

HEALTH CARE ISSUES UNDER THE WORKERS COMPENSATION ACT

A BRIEFING PAPER

ISSUE

This paper relates to the provision of health care benefits under Section 21 of the *Workers Compensation Act* and the interaction between the WCB and external health care providers. It does not deal with the operations of the Rehabilitation Centre.

BACKGROUND

1. *Introduction*

The Workers' Compensation Board provides for the delivery of health care to workers with occupational injuries and diseases. Subject to some restrictions, the WCB will pay for services rendered by physicians, hospitals, various "qualified practitioners", and other treatment and service providers.¹

The major elements of the responsibilities in this area are as follows:

- The WCB has authority to direct, supervise and control the treatment of an injured worker and to establish the fees payable for it.²
- All questions as to the necessity, character and sufficiency of the health care to be furnished are to be determined by the WCB.³

¹ See Section 21 of the *Workers Compensation Act* and Chapter 10 of the *Rehabilitation Services and Claims Manual*. A copy of Section 21 is attached in Appendix "A".

² See s. 21(6). The fees of health care professionals are normally governed by fee schedules approved by the WCB. Where there is not an approved fee schedule, the fees payable must be approved in advance by the WCB.

Fee schedules are currently in effect for physicians, all qualified practitioners (chiropractors, dentists, naturopaths, podiatrists), and various other service providers, such as physiotherapists and massage therapists.

Fee schedules are common in other jurisdictions in Canada and, in most cases, are based on a "fee for service" basis. Manitoba, however, has a "capitation" arrangement in effect for physiotherapists. "Capitation" is payment on a fee per person basis rather than a fee per service basis. In Manitoba, physiotherapists are paid a fixed fee per person. Treatment then becomes the physiotherapist's responsibility until it is of no further benefit. Exceptions are built into the system for more difficult cases, but even exceptions are paid on a single fixed fee basis.

³ See s. 21(6).

- Subject to the authority of the WCB to supervise and provide for the delivery of health care, the worker is allowed a free choice of the physician or other practitioner who will provide treatment.⁴ As alternatives to medical doctors, the *Act* allows treatment by “qualified practitioners” - dentists, chiropractors, naturopathic physicians and podiatrists.⁵ In addition, the worker may be treated by other practitioners such as physiotherapists who work under doctors’ supervision.
- The WCB covers stays at hospitals or other institutions made necessary by the worker’s injury.⁶ The WCB also maintains its own Rehabilitation Centre where many injured workers receive physio and other types of therapy.
- The WCB pays for drugs, supplies, prostheses or other equipment needed by a worker to recover from or improve his or her disability.⁷
- The WCB provides six types of allowances and services, over and above the benefits already noted: (1) clothing allowances,⁸ (2) personal care or nursing allowance,⁹ (3) independence and home maintenance allowance,¹⁰ (4) transportation allowance,¹¹ (5) subsistence allowance¹², and (6) home-maker services.¹³ The WCB will also pay for home renovations and other items for seriously disabled workers.¹⁴
- Section 56 of the *Act*¹⁵ sets out the duties of physicians and qualified practitioners who treat injured workers.
- Section 57¹⁶ gives the WCB authority to require a worker to be examined and allows the WCB to reduce or suspend compensation if a worker declines to undergo essential treatment or performs acts which retard or imperil his or her recovery.

Health care costs are a major component of workers’ compensation costs. In the 1995 WCB Annual Report, health care costs totalled \$216.33 million or nearly 19% of total compensation costs. (This figure includes liabilities for future health care payments as well.)

⁴ See s. 21(7).

⁵ See s. 1.

⁶ See #76.00 of the *Rehabilitation Services and Claims Manual*.

⁷ See #77.00 of the *Rehabilitation Services and Claims Manual*.

⁸ See #79.00 of the *Rehabilitation Services and Claims Manual*.

⁹ See #80.00 of the *Rehabilitation Services and Claims Manual*.

¹⁰ See #81.00 of the *Rehabilitation Services and Claims Manual*.

¹¹ See #82.00 of the *Rehabilitation Services and Claims Manual*.

¹² See #83.00 of the *Rehabilitation Services and Claims Manual*.

¹³ See #84A.00 of the *Rehabilitation Services and Claims Manual*.

¹⁴ See #90.00 of the *Rehabilitation Services and Claims Manual*.

¹⁵ Copy attached in Appendix “A”.

¹⁶ Copy attached in Appendix “A”. See #78.12, #78.13 and #78.24 of the *Rehabilitation Services and Claims Manual* for how this authority is to be exercised.

Workers' compensation health care costs are not the responsibility of the provincial medical services plan. As with other compensation benefits, health care costs are paid out of the accident fund.¹⁷

2. Historical Background

(a) Pineo Report - 1916¹⁸

The origin of the health care provisions of the *Act* is found in the 1916 Pineo Committee Report.

The Report stated that "the preponderance of opinion expressed by those who appeared before the Committee ... was that an adequate medical aid provision is an essential feature of every good workmen's compensation law".

Representatives of both employer and worker groups had signed an agreement whereby the employees were to contribute 1 cent a day "to equalize the cost of such medical aid". The WCB was "to have full supervision and control of all medical aid furnished under the provisions of the *Act*," while medical schemes then in existence or to be formed between employers and workers were to be permitted if approved by the WCB. The agreement was coupled with a three day waiting period for payment of compensation other than medical aid.

The agreement was unanimously approved by the Committee and included as an appendix to the Report.

(b) Sloan Report - 1942¹⁹

The 1942 Sloan Royal Commission Report noted that the relative contributions by workers and employers to the cost of health care was becoming disproportionate. It was recommended that the *Act* be amended to empower the WCB to increase the contribution of workers to the "Medical Aid Fund" from time to time to ensure the distribution of the cost between workers and employers "on the basis of fair equity".

¹⁷ Section 21(3) of the *Act* requires employers at their own expense to furnish an injured worker with immediate transportation to a hospital, physician or qualified practitioner. It has been suggested from time to time that the WCB assume the cost of this initial conveyance since it could be onerous on a small employer who might, for example, have to charter a helicopter to take a worker out of a remote workplace.

¹⁸ See the Report of the Committee of Investigation on Workmen's Compensation Laws, March 1, 1916, pp. 7, 8.

¹⁹ See the Report of the Commissioner relating to the Workmen's Compensation Board, 1942, pp. 72 - 106.

In 1943, the *Act* was so amended. Contributions from workers were to meet 50% of “Medical Aid Fund” costs. When they did not, the WCB was authorized to adjust the contribution to ensure the distribution of the cost of medical services on the basis of equality.

In 1946, the statutory requirement for contribution by workers to the “Medical Aid Fund” was repealed. However, the WCB retained legislative authority until 1972 to approve employer/worker medical aid plans to which workers would contribute. After the 1972 statutory amendments, health care became solely funded out of the accident fund.

The 1942 Sloan Report also considered several specific health care issues. In response to various submissions that the WCB should pay for physiotherapy, electrotherapy, chiropractic, naturopathic, osteopathic and chiropodist treatments, the Report noted that physiotherapy treatments were already accepted. In relation to the other forms of treatment, the Report stated that, since the Legislature had made the WCB responsible for paying for health care, the WCB must have the right to determine what kind of treatment would be most beneficial to the worker and who should administer it.

(c) Sloan Report - 1952²⁰

The 1952 Sloan Report considered worker choice of physician, in particular specialists, and worker change of physician. The Report concluded that the legislation provided the WCB with very wide authority over medical care and who should administer it. “The Board pays the bills and should, within reason, call the tune.” The WCB was found to be exercising its authority in relation to specialist choice in a reasonable manner.

In relation to worker change of physician, the Report stated that it was “desirable that the Board continue to exercise a reasonable restraint in relation to change of doctors”, but that “if an injured man is unhappy in his relations with the doctor of his first choice, the Board should not bind him too firmly to it. In other words, the medical officers’ discretion should be exercised for the welfare of the injured man, which is, after all, their paramount obligation and duty.”

The Report also considered the provision of treatment by chiropractors, chiropodists and naturopaths. At that time, workers were able to make their own decisions to see chiropractors and naturopaths, but treatment in excess of two weeks would not be paid for unless authorized by the WCB. The Report noted that this would allow WCB doctors to “maintain a reasonably close check on the progress of the treatment”. It concluded that the WCB could allow workers to see chiropodists if appropriate as well.

²⁰ See the Report of the Commissioner relating to The Workmen’s Compensation Act and Board, 1952, pp. 115 - 121, 127 - 130.

(d) Tysoe Report - 1966²¹

Employers made representations before the Tysoe Royal Commission that the WCB should conduct more and tighter supervision over health care. Among the measures suggested were:

- a “programme of education” aimed at physicians to better acquaint them with workers’ compensation and the role of the physician, and
- the creation of a schedule of average times for recovery from various types of injuries, with investigation of cases where recovery was taking longer than the general average.

In response, the Tysoe Report stated that the more information the WCB could disseminate among the medical profession the better. However, noting the dependence of the WCB upon physicians’ reports, the Report cautioned that any behaviour that the physicians might find “dictatorial or offensive” should be strongly resisted by the WCB. The proposed schedule might be useful to the WCB, but of less use to employers than the actual estimate of the attending physician in each case.

There was also discussion of the role of chiropractors. Physicians from the College of Physicians and Surgeons and from the BC Division of the Canadian Medical Association submitted that treatment by chiropractors should not be authorized. Representatives from the BC Chiropractors Association argued for more weight to be given to chiropractic treatment. However, the Report declined to discuss the merits and demerits of chiropractic treatment. It left the matter in the hands of the WCB to determine in each case.

(e) Administrative Inventories

Provision of health care was reviewed as part of the 1991 Administrative Inventory which focussed largely on the WCB’s compensation programs.²² However, none of the attention points dealt specifically with this area.

The 1993 Administrative Inventory on the WCB’s medical and rehabilitation programs²³ only dealt peripherally with treatment and services by providers in the external health care community.

Health care was dealt with more extensively in the 1996 Administrative Inventory²⁴ which focussed primarily on health care costs.

²¹ See Commission of Inquiry - Workmen’s Compensation Act - Report of the Commissioner, 1966, pp. 136 - 161.

²² H. Allan Hunt, Peter S. Barth, Michael J. Leahy, “Workers’ Compensation in British Columbia - An Administrative Inventory at a Time of Transition”, November, 1991.

²³ Jane Fulton and John Atkinson, “Medical and Rehabilitation Programs in Workers’ Compensation”, May, 1993.

²⁴ H. Allan Hunt, Peter S. Barth, Michael J. Leahy, “The Workers’ Compensation System of British Columbia: Still in Transition”, March, 1996.

The Administrative Inventory stated that “WCB health care costs in British Columbia have exploded in recent years.” It found that, on an incurred basis, aggregate health care costs had increased by 90 percent from 1991 to 1994. Costs on a “paid” basis grew by 35 percent for the same period. The authors noted that increases in health care costs were not unique to BC and that an “in-depth” examination of health care costs required a more extensive treatment than belonged in an Administrative Inventory.²⁵

DISCUSSION

This DISCUSSION section deals only with the broader issues relating to health care benefits. If issues are raised before the Royal Commission concerning individual health care benefits provided or funded by the WCB, further information will be forwarded on request.²⁶

1. ***Exercise of WCB “Direction, Supervision and Control” Authority***²⁷

Section 21(1) of the *Act* provides that “Health care ... shall at all times be subject to the direction, supervision and control of the board” and that “all questions as to the necessity, character and sufficiency of health care to be furnished shall be determined by the board”.

The WCB has taken the general approach that a worker’s doctor or other treating practitioner is responsible for the worker’s treatment. The WCB functions as an advisor to ensure that the practitioner is aware of all the alternative available treatments.²⁸

If there is more than one possible treatment, the choice is left to the practitioner and the worker. However, if the selection of a treatment will likely result in a significant increase in the length of disability, the WCB will normally authorize the treatment that is most likely to enable the worker to return to work at an early date. If there is substantial difference in costs of equally effective treatment, the WCB will authorize the less costly. If the worker chooses the more costly

²⁵ H. Allan Hunt et al, p. 100. The Administrative Inventory defined the “paid” basis to mean the actual payments made for health care each year, with the “incurred” basis including both the payments made on a claim that year and the expected future health care costs against that claim.

²⁶ Examples of possible such issues are whether Section 21(3) of the *Act* should be amended to have the WCB take over responsibility for initial transportation of the injured worker (see footnote 17); whether Section 21(8) should be amended to remove the requirement for an accident and for corroboration in relation to eyeglass breakage; how the WCB deals with cases of seemingly overprescription of addictive pain killers; WCB funding of particular kinds of preventive health care; and WCB funding of treatment prior to adjudication.

²⁷ See #78.10 of the *Rehabilitation Services and Claims Manual*.

²⁸ The Continuum of Care Models and the Case Management Protocols outlined later in this paper contemplate more active involvement by the WCB during post-acute phases of certain types of injuries.

option, the WCB will cover costs up to the amount that would have been paid for the less costly, but equally effective, option.

Where coverage for a non-standard treatment program, medical appliance or other health care benefit is contemplated, the WCB suggests the practitioner obtain pre-approval. Failure to do so may result in expenses being incurred that will not be covered by the WCB.

WCB policy provides for a number of specific restrictions and requirements for pre-approval in the provision of health care. For example:

- The WCB reserves the right to determine if any particular form of treatment, or provider of treatment, is one that should be recognized for the care of a worker.²⁹
- The WCB may object to the selection of physician or qualified practitioner made by the worker in certain circumstances, for example, where it appears that the worker is shopping around for the most favourable report.³⁰
- The WCB has established guidelines for treatment by chiropractors,³¹ naturopaths³² and physiotherapists.³³
- The WCB does not generally accept responsibility for acupuncture. Any exception must be previously authorized.³⁴

These restrictions and requirements for pre-approval appear to be designed to ensure that workers receive all health care necessary to “cure and relieve from the effects of the injury”, but in a cost effective manner. In some cases, they reflect the traditional “medical” model of health care delivery, with the assumption that key decisions on treatment are made by or on the advice of the attending physician, acting as “gatekeeper”, subject to the supervision of the WCB under the *Act*.

BC is not unique among Canadian jurisdictions in having restrictions on, and requirements for pre-approval of, various forms of treatment. However, there is some question as to the extent to which physicians do act as “gatekeepers” in the provision of health care.³⁵ There is also a certain “tension” between the medical model underlying this approach to health care and other models of care and treatment.

The restrictions or pre-approval requirements have emerged as issues from time to time. For example, both the BC Chiropractic Association and the BC Physiotherapists Association have made representations in the past for removal

²⁹ See #74.00 of the *Rehabilitation Services and Claims Manual*.

³⁰ See #74.50 of the *Rehabilitation Services and Claims Manual*.

³¹ See #74.20 of the *Rehabilitation Services and Claims Manual*.

³² See #74.40 of the *Rehabilitation Services and Claims Manual*.

³³ See #75.12 of the *Rehabilitation Services and Claims Manual*.

³⁴ See #78.14 of the *Rehabilitation Services and Claims Manual*.

³⁵ See page 15 of this paper on the Physician Outlier Project.

of their 8-week treatment restrictions. However, questions of timing, extent, duration and modalities of treatment in various areas are under review as a result of developments within the various professions and the evolving needs of the WCB.

2. Persons Authorized to Render Health Care

(a) Expansion of Definitions of “Qualified Practitioner” and “Other Persons Authorized to Render Health Care”

Health care provided under the *Act* may be supplied by “physicians”, “qualified practitioners” and “other persons authorized to render health care”.

Section 1 of the *Act* defines “physician” to mean “a person registered under the *Medical Practitioners Act*” and a “qualified practitioner” to mean “a person registered under the *Chiropractors Act*, the *Dentists Act*, the *Naturopaths Act* or the *Podiatrists Act*”. The “other persons authorized to render health care” are those authorized by WCB policy.

Both “physicians” and “qualified practitioners” are entitled to be primary health care providers. “Other persons authorized to render health care” normally must do so under the supervision of the attending physician.

Some health care providers wish the definition of “qualified practitioner” to be expanded. For example, the BC Physiotherapists Association has made representations for the inclusion of physiotherapists in the definition. Physiotherapists are among those providers who may only treat workers upon referral by the attending physician. Recognition as “qualified practitioners” would enable physiotherapists to become primary health care providers.

Other health care providers wish to be identified in WCB policy as “other persons authorized to render health care”. For example, the Massage Therapists Association has requested that the WCB develop a separate category in WCB policy recognizing massage therapists. In practice, when dealing with massage therapy, the WCB applies the policy developed for physiotherapists.

(b) Health Professions Council Review

The Health Professions Council is reviewing the scope of practice and legislative framework for all recognized health professions. This review stems from the recommendations of the Royal Commission on Health Care and Costs (the Seaton Commission). It represents an expanded role for the Council which was initially set up under the *Health Professions Act* to review applications from new professions for recognition under that *Act*.

The outcome of the review is anticipated in the next 18 - 24 months and could result in major shifts in the way health professions are regulated and significant changes in the authority and scope of practice of the professions. The results of the review may impact on the recognition of other "qualified practitioners" under the *Workers Compensation Act* and recognition of "other persons authorized to render health care" under WCB policy.

(c) Christian Science Practitioners

The Christian Science Committee for Publication for British Columbia has periodically requested that WCB policy or the *Act* be amended to provide for payment for Christian Science practitioners and treatment by spiritual means when sought by Christian Science workers.

Christian Science practitioners do not render the medical and other health care or treatment currently contemplated by the legislation. They would not produce the reports on diagnosis, disability and prognosis required by the WCB to adjudicate claims. Acceptance of the Committee's request would require the WCB to adjudicate claims on the basis of the extent and duration of disability for which, in the WCB's opinion, the worker would have been entitled to be paid had the worker undergone medical or other health care or treatment. Even if the statute were amended to permit this to be done, it is not clear how it could be accomplished in practice.

3. Worker Choice of Treatment Provider

The BC *Act* provides that, without restricting its authority to supervise and provide for the furnishing of health care in cases where the WCB considers it expedient, the WCB "shall permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner selected or employed by the injured worker".³⁶

Except in certain circumstances, the WCB gives the worker unlimited choice in selecting his or her attending physician or qualified practitioner or in changing physician or practitioner during the course of treatment.³⁷ These circumstances include when it appears to the WCB that the change will be harmful to the worker or the worker is "shopping around" to find the practitioner who is thought to be likely to write the most favourable report.

Issues arise over the interaction between worker choice of physician and other treatment provider and WCB health care supervision.

In most other Canadian jurisdictions, the worker also has a general freedom of choice of attending physicians and other health care givers. In some

³⁶ See s. 21(7).

³⁷ See #74.50 of the *Rehabilitation Services and Claims Manual*.

jurisdictions, this is provided by statute, in others by practice. In a few cases, the worker may choose his or her attending physician, but must select other health care providers from a list of providers approved by the WCB.

In Quebec and Ontario, choice is a basic entitlement. The Quebec legislation states that a worker is entitled to receive care from the health professional³⁸ and health establishment³⁹ of his or her choice. The Quebec Commission may, however, refer the worker to another health establishment if the required health care is not available at the chosen establishment within a reasonable time and the physician in charge of the worker agrees.⁴⁰ The Ontario legislation provides that the worker is entitled to make the initial choice of doctor or other qualified practitioner⁴¹. In practice, Ontario generally allows subsequent changes.⁴²

In Manitoba and Alberta, the WCB may permit health care to be administered by the physician selected by the worker if the WCB considers it "expedient" (Manitoba)⁴³ or "appropriate" (Alberta)⁴⁴. In practice, Manitoba has general freedom of choice with respect to virtually all practitioners.⁴⁵ However, while workers in Alberta have general freedom of choice with respect to selecting their own physicians, other providers must be selected from the WCB's "Authorized Provider Network".⁴⁶

³⁸ See s. 192 of the *Industrial Accidents and Occupational Diseases Act*, RSQ, c. A-3.001.

³⁹ See s. 193 of the *Industrial Accidents and Occupational Diseases Act*, RSQ, c. A-3.001.

⁴⁰ S. 193.

⁴¹ See s. 50(1) of the *Workers' Compensation Act*, RSO 1990, c. W.11. Bill 99, introduced in the Ontario Legislature on November 26, 1996, retains the right of initial choice.

⁴² In Ontario, there is an authorized provider network for the WCB's community clinic program for soft tissue injuries. Chiropractors and physiotherapists reply to Requests for Proposals to provide a special treatment program developed by the WCB for use in the community. The WCB will only pay for the special program if provided by one of the community clinics, but workers are not required to go there. Workers may be referred to other physiotherapists by their attending physician or go themselves to chiropractors.

⁴³ See s. 27(12) of the *Workers Compensation Act*, RSM 1987, c. W200.

⁴⁴ See s. 79 of the *Workers' Compensation Act*, SA 1981, c. W-16.

⁴⁵ Manitoba has "authorized provider lists" for chronic pain clinics, functional evaluation clinics and physical reconditioning clinics.

⁴⁶ The Alberta "Authorized Provider Network" includes most health care providers. Each provider is required to enter into a contract with the WCB that sets out standards for reporting, turnaround times, outcome expectations and how and when to communicate with the WCB. The goal is to achieve standardized treatment and reporting mechanisms. Members are monitored by a quality assurance program and receive report cards summarizing their performance and the performance of others in their area and across the province. It is anticipated that members will develop interdependencies and relationships as they work together over the longer term. Workers who go outside the Network for other health care providers are required to pay the cost of the service themselves.

Alberta is also negotiating with three clinics to provide health care as "Occupational Injury Service Clinics" on a trial basis. It is anticipated that each clinic will be "one stop shopping" for the worker from initial treatment and diagnosis to return to work. These clinics will focus on early intervention and serve as gateways to the Authorized Provider Network. Workers will be referred by either their employers or their attending physicians. It is up to workers, however, to decide whether they wish to be treated by their attending physicians or go to an "OIS" clinic. Clinic staff will receive WCB training to help understand WCB processes.

In the 7 remaining jurisdictions, that is Saskatchewan, New Brunswick, Nova Scotia, PEI, Newfoundland, the Yukon and the North West Territories, the statute is silent as to worker choice. In practice, however, Saskatchewan, New Brunswick, PEI, and Newfoundland have general worker choice of physician and other care givers.⁴⁷

In Nova Scotia, workers have freedom of choice with respect to attending physician, but must choose other health care providers from the WCB's "Approved Service Provider List."⁴⁸

In the Yukon, workers have free choice as to attending physician. However, the WCB decides other health care providers in conjunction with the attending physician because it is often necessary to send workers outside the territory for treatment. Similarly in the NWT workers have free choice as to attending physician. However, there is a "Service Provider List" from which providers outside the territory are selected.

4. Health Care Costs

The 1996 Administrative Inventory set out WCB health care costs for the period 1991 - 1994 on both a Paid and an Incurred basis.⁴⁹ The following tables update the information from the Administrative Inventory to 1995⁵⁰ with information based on the 1995 WCB Annual Report and WCB records.

Total Health Care Costs 1991 - 1995 (\$ Million)

	1991	1992	1993	1994	1995
Paid	\$98.74	\$109.97	\$118.63	\$133.20	\$141.3
Incurred	\$118.52	\$151.05	\$168.94	\$224.83	\$216.33

Health Care Costs 1991 - 1995 - Per Newly Registered Claim

	1991	1992	1993	1994	1995
Paid	\$485	\$555	\$608	\$673	\$727
Incurred	\$582	\$764	\$866	\$1,136	\$1,113

⁴⁷ New Brunswick accredits physiotherapy clinics and is currently working with the audiology association to develop an accreditation program as well.

⁴⁸ Any provider can apply to get on the List and has to meet certain minimum standards to do so. Workers who go outside the List to other health care providers must pay the cost of the services themselves.

⁴⁹ H. Allan Hunt et al, 1996, p. 119. The "Paid" basis consists of actual payments made for health care each year. The "Incurred" basis includes both the payments made on a claim that year and the expected future health care costs against that claim.

⁵⁰ Figures for 1996 are not available at the time of writing this paper. Based upon mid-year unaudited information, it appears that health care costs, on both a paid and incurred basis have risen in 1996.

5. **Current WCB Initiatives**

(a) **Duration**

Timeliness and effectiveness of health care are key to worker recovery and return to work. If a significant investment is made in health care, one would anticipate that outcomes, particularly in duration of disability, would improve.

This improvement did not take place during the period 1991 - 1994. Health care costs increased steadily during these 4 years and, as the following table shows, duration also increased.⁵¹

Duration of Claim, 1991 - 1994 (Days Paid Per Claim)

Year	In Injury Year	Total of All Years
1991	21.8	35.3
1992	23.1	40.5
1993	24.1	43.2
1994	24.3	45.1

There appears, however, to have been a turnaround in 1995, with a further reduction in duration in 1996.

Duration of Claim, 1995/1996 (Days Paid Per Claim)

Year	In Injury Year	Total of All Years
1995	23.3	43.3
1996	22.7	40.1

The WCB Administration reports a number of initiatives underway to encourage further decreases in duration. These initiatives may involve increases to health care costs in certain areas. If, however, they are successful, the investment in decreasing duration will benefit both workers and employers.⁵²

(b) **Continuum of Care Models**

⁵¹ See WCB Annual Report 1995.

⁵² This discussion may duplicate information provided to the Commission by the Administration. It was felt advisable, however, to also place the information in the context of health care issues generally.

The Rehabilitation Centre is currently developing time-based continuum of care models for soft tissue and other types of injuries. The continuum of care models contemplate a series of interventions that are designed to direct injured workers to appropriate rehabilitative programs. These programs focus on the worker's early recovery and return to work.

The operations of the Centre are generally beyond the scope of this paper. However, implementation of continuums of care will lead to a reorganization of the WCB approach to health care in the areas covered. Development of the models is integral to many of the initiatives being undertaken by the WCB with respect to duration.

The continuum of care model for soft tissue injuries is the most fully developed. It provides for a continuum of interventions, referrals, rehabilitative treatment and decisions on a claim over a period of 24 weeks from the date of injury.

Applying the soft tissue continuum of care, the Rehabilitation Centre contacts all workers still on wage loss after three weeks of disability from a sprain, strain or contusion. If the worker has no plans to return to work and the attending physician agrees, the worker is referred to an approved work conditioning centre within the worker's geographic area.

The Work Conditioning program is supervised by a physiotherapist and concentrates on physical exercise and education. A worker who is unable to return to work after a maximum of six weeks of work conditioning is referred to an Occupational Rehabilitation program.

Occupational Rehabilitation is offered by a team which includes physicians, psychologists, occupational therapists and physical therapists. This team provides a variety of services including functional assessment; medical and psychological education; work simulation; flexibility, strength and aerobic fitness training; pain management and communication; and job site analysis. Its focus is on a multidisciplinary approach to the worker's recovery and return to work.

If at any time before or during the Work Conditioning or Occupational Rehabilitation programs, there are medical factors compromising the worker's ability to participate, the worker may be referred to the Rehabilitation Centre's Medical Rehabilitation program. Medical Rehabilitation offers close medical supervision, expedited referral to medical specialists, occupational and physical therapy. Upon discharge, the worker is generally referred back to the original program.

A worker who is unable to return to work after Occupational Rehabilitation may, in certain circumstances be referred on to a Pain program. Workers who do not return to work after the Pain programs may be referred to the Vocational Rehabilitation Department for an employability assessment and Disability Awards for pension consideration if appropriate.

(c) Case Management Protocols

The WCB is exploring a “case management” approach to handling workers’ claims for compensation. Accountability for managing each claim would be assigned shortly after the initial entitlement decision was made. The case manager would then be responsible for the management of all services to be provided by or funded by the WCB.

“Case management” is, in general terms, the effective coordination of the delivery of multiple services and/or benefits to a recipient. As a service delivery approach, it is a neutral concept.⁵³ Disputes may arise, however, over how it is implemented and the type and extent of the services or benefits it is used to deliver.

“Case management protocols” are being developed by the WCB to guide case managers in handling claims for particular conditions. These protocols would assist case managers in working with attending physicians to ensure that the appropriate treatment as defined by the protocols was considered at the proper time and that gaps in treatment and delays were avoided. The treatment encouraged by the protocols is designed to promote the return to work of the injured worker.⁵⁴

Protocols have currently been drafted for low back pain, neck (cervical) pain, meniscal tears, epicondylitis, carpal tunnel syndrome, tendinitis, bursitis, and plantar fasciitis. A “Standardized Assessment” form has been developed for each condition to ensure that all treatment is covered by physician reporting.

The case management protocols are based on WCB experience in dealing with workers’ compensation claims. They have been discussed with the BC Medical Association through the BCMA/WCB medical liaison committee.

(d) Clinical Practice Guidelines

The WCB has developed draft “clinical practice guidelines” for low back pain using other models in existence and adapting them for BC. These guidelines are evidence based.⁵⁵ They outline what treatment works in relation to low back injuries and when it should be applied. They are aimed at family physicians for whom workers’ compensation clients form a small part of their practice.

The guidelines are under review by the Council of Clinical Practice Guidelines, a joint effort between the BC Medical Association and the Ministry of Health.

⁵³ It is found in areas other than workers’ compensation. For example, the Supreme Court of British Columbia started a “Case Management Pilot Project” for certain court cases in Vancouver in March, 1995 that is being extended to all court locations effective February 3 1997. (Notice was recently given to the legal profession of this extension.)

⁵⁴ The timelines for treatment of particular conditions have been matched to the timelines for the continuum of care models developed by the Rehabilitation Centre.

⁵⁵ “Evidence based guidelines” base their recommendations on scientific evidence. Research findings are stressed over expert opinion.

Pending completion of that review, they have been informally distributed to the physician community and seem to have been accepted.

(e) Physician Outlier Project

As part of its study of factors affecting duration of disability, the WCB has conducted a review of the number of days of wage loss paid for each of the 17,999 short term disability claims for sprains/strains and low back injuries "finalled" between January 1, 1995 and May 31, 1996. In identifying the number of days paid for each claim and the average number of days paid to the patients of each attending physician, the WCB has found evidence of possible substantial variation in duration across physicians.

The WCB is making the results of its review known to the physician community. It will then undertake discussions with individuals at both ends of the spectrum to determine whether there are significant variations in treatment provided. Educational opportunities will be made available to outliers. These opportunities will be tied to the development of the "Clinical Practice Guidelines" outlined above.

The WCB will also be focussing on the number of times a physician treats an injured worker. It has long been assumed that attending physicians act as "gatekeepers" to other treatment providers. This may not be occurring in actual practice and the individual physician may not have any influence over the duration of the individual claim.

(f) "Premiums" for Provision of Health Care

The WCB currently pays "premiums" to expedite certain health care services.

For example, the most recently negotiated agreement with the BCMA provides for financial incentives for the prompt submission of Form 11 Reports. If a report is received within 3 days of examination, the physician is paid \$1.00 over and above the normal form fee for the report. If the report is received 4 - 10 days after the examination, the normal form fee is paid. If the report is received more than 10 days after the examination, no form fee is paid.

The BCMA agreement also provides for additional fees for specialists for expedited consultations and reports.

Another example of expedited services relates to the provision of MRIs (a type of diagnostic procedure). The WCB has arranged with St. Paul's Hospital to conduct MRIs on a priority basis by staff willing to work after hours.

These practices may give rise to concerns that the WCB is promoting "two-tiered" health care and questions as to why workers receiving compensation should get access to services ahead of others.

To a certain extent, the *Workers Compensation Act* and WCB policy already provide for a level of health care superior to that provided by the medical

services plan. For example, MSP limits chiropractic treatment and physiotherapy to 12 treatments and does not pay for dentures or eyeglasses.

The WCB Administration reports concerns, however, that delays in medical treatment may prolong disability. Such prolonging is in the interest of neither workers who wish to return to work nor employers who must fund the further disability payments. The WCB is therefore looking for ways for injured workers to expedite care for injured workers, without causing detriment to others.

6. “Managed Care”

Considerable discussion and debate is taking place regarding the cost and effectiveness of the delivery of health care in Canada.⁵⁶ As a result, some attention is being focussed on “managed care” techniques adopted in the United States.

Proponents and critics of these techniques hold very strong views. Champions of “managed care” regard it as the measures necessary to deliver quality health care at affordable prices. Critics point to removal of patient choice of physician and fear substandard treatment as providers try to cut costs in order to remain competitive.

In view of the discussion and debate in the general health care system, an overview on “managed care” in the US has been prepared and attached as Appendix “B”.

⁵⁶ See, for example, the December 2, 1996 edition of “Macleans” magazine and its “special report” on the Canadian health care system.

7. Research Sources:

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Appendix "A" - Statutory References

1979

WORKERS COMPENSATION

RS CHAP. 437

WORKERS COMPENSATION ACT

CHAPTER 437

Note: All references to "medical aid" changed to "health care" by 1994 statutory amendments.

Medical aid

21. (1) In addition to the other compensation provided by this Part, the board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care of treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the board may adopt rules and regulations with respect to furnishing medical aid to injured workers entitled to it and for the payment of it. The board may make a daily allowance to an injured worker for his subsistence when, under its direction, he is undergoing treatment at a place other than the place where he resides, and the power of the board to make a daily allowance for subsistence under this section extends to an injured worker who receives compensation, regardless of the date he first became entitled to compensation.

(2) Where in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the board is called in to treat the injured worker, and if the board finds there was a justifiable cause and that the charge for services is reasonable, the cost of the services shall be paid by the board.

(3) The board may in its discretion authorize employers to furnish or provide medical aid at the expense of the board and on terms fixed by it. Every employer shall, at his own expense, furnish to a worker injured in his employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment.

(4) Where a worker received, before April 1, 1972, medical aid under
(a) the *Canada Shipping Act* (Canada); or
(b) a medical aid plan approved by the board,
he is entitled to receive, in accordance with this section, additional medical aid.

(5) Where additional medical aid is provided by the board under subsection (4), its cost may be charged in the manner the board considers proper.

(6) Medical aid furnished or provided under any of the preceding subsections of this section shall 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 medical aid required, and to agree on a scale of fees or remuneration for that medical aid; and all questions as to the necessity, character and sufficiency of medical aid to be furnished shall be determined by the board. The fees or remuneration for medical aid furnished under this Act shall not be more than would be properly and reasonably charged the worker if himself paying, and the amount shall be fixed and determined by the board, and no action for an amount larger than that fixed by the board shall lie in respect of medical aid.

(7) Without limiting the power of the board under this section to supervise and provide for the furnishing of medical aid in every case where it considers the exercise of that power is expedient, the board shall permit medical aid to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.

- (8) The board may assume the responsibility of replacement and repair of
- (a) artificial appliances, including artificial members damaged or broken as the result of an accident arising out of and in the course of the employment of the worker; and
 - (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of employment if that breakage is accompanied by objective signs of personal injury, or, where there is no personal injury, if the accident is otherwise corroborated and the board is satisfied the worker was not at fault.

(9) Where an injury to a worker results in serious impairment of his sight, the board may, to protect his remaining vision, provide him with protective eyeglasses.

1968-59-22; 1972-64-12; 1974-101-1, 17; 1975-81-4

Duty of physician or practitioner

56. (1) It is the duty of every physician or qualified practitioner attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in an industry within the scope of this Part

- (a) to furnish the reports in respect of the injury in the form required by the regulations or by the board, but the first report containing all information requested in it shall be furnished to the board within 3 days after the date of his first attendance on the worker;
- (b) to furnish a report within 3 days after the worker is, in the opinion of the physician or qualified practitioner, able to resume work and, if treatment is being continued after resumption of work, to furnish further adequate reports;
- (c) if the physician is a specialist whose opinion is requested by the attending physician, the worker or the board, or if he continues to treat the worker after being consulted as a specialist, to furnish his first report to the board within 3 days after completion of consultation; but if the specialist is regularly treating the worker, the specialist shall submit reports as required in paragraphs (a) and (b); and
- (d) to give all reasonable and necessary information, advice and assistance to the injured worker and his dependants in making application for compensation, and in furnishing in connection with it the required certificates and proofs, without charge to the worker.

(2) Every physician or qualified practitioner who is authorized by this Act to treat an injured worker is subject to like duties and responsibilities, and any aid furnished by him shall be subject to the direction, supervision and control of the board.

(3) Unless the board otherwise directs, no account for medical services or medical aid shall be paid that is submitted later than 90 days from the date that

- (a) the last treatment was given; or
- (b) the physician or person furnishing the medical service was first aware that the board may be liable for his services,

whichever first occurs.

(4) A physician, qualified practitioner or other person authorized to render medical aid under this Part shall confine his treatment to injuries to the parts of the body he is authorized to treat under the statute under which he is permitted to practise, and the giving of any unauthorized treatment is an offence against this Part.

(5) A physician, qualified practitioner or other person who fails to submit prompt, adequate and accurate reports and accounts as required by this Act or the board commits an offence against this Part, and his right to be selected by a worker to render medical aid may be cancelled by the board, or he may be suspended for a period to be determined by the board. When the right of a person to render medical aid is so cancelled or suspended, the board shall notify him of the cancellation or suspension, and shall likewise inform the governing body named in the Act under which he is authorized to treat human ailments, and the person whose right to render medical aid is cancelled or suspended shall also notify injured workers who seek treatment from him of the cancellation or suspension.

1968-59-53; 1972-64-26; 1974-101-1,30.

Worker to submit to examination

57. (1) The board may require a worker who applies for or is in receipt of compensation under this Part to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, his right to compensation shall be suspended until the examination has taken place, and no compensation is payable during the period of suspension.

- (2) The board may reduce or suspend compensation when the worker
- (a) persists in insanitary or injurious practices which tend to imperil or retard his recovery; or
 - (b) refuses to submit to medical or surgical treatment which the board considers, based on expert medical or surgical advice, is reasonably essential to promote his recovery.

1968-59-54; 1974-101-1.

Interpretation

1. In this Act

“physician” means a person registered under the *Medical Practitioners Act*;

“qualified practitioner” means a person registered under the *Chiropractors Act*, the *Dentists Act*, the *Naturopaths Act* or the *Podiatrists Act*.

Appendix “B” - “Managed Care”

1. Meaning of the Term

There is no agreement on the meaning of the term “managed care”. However, “managed care” is generally used to describe various cost containment approaches that were developed in the US in the mid-1980s in response to concerns over greatly increasing costs in the American health care system.

2. US General Health Care System

The United States is the only western industrialized country without a statutorily enacted national health care program that covers all residents. A 1993 study of the Canadian and American health care systems and workers’ compensation medical costs by the Association of Workers’ Compensation Boards of Canada described the American health care system as follows⁵⁷.

“The US health care system is a mix of private and public insurance plans. Employment based plans provide 55% of the population with health insurance, the Medicare⁵⁸ and Medicaid⁵⁹ programs provide coverage to roughly 25% of the population, smaller federal government programs cover around 5% of the population and between 13.9 to 15% of the American public does not have health insurance. In 1991, 30% of US health expenditures were paid for by the federal government, while 14% were paid for by state governments, and 56% by the private sector. Over 80% of US employers require employees to share the costs of providing health care benefits, and Medicare and Medicaid enrollees are also required to pay premiums or deductibles in order to retain basic health care coverage.”

From 1975 to 1986, general health care costs in the United States rose by 150 percent, far faster than the increase in the general cost of living. Hospital costs rose even faster, nearly tripling during the period.⁶⁰ Faced with escalating costs, government programs like Medicare and Medicaid took the lead in health care cost containment. Employers and insurers involved with providing health insurance to the nation’s work force also moved in the same direction. “Managed care” was the result.

“Managed care” as practised in the general US health care system includes a number of mechanisms designed to limit utilization and costs of services. Examples are prior authorization review for certain procedures, obtaining a

⁵⁷ See “The Canadian and US Health Care Systems and Workers’ Compensation Medical Costs”, Association of Workers’ Compensation Boards of Canada, 1993, p. i.

⁵⁸ Medicare uses federal funding to provide funds for health, hospital and acute care services for the elderly and for the permanently and totally disabled.

⁵⁹ Medicaid provides health care to low income individuals.

⁶⁰ WCRI Research Brief, “Innovative Approaches to Medical Cost Containment”, September 1987 - volume 3, number 9, pp. 1, 2.

second opinion for certain procedures, case management⁶¹, use of less costly treatment settings and procedures, selective enrollment, lifetime dollar limitations and limits on annual inpatient days and outpatient visits.⁶²

However, the most common “image” of a managed care system is an organization or network that has agreed to provide health care services, either directly or through providers with which it contracts, at agreed to rates and in accordance with specified guidelines for the treatment of patients.

There are several types of “managed care” organizations or networks. One of the most common is the Health Maintenance Organization (HMO):

“HMOs contract with employers or state agencies to provide a defined range of health care services for a pre-determined payment per insured. They generate cost savings through lower utilization rate physician costs, because fees are determined on a capitation instead of a fee for service basis. They employ a product line budgeting system which minimizes costs by limiting the resources which can be expended in treating any given health problem. If the total cost associated with treating a particular patient exceeds the allowable rate, health care providers participating in the HMO must bear the burden of the additional costs.”⁶³

There are a several different kinds of HMO structures. In the “Self Model”, the HMO provides health care services directly to persons enrolled in the plan through the HMO’s salaried physicians and other employees. In the “Group Model”, the HMO acts as “middleman”, contracting with a single group practice. This may be an exclusive contract or one of several the group practice holds. In the “Network Model”, the HMO also acts as “middleman”, contracting with multiple group practices and/or integrated health care organizations.⁶⁴

In HMO arrangements, the enrollee is limited to certain providers and generally cannot go outside the plan. There is a growing trend to payment on a “capitation” basis, that is a fixed fee per enrollee, whatever may be the services ultimately required. Critics are concerned that this type of arrangement results in enrollees being denied necessary treatment in order to keep total costs down.

As of 1995, there were 593 HMO health plans throughout the US. Approximately 25% of all Americans were enrolled in HMOs, representing nearly 54 million members. Blue Cross was the largest HMO, with approximately 8.5 million enrollees.⁶⁵

⁶¹ As pointed on page 14, “case management” is a service delivery approach. How it is used, and the extent of the services or benefits it is used to deliver, varies.

⁶² Cherlyn G. Murer, “Health Care Directions - An American Perspective Presented to the 1996 Association of Workers’ Compensation Boards of Canada Congress Committee”, June 24, 1996 (unpublished).

⁶³ Summarized from a number of sources by the Association of Workers’ Compensation Boards of Canada, “The Canadian and U.S. Health Care Systems and Workers’ Compensation Medical Costs”, 1993, p. 18, 19.

⁶⁴ Cherlyn G. Murer, “Health Care Directions - An American Perspective presented to the 1996 Association of Workers’ Compensation Boards of Canada Congress Committee”, June 24, 1996 (unpublished).

⁶⁵ Cherlyn G. Murer, “Health Care Directions - An American Perspective presented to the 1996 Association of Workers’ Compensation Boards of Canada Congress Committee”, June 24, 1996 (unpublished).

Another type of managed care network is the Preferred Provider Organization (PPO):

“PPOs seek out lower cost physicians and hospitals and provide a list of the lowest cost providers within the geographic area to their clients. PPO subscribers are usually large corporations or insurance companies. Employees who elect to participate in the PPO option on their benefits package are still covered by the services provided by non-preferred providers [to the extent of what would have been paid under the preferred plan], but corporations actively discourage this practice. PPOs may also perform a “gatekeeper” function by seeking out the services of a specialist. They achieve costs savings by requiring participants in the plan to offer their clients a defined set of services at a volume discount. However, providers are still paid on a fee for service basis. Costs are controlled through equality of bargaining power between the purchasers and the providers of health services.”⁶⁶

In PPO arrangements, enrollee choice is limited to the list of “preferred” physicians, hospitals and other health care providers. The enrollee pays more out of pocket for using a provider not on the list. Providers are paid on a fee-for-service basis, but with fees lower than usual through volume discounts. Critics are concerned that enrollees do not necessarily receive the best quality treatment, but only treatment from providers willing to charge lower fees.

Provision for and delivery of health care services are major industries in the United States. The introduction of cost containment, managed care and health care provider networks has changed the face of the American health care system.⁶⁷

In 1970, the system had the following characteristics:

- Indemnity insurance the norm
- Generally 80 - 100% of charges paid by indemnity insurance
- Physician fee for services
- Care options solely directed by physician
- Majority of physicians in solo practice
- Reimbursement oriented to inpatient care
- Difficulty in receiving reimbursement for outpatient services other than physical therapy unless hospital related
- General public did not know of “managed care” and the various types of health care provider networks

In 1996, the system had the following characteristics:

- Indemnity insurance less than 50% of market
- Charges are irrelevant; pre-negotiated fees norm
- Care options shared between physicians and case managers

⁶⁶ Summarized from a number of sources by the Association of Workers’ Compensation Boards of Canada, “The Canadian and U.S. Health Care Systems and Workers’ Compensation Medical Costs”, 1993, p. 19.

⁶⁷ This outline is based on Cherlyn G. Murer’s unpublished presentation noted above.

- Majority of physician in group practices
- Outpatient services recognized but not separately negotiated with managed care
- Proliferation of multi-size managed care providers

3. Health Care and US Workers' Compensation

In the United States, employers may be covered for workers' compensation purposes under an exclusive state fund, a private insurance carrier, or be deemed to be self-insured by a state agency or department. In 1990, approximately 58% of benefits paid came from private insurance carriers, while 23% were paid by state funds and 19% were paid by self-insurers.⁶⁸

Workers' compensation costs to US employers increased nationally from \$2.1 billion in 1960 to \$57.3 billion in 1993. The primary source of the higher costs was the increasing benefits, both medical/hospitalization and cash, paid to, or in respect of, injured workers. During many years, medical benefits increased more rapidly than cash benefits.⁶⁹

In 1993, medical benefits accounted for 41.9% of all workers' compensation benefits, - the highest percentage for any year since 1960.⁷⁰ In the same year, the Workers' Compensation Research Institute⁷¹ stated that "Reducing workers' compensation medical costs is the central challenge of the workers' compensation community today".⁷²

In 1994, the WCRI brought together researchers' and workers' compensation practitioners for the Institute's first major conference devoted to the issue of medical cost containment.⁷³ The major opportunities identified for cost savings were fee schedules, provider networks, utilization management, health maintenance organizations with capitation, cost sharing and practice guidelines.

⁶⁸ Social Security Bulletin, "Annual Statistical Supplement, 1992", at 313, as set out in the Association of Workers' Compensation Boards of Canada study at 43.

⁶⁹ See John F. Burton, Jr., "Workers' Compensation Twenty-Four Hour Coverage, and Managed Care", John Burton's Workers' Compensation Monitor, vol. 9, no. 1, January/February 1996, p. 11.

⁷⁰ The 41.9% is reported by John F. Burton, Jr., "Workers' Compensation Twenty-Four Hour Coverage and Managed Care", noted above. However, some authorities place the percentage as high as 50%. See, for example, Geoffrey Leavenworth, "Setting Standards for Workers' Comp.", *Business & Health*, vol. 12, no. 10, October, 1994, p 49, as cited in Charles M. Jacobs and Susan Barry, "Workers Compensation Needs Informed Case Management", *The Journal of Workers Compensation*, vol. 5, no. 45, Summer 1996, p. 10.

⁷¹ The Workers' Compensation Research Institute is a non-partisan, not-for-profit research organization providing objective information about public policy issues involving workers' compensation systems. The WCRI is particularly recognized for its series of Administrative Inventories of various state compensation systems.

⁷² See WCRI Research Brief, "Cost Savings Provided by Selected Managed Care", October, 1993 - vol. 9, no. 9.

⁷³ The proceedings of that conference were published by the WCRI in "Review, regulate or reform? What Works to Control Workers' Compensation Medical Costs", Thomas W. Grannemann, ed.. The Report is summarized in the WCRI Research Brief of the same title - August, 1994 - vol. 10, no. 8.

It is natural that, faced with the significant increases in workers' compensation health care costs, employers, insurance carriers, state regulators and others have looked to the "managed care" and other measures adopted in the US general health care system. As yet, however, there appears to have been little evaluation of the success of these cost containment measures or their effect on quality of treatment.⁷⁴ Certain legal issues particular to the workers' compensation system, such as freedom of choice of health care provider and requirements that workers receive full medical coverage at no expense, have also to be considered.⁷⁵

⁷⁴ See Jay Himmelstein and Glenn Pransky, "Measuring and Improving the Quality of Workers' Compensation Medical Care", *John Burton's Workers' Compensation Monitor*, vol. 8, no. 6, November/December 1995, p. 4, for a discussion of this lack of evaluation.

⁷⁵ See Arthur, N. Lerner, "Managed Care and Workers Compensation: Legal Considerations", *The Journal of Workers Compensation*, vol. 1, no. 2, Winter 1992, pp. 37 - 46.