Restructuring Workers' Compensation to Prevent Occupational Disease

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I will take the liberty of rephrasing the issue put to us in this roundtable session and word it as a question. Should the workers' compensation system be structured or restructured to prevent occupational disease? It is my conviction that, indeed, although prevention of disease and disability should be paramount social goals, one should perhaps not look to the financial compensation system as the vehicle for reaching that goal. Indeed, it is more than just conceivable that our traditional pattern of seeking to serve multiple goals through both workers' compensation and tort law processes—punishment, deterrence, and financial compensation—has contributed to the frustrations in these instruments of social accommodation and to their failure to deliver relative to their expected promise.

In a strict sense, the title given to this session, restructuring workers' compensation to prevent occupational disease, concerns the potential of the financial incentives to operate on the employer to offer a nonharmful workplace. The conventional wisdom has been that such incentives are effective and that one has only to increase the financial penalty to the employer for not providing for safety (that is, not preventing disease) sufficiently in order to reach an optimum level of safety and prevention.

Richard Victor, then at the Rand Corporation, indicated that the theoretic conventional wisdom is not necessarily borne out in practice. The relationship is much more complex than the simple statement would support. Financial incentives for injury prevention exceed those for disease prevention. Furthermore, as Victor has suggested, when high workers' compensation benefits do tend to be found in association with higher injury rates, it is not clear which is the independent variable. He has proposed that the high injury rates may cause high compensation benefits, rather than the reverse.[1] In a complementary study, Victor cautioned that generalizations about the size (or existence) of workers' compensation financial incentives should be made with the greatest of care.[2]

Another examination of this issue of incentives and prevention can be seen in a relatively recent study of the asbestos industry. An empirical study of that industry sought to determine what economically motivated behavior for controlling asbestos exposure among workers might have been expected if the employer, in 1948, had possessed the knowledge about the asbestos hazard and about the technology for controlling exposures that was available in later years. The conclusion reached in this inquiry was that such a hypothetical employer would have acted exactly as the real asbestos industry did.[3]

Our own inquiries, particularly for product liability and tort law suits, have indicated that deterrence as a function of threat of liability is a much less predictable outcome than may be generally believed. Furthermore, the end result may even be perverse.[4]

I would like to offer the following proposals:

1. A system of financial compensation for disease and disability or premature mortality should concentrate exclusively on the goal of financial compensation. That is, it should comprehend the combined desires of wage replacement, direct costs of medical care, plus, perhaps, certain important intangibles of loss of enjoyment due to incapacitation.

2. A system of financial compensation for injuries and disease associated with conditions in the workplace should be integrated with other social compensatory schemes. A distinction between that component of lung cancer which is due to underground mining and that arising from unknown cause or from cigarette smoking is one that is essentially impossible to make. To attempt to do so will inevitably lead to argument, disagreement, and tensions and in the long run will, in part, be arbitrary. I note with interest that the Canadians are moving in the direction of more general integration of their several schemes of compensation.

3. An important question arises as to whether we should continue to rely on the findings of causal association in deciding whether to compensate or in choosing the particular instrument for compensation. Again, particularly for disease, Canada has been moving away from a strict cleaving to cause for compensation decisions.

It is my conviction that if one is to preserve a test of causation, that test should be performed rigorously, observing all of the traditional tests of validity and quality of medical-scientific factual information. Otherwise, I would strongly urge that we not parade behind the fiction of observing cause as a test.

4. Finally, I would like to open up a new relation between practicing medicine and the functions of occupational medicine. Here, I return specifically to the issues of prevention. Traditionally, those professionals who have provided occupational health services to industry have been divorced from clinical practice and from the general care of employees and their families as patients. This situation has essentially been an economically dictated pattern of division of labor within the medical profession. It makes no sense. Furthermore, it detracts from efficient prevention endeavors in industry. I would urge some new and creative thinking about how to recombine these two functions. I would propose that a more integrated scheme could, indeed, bring benefits ultimately to the health of workers, including the prevention of disease and disability.

REFERENCES

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