reach their previous level of earnings after returning to work.

Over the last 25 years the cost of providing these 3 primary services has risen dramatically. Between 1970 and 1994 WCB expenditures grew from $1.32 billion to $5.04 billion (in 1994 dollars), a growth rate of 6.2% per annum.[1] The increase in costs occurred despite a decrease in the number of claims, which over the same period fell from 94.5 to 55.2 claims per 1000 labour-force participants. In addition, the increase in expenditures was not, for the most part, matched by an increase in the premium income collected from the firms insured by the WCBs.

Plausible explanations for the high rate of growth in WCB expenditures include changes both within and beyond the control of the provincial governments that regulate WCBs. One contributing factor may be the legislative and regulatory changes to eligibility requirements and benefit levels. Lists of qualifying medical conditions were expanded and benefit levels increased in many provinces in the middle to late 1980s.[2] Increases in benefit levels have both a direct effect on expenditures and an indirect effect through changes in the frequency and duration of claims.[3] Higher levels of income replacement may, for example, enable injured workers to initiate a claim in the first place and to take more time to recuperate from their injuries. Another contributing factor may be changing demographics, specifically an increase in the median age of the labour force. Older workers tend to take longer to recover from occupational accidents and have more severe injuries than younger workers.[4]

In response to the increased expenditures, many of Canada's WCBs have implemented reforms to ensure the financial viability of their programs. Most of these efforts have been targeted either at the revenue side of the problem, by increasing the premiums collected from firms, or at the expenditure side of the problem, namely indemnity benefits, and they have had little impact on physicians. However, many WCBs have also made changes to their rehabilitation strategies in an effort to reduce the frequency and duration of claims. For example, in 1998 the Ontario Workplace Safety & Insurance Board switched its focus from vocational rehabilitation to a much greater emphasis on returning people to work, to reduce the duration of claims, and from compensation to workplace safety and prevention, to reduce the frequency of claims.[5] The Quebec WCB had begun to revamp its rehabilitation programs before this, with efforts including improving communication with injured workers' physicians and, like Ontario, placing more emphasis on prevention and returning injured workers to work. The British Columbia WCB has also proposed reforms, including a review of their vocational rehabilitation programs (to improve the chances of claimants returning to work) and the introduction of a case manager to monitor claimants and the services provided by the WCB.[6]

What do these new strategies mean for physicians? Occupational health physicians will have the opportunity to increase their involvement in workplace safety and prevention. Increasingly, WCBs will be seeking partnerships to demonstrate their commitment to safety and prevention, and employers will be seeking partnerships to reduce their claim rates and, accordingly, their experience-rated workers' compensation premiums. A promising next step for occupational health physicians and their colleagues in related disciplines would involve focusing on the primary determinants of safety and health in the workplace, such as ergonomics and stress.[7] Occupational health physicians could

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endorse and promote the use of indicators related to these determinants, oversee the monitoring of these indicators and recommend action on the basis of these indicators.

Primary care physicians and certain specialists, such as orthopedic surgeons and respirologists, will probably not be greatly affected by these new strategies. They will keep doing what they do — diagnosing and treating injured workers and patients with industrial diseases — without much interference. Notwithstanding the release of a recent discussion paper by the Ontario Workplace Safety & Insurance Board that foresees a more active role for such physicians in quality improvement,[8] WCBs will probably continue to place relatively little emphasis on improving physicians' diagnosis and treatment decisions through, for example, practice guidelines or benchmarking initiatives. That is not to say there are no opportunities to help physicians cope with diagnostic and therapeutic challenges.[9] Guidelines for the diagnosis and treatment of acute low-back pain, for example, suggest that, in the absence of any "red flags" detected during a thorough history-taking and physical examination, patients can be safely provided with reassurance and educational materials only and physicians can safely avoid ordering x-rays and laboratory investigations.[10]

It is the return-to-work component of the new rehabilitation strategies of the WCBs that will probably have the greatest impact on the largest number of physicians. These new strategies will lead to a greater role for physicians in facilitating return to work, through increased interactions with both WCB case managers and the workplace. Just what form these interactions will take, and whether physicians will be provided with additional remuneration for these interactions, has yet to be seen. In addition, physicians may find themselves affected by other efforts to facilitate return to work, such as queue-jumping by WCB patients.[11] These new developments, however, will probably remain relatively unobtrusive, given that WCBs are far from being physicians' or health care facilities' main source of income. In addition, health care represents a small part of the total expenditures of WCBs, and therefore there is no financial reason for WCBs to single out physicians.[12] The silent payer may yet speak, but it almost certainly will not roar.

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References

1. *Social security statistics, Canada and provinces 1970–71 to 1994–95*. Ottawa: Human Resources Development Canada; 1994. Cat no MP90-2/17-1995. Available: www.hrdc-drhc.gc.ca/stratpol/socpol/statistics/70-71/stat71.shtml
2. Thomason T. The escalating costs of workers' compensation in Canada: causes and cures. In: Richards J, Watson WG, editors. *Chronic stress: workers' compensation in the 1990s*. Toronto: C.D. Howe Institute; 1995. p. 23-61.
3. Fortin B, Lanoie P. *Effects of Workers' Compensation: a survey*. Quebec City: University of Laval, Department of Economics; 1998.
4. Thomason T, Hyatt D. Workers' compensation costs in Canada, 1961–1993. In: Abbott MG, Beach CM, Chaykowski RP, editors. *Transitions and structural change in the North American labour market*. Kingston (ON): IRC Press; 1997. p. 235-55.
5. *An Act to secure the financial stability of the compensation system for injured workers, to promote the prevention of injury and disease in Ontario workplaces and to revise the Workers' Compensation Act and make related amendments to other Acts*, SO 1998, c. 16.
6. *Transforming the workers' compensation of British Columbia: a strategic plan*. Vancouver: Workers' Compensation Board of British Columbia; 1996.
7. Robson LS, Polyani MF, Kerr MS, Shannon HS. *How the workplace can influence employee illness and health* [Occasional Paper no 8]. Toronto: Institute for Work & Health; 1998.
8. *Health care model* [discussion paper]. Toronto: Workplace Safety & Insurance Board; 1999.
9. Frank J, Sinclair S, Hogg-Johnson S, Shannon H, Bombardier C, Beaton D, et al. Preventing disability from work-related low-back pain: new evidence gives new hope — if we can just get all the players onside. *CMAJ* 1998;158(12):1625-31.
10. Agency for Health Care Policy and Research. *Acute low back problems in adults*. Clinical Practice Guideline 14. Rockville (MD): US Department of Health and Human Services; 1994.
11. LeBourdais E. Preferential treatment for WCB patients angers some MDs. *CMAJ* 1999;161(7):859.
12. Pozzebon S, Thomason T. Medical benefit costs in Canadian workers' compensation programs: a comparative perspective. *Benefits Q* 1993;9:32-41.

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