WHY IS OCCUPATIONAL DISEASE UNDER-REPORTED?

Dana Howse [1] Joan Eakin,[1] Ron House,[1,2] and Linn Holness,[1,2]

REPORT OF THE RESULTS OF A DEVELOPMENT GRANT AWARDED BY THE RESEARCH ADVISORY COMMITTEE OF THE ONTARIO WORKPLACE SAFETY AND INSURANCE BOARD

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1. **Dalla Lana School of Public Health, University of Toronto**
2. **Department of Occupational and Environmental Health, St. Michael's Hospital, Toronto**

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ABSTRACT

Objectives
This pilot study was carried out to explore the conceptual basis and substantive issues influencing recognition and reporting of occupational disease.

Methods
The study used a qualitative design with seven focus groups selected to represent key stakeholders in occupational health and safety. The focus groups included WSIB front line occupational disease team members, WSIB front line operations team members, WSIB directors, health care professionals, union/worker representatives, employers and ill and/or injured workers.

Results
The evaluation of core concepts indicated that some factors such as (1) recognition and reporting and (2) disease and injury need to be considered as separate phenomena with potentially different determinants. The main new unit of analysis identified was stakeholder location and, in particular to whom stakeholders are accountable, which may be associated with different perspectives within and between stakeholder groups. Three main determinants of recognition and reporting were identified including: (1) psycho-social factors, (2) workplace cultural factors, and (3) systemic and structural factors.

Conclusions
This qualitative pilot study has identified key concepts, units of analysis and determinants of recognition and reporting that should be considered in future research.

PLAIN LANGUAGE SUMMARY

The recognition and reporting of occupational disease are important issues in occupational health and safety. Previous studies have indicated that occupational disease is under-recognized and under-reported with the estimates of under-reporting ranging from approximately 40% to 90% depending on the particular disease. There are significant consequences from under-reporting. If occupational disease is not recognized and reported to the WSIB, workers will not receive compensation benefits to which they are entitled, their health care costs will not be borne by the WSIB (and indirectly by employers) but will instead be displaced to the public health insurance system and WSIB statistics will not reflect the true burden of occupational disease so that an important stimulus for prevention efforts will not be identified. In addition to under-recognition and under-reporting of occupational disease, there are some instances in which over-recognition and over-reporting may occur although these appear to be less common. Therefore there is a need to understand the factors that affect recognition and reporting of occupational disease in more detail. This pilot study was carried out to explore the conceptual basis and substantive issues influencing recognition and reporting of occupational disease.

A qualitative study using focus groups selected to represent key stakeholders in occupational health and safety was used to address the objectives of the study. Seven focus groups were selected as follows: WSIB occupational disease team members, WSIB front line operations team members, WSIB directors, health care professionals, union/worker representatives, employers, and ill and/or injured workers. There were 42 participants overall.

The purpose of the focus group discussions were: (1) to clarify the key concepts that underpin research in this area, (2) to identify the units of analysis, including new units of analysis, needed to address this area of research in a comprehensive fashion, (3) to identify the determinants of recognition and reporting, including determinants that have not previously been documented in the literature. As well, because the language used by stakeholders may reflect their underlying assumptions, we described and evaluated some of the most relevant descriptive linguistic terms used by the various stakeholders which captured some of their key underlying beliefs about recognition and reporting of occupational disease.

Each focus group session took approximately two hours. A moderator/facilitator and two research assistants were present. The facilitator used a question guide to ensure that all of the relevant issues had been discussed by each group. The sessions were audio-taped and transcribed and the transcripts were imported into the Atlas Ti (2008) software program to facilitate organization, management and analysis of the qualitative data.

The analysis of the data identified a number of conceptual issues of importance to future research in this area: (1) recognition and reporting should be considered different phenomena whose determinants may differ, (2) disease and injury also need to be considered separately when evaluating under-reporting and under-recognition, and (3) terms such as “under-reporting” and “over-reporting” have different meanings to different stakeholders.

The main new unit of analysis identified that needs to be considered in future research is stakeholder location. The roles that the stakeholders have in the occupational health system and, in particular to whom they are accountable, create different perspectives on recognition and reporting within and between stakeholder groups.

Three groups of factors affecting recognition and reporting were identified: (1) *psycho-social factors*, such as perception of the seriousness and legitimacy of a condition and knowledge of workplace hazards and the WSIB reporting process, (2) *workplace cultural factors*, such as stigma and workplace norms, education and support within the workplace, employer pressure and fear of reprisal, and (3) *systemic and structural factors*, such as the content and format of the WSIB forms, the WSIB's information requirements for claimants, scientific and policy tensions in adjudication, the existence of employers not registered with the WSIB, financial incentives for employers not to report or to discourage reporting, workplace size and the support provided for workers, and knowledge of occupational disease by health care providers.

In summary, this pilot study has provided an in-depth evaluation of the conceptual basis and substantive issues that influence recognition and reporting of occupational disease and injury. In particular it has identified key concepts, units of analysis and determinants of recognition and reporting of occupational disease that should be considered in future research.

INTRODUCTION

This project developed from discussions with members of the Centre for Research Expertise in Occupational Disease (CREOD) Advisory Committee as part of the Centre's commitment to address issues of concern to its stakeholders. Recognition and reporting of occupational disease is important for many reasons. If a disease is not recognized as being caused by workplace agents, the appropriate treatment may not occur, resulting in a poorer health outcome for the worker. Even when work-related illness is recognized, it may not be reported to the workers' compensation agency or to other government authorities. This can have a number of consequences. First, the worker may not receive benefits, including health care, wage loss replacement, non-economic loss benefits and, in the case of fatal disease, survivor benefits. Second, health care costs will be displaced onto the public system. Finally, administrative statistics will underrepresent the true burden of disease that may result in a lack of prevention activities to prevent future disease.

While the problem of under-reporting is commonly discussed, and has been addressed in some studies focussed on the prevalence of under-reporting, there has been little systematic examination of this issue. This project was designed to develop capacity for investigating this important topic and to set the stage for future research. It explores in particular the conceptual basis and substantive issues for understanding of reporting and recognition of occupational disease.

BRIEF LITERATURE REVIEW

Most of the existing research on under-reporting of work-related illness has analyzed administrative or population health survey databases to reveal discrepancies between actual and reported occupational illness numbers or rates. The reported incidence of occupational illness significantly under represents the actual incidence of illness in the workplace. Research suggests that 40% to 90% of work-related injury and illness is not reported and only a small percentage of persons with occupational illness apply for worker's compensation, despite the availability of insurance for wage replacement and medical care costs.[1-7] Under-recognition and under-reporting of occupational disease is associated with numerous types of work-related illness,[8-10] and has been a major concern in public health for decades.[11] Reasons for under-reporting are rarely examined, but where they have been, findings suggest that there are three main sources of under-recognition and under-reporting of occupational disease: (1) physician and diagnosis-related challenges; (2) workplace dynamics/ social relations of work; and (3) structural determinants.

From a health care provider perspective, it is often difficult to diagnose an occupational disease, especially in the early stages. It is particularly difficult to diagnose an illness as being work-related because occupational diseases often develop over time with repeated exposure to hazardous agents or as a result of repetitious body movements required on the job. As a result, many work-related diseases are under-recognized. Also, physicians may under-report because they are not fully aware of the conditions that they are obliged to report. Other reasons suggested in the literature include administrative barriers and requirements, a lack of negative consequences for under-reporting and a lack of positive reinforcement for proper reporting.[12] The Filter Model has been proposed that describes the way information regarding a workplace injury is lost as the information progresses through the various steps in the reporting chain.[13-14]

The social relations of work have also been shown to influence a worker's reporting behavior. Workers, for example, have noted reluctance to report because of a fear of retaliation by their employer, a belief that their symptoms were a typical consequence of their job or of aging, a negative experience with management in prior reporting of occupational illness, and a fear of having to change job tasks or job locations and be displaced from their regular co-workers.[12]

Structural factors can also affect workers' reporting behavior. One cause of under-reporting in the workplace, for example, has been the introduction of safety incentive programs, initiatives which reward employers and employees for reducing workplace injury and illness but which may unintentionally discourage workers and employers from proper reporting.[12]

An analysis of the existing literature on the reasons for under-recognizing and under-reporting occupational illness revealed that the focus has mainly been on the second of these reasons - workplace dynamics and worker concerns. There is little known about the other factors contributing to this problem. The existing literature says little about the various stages and parties involved in the reporting process, or about the different locations and conditions in which under-recognition and under-reporting occur. Furthermore, these studies typically use quantitative methods (i.e. standardized questionnaires) which often cannot move beyond existing

conceptualizations of the problem, and are unable to tease out the important role of social context in responses to work-related ill-health. This project, in particular its use of interpretive qualitative methods, was carried out to develop a more nuanced and contextualized grasp of the problem.

RESEARCH OBJECTIVES

The purpose of this development grant was to explore key issues and concepts of under-reporting, in relation to the major stakeholders in the occupational health and safety arena. Five foci of investigation were identified:

1. Clarity of concepts

   There was a need to examine and elaborate the concepts that underpin research in this area. For example, the literature does not clearly define or distinguish between concepts in relation to '*under-recognition' and* '*under-reporting'*.

2. Relevant and meaningful language for stakeholder groups

   Different terms are used in the discussion of under-recognition and under-reporting. We needed to develop a taxonomy or language for research purposes which is commonly used by the workplace parties, and which is meaningful and understandable to them.

3. Units of analysis

   The scope of the existing literature is limited and therefore we wanted to appraise the suitability of units of analysis currently being used and to expand the range of such units (e.g. people, work sites, illnesses, places).

4. Influences on reporting

   To determine the focus of a larger project, we needed to identify determinants of under-recognition and under-reporting at various locations/stages of the reporting process which have not yet been documented in the literature.

5. Structural and political context

   Given the consequences faced by many of the parties affected by the reporting of occupational disease (e.g. harmful effects of reporting for workers, rate increases for employers with any rise in reporting) we needed to understand the socio-politics of doing this kind of research involving these various groups. We needed to identify what is at stake for the workplace parties, and what this might mean for doing research in this area so that we can anticipate issues that might influence a larger investigation and know how to interpret ultimate findings.

METHODS

Design

A focus group design was used to address the objectives of the project.

Ethical Approval

The study was approved by the Research Ethics Board of St Michael's Hospital.

Research Team

The Research Team included three researchers, a facilitator, two research assistants and a transcriptionist. The role of the facilitator was to support the communication and coordination of the team, the Steering Committee and the focus group participants as well as to moderate the focus group sessions. One research assistant (DH) attended focus group sessions to manage the audio recording equipment as well as to take notes, listen to the discussion and follow-up on comments needing clarification or elaboration. This assistant also carried out the primary data analysis and drafted the results write-up. A second research assistant helped with the planning and running of the focus groups sessions by helping the facilitator recruit and communicate with participants, obtaining participants' consent at the beginning of the focus group sessions and taking notes during the sessions. The transcriptionist transcribed the audio-recordings of the focus group discussions.

Steering Committee

A Steering committee comprised of individuals representing some of the occupational health and safety system stakeholders, was created to: 1) expand the research teams engagement with the OHS stakeholder community, 2) help broaden and deepen the research team's understanding of under-reporting, 3) inform focus group planning, 4) assist with recruiting focus group participants, and 5) assist with the interpretation of focus group data and the completion of the final report.

CREOD Advisory Committee members (Jerry LeBlanc, Lisa McCaskell, Joseline Sikorski, Fergus Kerr, Hal de Lair) assisted in identifying possible members of the Steering Committee. Recruitment to the Steering Committee was facilitated by significant interest in this topic by the potential members and early involvement in the research process. Individuals were asked to participate in two 3-hour meetings.

The Steering Committee included:
Donna Campbell, Executive Director, OHCOW Sudbury
Jim Harding, Manager, Occupational Health and Safety, Hydro One
Steve Mantis, Injured Workers, Community Lead, RAACWI
Lisa McCaskell, Senior Health and Safety Officer, OPSEU
Mike Schweigert, Occupational Medicine physician
Joseline Sikorski, CEO, OSACH

At the first meeting, the Steering Committee explored the topic of recognition and reporting in the form of a facilitated focus group. The Steering Committee then discussed and provided advice regarding the upcoming focus group recruitment process. In addition, Steering Committee members assisted with the recruitment of focus group participants.

A second meeting of the Steering Committee was held approximately 6 months later to discuss findings to that date. A summary of input was circulated to the committee in advance of this second meeting. This discussion informed the Research Team's perspective on how best to address the themes and issues emerging through the focus groups.

Focus Groups

Focus groups with five key workplace parties were initially proposed: workers, employers, worker representatives, the workers' compensation board (Workplace Safety and Insurance Board (WSIB)) and health care professionals. The five groups were selected because the literature suggested they were the most relevant, representing the different places and parties involved in the reporting process. However, it became clear that the WSIB viewpoint needed to be gathered from several perspectives resulting in a decision to run three distinct WSIB groups – for an overall total of 7 focus groups.

The seven focus groupings were:

- WSIB front line occupational disease team members
- WSIB front line operations team members
- WSIB Directors
- Health care professionals
- Union/worker representatives
- Employers
- Ill and/or injured workers

Recruitment and Participants

Discussion of recruitment occurred with the Research Team and then at the first Steering Committee meeting. Recruitment then became the responsibility of the facilitator. Recruitment of participants happened in a number of ways including personal, telephone, and email contact. The following presents the final number of participants in each group and briefly describes the process and challenges associated with recruiting the seven focus groups:

Union/worker representatives
Recruitment of union/worker representatives to the focus group was quite easy. The community appeared to be well networked and, once aware of the need, rapidly found individuals to participate. We began with CREOD, WSIB and Steering Committee contacts in the labour field and then followed up on their suggestions. Approximately 25 contacts led to six focus group participants. Recruitment included both the labour union community and the worker advisor/representative community.

Health Care Professionals
Recruitment to the health care professional focus group was more challenging. The focus group was held in the evening over dinner in an attempt to accommodate participants as they were leaving their clinics. The plan was to recruit a cross-disciplinary group of individuals with a mix of experience – industry, community, and hospital – and we were somewhat successful in this. The group was small, though, with a final cohort of five, which included three physicians (one community based, two industry based), one nurse practitioner, and one physiotherapist. Approximately 20 contacts were made in order to secure the five individuals.

Employers
Finding employers to participate in this group was extremely challenging. To begin, we contacted all employer representatives sitting on existing WSIB funded research centres – anticipating an already established interest in participating in research activity. Approximately ten companies were contacted and three focus group participants were identified. In the end, two individuals attended the focus group session representing employers. One participant worked as a consultant to employers and the second participant was a health professional working in a human resources department. As such, we must be cautious in our interpretation of data in terms of any attributions to the particular interest group of employers.

Injured/Ill workers
Again, participants for this group were challenging to recruit. We used contacts at clinics known to serve this population and were able to attract three individuals to the focus group. The session was held over the lunch hour with lunch provided. As some of the participants seemed somewhat uneasy initially, one-on-one interviews might have been more appropriate for the worker group and may have encouraged more participation from injured and ill workers.

WSIB
Three focus groups were held at the WSIB and, with the help of the WSIB and the Research Secretariat office, these groups came together relatively easily. The groups included:

1. An Occupational Disease front line team – 11 individuals
2. An operations front line team – 10 individuals
3. A Directors group – five individuals from a cross section of areas within the WSIB

Once an individual agreed to participate, he/she received an information package on the study including required ethics and consent information. At the focus group, participants were asked to sign their consent form and were given their honoraria. The WSIB participants did not receive honoraria and some other participants declined the honorarium.

It is important to note that the ability to recruit more easily for some groups than others reflects a bias in our sample. For example, the WSIB perspective was over-represented with three separate WSIB groups and at least five participants in each, while there was limited employer representation and only a few workers in our sample to offer their perspectives. Since the study was designed to address conceptual issues rather than to determine the distribution of phenomena or establish statistical associations, the skewing of our sample that resulted from these recruitment challenges was accommodated analytically in our interpretation of data and in our conclusions.

Data Collection

The focus groups discussion topics were developed based on the five information goals of the project (i.e. concept and language development, identification of new determinants and the units of analysis, understanding the socio-political research context). After the research team drafted a question guide, input from the steering committee was obtained.

Because this project was exploratory, we kept the questions as broad as possible. We wanted participants to provide and use their own definitions of the various terms we were exploring (i.e. reporting, recognition) rather than impose our own definitions. As a result, participants struggled with some of our questions and were concerned that they were not speaking about the 'right' things. In many cases, it appeared that the terms 'reporting' and 'recognition' were not particularly meaningful. Participants spoke about and referred to these phenomena but did not always use this language. A copy of the probes is included in Appendix 1.

At least three individuals from the research team were present at each of the focus groups: the moderator/facilitator and the two research assistants. In some groups, a lead researcher was also present to observe and ask questions. The moderator/facilitator welcomed the participants at the beginning of the focus group sessions, explained the purpose of the meeting, set the boundaries and guidelines for the discussions, asked questions and facilitated the discussion, and ended the session when appropriate.

Both research assistants took detailed notes of the discussions. Additionally, the research assistants distributed nametags and consent forms, managed audio-recording equipment, and prompted participants to elaborate on comments when necessary.

Each focus group session ran approximately 2 hours. As participants arrived they were given name tags and asked to sign consent forms. They were also given an honorarium upon arrival so that they could leave at any point without having to forfeit their honorarium. Once all participants had arrived they were welcomed and reminded of the purpose of the session. The facilitator then proceeded through the question guide until all research areas had been addressed and all points had been discussed. The participants were thanked and promised a summary of results. The focus groups sessions were audio-taped and transcribed. The recorder's notes were also transcribed and included in the data set.

Data Analysis

Transcripts of the focus group sessions were imported into the software program, Atlas Ti (2008), which facilitates the organization, management and analysis of qualitative data. After a review of the transcripts and notes, codes were created in relation to the five information goals and data were analyzed using a combination of straightforward face-value content analysis and a more interpretive depth of field (i.e. those data that were considered to have more 'depth' of meaning were subjected to a more critical interrogation).[17]

The interpretation of data was aligned with the theoretical perspective on focus groups.[17] That is, because the mode of data collection is itself an important influence on what people say, the interaction and dynamics of the group were considered relevant.

Once the data were coded according to the five information goals, the research assistant drafted a preliminary report of the results to be reviewed and analyzed by the research team. Important findings and key themes were discussed and new interpretations of the data emerged. The research team convened numerous times to discuss the data and emergent themes and the organization of the results write-up, which follows. The preliminary findings were also discussed with the Steering Committee.

RESULTS

(Re) Organization of Findings

At the outset of this pilot project, five information goals had been established to guide the content of the focus group discussions and the organization of study findings. These information goals were created based on five specific areas determined to be in need of exploration in advance of a larger, more comprehensive research project. Early analysis of the focus group data, however, revealed that the data pertaining to some of the information goals overlapped. Results are consequently presented in relation to three areas of inquiry: (1) clarification of concepts, (2) identification of new units of analysis, and (3) identification of new determinants of reporting.

Because the language stakeholders use to talk about recognition and reporting reflects their underlying assumptions, it is important to discuss initially some of the most relevant language findings in order to inform the interpretation and understanding of the results discussed below.

1. Significance of Language – Clarification of Concepts

The analysis of language used in focus group discussions proved to be helpful in guiding the interpretation of the data. We used stakeholders' language, for instance, to understand their conception of the various issues: the points they were making and how they saw the matter at hand. Because we were attentive to language, we were able to discern the range of meanings for the term 'reporting.' For example, stakeholders' regular reference to "incidents" when talking about reporting, reflects a certain pre-conception in the system toward injury. It is suggestive of how the topic is conceived, particularly how it is framed in terms relevant to injury and discreet events rather than to disease. The use of the term "incidents" reflects an underlying understanding of a cause that is clear and observed, and a focus on immediate effects, which can be seen and reported

Clarification of concepts

One of the goals of this pilot project was to examine the core concepts used in the literature on reporting. We had noted at the outset that there was no clearly laid out consensus on the meaning of the key notions, and that many were underdeveloped and ambiguous. Stakeholder focus group data revealed that the terms 'reporting', 'recognition', 'disease', 'injury', and 'over reporting' are understood and used in varying ways.

1.1. Reporting and recognition

In much of the literature 'recognition' (referring to the acknowledgement, knowledge or understanding of heath risks or problems in the first instance) is not typically differentiated from 'reporting' (the recording/documentation of or rendering public an occupational health problem/injury). A particular work-related health problem may be recognized as such, but not

reported or recorded officially. As the data have shown, recognition and reporting are rather different phenomena, governed by rather different circumstances and influences.

1.1.1. Reporting

Conceptions of 'reporting' vary according to what is reported, who reports and to whom a report is given. Reporting can be understood as incident reporting, as informing authorities, and as filing a compensation claim. These understandings of 'reporting' refer to responses to a witnessed or acknowledged work related injury or disease and/or the incident that caused them.

1.1.1.1. Reporting as incident reporting

'Reporting' is commonly understood in relation to 'incidents'; to specific events in the workplace for which cause, time and date can be established and which are to be reported to a supervisor or recorded in a workplace log,

> *Well, the first thing I guess on the shop floor is… the treatment record book. Usually when a worker has an injury or any kind of medical concern, they should go to the treatment record book, write it in, let their supervisor know and so on. And that's probably where things should start because, that should catch all incidences, however minor …* (WSIB)[1]

Here, reporting is seen as happening in relation to discrete events that are recorded, in this case in a workplace record book. 'Catching all the incidences' invokes a sense of counting and of keeping record for purposes of creating statistics. The speaker uses the word 'should' and talks normatively about what happens. That is, the speaker talks about what should happen rather than what actually happens. This weaving together of normative and descriptive explanations runs throughout the data, and hints at the moral overtones associated with notions of 'reporting'.

1.1.1.2. Reporting as informing the authorities

The previous quotation includes reference to 'letting the supervisor know' along with a notion of incidents. That is, 'reporting' is also conceived as the act of telling an authority, such as a supervisor, health care provider or the WSIB.

[1] The quotes provided in this report are typical of others on which the report and analysis is based. For this qualitative project, data were organized and brought to bear on the analysis and are used here to provide evidence of the findings presented. Not all the data upon which the analytic point is being made can be displayed, but an illustrative and typical quote is used to represent other data, and to give a flavour of how phenomena were perceived. To maintain participant confidentiality, quotes are attributed to the group to which the speaker belongs. In the case of the WSIB, no individual group is identified; quotes are attributed only to the WSIB. In cases where details might violate confidentiality, the attribution is made more ambiguous for ethical reasons. All quotes are verbatim from the focus group data.

1.1.1.3. Reporting as filing a claim

The term 'reporting' was often used synonymously with filing a compensation claim with the WSIB. This conception of reporting referred to the completion of a WSIB Form 6, 7 or 8 by a worker, employer or health care professional, respectively. This conception suggests that reporting can be seen as an act that involves not just workers. It also reflects how reporting becomes associated with particular institutional forms and procedures while the broader conception of the term disappears.

1.1.2. Recognition

The specific term 'recognition' did not seem meaningful to our participants. In the focus groups when the issue of 'recognition' was raised participants typically demonstrated some confusion and inability to grasp what was being asked of them. However, it was clear in the data that the problem of recognition, as we were using the term, was indeed acknowledged, particularly in reference to occupational disease. We distinguished several types or dimensions of recognition: work-relatedness, risk acknowledgment and deeming a condition reportable.

1.1.2.1. Recognition as work-relatedness

The acknowledgement of a condition as being related to or caused by work was commonly perceived as the first step in reporting. Some participants said that recognition is a critical point in reporting. One participant said that recognition, in the sense of acknowledging a problem as work-related, is more likely to happen when a link to health is already known:

> *…an engineer may go into a mine full of bats, inhale something, get ill, and not make the connection…Researchers (in) laboratories, react to feces or whatever, and they make the connection right away, because they're working in a laboratory...and they notice it, they're analyzing it…* (WSIB)

Distinguishing work-related causes from lifestyle factors was perceived to be a significant challenge and an important impediment to workers' making the link between their injury or symptoms and their work. Symptoms are often attributed to unhealthy personal habits and/or participation in recreational sports rather than to substances or tasks in the workplace,

> *…there are some diseases that are multifactorial, in which case they... could potentially be due to your smoking, drinking and carousing. But…there could also be a workplace component in there...So depending on the mindset of the person, they may choose to say, "Oh well, I did this to myself," and not make a claim, or…you know… "It's 100% work related."* (WSIB)

A link to work may also occur when workers notice other coworkers who have similar symptoms. This participant, an injured worker, indicated that they only began to consider the work-relatedness of their declining health when they saw coworkers with similar symptoms and complaints:

> *…they (were) complaining one day that they weren't feeling good either…they were having a lot of bloating, their stomach swelled...one said what the heck is going on here…how can two girls be, you know like this…And… (I) started to notice things…* (Worker)

The notion of recognition was also used to refer to the recognition of trends. That is, noticing when numerous claims or reports come from a particular industry or employer. This participant described how trends could be recognized by unions:

> *Potentially unions might be able to…connect the dots, seeing they see lots of different workers, you know…put the pieces together to say well…all these guys used to work at this one particular project, and now they all have this. Now, of course, they've spread out and don't even know each other anymore, but if they're able to connect that piece that they all worked at the you know baker's plant that's now knocked down, and they've all got…complaints…*(WSIB)

1.1.2.2. Recognition as risk acknowledgement

Similar to the notion of recognition as work-relatedness, a further usage of the notion of recognition includes the acknowledgment of *potential hazards or risks* in the workplace, which, if ignored, could result in a work-related injury or disease. This kind of recognition is implicit in workplace risk assessments, which reveal hazardous substances/tasks, or in the introduction of safe work practices to prevent known problems. For example, making ergonomic changes to work stations to prevent potential muskuloskeletal injuries indicates that a particular risk has been recognized,

> *… it's preached to us all the time, "take your micro-breaks, get up and stretch, move your mouse from your right hand to your left hand." And, we do ergonomic assessments to make sure that we're working at appropriate workstations… It's all in recognition that we're susceptible to…a hazard.* (WSIB)

1.1.2.3. Recognition as deeming a condition reportable

Recognition was also understood in terms of whether a work-related condition was considered to be reportable. What was considered a reportable condition varied within and between stakeholder groups. First, a reportable condition was conceived as one that is "serious enough" to report, including whether its symptoms were serious enough to interfere with the workers' ability to work. It was noted that some conditions are typically considered too minor to report. In addition to the seriousness of a condition, a serious and reportable condition was also conceived as one which is less commonplace and which does not occur on a regular basis. Conditions which are perceived to be "part of the job," may not be reported,

> *Well (in some industries), they cut themselves, they hit their finger with a hammer, like it's a daily occurrence. So little things, nobody reports. So those could be 30 or 40 accidents that none of them are reported because they're everyday occurrences, and they don't think of them as an actual accident happening. But, it is.* (WSIB)

Participants noted that conditions that are eligible for workers' compensation and that are listed in the WSIB schedules are considered reportable. This participant notes that conditions, which are not listed in the schedules or advertised by the WSIB as eligible for compensation, are thought by many to be not reportable:

> *Well…you have…certain diseases that are scheduled and certain that have policies. Now there are a whole set that we would compensate on a case-by-case basis for which there is no such open declarative information. So…people might not know…that we would compensate kidney cancer and asbestos. And they would think…because there's no policy on it, I would not make a claim.* (WSIB)

1.1.3. Summary

The concepts 'reporting' and 'recognition,' which tend to be taken for granted in the literature, have numerous, different uses and connotations for the various stakeholders involved.

1.2. The notion of 'over-reporting'

The notion of 'over-reporting' emerged in this pilot study, which is notable considering its relative absence in the literature. Both the terms 'under-reporting' and 'over-reporting' are, essentially, judgments, which are understood differently by different stakeholders. Like under-reporting, there are various ways in which 'over-reporting' is conceived: as misuse of the compensation system; as precautionary reporting in case of future problems; as an awareness-related influx of claims (cluster claims); as denied claims, and as exceeding institutional norms.

1.2.1. Over-reporting as misuse of the compensation system

'Over-reporting' can be used to refer to the intentional abuse or fraudulent use of the compensation system. Workers are often perceived as exaggerating their symptoms in order to get compensation benefits or purposely claiming for WSIB benefits for conditions that are not work related, to avoid using workplace benefits, and sick leave benefits in particular.

> *…Sometimes you go from the sublime to the ridiculous, you get people…who under-report, and don't report anything for five years, but then you get people who are, it's sort of like fishing, you know, "I've got these symptoms, and I'm exposed to something at work, mould, or perfumes, or anything like that…Therefore everything that I experience is related to this exposure."* (WSIB)

These participants suggested that the workplace benefit structure, which enables workers to accrue sick leave and use it for vacation time, may encourage over-reporting on the part of workers:

> *But it's this kind of benefit, so that if you don't use your sick time, you can accumulate up to two years. Save up…you get two years pay. If somebody gets hurt or something… rather than the (sick leave) that they could take as a vacation…they'd rather get comp.* (HCP)

This participant suggested that workers may also submit claims to the WSIB for non work-related conditions in order to maintain their seniority, which is affected by sick leave but not by time off on compensation:

> *…what you want to do is be ensured that your seniority is not going to be impacted and therefore you definitely want to make sure that you have a work-related issue. Because then you're going to be accommodated, and you're going to be continuing to work, and you're, it's going to be continuing to accrue seniority.* (HCP)

Participants described a "snitch line" – a WSIB fraud hotline which people can call to report workers who are abusing the Board's services by continuing to be active, i.e. "re-shingling their roof," while receiving benefits.

1.2.2. Over-reporting as precaution

Reporting of incidents that do not result in immediate injury or disease can also be considered as precautionary 'over-reporting.' The 'Program Exposure Incident Reporting' (PEIR) program at WSIB provides a means for workers to report incidents in their workplace, such as a spill, leak or explosion, to the WSIB so that potential exposures can be documented in case health problems arise in the future. Similarly, outside of PEIR, precautionary reporting of possible injuries (near-misses) is common. Multiple reports of this kind from a single incident at a single workplace can overwhelm the WSIB and prompt them to perceive these reports as administrative nuisance that detract from time and resources better spent on adjudicating actual claims,

> *…30 workers were working at [company name] and something spilled… and they think maybe they'll have a problem 30 years from now, so [company name] sends this to us… and we keep a list of these guys… Who is going to decide what is something that is reportable, in terms of …what has hazard attached to it? Who knows? …to collect information on hundreds of thousands of (what) could…one day…be a disease…when we're missing obvious diseases. It seems a whole lot of effort expended to an initiative that isn't likely to glean much because it's all uncorroborated.* (WSIB)

1.2.3. Over-reporting as "cluster claims"

Some participants suggested that 'cluster claims' – the influx of claims submitted to the WSIB in a certain period – is prompted by increased awareness resulting from media coverage of a condition, or from union education efforts. This is perceived as 'over-reporting' by some,

> *I think sometimes, historically, it's taken a precedent to happen, for us to sometimes recognize certain situations. And then once it's recognized, then you get everybody…if it's properly advertised in the media… and then you may be susceptible to um, an influx of over-reporting.* (WSIB)

It was noted that while raised awareness generates increased reporting, it actually generates quite appropriate reporting of legitimate problems,

> *…I know, for example when we've had these clusters…We've got a bunch of claims from a foundry. It was just by fluke of circumstance, in my view, that the union organized, picketed, the job site and…set up the awareness, and the claims came flowing in.* (WSIB)

1.2.4. Over-reporting as denied claims

A less common understanding of 'over-reporting' is that it involves the submission of claims to the WSIB, which end up being denied,

> *…if one were to assume that our decision making is perfect, then one might construe denials as over-reporting…* (WSIB)

This understanding assumes that some of the claims to the WSIB that are denied are for illegitimate or non-work related conditions that have been unintentionally 'over-reported.' Over-reporting in this sense can be on the part of the worker or the health care provider and is usually associated with occupational disease, where the work-relatedness is difficult to ascertain. One participant noted that because diseases are multi-factorial in causality, workers could report and file a compensation claim for a condition that was actually caused by factors outside the workplace:

> *… the work did not cause the problem potentially, exclusively or in it's entirety, yet the costs are borne only by one person, by one entity, that employer. So in a way employers would then be paying for many of the life-style factors. And…if work causes one in ten, at the individual level, you'll never know which of the ten it is, so you have to compensate all ten. So really there's a potential for under-reporting then, that…becomes explosive potential for over-reporting.* (WSIB)

1.2.5. Over-reporting as exceeding institutional norms

A final conception of over-reporting referred to rates of reporting, which exceed industry norms – that is, rates higher than the system expects for a particular industry or employer. These high rates of reporting could be a result of employer efforts to educate employees about work safety and reporting to the WSIB.

1.2.6. Summary

The data point to the notion of 'over-reporting' in addition to the issue of 'under-reporting'. Over-reporting is seen to occur in a number of different ways and for different reasons. Notions of over-reporting are associated workers in particular, but also with employers and health care providers.

1.3. Distinction between disease and injury

The difference between occupational disease and injury is seldom considered in the literature on reporting. This distinction between injury and disease is important to the issue of reporting. Our data illustrate the ways in which occupational disease is different from injury in terms of the determination of work-relatedness, the implications for claimants, perceived legitimacy, and treatment by the WSIB.

1.3.1. Determination of work-relatedness

A number of features of occupational disease were mentioned by participants as making it difficult to attribute a health condition to work, which, in turn, can impede recognition and reporting. Occupational disease, for example is often 'eventless'; it develops over time with repeated exposure to a hazardous substance or activity. Due to the lack of an acute event and a clear or single identifiable cause, occupational disease may be under-reported. Participants noted that conditions with later onsets may be under-reported because workers may be retired before they develop symptoms, and/or they may not make the connection to work, or have work histories that blur and complicate the possible etiological agents,

> *A lot of times like you know, is people don't know (they) have an occupational disease, until… you know, if it's 25 years later… then try to connect where I got what, they say it's work-related, but you've worked for 3 employers…Yeah, so a lot of people just don't bother putting in a claim because of the hassle.* (WSIB)

It was noted that other features of occupational disease, which include multiple causes, invisibility of effects, and difficulty of diagnosis and claim adjudication due to longer latency, which make attribution to work difficult, are typically less of an issue with occupational injury,

> *… because it's multifactorial, it's often a…bit of a waiting game, it's not straightforward. The correlation isn't obvious. So, that, when it's difficult for us, imagine, for the world out there to identify these and bring them forward….and the degree of exposure you have to have, those type of things.* (WSIB)

1.3.2. Implications for claimants

Participants noted that the above mentioned characteristics of occupational disease have significant implications for reporting. Because occupational disease is multi-factorial in its causality, there is greater tendency to consider causes outside the workplace. One participant said,

> *The closer the disease gets to being caused by other factors…the less likely it's reported as occupational. That's a given* (WRep)[2].

This participant said that workers with occupational disease face much more scrutiny about their personal lives because non-occupational factors need to be ruled out:

> *But from the employer's point of view, you know why should…I be blamed for all of this, when he's using the stuff at home? Is he exacerbating the condition because he's not complying with the restrictions at home? Why should I bear the whole cost?* (WSIB)

Participants indicated that, for this reason, claims for occupational disease are more invasive and complex than for occupational injury; they invade the workers' privacy. Workers not only have to talk about their work and their condition, they have to talk about their personal lives - their habits and activities – and they have to defend themselves.

Additionally, in the case of occupational disease, much more needs to be known about the workplace and the potential exposures in it in order to establish a work-related cause and there is currently little incentive for employers, adjudicators, and health care professionals to spend time searching for the detailed information required. Data suggested that because the science devoted to many occupational diseases is inconclusive and murky, physicians may need to do a lot of detective work to support a patient's occupational disease claim.

1.3.3. Perceived legitimacy of complaints

A further distinction between injury and illness in relation to reporting might lie in the issue of legitimacy, with the former being associated with fewer concerns about validity. Because injuries are more often associated with an acute event and known cause, they may be seen as more straightforward in terms of determining work-relatedness and the injured worker may get more support from the employer,

[2] WRep – Worker representative

> *They don't doubt it; it's so obvious. Whereas, with all the other claims, "oh yeah, sure… it probably happened at home... or it was due to your lifestyle factors." So you get the doubt creeping in.* (WSIB)

1.3.4. Differential treatment from WSIB

Some respondents suggested that the WSIB appears to treat disease and injury differently. The WSIB will accept disease claims long after the symptoms arose whereas injury claims will only be accepted up to six months after the incident. Additionally, the WSIB outreach and prevention initiatives focus mainly on injury, with very little focus on disease. The WSIB forms reflect their differential treatment of injury and disease and they illustrate the Board's general orientation toward injury. One group described the injury-focused nature of the forms:

> *... I think when people think about putting in a claim, they think about a muskuloskeletal injury and in fact, the Form 6 is the worker's report, and …it's designed towards a muskuloskeletal injury, so someone with dermatitis or cancer or any disease might get the Form 6 and be stumped as to how to fill it out.* (WSIB)

These differences, which are rarely considered or accounted for in the reporting literature, are extremely important as they have significant consequences for recognition and reporting of the different work-related conditions.

1.4 Summary

The focus group data revealed varying uses and understandings of the key concepts and terms used in the literature on reporting. By outlining the ways in which the concepts are used and understood by the various stakeholders, we are better able to identify, clarify and explore problems and determinants related to recognition and reporting. The development of these core concepts also informed the analysis and interpretation of the focus group data in relation to the other information goals.

2. Units of Analysis: Stakeholder Location

The experience of organizing and conducting the focus groups, combined with the analysis of the data, revealed that the participants' perspective was more associated with their *location* than with their stakeholder group classification. By 'location' we refer to participants' role and positioning within the occupational health and safety system. For instance, the participants' understanding of reporting– who they see as responsible and what they understand as important determinants of reporting – is shaped in important ways by their individual/organizational accountability (ie to whom they were answerable, such as to management, the WSIB, or injured workers), their professional commitments, and their positioning within the occupational health/compensation system. Participants appeared to see the system and issues of reporting in terms of their own job expectations and institutional accountabilities. Thus, for example, health care providers who

work in the corporate setting were more likely to talk about worker 'over-reporting' (in the sense of mis-using the system), whereas participants who were more aligned with workers tended to focus on the employers' mis-use of the system.

The three groups representing the WSIB had differing perspectives about the factors that most affect reporting and their own role in reporting, depending on the nature of their specific job at the Board. Due to the specific characteristics of occupational disease and the difficulty in ascertaining cause and work-relatedness, adjudicators dealing with occupational disease considered health care providers' diagnoses as central to their jobs and to the claim process. Participants in the operations front-line team, however, deal more with workplace injuries and the claims they receive rely less on medical opinion. These participants seemed to feel that personal factors of employers and workers are more important for reporting. The WSIB Director group, which doesn't deal directly with claims and approaches reporting from a broader perspective, understood reporting in terms of the need to balance incentives/encouragements to report with the resources available to the Board to pay for claims. The issue of reporting was thus understood through the lens of particular 'locations' within the WSIB.

3. Determinants of Reporting

A key objective of this pilot project was to enhance our appreciation of the type and range of factors that might relate to reporting. From the focus group discussions three main categories of determinants could be distinguished: 1) determinants related to psycho-social practices; 2) determinants related to workplace culture; and 3) organizational and systemic 'structural' determinants.

3.1. Determinants related to psycho-social practices

Both the psycho-social practices of workers and of workers and health care providers can influence reporting.

3.1.1. Psycho-social practices: worker-related

The reporting of an occupational injury or illness is affected by the extent to which individual workers might be aware of the various aspects of such problems, and by the seriousness they might attributed to the condition.

3.1.1.1. Awareness

Workers' awareness of potential hazards and conditions in their workplace as well as their knowledge of the WSIB process (how to initiate a claim, navigate the Board) plays a significant role in their decision and ability to report. As this participant explains, fears and misunderstandings, which arise from a lack of awareness, can prevent workers from reporting:

> *…Coworkers were worried that we'd shut the [company] down...because of …what these claims would cost. People also thought their taxes would go up… I got that a fair bit… and the third was… strangely enough, some widows would be afraid to take the money, thinking that they'd be cut off from their pensions from the company, the company would be upset with them. It was…you know that's a huge factor that they're worried about the repercussions. And there's really no education to the widows, to the families, to the survivors; it's just a labour person going in and saying, 'trust us…you can take this, this is yours'…* (WRep)

3.1.1.2. Perceived seriousness

As was previously noted in the section on "deeming a condition reportable", workers' decision to report was believed to depend on the seriousness of their condition. In jobs associated with heavy, manual work, the workers suffer what they see as 'minor' injuries regularly and see them as part of the job, as "everyday occurrences" that do not warrant reporting. This participant noted that workers only report when their condition worsens:

> *And then, down the road, if... there's an infection or something more serious, then it gets reported to us, because it could meet one of the reporting criteria…*(WSIB)

It is believed that workers might ignore or deny their symptoms and hope or assume that they will go away. Many, it is thought, do not report problems until "they're at the end of their rope" and only then do they seek medical attention. Some participants suggested that financial impacts are the biggest factor affecting whether workers will report. The point of recognition for many workers is only when their condition has gotten so bad that they can't work anymore; when it may interrupt their pay. This compromised income "forces them to seek medical attention." It was noted, though, that such delay, may then impact the workers' right to benefits.

3.1.2. Psycho-social practices: health care provider-related

By making diagnoses and providing medical information to workers and adjudicators, health care providers play a significant role in the reporting process. As such, a number of psycho-social factors related to health care providers have been identified as determinants of reporting. These health care provider-related factors include sufficiency of their knowledge, role confusion and perceptions of complaint legitimacy.

3.1.2.1. Knowledge sufficiency

Despite the importance of medical opinion in the adjudication of claims, health care providers may lack the necessary knowledge to diagnose workers with occupational injury or disease. Participants suggested that occupational health issues are given insufficient attention in medical school curriculum and as a result health care providers often lack the appropriate training to address needs and concerns of injured and ill workers. Participants also noted that even with

training and sensitivity to occupational health problems, physicians must distinguish work-related from other sources of symptoms.

> *A ... the awareness of the industry that their patients are coming from, awareness of types of injuries may occur, or what kinds of exposures they may have, so therefore what's looked for.*
> *B ... may actually be a barrier to ... reporting other things, because people say, "Oh, there is a very large automotive manufacturer and those guys always have muskuloskeletal injuries." Therefore, when something unusual comes up, there's oversight in the periphery because people are so attuned to paying attention to whatever their local geography is that they just like never at all thought about asthma, because it just didn't seem to fit with that...* (HCP)

3.1.2.2. Role confusion

Health care providers were perceived to not fully understand their role and responsibilities in official reporting systems. Three sorts of practices were identified by participants as affecting reporting. First, doctors can wrongly assume that they need to diagnosis a condition as 'occupational' in order to file a WSIB form (as opposed to only having reason to believe such is the case). Second, health care providers, some participants suggested, regularly (and sometimes indiscriminantly) attribute health problems to work,

> *I can think of one doctor, in particular...everything is work-related for him, and that's sort of his specialty, he diagnoses people with (the same condition)* (WSIB)

Third, participants suggested that physicians may not submit a claim if they consider the patient's condition to be not related to work (e.g. they won't submit a claim for cancer if the worker smokes.). This practice was sometimes referred to as "pre-adjudication": the physician makes the judgement as to work-relatedness before the claim enters the system. Some considered this inappropriate because determining work-relatedness is the responsibility of the WSIB, not of the physician. Further, it was noted that when health care providers diagnose a condition as 'work-related' it makes the adjudicators' job more difficult. Participants noted that once workers are told by a doctor that they have a work-related condition they can be less amenable to answering their adjudicator's questions and feel the doctor's opinion should be final.

3.1.2.3. Perceptions of complaint legitimacy

As was discussed earlier in the section on the differences between injury and disease, the perceived legitimacy of a worker's complaint is believed to be an important determinant of reporting. Health care providers' beliefs about particular workers in terms of their honesty and the legitimacy of their condition, for example, may affect whether they submit a Form 8 to the WSIB. They may be reluctant to file a WSIB form, for example, if they suspect the worker is being dishonest about the nature or cause of his or her condition i.e. workers who exceed typical

rehab guidelines or who have poor job satisfaction. This health care provider said that their assessment of the worker's truthfulness affects their reporting the condition as work-related:

> *"Yellow flags… (worker) goes way beyond the duration of the guidelines in terms of healing. Another is…where jobs are having actual performance issues, attendance issues. You know, you open a file and you realize that immediately...the guy was scheduled to be disciplined, and suddenly he went off work…Where there's strife in the workplace, claims go up."* (HCP)

On the other hand, some doctors are perceived to always be on the workers side and to presume the worker is being honest. These doctors will diagnose work-related conditions based solely on the worker's comments and do not corroborate their reported symptoms with objective tests,

> *A* *sudden sort of onset of the back… injury, or something like that. A lot of times, what we'll find is that the doctor reports pain. And pain is not something that we can measure or substantiate…*
> *B* *And he's gone on the word of the injured worker, rather than do an actual full grade physical exam, to find findings himself too.* (WSIB)

Some participants viewed such practices negatively, perceiving that doctors who are too trusting of workers' reports are 'over-reporting' by encouraging claims that are eventually disallowed for not being work-related. The assumption underlying such a perspective however is that workers cannot be 'trusted' to judge their own circumstances, and that only certain kinds of evidence constitute convincing demonstration of work relatedness.

3.2. Determinants related to workplace 'culture'

A number of factors affecting the reporting of work-related health problems are linked to the notion of workplace 'culture' – the social and cultural context in which workers learn about, consciously or not, appropriate and acceptable work-related behaviors. Aspects of workplace culture that can deter reporting on the part of workers include stigma associated with making claims, shared workplace attitudes and norms about injury/disease (e.g., machismo), employer pressure to handle work-related conditions in-house, and fear of reprisal from employers. Alternatively, aspects of workplace culture that can increase reporting on the part of workers include education and support from peers, a supportive and accommodating management, and an active union.

3.2.1. Stigma

Stigma (negative social 'marks', imputations of one's moral character) associated with work-related injury and disease and with filing compensation claims (widely acknowledged in the literature) was also underscored in this project. Fear of stigma is evident, for example, in this worker's commentary about feeling deterred from revealing to her supervisor that she was filing a compensation claim:

> *…(I) didn't really want to tell my boss, but I had to… I knew that my job was now in jeopardy… cause I knew what their attitude was.* (Worker)

Another injured worker, employed in a job that involved tips, described the stigma she faced when doing modified work:

> *You look down on yourself…people are like saying things…even your co-workers. Especially like my situation because there's involvement with gratuities, right? …They put me on modified duties but I get the same pay.* (Worker)

3.2.2. Social norms

In addition to workplace stigma, participants also referred to social norms in some workplaces that discourage reporting on the part of workers. In some trades, for example, where jobs are male-oriented and require heavy, manual work, a workplace 'machismo' culture develops and deters reporting of many conditions, which are considered too minor or too commonplace. This participant suggested that back pain, for example, is commonly ignored:

> *…that machismo, it's like, "We all have back pain, suck it up." They'll tell you "I have back pain, I've had back pain off and on for years." … The employers say, "I don't see what his problem is, we all work with back pain. So why does he have to take time off?"* (WSIB)

3.2.3. Employer pressure

Employer pressure to not report and to handle problems in-house was seen as a significant factor affecting reporting. It was suggested that experience rating programs at the WSIB, which reward and penalize employers with good and poor safety records respectively, create an incentive among employers to keep down the firm's claim rates and to achieve this by discouraging workers from reporting injuries and illnesses that are related to their workplace,

> *… And depending on your experience…you may get a surcharge or a rebate… so that's a motive to not report claims.* (WSIB)

An injured worker described a situation where his employer tried to convince him to not file a claim with workers' compensation. He recalled the conversation,

> *… you go to your foreman, " I just cut my finger." "Oh, go wash it out. Tape it up." "It's still bleeding, it's bothering me a lot… I'm going to the doctor." "No don't go to the doctor, I'll take care of you." They have a first aid person who comes and fixes you up and you're going, "Oh, I want to go to the doctor." "Oh no, take it easy for the day…if you go to workman compensation, our insurance will go up more for the year." They just play with your head for that day and the next morning (you) come in, you're crying. They, say, "Oh just take it easy. Take a broom and try and sweep."* (Worker)

In some cases, employer pressure is described as less direct. Employees can misconstrue employer-driven workplace safety initiatives and incentives as not only pressure to conform to safe work habits, but also pressure to not report work-related injury or disease. One participant described a situation where a positive workplace culture with a supportive and involved management had an inadvertent affect on reporting:

> *… they (employer) were very proactive when it came to WSIB, which was great. They had gone 2000 plus days without a lost time injury. It was a benchmark for the company; it was well advertised, there was a display board when you came to the parking lot. … I would see employees… with injury, or illness… However, they didn't want to report it because they didn't want to be the one, that... brought that number back to zero.* (Emp)

3.2.4. Fear of reprisal

Employer pressures to reduce reporting and keep costs down are factored into workers' decisions to file a claim or tell their supervisor about an injury or disease. As this health care provider indicated, workers fear they'll lose their job or face other repercussions at their workplace if they file a claim:

> *…whether or not there's some sort of a personal consequence if you report; consequence because of your benefits, risk of becoming unemployed, the fear of repercussions, thinking that you'll only get the low seniority jobs, whatever…*(HCP)

3.2.5. Support and knowledge

Peer support appeared to influence workers' reporting behavior. As this participant notes, in many industries workers tend to stay in the same workplace for long periods of time, which might increase workers' likelihood of being educated by their coworkers regarding what is considered acceptable reporting practice in that particular workplace,

> *... (If) I have a fixed work site… I'm there, you know, 300 days of the year, your co-workers educate you as well…May educate you to say… like you shouldn't be accepting that.* (WSIB)

A supportive management which takes complaints seriously and which is willing to accommodate workers was also associated with improved reporting,

> *Or if there's a culture of a management that is extremely supportive and we want to make sure that we accommodate everybody at all costs and therefore we, we have a big preventive program in place… going to encourage (reporting).* (HCP)

Finally, the presence of an active union can create a workplace culture which supports workers in filing compensation claims. Unionized workers have access to training and support related to occupational health and information about reporting and the WSIB process. Participants noted that unions can significantly increase reporting by increasing workers' awareness of the hazards they may be exposed to and the conditions they may develop:

> *…I just think of unions raising the awareness…We have a lot of clusters of (claims) that would come in - five and six hundred at a time. And, that would be through a union group, like the [union] or the [union] organizing a sort of intake clinic in a community where they felt that there was a heavy industrial presence and that there was (risk)…The organized ones raise the awareness.* (WSIB*)*

Many workers, especially non-unionized workers, lack the necessary knowledge regarding the WSIB process (how to initiate a claim, navigate the Board). Participants said that having a representative or consultant who knows the system and who can help workers to navigate it would improve reporting.

3.3. Organizational and systemic 'structural' determinants

Many of the determinants of recognition and reporting, which emerged from the focus group discussions, referred to structural or systemic factors. Some of these structural factors can be organized according to the stakeholder group with which they are associated: WSIB-related determinants; employer-related determinants; health care provider-related determinants; worker-related determinants and worker representative-related determinants. The remaining determinants are broader structural factors that are not associated with a single stakeholder group.

3.3.1. Structural determinants: WSIB-related

A number of systemic and procedural factors at the WSIB were associated with under-reporting. Participants raised issues related to the Board's reporting forms, information requirements, scientific and policy tensions, and need to balance conflicting responsibilities. The Board,

however, was also seen to play a positive role in reporting through its education and prevention efforts.

3.3.1.1. Reporting forms

Reporting to the WSIB occurs through the submission of Forms 6, 7 and 8. Because they are required by the Board to initiate a claim, these forms play a significant role in the reporting of occupational conditions. However, many participants described these forms as onerous to complete, and flawed in design: information was asked for that wasn't relevant or that duplicated information asked for elsewhere, on-line completion and submission was not available, insufficient space was allowed for important information etc. In addition, the process of filing forms was viewed as complex and problematic. Some participants believed a single form for all insurers would facilitate the reporting process,

> *A* *A single form that is easy for physicians, regardless if it's from WSIB, RBC, CPP - one standard form for all insurers (like Australian system)*
>
> *B* *It's complex - knowing when, where, who, why. Need one universal process.* (HCP)

It is perhaps noteworthy that, in these data, primarily issues of efficiency and convenience emerged in relation to reporting forms.

3.3.1.2. Information requirements for claims

The nature of the information that the WSIB requires - the timing of the information and the reliance on medical opinion – appeared to be another structural determinant of reporting. WSIB groups indicated that immediate reporting from the health care provider and employer to the WSIB increases the chances of a successful claim. This requirement reflects the system's general orientation toward injury and more acute events as this protocol does not consider the nature of many diseases that have a long latency after initial exposure.

Similarly, the claims process appears to be medically driven in that the WSIB requires "objective" medical evidence to prove a condition is work-related and to approve the worker's claim. This reinforces the injury bias since objective information is easier to obtain for an acute injury with a known cause and date. Such information is harder to obtain for workers who do not know when and to what they were exposed and often have no witnesses or incident report to support their complaints. This participant explained that subjective reports are not enough:

> *But a lot of those physicians do that…based on subjective reports. The worker comes in and says, "doctor, I've smelled this smell and now I can't breath." And he says, "Oh that's a work related fumes exposure." He has no idea what's in the environment…and whereas you're going and looking for objective data.* (WSIB*)*

Despite the WSIBs heavy reliance on objective, medical information, there is a perceived lack of information exchange between health care providers and the WSIB, which complicates the diagnosis and adjudication process. Both groups spoke about their struggles with "scrounging for information." As this participant indicated, the WSIB often gets incomplete or irrelevant information in the physician reports:

> *Maybe more communication with doctors… Sometimes they don't give us relevant information or the information that we're looking for…Making them understand exactly what we're looking for…getting them to probe a little further…and maybe even rewarding them more for doing it.* (WSIB)

3.3.1.3. Scientific and policy tensions

Another structural factor affecting reporting is scientific and policy tensions at the WSIB, of which there are three different dimensions: 1) policy, 2) practice, and 3) science. First, the Board's policies can be unclear regarding the conditions it deems eligible for compensation. The Board's schedules, by listing the conditions that have been established as work-related and which, therefore, are compensated, determine what kinds of conditions get reported. Some diseases which are not listed in the schedule but which are still eligible for compensation by the WSIB may be less likely to be reported because workers and health care providers are not aware that they are, indeed, recognized and compensated.

Data suggested that this inconsistency between WSIB schedules and compensated diseases can make adjudication of claims difficult. Participants noted that adjudication of claims for unlisted diseases can be "murky" because there is a lack of empirical evidence documenting their work-relatedness and there are no polices in place. As a result adjudicators have to make more discretionary judgements, which may be, or appear to be inconsistent. A worker representative also expressed concerns about the lack of transparency in WSIB policies: "If they establish any kind of reasonable guidelines around what you are entitled to…they just don't get it out there to anybody (Wrep)."

Another WSIB policy, the Experience Rating Program, rewards and penalizes employers according to their injury and disease rates as incentive to achieve better health and safety records. In actuality, some propose, the program can lead employers to discourage workers from filing a claim, in addition to or instead of making their workplaces safer. One participant said,

> *"The Experience Rating system sets it up, so that, that employers… try and avoid reporting accidents, they try and have no lost time injuries so that they can get rebates…(*WRep)"

Second, WSIB practices - how the WSIB functions on a daily basis - can also affect reporting. For example, some participants referred to poor communication between WSIB departments, such as between adjudicators and those charged with prevention activities.

> *…(the Prevention Department) sort of are disconnected from…the front line. If we…identify a trend or something that's going on, you would think you would call them, and say, "okay, give them some you know, go speak to (employers)."…If it doesn't happen that way, they sort of leave it…to the front line staff, to sort of figure out some type of solution. And we don't have enforcing powers here at the Board. So, …sometimes you feel like…if you had a worker calling you and they're frustrated cause something's going on, and it's like, "well I'm sorry, I can't help you, call Ministry of Labour… they've got a mandate for that. We don't." So, you sort of feel powerless sometimes…But there's a disconnect I think, from what they do, and those of us who work with actual employers and workers…*(WSIB)

This participant suggests that because adjudicators do not have a protocol for dealing with trends and because they do not communicate with more prevention-oriented departments, education or prevention efforts for addressing the trend and to encourage reporting may not be developed or targeted at the identified industry or workplace.

Third, the Board's reliance on scientific evidence in establishing work-relatedness of conditions and in adjudicating individual claims can also affect reporting. WSIB schedules are developed based on available science and research, which empirically shows that a particular condition is associated with a particular industry or job. Problems arise when new science suggests that the old science is inaccurate or unfounded. Participants noted that although the work-relatedness of some conditions has become unclear, the Board continues to recognize and accept claims for them. On the other hand, as this participant explained, claims for conditions that haven't been scientifically shown to be work-related, are usually denied:

> *…there are things that we allow, that we should not be allowing, and then there are things we don't know enough about, so we end up denying them. So, for example, allowing (a condition as work-related), when the research says no, yet we readily allow them. Yet something else will come in that we, the literature hasn't caught up with yet, and we deny them.* (WSIB)

3.3.1.4. Balancing conflicting responsibilities

Another structural factor impinging on reporting may reflect competing demands and responsibilities of the WSIB. As this participant explains, 'shaking the tree' to increase reporting may not be a priority interest to the WSIB compared to addressing already existing burden of claims in the system.

> *… we could shake the tree. I'm sure that we would bring out a lot of claims. But there's some indecision…I think there's a preference that this come from the community end, rather than that we be seen to go out there. … You know, we'll gladly set out what the rules are, what we compensate, what we don't compensate. We have policies…that are open and declarative. But as far as our reaching out and grabbing in the claims…that's the tension…And then there's a workload issue…so you're always vulnerable to having these en mass submissions of clusters... So that becomes very difficult to juggle.* (WSIB)

At the same time, it was noted that the WSIB has devoted a lot of effort and resources to prevention and outreach campaigns. Yet, employers, to whom the WSIB is also accountable, might view efforts to increase reporting as "shopping for claims", as this participant put it:

> *But do we sit around and think about reporting? No… we react to the claims that we get. And we'll often get a claim for something, like a mesothelioma and we'll be able to draw a link to a specific firm through our inquiries. But do we then go back and search that firm to see if we've ever had claims for other workers from that firm? Sometimes you might out of curiosity. But you might not. We do not go out and…and we have to balance the employers concerns as well, because we can't be sort of seen as shopping around for claims…*(WSIB)

The potential financial impact of increased reporting was also noted.

> *…If we have a new accepted claim, for (condition) and we've been able to establish the exposure or whatever it may be… if that employer is still in business, that they go through their records...that would be one thing. But that would probably bankrupt us.* (WSIB)

In contrast to this dynamic, an employer representative referred to a "conflict of interest" confronting the WSIB: successful prevention means fewer injuries and illnesses and a correspondingly lesser need for staff and budget. These various perspectives point to the tension between reporting, organizational capacity, and the implications of identifying the actual burden of (unreported) injury and illness.

3.3.1.5. Education, prevention and outreach

In addition to the myriad of structural and systemic factors within the WSIB, which are believed to contribute to under-reporting, the WSIB is also seen as playing a positive role in reporting through its prevention, education and outreach. Participants spoke about the WSIB's intensified prevention and education initiatives, which include posters for workplaces, training sessions and training material for workplaces, outreach efforts at workplaces and in-take clinics to increase reporting, and efforts to educate health care providers about occupational health issues and the appropriate questions they should ask patients. These participants perceive the WSIB education and outreach efforts to be effective in encouraging reporting:

A *Tomorrow night we're going up to Barrie and we're putting on a workshop… or maybe registering employers. And part of the messaging is around reporting your accidents and reporting illnesses.*

B *And outreaches we do as well. (We) go out and meet employers just to sort of see what their business is about. We've done a couple of condos now, where we've actually walked around to see how they actually conduct their business, and what's going on …discover how we can actually help them with reporting…* (WSIB)

3.3.2. Structural determinants: employer-related

In addition to structural factors associated with the WSIB which affect reporting, participants identified a number of organizational and structural factors affecting reporting that are related to the employer. Participants linked reporting to employers' ability to remain in an underground economy and employers' financial incentives.

3.3.2.1. Unregistered employers

While all businesses covered by the Workplace Safety and Insurance Act that employ workers are required by law to register with the WSIB, our participants told us that many employers do not, in fact, register. These unregistered employers belong to what is called the 'underground economy', where they do not get inspected, are not held accountable for the rates of injury and disease in their workplace, and are not subject to fluctuating insurance premiums, surcharges or rebates. These employers do not report to anyone, which includes not reporting workplace injury and illness to the WSIB. Further, it is reasoned, these employers may try to manage incidents 'in-house' and to pressure their employees to not report their injuries or illnesses.

3.3.2.2. Financial (dis) incentives

Employers were widely seen by the various stakeholders as primarily interested in making a profit and keeping employee and insurance costs down. Employers who are registered with the WSIB pay insurance premiums, which are calculated based on their industry and safety record. Industries, which are associated with more injuries and diseases, such as construction and manufacturing, tend to have higher insurance premiums. It is believed that employers in these industries are especially interested in keeping injury and disease rates down to maintain the lowest insurance cost possible. Participants noted that one way to keep rates down is not to report them. As this participant notes, these employers are motivated to discourage reporting:

…employers in some (industries) pay on average very large premium rates, in comparison to some of the other industries. So, you know some …people are paying…over 10 percent of what they pay to their workers. In other industries, it may be you know in the under… one or two percent. But certainly won't be near the, the rates in the (high risk) industry, and, because your rates are impacted by your… accident frequency, and the cost for the accidents, there's more of an incentive not to have them, or if you're having them, not to report them. (WSIB)

In trying to keep injury and disease rates, and ultimately, their costs, low, employers try to manage problems in-house by offering to pay for first aid or medical care. As this worker representative explains, employers will also offer workers other forms of benefits or pay:

> *A ...employers will try and put the workers on insurance plans. Like short term disability plan, versus compensation…*
> *B Which… leads into the reasons for it… the experience rating…*
> *A It's, into the experience. But they will… or pay them to stay home…*(WRep)

This participant noted that, in addition to having higher insurance costs, having high injury and illness rates can also affect employers' ability, in certain industries at least, to do business:

> *What comes into play a lot of times in bidding on jobs, is… your accident rating…like how many accidents you've had, and the costs associated with it… It's a factor when they're bidding on work, and they may be excluded on that basis, from any sort of competition on a large job…*(WSIB)

It was noted that employers can increase reporting by assessing their workplaces for potential hazards and risks. Employers, however, who are commonly perceived as being most interested in 'the bottom line,' were reported to not want to assess for hazards or document their liability. One participant said that employers are only concerned with hazards that could end up costing them money. *"It's a reactive system', said one employer participant:* only if the Board produces a list of hazards and conditions with established causes and effects, which might affect them, will employers deal with the situation and seek a workplace assessment;

Employers, then, with their focus on keeping their insurance and production-related costs low were generally perceived as playing a significant role in both the under-recognition and under-reporting of work-related injury and disease. Given the existing structure of the WSIB's reporting system, which unintentionally discourages reporting by penalizing employers with bad safety records and which faces challenges in enforcing mandatory registration of employers with the Board, some employers are both able and motivated to impede the reporting of work-related injuries and diseases in their workplaces.

3.3.3. Structural determinants: health care provider-related

As with employers, structural factors associated with health care providers can affect reporting. Participants believed that reporting to a health care provider was extremely important for workers to have a successful claim and said,

> *"it starts the ball rolling…the claim being established. The doctor has the responsibility to notify the WSIB, and it forces other things to happen*". (WSIB)

This statement, while it emphasizes the value of health care providers in the reporting of occupational conditions, is incorrect and reflects stakeholders' confusion around the role and

responsibility of health care providers. Health care providers may initiate a claim on their patient's behalf, and they are obligated to provide information to the WSIB concerning their patient's claim-related injury or illness.

While the employer-related structural factors affecting reporting are mainly financial, structural factors related to health care providers include continuity of care, communication between stakeholders and professional incentives and constraints.

3.3.3.1. Continuity of care

It was asserted that doctors who know or ask about their patients' work lives – such as family doctors - are more likely to recognize work-related conditions. A shortage of regular family doctors in many areas, however, forces workers to visit walk-in clinics to seek treatment for their work-related condition where the doctors tend to focus on the immediate problem and often do not address causal issues. In such environments there is no continuity of care so physicians are less likely to know the patients' work histories. This participant suggested that many doctors do not want to get into the patients' histories:

> *Our health care system is in such a state, that a lot of people don't have family doctors… A lot of people work in a walk-in clinic cause they don't want to deal with a person, day in, day out, so they don't want to get into the nitty gritty, it's like, "let me fix why you're here, and I don't want to hear about the rest of this"…When he goes back next week, it'll be a different doctor again.* (WSIB)

Because occupational conditions often require multiple physician visits, documentation of work history and medical examinations in order to be diagnosed, the shortage of family physicians and the subsequent lack of continuous health care experienced by injured and ill workers was believed to decrease the likelihood of occupational conditions getting recognized and reported.

3.3.3.2. Inadequate communication

The complex reporting process, which involves the exchange of WSIB forms and information related to the worker's condition between health care providers and WSIB adjudicators, was seen as impeding reporting. A lack of, or poor quality communication between the health care provider and adjudicator appears to create delays and may reduce the success of claims. One health care provider said they waste too much time searching for information, which they need in order to issue return-to-work recommendations:

> *What am I going to do now, because I've identified that occasionally there's this disconnect of... people coming to return to work, I don't know what type of claim they have, necessarily, or if they have a claim. I have an idea that they have a work-related injury, I have no idea what the Board did with that. So anyway, I find myself struggling with that…to get the proper information.* (HCP)

If inadequate communication between health care providers and WSIB adjudicators leads to fewer successful claims, fewer injured and ill workers may believe their own claim will be accepted and, as a result, may be deterred from filing a claim. Furthermore, the difficulties that some health care providers have with the WSIB may encourage them to avoid occupational health cases.

3.3.3.3. Professional incentives and constraints

Health care providers may under-report as a result of job constraints such as a lack of time or insufficient information. A recent increase in reporting by emergency physicians was believed to be a result of the financial incentive paid by the WSIB to health care providers who complete Form 8.

> *A* *... they're taking initiative whereas before, the doctors wouldn't… Most of the time now I'm finding it's…as soon as they mention work…the hospitals are sending in the form 8. It's not even the emerg report, it's the actual form 8 that they complete…*
> *B* *We pay sixty bucks or whatever …We pay more than what they get from OHIP.*
> *A* *Yeah, maybe that's it…*(WSIB).

Recognizing such constraints for physicians, and the time and effort required to do WSIB claims work, one participant suggested the possible advantages of better remuneration:

> *…Because sometimes it's missed or sometimes the doctor's don't probe enough and ask the questions enough. And sometimes they don't give us…the information that we're looking for. So, maybe…more communication with the doctors, making them understand, exactly what we're looking for, getting them to probe a little further, and…maybe even rewarding them more for doing it.* (WSIB)

In the case of some symptoms, which are not visible and cannot be assessed via medical tests (e.g. pain), it was noted that doctors can only make a diagnosis or complete a report based on the information the worker provides which may be incomplete or insufficient. Similarly, doctors can only know which tests to run based on the preliminary information their patient gives them. As some participants noted, this can be problematic since some workers may assume doctors know enough and thus don't tell them all relevant information:

> *On the other hand you have, the worker who sits on the other side, and especially older workers, I think may be more intimidated of that you know professional designation… and may not say things that...they think, well it's so obvious they're not going to say this to the doctor ... he'll or she'll know. So… it's not a good two-way communication. And that may be contributing to the unintentional under-reporting.* (WSIB)

3.3.4. Structural determinants: worker-related

Participants linked workers' desire and/or ability to report to two key structural determinants: financial disincentives and job context.

3.3.4.1. Financial disincentives

The economic context in which workers live and work can play a significant role in their decision to report. Immigrant workers, who may be in the country illegally, belong to what is known as the "informal economy" – which is associated with no payment of taxes, poor (or no) benefits and poor job security. These workers fear that reporting an injury or disease would result in job loss and difficulty in securing a new job and, thus, may to be reluctant to report.

A worker's geographic location can also limit workers' job alternatives and job security, especially for workers living in remote, single-industry communities. This participant explains that, in the absence of job alternatives, workers may be reluctant to report:

> *...geographic location plays a role…what's happening economically within various areas. I can think of a number of examples where people weren't reporting partly because they didn't know that the exposures they had were not good for them, but also that was the only employer in town. So to report, meant that those who were relatively uneducated cause they were labour based jobs, wouldn't have a job.* (HCP)

Some participants perceived that the workplace benefit structure provides financial incentive for workers to take advantage of the compensation system and 'over-report.' Many employers allow workers to accrue sick days and later use them as vacation time. As this participant's example illustrates, workers may file claims with the WSIB for conditions that are not work-related in order to access compensation without depleting the benefits they earned:

> *...another thing that may influence reporting would be the benefit structure ... people have attendance credits, they want to keep their tenure. So you have reporting like ... I've got so many little examples, (worker) turned "good morning" to a co-worker… and then had 'a pain in my neck' ...Got some pain and they may or may not you know where from…They'd rather report it to the WSIB than have them taken from their sick bank.* (HCP)

3.3.4.2. Job context

A number of job-related factors, which appear to affect whether workers report an occupational injury or disease, include the size of their workplace, their union status, and their seniority on the job. Participants said workers in small workplaces are less likely to report because it is difficult to hide and "everyone is looking at you". Small workplaces tend to employ more immigrants and have more non-unionized employees than do larger ones. Such workers are likely to have low seniority, have less job security and protection from employer retaliation, and have little access to occupational health and safety training and support – all of which is likely to reduce the reporting of work-related injury and illness.

3.3.5. Structural determinants: worker representative-related

Worker representatives are believed to raise levels of reporting because of their role in helping injured and sick workers recognize and report work-related conditions, and navigate the compensation process. However, it was noted that representatives are limited in how much they can do by a lack of resources.

> *...we don't have the resources to actually follow up on this the way it has to be followed up on. So people file claims, or people know about it and they file claims and you can't actually represent them effectively. So what have you accomplished? And then when people aren't winning claims, other people aren't going to file claims. Uh, so that's a big problem.* (WRep)

The lack of adequate support and representation for workers who are trying to find their way through the compensation system is believed to reduce the likelihood that workers' claims will be accepted, and thereby reduce workers' individual and collective sense that the system can help them, and undermine incentive to report problems in the future.

3.3.6. Structural determinants: system-related

A number of the structural factors that were identified reflect broader factors affecting reporting that are not related to any single stakeholder group. In many cases, these broader factors shape the reporting-related understandings and behavior of all the stakeholder groups and the system within which they operate. These determinants include: stigma associated with the discourse of system abuse, and the general structure of the disability insurance system.

3.3.6.1. Stigma and the discourse of abuse

Injured and ill workers are subject to a prevailing "discourse of abuse"[3] (18) that implies they may be 'misusing' compensation by filing claims with the WSIB for conditions that are not work-related or that are exaggerated or falsely presented. The discourse contributes to profound negative imputations attached to being an injured worker and a compensation claimant. Out of fear of being suspected of malingering or of taking advantage of 'easy money', many workers are reluctant to report their condition. They referred numerous times to their need for a diagnosis or proof of their condition as well as their fear of being "laughed off". They perceived a physician diagnosis as very important to proving the legitimacy of their condition,

[3] A concept generated by Eakin, MacEachen and Clarke in their study of return-to-work in small workplaces (2003). Discourse is a shared way of talking, thinking and acting about a particular topic, which is exhibited in everyday behaviour, institutional texts and public images. Eakin et al. found that the injured workers in their study perceived continuous scrutiny about the legitimacy of their injuries and their entitlement to compensation and time away from work. This 'discourse of abuse' was found to influence how injured workers responded to their condition and their return to work.

> *I finally got the doctor to diagnose me…That's where I was actually recognized finally and I thought, oh there, my boss can't say anything now.* (Worker)

The same worker reported feeling that their concerns and symptoms wouldn't be taken seriously by their employer:

> *…that's why I wanted to get proof too…that it's something… if there was the chemicals I wanted to get proof so they just couldn't…laugh me off.* (Worker)

The stigma associated with work injury and compensation has been widely noted in the literature, and was echoed also in our data.

3.3.6.2. General structure of disability insurance system

In the current system, disability that results from work injury or disease is handled separately from other types of disability and is not part of general disability insurance. This means that determining work-relatedness is central to the workers' compensation process; the connection between injury or disease and work is paramount to the awarding and, even the initiation of, a compensation claim. Under-reporting is likely to happen when this connection is difficult or impossible to make. For this reason, workers, health care providers, adjudicators and, sometimes, employers, devote a great of deal time and effort in the reporting process to establishing a link between the injury or disease and work. Participants noted that all of these stakeholders may question whether workers' symptoms are due to work or to non work factors such as recreational activity, normal aging, and so on:

> *I think there's also a challenge for some of the, the muskuloskeletal domain, what truly is work-related and what isn't. And how much is. And I think what we're seeing now is, how much is work related and how much is due to just usual recreational activities... or aging.* (HCP)

The need to establish that a health problem is attributable specifically to work is the source of much difficulty and conflict in the workers' compensation system. A universal insurance system, which assesses and compensates workers for their disability, regardless of its work-relatedness, allows the system to shift much of the effort and resources, which are currently devoted to establishing an occupational connection, to treatment, compensation and return-to-work initiatives. This participant described a universal system in Holland:

> *…whether it's from work or whatever, the employer pays for two years, it doesn't matter what…So they don't worry about causation. His job (Dutch physician) actually is to assess disability. That was his job… whether this person can work, or cannot work…* (HCP)

The general structure of the existing workers' compensation insurance system, which emphasizes a work-related connection as it only compensates work-related conditions, is the overarching framework for the context in which the reporting process plays out. For this reason, all of the

stakeholder groups are often primarily focused on attributing the worker's injury or disease to his or her workplace. Workers who cannot clearly make a link between their symptoms and work, then, may be less likely to receive insurance benefits, regardless of the extent of their disability. Those workers who know how the system is structured may be reluctant to report.

CONCLUSIONS

This project sought information related to five areas we had identified as necessary prerequisites to further research. We wanted to: 1) differentiate and elaborate the concepts used in this area of research; 2) develop the appropriate language and taxonomies for further investigation of the topic; 3) identify new determinants of under-recognition and under-reporting; 4) identify a fuller range of units of analysis that are relevant and appropriate; and 5) gain a better understanding of the socio-politics of doing this kind of research involving these various groups. Once the focus group data were analyzed, it was determined that much of the data pertaining to these five information goals overlapped and the project's findings could be organized into three main categories: 1) clarification of concepts, 2) identification of new units of analysis (specifically stakeholder location), and 3) identification of new determinants of reporting.

An examination of the core concepts used in the literature on reporting revealed that a relatively small number of terms are used by stakeholders to refer to numerous conceptions and notions related to recognition and reporting. The term 'reporting', for example, referred to incident reporting, informing the authorities and filing a compensation claim. While the term 'recognition' was used less often, the notion of recognition as we were using it (the acknowledgement, knowledge or understanding of heath risks or problems) was acknowledged in a number of ways. 'Recognition' was conceived as establishing work-relatedness, acknowledging risk in the workplace and deeming a condition reportable. Data also revealed multiple understandings associated with the term 'over-reporting.' While this term is rarely considered in the literature, it was regularly used by stakeholders in reference to various phenomena including: the misuse of the compensation system, precautionary reporting in case of future problems, awareness-related influx of claims, denied claims and reporting which exceeds institutional norms. A final finding emerging from the analysis of core concepts, was the significant differences between 'disease' and 'injury', which have important implications for recognition and reporting. Disease was considered different from injury in terms of the clarity of work-relatedness, the implications for claimants, and the perceived legitimacy of workers' complaints by the WSIB.

The second main finding of this study relates to units of analysis and, specifically, to the significance of stakeholder location. Through the course of organizing and conducting focus groups, it became apparent that stakeholders' location (their role and position in the occupational health system, whom they are accountable to, their professional orientation and commitments) was central to their perspectives, more so than the type of stakeholder group to which they belonged. Participants' understanding of reporting and recognition – who they identify as key players, what they see as determinants - appears to be shaped by their organizational, professional and employment 'location' and the associated relationship to workers, employers and the WSIB.

Finally, the data informed our examination of the determinants of reporting. Three categories of factors were identified: 1) determinants related to psycho-social practices; 2) determinants related to workplace culture; and 3) determinants related to structural and systemic factors.

The data suggested that the psycho-social practices of workers and health care providers are factors influencing recognition and reporting. Participants proposed, for example, that workers' perceptions of the seriousness of their condition, their awareness of the potential hazards and conditions in their workplace as well as their knowledge of the WSIB process plays a significant role in their decision and ability to recognize and report a work-related injury or illness. Also considered relevant were health care provider-related psycho-social factors, such as their knowledge of and ability to diagnose occupational health conditions, their understanding of their role in the occupational health system and their perception of the legitimacy of patients' complaints.

A number of factors related to workplace culture also emerged as having an influence on the recognition and reporting of occupational injury and disease. Stigma and social norms, employer pressure and fear of reprisal can deter workers from reporting a work-related condition, while education and support within the workplace, from peers, management and unions, was believed to increase reporting.

Many determinants of reporting identified in the data are organizational and 'structural' in nature. Some structural determinants are linked to the stakeholder group, while other more system-related determinants, run across the various stakeholder groups. Structural factors within the WSIB which appear to influence recognition and reporting include the content and format of its reporting forms, the Board's information requirements for claimants, scientific and policy tensions at the WSIB, and the Board's conflicting responsibilities. Structural determinants of recognition and reporting that are related to employer factors include the existence of unregistered employers and financial incentives for employers to not report work-related conditions or to discourage reporting on the part of workers. Structural factors related to health care providers that were believed to negatively affect reporting include a lack of continuous care provided by regular family doctors, a lack of communication between health care providers and the WSIB, as well as providers' professional incentives and constraints. The structural factors that were linked to workers' decision and/or ability to report were workers' financial incentives (availability of job alternatives, advantages of receiving benefits from the WSIB versus their employer) and workers' job contexts (workplace size, union status and seniority). The existence of worker representatives and the help and education they offer to workers was considered a structural factor that improves reporting, although it was also noted that such support is generally constrained by resource limitations. Finally, determinants which affect reporting but which are not so directly linked to any particular stakeholder group include the system/society-wide "discourse of abuse,", and the structure of the workers' compensation system, particularly its dependence on the determination of work-relatedness.

CONTRIBUTION OF THIS RESEARCH TO OCCUPATIONAL HEALTH AND SAFETY

The findings presented above will contribute to the development of research on this important topic in the field of occupational health and safety. They have also, themselves, enhanced our understanding of recognition and reporting. The development of the core concepts used in the reporting literature and by the various stakeholders, for instance, revealed important distinctions and heterogeneity in the way the terms are used and understood. Furthermore, the analysis of determinants of reporting offered interesting possibilities for explaining the how and why of recognition and reporting.

1. Untangling some concepts

An important contribution of this project is its analysis and development of key terms and concepts. To date, the numerous referents and connotations associated with widely-used notions in this field of investigation have not been acknowledged, or explored. Reporting as "claims filing," for example, is quite a different idea than is reporting as "incident recording". It is important to clearly distinguish between the two connotations because different factors will be relevant for each when trying to better understand or improve reporting. If 'reporting' refers specifically to submitting a claim with the WSIB, for example, then health care professionals and the WSIB will be important determinants. Other factors, such as whether the employer is registered with the WSIB and whether the employer has a good experience rating would also be important. These factors would be less relevant, however, if reporting were conceptualized or operationalized as "incident counting."

Noting the conceptual distinction between the terms 'illness' and 'disease' also has significance. Clearly the terms should not be used interchangeably as they can signify quite different things to different people. For example, the notion of 'illness' can refer to individuals' experience of symptoms, pain, bodily abnormality and dysfunction, which may or may not coincide with 'disease', a classificatory medical label assigned to various clusters or patterns of signs and symptoms. Acknowledging this conceptual distinction is necessary to the proper investigation of reporting issues.

It seemed evident to us throughout this project that conceptually and organizationally the occupational health system is primarily oriented to injury as opposed to disease, and that this orientation shapes the context in which recognition and reporting occur. For example, the reporting process is conceived and designed with injury in mind, and normative behavioural expectations align accordingly (an 'injured worker' model). Such expectations, however, do not always 'work' in the case of occupational disease and illness, and can compromise the willingness and ability of workers (indeed all stakeholders) to recognize and report work-related risks and harms, and may even make workers more vulnerable to suspicion and its associated stigma.

2. Broadening the notion of what influences recognition and reporting

While the study unearthed many of the 'usual suspects' in accounting for what determines recognition and reporting, some new and under acknowledged issues also emerged.

The observation that the WSIB has to balance conflicting accountabilities, and that this influences perspectives on reporting, is a new dimension of the topic. The WSIB's commitment to reducing the prevalence and burden of work-related disease and injury directs it to educate workers about work-related hazards and resulting injuries and diseases and this may increase claims. At the same time, the WSIB has fiscal responsibilities institutionally and must manage the bureaucratic and administrative challenges associated with a large and complex organization. Increasing reporting has implications in terms of staffing, administrative process, costs and may influence institutional perspectives on the 'problem' of reporting.

The WSIB does not appear to be alone in its efforts to balance competing issues. Health care providers, worker representatives and employers, for instance, also encounter parallel conflicts between uncovering new burden and handling existing burden within the current system. The whole system seems to be operating under 'lids' where 'raising the lid' for one group will affect all other groups. For example, as noted earlier, worker representatives aim to educate and support workers as they navigate the reporting process. However, they, like the WSIB, are limited in the amount of cases and claims they can process. Any activity which increases claiming by workers will impact worker representatives' workloads and resources just as it will also affect the Board's and health care providers' workloads.

IMPLICATIONS FOR FUTURE RESEARCH

One important issue underscored by this research is the observation that there is not just one singular 'problem' of under-reporting. What the 'problem' is varies according to the stakeholder and institutional relationship to reporting, the matter of *positionality*. Future research and action in this area will have to contend with this important political point. Indeed future research should further investigate the very political nature of reporting – with so many different and competing stakes in reporting, how are we to understand its nature and determinants and issues of change? How is power implicated in the issue of reporting and whose stakes get prioritized in responses to the claim that the actual burden of occupational harm is not being recognized and addressed? What kind of change can be expected as a consequence of the political landscape surrounding the issue of recognizing and reporting injury and ill-health caused by work?

At the level of individual practices, research issues abound. One interesting possibility for future exploration is the role of WSIB forms and polices in reporting practices. In the present study stakeholders noted the effects of the structure of forms on reporting (e.g. insufficient space to fill in necessary information), the nature of the information required (e.g. some requests irrelevant to disease, such as date of incident), impediments to completing and submitting the form quickly (e.g. inability to access, complete and submit the forms online). While procedural language associated with the compensation process has been documented in the return–to-work literature as a determinant of successful rehabilitation[19], a particular focus on the Board's forms, has received relatively little attention in the reporting literature. Research related to the form and content of the textual technologies for collecting information and initiating claims would seem called for. Some elements of a research methodology designed to reveal the function and governing qualities of institutional documents/texts (called 'institutional ethnography'[20]) offers promise for further investigation of this important mediator of reporting in the field of occupational health.

At the level of methodology, the project also has something to say to future research, drawing on our experience with focus group methods and the need to engage the participation of the broad range of participants with a stake in reporting issues. Employers were extremely difficult to recruit. There may also be differences within various groups. Do individuals who work as consultants for employers represent the employer perspective? The recruitment of workers can also be challenging. There are important differences between different groups of workers, and between injured workers with experience in the compensation process and those who have not had such experiences. There is some suggestion from this project that individual interviews might be more appropriate for workers who may have stigma and confidentiality concerns.

At a more theoretical/methodological level, the project has relevance to future research that wishes to focus on the structural, system-level dimensions of behavioural practices around reporting. We found generally that participants in our focus groups were ideally suited to talk about reporting in relation to their own position/role within the system. Although they sometimes mentioned important structural pre-conditions of reporting, they were not themselves generally aware of or articulate about the nature of such forces. This reminds researchers that understanding the structural embeddedness of reporting practices is an analytic task of the

researchers, and cannot be expected to emerge on its own from the data. That also applies to most other dimensions of reporting that our participants spoke about: what people think, say and do about reporting is itself *situated knowledge and action*, that is, how they see the issues, and the stakes that they reveal that they have in them are themselves data that then must be conceptualized and theorized in some way separately from the substantive data.

Future research on reporting must treat the input of stakeholders as data themselves rather than as unproblematic objective knowledge on the topic that can be taken at face value. It is precisely the situational content of their perspectives, the interplay of political and professional interests around the issue of reporting that is possibly its most significant 'determinant'. Thus, understanding the place and function of reporting in the context of the occupational health system as a whole is essential to grasping what will be needed for different types of change, for different players.

DISSEMINATION

There will be several methods of dissemination. Members of the Steering Committee will receive the final report and a further meeting of the Steering Committee may be held to further explore the findings, their implications and opportunities for further work.

A summary of the work will be provided to each of the participants. Presentations will also be arranged both for participants in the study if they wish and also with occupational health and safety stakeholder and professional audiences. The results will be written up for publication.

REFERENCES

1. Jefferson JR, McGrath PJ. Back pain and peripheral joint pain in an industrial setting. Arch Phys Med Rehabil 1996;77:385-390

2. Weddle M. Reporting occupational injuries: the first step. J Safety Res 1996;27:217-223.

3. Higgs P, Young VL, Seaton M, Edwards D, Feely C. Upper extremity impairment in workers' performing repetitive tasks. Plast Reconstr Surg 1992;90:614-620.

4. Silverstein BA, Stetson DS, Keyserling WM, Fine LJ. . Work-related musculoskeletal disorders: comparison of data sources for surveillance. Am J Ind Med 1997;31:600-608.

5. Gupta A, Rosenman KD. Hypersensitivity Pneumonitis Due to Metal Working Fluids: Sporadic or Under Reported? Am J Ind Med 2006;9:423-433.

6. Shannon HS, Lowe GS. How many injured workers do not file claims for workers' compensation benefits? Am J Ind Med 2002;42:467-473.

7. Rosenman KD, Gardiner JC, Wang J, et al. Why most workers with occupational repetitive trauma do not file for workers' compensation. J Occup Environ Med 2000;42:25-32.

8. Biddle J Roberts K, Rosenman KD, Welch EM. What percentage of workers with work-related illnesses receive workers' compensation benefits? J Occup Environ Med 1998;40:325-331.

9. Morse T, Dillon C, Weber J, Warren N, Bruneau H, Fu R.. Prevalence and reporting of occupational illness by company size: population trends and regulatory implications. Am J Ind Med 2004;45:361-370.

10. Scott DF, Grayson RL, Metz EA. Disease and illness in US mining, 1983-2003. J Occup Environ Med 2004;46:1272-1277.

11. Halperin, W. and Baker, E. Public Health Surveillance. New York: Van Nostrand Reinhold, 1992.

12. Pransky G, Snyder T, Dembe A, Himmelstein J. Under-reporting of work-related disorders in the workplace: a case study and review of the literature. Ergonomics 1999;42:171-182.

13. Webb GR, Redman S, Wilkinson C, Sanson-Fisher RW. Filtering effects in reporting work injuries. Accid Anal Prev 1989;21:115-123.

14. Azaroff LS, Levenstein C, Egman DH. Occupational injury and illness surveillance: conceptual filters explain underreporting. Am J Public Health 2002;92:1421;1429.

15. Kuzel A. Sampling in qualitative inquiry. In Crabtree, B., Miller, W., eds. Doing qualitative research (2nd Ed.). Thousand Oaks: Sage, 1999.

16. Patton, M. Qualitative Research and Evaluation Methods. Thousand Oaks: Sage, 2002.

17. Barbour, R. and Kitzinger, J. Developing Focus Group Research London: Sage, 1999.

18. Eakin, J. and MacEachen, E., & Clarke, J. (2003). 'Playing it smart' with return to work: Small workplace experience under Ontario's policy of self-reliance and early return. Policy and Practice in Health and Safety 2003;1(2):19-40.

19. Roberts-yates, C. (2003). The concerns and issues of injured workers in relation to claims/injury management and rehabilitation: the need for new operational frameworks. Disability and Rehabilitation 2003:25(16):898-907.

20. Devault, M. (2006). Introduction: What is Institutional Ethnography? Social Problems 2006;53(3):294-298.

APPENDIX 1

FOCUS GROUP PROBES

The Reporting and Recognition of Occupational Illness

Question Guide for Focus Groups

WSIB

1. Can you tell everyone your name and what you do? (for director's group ask what area they represent)

2. When we talk about 'reporting' of occupational injury and illness, what comes to your mind?
    a. Do you feel it is under or over reported? (if not mentioned in response to #2)
    b. Where does recognition fit in (if not mentioned in response to #2)

3. How does reporting matter to you? Does it have any implications for you in doing your job?

4. Who and what influences reporting of occupational injury and illness?
    a. How does WSIB – its policy and practices, how it operates - affect the reporting of occupational injury and illness?

If not already discussed, ask question #5:

5. One might think reporting is different for injury than it is for illness. Do you agree? Why/why not?

6. Is there any move that WSIB could make that would change the nature or patterns of reporting? (for better or worse)

7. Is there anything else you might like to add that you think is important in understanding this issue?

8. Since we are interested in doing more research in this area in the future, it is helpful to learn how best to do this. So we would like to ask you to reflect on your participation – Did (or do) you have any concerns about participating in this group? Are there topics that inhibited you or might inhibit future respondents from being open or at ease?

All other groups

1. Can you tell everyone your name and what you do?

2. When we talk about 'reporting' of occupational injury and illness, what comes to your mind?
    a. Do you feel it is under or over reported? (if not mentioned in response to #2)
    b. Where does recognition fit in (if not mentioned in response to #2)

3. How does reporting matter to you? Does it have any implications for you in doing your job?

4. Who and what influences reporting of occupational injury and illness?
    c. How do XXs affect the reporting of occupational injury and illness?

If not already discussed, ask question #5:

5. One might think reporting is different for injury than it is for illness. Do you agree? Why/why not?

6. If one thing could be changed that would make reporting work better what would it be?

7. Is there anything else you might like to add that you think is important in understanding this issue?

8. Since we are interested in doing more research in this area in the future, it is helpful to learn how best to do this. So we would like to ask you to reflect on your participation – Did (or do) you have any concerns about participating in this group? Are there topics that inhibited you or might inhibit future respondents from being open or at ease?