The Future Role of Managed Care and Capitation in Workers' Compensation

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A patient of mine, Mrs. Lopez, suffered a lower back injury while lifting heavy equipment. She sustained the injury while working in the housekeeping department at a local college. I telephoned her supervisor and asked him about Mrs. Lopez's injury. He assured me that he had forwarded an accident report to the benefits department. He said he was unaware of any employer policies or training programs governing heavy lifting. The college did not have an employee health service, but instead relied on a local law firm to handle the administration of its workers' compensation. When I informed the supervisor that I thought Mrs. Lopez might be able to return to a restricted duty job soon, he said that he did not want Mrs. Lopez to return until "she was 100%." I told him that this employee would benefit medically from returning to a restricted duty job as soon as it was reasonable rather than waiting until she could perform heavy lifting again. However, the supervisor replied "Don't you worry about returning her to work so soon. Workers' compensation will pay for it.”

Because of her employer's policies, Mrs. Lopez did not return to work for more than two months. She became deconditioned from the lack of normal daily exercise—which could have been avoided by providing restricted work—and the delay hampered her return to employment. Mrs. Lopez also became depressed, in part from being isolated from her workplace, and required antidepressant drug treatment. Although Mrs. Lopez appeared leery about returning to restricted duty when I initially broached the subject, she expressed a wish to return to work at later visits, especially when she felt able to perform the bulk of her regular job. Despite my repeated overtures to her supervisor, the supervisor did not allow Mrs. Lopez to return to work until she was completely recovered, even when she had recovered to the point of being able to perform almost all of her usual functions at work. Her employer paid for all of her medical treatment, including office visits and physical therapy, and did not have a utilization review agent—as is required by Massachusetts regulations—who should have contacted me to check on the appropriateness and necessity of treatment. I later learned that the college's legal counsel on workers' compensation issues...
questioned the legal basis for the state's utilization review regulations and advised its clients that it was not necessary to comply with them.

The approach taken by Mrs. Lopez's employer typifies a more general view. It assumes that the medical care provided injured employees should not differ from that given to other patients. This view also maintains a separation of medical care from the legal and administrative aspects of workers' compensation. Mrs. Lopez's employer viewed the medical care component simply as a health care financing problem and did not link it to other programs devoted to workplace safety or personnel policies. This separatist approach fails to establish the kinds of incentives that are essential to reduce the economic and human costs of workplace accidents. It prevents applicable medical knowledge from being implemented into practice. In the above example, the employer probably incurred greater costs than it otherwise would have by not implementing return-to-work and injury-prevention programs.

I. INTRODUCTION

Mrs. Lopez's story illustrates a significant structural flaw in the workers' compensation system. Employers tend to view medical care, including injury prevention and rehabilitation, solely as the responsibility of the medical sector. At the same time, health care providers have failed to educate employers about the benefit of return-to-work programs and injury-prevention approaches. In the foregoing story, returning the employee earlier to restricted work duties would have reduced the total cost of productivity reductions arising from her employment absence and medical expenses.

Commentators have heavily criticized the workers' compensation system for failure to provide sufficient incentives to reduce the costs of workplace accidents. Legislatures and the public view workers' compensation as too expensive and as providing inadequate deterrence to workplace injuries. Medical expenses account for as much as half of all workers' compensation costs. During the past decade, medical costs associated with workers' compensation increased more than one and one-half times faster than general health expenditures. Because of the high costs of the health care component of workers' compensation,

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1 Legal academics have previously discussed the concept of separatist legal institutions in the context of judicial adjudication of disputes involving scientific and technological issues. See, e.g., Stephen L. Carter, Separatism and Skepticism, 92 YALE L.J. 1334, 1334-39 (1983); Joel Yellin, High Technology and the Courts: Nuclear Power and the Need for Institutional Reform, 94 HARV. L. REV. 489, 555-58 (1981); Joel Yellin, Science, Technology, and Administrative Government: Institutional Designs for Environmental Decisionmaking, 92 YALE L.J. 1300, 1306-09 (1983). Separatists argue that scientific issues should be separated from legal and policy issues and decided by scientific experts. Thus, science courts—composed of scientific experts—should decide scientific and technological issues, and law courts should be deferential to the decisions rendered by science courts. See Yellin, supra, 92 YALE L.J. at 1308-09. In this Article, I contend that an analogous phenomenon has in fact occurred in the workers' compensation system. Separatist businesses have failed to integrate the science of occupational medicine into their administrative practices and instead have presumed that physicians practicing in the community can take care of the medical aspects of workers' compensation. However, this separatist approach is flawed because community physicians, by-and-large, do not have occupational medicine expertise and thus have not initiated important public health measures, such as return-to-work and accident-prevention programs. Thus, I argue that private regulation in the form of managed care systems should be created to encourage the application of known scientific principles to workplaces by breaking down the administrative barriers created by the current separatist approach.


3 See id. at 122.


5 See Rosalind Resnick, Managed Care Comes to Workers' Compensation, BUS. & HEALTH, Sept. 1992, at 32, at 34.
commentators have recently made a vigorous call for the implementation of managed care.6 Unlike other health care financing programs, workers’ compensation provides complete medical care for work-related injuries and diseases without deductibles or copayments.7 In the past, state regulators used fee schedules as the major device to limit medical costs.8 Historically, these rates were low relative to other health financing systems and thus encouraged the participation of a relatively small proportion of health care providers.9 Because managed care has lowered payments to providers in regular health care delivery, however, an increasing number of providers and medical organizations have become interested in treating workers’ compensation patients.10 At the same time, an increasing number of states are considering ways to implement managed care in workers’ compensation.11

Many assume that states may implement managed care in workers’ compensation in the same way states have implemented it in the regular health care delivery system: by emphasizing the reduction in the amount of treatment given to injured employees.12 Yet, managed care is an ambiguous term, and it describes reliance on several different kinds of private regulatory systems. The most common form of current managed care in workers’ compensation involves reliance on treatment guidelines and utilization review.13 State regulators adopt treatment guidelines and require insurers to use them to determine the necessity and appropriateness of treatment.14 This approach requires approval from utilization review agents before treatment continues after the initial visit.15 A second major form of managed care relies on health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to provide care based on contractual relationships with employers or insurers.16 Because HMOs and PPOs operate on a fixed financial rate based on the size and characteristics of the employee group, they have a direct financial incentive to establish ways to minimize costs.17 The third form of managed care, capitation, establishes a direct

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8 See Frank Cerne, Managed Care: Lowering the Boom on Workers’ Comp, HOSP. & HEALTH NETWORKS, Aug. 20, 1994, at 50, 50.
9 In particular, many surgical specialists, such as orthopedic surgeons, maintain a policy of not treating workers’ compensation patients because of substantial differences in compensation compared to mainstream medical practice.
10 Workers’ compensation programs have not yet embraced managed care programs on a large-scale basis as compared to the mainstream medical care system. See Phillip L. Polakoff & Paul F. O’Rourke, Managed Care Applications for Workers’ Compensation, BUS. & HEALTH, Mar. 1987, at 26, 26.
11 See Resnick, supra note 5, at 32, 35.
12 Currently, worker’s compensation systems do not reward physicians for treatments that result in returning employees to their employment promptly. See Cerne, supra note 8, at 52.
13 In Massachusetts, for example, a statute gives responsibility for developing guidelines to the health care services board, comprised of physicians and community members. See MASS. GEN. LAWS ANN., ch. 152, § 13(3) (West 1988 & Supp. 1996).
14 See, e.g., id. § 13(2).
15 In utilization review, the agent pre-approves a set amount of treatment by the provider and thus assists in the planning and delivery of health care. See Michael R. Costigan & Dwight L. Robertson, Workers’ Compensation: What Works in Managed Care, RISK MGMT., Nov. 1992, at 59, 60, 62. For a more general description of utilization review techniques, see Joanne Lamprey & Charlotte K. Corcoran, Utilization Review: Changing Perspectives, in MAKING MANAGED HEALTHCARE WORK: A PRACTICAL GUIDE TO STRATEGIES AND SOLUTIONS 401, 401-14 (Peter Boland ed., 1993) [hereinafter MAKING MANAGED HEALTHCARE WORK].
17 See Solomon, supra note 4, at 62.
financial incentive for treating physicians to minimize the costs of treatment.\textsuperscript{18} A portion of the treating physician's income may vary depending on the costs of the treatment or referrals to specialists by the physician group to which he or she belongs.\textsuperscript{19} Thus, managed care may encompass one or all of these major kinds of mechanisms aimed primarily at reducing treatment costs.

This Article describes how the workers' compensation system created a structural separation between the legal/administrative system that governs the workplace and the medical delivery system that treats injured employees. This structure creates incentives that encourage the legal/administrative system to concentrate primarily on compensating employees for work-related illnesses, rather than reducing work-related health costs through mitigation and prevention of work-related injury and disease with the input of medical expertise. Similarly, the medical care delivery system emphasizes taking care of work-related illnesses by treating the individual patient, rather than also changing workplace practices. In Part II, this Article describes the legal and health care components of the workers' compensation legal system. Part III analyzes the workers' compensation system's failure to encourage the optimal reduction of workplace cost. The rising costs of workers' compensation have not stimulated investments by employers in programs which prevent or mitigate workplace accident costs.

Part IV hypothesizes that this phenomenon results from the independence of the legal/administrative system from the health care delivery system. Here, I trace the separation of these systems within workers' compensation to traditional beliefs held by employers, health care providers, and employees. Part IV also discusses why business managers developed a general tendency to view workers' compensation as a social welfare program, rather than as an incentive to reduce the costs of workplace-related illness. Business managers have tended to rely on regulatory compliance with health and safety standards as the major means of controlling the incidence of workplace-related illness. Similarly, employees have tended to view workers' compensation as an entitlement due to them if they suffer from a work-related illness. Part IV furthermore describes how the medical care delivery system has traditionally dealt with work-related illness. Health care providers viewed workers' compensation as a health care financing system, and have generally taken a traditional patient-centered approach, rather than reforming workplace practices.

In Part IV, I analyze the potential role of managed care and capitation in workers' compensation. Managed care may not optimally lower the overall costs of workplace accidents if it primarily emphasizes reducing the amount of health care provided to injured employees. Reduction in the amount of treatment per injured employee may further encourage provision of health delivery on a high-volume and low-quality basis. Such an approach would likely result in higher indemnity costs, which cover lost wages if employees cannot return to work on a timely basis because of inferior medical treatment. Furthermore, if managed care confines itself to affecting only treatment decisions, then neglect of preventive strategies will continue. Alternatively, however, managed care may represent an opportunity to restructure the delivery of health care in a manner that improves quality and efficacy of treatment, encourages the prevention of workplace injuries, and provides for a timely return to work when medically reasonable. This optimal implementation of managed care and capitation in workers' compensation requires a paradigmatic shift to a community commitment based on a public health imperative to ensure quality medical care.

\textsuperscript{18} For examples of state pilot projects involving use of capitation, see Leavenworth, supra note 6, at 38; Vera Tweed, Moving Toward 24-Hour Care, BUS. & HEALTH, Sept. 1994, at 54, 58.

\textsuperscript{19} For a general discussion describing the capitation method, see Peter R. Kongstvedt, Compensation of Primary Care Physicians in Open Panels, in THE MANAGED HEALTH CARE HANDBOOK 55, 55-61 (Peter R. Kongstvedt ed., 2d ed. 1993).
In Part V, I propose that the focus shift to a public health paradigm that emphasizes prevention and mitigation of injuries and disease in addition to quality of care. Such a community commitment to public health would be consistent with implementing occupational medicine principles through managed care. The practice of occupational medicine may serve to reduce the costs of accidents in workplaces by emphasizing—in addition to effective and efficient treatment—prevention and mitigation of work-related injuries. Indeed, the practice of occupational medicine may be particularly compatible with managed care because physicians in this specialty have developed pragmatic approaches to accommodate the tensions created by owing duties to both employee-patients and employers. This expertise has not yet been implemented on a widespread basis, however. Occupational medicine principles should provide a basis for a managed care approach that better optimizes a reduction in workplace accident costs. Part VI demonstrates how an emphasis on this public health imperative advances interests shared by employers, employees, and physicians.

II. THE LEGAL AND MEDICAL COMPONENTS OF WORKERS’ COMPENSATION

Workers’ compensation constitutes the first and most enduring tort reform measure in the United States. States initiated the idea at the turn of this century to provide an exclusive remedy for work-related injuries and diseases. The remedy consists of indemnity and medical payments. Thus, this innovation created a health care payment system within the legal structure of workers’ compensation.

A. THE LEGAL STRUCTURE

State legislatures established workers’ compensation systems holding employers strictly liable to their employees for injuries and diseases caused by the workplace. To qualify for benefits, the employee must show three major elements: (1) the existence of an injury or illness; (2) that the injury or illness arose from and in the course of employment; (3) and the resulting harm to the employee in lost wages, disfigurement, medical, or rehabilitation costs. The amount of recovery depends on the degree of impairment and disability. The determination of impairment is a medical judgment focusing on the functional limitations of the injured employee. In contrast, the determination of disability is a legal judgment about the effect of the impairment on the ability of the injured employee to work. Workers’ compensation provides lower benefits than those traditionally available.


22 Subsequently, the federal government established workers’ compensation systems for its employees. See id.

23 Id. Most of the statutes limit the use of workers’ compensation law to accidental injuries. See KEETON ET AL., supra note 20, at 575.


25 Id. at 89-90.

26 Id. at 89.
under tort law. Typically, employees recover only about two-thirds of lost income. Workers' compensation does not provide payments for pain and suffering. Workers' compensation provides the sole remedy for employees who qualify and, generally, they are barred from suing their employers in tort law.

Workers' compensation systems rely primarily on an administrative system to resolve disputes over claims. Prior to administrative adjudication, the system allows insurers in many states to have independent medical examiners (IMEs) evaluate claimants to determine whether the insurer should initiate or continue payments. The IMEs, who are physicians paid by insurers, determine such issues as: whether the claimant's injury or illness falls within the jurisdiction of workers' compensation; whether the claimant is presently impaired and disabled; and whether the medical treatment rendered has been necessary and appropriate. If an insurer decides not to initiate or continue payment to the claimant based on the IME report, the claimant may still present the claim to an administrative judge for a legal decision on the above issues. While the original purpose motivating the establishment of workers' compensation systems was to provide an administrative claims system more efficient and speedier than the tort system, litigation before a claim is decided may cause substantial delays.

Workers' compensation requires the employer to obtain insurance or to self-insure, thus shifting the costs of workplace injury from the employee to the employer. The employer's insurance premium rates depend on the hazardous risks of the particular workplace and the employer's experience. From an economic perspective, therefore, workers' compensation should ideally internalize the costs of workplace accidents that injure employees by passing the costs on to consumers of the employer's products and services. If the costs of workplace accidents exceed the costs of prevention, then a rational employer would ideally invest in improving workplace safety.

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27 See KEETON ET AL., supra note 20, at 574 ("[T]his remedy is in the nature of a compromise.").
28 Junius C. McElveen, Jr. & Thomas Beck, Legal and Ethical Issues, in A PRACTICAL APPROACH, supra note 24, at 20, 21. Data show that there is approximately a 60% wage replacement for occupational injury victims and 40% for those who are severely disabled from occupational disease. U.S. DEP'T OF LABOR, AN INTERIM REPORT TO CONGRESS ON OCCUPATIONAL DISEASES (1980), reprinted in ASHFORD & CALDART, supra note 20, at 462 [hereinafter U.S. DEP'T OF LABOR INTERIM REPORT].
29 See Spieler, Perpetuating Risk?, supra note 2, at 209.
30 The basic exceptions to exclusivity include intentional misconduct by employers, see KEETON ET AL., supra note 20, at 576-77, or when an employer acts in a dual capacity as an employer and a manufacturer-supplier of a product which harms an employee.
31 See Brigham & Engelberg, supra note 24, at 85.
32 See id. For recent legal cases that define the role of IME physicians in Massachusetts, see Neff v. Commissioner of the Dep't of Indus. Accidents, 653 N.E.2d 556 (Mass. 1995) (holding that workers' compensation statute implicitly confers authority to grant waivers to indigent claimants of required IME fee); Scheffler's Case, 643 N.E.2d 1023 (Mass. 1994) (holding that IME report was prima facie evidence for issues of medical matters and vocational status or ability to perform a specific job); Murphy v. Commissioner of the Dep't of Indus. Accidents, 635 N.E.2d 1180 (Mass. 1994) (holding unconstitutional provisions regarding payment of fees). For recent criticism of expert testimony, see Jay Katz, "The Fallacy of the Impartial Expert" Revisited, 20 BULL. AM. ACAD. PSYCHIATRY L. 141 (1992).
33 See Beck, Legal and Ethical Issues, supra note 24, at 75-76. The administrative judge decides on the merits of the workers' compensation claim. See, e.g., MASS. GEN. LAWS ANN. ch. 152, § 45 (West 1988).
35 Id.
37 See GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 95-129 (1977). Thus, workers' compensation, like tort law, may encourage specific deterrence of imposing economically unreasonable risks on employees. This specific deterrence approach contrasts with the general deterrence by regulations that discourage the imposition of defined categories of risks. Specific deterrence
B. THE HEALTH CARE DELIVERY STRUCTURE

Unlike other health care financing programs, workers' compensation provides complete medical care for work-related injuries and diseases without deductibles, copayments, or other limits. In essence, employees who suffer from work-related injuries or illnesses have a right to health care as part of their workers' compensation benefits. These health care benefits may include provider fees, physical therapy, medications, medical devices, rehabilitation services, and vocational training. The workers' compensation system usually relies on fee schedules to determine the amount of the payment provided for these various benefits.

Health care providers serve as the gatekeepers to workers' compensation health care delivery, and they also provide important information to the attorneys and adjudicators of legal claims. Insurers and IMEs rely on information in the medical record which indicates whether the injury is work-related and thus within the purview of workers' compensation. Attorneys frequently request that treating providers assess the degree of impairment and disability in addition to whether the injury is work-related. IMEs may serve as a check on health care providers by determining whether a particular injury is work-related and the degree of impairment and disability. Insurers may stop or fail to initiate payment for medical services if an IME decides either that an injury is not work-related or that a employee is medically ready to return to work.

III. THE WORKERS' COMPENSATION SYSTEM'S FAILURE TO DETER WORKPLACE ACCIDENTS

The workers' compensation system presently fails to encourage optimal reduction of workplace accident costs. This failure currently manifests itself in the rising workers'...
compensation costs and a lack of a corresponding increase in investment in improving workplace safety.\textsuperscript{48} Because the managed care approach dominates mainstream health care delivery systems, this approach will also likely be implemented in the workers’ compensation system to reduce medical treatment costs.

A. RISING WORKERS’ COMPENSATION COSTS

Despite the rising costs of workers’ compensation, there has been no corresponding reduction in workplace injuries and diseases. Between 1985 and 1990, workers’ compensation costs doubled and by 1990 totaled an annual $60 to $70 billion nationwide.\textsuperscript{49} These costs already constitute over two percent of payroll.\textsuperscript{50} Moreover, workers’ compensation costs are expected to “top the $140 billion mark by the year 2000.”\textsuperscript{51} While the rate of increase in the costs of workers’ compensation has been moderate in the last few years, there is still considerable concern about how to control these costs.\textsuperscript{52} Injury rates in the workplace have not declined at all in this period of rising costs.\textsuperscript{53} Thus, the workers’ compensation system does not appear to provide adequate incentive to reduce the costs of workplace accidents.\textsuperscript{54}

Professor Emily Spieler recently published a seminal article describing this phenomenon, which she calls a paradox.\textsuperscript{55} Professor Spieler noted that “[i]t would seem reasonable to expect that rising compensation costs would stimulate employers to engage in efforts to prevent occupational injury and disease. There is no persuasive evidence that this is so, however.”\textsuperscript{56} She concludes that this failure of employers to invest in prevention is “remarkable in view of the fact that . . . enterprises with aggressive safety programs often exhibit lower, sometimes substantially lower, workers’ compensation costs, and that the reduction in these costs more than offsets the cost of safety initiatives.”\textsuperscript{57} Finally, Professor Spieler points out that arguing over the degree of optimization in reducing occupational risk should not be the controlling issue for debate because “we have failed to achieve an optimal solution from the standpoint of public health advocacy and economic efficiency and social utility.”\textsuperscript{58}

\textsuperscript{48} Id.
\textsuperscript{49} See Solomon, supra note 4, at 59.
\textsuperscript{51} See Solomon, supra note 4, at 59.
\textsuperscript{52} Id. at 59-60.
\textsuperscript{53} Spieler, Perpetuating Risk?, supra note 2, at 130-39.
\textsuperscript{54} Id. at 123.
\textsuperscript{55} Id. at 129-61.
\textsuperscript{56} Id. at 123.
\textsuperscript{57} Id.
\textsuperscript{58} Id. at 125-26. Besides describing the paradox concerning the failure of businesses to invest in prevention of workplace injuries despite apparent economic advantages, Professor Spieler also addresses the causes of this phenomenon. She provides four interrelated explanations including: (1) the workers’ compensation paradigm that assumes an inevitability of workplace harms and relieves employers of fault; (2) the workers’ compensation insurance system that dilutes the deterrent effect of costs; (3) employers’ tendency to decrease claims costs independent of the injury rate; and (4) employer ignorance about the effectiveness of prevention. Id. at 161-244.

While I draw similar conclusions about the etiology of the failure by employers to invest in programs aimed at prevention and mitigation of workplace injuries and diseases, this Article’s explanation is not limited in its focus on employers’ beliefs and inaction. Rather, it provides a description based on perceptions and attitudes of employees and health care providers as well. Moreover, this Article addresses this problem in the context of the advent of managed care and capitation in workers’ compensation. This Article proposes that, given the inevitability of the imposition of managed care in this arena, this new regulatory effort should not perpetuate or even expand the systemic flaw which permits the apparent lack of effect of rising workers’
B. THE ADVENT OF MANAGED CARE

Because nearly half of all workers' compensation costs have been attributed to medical expenses, there has recently been a call for the implementation of managed care and capitation in workers' compensation. Some experts predict "that virtually all medical care for workers' comp[ensation] claims will be provided through managed-care systems" by the end of this decade. As a practical matter, managed care will soon dominate health care delivery in workers' compensation in nearly all states because of cost concerns. Realistically, the current social debate focuses not on whether managed care will be imposed on workers' compensation, but rather on what form it will take.

Based on present trends, it appears likely that states will impose managed care in a way which emphasizes reductions in medical treatment. In a sense, states are grafting managed care from mainstream health care delivery onto the workers' compensation system without accounting for the interrelationship between health care and employees' productivity. Instead, policymakers view health care delivery in workers' compensation as an independent concern apart from the legal/administrative structure. I discuss below how this separatist approach arose from the beliefs of employers, health care providers, and employees.

IV. THE SEPARATION OF THE LEGAL/ADMINISTRATIVE AND HEALTH CARE DELIVERY SYSTEMS

The failure of the workers' compensation system to encourage an optimal level of workplace safety results from a disjunction of the health care delivery system and the legal/administrative system that assesses whether the costs of workplace accidents exceed the costs of prevention. This systemic flaw results from various beliefs about workers' compensation, held by employers, health care providers, and employees, which define health care treatment in a manner that does not include reform of workplace practices. Thus, implementation of managed care in workers' compensation appears currently to focus on treatment costs, rather than on also looking at the potential impact of managed care on indemnity costs, including lost work time and other compensation based on the amount of disability. This narrow focus fails to consider other ways to reduce total workers' compensation costs, such as preventing workplace accidents and developing return-to-work programs. Moreover, if the emphasis of managed care remains solely on reductions in treatment costs, then indemnity costs and total workers' compensation costs may potentially remain unchanged or even increase because of increases in lost work time resulting from inferior medical treatments.

compensation costs on incentives to reduce and mitigate injuries associated with workplaces. Instead, this Article argues that managed care should be implemented in a manner that reduces total workplace costs, rather than focusing only on treatment costs. Professor Spieler does not address the role of managed care in workers' compensation.

59 Solomon, supra note 4, at 59-64.
60 Leavenworth, supra note 6, at 37 (citing a 1994 Louis Harris & Associates study that surveyed risk managers).
61 See Doherty, supra note 6, at 36.
62 Id.
63 Id.
64 For example, because fee schedules set a ceiling on reimbursements, they prevent health care providers from relying on treatments that may be more expensive and yet economically worthwhile because of effectiveness in returning patients to their jobs. Similarly, within HMOs, preferred provider networks, and capitated systems, conventional managed care emphasizes reductions in amount of treatment and referral to specialists.
A. THE SEPARATIST APPROACH WITHIN BUSINESS ORGANIZATIONS

Employers tend to view workers' compensation as a welfare benefit system. If employers believed, instead, that workers' compensation primarily serves as a means of optimally reducing the costs of workplace accidents and the costs of prevention, they would integrate their business organizations in a manner that allows the health care delivery system to inform the administrative system about ways to reduce total accident costs through accident prevention and mitigation. However, because employers tend to view workers' compensation as a welfare benefit system, the administrative system remains separate from the health care delivery system, and the administrative system relies on regulatory compliance with safety standards, rather than on workers' compensation claims experience or advice from health care providers.

1. The Welfare Benefit Paradigm

Employers tend to believe that the imposition of managed care on workers' compensation is consistent with other welfare reform movements, such as cutbacks in Medicare and Medicaid. Within this legal vision, the workers' compensation system represents a social welfare system that provides minimal support to keep injured employees from destitution. Legal historians sometimes view the workers' compensation system as representing a humanitarian gesture to provide welfare assistance. The welfare benefit paradigm justifies managed care that focuses only on treatment and reduces the amount of treatment provided. Such a reform bases its justification on the need to reduce costs in order to make the system more economically sustainable.

In Texas Workers' Compensation Commission v. Garcia, the defendants based their justification for a legislative reduction of medical benefits in workers' compensation on this analogy to welfare reform. They argued that the legislature should be "free to use any rational system for the delivery of benefits." Thus, they asserted that reliance on a pure impairment-rating system with a minimal threshold amount was constitutional. The appellate court rejected this argument and noted that "[a]ccording to this argument, any substitute will do. . . . [T]he legislature could decree that a worker will be paid $100, or even one dollar, for any injury sustained, no matter how severe." Thus, the defendants in Garcia

65 By using the term welfare benefit, I refer to the ability of state legislatures to reduce the amount provided to claimants by legislation or changes in regulation. In contrast, the term legal right refers to those benefits granted to defined classes of people which cannot be reduced by simple legislation or regulation, but which requires amendments to state or federal constitutions. Thus, I do not differentiate between benefits based on need as compared to other entitlements. My use of this terminology instead turns on the degree to which our society guarantees the workers' compensation benefit. This approach distinguishes between gratuities which can be easily reduced and entitlements which require greater efforts to change.

66 See supra notes 31-37 and accompanying text.

67 Medicare and Medicaid programs bear similarity to workers' compensation systems because they function as social insurance programs subject to statutory or regulatory changes.

68 See Scarzafava & Herrera, supra note 34, at 944.

69 See, e.g., Gurtler, supra note 20, at 294 (characterizing workers' compensation as a social benefit); Spieler, Perpetuating Risk?, supra note 2, at 180-81 n.254 (comparing workers' compensation to other social insurance programs).


72 Id.

73 Id. at 88.

74 Id. at 86. The Texas Supreme Court ultimately overruled the appellate court and held that, the reform legislation provided an adequate remedy to employees so as not to violate of the state constitution. 893 S.W.2d 504, 521-22 (Tex. 1995).
relied on a legal argument consistent with the view that workers' compensation represents a welfare benefit.

Because employers tend to treat workers' compensation as a welfare benefit, they assume that the health care provided to injured employees represents part of a welfare system. Thus, they emphasize financing medical care in a nominal way, such as reliance on fee schedules that set a ceiling on payments to health care providers. Under the welfare-benefit paradigm, employers fulfill their obligation by providing financial assistance for medical treatment. This results in a system which separates the delivery of health care from the departments within business organizations devoted to administering other aspects of workers' compensation.

This separatist administrative system gives autonomy to health care providers, but also limits their effectiveness. By assuming that employers fulfill their obligations by financing health care, businesses typically do not attempt to ensure the quality of health care delivery to their injured employees. Furthermore, health care providers in the community do not have informational input on business decisions concerning workplace safety.

2. The Effect of the Welfare-Benefit Paradigm on the Structure of Business Organizations

Because separatist businesses view workers' compensation primarily as a welfare benefit, they may administer it through the personnel department. Thus, a personnel office collects workers' compensation information so it can make compensation decisions, rather than improve workplace safety. A separatist business may also assign all responsibility for workplace safety to an environmental health and safety office. The office primarily focuses on compliance with government regulations rather than on gathering the information necessary, including workers' compensation data, to determine the optimal approach to reduce workplace accidents and to implement company-wide programs based on this information. This separatist organization does not encourage business administrators to use experience from workers' compensation in imposing workplace measures aimed at prevention of workplace accidents. Thus, the existence of separatist business organizations may explain the paradoxical failure of rising workers' compensation costs to encourage additional investment by employers in prevention and mitigation of workplace injuries and diseases.

Why do separatist businesses not reorganize themselves internally in the face of rising workers' compensation costs? While separatist businesses may initially treat workers' compensation as a welfare benefit, they could integrate departments in response to these rising costs. However, businesses retain their separatist organizations for at least two reasons: (1) a focus on the short term; and (2) an underreporting of work-related injuries and diseases.

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75 See, e.g., Spieler, Perpetuating Risk?, supra note 2, at 180-81 n.254.
76 Fee schedules set the upper limits of reimbursements, and thus fail to assure quality of care.
77 See Spieler, Perpetuating Risk?, supra note 2, at 180-81 n.254.
78 Typically, a primary care or emergency room physician treats the injured employee after a work-related accident. Thus, the vast majority of work-related injuries and diseases are treated within mainstream medicine, but are not subject to managed care regulation. See Polakoff & O'Rourke, supra note 10, at 26.
79 Large businesses may hire in-house health care providers to treat employees, but usually injured employees seek their own physicians within mainstream medicine. See id.
80 Nor are insurers likely to serve as coordinators of legal and medical issues under the current system. Insurers have mainly acted as financial institutions that charge appropriate premiums and pay out or deny claims. Outside of this function, insurers have largely limited their activities to implementing traditional managed health care directives, such as utilization review of medical providers. Insurers have not generally undertaken the role of inspecting workplaces or requiring programs to reduce accident costs through adoption of appropriate return-to-work programs, for example.
First, separatist business organizations may refuse to reorganize even in the face of rising workers’ compensation costs because they fail to take a long-term perspective. The initial investment in developing the necessary integrated organizational structure and in establishing programs aimed at prevention and return-to-work may not result in overall savings in workers’ compensation costs until several years later. Indeed, workers’ compensation claims may actually increase after initial implementation of programs aimed at injury prevention and mitigation due to rising employees’ awareness in identifying work-related injuries. Thus, implementing these programs requires a long-term perspective.

However, middle management of American business tends to focus on the short term. Management may focus on immediate investment returns because of dependence on short-term financial measurements, such as annual profits. Thus, separatist businesses may not invest in injury prevention and mitigation programs because of their focus on short-term profits.

Second, separatist businesses may take an alternative approach, in lieu of integration even in the face of rising work-related injuries and diseases. The lack of available medical expertise within the personnel departments of separatist business organizations may result in the underreporting of work-related injuries and diseases. Underreporting reduces the economic incentive to devote resources to lowering the cost of workplace accidents. An employee or supervisor may not perceive an injury or disease as work-related. For example, injuries from repetitive motion result not from a single work-related event but develop insidiously over time. Thus, businesses may not correctly determine the link between workplace exposures and injuries. Furthermore, expensive workers’ compensation premiums constitute an incentive for the employer to underreport work-related injuries and illnesses. This underreporting avoids having to pay premiums for indemnity and health care, and thus externalizes these costs. Externalization of costs reduces the financial incentive to make the workplace safer.


82 Id.


85 Personnel departments usually obtain medical information either from outside consultants, community providers, or environmental health and safety sources. Employees themselves may be reluctant to file workers’ compensation claims. See Spieler, Perpetuating Risk?, supra note 2, at 217-18.

86 See id. at 127.

87 One approach for identifying high-hazard jobs—passive surveillance—relies on medical, insurance, and safety records and may underestimate the true extent of cumulative trauma problems. W. Monroe Keyserling, Occupational Ergonomics: Promoting Safety and Health Through Work Design, in OCCUPATIONAL HEALTH, supra note 21, at 161, 175.

88 See id.

89 One commentator contends that the workers’ compensation system does not reduce the costs of accidents because of this incentive to underreport claims rather than to make the workplace safer. See Spieler, Perpetuating Risk?, supra note 2, at 217-37.

90 See id. at 231-33.

91 The failure to internalize these costs means that nonworkers’ compensation insurers and employees pay the medical costs. Employers do not bear the costs and thus do not experience the financial pressure to reduce these costs.
A separatist administrative system fails to reduce workplace accident costs by not internalizing these costs appropriately. A rational employer would invest in workplace safety if the costs of workplace accidents exceeded the costs of prevention. A disjunction between health care delivery and the administrative component of workers' compensation explains the failure of workers' compensation to reduce the costs of accidents. This separation reduces administrative access to appropriate medical expertise and creates barriers that prevent the optimal investment in accident prevention.

3. The Limitations of Implementing Managed Care Under the Welfare Benefit Paradigm

The optimal prevention of workplace injuries requires coordination among these departments and among all supervisors for monitoring workplace safety at the grassroots level. Thus, successful accident prevention programs require a commitment from many departments within a business organization and depend on cooperation among departments otherwise insulated from each other. In a separatist administrative system, however, this cooperation does not occur. Instead, various departments and offices tend to operate on independent budgets and thereby lack incentives to cooperate unless mandated to do so. To design, implement, and monitor workplace safety at an optimal level, all these departments should rely on and share data to reduce workplace accidents. Each supervisor must understand the importance of workplace safety and implement effective return-to-work policies.

Managed care implemented under a separatist administrative system will emphasize reductions in treatment costs, rather than involve strategies requiring an interaction between the administrative and health care delivery systems. A separatist administrative system views managed care as akin to past reliance on fee schedules—that is, managed care becomes simply a means of lowering treatment costs. Similarly, a separatist administrative system will not adopt programs aimed at preventing workplace-related injuries and diseases or return-to-work programs because such programs require close cooperation between administrative systems and health care providers.

This welfare reform approach fails to appreciate that workers' compensation, unlike general welfare programs, arose from the particular relationship between employers and employees. Employers bear social responsibility for injuries that arise in work-

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92 See supra notes 75-79 and accompanying text.
93 See Calabresi, supra note 37, at 95-96.
95 See Cynthia Robinson, Office of Policy Research, California Dep't of Ins., Lowering Workers' Compensation Insurance Costs by Reducing Injuries and Illnesses at Work 99-100 (1993) [hereinafter California Insurance Study].
96 A separatist administrative system, by definition, views health care financing as independent from indemnity payments. Such a system concentrates on reducing health care financing without taking into account that certain reductions in health care financing may increase indemnity payments because they reduce the quality of health care that, in turn, increases lost work time. Similarly, a separatist administrative system does not consider the alternative possibility that increasing health care financing may reduce total workers' compensation costs if it results in improving the quality of health care in a manner that reduces lost work time.
97 Fee schedules control costs by setting a ceiling on the payment for procedures or provider visits. Thus, the quality of care rendered remains unregulated by fee schedules.
98 Injury-prevention and return-to-work programs require integration of the administrative and the medical care systems. See infra part V.B.
99 Under workers' compensation, the employer bears financial responsibility for all injuries arising from the workplace, without regard to the employer's or employee's negligence. See Dan B. Dobbs, Torts and Compensation: Personal Accountability and Social Responsibility for Injury 870 (1993). Thus, workers' compensation should ideally provide a financial incentive to employers to make the workplace safer. In comparison, the public-at-large pays for general welfare programs. See Emily A. Spieler,
places. This responsibility explains why employees do not have to make monetary contributions to receive workers' compensation, in contrast to social welfare programs such as social security. Workers' compensation resulted from this recognition of the social responsibility of employers to their injured employees.

Thus, managed care programs aimed merely at minimizing treatment costs may, at some point, compromise this social responsibility.

The welfare benefit paradigm, furthermore, could justify any and all cutbacks in health care. It fails to provide guidance in developing a system that encourages efficiency and quality of health care. Instead, this paradigm perpetuates the separation of health care delivery from the administration of health and safety programs. The welfare benefit paradigm ignores the potential value found in the common interests shared by employers and employees with respect to health care. A high quality system of health care that focuses on treatment, prevention, and mitigation of injuries actually would provide benefits to both groups.

B. THE PERSPECTIVE OF EMPLOYEES

Employees tend to perceive the provision of health care through workers' compensation as a legal entitlement. Such a perception fails to provide incentives to mitigate the costs of health care. Furthermore, employees may oppose the imposition of any managed care program based on this belief.

1. The Rights Paradigm

Employees perceive the financing of health care provided by the workers' compensation system as a legal right. While the general public has no guaranteed right to health care, the workers' compensation system legally entitles employees who have sustained a work-related injury to full coverage of medical costs. The historical understanding on which workers' compensation began concurs with this idea. Prior to the establishment of workers' compensation systems, employees could sue their employers for workplace injuries in tort law. Under the workers' compensation reform, employees forfeited the right to sue their employers in tort law in exchange for a guaranteed set of benefits, including complete coverage of medical costs. Because of this guaranteed right to coverage, insurers do not currently expect injured employees to pay deductibles or copayments. Thus,
employees at least initially will tend to see the imposition of managed care as employers abandoning their agreement to provide health care coverage unfettered by cost controls. An example of a rights-based approach to reductions in workers' compensation benefits can again be found in Texas Workers’ Compensation Commission v. Garcia. In that case, employees and unions challenged the constitutionality of Texas workers’ compensation legislative reforms. The state appellate court held that the legislative reforms were unconstitutional on a number of grounds. In particular, the appellate court found that a fifteen percent impairment-rating threshold as a qualification for supplemental benefits violated the state constitution’s “open courts and due course provisions.” The court reasoned that pure reliance on an impairment-based system did “not adequately compensate workers for the loss of their common law rights [to sue in tort law]” and thus was not rational. Thus, employees in Garcia premised their argument on the belief that workers’ compensation constituted a legal right that should not be compromised by reforms that reduced benefits.

2. The Resulting Lack of Incentives to Mitigate Health Care Costs

For employees, the interdependence of legal claims and health issues encourages the overutilization of the health care delivery system. Because of the absence of deductibles or copayments, employees have no direct incentives to act as prudent purchasers of health care. Thus, employees do not have a financial incentive to choose the best managed medical care program. Because primary care physicians may have little expertise in occupational medicine, employees may have difficulty identifying appropriate providers. Furthermore, because the opinions of health care professionals may influence compensation decisions, employees may engage in physician shopping, especially if a provider renders an opinion that may adversely affect their legal claims. Finally, employees may have a financial incentive to choose health professionals who provide excessive medical services. Injured employees may use the amount of medical care provided as evidence of the severity of disability to justify benefit payments under the indemnity portion of workers’ compensation.

113 See Doherty, supra note 6, at 38.
114 862 S.W.2d 61 (Tex. Ct. App. 1993). At present, there are no published cases which directly address whether managed care provisions in a workers' compensation system may violate the rights of employees.
115 893 S.W.2d 504, 516 (Tex. 1995).
116 862 S.W.2d at 81-88, 93-96 (finding that the act violated Texas constitutional provisions guaranteeing rights to open courts, due course of law, equal protection, and jury trials).
117 Id. at 86.
118 Id. at 87. In other words, the impairment-based system that required a 15% threshold was not an “adequate or reasonable substitute” for common law negligence actions. Id. at 86.
119 The Texas Supreme Court, however, ultimately overruled the appellate court and found that the reform legislation provided an adequate remedy. 893 S.W.2d at 521.
120 See Ballen, supra note 38, at 1293.
121 Traditional managed care programs may not contain the kind of providers necessary to care for injured employees. See Costigan & Robertson, supra note 15, at 60.
122 Thus, the health care provider not only treats the injury or disease, but also influences whether it will be categorized as a workers' compensation case as well as the amount of compensation obtained. This additional responsibility may encourage more doctor shopping as compared to that found within the regular health care delivery system. See Ballen, supra note 38, at 1293.
123 Studies show that workers' compensation patients take longer to recover and require more treatment than similar patients in the regular health care delivery system. See C.G. Greenough & R.D. Fraser, The Effects of Compensation on Recovery from Low-Back Injury, 14 SPINE 947, 953 (1989); Tweed, supra note 18, at 56.
124 See Ballen, supra note 38, at 1293.
3. The Limitations of Implementing Health Care Under the Rights Paradigm

If states administer health care under this rights paradigm, then ultimately the debate must turn on what constitutes adequate health care. Employers surely are not responsible for guaranteeing health care coverage for unnecessary or excessive medical treatments. Yet, the adequacy of health care cannot be defined objectively. The definition includes many subjective factors, such as the quality of the physician/patient relationship and the expected degree of therapeutic effectiveness. The preservation of the patient’s choice of health care providers may serve as an important way of resolving this tension.

However, employees will face difficulty in defending the proposition that health care received through workers’ compensation should be totally unfettered by cost concerns, especially given that regular health care delivery now depends on managed care systems. Historically, states have generally imposed cost controls on health care provided through workers’ compensation. States have long relied on setting fee schedules to limit the amounts of payments made for medical services.

The rights legal paradigm not only challenges managed care of treatment, but it also undermines the imposition of injury-prevention and return-to-work programs. Under the rights paradigm, employers may assert their own property right to prevent access to the workplace by health care providers. Employers may object to the intrusion by providers into their workplaces and may reject advice suggesting improvements in work practices. Both employers and employees might well object to return-to-work programs. Such programs represent an intrusion on workplaces owned and controlled by employers, and employees may resist the notion that the program should require them to return to work while still suffering from their injuries.

Thus, this paradigm perpetuates the disjunction of health care delivery from administration of health and safety in workers’ compensation. The rights paradigm threatens the application of managed care aimed at the prevention and mitigation of workplace injuries.

The manner in which states implement managed care in workers’ compensation in the future depends on how the system characterizes the provision of health care. Employees will likely characterize the provision of health care as a right and thus oppose the imposition of managed care. Alternatively, employers and insurers will likely characterize the provision of health care as a welfare benefit and thus contend that cost saving necessitates.

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125 Thus, managed care programs have grown in number during the past several years to keep medical costs reasonable. See id. at 1293-94.
127 See Elhauge, supra note 126, at 1465-72.
128 See id. at 1525-26 (noting the importance of allowing individuals to choose their care-allocating plan).
129 Managed care has become the dominant force in mainstream health care delivery. See Peter Boland, Market Overview and Delivery System Dynamics, in MAKING MANAGED HEALTHCARE WORK, supra note 15, at 3, 3.
130 The most common forms of cost controls have been fee schedules and utilization review. See supra note 41 and accompanying text.
131 See id.
132 Health care providers do not have a comparable right to gain access to workplaces, although individual employees may provide information to their providers concerning workplace safety.
133 Health care providers do not possess the same authority as, for example, Occupational Safety and Health Administration inspectors.
134 Physicians should identify the optimal time to return to work prior to complete recovery. They should not, however, recommend return to work if the patient cannot withstand the demands placed on him or her by the restricted duty. See Harold R. Imbus, Clinical Aspects of Occupational Medicine, in OCCUPATIONAL MEDICINE 3, 10 (Carl Zenz et al. eds., 3d ed. 1994).
the implementation of managed care. Because of rising workers' compensation costs, legis-
latures and courts will likely side with employers and insurers and require implementa-
tion of managed care.135 Neither characterization, however, encourages optimal health care de-
livery. Indeed, both characterizations support a separatist approach to managed care. Be-
cause the imposition of managed care appears inevitable, participants should focus, instead, on a community commitment to improving public health. Such a community commitment would emphasize the importance of quality of care and would also encourage the reduction and mitigation of workplace injuries. The current health care delivery system, however, fails to provide a public health approach.

C. THE SEPARATIST APPROACH IN HEALTH CARE DELIVERY

Presently, the workers' compensation system encourages a separatist health care delivery system. Because the separatist administrative system gives health care providers discretion in their practices, the natural tendency of physicians has been to maintain their traditional practices inadequately tailored to caring for work-related diseases and injuries. The average primary care physician possesses little training in either identifying work-related illness or treating employees differently than other patients because medical schools generally provide meager training in occupational medicine.136 Instead, most physicians take a traditional patient-centered approach to treating occupationally related illness. This approach fails to emphasize prevention or mitigation of workplace illnesses.

1. The Patient-Centered Paradigm

In a separatist health care delivery system, medical treatment centers on the patient and focuses on the treatment that may alter the patient's internal biology.137 Instead of promoting injury prevention and mitigation, a health care provider renders treatment to individual patients with outcomes assessments based on reductions in mortality and morbidity rates, often defined in terms of length of treatment or hospitalization.138 Managed care in this setting focuses on reducing treatment costs based on these outcomes assessments.139

The patient-centered approach limits preventive medicine to procedures that affect the employee's physiology, such as immunization and mammography.140 While managed care in the regular health care system often sells itself to the public by emphasizing the incentive it provides to health care providers to keep their patients healthy,141 a patient-centered pre-

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135 See, e.g., Texas Workers' Compensation Comm'n v. Garcia, 893 S.W.2d 504 (Tex. 1995) (sustaining validity of workers' compensation reform against constitutional challenge by employees and unions).
137 Traditional medicine disciplines focus on the internal biology of patients. Primary care disciplines include internal medicine, family medicine, and pediatrics. Internists focus on the internal biology of adults, while pediatricians specialize in treatment based on the internal biology of children. Family medicine practitioners take a broader view of the dynamics of families, but still focus on internal medicine and pediatrics. The discipline of occupational and environmental health represents a relatively new approach to medicine, by focusing on environmental determinants of disease.
138 Mainstream managed care programs thus focus on reductions in mortality and morbidity rates as criteria for quality of care. See Kathleen Jennison, Organizational Dynamics of Quality Control, in MAKING MANAGED HEALTHCARE WORK, supra note 15, at 421, 427.
140 Traditional medicine focuses on what can be done in the physician's office. Alternatively, occupational medicine physicians treat the workplace to prevent and ameliorate injury and disease.
ventive medicine approach becomes less useful when confronted with workplace injuries. The more effective approach relies on altering workplace practices and exposures causing the injuries, rather than limiting medical intervention to alteration of patient physiology.\textsuperscript{142}

2. The Resulting Failure to Mitigate and Prevent Workplace Injuries and Diseases

At present, the health care delivery system also fosters its separation from the administrative system governing the workplace. Many treating physicians lack the expertise to identify and treat appropriately injuries and diseases caused in the workplace. Medical schools and residency programs fail to provide adequate training in occupational medicine principles.\textsuperscript{143} Historically, physicians have had a financial incentive not to identify work-related illness in order to receive payments larger than are available through workers’ compensation fee schedules.\textsuperscript{144} By not identifying an illness as work-related, physicians may also avoid the administrative inconveniences of filing appropriate paperwork. Furthermore, physicians may want to avoid involvement in the workers’ compensation legal system. Finally, because health care providers receive payments based on the amount of treatment, workers’ compensation actually provides incentives to overtreat and fails to encourage the prevention and mitigation of workplace injuries and diseases.\textsuperscript{145} Primary care physicians, who lack occupational medicine training, may be reluctant to return a patient to work against that patient’s wishes, even if the patient is physically capable of returning to work. While a patient may sue a physician for malpractice for returning him or her to work prematurely, the workers’ compensation system does not provide a similar deterrent for failure to return a patient to work on a timely basis.

3. The Limitations of Implementing Managed Care Under the Patient-Centered Paradigm

The patient-centered approach to treatment does not result in an optimum reduction of the costs of workplace accidents. The costs associated with an injured employee include not only treatment costs, but also indemnity costs associated with time away from the job.\textsuperscript{146} Thus, insurers should not make quality assessments based on length of treatment and hospitalization of injured employees, but should instead also concentrate on measuring the loss in work time. Treatments which have greater effectiveness in returning injured employees to their jobs more quickly might be economically justifiable even if they cost more.\textsuperscript{147} Furthermore, managed care under this patient-centered approach ignores the usefulness of return-to-work programs in mitigating the costs of workplace accidents.\textsuperscript{148} Modification of work which allows an injured employee to return sooner than otherwise

\textsuperscript{142} See infra part V.
\textsuperscript{143} See Joseph LaDou, The Practice of Occupational Medicine, in OCCUPATIONAL MEDICINE 1, 1 (Joseph LaDou ed., 1990).
\textsuperscript{144} Professor Spieler noted that: doctors in particular have a profound influence on the cost of both medical treatment and workers’ benefits. As a result, physicians are painted (sometimes accurately) as professionals who tend to overtreat, overcharge, and offer opinions which are influenced more by the source of the payment than by the actual condition of the patient. Spieler, supra note 2, at 241.
\textsuperscript{145} Fee schedules may encourage overutilization if they simply fix the amount paid per visit or procedure. Thus, if fee schedules fix the fees per visit or services and ensure comprehensive service, health care providers seeking to maximize income may increase the quality of services provided. See WILLIAM G. JOHNSON ET AL., THE ZENITH PROJECT: REPORT No. 1, THE EXCESS COSTS OF HEALTH CARE FOR WORK-RELATED INJURIES 7 (1995).
\textsuperscript{146} See supra note 21 and accompanying text.
\textsuperscript{147} See Ballen, supra note 38, at 1293.
\textsuperscript{148} See Newman, supra note 136, at 1133.
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may be more effective than simply relying on a treatment’s effectiveness in altering the physiology of the patient.\(^{149}\) The workers’ compensation system thus encourages a segregation between business administration and medical providers that fails to encourage alteration of workplace practices and exposures based on the experience of health care providers.

V. TOWARD A PUBLIC HEALTH PARADIGM

Unfortunately, the current public debate focuses almost exclusively on choosing between the rights and the welfare benefit paradigms,\(^{150}\) although neither choice leads to the goal of an optimal reduction in the overall costs of accidents in workplaces. Both paradigms justify the disjunction of health care delivery from the administration of health and safety programs in workplaces. The debate ought to shift to consideration of a different paradigm I propose here. My paradigm emphasizes a community commitment to public health.

Public health emphasizes the promotion and preservation of health in communities.\(^{151}\) Preventive medicine, which includes the subspecialty of occupational medicine, encourages public health promotion in addition to treatment and cure.\(^{152}\) Unlike a typical clinical medical practice that emphasizes the healing of an individual patient’s sickness, a public health practice brings to bear all community resources—including law—in an attempt to prevent and treat a public health problem.\(^{153}\)

The public health perspective emphasizes rehabilitation and prevention of injuries and diseases through measures that change social conditions. Such a paradigm recognizes the importance of cost containment, but does not lose sight of human concerns.\(^{154}\) Under the public health focus on workplace safety, employers, employees, health care providers, insurers, and the government shoulder the responsibility to integrate their efforts in practical ways to reduce the social and economic costs of accidents. Thus, encouraging accident prevention and injury mitigation could become just as important as monitoring treatment. Workplace safety becomes a community commitment, rather than a matter of choosing between the interests of either the employer or the employee. If state governments adopted this paradigm, they might encourage occupational medicine principles that emphasize both quality and efficiency in treatment.

Implementing occupational medicine principles through managed care systems would be consistent with the public health paradigm. Occupational medicine physicians train to identify work-related diseases and injuries by taking an occupational history and applying

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\(^{149}\) Physicians, in making return-to-work evaluations, allow patients to return to those work duties which will not adversely affect their health. See Robert J. McCunney, Occupational Medical Services, in A PRACTICAL APPROACH, supra note 24, at 3, 8.

\(^{150}\) See supra part IV.A-B.

\(^{151}\) See John M. Last, Scope and Methods of Prevention, in PUBLIC HEALTH AND PREVENTIVE MEDICINE 3, 3 (John M. Last et al. eds., 12th ed. 1986). Prevention consists of three components: (1) primary prevention prevents the occurrence of disease or injury; (2) secondary prevention provides for early detection and intervention, ideally before the pathology becomes evident; and (3) tertiary prevention minimizes the effect of disease and disability. Id. For the purposes of this Article, the term prevention refers to primary and secondary prevention. Return-to-work programs represent an example of tertiary prevention.

\(^{152}\) Id.

\(^{153}\) Id. at 4.

\(^{154}\) In Texas Workers’ Compensation Commission v. Garcia, the Texas Supreme Court noted that the original Texas workers’ compensation act, like other workers’ compensation statutes, “was part of a nationwide compensation movement, [and] was perceived to be in the best interests of both employers and employees.” 893 S.W.2d 504, 511 (Tex. 1995).
the principles and knowledge of epidemiology, toxicology, and public health. Occupational medicine also involves the study and application of ergonomics, a discipline that examines the effects of physical and emotional stress on workplace performance. Some ergonomics programs have been shown to improve both health and workplace productivity by preventing back and repetitive trauma injuries. Additional prevention-oriented activities in occupational medicine include preplacement physical examination, drug testing, and compliance with health and safety regulations. Finally, occupational medicine physicians routinely walk through workplaces to familiarize themselves with job functions and to identify hazardous exposures.

Although modern medicine has incorporated occupational medicine principles, practicing physicians have not yet systematically used them in their clinical practice. In a nation with relatively few board-certified specialists in occupational medicine, most patients are treated by primary care physicians who have little or no training in occupational medicine principles. The advent of managed care in workers’ compensation provides a significant opportunity to implement these principles widely. Occupational medicine physicians should participate in developing and implementing managed care programs. They can educate and supervise other providers, encourage the utilization of programs aimed at prevention and mitigation of injuries, discourage overutilization of provider services, and improve the quality of care.

A. DISCOURAGING OVERUTILIZATION OF TREATMENT AND PROMOTING THE IMPROVEMENT OF THE QUALITY OF CARE

A system of managed care that relies on occupational medicine principles would discourage overutilization and improve the quality of health care. Such an approach would also discourage overutilization by encouraging both efficient and high quality treatment. If managed care only emphasizes the minimization of treatment costs, indemnity costs associated with longer absences from work due to inferior medical treatment may counterbalance these savings. If we wish to optimize both efficiency and public health concerns, then we need to emphasize equally treatment costs and quality. Workers’ compensation should favor quality health care that returns employees to productive employment sooner at a reasonable cost over an approach that merely emphasizes the minimization of treatment costs. A growing medical literature describes treatment approaches that focus on efficacy in returning patients to the workplace. For example, occupational medicine currently emphasizes encouraging patients with lower back strains to return to work as soon as medically reasonable because early return to work improves medical prognosis and prevents

155 For a summary of the clinical approach to occupational medicine, see Imbus, supra note 134, at 3-12.
156 See O. Bruce Dickerson & Walter E. Baker, Practical Ergonomics and Work with Video Display Terminals, in OCCUPATIONAL MEDICINE, supra note 134, at 428, 428-29.
157 See infra part VI.A.
158 See McCunney, supra note 149, at 3-16.
160 See McCunney, supra note 149, at 3; Newman, supra note 136, at 1128 (few physicians are “trained to recognize or prevent occupationally induced illness”).
161 See McCunney, supra note 149, at 3.
162 The total costs of workplace accidents include accident costs and the costs of their prevention. Accident costs include lost work time and medical treatment costs.
physical deconditioning associated with isolation from regular activity. The alignment of economic efficiency and quality of care suggests that health care providers use this occupational medicine knowledge to return patients to work when medically reasonable.

Regulators of health care within the workers' compensation system therefore should encourage health care providers to rely on occupational medicine principles. States should set fee schedules at levels commensurate with those set in the regular health care delivery system to encourage quality care. If the state sets fee schedules too low, only a small number of providers will be willing to participate, and they will provide health care on a high-volume, but low-quality, basis.

Regulators may encourage both efficiency and quality of care in a variety of managed care systems. Occupational medicine physicians should assist regulators in establishing treatment guidelines that encourage both efficiency and quality of care. Utilization review should allow for provider discretion to pursue aggressive diagnosis and treatment protocols if providers can prove their approaches successfully promote both efficiency and improvement of health outcomes. Regulators should require that HMOs and provider groups incorporate oversight that utilizes occupational medicine expertise, especially in identifying work-related injuries and illnesses.

States should not judge capitation programs in the workers' compensation system by the same criteria used in capitation systems within the regular health care delivery system. If early referrals to physical therapy or certain specialists result in more optimal outcomes in returning employees to their jobs, a capitation program should not discourage these practices. States should assess capitation programs based on their effectiveness in reducing total accident costs—including their ability to return employees to their jobs when it is medically reasonable.

Because of the dearth of empirical information about effectiveness of managed care programs in workers' compensation, state government regulators should establish data collection systems to track the effectiveness of various managed care systems and medical treatment approaches. This data would also provide a better basis to determine the reasonableness of payments to providers through group health plans and capitation systems. States should offer employers and employees choices among various managed care alternatives in order to encourage competition. The success of workers' compensation reforms may depend on allowing competition among alternative health care plans because of the variety of business activities and sizes, the various arrangements that providers may have with businesses, and the lack of empirical data indicating the likely success of any particular alternative in all situations.

B. ENCOURAGING PROGRAMS AIMED AT PREVENTION AND MITIGATION OF INJURIES

As previously noted, the discipline of occupational medicine represents an integration of medical, administrative, and legal knowledge concerning workplace injuries and diseases. This multi-disciplinary expertise facilitates provision of a number of different services to various departments within a single business organization. Occupational medicine physicians routinely interact with employees, employers, industrial hygienists, safety specialists, benefit administrators, supervisors, attorneys, insurers, and others to prevent, treat,
and mitigate workplace injuries. The role of an in-house occupational medicine physician may also include tracking the recovery of employees treated by physicians practicing in the community. Occupational medicine physicians collaborate with (1) administrators and personnel managers to establish return-to-work programs; (2) environmental health and safety officers to establish practices and programs to prevent future injuries; and (3) risk managers to determine the etiology of work-related injuries and to assist in evaluating prognoses, impairments, and disabilities of injured employees. Thus, the appropriately trained occupational medicine physician has unique qualifications to facilitate effective integration of various efforts to improve workplace health and safety.

As one important example of mitigation of injuries, restricted duty positions are designed to allow employees to engage in return-to-work activities that will not interfere with recovery. Restricted duty assignments may actually benefit a recovering employee because they tend to prevent physical deconditioning associated with isolation from regular activity. For instance, prolonged work absence due to back injury is associated with poor prognosis. A restricted duty job, however, allows an injured employee to develop and maintain the physical strength to return to regular duty, and it may serve as a useful gauge of recovery. State regulators may encourage return-to-work and accident-prevention programs by restructuring fee schedules and by offering a reduction in workers' compensation premiums to employers who establish them.

The consolidation of workers' compensation and regular health care delivery within HMOs and pre-paid group practices would remove, or at least diminish, the incentive to cost-shift by failing to identify work-related injuries. This approach would internalize the costs of workplace accidents and encourage employers to invest more in workplace safety. The success of this approach depends, however, on the ability of HMOs and pre-paid group practices to implement occupational medicine principles within their organizations. These health care systems could accomplish this goal by having occupational medicine physicians develop protocols and supervise primary care providers.

Capitation programs in workers' compensation may not be more effective than reliance on treatment guidelines and utilization review. In workers' compensation, providers already have a strong financial incentive to rely on efficient treatments because of contractual ties to employers. Employers may simply direct their injured employees to providers who offer more effective managed care. Moreover, capitation may create greater patient

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166 See Frank H. Leone, Working with the Business Community, in A PRACTICAL APPROACH, supra note 24, at 106, 108.
168 See Jeffrey S. Harris, Economics of Occupational Medicine, in A PRACTICAL APPROACH, supra note 24, at 491, 496.
169 See Hoffman & Gray, supra note 159, at 50-52.
170 See id. at 54-56.
171 See Robert J. McCunney & Reid T. Boswell, Musculoskeletal Disorders, in A PRACTICAL APPROACH, supra note 24, at 166, 170.
172 See id.
173 See Greenough & Fraser, supra note 123, at 954.
174 See McCunney & Boswell, supra note 171, at 170.
175 Small businesses may have difficulty establishing restricted duty positions because of less flexible employment arrangements. Perhaps the establishment of cooperative arrangements among small businesses or providing community service restricted duty jobs may be helpful.
176 If workers' compensation provides more generous reimbursement, cost-shifting may occur in the opposite direction. Cost-shifting may be occurring in both directions, depending on the particular payment mechanisms employed.
distrust of physicians in workers' compensation compared to regular health care systems because of the explicit nature of the direct payments by employers through their insurers. The treatment decisions of physicians in workers' compensation not only affect the amount of treatment provided, but also impact the indemnity payments made to patients.

Capitated programs may prove more effective, however, if managed care not only discourages overutilization, but also encourages prevention and mitigation of the effects of workplace injuries. If regulatory systems encourage physician access to workplaces to establish injury prevention and return-to-work programs, then capitation may provide significant incentives to providers to reduce the costs of workplace accidents through these means. If capitation focuses only on minimizing treatment, the costs of accidents in the workplace may actually increase because of larger indemnity payments associated with increased absenteeism when treatments are less effective.

Managed care programs, including capitation, should encourage prevention and mitigation of the effects of workplace injuries to optimize the reduction in the costs of accidents in the workplace. Such an approach would also make managed care more acceptable to employees, and it relies on a community commitment to public health. Thus, the implementation of managed care could serve as an opportunity to advance occupational medicine principles in workers' compensation.

VI. ADVANCING SHARED INTERESTS IN PUBLIC HEALTH

Employers, employees, and health care providers share objectives consistent with the public health imperatives of improving treatment quality and implementing return-to-work and injury-prevention programs. Thus, implementing these public health programs provides a potential means for achieving the community goal of reducing the costs of workers' compensation.

A. EMPLOYERS' INTERESTS

Employers should be concerned about the overall costs of workers' compensation—including indemnity costs associated with lost work time—rather than focusing solely on reducing treatment costs. Employers pay workers' compensation premiums that reflect not just treatments costs, but also indemnity costs. Thus, employers should favor high quality medical treatment which results in returning employees to work sooner over cheaper, less-effective medical treatment. A managed care program at the Johns Hopkins Institute demonstrated that it could reduce total workers' compensation costs by delivering high quality treatment. This program included reduced wait periods for treatment, increased diagnostic testing to improve reliability, and close coordination between the occupational medicine physician and other specialists. Such high quality treatment has reduced total workers' compensations by more than thirty percent.

Employers should also place greater emphasis on preventing injuries and diseases because of economic savings and improved employee productivity. Professor Spieler states

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177 I recognize that this is an optimistic view. It would be necessary to encourage long-term relationships between providers and employers in these situations. The positive results might not become manifest until several years after injury-prevention programs begin. Indeed, as noted earlier, the initiation of these programs may trigger an increase in workers' compensation claims in the short term because physicians would educate injured employees about the relationship between their injuries and work.

178 For a description of various capitation pilot projects, see Leavenworth, supra note 6, at 38-41.


180 See id. at 67-68.

181 Id. at 67.
that "[e]vidence does indicate . . . that if employers take prevention seriously, the cost savings can be substantial."  

Employers also benefit from return-to-work programs because of decreased disability payments. Researchers have demonstrated the effectiveness of such programs, especially with respect to back injuries. About two percent of the U.S. industrial work force suffers compensable back injury every year, and these injuries account for ninety percent of total compensation costs. Return-to-work programs allow injured employees to return to work when it is medically reasonable. They result in decreased disability payments and decreased risk of permanent disability. For example, implementation of a return-to-work program at a community hospital reportedly saved $900 per back injury and reduced lost work time by four weeks. Similarly, employers can obtain a substantial economic savings for other occupational injuries. Thus, managed care programs should encourage employers to make reasonable accommodations for temporarily impaired employees through establishment of return-to-work programs.

B. Employees' Interests

The imposition of managed care on workers' compensation appears inevitable. A 1994 survey of risk managers predicted that within five years virtually all medical treatment rendered under workers' compensation will be provided through managed care systems. An emphasis by managed care programs on high quality treatments, rather than reduction in disability payments, would not be extraordinary, given the requirements under the Americans with Disabilities Act (ADA), which require employers to make reasonable accommodations for disabled employees. It prohibits employment discrimination against the disabled and applies to employers with 15 or more employees. 29 U.S.C. § 12101 (1994). The ADA defines disability as (1) a physical or mental impairment that substantially limits one or more life activities, (2) a record of such an impairment, or (3) being regarded as having such an impairment. 29 C.F.R. § 1630.2(g) (1995). Under the ADA, the employer must make reasonable accommodations for disabled individuals who can perform the essential function of a job with or without reasonable accommodations. 42 U.S.C. § 12112(b)(5). Similarly, in return-to-work programs, an employer identifies available jobs which can be performed by temporarily disabled employees.
treatment costs alone, should benefit employees. High quality treatments should reduce morbidity and the extent of disability. For example, the managed care program at the Johns Hopkins Institute has managed not only to retain patients despite their freedom to see providers outside the network, but to attract injured employees from outside providers. Thus, the right of patients to choose freely among provider networks does not necessarily interfere with the imposition of managed care programs if such programs provide quality treatment. Preservation of patient choice of providers allows for quality assurance and a necessary degree of patient autonomy.

Employees also benefit from injury prevention programs. Employees generally suffer a substantial economic loss from work-related injuries and diseases. Public and private support programs only replace about forty percent of wages lost by employees who are severely disabled by occupational disease and about sixty percent of wages by those suffering from occupational injury. Moreover, any pain and suffering associated with a work-related injury or disease is not compensated under workers' compensation. Thus, an emphasis on injury prevention benefits employees economically. Obviously, such an approach also benefits employees by avoiding the impairment and pain associated with workplace injuries. In fact, labor groups eventually altered their initial opposition to the adoption of workers' compensation statutes because they believed that the statutes would provide an economic incentive to prevent workplace accidents.

Finally, employees also benefit from return-to-work programs if administered in a rational and humane manner. On-the-job rehabilitation following occupational injury should play an important role in a employee's recovery. As a general matter, the longer employees are away from their jobs, the more difficult it is for them to return to the work force. Return-to-work programs should be tailored to the individual patient, allowing only those activities which can be safely performed.

Thus, both employers and employees may benefit mutually from managed care programs that emphasize high quality care, injury-prevention, and return-to-work programs.

C. THE PROFESSIONAL ETHIC OF MEDICAL PRACTICE

The practice of medicine in the age of managed care represents a challenge to the very identity of the medical profession. The danger exists that patients may perceive physicians as brokers for competing financial interests, damaging their professional integrity. In the case of workers' compensation, the most serious danger to the medical profession may arise in situations where patients feel that their physicians minimize treatments based not on pro-

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194 See Wise, supra note 179, at 67.
195 See id. at 70.
196 See Leavenworth, supra note 6, at 38; Managed Care: High Quality Medical Providers Can Encourage Savings, Use of Programs, 6 Workers' Compensation Rep. (BNA) No. 22, at 529, 529-30 (Oct. 30, 1995).
197 See Cerne, supra note 8, at 52 (president of managed care firm in California states that whether patients stay is a function of quality of care, rather than if there is mandatory lock-in with one provider); Elhauge, supra note 126, at 1538-41.
199 See Boden, supra note 21, at 204.
200 Office of Technology Assessment, U.S. Congress, Preventing Illness and Injury in the Workplace, in ASHFORD & CALDART, supra note 20, at 454.
201 See Kasdan & McElwain, supra note 163, at 539.
202 Greenough & Fraser, supra note 123, at 954; Kasdan & McElwain, supra note 163, at 539.
fessional standards, but on what an insurer or employer will pay.\textsuperscript{204} Patients' perceptions that capitated systems financially reward their physicians for minimizing treatments and impairment assessments at the expense of potential indemnity awards to patients exacerbate this situation.

The challenge to physicians lies in shaping managed care programs in ways that preserve their professional integrity. The practice of occupational medicine may provide useful lessons about how physicians may cope with conflicts of interest created by managed care systems. Occupational medicine physicians cope with intense issues of conflicts of interest,\textsuperscript{205} have developed pragmatic approaches to preserve the physician/patient relationship, and yet remain faithful to the calling of this public health profession.\textsuperscript{206}

The occupational medicine physician must serve at least two masters. He or she owes legal and ethical duties to both the employee-patient\textsuperscript{207} and the employer.\textsuperscript{208} Moreover, the financial incentive to satisfy the employer's wishes further complicates the dual duties. The physician in this specialty accommodates these conflicts in several pragmatic ways. Communication with patients and adherence to confidentiality whenever feasible preserve the traditional core of the physician-patient relationship. The physician should inform the patient that medical information may be released to the employer if it is a workers' compensation case. The physician maintains confidentiality of information the employer does not

\textsuperscript{204} See Council on Ethical and Judicial Affairs, American Medical Ass'n, Ethical Issues in Managed Care, 273 JAMA 330, 331 (1995).

\textsuperscript{205} See Kathleen M. Rest, Ethics in Occupational and Environmental Health, in OCCUPATIONAL HEALTH, supra note 21, at 241, 252.

\textsuperscript{206} See id. at 241-53.

\textsuperscript{207} The code of ethical conduct for occupational medicine physicians requires that they "accord the highest priority to the health and safety of individuals in both the workplace and the environment." See AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, CODE OF ETHICAL CONDUCT, reprinted in OCCUPATIONAL HEALTH, supra note 21, at 252 [hereinafter OCCUPATIONAL MEDICINE CODE OF ETHICAL CONDUCT]. Even if paid by the employer, an occupational medicine physician may have a legal duty under tort law to provide quality care to patients. The vulnerability of occupational medicine physicians to malpractice actions under tort law depends on their contractual relationship with their employer. See Lawrence P. Postol, Suing the Doctor: Lawsuits by Injured Workers Against the Occupational Physician, 31 J. OCCUPATIONAL MED. 891, 891 (1989). The contractual relationship does not protect from liability physicians who serve as independent consultants or who work in independent clinics. See Barbara P. Billauer, The Legal Liability of the Occupational Health Professional, 27 J. OCCUPATIONAL MED. 185, 186 (1985). This duty includes the responsibility of proper diagnosis, treatment, and return-to-work decision-making. The failure to satisfy this duty may result in medical malpractice. See, e.g., Williams v. Katz, 23 F.3d 190 (7th Cir. 1994). To satisfy the duty to diagnose properly, a physician must recognize the work-relatedness of an injury or illness. Indeed, this determination, if not properly made, could detrimentally affect the health of the patient. If a physician failed to diagnose occupational asthma, for example, the physician's inaction may fatally harm the patient on return to the workplace exposure. The standard of care for treatment would require the physician to provide care consistent with that provided by other occupational medicine specialists. See Billauer, supra, at 186. A physician also has a duty not to return a patient to work until medically reasonable. See, e.g., Ewing v. St. Louis-Clayton Ortho Group, Inc., 790 F.2d 682 (8th Cir. 1986).

\textsuperscript{208} There are three typical contractual arrangements between occupational medicine physicians and employers. First, the physician may serve as a medical director or staff physician within the medical department of a company. Second, the physician may work as a consultant to handle various occupational health issues as they arise. Third, the physician may work in an independent clinic and provide medical services to the employees of businesses. The businesses may contract directly with the clinic. In all three situations, the physician has a strong financial incentive to share common objectives with employers. If physicians serve as medical directors of a company, they may have the most stable financial relationship and a longer time horizon to achieve desired goals. Physicians who serve as consultants or who work in independent clinics have less stable financial relationships with employers. For example, the contracts of these physicians might be renewable on an annual basis or even subject to termination at will. Thus, consultants and physicians in independent clinics may have the strongest financial incentives to satisfy the objectives shared with employers within a shorter time horizon.
need to resolve personnel issues. For example, a physician should not divulge unnecessary information such as diagnosis or specific medical information. Instead, the physician may indicate what physical impairments the employee has in order for the employer to decide if it can make reasonable accommodations for continued employment. Furthermore, the physician remains obligated to communicate relevant medical information to the patient even if the medical finding only incidentally relates to the objective of the testing. While an employer may obligate the physician to fulfill tasks which the employer orders, the physician should inform the patient about findings relevant to his or her health. Moreover, the ethical physician informs the patient of the physician’s business relationship with the employer.

Ideally, the occupational medicine physician bases treatment on both quality of care and efficiency. Such treatments not merely represent an ethical ideal, but also may be economically justifiable. The employer must pay not only for medical treatments, but also for a broader benefit package which includes indemnity for lost wages. Thus, effective but more expensive treatments which accelerate recovery and return to work save indemnity costs, including lost wages. Furthermore, when occupational medicine physicians track the treatment by other providers, they should avoid overutilization and ensure that the employee gets quality care.

The focus in occupational medicine on an objective shared by employers, employees, and the community at large—improving the health and safety of workplaces—has reduced the potential conflict associated with the dual duties outlined above. The commitment to certain public values constitutes a defining feature of professionalism. The occupational medicine focus means that the physician not only commits to assisting others in their pursuit of self-interests, but also carries a social obligation to pursue certain public health objectives.

The code of ethical conduct for occupational medicine physicians includes according the “highest priority to the health and safety of individuals in . . . the workplace.” Indeed, employers, employees, and physicians share this interest, which represents a larger public health interest as well. This profession’s belief about high quality occupational medicine furthers the interest of the community at large. Occupational medicine grew out of an older discipline of industrial medicine, which focused almost exclusively on the treatment of work-related injuries. Patients perceived company doctors who practiced industrial medicine as biased toward protecting the employers’ interests. The modern discipline of occupational medicine recognizes the importance of treating work-related injuries, and emphasizes the prevention of injuries and the mitigation of the effects of injuries on workplace activities. Focusing on this broader interest avoids forcing the physician to choose between potentially conflicting interests of employers and employees.

210 See OCCUPATIONAL MEDICINE CODE OF ETHICAL CONDUCT, supra note 207, at 252.
211 See Council on Ethical and Judicial Affairs, supra note 204, at 335.
212 These approaches are consistent with those recently recommended for all physicians by the Council on Ethical and Judicial Affairs of the American Medical Association. See id. at 334-35.
213 See supra part VI.A.
214 See Ballen, supra note 38, at 1293.
215 Analogously, attorneys not only act in the interests of their clients, but are also officers of the court who are committed to certain public ideals.
216 OCCUPATIONAL MEDICINE CODE OF ETHICAL CONDUCT, supra note 207, at 252.
218 For a fascinating study of how corporate physicians cope with their modern day conflicts of interest, see DIANA C. WALSH, CORPORATE PHYSICIANS: BETWEEN MEDICINE AND MANAGEMENT (1987).
The potential conflict of interest faced by the occupational medicine physician will inevitably lead to some extremely difficult situations in which either the employer (or its insurer) or the employee fundamentally questions what the physician has done. In these circumstances, it is helpful to provide some safety valves in the form of second medical opinions or the selection of another provider. Employers and their insurers in some states may rely on IME evaluations by physicians of their choice as a check on the health care provider. Indeed, treating physicians may recommend to an insurer that an IME evaluation should be ordered, particularly if they feel that such an evaluation might support an evaluation that may be at odds with a patient’s beliefs. Some state systems may allow patients to seek a second medical opinion or to continue treatment with a different physician if they become unsatisfied about their relationship with the initial treating physician. Especially if patients no longer trust their physician, these alternatives help to alleviate tensions or disputes. However, that the vast majority of workers’ compensation patients stay with their initial treating physicians demonstrates an overall patient satisfaction, despite the existence of potential conflicts of interest.

Physicians should seek a common ground among competing interests and strive to maintain the physician/patient trust. It remains important that physicians’ public values, not what side they take, shape the professional identity of health care providers within workers’ compensation. Physicians should shape managed care systems to match public health ideals, rather than to allow these systems to shape their identity as professionals.

VII. CONCLUSION

The advent of managed care in workers’ compensation brings us to a crossroads in workers’ compensation health care policy. We could, perhaps more easily, implement managed care under the conventional approach that perpetuates the schism between the administration and health care systems. Thus, if the administrators of managed care emphasize reductions in treatment costs, experiences similar to Mrs. Lopez’s will recur. Such a separatist approach, in fact, encourages physicians to remain uninvolved with the safety of workplaces because it fails to give financial incentives for this activity. A separatist approach also exacerbates the adversarial tension between employers and employees because it decreases the medical care available for workplace injuries and diseases. Moreover, a conventional managed care approach coerces the physician to side with the employer in offering less medical treatment. Although Mrs. Lopez received full satisfaction of her right to medical care, this approach failed to encourage high quality care, prevention, or return to work.

We do not have to go in this direction, although conventional wisdom suggests it. I believe that managed care, by incorporating a public health perspective, can benefit employers, employees, and physicians, and can only be achieved if all these participants agree to assume new responsibilities. Mrs. Lopez’s employer should have taken responsibility for hiring health care providers to establish and administer injury-prevention and return-to-work programs. In turn, Mrs. Lopez should understand that she has the responsibility, as well as the right, to return to work as soon as it becomes medically reasonable. Health care providers would have to realize that patients must be treated in the context of the work environment and that the workplace itself requires scrutiny. This integrationist approach thus

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219 State laws allowing employees to choose their own providers have not significantly hampered the implementation of managed care. See Solomon, supra note 4, at 62. Managed care programs that provide high quality care not only retain patients referred by employers, see Leavenworth, supra note 6, at 38, but actually attract employees from outside the system. See Wise, supra note 179, at 70.

220 See Leavenworth, supra note 6, at 38; Resnick, supra note 5, at 38; Solomon, supra note 4, at 62.
requires more complex cooperation compared to the conventional managed care approach, but opens the gateway to greater possibility.