Disability Expenditures in Canada, 1970-1996: Trends, Reform Efforts and a Path for the Future

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This paper reviews the programs — both public and private — that comprise the safety net for disabled persons in Canada. The paper has several objectives. First, we describe the trends in program expenditures in Canada between 1970 and 1996. Second, we discuss the plausible explanations for these trends and, where possible, the empirical evidence that establishes the relative importance of these explanations. Third, we discuss reform efforts implemented in the 1990s which seek to secure the financial viability of these programs. Finally, we discuss the need for additional program coordination and benefit integration in this system. If the support system for disabled persons in Canada is to move toward a more harmonized system in the future, it will be essential that these programs are examined and, if necessary, reformed as a single system rather than as separate or separable systems.
INTRODUCTION

Canada has an extensive array of programs available for the support of disabled persons. These programs are provided by federal and provincial governments as well as private insurers. Disabled persons rely on these programs for one or more types of services: income replacement or income support, medical rehabilitation, and vocational rehabilitation.1 The programs that offer income support include the provincial workers’ compensation boards, the Canada/Quebec Pension Plan disability program, Employment Insurance sickness benefits program, private disability insurance policies, the Veteran and Civilian disability pension program and provincial welfare programs. Workers’ compensation boards, in addition to providing income support, also pay for the medical rehabilitation and vocational rehabilitation of eligible beneficiaries. The federal and provincial governments also pay for some vocational rehabilitation through the cost-shared Vocational Rehabilitation of Disabled Persons program.

These programs have, for the most part, experienced large growth rates in their expenditures over the past three decades. Chaykowski and Thomason (1995) provide an example of the magnitude of the expenditure increases facing workers’ compensation boards: whereas workers’ compensation benefits were 0.60 percent of the wages and compensation component of Canada’s gross domestic product (GDP) in 1960, by 1991 this share had risen to 1.26 percent. Another example can be drawn from the disability pensions paid for by the Canada and Quebec Pension Plans. In 1970 these two programs paid just under $17 million (in constant 1996 dollars) in benefits; by 1994 expenditures had risen to $3,121.1 million dollars.

This paper has several objectives: first, we describe the trends in program expenditures in Canada between 1970 and 1996. Second, we discuss the plausible explanations for these trends and, where possible, the empirical evidence supporting these explanations. Third, we discuss reform efforts implemented in the 1990s which seek to ensure the financial viability of these programs. Finally, we discuss the need for additional coordination or harmonization of these programs. While many of these issues have been discussed by others, no one has examined these programs as a system. In fact, if the support system for disabled persons in Canada is to move toward a harmonized system in the future, it will be essential that these programs are examined and, if necessary, reformed as a system rather than as separate pieces.

The paper will proceed as follows. In the first section we present an overview of the major programs that support persons with disabilities. In the second section, we provide a description and discuss some of the limitations of the data used in the paper. In section three, we examine trends in disability expenditures and some of the plausible explanations for the growth in these program expenditures as well as the empirical evidence, if any, concerning the relative importance of these explanations. We also describe the reform efforts that have been undertaken over the past decades in this section. We begin the discussion in the third section with the data on the number of beneficiaries and income-replacement expenditures for these programs and then turn to health care and vocational rehabilitation expenditures. In the fourth section, we discuss some of the benefits and rationales for a more harmonized disability system. In the concluding section we provide summary comments and policy recommendations.

CANADA’S DISABILITY PROGRAMS: AN OVERVIEW

Four primary programs provide most of the support for disabled persons in Canada who are members of the labour force: the provincial workers’ compensation boards (WCBs), the Canada/Quebec Pension Plan (C/QPP) disability program, the Employment Insurance (EI) sickness benefits program, and private disability insurance (PDI) programs. There are
### TABLE 1
Canadian Disability Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Source and Incidence of Payment</th>
<th>Eligibility</th>
<th>Income Replacement</th>
<th>Vocational Rehabilitation Expenditures</th>
<th>Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ Compensation Boards (WCBs)</td>
<td>employer premium set by industrial sector and by each firm’s accident record</td>
<td>disablement arising out of and in the course of employment (i.e., work accident or industrial disease)</td>
<td>replacement rate set as a proportion of gross or net pre-disablement earnings</td>
<td>all expenses paid (uptake compulsory in some jurisdictions)</td>
<td>all expenses paid</td>
</tr>
<tr>
<td>Canada/Quebec Pension Plan (C/QPP) disability pension</td>
<td>employee and employer premia, with former set as proportion of payroll and with the latter set as a proportion of gross earnings, subject to a maximum pensionable earnings limit</td>
<td>disablement, not necessarily arising out of or in the course of employment, and satisfies C/QPP eligibility requirements (which include having made contributions to C/QPP for some fixed period of time)</td>
<td>pension level set using both a flat rate portion, unrelated to previous earnings, and an earnings-related portion (subject to minimum/maximum payments); claimants with eligible children receive a supplement</td>
<td>all expenses paid (uptake at discretion of the individual)</td>
<td></td>
</tr>
<tr>
<td>Employment Insurance (EI) Sickness Benefits</td>
<td>employer and employee premia with the former set as a proportion of payroll and the latter set as a proportion of gross earnings (subject to maximum insurable limit)</td>
<td>disablement not arising out of or in the course of employment and satisfies EI eligibility requirements (which include having made contributions to EI for some fixed period of time)</td>
<td>replacement rate set as a proportion of gross pre-disablement earnings; low income claimants may qualify for a family supplement (subject to minimum/maximum payments)</td>
<td>all expenses paid (uptake at discretion of the individual)</td>
<td>-</td>
</tr>
<tr>
<td>private disability insurance</td>
<td>employer and/or employee contributions or individual contributions</td>
<td>disablement not necessarily arising in the course of employment and satisfies eligibility requirements of the plan</td>
<td>replacement rate set as a proportion of gross or net pre-disablement earnings (subject to minimum/maximum payments)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Program</th>
<th>Source and Incidence of Payment</th>
<th>Eligibility</th>
<th>Available Programs</th>
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</thead>
<tbody>
<tr>
<td>Veterans' and Civilians' Disability Pension</td>
<td>general federal tax revenue</td>
<td>veterans and civilians (or their survivors) with disability arising from a war injury</td>
<td>pension set by the extent of the disability</td>
</tr>
<tr>
<td>Vocational Rehabilitation of Disabled Persons (VRDP)</td>
<td>general federal and provincial tax revenues (a cost-shared program)</td>
<td>disablement not arising out of or in the course of employment</td>
<td>participants may be eligible for training allowances</td>
</tr>
<tr>
<td>provincial welfare</td>
<td>general provincial tax revenue, as well as some federal funds</td>
<td>disablement, not necessarily arising out of or in the course of employment and satisfies family benefits requirements</td>
<td>means tested</td>
</tr>
</tbody>
</table>

Note: Assistive devices includes items such as canes, walkers, and wheelchairs.
also three other programs that offer support for disabled persons: Veterans’ and Civilians’ Disability Pension, the federal and provincial cost-shared Vocational Rehabilitation of Disabled Persons (VRDP) program, and provincial welfare programs. We focus most of our discussion on the four primary programs, but we provide a summary of the key features of all these programs in Table 1.

**Workers’ Compensation**

The provincial WCBs are the oldest social assistance program in Canada. They are also the largest provider of support for disabled persons in Canada. A major goal of the provincial WCBs is to ensure that once an injured worker has reached the point of maximum medical rehabilitation, they can return to work at a level of earnings comparable to their pre-injury level. To achieve this goal, WCBs provide vocational rehabilitation services to individuals, which may include job placement, career counselling and other forms of training. At the same time, while a person is unable to work they receive income replacement benefits from the WCB. In 1996, the WCBs of Canada spent $4,913.9 million on income-replacement programs, medical rehabilitation, and vocational rehabilitation for individuals who experienced workplace accidents or suffered from industrial diseases.

The WCBs provide both temporary and permanent disability pensions to eligible workers. Injured workers who file a lost time claim will initially receive temporary disability benefits. If injured workers fully recover from their injuries, they will return to work. However, if they never fully recover, they may receive a permanent disability pension which compensates them for lost earnings or lost earnings capacity. Workers’ compensation benefits are paid as a percentage of gross or net pre-injury earnings, subject to minimum or maximum weekly payments, with the replacement rate for the benefits varying from province to province. These benefits are non-taxable. Most WCBs integrate their income-replacement benefits with the Canada/Quebec Pension Plan disability pensions, albeit to varying degrees. This means that if a beneficiary receives a disability pension, some or all of these benefits will be deducted from their workers’ compensation benefits, so that the value of multiple benefits is less than the sum of their individual entitlements.

The WCBs are funded by payroll contributions from insured firms. An insured firm’s premium depends on their WCB industry classification. Industries that have higher rates of workplace accidents or industrial diseases pay higher premia than industries with lower rates. An insured firm’s premium also depends on how its rate of workplace accidents or industrial diseases compares to other firms in the same industry — a practice known as experience rating (which is often directed at large firms). Experience rating shifts the burden of paying premia within an industry group to firms with poor records. This practice provides an incentive for employers to invest in workplace health and safety, although it often encourages employers to reduce their workers’ compensation costs in other ways.

**Canada/Quebec Pension Plan (C/QPP) Disability Program**

The Canada/Quebec Pension Plan (C/QPP) has paid income-replacement benefits and paid for vocational rehabilitation services since 1970 to persons suffering a prolonged mental or physical disability. Eligibility for this program depends on both the ability to be employed and the contribution requirements of the C/QPP pension plans. Current legislation requires contributions to the plan for four of the last six years or five of the last ten years. Unlike workers’ compensation, the disability does not have to be the product of a workplace accident or industrial disease. The C/QPP disability also differs from workers’ compensation in the source of its financing (both employers and employees make payroll contributions) and in its coverage of the workforce (all employed individuals in the labour force are required to make contributions, regardless of industry). Unlike workers’ compensation benefits, income-replacement benefits in the CPP disability program are comprised of several components: a fixed sum unrelated to labour market earnings; a
portion related to labour market earnings; and, for beneficiaries with eligible children, a supplement for each dependent child. Also, whereas WCB benefits are non-taxable, C/QPP disability benefits are a taxable source of income. The duration of C/QPP claims tends to be longer than WCB claims. For example, the average duration of a CPP disability claim in 1997 was six years and two months.8

**Employment Insurance (EI) Sickness Benefits**

Employment Insurance (EI) (formerly Unemployment Insurance) sickness benefits have been part of Canadian EI legislation since 1953. EI sickness benefits are available to persons who are ill, in quarantine or who have suffered a non-work-related injury, and are unable to work and satisfy the EI eligibility requirements. Eligibility for EI currently requires working a specified minimum number of hours, with the required number varying by the regional unemployment rate. This program only provides temporary income support and benefits currently last 15 weeks. This differs from workers’ compensation and C/QPP disability programs, which do not place a time limit on benefits but re-evaluate the medical status of claimants from time to time. The EI sickness benefits program provides claimants with job training, career counselling and vocational rehabilitation. Like the C/QPP, the EI sickness benefits program differs from workers’ compensation in that the cost of the program is shared between employees and employers. Income-replacement benefits are computed as a fraction of gross earnings (the current replacement rate is 55 percent) and these benefits are taxable.

**Private Disability Insurance (PDI) Programs**

Private disability insurance (PDI) programs are provided by some employers to their employees. Individuals who are not covered by their employers can also purchase individual coverage. Employer-sponsored programs can be classified as short-term (group) and long-term (group) disability, while individuals purchase income-replacement insurance. Employer-sponsored group programs are financed by premia collected from both employers and employees. The employer-sponsored and individual programs, after a specified number of days, begin to pay income-replacement benefits to the insured person when the individual is not able to work. The benefits are paid, by most insurers, as a fraction of gross pre-injury earnings, with the replacement rate varying among insurers and employers.9 As in most programs, PDI benefits are taxable. Another feature of long-term disability insurance is the dual definition of disability used to determine eligibility. In the first two years, long-term disability insurance pays income-replacement benefits if the individual is unable to pursue his or her own occupation. After the second year of disability, income-replacement benefits depend on whether the individual is able to perform any occupation.

**Other Programs**

Three other programs provide support to disabled persons in Canada: Veterans’ and Civilians’ Disability Pensions, the Vocational Rehabilitation of Disabled Persons (VRDP) program and the provincial welfare programs for disabled persons. The Department of Veterans Affairs pays a pension to disabled veterans and civilians who served in close support of the armed forces, or their survivors. These pensions are financed out of the federal government’s general tax revenues. The VRDP program pays for the vocational rehabilitation of disabled persons. It began in 1961 to help persons with disabilities obtain sustainable employment. The costs of the VRDP are shared equally between the federal and provincial governments. The VRDP pays for assessment, counselling, books, tools, restorative services, vocational training and job training, equipment, and aids and training allowances. Provincial welfare programs provide support to disabled persons, primarily in the form of income support, and also pay for aids and medical devices.

**Data**

For this paper, we draw on disability expenditure data for the period 1970-96. All data on provincial and federal programs were obtained from Human
Resources and Development Canada (HRDC). Some data were not available for the entire study period. The WCB vocational rehabilitation program expenditures were only available as a separate category from health-care expenditures as of 1987. Prior to 1987, vocational rehabilitation expenditures were included in health-care expenditures. The EI sickness benefits program has no data for 1970, the base year. The data on private disability insurance programs were collected from the Canadian Life and Health Insurance Association’s Survey of Health Insurance Benefits and are available annually from 1980 to 1996. The health insurance data include the number of individuals covered by the program but lack the number of beneficiaries receiving compensation. All program expenditures are presented in real (1996) dollars unless otherwise noted.

**RESULTS**

In this section, we present a discussion of the trends in disability expenditures and some explanations for their increases. The discussion of trends in disability expenditures will focus on five programs that provide support to disabled persons: workers’ compensation, C/QPP disability pension, EI sickness benefits, private disability insurance, and the VRDP. We discuss trends in two broad areas: (i) the number of beneficiaries and income-replacement expenditures; and (ii) health-care and vocational rehabilitation expenditures. We report the number of beneficiaries per thousand members of the labour force to adjust for the growth in the labour force.

**The Number of Beneficiaries and Income-Replacement Expenditures**

**Workers’ Compensation**

We examine the trends in the two types of workers’ compensation beneficiaries: lost-time beneficiaries (i.e., beneficiaries who receive temporary or permanent disability benefits or survivor benefits); and, medical aid-only beneficiaries (i.e., individuals who only receive health-care services from the workers’ compensation board) (see Figure 1a). Both types of beneficiaries have followed a cyclical pattern over the study period but with a decreasing trend. The number of lost-time beneficiaries per 1,000 of the labour force fell from 36 in 1970 to 25.1 in 1996. The decline in medical aid-only beneficiaries is far more pronounced, falling from 58.5 in 1970 to 26.8 in 1996. Thomason (1995) notes that these declines may be attributed to several factors: (i) the changing structure of the Canadian economy, as it has moved from the more hazardous primary industries to service provision; (ii) technological changes, particularly the introduction of more automated and safer technologies in hazardous industries; (iii) the increased use of experience rating by the WCBs of Canada; and, (iv) the changing demographic composition of the Canadian population (specifically, the increase in the median age of the Canadian population, which means that the labour force likely consists of more experienced workers who suffer fewer occupational accidents than younger, less experienced workers [Thomason and Hyatt 1997]). However, although older workers may be less likely to suffer occupational accidents, the duration of their claims may increase because older workers take longer to recuperate from occupational injuries than younger workers (ibid.). The pro-cyclical pattern of claims arises because as the economy and employment expand, so will the number of beneficiaries.

Income replacement represents the largest component of the expenditures of most disability support programs. In 1996, the WCBs of Canada paid $3,605.2 million in income-replacement benefits, including $1,906.7 million on temporary disability claims and $1,698.5 million in permanent disability and survivor benefits. The provincial WCBs have seen their expenditures on income replacement increase (in real terms) at a rate of 5.6 percent per annum between 1970 and 1996. In Figure 2, we present these expenditures for the 27 years in the study period. These increases in expenditures are somewhat surprising given the decline in the incidence of WCB claimants in the labour force. The
**Figure 1a**
Beneficiaries by Program

Note: The number of beneficiaries is reported per thousand members of the labour force.

**Figure 1b**
Persons Covered, Private Insurance

Note: The number of persons is reported per thousand members of the labour force.
increase in expenditures is even more remarkable if we examine it in terms of expenditures per beneficiary. Income-replacement expenditures per beneficiary rise from $3,318.15 per claim in 1970 to $9,481.91 per claim in 1996, a growth rate of 4.8 percent per annum during the study period.

Several explanations have been put forward to explain the increase in income-replacement expenditures. Some analysts have argued that the increase in benefit expenditures can be attributed to the increased generosity of the benefits over time. As an example of the increased generosity of WCB benefits, Chaykowski and Thomason (1995) report that the real average weekly maximum temporary disability benefit (in 1991 dollars) has risen from $290.97 in 1960 to $569.38 in 1991. In addition to this, benefit generosity affects WCB expenditures not only through its direct effects on the amount spent per claim of fixed duration but also through indirect effects on the frequency and duration of claims. For example, Fortin and Lanoie (1992,1999) report that a 10 percent increase in workers’ compensation benefits leads to a 2 to 13 percent increase in the duration of workers’ compensation claims and to a 4 to 10 percent increase in the frequency of workers’ compensation claims.\textsuperscript{12}

FIGURE 2
Benefit Expenditures

Thomason and Hyatt (1997) conducted an empirical investigation of the determinants of trends in WCB expenditures in Canada between 1961 and 1993.\textsuperscript{13} They found that the rising costs of benefit expenditures are due primarily to increased claim severity, as measured by benefit expenditures per claim (i.e., they are due to an increase in the duration of claims), rather than an increase in the incidence of workplace injuries and compensation claims. Their regression analysis reveals that more generous benefits, higher unemployment rates, and a more extensive level of union organization are the primary factors driving the increases in expenditures between 1961 and 1993.\textsuperscript{14} The results of Thomason
and Hyatt’s regression analysis are supported by Chaykowski and Thomason (1995) who argue, in their analysis of aggregate Canadian data from 1960 to 1991, that the direct effect of higher indemnity benefits is partially, although not completely, responsible for the increase in compensation costs from 1960 to 1991. These findings suggest that the increased benefit generosity of workers’ compensation benefits has contributed — both directly and indirectly — to the increase in WCB income-replacement expenditures.

The escalation of costs associated with workplace accidents and industrial diseases over the last few decades has not been offset by increases in premium revenues. These accumulated deficits are referred to as unfunded liabilities. In response to these increasing expenditures and funding problems, many of Canada’s WCBs have started reforming their workers’ compensation systems to ensure their financial viability. Some of these initiatives include: shifting the emphasis from vocational rehabilitation to encouraging return-to-work, prevention, and workplace safety (British Columbia, Ontario, and Quebec); adopting long-term funding strategies (Nova Scotia, Newfoundland, and Prince Edward Island); and establishing prudent reserves to fund accidents whose claim costs are spread out over several years (British Columbia, Manitoba, and New Brunswick).

**C/QPP Disability**

While the workers’ compensation boards have experienced an overall downward trend in the number of beneficiaries per 1,000 of the labour force, this is not the case with the C/QPP disability pension. The number of C/QPP disability beneficiaries per 1,000 of the labour force rose from 0.25 in 1970 to 22.75 in 1996, an annual growth rate of 10.9 percent (see Figure 1a). Not surprisingly, expenditures on income replacement by the C/QPP program have increased a great deal over the study period. In 1970, just under $17 million dollars in benefits was paid out by the C/QPP disability program. By 1996, benefit expenditures reached $2,954.0 million, a growth rate of 14.7 percent per annum during the study period. As shown in Figure 2, benefit expenditures in the C/QPP program increased steadily until the mid-1980s. After 1986, the total benefit payments of the CPP more than doubled. However, this masks the experience of the QPP disability program, where disability payments have not increased as dramatically.

One of the plausible explanations for the growth in the number of beneficiaries and increased benefit expenditures in the CPP disability program is the relaxation of eligibility requirements (CPP Consultations 1996), an approach that was not taken by the QPP. Some of the administrative changes that led to this relaxation of eligibility requirements include: in 1987 reducing the number of years that individuals had to contribute to the plan before becoming eligible for benefits and introducing an early retirement option (at age 60) (the QPP program had an early retirement option in place prior to 1987); in 1989 allowing non-medical factors to be taken into consideration when determining eligibility; and, in 1992 extending the start date retroactively to when a person actually became disabled rather than the date of the application. Another plausible explanation for the growth in this program may be the benefit enrichments which occurred during the study period. For example, disability benefits were increased in 1987 (the flat rate portion of the CPP disability benefit was raised by over $150 per month, a 36 percent increase, to make it comparable to the QPP level) and benefits have also been fully indexed to changes in the cost of living since 1975. The extent of the increase in generosity is especially apparent if benefits are computed per beneficiary. Real C/QPP benefits per beneficiary rose from $5,987.91 in 1975 to a peak of $9,799.82 in 1993.

In addition to these legislative changes, there were also increased referrals to the CPP disability program from provincial social assistance and private insurance programs, as well as increased public awareness of the program’s availability (CPP Consultations 1996). As well, during the 1980s, there
was also a greater emphasis on the integration of workers’ compensation benefits with C/QPP disability pensions (see Weiler 1980). Many provincial WCBs view the C/QPP disability pension benefit as a minimum floor for all workers. Therefore, these WCBs see their role as the residual insurer, making up the remaining income losses (WCB of British Columbia 1997). Each of these factors may have contributed to the increase in the number of CPP disability pension beneficiaries and program expenditures.19

To our knowledge, no empirical investigation of the factors driving the growth in CPP disability expenditures (as has been done for workers’ compensation expenditures) has been undertaken. This is due, in part, to the difficulty in collecting data on some of the plausible determinants of growth in expenditures.20 Thus, it is difficult to identify the most important factors driving program expenditures. There has also been very little study of the C/QPP disability programs’ effects on labour supply, in contrast to the literature that exists for the United States’s disability insurance program. In fact, there is a great deal of debate regarding the size of the effect of disability insurance benefits on labour force participation rates in the United States, particularly for older men. For example, Parsons (1980) found that disability insurance benefits have a large effect on labour supply decisions (a 10 percent increase in benefits ceteris paribus would lead to a 6 percent increase in non-participation). On the other hand, Haveman and Wolfe (1984) argue, as does Bound (1989), for a number of reasons, that Parsons’ results overestimate the impact of disability insurance benefits on labour force participation rates in the United States, particularly for older men. For example, Parsons (1980) found that disability insurance benefits have a large effect on labour supply decisions (a 10 percent increase in benefits ceteris paribus would lead to a 6 percent increase in non-participation). On the other hand, Haveman and Wolfe (1984) argue, as does Bound (1989), for a number of reasons, that Parsons’ results overestimate the impact of disability insurance benefits on labour force participation rates.

The existing evidence on the effect of disability pension payments on labour supply in Canada suggests that enhanced benefits and relaxed eligibility requirements have contributed to the early withdrawal of males aged 45 to 64 from the labour force. For example, Maki (1993) found a strong negative correlation between C/QPP disability benefits and labour force participation rates of males aged 45 to 64. His results indicate that the C/QPP disability benefits are responsible for 40 percent of the reduction in the males aged 45 to 64 labour force participation rates between 1975 and 1983. Gruber (1996; see also HRDC 1997) examined the effect of the 1987 increase in CPP disability pension benefits on male (aged 45 to 59) labour force participation (using micro data from the survey of Consumer Finances from 1985 to 1989). Recall that in 1987 the eligibility requirements, in terms of years of contribution to the plan, were also relaxed somewhat and an early retirement option was introduced. Gruber found that these changes were associated with a 11.5 percent increase in non-employment. The results from these papers indicate that, at the very least, the increases in benefits and relaxed eligibility criteria have contributed to the increase in the frequency of CPP disability claims and the increase in total expenditures.

All insurance programs, both public and private, are subject to moral hazard problems. This means that it is plausible that the increased generosity of C/QPP disability payments may have also led to an increase in the duration of these claims (as well as their frequency). No empirical investigation of this has been undertaken for the C/QPP disability program. The data we have collected indicate there has been an increase in both the frequency and the duration of CPP disability claims in the 1990s. For example, the average duration of CPP disability pensions increased from four years and three months in 1993 to six years and two months by 1997.21 However, without controlling for other variables, we are not able to separate out the effect of more generous benefits from other observable characteristics, such as the increased prevalence of chronic degenerative diseases (e.g., arthritis, back pain, and heart disease) (Baldwin and Johnson 1998), on the
duration of a disability pension. This remains an unresolved issue and a matter for future empirical investigation. In summary, the empirical evidence regarding the growth in CPP disability expenditures is thin, so it is difficult to make firm conclusions regarding the drivers of the program costs. However, the available evidence points to relaxed eligibility criteria and more generous benefits as contributing factors.

The dramatic increase in CPP disability and retirement program expenditures led the federal government to reform the administration and management of the disability benefits program. Some of the initiatives to reform the disability pension program that have been undertaken since 1994 include: (i) increasing employer and employee contribution rates, which will rise from 5.85 percent of contributory earnings in 1997 to 9.9 percent of contributory earnings by 2003 and then remain at that level; (ii) tightening eligibility requirements by, (a) using only medical, and not socio-economic factors, to determine eligibility; (b) requiring contributions to the CPP for four of the last six years, rather than two of the last three years, or five of the last ten years; and (c) detecting ineligible beneficiaries who are making claims to both CPP and EI (through a CPP/EI data-matching initiative); and, (iii) reducing the incidence and duration of claims by, (a) mandating the reporting of improvements in health and, if significant, mandating return to work; (b) instituting a vigorous program of reassessments to determine which individuals had sufficiently improved to make them no longer eligible for benefits; (c) allowing a trial work period of three months before benefits are terminated and allowing full-time volunteer activities or school attendance; and (d) having QPP medical adjudicators review a sample of CPP files to identify differences in decision-making and administration of claims. These reforms have helped to slow the growth in the number of beneficiaries and benefit payments made by the CPP disability program. We should also note that the funding of the CPP program was changed from a pay-as-you-go system to a fully-funded system and this may have consequences for (intergenerational) allocation and distribution (Stevens et al. 1995).

**EI Sickness Benefits**

The EI sickness benefits program has experienced a low growth rate in the number of beneficiaries between 1971 and 1996. The number of beneficiaries (per 1,000 of the labour force) has increased modestly during this period, rising from 1.54 in 1970 (reaching a peak of 3.92 in 1974) to 2.29 in 1996. For the most part, the EI sickness benefits program has not been affected by the forces that have led to an increased number of beneficiaries in the workers’ compensation and CPP disability programs. This low growth rate is most likely due to the fact that the EI sickness benefits are paid for a very short period of time, unlike the C/QPP or workers’ compensation benefits, which use medical criteria to determine the duration of benefit payments. The program does not appear to be used a great deal by CPP disability beneficiaries prior to receiving their disability pensions. For example, in 1984, 1989, and 1993 CPP disability beneficiaries collected on average between 1.3 and 1.6 weeks of benefits prior to receiving their CPP disability pension (HRDC 1996b). If this program were used as a bridge to C/QPP benefits then one would expect to see a much greater utilization of this program by C/QPP beneficiaries prior to receiving their pensions. In light of this, the EI sickness program may overestimate the “true” costs of supporting disabled persons because it may reflect expenditures used to support persons with illnesses or ailments that are much more temporary in nature.

The EI sickness benefits program has seen a moderate increase in benefit expenditures (see Figure 2); benefit payments have grown at a rate of 2.9 percent per annum. The increase in benefit expenditures per beneficiary, which was 1.7 percent per annum between 1971 and 1996, is also much smaller than those in the C/QPP and WCB programs. Since the number of EI sickness beneficiaries has remained roughly constant during the study period and the length of a benefit spell (unlike C/QPP disability
and WCB benefits) is capped, most of the increase in this program’s expenditures can be attributed to the increased generosity of EI benefits (Sargent 1995). For example, in 1972 the replacement rate (as a fraction of gross earnings) was increased from 51 percent to 67 percent and the maximum weekly benefit was increased from $53 to $100 (in nominal dollars). In 1979, the replacement rate was lowered to 60 percent and remained there until 1992, although the maximum weekly EI benefit was increased frequently during this period.

There have been a number of reforms made to EI sickness benefits legislation in Canada. However, reforms to EI legislation were the result of increased expenditures in the regular benefits program, not the sickness benefits program. In particular, the perceived increases in the disincentive effects of the Canadian EI system (Baker and Rea 1998; Christofides and McKenna 1996; Green and Riddell 1997) and the persistent deficits that the EI fund ran for most of the years between 1983 and 1993 have led to reforms in the EI legislation in recent years. EI reforms have tightened eligibility requirements and reduced the generosity of benefits. As an example of the latter, the replacement rate for earnings was lowered to 55 percent in 1994. The EI program also significantly increased employer and employee contribution rates. For example, the premium rate for employees was 2.25 percent and the employer’s contribution was 3.15 percent in 1991. By 1997, the employee’s contribution rate was 2.90 percent and employer’s contribution rate was 4.06 percent (HRDC 1998a). The increases in premia, the reduction in the income-replacement rate and the recovery of the Canadian economy have led to surpluses in the EI fund since 1994 (Lin 1998).

Private Disability Insurance Programs
As noted earlier, we were not able to obtain data on the number of beneficiaries for the PDI programs because the Canadian Health Insurance Association does not collect this information. Instead, we present information on the coverage rates of PDI programs in Figure 1b. The total coverage of the labour force (measured per 1,000 of the labour force) has declined from 520.7 in 1980 to 473.6 in 1996. Most of this decline can be attributed to a fall in the number of persons per 1,000 of the labour force covered by short-term (group) disability insurance which fell from 191.6 in 1980 to 102.9 in 1996. The coverage rate of individuals who purchase individual income replacement has also fallen slightly during the years for which we were able to obtain data, from 53.8 in 1980 to 50.3 in 1996. However, long-term (group) disability insurance programs have increased their coverage of the labour force; rising from 275.2 in 1980 to 320.4 in 1996, a growth rate of 1.5 percent per annum.

The total benefit expenditures of PDI programs have increased from $1.65 billion in 1980 to $2.5 billion in 1996, a real annual growth rate of 3.2 percent. However, there are some differences in expenditures by type of insurance. Short-term (group) disability expenditures fell from $757.5 million in 1980 to $451.9 million in 1996. This is not surprising given that the number of individuals covered by short-term (group) disability insurance has fallen dramatically during this period. Unlike short-term (group) disability insurance, both long-term (group) and individual income-replacement insurance plans have experienced growth in their benefit expenditures. Long-term (group) disability benefit expenditures have increased from $807.6 million in 1980 to $1.8 billion in 1996, a growth rate of 5.7 percent per annum. The benefit expenditures from individual income-replacement programs have risen from $86.2 million in 1980 to $250.8 in 1996, a growth rate of 6.7 percent per annum.

Some of the more plausible explanations for the increase in PDI expenditures include increased benefit generosity, increased frequency of claims, and increased duration of claims. However, it is not possible to draw any conclusions about the relative importance of these explanations since we have no data on the number of persons receiving these benefits or the duration of these claims. The lack of data on the number of beneficiaries also complicates
the analysis because we cannot determine if there has been an increase in the number of beneficiaries and compute benefit expenditures per beneficiary, which would give us a sense of the degree to which the increase in benefits is due to increased benefit generosity and increased claim duration. This issue is further complicated by the fact that income-replacement rates vary from insurer to insurer. The limitations of the available data on PDI programs prevent us from drawing any firm conclusions on the relative importance of the various explanations for the growth in these expenditures.

Health-Care and Vocational-Rehabilitation Expenditures

The provincial workers’ compensation programs offer health-care (medical rehabilitation) and vocational-rehabilitation (VR) services to claimants, and the federal government, in conjunction with provincial governments, offers the Vocational Rehabilitation of Disabled Persons (VRDP) program.

When an individual suffers a workplace accident or industrial disease, the workers’ compensation system pays for both the health-care and vocational-rehabilitation costs incurred by the individual. Medical rehabilitation aims to restore the individual’s health status to the pre-injury level. Vocational rehabilitation, on the other hand, aims to restore the individual’s earnings capacity to the pre-injury level. Their combined goal, once the worker has reached the point of maximum medical rehabilitation, is to return the individual to work at a level of earnings comparable to their pre-injury earnings. In Figure 3, we present WCB health-care expenditures, which in the period prior to 1987 were combined with vocational-rehabilitation expenditures. The combined expenditures on health care and vocational rehabilitation grew steadily from $336.0 million in 1970 to $975.4 million in 1987. Health-care expenditures (excluding VR) reached $731.9 million in 1996. The combined health-care and vocational-rehabilitation expenditures grew at an annual rate of 6.4 percent.

**Figure 3**

**Health-Care Expenditures**

Expenditures (1996 Dollars, Thousands)

<table>
<thead>
<tr>
<th>Year</th>
<th>WCB Health Care (Combined with VR)</th>
<th>WCB Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>200000</td>
<td>200000</td>
</tr>
<tr>
<td>1972</td>
<td>220000</td>
<td>220000</td>
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<tr>
<td>1974</td>
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<td>1994</td>
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</tr>
<tr>
<td>1996</td>
<td>460000</td>
<td>460000</td>
</tr>
</tbody>
</table>
between 1970 and 1996. However, for the period between 1987 and 1996 the annual growth rate in health-care expenditures alone was 3.1 percent per annum.

Between 1987 and 1996, vocational-rehabilitation expenditures grew at an annual rate of 4.5 percent (Figure 4), although the growth rate was much higher in the earlier part of this period.26 Much of the growth during the late 1980s and the early 1990s was driven by increased expenditures on vocational-rehabilitation in Ontario and Quebec. Both of these provinces attached greater importance to vocational-rehabilitation strategies following legislative changes made during this period. However, during the early and mid-1990s some of Canada’s WCBs began to de-emphasize vocational rehabilitation in an effort to reduce costs. For example, since 1993 Quebec’s WCB (Commision de la santé et de la sécurité du Travail [CSST]) has changed its focus from rehabilitation to preventing injuries and fostering injured workers’ return to work. More recently, Ontario and British Columbia have undertaken a similar reorientation.

The other principal source of vocational rehabilitation is the cost-shared (federal and provincial) Vocational Rehabilitation of Disabled Persons (VRDP) program, which is available to disabled persons. Its expenditures are also plotted in Figure 4. Federal and provincial expenditures on the VRDP have also grown quite steadily since 1970. In 1970, $44.9 million was spent by this program; by 1996, expenditures had reached $510 million, a real growth rate of 8 percent per annum. The VRDP program was discontinued after the 1997-98 fiscal year and replaced by the Employment Assistance for People with Disabilities (EAPD). This program, like its predecessor, is cost-shared with the provinces but places more emphasis on re-employment of disabled persons than the VRDP. In addition to the EAPD, the federal government has also started the

---

**Figure 4**

Vocational-Rehabilitation Expenditures

![Graph showing vocational-rehabilitation expenditures](image-url)
Opportunities Fund, a three-year program (beginning in 1997) with a budget of $30 million dollars per year, which helps 4,000 to 6,000 people with disabilities prepare for, find, and secure work. These programs are part of the initiatives proposed by the provincial (with the exception of Quebec) and federal ministers of social services discussion paper “In Unison: A Canadian Approach to Disability Issues” (HRDC 1998b).

A HARMONIZED SUPPORT SYSTEM FOR DISABLED PERSONS

The current support system for disabled persons in Canada consists of a number of programs provided by federal and provincial governments as well as private insurers. This system is best characterized as a multi-payer system, that is, a system with many different payers and no centralized administration. However, we should note that a single-payer system does exist in Quebec. Here, the provincial government administers most of the support programs for disabled persons. For example, workers’ compensation, QPP disability, and social assistance benefits are all paid by the provincial government. The advantage of such a system is that the roles of these programs are more clearly defined, unlike the rest of Canada in which there are still debates regarding the role of and interaction between programs. For example, Quebec’s WCB, the CSST, integrates WCB benefits with the QPP disability pension and is legislated to be the first payer while the QPP disability program acts as the residual insurer (HRDC 1996b).

The multi-payer system which exists in most of Canada means that beneficiaries can draw support from several programs. This can be illustrated with the survey of CPP disability beneficiaries conducted by HRDC (ibid.). This survey found that many CPP disability beneficiaries were receiving benefits from other programs, both public and private. The survey respondents indicated that, in addition to collecting their CPP disability pensions, 25 percent were receiving support from PDI programs and 17 percent were receiving benefits from WCBs. The results from this survey also indicate that the biggest share of respondents’ income was CPP disability, which accounted for 52 percent of respondents’ income (HRDC 1996b). The next largest source of income was from PDI programs, WCB programs, and auto insurance, which together made up 25 percent of income (ibid.). Another estimate, in aggregate terms, of the overlap between WCBs and the CPP disability program is provided by the Auditor General of Canada. The Auditor General of Canada estimated for the 1995-96 fiscal year that if the CPP disability program adopted a policy where the provincial WCBs were the first payer, it would save the CPP disability program between $9 and $40 million (in nominal dollars) in benefit payments.28

Recently, there has been renewed interest in the harmonization of the support network for disabled persons. Arguments have been made in favour of the integration of WCB benefits with CPP disability benefits at least since the early 1980s (e.g., Weiler 1980; Rea 1981), and similar arguments are now being made for other programs. For example, HRDC’s evaluation of the CPP disability pension suggested that there should be more integration between the CPP disability pension and private insurers: “While payments from multiple sources is an inevitable outcome of an income security system composed of a variety of programs with different objectives and rationales, many provincial stakeholders suggested that it is important to develop greater coordination and integration of PDI programs which ensue from such overlaps” (HRDC 1996b, p. 33). More recently, the initiative launched by the federal and provincial social services ministers, “In Unison,” has set out to ensure increased coordination between federal and provincial social services programs as well as the CPP disability program. Clearly, the push for greater coordination between programs is an important direction for future policy reforms.29 However, to date, there has been very little progress in improving coordination and benefit integration. For example, the CPP legislation of 1997 that allowed the CPP disability program...
to negotiate integration agreements with the WCBs on a province-by-province basis has yielded no agreements to date. This is unfortunate as these two programs are the largest payers in the system.

The potential benefits of a coordinated support system can be evaluated in terms of efficiency and equity. Efficiency refers to social welfare, which can be defined as the combined welfare of all individuals in society. An efficient outcome is one that maximizes social welfare. Equity, on the other hand, refers to the distribution of welfare among individuals. Equity can be evaluated in terms of horizontal equity (i.e., people in similar circumstances are treated similarly) and vertical equity (i.e., people who are different in some important way are treated differently). Horizontal equity implies that individuals who suffer the same degree of loss should receive the same level of compensation. Vertical equity suggests that individuals who experience greater losses should receive additional compensation. One of the advantages of a more harmonized support system, with integrated benefits, would be greater equity for the claimants, and perhaps also improve the efficiency of the system (i.e., maximize the net benefits of the programs).

The lack of progress in the integration of benefits perpetuates a degree of inequity in the treatment of disabled workers. Recall that a few provinces currently allow WCB benefits to be stacked with CPP disability benefits, while most provinces do not allow benefit stacking. This may allow claimants in provinces that permit stacked benefits to obtain more than 100 percent of pre-injury earnings. In other words, a consensus on benefit stacking could improve the degree of horizontal equity in the support system. Future discussions on benefit integration should also include other programs, both public and private, to determine who will be the first payer and who will be the residual insurer, and whether benefits should be stacked or integrated.

On a related note, some WCBs (for instance, Ontario and Quebec) have dual award systems which compensate workers with permanent disabilities for non-economic and economic losses, while other boards continue to use disability rating schedules (Gunderson and Hyatt 1998). Thus, more severely injured workers are not treated equally across provinces, in that there are vertical inequities. A common approach to the compensation of permanent disabilities may improve the degree of vertical equity in the support system for disabled persons.

Integrating benefits across programs may have implications for the funding and the financing of the component programs, as benefit and other program expenditures are shifted between programs. This will be especially true if the component programs in the current support system were replaced by a single centrally administered system. In the existing system, most program costs are shared by employers and employees (for example, C/QPP disability pensions and PDI programs). However, workers’ compensation programs are financed entirely by employer premia which, for the most part, vary across industry type and individual employer (i.e., they are experience-rated). As a result, employers face a number of behavioural incentives in workers’ compensation systems. Specifically, when the premia used to fund workers’ compensation are experience-rated to reflect an employer’s accident history, the employer has an incentive to invest in workplace health and safety. If the existing disability system were harmonized and centrally administered, injuries previously insured by WCBs would fall under the jurisdiction of the new centrally administered system. If this system were financed in the manner of the C/QPP disability program (i.e., contributions shared by employers and employees), some of the incentives for employers to invest in workplace health and safety would be removed. However, such a system could be funded with an employee portion and an experience-rated employer portion (as in the Dutch disability insurance system), (Aarts, Burkhauser and DeJong 1996) to introduce employer incentives. The funding and financing structure of any new system must consider the behavioural incentives for both employers and employees.
As noted earlier, Canada’s support network for disabled persons consists of programs that are administered by provincial governments, the federal government, and private insurers. A unified support system that insures both occupational and non-occupational injuries, administered by one level of government (for example, a system like the Dutch disability insurance system [ibid.], is not likely to evolve in the near term because of the number of obstacles involved. A more feasible solution may be the approach suggested by “In Unison,” which was undertaken by provincial and federal social services ministries. This would entail a set of agreements between providers of private and public disability insurance programs on issues such as the level of coordination of services, benefit stacking versus benefit integration, determination of first payer and the residual insurer, and the compensation of permanent disabilities. Reaching a consensus on these issues may improve the degree of equity in the Canadian disability insurance system and lay the foundation for the reform of the support system for disabled persons.

Another advantage of increased coordination or harmonization between programs would be greater information-sharing, potentially through a federal clearing house that would ensure the privacy and confidentiality of the data. Currently, only the EI and CPP disability programs have formal information-sharing agreements (specifically, a data-matching initiative that allows them to determine whether duplicate benefits are being collected). All other programs rely on beneficiaries reporting whether they receive benefits from other programs; there is no formal communication or transfer of information between these programs. Increased information-sharing may reduce some of the overlap between programs, possibly improve the match of beneficiaries with programs, and reduce the administrative costs of processing claims (Bogyo 1995).

Information-sharing also enables determination of the actual overlap that occurs between programs rather than using the estimates which are currently available. In addition, information-sharing may make it easier to track beneficiaries across programs and actually determine what happens to the persons supported by these programs. For example, much has been said in the press about “people falling through the cracks” of the disability system (Bogyo 1995). Given the current state of the information collected on the component programs of the disability support system, it is difficult to assess the extent to which this occurs. Formal information-sharing agreements between programs may be the first step in answering this question.

Conclusions

This paper has examined trends in program expenditures, both public and private, that support disabled persons. These expenditures have, for the most part, increased steadily over the last several decades. The empirical evidence we have reviewed suggests (for some programs) that a large portion of these increases is due to increased benefit generosity, through both direct effects on benefit levels and indirect effects on the duration and frequency of claims. This suggests that reforms that have involved cutting benefits may have been a doubly effective way to control expenditures. In addition, initiatives that aimed to reduce the duration and frequency of claims may have also been very effective ways to control expenditures. However, we should note that the component programs of the Canadian support system for disabled persons, with the exception of workers’ compensation, have been the subject of very little empirical analysis. Thus, there are still gaps in our knowledge about the economic implications of these programs, which makes it more difficult to inform the economic dimensions of policy reforms for these programs.

The current network that supports disabled persons was assembled piece by piece during this century. Consequently, issues such as increased coordination and benefit integration between the component programs were not a central part of the
design. As we enter the next century this is no longer the case. The evidence we have reviewed in this paper suggests that there is, to varying degrees, overlap between the component programs. However, this support system is still far from being a harmonized system. Although the goal of recent reform efforts and initiatives adopted by the providers of these programs is increased benefit integration and coordination between the component programs, much remains to be done to achieve a harmonized disability support system.

NOTES

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1 The definition of disability varies from program to program. For example, in workers’ compensation systems a disability is defined in terms of a functional impairment, while in the Canada Pension Plan a disability is defined in terms of an individual suffering a prolonged mental or physical disability that prevents them from working at any job.

2 Some WCBs, like those in Ontario and Quebec, have also implemented dual award systems for workers with permanent partial disabilities. This system provides an award for the claimant’s non-economic losses based on the extent of their functional impairment and an award for the claimant’s economic losses based on their actual or predicted wage loss due to disability.

3 Some WCBs, like those in Alberta, the Northwest Territories, Quebec, and Saskatchewan pay their benefits as 90 percent of net pre-injury earnings. The WCBs of British Columbia and the Yukon pay benefits as 75 percent of pre-injury gross earnings. Ontario’s WSIB currently pays 85 percent of net pre-injury earnings, although prior to January 1998 benefits were paid as 90 percent of net pre-injury earnings. Some provinces (Manitoba, New Brunswick, Newfoundland, Nova Scotia, and Prince Edward Island) alter the replacement after a certain period of time. For example, in Nova Scotia benefits are computed as 75 percent of net earnings for the first 26 weeks and 85 percent of net earnings thereafter.

4 Some provinces allow for stacked benefits, that is, a claimant can collect benefits from both the CPP disability program and the WCB. For example, British Columbia, Alberta, and the two territories allow for stacked worker benefits and Alberta, Manitoba, Quebec, Nova Scotia, Newfoundland, and the territories allow for stacked survivor benefits.

5 Although firms pay the premia that finance the WCBs in Canada, the employees of the insured firms may ultimately bear the incidence of the payroll tax. Dahlby (1993) found workers bear one-half to two-thirds of a payroll tax in the medium term and almost the whole cost in the long-term. Chelius and Burton (1995) found in their survey of the empirical evidence on the incidence of workers’ compensation premia that a substantial portion, and in some studies all, of these premia are passed on to workers.

6 Some organizations, such as federal and provincial governments, Crown agencies, railways, and airlines are self-insured, that is, they are individually liable for compensation claims, although the provincial workers’ compensation boards administer the claims. The percentage of the employed labour force that is insured varies from province to province; for example, in 1998 the coverage rates were 90 percent in British Columbia, 68 percent in Ontario and 96.7 percent in Quebec (Association of Workers’ Compensation Boards of Canada 1999).

7 Although the intent of experience rating is to provide incentives for employers to invest in workplace health and safety this not what often occurs in practice. Rather than investing in health and safety, experience rating has been found to encourage many employers to reduce their costs of workers’ compensation in other ways (for example, contesting claims and providing modified work to injured workers). A more complete discussion of these issues can be found in Kralj (2000) and Hyatt and Thomason (1998).

8 Source: HRDC, Statistics, Trend Analysis and Result Measurements, Planning and Strategic Studies, special tabulation.

9 Income-replacement rates in long-term (group) disability insurance can range from 40 to 80 percent,
depending on whether the insurance is structured to provide income on gross or net pre-injury income.

10 We exclude the veterans’ disability pensions from the discussion because they are available to very specific members of the population and because the program expenditures have not experienced large increases over the study period (the real annual growth rate has been 0.3 percent during our study period).

We also exclude payments made to disabled persons by provincial welfare programs from the discussion because we were not able to obtain this information. The exclusion of social assistance payments is unfortunate because these programs are considered by some to be an important part of the support system for disabled individuals. In light of this, our analysis does not consider the whole support network for disabled persons, but rather a substantial part of this system.

11 In 1996, $9,497.3 million was spent annually on income-replacement benefits, by WCBs, the C/QPP disability program, EI sickness and private disability insurance, which includes short- and long-term (group) insurance programs and individual income-replacement programs. The WCBs accounted for 38 percent of this total. The other program shares were as follows: 31 percent was paid by the C/QPP disability pension program ($2,954.0 million), 4.6 percent by the EI sickness benefits program ($435.8 million), and 26 percent ($2,502.2 million) by private disability insurance programs.

12 Fortin and Lanoie (1992) also find evidence of substitution between the EI program (note this is the regular benefits program not the sickness benefits) and WCB program in Quebec. Specifically, they find that a 10 percent increase in the generosity of EI benefits would be associated with a 5 to 7 percent reduction in the duration of WCB claims.

13 Thomason and Hyatt (1997) conduct an empirical investigation of the determinants of increased workers’ compensation expenditures. They examined the following variables: increased benefit generosity; increased injury severity; shifts in the composition of the Canadian labour market (for example, shifts in industrial composition, aging of the workforce, and changes in union density); demographic factors; increased unionization; and, business-cycle effects.

14 Thomason and Hyatt’s findings are also consistent with findings from the analysis of WCB expenditures in the United States. Butler and Worrall (1983) and Butler (1994) find that increased benefit generosity and reduced waiting periods have significantly contributed to the increasing American WCB claim costs during the last several decades.

15 The unfunded liability represents the shortfall in funds that would occur if a WCB were called upon to present assets to pay off all its current and future obligations. In other words, the unfunded liability is the difference between the value of the WCB’s assets and the present value of its liabilities.

16 Long-term funding strategies proceed by adding a surcharge to a firm’s premium which is devoted strictly to the retirement of the unfunded liability over a fairly long period of time (20 to 25 years is typical).

17 While the number of beneficiaries receiving CPP disability pensions has increased dramatically, the number of beneficiaries receiving QPP disability has not. As an example, consider the number of beneficiaries per 1,000 of the labor force in the CPP and the QPP disability program. In the QPP program the number of beneficiaries increased from 12.63 in 1986 to 13.19 in 1997. However, in the CPP the number of beneficiaries increased from 15.33 to 25.79 during the same period. It should also be noted that the QPP disability program maintained much tighter eligibility criteria, although these criteria are much less stringent for workers aged 60 than 64, during the study period.

18 Non-medical factors can include the unemployment rate in a region, the availability of particular sorts of jobs in a region, and a person’s skills. As well, individuals over age 55 were considered disabled if they could not do the particular job they held, as opposed to any job.

19 In 1989 the incidence of new disability cases was 4.28 per thousand persons for males and 2.99 per thousand for females. By 1994, these rates had increased to 6.34 per thousand for males and 5.79 per thousand for females (Source: Canada Pension Plan Consultations 1996).

20 For example, data on the number of referrals from provincial social assistance ministries and the number of individuals qualifying for benefits based on socio-economic criteria are not readily available.

21 Source: HRDC, Statistics, Trend Analysis and Result Measurements, Planning and Strategic Studies, special tabulation.
The increase in contribution rates was an initiative undertaken to ensure the financial viability of all CPP programs, not just the disability component. Consider the projected costs of the CPP program in 2030. When the CPP program began, the costs as a percentage of contributory earnings were projected as 5.5 percent in 2030. However, as a consequence of changed demographics, changed economics, enrichment of benefits and the increased numbers claiming disability pensions, the CPP costs in 2030 as of 1996 were projected as 14.2 percent of contributory earnings. The difference between the two projected costs (i.e., 5.5 percent and 14.2 percent) can be decomposed as follows: 1.5 percent is attributed to the disability component, 2.6 percent is due to changed demographics, 2.2 percent changed economics, and 2.4 percent is due to the enrichment of benefits (CPP Consultations 1996).

We should also note we were not able to find any literature specifically related to the analysis of the sickness benefits program. In contrast, the regular benefits program has been extensively examined in the literature (Benjamin, Gunderson and Riddell 1998).

Although the coverage rates of the labour force have fallen during the years in question, the number of persons covered by these programs has increased from just over 6 million in 1980 to 7.2 million persons by 1996. It may be plausible that the increase in total expenditures may be due to an increase in the number of persons collecting these benefits.

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We should note that WCB VR expenditures were much larger during the early 1990s. Between 1987 and 1992, the year in which VR expenditures peaked, expenditures grew at a rate of 13.7 percent per annum, before beginning a steady decline during the remaining years of our study period.

Some concerns regarding the overall quality of the CPP beneficiary survey have been raised (HRDC 1996b). The principal concerns about the survey are a small sample size (just over 3,000 respondents), selection biases (some subgroups represent a disproportionately large subset of respondents as compared to their distribution in the beneficiary population), and high non-response rate (54 percent).

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experience symptoms of back pain each year) and is forming an increasing proportion of WCB’s claims (Butler, Durbin and Helvacian 1996). Since WCB replacement rates and benefit maximums are greater than those in the C/QPP disability program, workers with non-occupational injuries are not treated as generously as those with occupational injuries. Rather than compensating injured workers for a portion of their lost earnings, a harmonized system may need to base benefits on a disability rating schedule to ensure equity between occupational and non-occupational injuries. Such a system currently exists in the Netherlands (see De Jong 1999), where occupational and non-occupational injuries are insured within the same disability insurance system. The Dutch disability insurance system uses eight disability categories: less than 15 percent, 15 to 25 percent, and other categories up to a maximum of 80 to 100 percent. Disability benefits are calculated as the disability rating multiplied by the replacement rate.

33 Prior to introducing experience rating, the Dutch used a system of bonuses and penalties to make employers more cost-conscious. If an employee enters the disability rolls, the employer was required to pay a penalty (to a maximum of half a year’s wages) into a fund. Conversely, if an employer employed a disability beneficiary, they would receive a bonus (to a maximum of half a year’s wages) from the fund. However, we should note that such penalties induce employers to reduce the costs associated with disability programs and not to invest in workplace health and safety.

34 Another relevant issue in harmonized disability insurance systems is compensating wage differentials. If the level of benefits in a harmonized disability insurance system were less than that currently available in workers’ compensation systems, some of the risks faced by injured workers will be uncompensated. In light of this, there may be a role for private insurers to provide coverage for uncompensated risks.

35 In some ways, a more coordinated disability support system may be a better alternative to a centrally administered harmonized support system. Specifically, since Canada is a large, geographically diverse nation, there can be substantial differences in the cost of living from one region to another. Furthermore, provincial tax rates will differ. Thus, as discussed in note 30, a system with variations in the level of benefits may be more equitable than a harmonized system with a common benefit level insofar as it reflects differences in the cost of living across the country.

36 The WCB of British Columbia commissioned a data set containing linked WCB records, provincial health records, and provincial social assistance records (see Hertzman, McGrail and Hirtle 1999). This data covers a ten-year period and allows for the tracking of individuals between these provincial programs, although it still lacks information on the federal programs (and private programs), which would provide a more complete picture. In a preliminary analysis of the data, Hertzman et al. (1999) found that in British Columbia WCB applicants were more likely to become social assistance recipients following an injury than other British Columbians. A more detailed analysis of this data set, or others similar to it, might produce the information needed to answer unresolved questions regarding the overlap between programs.

REFERENCES


