Health Care and Workers' Compensation

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Terry Thomason’s career was marked by his interest in the economic consequences of workers’ compensation policies across North America, including both the observed variations within U.S. states, as well as the differences that emerged over time between the Canadian and the U.S. policy contexts. One important difference between these two jurisdictions has been the divergent trends in health care expenditures. Gross domestic product (GDP) expenditure shares for health care in Canada and the United States began a long-term trend of divergence in the 1970s. This story is now well known to scholars and policymakers who maintain a weather-eye on comparative trends in national health care expenditure. In the period 1970–1975, expenditures on medical care were equivalent in Canada and the United States, at about 7.5 percent of GDP in both countries. By 1995–2000, GDP share allocated to health care in Canada had increased to 9.5–10.0 percent. In the United States, by contrast, total health spending as a share of GDP was 13.0 percent. These divergent developments occurred in a period in which average economic growth was stronger in the United States than Canada. Over the period 1990–2000, GDP per capita grew by 1.7 percent in Canada and health care spending increased in parallel, with an annual average growth in health care spending of 1.8 percent. In contrast, over this period U.S. health care spending increased at an annual rate of 3.2 per-
cent, a rate of increase more rapid than the 2.3 percent average growth in GDP (Anderson et al. 2003).

The divergent Canadian and U.S. trends in health care expenditure growth is but one area of policy research interest arising from the natural experiment of the very different principles underlying the design of the two systems. The consequences arising from the differences in the financing and organization of health care services in Canada and the United States has been the subject of longstanding research attention (Anderson et al. 2003; Detsky et al. 1990; Evans 1984; Evans, Barer, and Hertzman 1991; Fuchs and Hahn 1990; Redelmeir and Fuchs 1993; Woolhandler, Campbell, and Himmelstein 2003). A comparison of health care systems in Canada and the United States invites observations of the relative efficiency of the two systems, one based on markets and one based on public governance and insurance monopolies. (This same policy contrast describes the finance and administration of workers’ compensation insurance in the two countries.) This research tells an important story about the potential limits of private markets in efficiently providing goods of value to the health of populations. Although less thoroughly studied, the comparison of workers’ compensation systems in Canada and the United States is an important opportunity to understand the relative performance of private markets versus public administration in achieving outcomes that are efficient, equitable, and of the highest possible quality.

Aside from the very substantial differences between the two countries in the financing of health care, there are otherwise broad similarities in the organization and delivery of health care services to general populations. Within this broad similarity of the two health care systems, there are some useful distinctions to note in the provision of health care services to injured workers receiving compensation from workers’ compensation programs. In most U.S. states, the employer or insurer chooses the treating physician and other health care providers for the treatment of workplace injury or disease compensated by workers’ compensation. Provider reimbursement is provided directly by the employer or the compensation insurance carrier. In Canada, the injured worker has the right to choose his or her treating physician (who is typically the regular provider of health care). In most Canadian provinces, the treating physician is reimbursed by the provincial single-payer health care insurance plan, which in turn bills the workers’ compensation author-
ity for the reimbursement of the costs of care. Care provided by allied health professionals, hospital care, and pharmaceuticals are reimbursed directly by workers’ compensation agencies.

A SUMMARY OF THE THOMASON/BURTON STUDY

Terry Thomason and John Burton collaborated on a study of the employers’ costs of workers’ compensation insurance in two Canadian provinces, Ontario and British Columbia, relative to costs in several jurisdictions in the United States over the period 1975–1995 (Thomason and Burton 2000). The key finding from this study suggested that the costs of workers’ compensation insurance are lower in jurisdictions with single payer, publicly owned insurance providers (“monopolistic public funds” in the language of Thomason and Burton). However, the authors noted very real challenges in accurately adjusting for differences in the design and administration of the Canadian and U.S. programs and argued for the importance of a more refined study methodology.

Thomason and Burton subsequently revised their methodology to address some of the limitations they identified in their earlier study (Thomason and Burton 2001). Among the more important revisions included 1) the addition of three U.S. states with exclusive state fund insurance provision, 2) adjustments to inter-jurisdictional differences in rate group classification and in payroll calculations, 3) adjustments to more accurately account for unfunded liabilities in the Canadian jurisdictions, and 4) examining in more detail the possibility that health care costs may be shifted from the workers’ compensation program to the universal single payer health care insurance programs in Canadian jurisdictions.

Consistent with the results of their earlier study, the revised Thomason and Burton study reported that Ontario workers’ compensation insurance costs were equal to or lower than the costs in the median cost jurisdiction in the United States over the time series, and that in recent years, actual Ontario costs were in the lowest quartile of workers’ compensation jurisdictions included in the study sample. While performing as one of the four lowest cost jurisdictions in North America, the Workplace Safety and Insurance Board in Ontario also achieved a higher wage replacement rate than most U.S. jurisdictions, experienced
a lower rate of permanent partial disability awards, and incurred lower medical care expenditures as a proportion of premium revenue.

Building from the observation that the Ontario workers’ compensation system incurs lower medical care expenditures, the objective of this chapter is to examine factors that may account for this important difference in resource allocation between Canadian and U.S. workers’ compensation programs. Among the factors that appear to be responsible for these differences are 1) lower medical care prices in Canada, 2) lower medical care price inflation in Canada, and 3) higher intensity of health care services in the United States. We argue three central points in this chapter. First, contrasting the U.S. model of market-based health insurance provision with the universal tax-financed single-payer model in Canada suggests the latter is substantially more efficient (both in general health services and in services purchased to treat compensable work-related injury and disease). Second, the greater intensity of health care treatment typically provided in the United States does not appear to result in substantially better health outcomes for U.S. patients relative to Canadian patients. Third, both the Canadian and U.S. health care systems have struggled to align incentives to consistently improve the efficiency and the quality of health care.

WHAT WE HAVE LEARNED

After 30 years of North American policy experiment and reform in the finance and delivery of health services, we have learned a number of lessons about the efficiency of different insurance funding models and the effectiveness of different health care financing models in purchasing quality.

Efficiency in the Financing and Funding of Health Care

In their study of workers’ compensation program cost differences between Canada and the United States, Thomason and Burton (2001) directly compared prices for 10 common medical procedures used in 39 U.S. state compensation programs and the province of Ontario. In this comparison, after adjusting for differences in the values of the Canadian and U.S. dollars, they found that the price for medical procedures
in the United States is substantially greater than the price for similar procedures in Ontario, with the ratio of the median fee in the United States to the fee in Ontario ranging from 1.6 to 7.1. Taking a simple average of fees across the 10 procedures, the average median fee in the United States was found to be 4.6 times greater than the average fee in Ontario.

The observation that health care prices are generally higher in the United States relative to Canada has been extensively reported in the health services research literature (Detsky et al. 1990; Fuchs and Hahn 1990; Redelmeir and Fuchs 1993). Anderson et al. (2003), for example, have recently reported findings from a cross-national comparison of Organisation for Economic Co-operation and Development (OECD) economies, examining evidence for the proposition that the higher U.S. spending on health care (as a percent of GDP) is primarily due to higher relative prices for health care goods and services in the United States, rather than a greater intensity of use of equivalently priced health care resources. In 2000, the United States spent 13 percent of GDP on health care, Switzerland 10.7 percent, and Canada 9.1 percent. The OECD median was 8.0 percent. Paradoxically, however, the United States had fewer of each of the following than the median OECD country: physicians per 1,000 population, physician visits per capita, acute beds per capita, hospital admissions per 1,000 population, and acute care days per capita. Anderson et al. (2003) conclude that higher average prices is the likely explanation for the paradoxical pattern observed in the United States of lower aggregate utilization of health care services and higher per capita expenditures on health care.

Thomason and Burton’s observation of very substantial medical care price differentials between Ontario and the sample of 44 U.S. states for a selection of 10 common procedures is based on fee information at the end of the 20-year observation period of their study. It is important to note that this differential in the price of medical care in the two countries has emerged over the 20-year period 1975–1995. As shown in Figure 8.1, in the period 1975–1979, prices for medical care purchased by workers’ compensation insurance providers were essentially identical in Canada and the United States.

Medical care price inflation has been a persistent policy challenge in the United States. In addition, there is good evidence that medical care expenditures for the treatment of occupational conditions in the United
Figure 8.1  Real Medical Benefit Costs, 1975–1995 ($)

States exceed those for the treatment of similar conditions insured under general health insurance plans (Baker and Krueger 1995; Baldwin, Johnson, and Marcus 2002; Durbin, Corro, and Helvacian 1996; Johnson et al. 1993; Johnson, Baldwin, and Burton 1996). In contrast, medical care price changes in Canada have been more tightly aligned to the macroeconomic growth profile of the country. There are a number of explanations for the difference in medical care price growth between the two countries. The most prominent explanation is the price-setting power of the monopoly universal health insurance programs in Canadian provinces relative to the fragmented and competitive structure of private market health care insurance in the United States (Evans 2000; Evans, Barer, and Hertzman 1991).

The Ontario Workplace Safety and Insurance Board (WSIB) has legislated authority to function as a health insurance provider and to purchase health care services for the treatment of work-related injury
and disease. This authority predates the establishment of the single-payer universal health insurance programs in Canada in the period 1960–1970. The federal legislation creating public single-payer health care insurance agencies in Canadian provinces created insurance monopolies by explicitly prohibiting private insurance carriers from providing health plans that covered services insured by the single payer plans. Provincial workers’ compensation programs in Canada function as a parallel health insurance provider. They are, however, a minor purchaser. In the province of Ontario, the WSIB purchases approximately $350 million of health care services annually in a publicly funded health care system of $10 billion. The health care costs of work-related injuries range between 2 and 5 percent of total health care costs, although this proportion is larger when total public health care expenditures are restricted to working age populations (Association of Workers’ Compensation Boards of Canada 2001). With limited exceptions, workers’ compensation authorities purchase care for injured workers within the structure of the publicly funded system (Association of Workers’ Compensation Boards of Canada 2001). The workers’ compensation authorities in Canada, by buying within the publicly funded health care system, have been able to benefit (free-ride) from the price-setting power of the large universal single-payer health insurance plans.

There appear to be very substantial administration costs associated with the provision of health care insurance through multiple insurers in private markets. Woolhander and colleagues have documented a durable pattern of higher administrative expenditures in the U.S. health care system relative to Canada (Himmelstein and Woolhandler 1986; Woolhandler, Campbell, and Himmelstein 2003; Woolhandler and Himmelstein 1991, 1997). They have estimated that 31 percent of U.S. health care expenditures in 1999 were allocated to administration functions ($US1,059 per capita) compared to 16.7 percent of Canadian health care expenditures ($US307 per capita). Between 1969 and 1999, the share of the U.S. health care labor force engaged in administrative tasks increased from 18.2 percent to 27.3 percent. During the same period in Canada, the health care labor force engaged in administration grew from 16.0 percent to 19.1 percent. Insurance overheads in Canada are estimated to be 1.9 percent of health care system expenditures. In the United States, private insurance provider overheads are estimated to be 11.9 percent, Medicare overheads to be 3.6 percent and Medicaid over-
heads to be 6.8 percent. Clearly, the challenges of technical and allocative efficiency decisions within the complexity of contemporary health care systems require a commitment to intensive and sophisticated management. What remains uncertain is the optimal level of administration expenditure in a health care system.

Greater medical care price inflation and higher administrative costs in the United States will account for an important fraction of the higher average U.S. expenditure on health care services in the treatment of injuries and disease compensated by workers’ compensation insurance. A number of researchers have noted, in addition, that medical care expenditures for the treatment of occupational conditions exceed those for the treatment of similar conditions insured under general health insurance plans (Baker and Krueger 1995; Baldwin, Johnson, and Marcus 2002; Durbin, Corro, and Helvacian 1996; Johnson et al. 1993; Johnson, Baldwin, and Burton 1996). By way of explanation, Himmelstein et al. (1999) note that the coverage of both medical care and wage-loss benefits distinguishes workers’ compensation insurance from typical health insurance plans. The dual responsibility for medical care costs and wage-loss costs creates stronger incentives for insurance providers to select therapeutic options that may expedite earlier recovery and earlier return to work. As Himmelstein et al. (1999, p. 430) observe, “Where a traditional insurer or HMO might seek costs savings by delaying or denying medical tests or treatments, workers’ compensation insurers might seek to accelerate appropriate medical care,” or be receptive to the promise of more intensive medical care. In general, these incentives can be understood to influence to a similar degree both single payer Canadian insurers and U.S. private market insurers. However, as noted earlier, the Canadian single-payer compensation insurers in general have purchased health care services within the fee schedules of the publicly funded health care system. There is some evidence that workers’ compensation insurers in the United States have offered more lucrative provider fees in the interests of purchasing expedited care (Baker and Krueger 1995; Baldwin, Johnson, and Marcus 2002; Durbin, Corro, and Helvacian 1996; Johnson et al. 1993; Johnson, Baldwin, and Burton 1996).

The theory of neoclassical economics predicts that the private health care insurance market will be a more efficient instrument than a public monopoly insurance provider. Market competition will dis-
cipline insurance prices and the efficiency of the insurance function. However, as suggested by the Thomason and Burton comparison of Canadian and U.S. workers’ compensation health care expenditures, the empirical evidence appears to indicate that public single-payer health insurance may be more efficient than private markets. Robert Evans, who authored an important early treatise on economic behavior in the health care industry, has provided a thoughtful analysis of some of the trade-offs in the design of health insurance (Evans 1984). In particular, he has emphasized the risks of market failure in private health insurance markets. These risks arise from economies of scale, adverse selection, and moral hazard.

The provision of health insurance is subject to economies of scale, rendering economic advantage to large insurers. In addition, there are diseconomies arising from private health insurance markets. Health care providers face compliance costs in dealing with many different insurance providers. Insurance providers face marketing and commission expenses associated with market competition. A “public utility” insurance model, relying on a monopoly provider, captures the economies of scale and avoids the costs of compliance, marketing, and profit-making associated with private markets. There are a number of examples of insurance market failure in the United States (the numbers of uninsured citizens and the withdrawal of providers from workers’ compensation insurance markets in some states), which may be related to the inability of markets to capture economies of scale.

Adverse selection is a clearly understood phenomena in private insurance markets, where people of different risk statuses are more or less likely to buy insurance. Segmenting health insurance products by benefit coverage, copayment conditions, and risk status will result in insurance coverage costs for high-risk groups being more expensive than insurance provided under a community-rating model. Insurance market failure occurs when groups or individuals wish to purchase coverage but are priced out of the market. The moral hazard risk of insurance has received a great deal of attention from health economists. Moral hazard in the context of health insurance refers to a risk that the existence of insurance coverage will increase the probability or intensity of health care use. Moral hazard appears to be an equivalent risk for health insurance provided by private markets or by public monopolies.
Efficiency in the Organization and Delivery of Health Services

A number of features of the organization and delivery of health services are frequently contrasted in comparisons of the Canadian and U.S. health care systems. The Canadian system is often characterized, for example, as having a more constrained supply of some medical care services than the United States. One perspective views supply constraints as having large potentially negative effects, arising from unmet medical care needs or in delays in the receipt of effective care. An alternate perspective notes that a supply-constrained system will more likely be more efficient in each treatment encounter than a system with substantial surplus human and physical capital. In this section we consider some of the evidence for efficiency differences in the organization and delivery of health services in the two countries.

The health effects of delays in the provision of care or barriers to access to care have been a focus of health services research attention in both the United States and Canada. In the United States, concern focuses on the health effects arising from barriers to accessing medical care among persons without health care insurance. In the Canadian system, with universal insurance coverage, concern has focused on the health effects of delays in the provision of care arising from a less generous supply of health care providers and health care services relative to the United States.

Research studies designed to compare the structure, process, and outcome of health care in Canada and the United States can be informative. One example is a study comparing the clinical management of acute myocardial infarction in a sample of 2,600 U.S. patients and a group of 400 Canadian patients with very similar clinical and demographic profiles (Mark et al. 1994). Patients in both countries were interviewed by telephone 30 days, six months, and one year after myocardial infarction to determine their use of medical care and quality of life. The clinical management of Canadian patients was less intensive than provided to U.S. patients. Canadian patients had a lower rate of cardiac catheterization (25 percent versus 72 percent), coronary angioplasty (11 percent versus 29 percent) and coronary bypass surgery (3 percent versus 14 percent). At one year, 24 percent of the Canadian patients and 53 percent of the U.S. patients had undergone angioplasty or bypass surgery at least once. Despite these differences in the intensity
of invasive procedures, unadjusted survival rates for the U.S. cohort at 30 days (93.2 percent) and one year (90.7 percent) were equivalent to survival rates in the Canadian cohort (92.4 percent at 30 days and 90.3 percent at one year). While there were no important differences in functional status at 30 days between two patient cohorts, the study did report marginally better average quality of life among U.S. patients at one year compared to Canadian patients. Although this study did not report the precise measures of the economic value of the differences in health care utilization between the two cohorts, these expenditure differences must be substantial. The large differences in resource utilization observed in this study were not associated with strong differences in clinical outcome.

The provision of health care services in the treatment of acute low-back pain is a second example of a dissonant pattern, where the intensity of health care service use is not directly related to the duration of disability. Disabling back pain is common and, whether caused by work-related exposures or non-work-related exposures, is one of the most frequent reasons that patients visit primary care physicians. Patients with acute low-back pain may seek care from among several types of health care providers: primary care physicians, specialty-qualified physicians (particularly orthopedic specialists), or chiropractors. A number of studies in both Canada (Côté et al. 2001) and the United States (Carey et al. 1995; Deyo et al. 1991; Deyo and Tsui-Wu 1987) have documented wide variation in the intensity of treatment for low-back pain, both within clinical professions and between clinical professions. For example, Carey et al. (1995) followed a group of 1,500 adults in North Carolina who presented symptoms of low-back pain to one of six types of practitioners: 1) urban primary care physicians, 2) rural primary care physicians, 3) urban chiropractors, 4) rural chiropractors, 5) orthopedic surgeons, and 6) primary care physicians in a group-model health maintenance organization. At the six-month follow-up, the times to functional recovery, return to work, and complete recovery from low-back pain were similar among patients seen by all six groups of providers. Despite the similarities in clinical and functional outcomes, there were marked differences in the intensity of health service utilization. Mean total direct outpatient costs per episode of low-back pain ranged from $435 for patients seeing an HMO provider to $783 for patients seeing an urban chiropractor. Given the high prevalence of acute back pain in
working-age populations, these differences in health care resource use will be substantial. The absence of evidence of clinical benefit associated with more intensive clinical resource use suggests that intensive treatment of acute low-back pain is inefficient.

As a final example, we summarize a study that used an identical study protocol to measure the prevalence of mental health disorder in representative samples of U.S. residents and residents of the Canadian province of Ontario (Katz, Kessler, Frank, Leaf, and Lin 1997; Katz, Kessler, Frank, Leaf, Lin, and Edmund 1997). This study has produced a fascinating series of findings. Among the findings salient for the purposes of this chapter was the observation that the use of mental health services by persons without detectable mental health morbidity or disability in the U.S. sample was 75 percent higher than observed among well-functioning Ontario respondents in the sample. This finding suggests that the probability of inappropriate use of mental health services (treatment where no treatment was indicated) may be more likely in a health care system with generous service supply. The study finding also suggests that the moral hazard potential of a universal single-payer first-dollar insurance program (also known as Canadian health care) may be overstated. In an important parallel finding, the study reported that persons with detectable mental health disorder were more likely to be provided mental health treatment services if resident in Ontario than in the United States.

**Effectiveness in Purchasing Quality Care**

Contemporary health care systems face persistent deficits in delivering health care of the highest quality. For example, one of the most consistent findings in health services research is the gap between evidence and practice (Grol and Grimshaw 2003). Studies of health care systems in the developed economies typically find that about 30–40 percent of patients do not receive care according to current scientific evidence, and that about 20–25 percent of care provided is not needed or is potentially harmful (Schuster, McGlynn, and Brook 1998). In the United States, only one-half of the population receive needed preventive care; 70 percent receive recommended care for acute problems, such as colds or stomach pain; and just 60 percent of those with a chronic illness such as diabetes or hypertension get the care they need. In addition, about one-
fifth of the care given to persons with chronic conditions is unnecessary and possibly harmful (McGlynn and Brook 2001).

Evidence of uneven quality performance in health care systems is frequently suspected when different treatment rates or variations in treatment intensity are observed between similar geographic populations. As one example of high variation in treatment across populations, Lavis et al. (1998) described trends in hospital use for neck and back problems (common conditions in workers’ compensation claims) in Ontario and the United States. Between 1982 and 1992, the hospital admission rate for medically treated cases (without surgery) decreased by 52 percent in Ontario and by 75 percent in the United States. Over the same period, the admission rate for surgically treated cases increased by 14 percent and by 35 percent respectively. By 1992, the admission rate for medically treated cases in the United States was 23 percent higher than in Ontario, whereas the rate for surgically treated cases was 164 percent higher. In this study, the reduction in hospital admission for medically treated cases would appear to be consistent with evidence that bed rest and traction, two common forms of inpatient medical treatment, were not effective. In contrast, the relatively strong increase in the frequency of surgical treatment for neck and spine disorders in the United States would appear to be more related to the more ample supply of surgical specialist and diagnostic imaging facilities in the United States than to clear evidence of the effectiveness of surgical intervention.

Over the past two decades, there has been more experimentation in alternate approaches to the purchasing, organization, and delivery of health services in the United States than in Canada. Most of these organizational reforms have been motivated by the twin goals of improving efficiency and improving effectiveness of health care services. Baldwin, Johnson, and Marcus (2002) have recently reported on health care costs and service differentials between preferred provider networks and nonnetwork providers in the treatment of work-related injuries in the United States. A sample of approximately 38,000 workers’ compensation claims with work absences of less than seven days that were provided care by network providers were compared with a matched sample of 64,000 workers’ compensation claims provided care by nonnetwork providers (claims were matched on type of injury, age, and gender). The motivation of this study was to clarify how networks succeed in reducing costs, by examining evidence for cost reductions arising from three
alternate strategies: 1) reducing the quantities of services provided to
injured workers, 2) shifting to more economical services, or 3) simply
reducing per unit prices.

In this sample of injured workers, the study found that average health
care costs are lower for network claims than for matched nonnetwork
claims. Price discounts explain the largest part of the cost differential,
with reductions in service utilization also being important for under-
standing resource use differentials in the treatment of acute back inju-
ries and the treatment of cumulative stress injuries. Given that network
savings primarily reflect price discounts for the same services provided
by nonnetwork providers, network strategies result in an increase in the
efficiency and, therefore, the cost-effectiveness of care.

McGlynn and Brook (2001, p. 84) document the persistent failure
of public and private policymakers in the United States and elsewhere
to identify and solve the factors underlying the inconsistent quality per-
formance of contemporary healthcare.

Serious deficits are also manifest in how skilfully care is deliv-
ered. Coronary angiography is an invasive test used to diagnose
cardiac disease and determine what treatment is appropriate for a
patient. Analysis of a random sample of angiographies performed
in one state showed that only half of the tests were done compet-
tently enough to be accurately interpreted. When the tests were
reread by a group of expert cardiologists, one-quarter of patients
determined by the original reading to have the most severe disease
did not have it. Six percent of persons who were told that their test
results were not severely abnormal actually had severely abnormal
results. One third of persons whose bypass surgery was considered
necessary or appropriate based on the original interpretation of the
angiography results underwent surgery that was of uncertain ben-
efit or inappropriate based on the gold-standard review. Nearly 1.3
million coronary angiographies were performed in 1998 nation-
ally. If the results of this study held nationally, nearly 650,000 tests
would be difficult to interpret accurately; at $12,450 per test, that
is more than $8 billion in wasted expense.

Suboptimal health care quality is both inefficient and ineffective.
McGlynn identifies the following factors which, in their view, account
for the absence of a strong policy commitment to quality improvement
in contemporary health care. First, the responsibility for quality is dif-
fuse, distributed among professional regulatory bodies, health protec-
tion agencies, accreditation bodies, regulators, health care purchasers, (and lawyers who bring malpractice suits alleging substandard care). An unfortunate consequence of this diffusion of responsibility is a persistent policy failure to respond to substandard care practices. Second, health care is characterized by *outmoded system design*, where quality performance protocols well-established in other fields have either been resisted or not adopted in much of contemporary health care. Finally, there are very large *information voids*. There is, for example, no regular, ongoing surveillance of the quality of health care encounters, and no monitoring of the progress across the system in adopting practices with demonstrated effectiveness to improve quality. These problems are as prevalent in the organization and delivery of health care services to workers’ compensation beneficiaries as they are in the general health care system. McGlynn and Brook argue that improvements will come from policy initiatives which 1) create quality champions (presumably with some authority to set financial rewards and penalties); 2) create functional information systems, and 3) routinely monitor and report on the quality performance of the health care system.

**LESSONS LEARNED**

Thomason and Burton’s study of the economic performance of workers’ compensation programs in Canada and the United States is an excellent example of the potential of comparative cross-national studies to inform our understanding of the implications of different policy choices. A comparison of the efficiency and effectiveness of health care services purchased by workers’ compensation insurance providers in Canada and the United States is an important case study of the more global question of the relative benefits and limitations of private markets and public monopolies in the provision of health care insurance.

Canadian workers’ compensation agencies purchase health services within the publicly funded, single-payer health care insurance programs in each province. In the United States, workers’ compensation insurance is provided through private markets in a substantial number of state jurisdictions, and health services for injured workers are purchased in competitive provider markets.
In comparing the experience of the two systems over the past 30 years, it is clear that the publicly funded, single-payer health care insurance programs have been more successful in limiting medical care price inflation. In addition to less success in disciplining medical care prices, the U.S. reliance on private insurance markets appears to result in a substantially higher proportion of health care resources allocated to administrative functions. This higher expenditure on administrative functions does not appear to increase the relative efficiency of the U.S. health care system.

There is evidence that the more constrained supply of human and physical capital in the Canadian health care system is associated with less intensive medical care treatment compared to the United States. There also is some evidence, however, that more intensive medical care treatment does not result in significant health benefits for many classes of morbidity.

Finally, both the Canadian and U.S. health care systems have struggled to align incentives to consistently improve the efficiency and the quality of health care. Brook (1998) has argued that a systemic commitment to quality improvement in health care will require a stronger commitment to ensuring that effective medical care is appropriately delivered to patients with need for care, and that care is provided to a high standard of technical excellence. Aligning incentives to improve quality is a challenge shared by health care purchasers in both Canada and the United States.
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