

BAD MEDICINE

A report on the WSIB's
transformation of its
health care spending

CO-AUTHORS

BAD MEDICINE: A REPORT ON THE WSIB'S
TRANSFORMATION OF ITS HEALTH CARE SPENDING

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EXECUTIVE SUMMARY

In 2010, in response to the Ontario Auditor General's 2009 report on the WSIB's unfunded liability, the WSIB embarked on an "historical transformation" of its business model.

The WSIB's "transformation" has been a remarkable success in reducing its unfunded liability: the WSIB is on track to eliminate it completely six years ahead of schedule, even while granting employers a substantial reduction in premiums. But advocates and health care professionals who work with injured workers believe the transformation has had a dramatic negative impact on injured workers. They say that the WSIB routinely disregards medical evidence; forces workers back to work before they are fit to do so; cuts compensation benefits without just cause; and denies entitlement to necessary health care treatments.

This report examines the effect the WSIB's "transformation" has had on a single but critical category of benefits: health care benefits.

This report examines the effect that the WSIB's "transformation" has had on a single but critical category of benefits: **health care benefits**.

The WSIB has a legal duty to pay for injured workers' health care. The Legislature imposed this duty with good reason: for people who are injured at work or develop an occupational illness, health care benefits are vitally important, both to their recovery and, if the injury leaves them with a permanent disability, their ongoing quality of life.

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Our report describes the effect that the WSIB’s transformation has had on health care benefits by analysing the WSIB’s own data in the context of the changes it made to its business model and the experience of injured workers.

The evidence we present supports three stark conclusions:

1. There has been a significant cut in prescription drug benefits that affects thousands of injured workers per year.
2. Health care spending has progressively shifted away from services whose sole focus is patient welfare, and towards services that are structured to drive down the cost of benefits paid to injured workers.
3. The primary measures the WSIB uses as evidence of improved health outcomes - the reduction in the incidence and severity of permanent impairments - are the result of changes to the WSIB’s adjudication practices. They constitute a cut in benefits themselves, rather than a reflection of improved health care.

Our findings run counter to the WSIB’s narrative that its “transformation” has benefitted injured workers by improving recovery and return to work outcomes.



There has been a significant cut in prescription drug benefits that affects thousands of injured workers per year.

The WSIB has reduced the amount it spends on prescription drugs by one-third since it began its transformation, from \$96,252,000 in 2010 to \$62,341,000 in 2015.

The WSIB claims that this reduction is the result of two things: drug price reductions and a decrease in the overall number of claims entering the system.

However, the WSIB’s own data shows that neither of these explanations makes sense. Instead, its data shows that every year since 2010, the WSIB has reduced both the number and proportion of claims in which it grants entitlement to drug benefits. In

2010, the number of claims with drug benefits was 38 percent of the total of allowed claims entering the system; by 2015, that had reduced to 27 percent.

Over the last six years, an increasing number of injured workers have been excluded from the WSIB's drug benefit coverage. As things currently stand, some 18,000 injured workers per year have disappeared from the drug benefits program, with no viable explanation from the WSIB.

We suggest the explanation can be found in the array of WSIB policies and procedures in force during this period that affected entitlement to drug benefits, including:

- The removal of drugs from the WSIB drug formularies
- The WSIB's secrecy about the contents of its drug formularies
- Administrative barriers to ongoing entitlement to medications, and
- The absence of meaningful oversight over the WSIB's decisions about drug benefits.



Health care spending has progressively shifted away from services whose sole focus is patient welfare, and towards services that are structured to drive down the cost of benefits paid to injured workers.

A primary element of the WSIB's transformation was its "Health Care Strategy." This has involved a significant, ongoing transfer of resources from direct health care (services provided by health care professionals directly to injured workers) to "integrated health care," which comprises three broad categories of services known as Programs of Care, Specialty Clinics, and Physician Services.

The most significant element of this transfer of resources was the development of three Programs of Care for musculoskeletal injuries. By 2015, the three Programs of Care almost entirely replaced direct health care treatments for musculoskeletal injuries.

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Under the direct health care model, health care professionals' sole focus in providing treatment was the welfare of their patients. In conjunction with the workers they treated, they determined the type of treatment appropriate to the recovery in the individual case, and if additional treatment beyond what was allowed by the WSIB was required, they could seek approval for additional treatment directly from the WSIB.

By contrast, integrated health care services are designed by the WSIB to incorporate cost control measures into the provision of health services. We detail an array of these measures in our report, but some examples are:

- Capping the length of treatment in Programs of Care regardless of the worker's type of injury or outcome
- Imposing diminishing fee structures in some cases so that health care providers are paid less for each treatment after the first four weeks
- Paying health care providers up to 33% less if they advise the worker cannot return to their pre-injury job, and
- Requiring Specialty Clinic doctors to include an opinion on expected recovery dates.

One of the three categories of services included in the "Health Care Strategy," the WSIB's Physician Programs, are not even services provided to workers at all. Rather, they are services provided *to the WSIB* to assist in the adjudication of claims.



The primary measures the WSIB uses as evidence of improved health outcomes—the reduction in the incidence and severity of permanent impairments—are the result of changes to the WSIB's adjudication practices. They constitute a cut in benefits themselves, rather than a reflection of improved health care.

The WSIB's "transformation" has resulted in a remarkable reduction in the incidence and severity of permanent impairment awards. In 2010, the WSIB accepted that 9.3 percent of injuries resulted in a permanent impairment; by 2015, the incidence of permanent impairments had reduced by more than a third, to 5.9 percent of injuries. The average size of the permanent impairments recognized by the WSIB decreased at a similar rate: in 2010, the average award was 14.6%; in 2015, it was 9.5%.

The WSIB's permanent impairment data do not give a direct, independent measure of the actual health outcomes of injured workers. They instead record the WSIB's adjudicative decisions about entitlement to benefits. Nonetheless, the WSIB repeatedly cites its data on permanent impairments as evidence that the Health Care Strategy has resulted in improved outcomes for injured workers. The WSIB conflates actual health outcomes with its own adjudicative rulings about those outcomes.

The WSIB's own data shows that its explanation does not make sense because **both the incidence and average size of permanent impairment awards were going down *before*** the WSIB started funding most of its integrated health care programs.

Instead, the WSIB's data, when considered in the context of the WSIB's "transformation" and the experiences of injured workers, shows that the reduction in the incidence and size of permanent impairment awards is primarily the result of three austerity measures in the WSIB's adjudication practices. At the time when the reduction began:

- The WSIB stopped using independent physicians in the community to examine workers and measure their level of impairment. Instead, the WSIB assigned that job to their own employees, who are subject to their management's imperative to reduce the unfunded liability, who are generally not medically trained, and who never meet, let alone conduct a medical examination of, the injured worker.
- The WSIB began a new practice of discounting (or "apportioning") the NEL ratings of workers with pre-existing conditions, even where the worker had no pre-accident symptoms or impairment. The apportioning of NEL awards for

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asymptomatic pre-existing conditions is now the WSIB's standard practice, despite numerous rulings by the Workplace Safety and Insurance Appeals Tribunal that such apportioning is not permitted by the *WSIA*.

- The WSIB also began using asymptomatic pre-existing conditions to rescind ongoing entitlement to benefits, resulting in permanent impairments either going unrecognized by WSIB adjudicative staff, or attributed entirely to non-work-related causes.

For injured workers, the WSIB's historic "transformation" has resulted in substantial, harmful cuts to health care benefits. The WSIB has cut thousands of workers out of its drug benefits program. The WSIB has transformed direct health care services into programs that integrate benefit cost control measures. And the WSIB has used pre-existing conditions to deny and reduce permanent impairment benefits, all while claiming these cuts as the evidence of improved recovery outcomes. For injured workers, the supposed benefits of the WSIB's "transformation" are an illusion. The cuts, by contrast, hurt because they are all too real.

I. INTRODUCTION

In 2010, the WSIB embarked on an “historical transformation” of its business model, in response to the Ontario Auditor General’s 2009 report on the WSIB’s unfunded liability.¹

There is no dispute that this transformation has been dramatic. What is disputed is its effect on injured workers.

Advocates and health care professionals who work with injured workers believe the transformation has resulted in the WSIB:

- Routinely disregarding medical evidence;
- Forcing workers back to work before they are fit to do so, sometimes causing re-injury;
- Cutting compensation benefits;
- Denying entitlement to necessary health care treatments; and
- Creating a massive appeal backlog at the Workplace Safety and Insurance Appeals Tribunal.²

¹ Ontario, Workplace Safety and Insurance Board, *The Transformation of the Workplace Safety and Insurance Board*, online:

<<http://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdyw/~edisp/wsib060403.pdf>>.

² Ontario Federation of Labour and The Ontario Network of Injured Workers Groups, *Prescription Over-Ruled: Report on How Ontario’s Workplace Safety and Insurance Board Systematically Ignores the Advice of Medical Professionals* (05 November 2015), online: <<http://ofl.ca/wp-content/uploads/2015.11.05-Report-WSIB.pdf>> [Prescription Over-Ruled]; Ontario Federation of Labour and The Ontario Network of Injured Workers Group, *Submission to the Ontario Ombuds Office* (29 January 2016) [*Submission to the Ontario Ombuds Office*]; Sara Mojtehdzadeh, “WSIB policy pushed hurt workers into ‘humiliating’ jobs and unemployment, critics say” *Toronto Star* (12 September 2016), online: <<https://www.thestar.com/news/canada/2016/09/12/wsib-policy-pushes-hurt-workers-into->

The WSIB, by contrast, claims that it has successfully driven down the unfunded liability while *improving* outcomes for injured workers. By implementing its new “Better at Work” and Health Care strategies, the WSIB says, it has “improved recovery and return to work outcomes.” For example, the WSIB states that more workers return to work within twelve months with no wage loss, there has been a “marked decrease in

OUR PURPOSE: To describe the effect the WSIB’s change to health care benefits has had on injured workers, by analyzing the WSIB’s data.

permanent impairments among injured workers,” and the severity of permanent impairments has been reduced.³

This report examines one category of benefits that WSIB provides injured workers: health care benefits. Our purpose is to describe the effect that the WSIB’s transformation has had on the provision of health care benefits to injured workers, by analysing the WSIB’s own data in the context of the changes the WSIB has made to its business model and the experience of injured workers.

humiliating-jobs-and-unemployment-critics-say.html>; Sara Mojtehdzadeh, “WSIB critics say spending cuts are ‘devastating’ injured workers” *Toronto Star* (10 June 2016), online: <<https://www.thestar.com/news/gta/2016/06/10/inadequate-health-care-devastating-injured-workers-critics-say.html>>; “Ontario psychologists claim WSIB unfairly denying patient claims” *CBC News* (04 November 2015), online: <<http://www.cbc.ca/news/canada/toronto/programs/metromorning/ontario-psychologists-claim-wsib-unfairly-denying-patient-claims-1.3302778>>; “Sudbury WSIB claimant’s doctor pushes to change ‘unresponsive’ system” *CBC News* (09 November 2015), online: <<http://www.cbc.ca/news/canada/sudbury/keith-klassen-wsib-paul-chartrand-1.3310497>>; Sara Mojtehdzadeh, “Fair appeals for injured workers under threat, experts warn” *Toronto Star* (06 April 2016), online: <<https://www.thestar.com/news/gta/2016/04/06/fair-appeals-for-injured-workers-under-threat-experts-warn.html>>.

³ WSIB, response to IAVGO data request DR2032 at 6. See also: Ontario, Workplace Safety and Insurance Board, *2012-2106 Strategic Plan: Measuring Results Q4 2012*, at 16; Ontario, Workplace Safety and Insurance Board, *2012-2016 Strategic Plan: Measuring Results Q1 2013*, at 3 [2012-2016 Strategic Plan: Measuring Results Q1 2013]; Ontario, Workplace Safety and Insurance Board, *2012-2106 Strategic Plan: Measuring Results Q2 2014*, at 4; E. Witmer and D. Marshall, “Ontario’s worker safety board on path to sustainability” *Financial Post* (21 January 2016), online: <<http://business.financialpost.com/fp-comment/ontarios-worker-safety-board-on-path-to-sustainability>>.

The evidence we present supports the following stark conclusions. Since 2010:

- a) There has been a significant cut in prescription drug benefits that affects thousands of injured workers per year.

- b) Health care spending has progressively shifted away from services whose sole focus is patient welfare, and
towards services that are
structured to drive down the
cost of benefits paid to
injured workers.
**Shift in WSIB health care spending:
from patient welfare to driving down
costs**

- c) The primary measures used by the WSIB as evidence of improved health outcomes (the reduction in the incidence and severity of permanent impairments) are the result of changes to the WSIB's adjudication practices. They constitute a cut in benefits themselves, rather than a reflection of improved health care.

Our findings show that there is no support for the WSIB's claims that its transformation of health care services has improved the lives of injured workers. To the extent that the WSIB believes its own claims, it inhabits a reality separate and apart from the people it was established to serve.

II. BACKGROUND

A. THE WSIB'S DUTY TO PROVIDE HEALTH CARE BENEFITS

“Health care benefits” are the health care costs that are incurred by injured workers and paid for by the WSIB.

The WSIB has a legal duty to pay for injured workers’ health care under section 33(1) of the *Workplace Safety and Insurance Act, 1997*, which provides:

A worker who sustains an injury is entitled to such health care as may be *necessary, appropriate and sufficient* as a result of the injury [*emphasis added*].⁴

The WSIB has a legal duty to pay for injured workers’ health care under section 33(1) of the *Workplace Safety and Insurance Act, 1997*.

This duty covers a wide range of products and services. Section 32 of the *WSIA* defines “health care” as:

- (a) professional services provided by a health care practitioner,
- (b) services provided by or at hospitals and health facilities,
- (c) drugs,
- (d) the services of an attendant,
- (e) modifications to a person’s home and vehicle and other measures to facilitate independent living as in the Board’s opinion are appropriate,
- (f) assistive devices and prostheses,
- (g) extraordinary transportation costs to obtain health care,
- (h) such measures to improve the quality of life of severely impaired workers as, in the Board’s opinion, are appropriate.⁵

⁴ *Workplace Safety and Insurance Act*, SO 1997, c. 16, Sched. A, ss 33(1) [*WSIA*].

⁵ *Ibid* at s 32.

For people who are injured at work or develop an occupational illness, health care benefits are vitally important, both to their recovery and, if the injury leaves them with a permanent impairment, to their ongoing quality of life.

B. THE TRANSFORMATION OF THE WSIB

The WSIB began making significant changes to its business model in 2008. Prompted by concerns about poor results in return to work, the WSIB replaced its “self-reliance” model with “work reintegration” policies and practices that increased the active involvement of WSIB staff in early and safe return to work.

The scope and depth of this change increased dramatically in 2010, following the publication of the Auditor General’s report. The government appointed a new CEO, David Marshall, who took the view that the WSIB “had a serious expense problem” and that there was “something fundamentally wrong with [its] business model.”⁶ Under Marshall’s leadership, the WSIB undertook two major, related initiatives that were designed to drive down benefit expenditure, ostensibly by improving workers’ recovery: Better at Work and the Health Care Strategy.

i. Better at Work

The Better at Work principle—that “staying at work or returning to work is part of the recovery process”—was adopted by the WSIB in 2011 as part of its case management program, in accordance with “best practice internationally.” The WSIB states that this principle is grounded in “research” that shows that “return to work is critical to the

⁶ David Marshall, “The WSIB: An Historic Transformation” (Speech delivered at the C.D. Howe Institute, 01 April 2014).

recovery process” and “should be used as rehabilitation to enhance recovery, increase activity and function, and optimize successful and sustained employment.”⁷

Limitations of space and resources mean that this report cannot examine the effect of Better at Work on injured workers. However, it should be noted that, notwithstanding the WSIB’s characterisation of Better at Work as “best practice” justified by “research,” the principle that “staying at work or returning to work is part of the recovery process” is a matter of significant controversy. For example:

- The WSIB’s primary authority for the principle, the American College of Occupational and Environmental Medicine, has been described in the *International Journal of Occupational and Environmental Health* as “a professional association that represents the interests of its company-employed physician members... [it] provides a legitimizing professional association for company doctors, and continues to provide a vehicle to advance the agendas of their corporate sponsors.”⁸
- The WSIB’s extrapolation from, and misuse of, the limited evidence about the relationship between activity (rather than return to work) and health outcomes has been the subject of significant criticism by leading academic experts.⁹

Health professionals are concerned the WSIB has not followed their advice on workers’ return to work

⁷ Ontario, Workplace Safety and Insurance Board, *Better at Work*, online: <<http://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdey/~edisp/wsib012242.pdf>>; Ontario, Workplace Safety and Insurance Board, *2012-2016 Strategic Plan: Measuring Results Q1 2013* at 21.

⁸ J. Ladou et al., “American College of Occupational and Environmental Medicine (ACOEM): A professional association in service to industry” (2007) 13:1 *International Journal of Occupational and Environmental Health* 404 at para 1. See also M. Lax, “Not Quite a Win-Win: The Corporate Agenda of the Stay at Work/Return to Work Project” (2015) 25:1 *New Solutions: A Journal of Environmental and Occupational Medicine* 4-24.

⁹ E. MacEachen et al., “A deliberation on ‘hurt versus harm’ logic in early return to work policy” (2007) 5:20 *Policy and Practice in Health and Safety* 41-62.

- The WSIB’s rigid implementation of Better at Work has caused consternation among health care professionals who care for injured workers, who see their recommendations about the appropriate timing of return to work repeatedly ignored by the WSIB in individual cases.¹⁰

ii. The Health Care Strategy

In 2010, the WSIB began implementing its Health Care Strategy, which it describes as “mov[ing] away from fee-for-service models [and] towards structured and planned health care programs that integrate recovery and return to work planning.”¹¹ This process involved a significant transfer of resources from “direct health care” (services provided by health care professionals directly to injured workers) to “integrated health care,” which comprises three broad categories of services:

- Programs of Care, which the WSIB describes as “evidence-based health care delivery plans that provide treatment shown to be effective for specific injuries and illnesses,” and are primarily delivered by physiotherapists, chiropractors and massage therapists.
- Specialty Clinics, which are hospital based services that the WSIB refers workers with “specific recovery difficulties” to for assessment and, in appropriate cases, expedited diagnostic imaging and treatment.
- Physician Programs, which are services provided by doctors employed by, or working under contract for, the WSIB, to assist in the adjudication of claims.

¹⁰ *Prescription Over-ruled*, *supra* note 2 at 6. See also the media reports listed in note 1. There is also a significant recent body of case law at the Workplace Safety and Insurance Appeals Tribunal granting benefits to injured workers who were denied benefits because they failed to return to work when the WSIB thought they should. In most of these cases, workers decided not to return to work because their doctors told them not to. See e.g., *Decisions Nos 2525/16, 2524/16, 63 16, 888/16, 1889/15, 1069/16, 1133/16, 1437/16, 1062/16, 1436/16, 1479/16, 989/16, 1886/16, 2949/16.*

¹¹ Ontario, Workplace Safety and Insurance Board, *2012-2016 Strategic Plan: Measuring Results Q2 2014* at 4 [*Measuring Results Q2 2014*].

As discussed in detail below, the first two of these elements of the Health Care Strategy “integrate” benefit cost control measures with treatment. These measures sometimes run contrary to the provision of necessary, appropriate and sufficient health care for individual workers. Physician Programs, the third element, are not treatment services provided to workers at all.

iii. Changes to Adjudicative Practices

Around the same time it introduced Better at Work and the Health Care Strategy, the WSIB changed its adjudicative practices in two important ways:

- It adopted a “more aggressive approach to the determination of Permanent Impairment (PI) using health information in the worker’s file,”¹² almost completely eliminating the use of independent medical examiners to evaluate the severity of workers’ permanent impairments,¹³ and
 - It began treating asymptomatic pre-existing conditions differently, using those conditions to deny, or limit the duration of, entitlement to benefits.¹⁴
- The WSIB adopted a more aggressive approach to determining Permanent Impairment: by almost eliminating independent medical reports.**

These adjudicative practices are relevant to assessing the validity of the WSIB’s claim that its Better at Work and Health Care Strategy initiatives have reduced incidence and severity of permanent impairments. They will be described in more detail in the final

¹² Ontario, Workplace Safety and Insurance Board, *Orientation: Permanent Impairment Branch*, (17 May 2012 revised 08 June 2012) at 8 (included in the WSIB’s disclosure to the Standing Committee on Government Agencies July 31, 2012 at 3540 [*Orientation: Permanent Impairment Branch*]).

¹³ For a discussion of the elimination of independent medical examinations, see Part V of this report, below.

¹⁴ For a discussion of changes to the way the WSIB treats asymptomatic pre-existing conditions, see Part V of this report, below.

section of this report, which discusses the WSIB's data on permanent impairments and Non-Economic Loss awards.

III. PRESCRIPTION DRUGS

A. REMARKABLE REDUCTION IN SPENDING ON PRESCRIPTION DRUGS

The WSIB has reduced the amount it spends on prescription drugs remarkably since it began its transformation. Table One shows that payments for drug benefits decreased from \$96,252,000 in 2010 to \$63,341,000 in 2015. That's a *one-third* reduction in six years, even without adjusting for inflation.

Table One: Spending on Drug Benefits (\$000's)

	2010	2011	2012	2013	2014	2015
Schedule One	88,777	81,432	71,129	64,456	61,883	57,542
Schedule Two	7,475	6,735	5,860	5,272	5,015	4,799
Total	96,252	88,167	76,989	69,728	66,898	62,341

Source: WSIB, *By The Numbers: WSIB Statistical Reports*, 2011-2015.

Does a one-third (or 34 million dollar) reduction in drug spending amount to a cut in benefits for injured workers? The WSIB claims that it does not. It attributes the reduction in spending to two factors, namely:

Payments from drug benefits decreased from \$96,252,000 in 2010 to \$63,341,000 in 2015—a one-third reduction in six years.

- a) Price reductions (due to greater use of generic drugs and non-narcotic analgesics, replacing costlier narcotics), and
- b) A decrease in the overall number of claims entering the system.

However, the WSIB’s own data shows that neither of these factors account for the reduction in drug spending. Instead, the data shows that the reduced spending is primarily the result of a steady reduction in the proportion of injured workers with allowed claims whose prescription drugs are paid for by the WSIB.

This indicates that, over the last six years, an increasing number of injured workers have been excluded from the WSIB’s drug benefit coverage—clear evidence that the reduction in spending constitutes a cut in benefits.

Reduced drug spending: primarily a result of reduction in the proportion of injured workers with allowed claims whose prescription drugs are paid for by the WSIB.

B. DRUG PRICE REDUCTIONS DO NOT EXPLAIN THE REDUCTION IN SPENDING

The WSIB has repeatedly offered the same (extremely brief) explanation of the reduction in spending in drug benefits in its quarterly *Stakeholder Reports*: that spending has gone down because of reductions in the price of drugs. For example, in the *Stakeholder Report* for the third-quarter of 2013, the WSIB reported a “a \$5 million reduction in drug payments reflecting price reductions due to greater use of generic drugs and non-narcotic analgesics, replacing costlier narcotics.”¹⁵

If the reduction in drug spending was primarily attributable to lower drug prices, we would expect to see this reflected in the average amount spent on drugs per claim in which the WSIB has granted entitlement to drug benefits. In other words, the amount

¹⁵ Ontario, Workplace Safety and Insurance Board, *Third Quarter 2013 Report to Stakeholders*, at 9. See also the WSIB’s Report to Stakeholders for: Q2 2012 at 10, Q3 2012 at 10, Q4 2012 at 16, Q2 2013 at 9, Q4 2013 at 4, Q1 2014 at 9; Ontario, Workplace Safety and Insurance Board, *Annual Report 2013* at 24.

spent per drug claim would reduce over time in a way that is consistent with the overall reduction in drug spending.

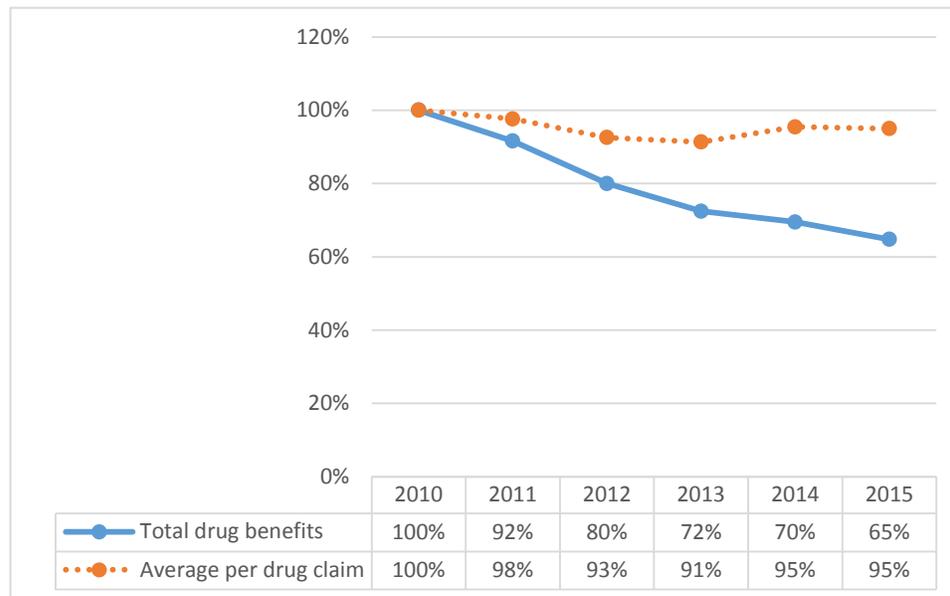
However, this is not the case, as Table Two and Figure One below illustrate. While overall drug spending went down approximately 7% percent *every year* from 2010 to 2015, the cost per claim went down by only 3% each year until 2013, and then *increased* in 2014 and held steady in 2015. By 2015, the cost per claim was 95% of its 2010 level, whereas overall drug spending had decreased dramatically, to 65% of the 2010 amount.

Table Two: Average amount spent on drugs per claim with entitlement to drug benefits

	2010	2011	2012	2013	2014	2015
No. of claims with entitlement to drug benefits	69,646	65,377	60,214	55,251	50,717	47,263
Average spent per claim	\$1,382	\$1,349	\$1,279	\$1,262	\$1,319	\$1,319

Source: WSIB, response to IAVGO data requests DR1804 and DR2344; WSIB, By The Numbers: WSIB Statistical Reports, 2011-2015. (“No. of claims with entitlement to drug benefits” is the sum of the totals for Schedules 1 and 2. The “average spent per claim” is calculated by dividing the total spending on drug benefits (Schedules 1 and 2 combined) by the number of claims with entitlement to drug benefits.)

Figure One: Change in spending on drug benefits as a percentage of 2010 amounts, total vs. per drug claim spending



Source: WSIB, Response to IAVGO data requests DR1804 and DR2344; WSIB, By The Numbers: WSIB Statistical Reports, 2011-2015. (Percentages are calculated using the dollar amounts set out above in Table One (for “total drug benefits”) and Table Two (“average per drug claim.”))

Moreover, there is no evidence to support the WSIB’s claim that the reduction in the price of narcotics has contributed to the reduction in overall drug spending.

By way of background, in 2010 the WSIB implemented a new “Narcotic Strategy,” which it developed because of

WSIB singled out narcotics to explain reduction in drug spending, but there is no evidence narcotics have had any effect on drug spending

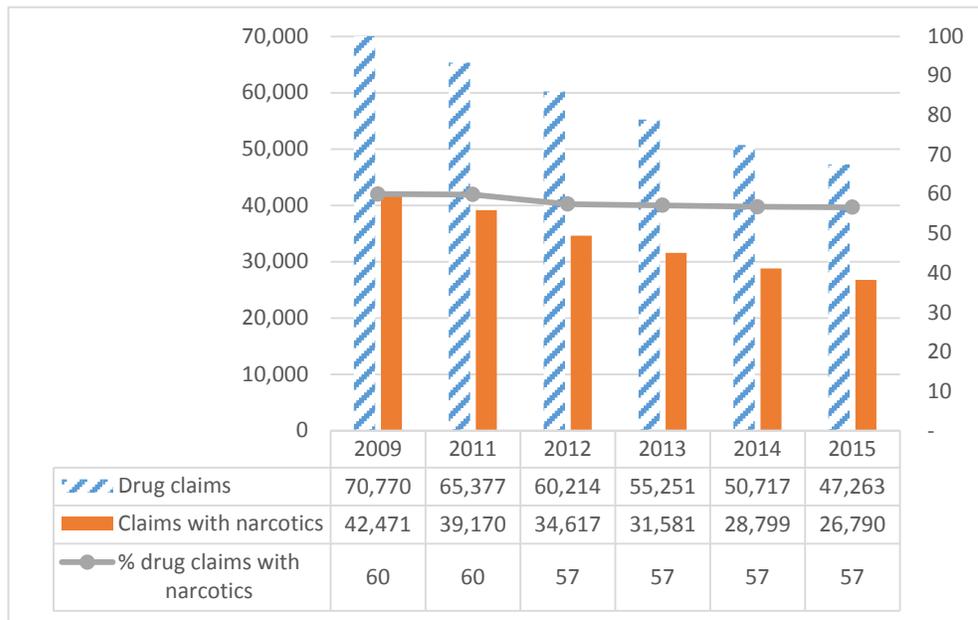
concerns about the escalating cost of narcotics during the previous decade, and the high incidence of narcotic prescriptions relative to other types of drugs provided to workers with “locked-in” compensation benefits. The WSIB describes the strategy as a “graduated approach to narcotic management” that involves “increased oversight of

how narcotics support treatment goals, including improvement in function, quality of life, and safe and sustained return to work.”¹⁶

The Narcotics Strategy may have achieved its goal of encouraging doctors to adopt safer narcotic prescribing practices, such as preferring short-acting narcotics to long-acting ones, and using lower dosages. However, the WSIB’s data shows that it has had no discernible effect on either the incidence or per-claim cost of narcotic drugs, and therefore does not explain the reduction in drug benefit spending. Figure Two shows that the ratio of narcotic claims to overall drug claims reduced only modestly—by three percent—in the earliest years of the narcotics strategy, and has held steady from 2012 onwards. Figures Three and Four show that the cost of narcotic drugs per claim actually *increased* slightly between 2013 and 2015, even as overall drug benefit spending went down. (Note that the WSIB did not provide us with narcotic data for 2010, so we have used 2009 data in its stead).

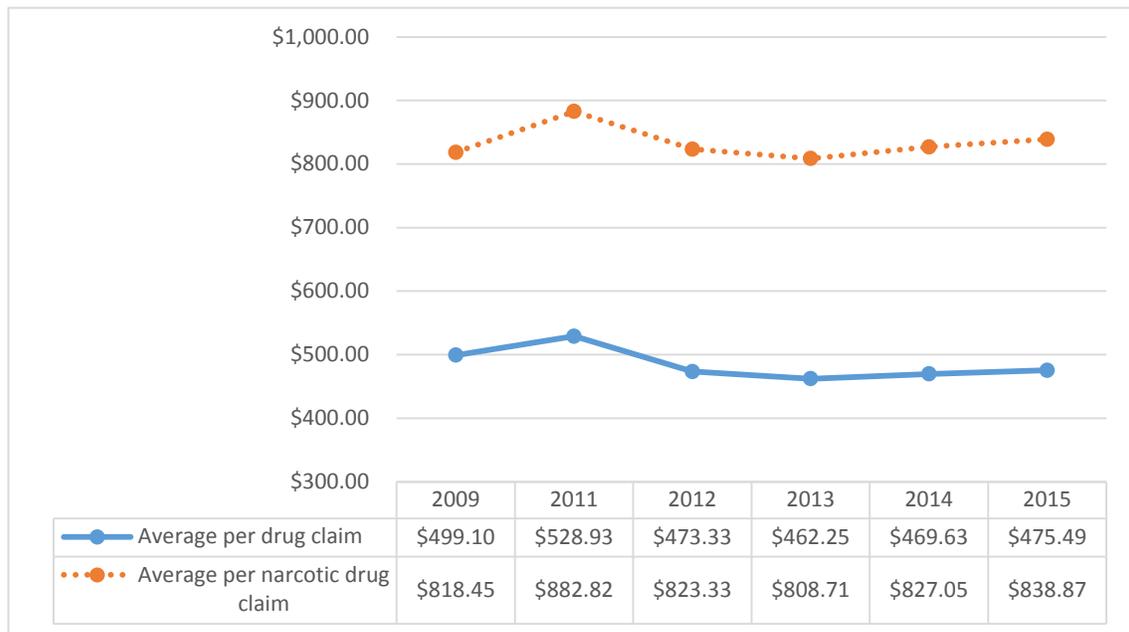
¹⁶ Ontario, Workplace Safety and Insurance Board, *Enhanced narcotics management for injured workers*.

Figure Two: the incidence of narcotic drug claims vs. drug claims, 2009-2015



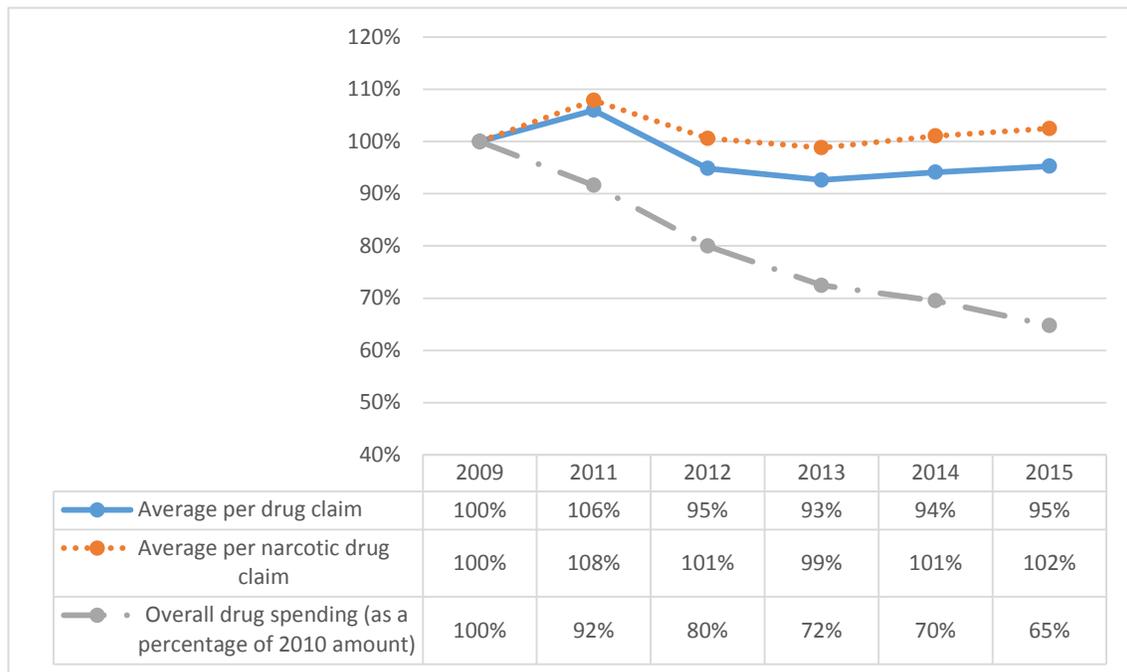
Source: WSIB, Response to IAVGO data requests DR1804, DR2032 and 2344. (The number of “drug claims” is the sum of the claim counts for Schedules 1 and 2, as per Table Two, above. The WSIB provided the number of “claims with narcotics” for both schedules already combined in DR1804, DR2032 and 2344.)

Figure Three: Average amount spent on narcotic drugs, per drug claim and per claim with narcotic drugs, 2009-2015



Source: WSIB, Response to IAVGO data requests DR1804, DR2032 and 2344.
 (Averages are calculated by dividing the dollar amounts of total narcotic spending provided by the WSIB in DR1804, DR2032 and 2344 by the number of “drug claims” and “narcotic claims” per Table Two and Figure Two, above.)

Figure Four: Change in per-claim spending on narcotic drugs a percentage of 2009 amounts vs. overall spending on drug benefits



Source: WSIB, Response to IAVGO data requests DR1804, DR2032 and 2344. (Percentages are calculated using the dollar amounts of set out above in Figure Three (for “average per drug claim” and “average per narcotic drug claim”) and Table Two (“average per drug claim.”))

C. THE DECREASE IN THE OVERALL NUMBER OF ALLOWED NEW CLAIMS DOES NOT EXPLAIN THE REDUCTION IN SPENDING

The WSIB suggests the reduction in drug benefit spending is caused by the decrease in the overall number of claims entering the WSIB system. For example, in response to IAVGO’s request for data about drug spending, the WSIB asked us to consider its data in the context of the following explanation:

Health Care costs have been decreasing year over year since 2011. This can be explained by a decrease in the overall number of new claims as well as the implementation of the new health care programs.¹⁷

This is a minor variation of the explanation in the WSIB’s statistical publication, *By the Numbers*, which states

Health Care payments have been steadily decreasing since 2010 which can mainly be attributed to a decrease in the overall number of claims entering the system, and the implementation of the Health Care and Narcotics Strategies.¹⁸

It is true that the number of new claims entering the WSIB system has slowly declined year by year, for lost-time and no-lost-time claims, and for both Schedule 1 and Schedule 2 employers:

Table Three: allowed new claims per year, 2010-2015

		2010	2011	2012	2013	2014	2015
Schedule One	Lost-time claims	46,160	43,371	42,702	41,508	40,585	38,953
	No-lost-time claims	108,660	108,954	109,648	110,120	110,196	107,507
	Subtotal	154,820	152,325	152,350	151,628	150,781	146,460
Schedule Two	Lost-time claims	14,040	13,301	12,823	12,922	13,103	12,617
	No-lost-time claims	15,192	14,721	14,371	15,208	15,328	14,629
	Subtotal	29,232	28,022	27,194	28,130	28,431	27,246
TOTAL ALLOWED NEW CLAIMS		184,052	180,347	179,544	179,758	179,212	173,706

Source: WSIB, *By The Numbers: WSIB Statistical Reports*, 2015.

¹⁷ Ontario, Workplace Safety and Insurance Board, response to data request DR2032 at 2 [DR2032].

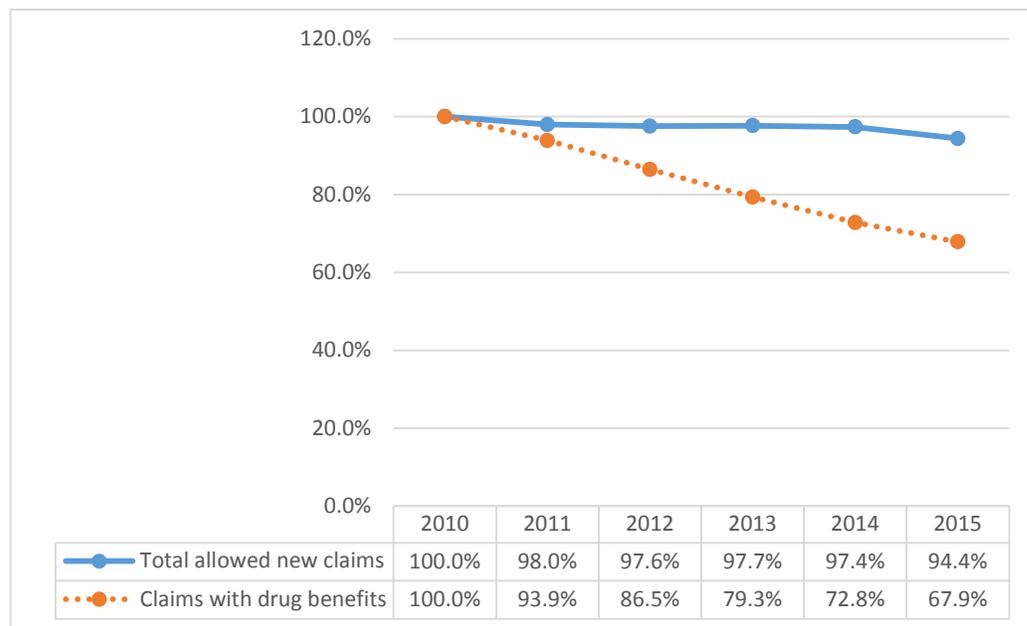
¹⁸ WSIB, *By The Numbers: 2014 WSIB Statistical Report | SCHEDULE 1* at 34.

But whatever its relationship with health care spending overall, the decline in the number of allowed claims entering the system does not explain the reduction in *drug benefit spending*.

If, as the WSIB suggests, the reduction in drug benefit spending “can *mainly* be attributed to a decrease in the overall number of claims entering the system,” we would expect to see the number of drug claims decrease at similar rate to new claims entering the system.¹⁹

However, that is not what has occurred. Instead, every year since 2010, the number of drug claims has decreased at a considerably faster rate than the decrease in new claims entering the system. This disparity in the rates of change is illustrated in Figure Five, below, which presents the WSIB’s claim count data (from Table Two and Three above) as a percentage of the 2010 claim counts.

Figure Five: Change in allowed new claims entering the system vs. claims with entitlement to drug benefits, as a percentage of 2010 claim counts, 2010 to 2015



¹⁹ WSIB, *By The Numbers: 2014 WSIB Statistical Report / SCHEDULE 1* at 34 [emphasis added].

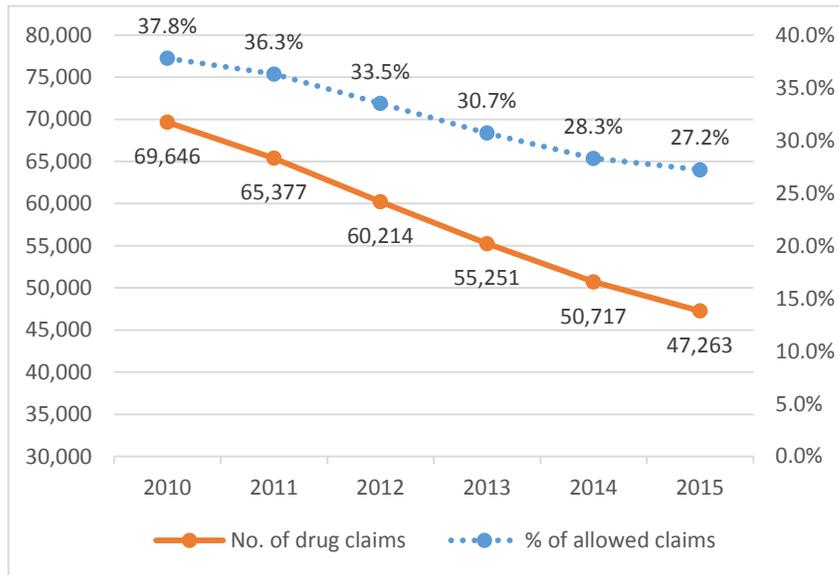
Source: WSIB, *Response to IAVGO data requests DR1804 and DR2344*; WSIB, *By The Numbers: WSIB Statistical Reports, 2011-2015*. (Percentages are calculated using the claim counts of Schedule 1 and 2 combined set out above in Table Three (for “total allowed new claims” and Table Two (“claims with drug benefits.”))

Figure Five indicates that there is *no* meaningful association between the decrease in total number of allowed new claims entering the system and reduction in claims granted entitlement to drug benefits. Over the six-year period, the number of allowed new claims went down by 5.6% in total, and several years (2012-2014) saw no appreciable change at all. But contrast, the number of drug claims decreased significantly—by six or seven percent—*every* year, and the end of the six-year period were down by *one third* overall. Clearly factors other than natural attrition have driven the WSIB’s reduction in drug benefit spending.

D. AN INCREASING NUMBER OF INJURED WORKERS HAVE BEEN EXCLUDED FROM THE WSIB’S DRUG BENEFIT COVERAGE

Underlying the trends in Figure Five, above, is a simple phenomenon: every year since 2010, the WSIB has reduced the number of claims in which it grants entitlement to drug benefits, and this reduction has exceeded the decline in the total number of allowed claims entering the system. In 2010, the number of claims with drug benefits was 38 percent of the total of allowed claims entering the system; by 2015, that had reduced to 27 percent.

Figure Six: Entitlement to drug benefits: number of drug claims, and drug claims as a percentage of total allowed claims, 2010-2015



Source: WSIB, response to IAVGO data request DR1804; WSIB, *By The Numbers: WSIB Statistical Reports*, 2011-2015. (Percentages are calculated by dividing the number of claims with entitlement to drug benefits in Schedules 1 and 2 combined (as per Table Two, above) by the total new claim count data for Schedules 1 and 2 combined (Table Three, above.)

This change has affected a tremendous number of individual workers. If the proportion of workers with allowed claims who are entitled to drug benefits had remained steady over time, then in 2015 we would

About 18,000 injured workers per year have disappeared from the drug benefits program, with no viable explanation from the WSIB.

expect to see approximately 65,600 workers receiving drug benefits, instead of 47,263.²⁰ As things currently stand, some 18,000 injured workers per year have disappeared from the drug benefits program, with no viable explanation from the WSIB.

To find an explanation for the disappearance of thousands of injured workers from the drug benefits program, we considered the WSIB's procedures and practices that affect entitlement to drug benefits in the context of the experience of injured workers and the health care professionals who care for them, namely:

- The removal of drugs from the WSIB drug formularies
- The WSIB's secrecy about the contents of its drug formularies
- Administrative barriers to ongoing entitlement to medications, and
- The absence of meaningful oversight over the WSIB's decisions about drug benefits.

i. The removal of drugs from the WSIB drug formularies

To administer its drug benefits program, the WSIB has established thirteen drug formularies, each of which lists the medications that, in the WSIB's view, constitute the appropriate drug treatments for a particular category of injury or illness.

Individual claims are assigned to the formulary that applies to the worker's compensable injury. If a doctor prescribes a drug that is not on the worker's assigned formulary, coverage for that drug is automatically denied.

In the last seven years, the WSIB removed many drugs from its formularies, including some that have been widely prescribed for the treatment of pain (such as tramadol (Tramacet®) and pregabalin (Lyrica®))²¹ or psychological conditions (such as

²⁰ As noted in Table Three above, in 2015 there was a total of 173,706 claims. If in 2015 the same proportion of allowed claims were granted drug benefits as in 2010 (37.8%), there would be 65,660 drug claims.

²¹ Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions: TRAMADOL* (17 November 2008 revised 29 January 2013); Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions: PERGABALIN* (16 February 2009 revised 29 January 2013).

duloxetine (Cymbalta®)).²² Some of these drugs were restored to the formularies several years later, in their generic form only (e.g. pregabalin was restored to the formulary after an absence of six years, duloxetine after seven).²³

The WSIB says that it removed these drugs on the advice of a committee of experts, known as the Drug Advisory Committee (DAC), which makes recommendations based on evidence about the drugs they consider. There may be merit to these decisions, but the WSIB makes this impossible to independently verify, because the DAC keeps no minutes of its meetings. Indeed, the WSIB is so secretive about the workings of the DAC that it refused to disclose the identity of its members to IAVGO for years (even though the WSIB requires them, as a condition of membership, to agree to making their *Curriculum Vitae* publicly available)²⁴, until the Information and Privacy Commission ordered the WSIB to do so on January 31, 2017.²⁵

The WSIB refused to disclose the identity of Drug Advisory Committee (DAC) members to IAVGO for years.

Legitimate or otherwise, the WSIB's decision to remove drugs from its formularies has resulted in claims being excluded from its drug program.

New claims for a removed drug—that is, prescriptions issued for the first time *after* the drug was removed from the formulary—are automatically denied. Workers in this situation then face the problem of identifying and obtaining a prescription for an alternative that *is* on the formulary, described in the section on the “secret formularies” below, which causes some workers to seek alternatives to the WSIB drug program.

²² Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions: PREGABALIN* (02 March 2015); Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions: DULOXETINE* (30 June 2016).

²³ Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions: PREGABALIN* (02 March 2015); Ontario, Workplace Safety and Insurance Board, *Formulary Drug Listing Decisions, DULOXETINE* (30 June 2016).

²⁴ WSIB, *Drug Advisory Committee Terms of Reference*, s 7(e) (November 2010).

²⁵ *Workplace Safety and Insurance Board (Re)*, 2017 CanLII 6302 (ON IPC)

Other workers, whose prescriptions were covered by the WSIB *prior* to the removal of the drug from the formulary, had their entitlement rescinded in the months that followed the drug’s removal (the WSIB conducts frequent reviews of drug benefits, as described below in the section on “administrative barriers”). When drugs have subsequently been restored to the formulary, the WSIB has made no attempt that IAVGO is aware of to contact the workers affected and advise them that their entitlement might also be restored.

In IAVGO’s experience, workers who have developed long-standing, stable drug therapy regimes with their physicians are understandably reluctant to alter their medications because of a change in the WSIB’s formulary. Those who have access to other insurance plans that pay for prescriptions drugs (such as employment benefit plans, the Ontario Drug Benefit and the Trillium Drug Program) make use of those plans instead of the WSIB. This removes those workers’ claims from the WSIB’s drug benefit program and shifts some of the cost of their workplace injury to private insurers or provincial social programs.

Workers who have other insurance plans use these instead of WSIB, shifting costs to private insurers or provincial social programs.

ii. The WSIB’s secrecy about the contents of its drug formularies

The use of formularies is a common practice in administering drug programs. However, unlike the Ontario Drug Benefit and the Trillium Drug Program, whose formularies have been available to the public for years, the WSIB kept its formularies a closely guarded secret until this report was in its final stages of preparation.

The WSIB announced its decision to disclose its formularies in January 2017,²⁶ following an extended legal and media fight by an injured workers group, Injured Workers Action for Justice, and IAVGO. For a number of years, the WSIB had consistently refused disclose its formularies, even when they were formally requested by IAVGO under the *Freedom of Information and Protection of Privacy Act*. The change of heart came shortly before the Information and Privacy Commissioner (IPC) was expected to rule on IAVGO’s appeal of that refusal.

Notably, in the proceedings before the IPC, the WSIB’s justification for its secrecy was that making the formularies public “would drive up costs on a publicly funded insurance system that

The WSIB decided the disclose formularies only after an extended legal and media fight.

provides compensation to workers” and “overburden a system that [was] trying to eliminate its \$14.2 billion unfunded liability, as there would be a spike in prescription costs.”²⁷

Given that the WSIB has total control over entitlement to drug benefits in individual cases (subject to an appeal to WSIAT), this justification was an admission that releasing

The WSIB kept the formularies a secret for years to reduce to amount it spent on drug benefits.

²⁶ Letter from the Workplace Safety and Insurance Board Privacy Office to IAVGO (23 January 2017); WSIB, News Release, “WSIB Posts Searchable Drug Formularies” (25 January 2017), online: <http://www.wsib.on.ca/WSIBPortal/faces/WSIBDetailPage?cGUID=WSIB070248&rDef=WSIB_RD_ARTICLE&_afLoop=1049380873854000&_afWindowMode=0&_afWindowId=f9hll75b6_101#%40%3FcGUID%3DWSIB070248%26_afWindowId%3Df9hll75b6_101%26_afLoop%3D1049380873854000%26rDef%3DWSIB_RD_ARTICLE%26_afWindowMode%3D0%26_adf.ctrl-state%3Df9hll75b6_129>.

²⁷ *Re Workplace Safety and Insurance Board*, 2017 CanLII 6302, (On IPC) (Submission of the WSIB).

the formularies would result more workers *who are entitled to drug benefits under the WSIA* actually receiving them. Keeping the formularies secret for all these years was a tool the WSIB used to reduce the amount it spent on drug benefits.

IAVGO's clients' experiences show how this tool operated in practice. Workers did not find out that a drug their doctor prescribed was not on the formulary *until they got to the pharmacy* and the pharmacist informed them their WSIB coverage was denied. They then had to make another appointment to see their (busy) family doctor or spend more time waiting for an appointment at a walk-in clinic to obtain a different prescription; and then go back to the pharmacy and hope for a better outcome.

Faced with this situation, some workers simply gave up on the WSIB. They either found another way to pay for the medication originally prescribed to them (because they reasonably believed that, as it was prescribed for them by their treating physician, it was the appropriate treatment for their injury), or resorted to self-medication with alternatives such as over the counter medications, alcohol, or drugs obtained on the street. Others did their best to work within the system. One such worker, appealing to the Tribunal, described their experience in the following terms:²⁸

“WSIB suggestion is to continue to try other meds for my condition... till I find one that has no side effect then submit to WSIB to see if they will pay for it. This could continue for some time as they will not supply info as to what meds they have on their list. This procedure is also hard on me.”

²⁸ *Workplace Safety and Insurance Appeals Tribunal Decision No. 2157/14* (15 January 2015), online: <<http://www.wsiat.on.ca/Decisions/2015/2157%2014.pdf>> at para 15.

Readers can gain a hint of the Kafkaesque world that the WSIB's secrecy for years forced workers to inhabit, from another rare case where a determined worker, this one supported by his employer, appealed his claim all the way to the Tribunal. The worker paid for a drug out of pocket and over a period of months responded diligently to various bureaucratic demands made by WSIB staff—only to be told, once he had done all that was asked of him, that coverage was denied because the drug was not on the formulary. The Tribunal observed:

As the employer so aptly indicated, the worker was very proactive in providing the Board with notice of the change in his medications. It would have been helpful if the worker had been told, up front, that this medication was not covered in the Board's formulary, and therefore, it would never be covered. However, it was not until after the worker had jumped through a number of hoops, and proactively followed up with the Board on a number of occasions, that he was told that the medication was not in the Board's formulary, and therefore would not be covered.²⁹

The WSIB's recent decision to make its formularies public is welcome, and the WSIB deserves credit for making a helpful online search tool to access them.³⁰ However, its years of secrecy pushed injured workers out of its drug benefit program and contributed to the WSIB's reduction in its drug benefit spending.

iii. Administrative barriers to ongoing entitlement

The WSIB requires physicians—often and repeatedly—to complete and file paperwork justifying ongoing drug treatment, even in cases where a worker has a long-standing, stable drug treatment regime for a permanent impairment that requires indefinite management with medication.

²⁹ *Workplace Safety and Insurance Appeals Tribunal Decision No. 1012/16* (27 April 2016), online: <<http://www.wsiat.on.ca/Decisions/2016/1012%2016.pdf>> at para 22.

³⁰ Workplace Safety and Insurance Board, "Drug benefit program formulary search" (25 January 2017), online: <http://www.wsib.on.ca/WSIBPortal/faces/WSIBDetailPage?cGUID=WSIB069352&rDef=WSIB_RD_ARTICLE&afrLoop=1054959922404000&afrWindowMode=0&afrWindowId=null#%40%3FcGUID%3DWSIB069352%26_afrWindowId%3Dnull%26_afrLoop%3D1054959922404000%26rDef%3DWSIB_RD_ARTICLE%26_afrWindowMode%3D0%26_adf.ctrl-state%3Df9hll75b6_392>.

Many family physicians find these administrative requirements unduly onerous, and IAVGO is aware of a several physicians who now refuse to take on WSIB claimants as patients—a phenomenon that has also been documented by other worker advocacy groups.³¹ More commonly, physicians encourage workers who have access to other insurance plans that pay for prescriptions drugs (such as employment benefit plans, the Ontario Drug Benefit and the Trillium Drug Program) to make use of those plans instead of the WSIB, because they do not consume the scare resource of doctors' time with repetitious administrative tasks.

Again, this removes those workers' claims from the WSIB's drug benefit program and shifts some of the cost of their workplace injury to private insurers or provincial social programs.

iv. No check on denial of entitlement through the appeal system

Another factor that contributes to the disappearance of workers from the drug benefits program is that the appeals system does not provide a check on the WSIB's decisions denying entitlement in individual cases.

The workers' compensation appeal system is not a viable means of challenging decisions to deny entitlement to a prescription drug in most circumstances, for two reasons.

First, the appeal system is far too slow to provide access to a meaningful remedy for prescription drug cases. It typically takes more than three years for a hearing to be completed at the Tribunal, whereas prescription drug claims relate to workers' immediate needs for medication. Unsurprisingly, in IAVGO's experience workers give up on the appeal process when they learn how long it will take, and try to find other means of paying for medication.

³¹ *Prescription Over-ruled*, *supra* note 2 at 7.

Second, the nature of the remedy in drug appeals means that workers generally cannot obtain legal representation, even though the medical evidence and legal issues involved can be complex.

Because the monetary value of the claims is usually relatively low (compared, that is, to appeals for Loss of Earnings benefits), publicly funded representation is generally not available. The Office of the Worker Adviser does not represent workers in stand-alone appeals for health care benefits. Nor do IAVGO or other legal clinics who assist injured workers, except on rare occasions where an appeal can be used as a test case to further the clinics' law reform mandate.

Nor is representation by private bar lawyers and paralegals a realistic option.

Prescription drug appeals are not suitable for contingent fee arrangements, because winning ongoing entitlement to a prescription drug results in the WSIB making future payments directly to a pharmacy, and the retroactive benefits (which are only paid if the worker paid out of pocket for the drug and is being reimbursed in cash) are generally too small to make for a viable contingent fee. Paying by the hour is not a realistic alternative either, because the fees for going through the Tribunal's long process could easily exceed the value of the claim (so a worker who could afford the fees would be better off paying for the drug herself).

As a result, the WSIB can generally deny entitlement to prescription drugs with impunity.

IV. THE HEALTH CARE STRATEGY

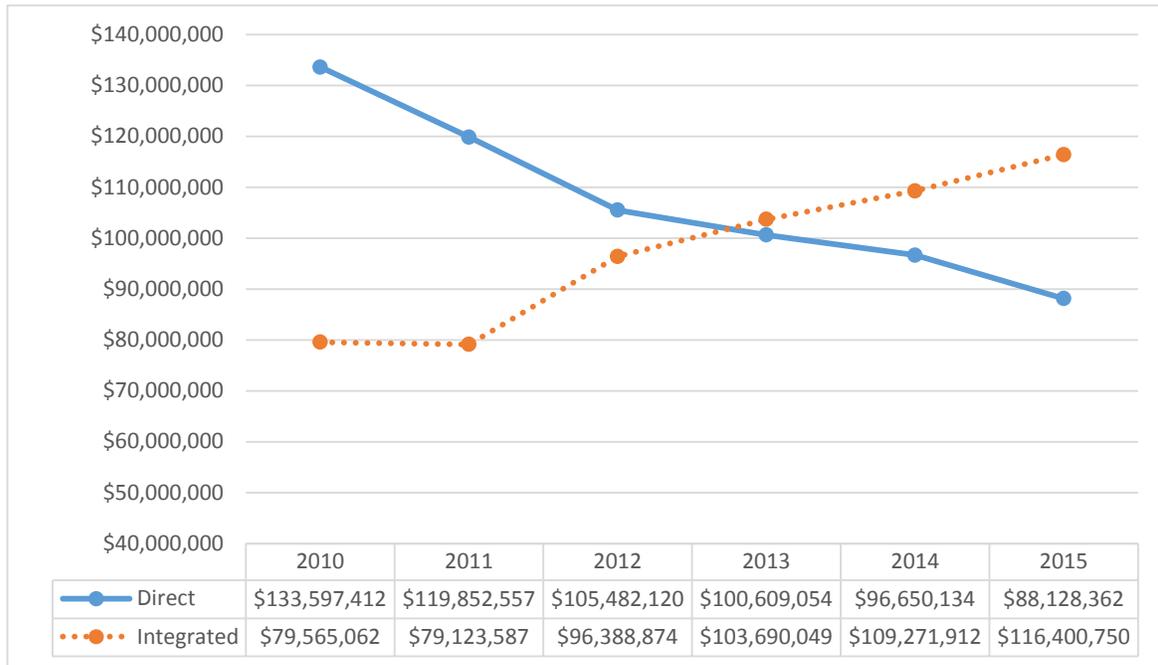
As part of its transformation, in or around 2010 the WSIB began implementing its Health Care Strategy, which it describes as “mov[ing] away from fee-for-service models [and] towards structured and planned health care programs that integrate recovery and return to work planning.”³² This has involved a significant, ongoing transfer of resources from “direct health care” (services provided by health care professionals directly to injured workers) to “integrated health care,” which comprises three broad categories of services known as Programs of Care, Speciality Clinics, and Physician Services (all of which are discussed in greater detail below).

The WSIB’s statistics on health care spending show the continuing roll-out of integrated health care services over the last six years, coupled with a steady transfer of benefit spending away from direct health care and toward integrated healthcare.

As shown in Figure Seven, spending on integrated health care increased by approximately a third, from a little under \$80 million in 2010 to \$116.4 million in 2016. At the same time, spending on direct health care decreased at roughly the same rate, going from \$133.5 million in 2010 to a little over \$88 million.

³² *Measuring Results Q2 2014 supra* note 11 at 4.

Figure Seven: Annual spending on direct and integrated healthcare, 2010 to 2015

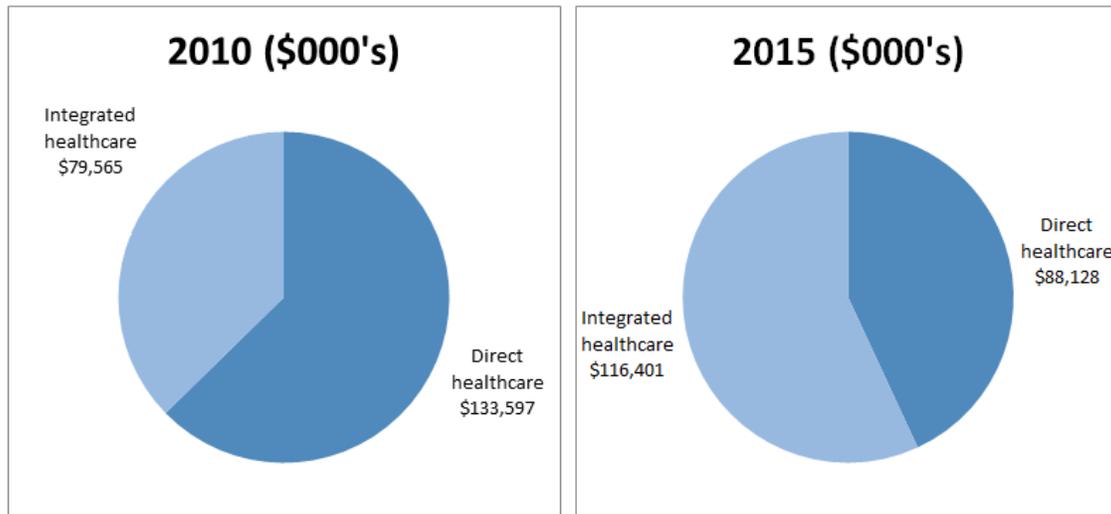


Source: WSIB, response to IAVGO data request DR2032. (Dollar amounts are the sum of the totals for Schedules 1 and 2.)

Figure Eight presents the 2010 and 2015 data in the form of “before and after” pie charts, as another way of visualising the transfer of resources from direct to integrated healthcare. Integrated health care accounted for approximately one third of combined spending on direct and integrated health care in 2010, and approximately two thirds in 2015.

Integrated health care accounted for approximately one third of combined spending on direct and integrated health care in 2010, and approximately two thirds in 2015.

Figure Eight: Direct vs. Integrated Health Care spending, 2010 and 2015



Source: WSIB, response to IAVGO data request DR2032. (Dollar amounts are the sum of the totals for Schedules 1 and 2.)

The WSIB asked us to consider its statistics in the context of the following explanation:

Direct Health Care payments have steadily decreased year over year since 2011. This has been generally offset by increase in Integrated Health Care payments. Total Health Care Payments have declined partly due to a decrease in the overall number of new claims. Our expanded province-wide network of expert, specialized medical assessment and treatment services ensure that injured workers have access to high quality providers and, when needed, specialized hospital-based clinics for more complex injuries or occupational illnesses.³³

³³DR2032, *supra* note 17 at 8.

A. PROGRAMS OF CARE FOR MUSCULOSKELETAL INJURIES

The most significant element of the Health Care Strategy, in terms of the amount of money spent and the number of claims affected, is the WSIB’s development of its Programs of Care (POCs) for musculoskeletal injuries.

The WSIB describes POCs as “evidence-based health care delivery plans that provide treatment shown to be effective for specific injuries and illnesses.”³⁴ They are primarily delivered by health care providers such as physiotherapists, chiropractors and massage therapists. There are three POCs for musculoskeletal injuries:

Programs of care: the most significant element of the WSIB’s Health Care Strategy

i. The Low Back POC

Prior to the transformation, the WSIB provided health care to a small group of workers under the Acute Low Back POC. In March 2011, the POC was substantially revised and expanded—and renamed the Low Back POC.³⁵ Since then, health care providers have been required to treat all workers with acute low back injuries through the POC, unless they fall outside the admission timeframe (six weeks after the date of injury) or there is a clinical “red flag” that makes them ineligible (e.g. major neurological deficits, infections, fractures or tumours).³⁶ The POC “focuses on evidence-based treatment interventions, which include patient education, pain and self-

³⁴ *Ibid* at 6.

³⁵ “Low Back Program of Care” (undated), *Workplace Safety and Insurance Board* (website), online: http://www.wsib.on.ca/WSIBPortal/faces/WSIBArticlePage?fGUID=835502100635000410&_afLoop=1393749785526000&_afWindowMode=0&_afWindowId=null#%40%3F_afWindowId%3Dnull%26_afLoop%3D1393749785526000%26_afWindowMode%3D0%26fGUID%3D835502100635000410%26_adf.ctrl-state%3D14uzclikxa_54 [“Low Back POC”].

³⁶ Ontario, Workplace Safety and Insurance Board, *Low Back Injuries Program of Care Reference Guide*, 4th ed (Canada: Workplace Safety and Insurance Board, 2014) at 7 [*Low Back Injuries*].

management strategies, treatment (exercises, spinal manipulation and/or mobilization), progressive pain management steps and transition to work.”³⁷

ii. The Shoulder POC

Since October 31, 2012, health care providers have been required to treat “all workers with a new shoulder injury” through the Shoulder POC.³⁸ More specifically, the POC is “for workers with an allowed shoulder claim by the WSIB within 16 weeks of injury or recurrence” who have a “diagnosis of bursitis, bruises/contusions, impingement syndrome, rotator cuff tendinitis, sprains/strains or partial tear(s) of the rotator cuff or other shoulder structures.”³⁹ The POC “focuses on the best treatment interventions after a shoulder injury, and includes worker education, injury treatment, including exercise and manual therapy... [and] return to work planning.”⁴⁰

iii. The Musculoskeletal POC (“MSK POC”)

Since August 1, 2014, health care providers have been required to treat all workers with musculoskeletal injuries, except low back and shoulder injuries, under the MSK POC.⁴¹ More specifically, the MSK POC applies to “workers with one injury or more: *To a muscle, tendon, ligament, fascia, intra- articular structure or any combination of these structures, causing mild to moderate tissue damage (Grade I or II) but does not include complete tears, and ruptures (Grade III) which may require surgical repair*” (emphasis

³⁷“Low Back POC” *supra* note 33.

³⁸ “Shoulder Program of Care” (undated), *Workplace Safety and Insurance Board* (website), online: <http://www.wsib.on.ca/WSIBPortal/faces/WSIBArticlePage?fgUID=835502100635000409&_afLoop=1210845170956000&_afWindowMode=0&_afWindowId=null#%40%3F_afWindowId%3Dnull%26_afLoop%3D1210845170956000%26_afWindowMode%3D0%26fgUID%3D835502100635000409%26_adf.ctrl-state%3Dtq998odz_54> [“Shoulder Program”].

³⁹ Ontario, Workplace Safety and Insurance Board, *Shoulder Program of Care Reference Guide*, (Canada: Workplace Safety and Insurance Board, Oct 2012) at 6 [*Shoulder Program Reference*].

⁴⁰ “Shoulder Program” *supra* note 36.

⁴¹ “Musculoskeletal Program of Care (MSK POV)” (undated), *Workplace Safety and Insurance Board* (website), online: <http://www.wsib.on.ca/WSIBPortal/faces/WSIBDetailPage?cGUID=WSIB027007&rDef=WSIB_RD_ARTICLE&_afLoop=1211860754198000&_afWindowMode=0&_afWindowId=tzq998odz_193#%40%3FcgUID%3DWSIB027007%26_afWindowId%3Dtq998odz_193%26_afLoop%3D1211860754198000%26rDef%3DWSIB_RD_ARTICLE%26_afWindowMode%3D0%26_adf.ctrl-state%3Dtq998odz_221> [“MSK POV”].

in original).⁴² The POC “emphasizes task-specific and worker-specific rehabilitation and, consistent with the ‘Better at Work’ philosophy, makes staying at work or returning to work an integral component of rehabilitation.”⁴³

iv. Participation and spending on the POCs

By 2015, the three POCs almost entirely replaced fee-for-service treatments for musculoskeletal injuries. The WSIB now no longer funds any fee-for-service treatment, apart from exceptional cases in which it grants prior approval (which generally involve serious injuries where the type of treatment provided under the POC is not clinically appropriate).⁴⁴

As one might expect, spending on the three musculoskeletal POCs increased rapidly and consistently since 2010. As Figure Nine shows, it increased from \$1.6 million in 2010 to \$20.9 million in 2015. Figure Ten shows that participation in the three POCs—that is, the number of workers whose treatment is provided under one of the POCs—has increased at a similarly rapid rate. In 2010, only 3,468 workers received care under the one musculoskeletal POC in existence; by 2015, when all three POCs were in full operation, that number had increased ten-fold, to 37,006 workers.

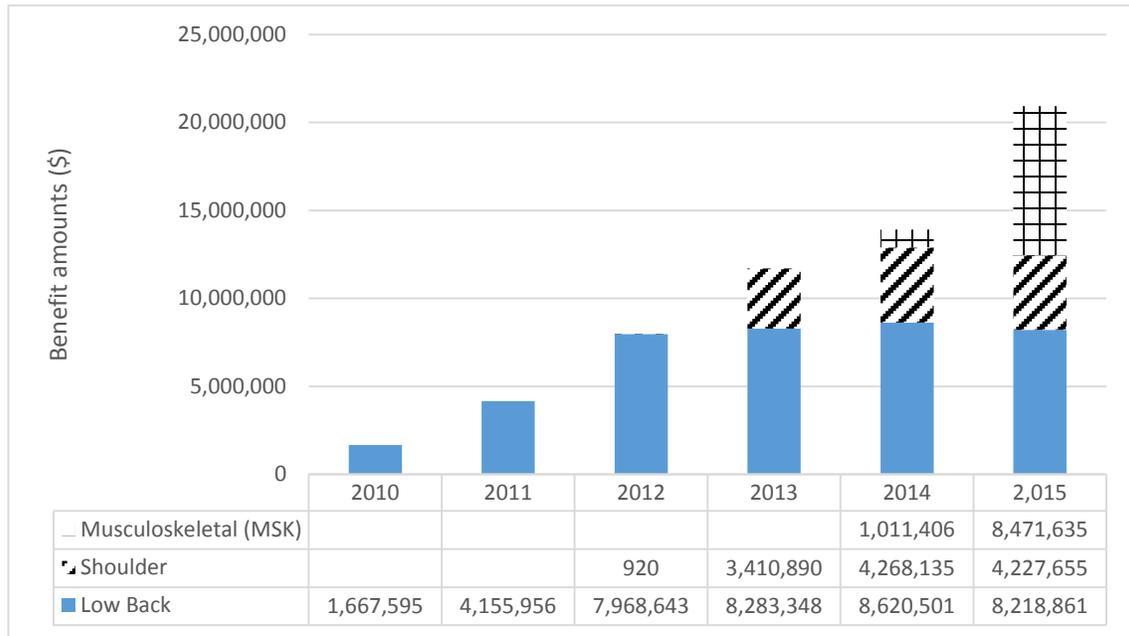
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⁴² Ontario, Workplace Safety and Insurance Board, *Musculoskeletal Program of Care Reference Guide*, (Canada: Workplace Safety and Insurance Board, August 1 2014) at 3 [*Musculoskeletal Program Reference*].

⁴³ “MSK POV” *supra* note 39.

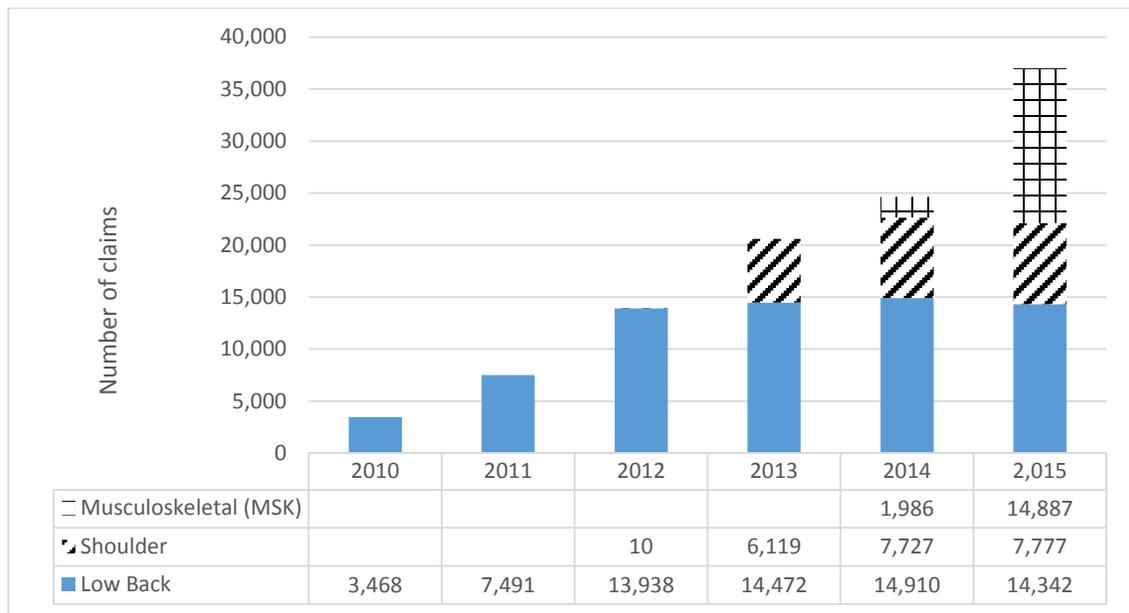
⁴⁴ For example, workers with significant neurological deficits, signs of infection, tumour or a systemic condition may be excluded from the musculoskeletal POC; “MSK POV” *supra* note 39 at 4.

Figure Nine: spending on three major POC's, 2010 and 2015



Source: WSIB, response to IAVGO data request DR2032. (Dollar amounts are the sum of the totals for Schedules 1 and 2.)

Figure Ten: participation in three major POC's, 2010 and 2015



Source: WSIB, response to IAVGO data request DR2032. (Claim counts are the sum of the totals for Schedules 1 and 2.)

v. Cost control measures “integrated” into the POCs

The WSIB used the POCs to transform the fee structure it uses to pay health care providers. Prior to the roll-out of the POCs, the WSIB primarily paid for health care services using a fee-for-service model. By contrast, under the POCs, the WSIB established service caps and various flat-rate fees designed to incorporate benefit cost control measures in the provision of health care.

Under the fee for service model, health care providers’ sole focus in providing treatment was the welfare of their patients. In conjunction with the workers they treated, they determined the type of treatment appropriate to the recovery in the individual case, and if additional treatment beyond what was allowed by the WSIB was required, they could seek approval for additional treatment directly from the WSIB.

By contrast, all three POCs control health care expenditure by capping the length of treatment at eight weeks,⁴⁵

regardless of either the “expected recovery time” for the worker’s type of injury, or the outcome in the individual case.

Further treatment is only available if an adjudicator determines (a) the case warrants

a referral for an assessment by a

Specialty Clinic or a physician working under the WSIB’s Physician Program, or a review by a Medical Consultant, and (b) the assessor or Medical Consultant recommends additional treatment.

Under the fee for service model, health care providers’ sole focus in providing treatment was the welfare of their patients. By contrast, all three POCs control health care expenditure by capping the length of treatment at eight weeks.

⁴⁵ *Shoulder Program supra* note 37 at 11; *Musculoskeletal Program supra* note 40 at 4; *Low Back Injuries supra* note 34 at 4.

The WSIB's cost control measures are integrated into these further assessments too. As will be discussed in more detail below:

- Specialty Clinics are also required by the WSIB to make use of expected recovery times in making their recommendations, which are then frequently relied on by adjudicators as conclusive in individual cases.
- The back and shoulder assessments under the WSIB's Physician Programs are conducted by the WSIB's own physicians or "external contracted physicians who work from their own locations and are paid on a fee-for-service basis for case file reviews", whose primary duty is to their employer or client (the WSIB), rather than the best interests of the worker.⁴⁶

In all three POCs, health care providers are paid a flat fee, for which they are required to provide a minimum number of treatments within a given timeframe.

In the case of the Shoulder POC, the fee arrangement is straightforward: health care practitioners are paid a flat fee of \$560 for a minimum of seven treatments during the eight weeks of the program, plus \$40 for the completion of a mandatory "Care and Outcomes Summary Form."⁴⁷

The Low Back and MSK POCs have **additional cost control** elements built in to their fee structures. In the Low Back POC, the amount of the fee diminishes over the time:⁴⁸

⁴⁶ DR2032 *supra* note 17 at 16.

⁴⁷ Ontario, Workplace Safety and Insurance Board, *Shoulder Program of Care Fee Schedule* (Canada: Workplace Safety and Insurance Board, Oct 2012).

⁴⁸ Ontario, Workplace and Safety Insurance Board, *Low Back Injuries Program of Care Fee Schedule* (Canada: Workplace Safety and Insurance Board, May 2014).

Week of program	Minimum number of treatments	Flat fee
Weeks 1 to 4	3	\$400
Weeks 5 to 6	3	\$180
Weeks 7 to 8	3	\$160

In addition to reducing the cost of physiotherapy for back injuries in the final four weeks of treatment, the Low Back POC’s diminishing fee structure provides a financial disincentive to provide treatment after the first four weeks of the program. For example, IAVGO is aware of cases in which physiotherapists have asked clients to claim the latter part of their treatment on the health insurance provided as part of their employment benefits—thereby shifting the cost from the WSIB to a private insurer.

In the MSK POC, the integration of cost control measures extends beyond health care benefits to compensation benefits. In the mandatory “Care and Outcomes Summary Form” submitted at the end of the program, the health care provider is required to state whether the worker is “able to return to all regular work duties and hours at the conclusion of the MSK POC.”⁴⁹

The amount the health care provider is paid depends on the answer to this question. If the answer is “yes,” the flat fee is \$600. If the answer is “no,” the fee is reduced to \$500, provided that the health care provider advised the WSIB that this was the likely outcome before the end of the sixth week of the program (thereby giving the WSIB the opportunity to engage in some “case management” before the conclusion of the POC). The fee is further reduced, to \$400, if

Where the worker is not fit to return to her pre-injury job, the MSK-POC fee structure puts the health care provider’s financial interests in conflict with the interests of the worker – who may need additional treatment and time to recover from her injury.

⁴⁹ Ontario, Workplace Safety and Insurance Board, *Musculoskeletal Program of Care (MSK POC) Fee Schedule* (Canada: Workplace Safety and Insurance Board, August 2014).

the answer is “no” and the health care provider did not advise the WSIB prior to the end of the sixth week.⁵⁰

Thus, in cases where the worker is not fit to return to her pre-injury job, the MSK POC fee structure puts the health care provider’s financial interests in conflict with the interests of the worker, who may need additional treatment and time to recover from her injury.

Moreover, advising the WSIB that a worker can return to her pre-injury job provides the WSIB with justification for terminating LOE benefits and closing a claim, even if there is no actual return to work. (While WSIB frequently disregards opinion of treating health care providers, such as physiotherapists, that worker cannot return to work, in IAVGO’s experience it accepts without exception health care providers’ opinions that a worker is fit to return to work.)

B. SPECIALTY CLINICS

Specialty Clinics are hospital based services to which the WSIB refers workers with “specific recovery difficulties” for assessment and, in appropriate cases, expedited diagnostic imaging and treatment.⁵¹

The WSIB made use of specialty clinics prior to its transformation. However, in 2010, the WSIB entered into new contracts with the hospitals, changing and expanding the services they provide. According to the WSIB, “the magnitude of changes and expansions in the various specialty programs make year over year [statistical]

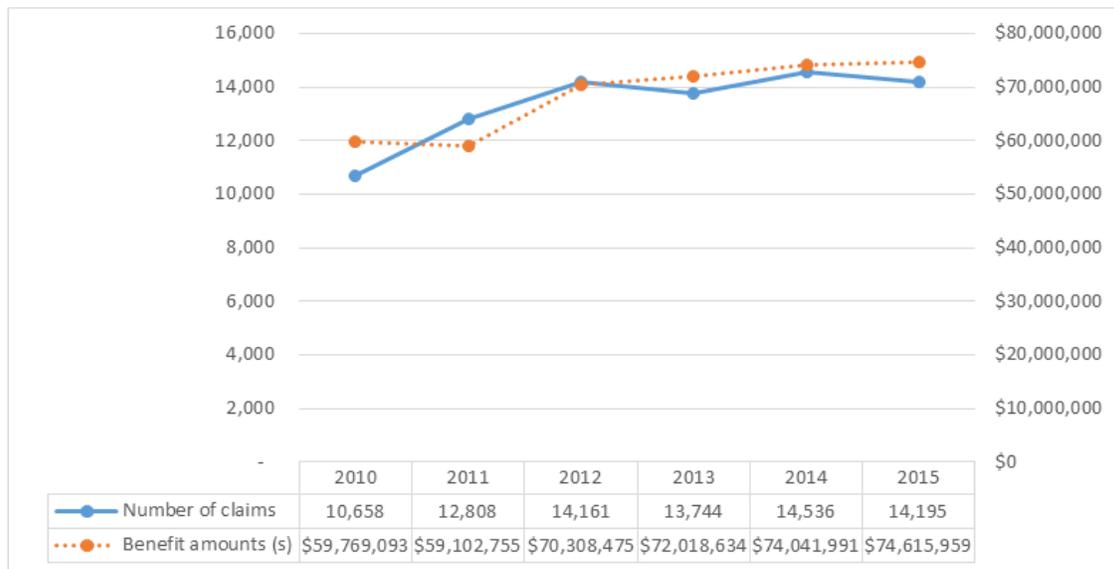
⁵⁰ *Ibid.*

⁵¹ DR2032 *supra* note 17 at 16. The WSIB also refers migrant agricultural workers to Specialty Clinics for assessments to expedite the adjudication of their claims prior to their return to their home country.

comparisons [with years prior to 2010] not possible,”⁵² and therefore they would not provide us with the data we requested from 2005 to 2010.

However, the WSIB did provide us with data about the number of claims referred to speciality clinics, and the amount of money spent on them, from 2010 onwards. As Figure Eleven shows, the number of claims referred to Speciality Clinics rose by approximately one third, from 10,658 in 2010 to 14,195 in 2015. At the same time, spending on Speciality Clinics rose by about a quarter, from just under \$60 million in 2010, to \$74.6 million in 2015. Most of the increase, both in referrals and spending, was achieved by the end of 2012.

Figure Eleven: number of claims and spending on Speciality Clinics, 2010 and 2015



Source: WSIB, response to IAVGO data request DR2032 at 12-13. (Dollar amounts and claim counts are the sum of the totals for Schedules 1 and 2.)

⁵² DR2032 *supra* note 17 at 10.

For some injured workers, being referred to a Specialty Clinic does result in improved care, because it results in expedited access to diagnostic tests and imaging, and sometimes surgical, medical and rehabilitative treatment.

However, referrals to Specialty Clinics are frequently used by the WSIB as a mechanism to control the cost of benefits in a claim. The WSIB sets the terms under which the Clinics make their reports, by providing the form in which the report is to be made and setting out the specific way that they want the Clinic doctors to frame their answers. In most cases, Specialty Clinic doctors are required to include in their report an opinion on the anticipated duration of both the workers' functional limitations and any course of treatment they recommend, based on the "expected recovery time" for the worker's injury.

Referrals to Specialty Clinics are frequently used by the WSIB to control cost of benefits: the WSIB provides the form for the doctors' report and sets out how they want Clinic doctors to frame their answers.

In IAVGO's experience, adjudicators use this information to issue decisions that prospectively "close" the claim. They arrange things so that approval for health care and/or payment of benefits terminates on the date calculated using the "expected recovery time" in the report, and send a decision letter to the injured worker that:

- Advises the worker that the medical evidence is that they will be fully recovered by that date,
- Sets out the limited entitlement to benefits the worker has until that date, and
- Advises the worker that they are closing the worker's file.

In IAVGO's view, the prospective closure of claims in this fashion violates the WSIB's obligation under section 119(1) of the *WSIA* to "make its decision based upon the merits and justice of a case," because the decision is based on data about expected recovery times derived from the population of people with an injury, rather than the evidence

about the individual “case” before them. It puts the onus on the worker to *re-establish* her entitlement to benefits after the closure date if she is still affected by her injury—something that for many unrepresented workers, who know little about workers’ compensation law and procedure, is difficult or impossible to do. Again, this violates section 119(1): the “merits and justice” provision establishes an investigative mandate, which means that it is the WSIB, and not the worker, who should be taking the initiative in determining whether the worker has ongoing entitlement to benefits after the expected recovery time. This includes considering whether the injury resulted in a permanent impairment—an issue that is improperly foreclosed by the pre-emptive closure of a claim before treatment is complete. (This will be discussed further in the section on Permanent Impairments, below).

C. PHYSICIAN PROGRAMS

The WSIB includes in integrated health care a category of services it calls Physician Programs, which the WSIB describes as follows:

Began in 2012... [t]he Physician programs are a combination of internal WSIB staff physicians, and external contracted physicians who work from their own locations and are paid on a fee-for-service basis for case file reviews.⁵³

In other words, Physician Programs are services provided *to the WSIB* by doctors employed by, or working under contract for, the WSIB, to assist in the adjudication of claims. They are not health

care services provided to workers at all.

Table Three sets out the amount the WSIB spent on Physician Programs, and the number of claims the

Physician Programs are services provided to the WSIB by doctors employed by, or working under contract for, the WSIB, to assist in the adjudication of claims; not health care services provided to workers at all.

⁵³ WSIB, response to IAVGO data request DR2032 at 16.

WSIB referred to them, since their inception in 2012.

Table Four: Physician Programs, 2012-2015

Category	Years	Schedule 1		Schedule 2		Combined Schedules	
		Count of Claims	Benefit Payments	Count of Claims	Benefit Payments	Count of Claims	Benefit Payments
Case File Reviews	2012	7,544	\$4,208,755	1,016	\$551,925	8,560	\$4,760,680
	2013	8,798	\$4,903,960	1,530	\$852,515	10,328	\$5,756,475
	2014	8,598	\$4,836,322	1,563	\$895,200	10,161	\$5,731,522
	2015	8,675	\$4,725,560	1,660	\$897,350	10,335	\$5,622,910
Low Back Examinations	2012	72	\$47,050	8	\$5,275	80	\$52,325
	2013	760	\$490,725	97	\$62,950	857	\$553,675
	2014	742	\$480,024	87	\$56,150	829	\$536,174
	2015	579	\$379,125	78	\$50,350	657	\$429,475
Shoulder Specialist Assessments	2012	<5	\$1,100	N/A	N/A	N/A	N/A
	2013	649	\$690,160	132	\$142,190	781	\$832,350
	2014	892	\$802,148	196	\$180,591	1,088	\$982,739
	2015	966	\$900,405	235	\$223,221	1,201	\$1,123,626

Source: WSIB, response to IAVGO data request DR2032 at 11.

As Table Four shows, by far the most significant program is the Case File Review program, which, once it was fully underway, has been used steadily by the WSIB in over 10,000 workers' claims per year.

In a Case File Review, a WSIB adjudicator seeks the opinion of a medical consultant about a particular issue in the file, such as whether an injury is work-related, or whether the medical treatments, or medical restrictions and return to work recommendations, of a worker's treating physician should be accepted. The consultant, who is a doctor employed by one of several for-profit consulting companies under contract with the WSIB, provides an opinion solely based on the medical documents in the claim file.

The WSIB's use of medical consultants in this way has been the subject of multiple public complaints from injured workers, the health care professionals who treat them,

and labour and injured worker advocacy groups.⁵⁴ The objections to the WSIB's use of case file reviews include the following:

- Adjudicators typically refer a claim to a medical consultant to obtain a second opinion when a worker's treating physician or specialist supports entitlement to benefits or sets out medical restrictions that prevent, or limit, return to work. Although medical consultants never meet the worker, adjudicators almost always give the medical consultant's opinion more weight than that of the worker's treating physician. Many workers are thereby denied entitlement to medication and treatment, forced to return to work before they are fit to do so, and have significant difficulty obtaining benefits to which they are legally entitled.⁵⁵

While the WSIB gives the consultant's opinion greater weight than the worker's own family doctor and specialist, the worker has no means of assessing (let alone challenging) the qualifications of the consultant.

- The qualifications of the medical consultants are unknown, apart from the bare minimum publicly available on the website of the College of Physicians and Surgeons of Ontario (which in our experience generally lists them as licensed to practice family medicine). The WSIB refuses to provide any additional information about their education, training and experience. Thus, while the WSIB treats the consultant as a medical expert, according her more authority than the worker's own family doctor and specialist, the worker has no means of assessing (let alone challenging) the consultant's supposed expertise on the specific medical issue in question. If the case reaches the Tribunal and the worker files expert medical evidence of her own, the Tribunal's *Practice Directions* require her to file the *Curriculum Vitae* of her medical expert so that the employer can

⁵⁴ *Prescription Over-Ruled*, supra note 2.

⁵⁵ *Submission to the Ontario Ombuds Office*, supra note 2.

contest, and the Tribunal determine, the qualifications of the expert and the weight that should be accorded to his or her opinion.⁵⁶ The WSIB’s consultant, by contrast, is sheltered from this kind of scrutiny.

- Frequently, adjudicators frame their request for an opinion in a manner designed to elicit an answer that will justify denying entitlement to benefits. Typically, the adjudicator will say in the referral request that the worker’s primary diagnosed condition (e.g. the condition shown in diagnostic imaging like an MRI) is a pre-existing condition, and will then ask whether the worker’s ongoing problems are caused by the workplace accident or the pre-existing condition. Framed this way, the Medical Consultant has no choice but to provide an opinion based on the assumption that the worker has a significant, non-work-related pre-existing condition. But this assumption is frequently contestable, either because there is

Case file reviews are not health care services provided to workers. They are adjudicative tools used by the WSIB to control costs. no evidence that the pre-existing condition was symptomatic prior to the accident, or because the real medical-legal issue in the claim is whether the worker’s accident or job duties contributed to the development of the supposed pre-existing condition. Unsurprisingly, in these cases the Medical Consultants give opinions that workers’ ongoing disabilities are not caused by the workplace accident.⁵⁷

⁵⁶ Ontario, Workplace Safety and Insurance Board, *Practice Direction: Expert Evidence* (01 July 2014), online: <<http://wsiat.on.ca/english/pd/pdExpert.htm>>.

⁵⁷ See e.g. *Workplace Safety and Insurance Appeals Tribunal Decision No. 2932/16* (21 November 2016) at paras 34, 36, online: <http://wsiat.on.ca/decisions/2016/2932%2016.pdf>, *Workplace Safety and Insurance Appeals Tribunal Decision No. 938/16* (21 April 2016) at paras 25, 29-33, online: <http://www.wsiat.on.ca/Decisions/2016/938%2016.pdf>, and *Workplace Safety and Insurance Appeals Tribunal Decision No. 585/17* (19 April 2017) at paras. 31, online: <http://www.wsiat.on.ca/Decisions/2017/585%2017.pdf>. In the later case, the Vice-Chair stated, “The fact that the Board’s request for medical information stated that “strains are not assessable” may have influenced Dr. Choi’s opinion that the worker had not sustained a permanent impairment of the neck, and I attribute limited weight to this aspect of his report for this reason as well.”

The controversy about case file reviews aside, there can be no dispute that they are *not* health care services *provided to workers*. The fact that the WSIB has decided to include them in the category of “integrated health care” lays bare the purpose of the Health Care Strategy. It is designed to “integrate” the provision of health care with claim cost control.

V. PERMANENT IMPAIRMENTS

A. REMARKABLE REDUCTION IN THE INCIDENCE AND SIZE OF PERMANENT IMPAIRMENT AWARDS

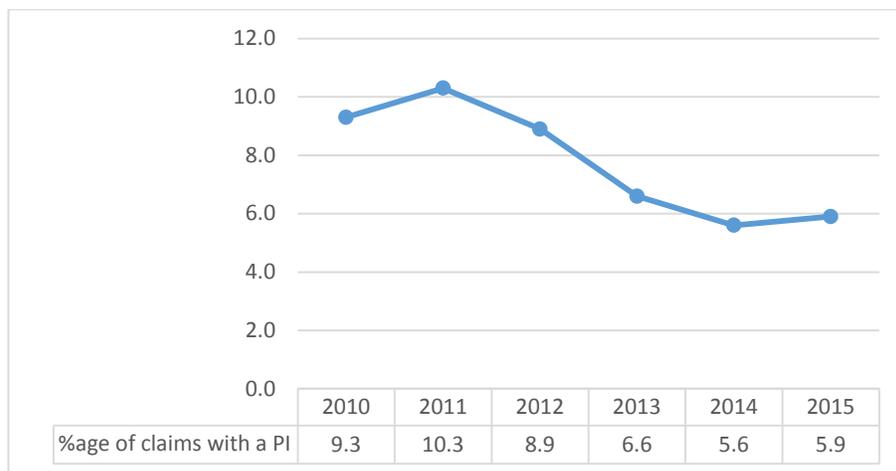
The number of claims in which the WSIB has recognized a permanent impairment (PI) has decreased remarkably since the WSIB began its transformation.

In 2010, the WSIB accepted that 9.3% of injuries resulted in a PI; by 2015, the incidence of permanent impairments had reduced by *more than a third*, to 5.9%.

In 2010, the WSIB accepted that 9.3% of injuries resulted in a PI; by 2015, the incidence of PI's had reduced by *more than a third*, to 5.9% of injuries. Figure Twelve

shows that this reduction was achieved in a three-year period (2012-2014).

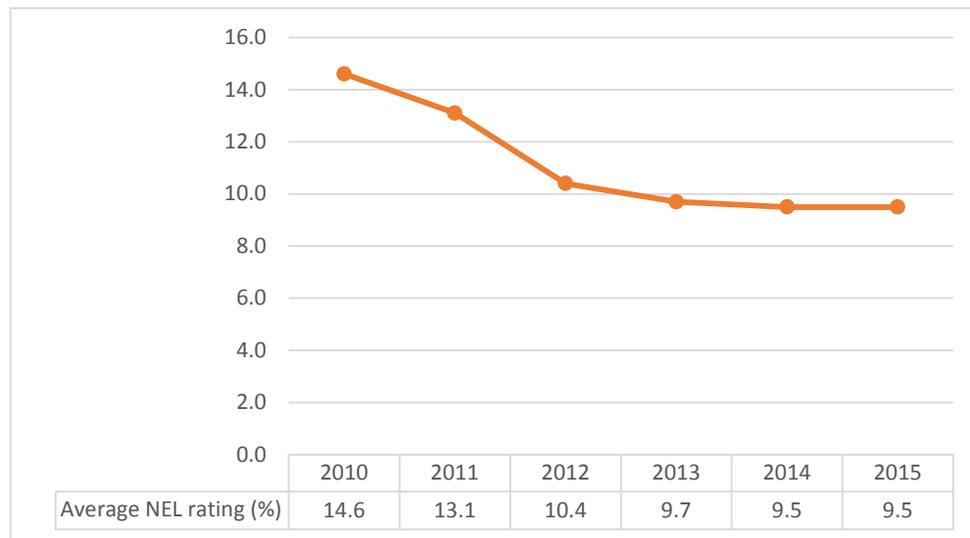
Figure Twelve: Percentage of claims in which the WSIB has recognized a permanent impairment, 2010-2015



Source: WSIB, Response to IAVGO data request DR1804; WSIB, *2012-2016 Strategic Plan: Measuring Results*, Q1, 2012, Q4 2012, Q4 2013, Q4 2014, Q4 2015. (NB: for 2011, the WSIB has not published an annual statistic. IAVGO calculated an annual statistic for 2011 by averaging the four quarterly statistics for 2011 reported in the *Strategic Plan: Measuring Results*, Q1, 2012.)

The average size of the PIs recognized by the WSIB has also decreased remarkably since 2010, again by approximately one third. In 2010, the average NEL award was 14.6%; in 2015, it was 9.56%. Figure Thirteen, below, shows how this reduction occurred over time. More than half of the reduction occurred in a single year, 2012, which saw a drop of 2.7% out of a total of 5%, and by 2013 the overall reduction was largely complete.

Figure Thirteen: Average Non-Economic Loss award, 2010-2015



Source: WSIB, Response to IAVGO data request DR1804; WSIB, 2012-2016 Strategic Plan: Measuring Results, Q1, 2012, Q4 2012, Q4 2013, Q4 2014, Q4 2015. (NB: for 2011, the WSIB has not published an annual statistic. IAVGO calculated an annual statistic for 2011 by averaging the four quarterly statistics for 2011 reported in the Strategic Plan: Measuring Results, Q1, 2012.)

B. THE WSIB’S EXPLANATION OF THE REDUCTION IN PI AWARDS

The WSIB repeatedly cites its data on permanent impairments as evidence that the Health Care Strategy has resulted in improved outcomes for injured workers. For example, in response to IAVGO’s request for data about the incidence and size of NEL awards, the WSIB asked us to consider its statistics in the following context:

One of the most positive outcomes of the WSIB's health care strategy has been a marked decrease in permanent impairments among injured workers. Investments in health care, in particular Programs of Care, has had a particularly striking impact on the number of permanent impairments resulting from certain types of injuries. Programs of Care are evidence-based health care delivery plans that provide treatment shown to be effective for specific injuries and illnesses. For example, since 2010, the number of workers developing permanent impairments from lower back injuries has dropped by over 80 per cent.⁵⁸

Similar statements appear regularly in the WSIB's public reports on the implementation of its strategic plan, *Measuring Results*, published both while the reduction was occurring and after it was substantially complete. Consider, for example, the following statements from the first quarter reports for 2013 and 2015 respectively:

This investment in health care on behalf of injured workers and employers is improving recovery outcomes. The percentage of workers with a permanent impairment (PI) decreased to 7.6% in Q1 2013, from 9.8% in Q1 2012. During this period, the average PI award also decreased to 9.9% from 10.6%.⁵⁹

This quarter, 40.6 percent of claims were treated through WSIB's integrated health care programs, up 5.2 percentage points compared to Q1 last year. This ongoing emphasis on early, expert medical care for injured workers through services such as Specialty Clinics and Programs of Care helped to ensure that the percentage of workers who develop a permanent impairment remains low, currently at 5.6 percent and unchanged since 2014. These services also helped to improve the average percentage of impairment, from 9.9 percent in 2014 to 9.6 percent this year.⁶⁰

⁵⁸ DR2032 *supra* note 17 at 6. Notably, back injuries have been the primary target of the WSIB's use of asymptomatic pre-existing conditions to deny or limit entitlement to benefits, discussed in detail below. We asked the WSIB for data on the average PI percentage for low back injuries from 2005 to 2014, and received the following response:

This data is unavailable as there is not a one-to-one correlation between assessed permanent impairment and part of body in our source data system (WSIB, *Response to IAVGO data request DR1804*).

⁵⁹ 2012-2016 *Strategic Plan: Measuring Results Q1 2013 supra* note 3 at 3.

⁶⁰ Ontario, Workplace Safety and Insurance Board, 2012-2106 *Strategic Plan: Measuring Results Q1 2015* at 3.

We must be cautious about accepting the WSIB's PI data as a measurement of the actual health outcomes of injured workers (and therefore as evidence of the positive affects of the Health Care Strategy), because doing so conflates actual health outcomes with the WSIB's adjudicative rulings about those outcomes. The WSIB's data for the incidence of PI is not a

direct, independent measure of workers' health status; rather it measures the incidence of cases in which the WSIB determines that a worker has a work-related PI for the purposes of

We must be cautious about accepting the WSIB's PI data as a measurement of the actual health outcomes of injured workers (and therefore as evidence of the positive affects of the Health Care Strategy). Doing so conflates actual health outcomes with the WSIB's adjudicative rulings about those outcomes.

entitlement to a NEL benefit. Similarly, the WSIB's data on the size of PIs is not a direct, independent measure of the actual severity of impairments; rather it is a measure of the WSIB's determination of the size of the work-related component of the PI for the purposes of calculating the dollar amount of the NEL benefit.

Both measures, then, are artefacts of the WSIB's adjudication of workers' entitlement to NEL benefits.⁶¹ This raises the question of whether, and to what extent, the WSIB's NEL benefit adjudication provides reliable evidence of improved health outcomes for injured workers.

In our view, it does not. As described below, the WSIB's data, when considered in the context of the WSIB's transformation and the experiences of injured workers, shows that the reduction in the incidence and size of PIs is primarily the result of changes to

⁶¹ This is something the WSIB has partially acknowledged:

As the result of improved health care and the *consistent assessment and application of policy*, the percentage of workers with a PI has decreased by 1.9% from Q4 2011. The average PI award percentage decreased to 9.7% from 14.0%; Ontario, Workplace Safety and Insurance Board, *2012-2016 Strategic Plan: Measuring Results Q4 2012* at 16 [*italics added*].

the WSIB's adjudication practices, rather than the Health Care Strategy. The reduction therefore constitutes a cut in benefits, in the form of fewer, and smaller, NEL awards.

C. THE WSIB'S EXPLANATION IS NOT SUPPORTED BY ITS OWN DATA

As noted above, the WSIB conflates the reduction in the average size of NEL awards with a reduction in the severity of injured workers' permanent impairments, and cites this reduction as evidence that the Health Care Strategy has resulted in improved health outcomes for injured workers. Similarly, the WSIB cites the reduced incidence of claims in which it chooses to compensate a permanent impairment as evidence that the Health Care Strategy has resulted a reduction in permanent impairments.

However, the WSIB's position does not make sense, because both the average size and incidence of PIs were going down *before* the WSIB started funding its integrated health care programs.

As noted above, Figure Thirteen shows that more than half of the reduction in the average size of NEL awards occurred in a single year, 2012, and by 2013 the overall reduction largely complete.

After an initial, steep reduction in 2011 and 2012, the average size of PI's remained stable from 2013 onwards (9.7% in 2013, and 9.5% in 2014 and 2015). Similarly, Figure Twelve

shows that the reduction in the incidence of NEL awards began in 2012 and was largely complete by 2013.

The WSIB's position does not make sense, because both the average size and incidence of PIs were going down *before* the WSIB started funding its integrated health care programs.

By contrast, most of the increased spending and participation in integrated health care occurred *after* 2012. As Figure Seven above shows, *more than half* (54%) of the increased spending on integrated health care occurred between 2013 and 2015. The same can be said of the POCs, the element of the Health Care Strategy that the WSIB singled out in its explanation to IAVGO of the NEL data. As Figure Ten shows, participation in the three main POCs more than doubled *after* 2012; two of them, the Shoulder and MSK POC's, did not even come into effect until 2013 and 2014 respectively.

By contrast, most of the increased spending and participation in integrated health care occurred *after* 2012.

D. CHANGES TO THE WSIB'S ADJUDICATIVE PRACTICES

By contrast, the timing of the reduction in the incidence and average size of PI awards is compatible with three significant changes to the WSIB's adjudicative practices:

- 1) the elimination of independent assessments of permanent impairments
- 2) discounting the NEL awards of workers for asymptomatic pre-existing conditions, and
- 3) using asymptomatic pre-existing conditions to rescind ongoing entitlement to benefits.

i. The elimination of independent assessments

In order to calculate the amount of a NEL benefit, the WSIB must determine the severity of a worker's permanent impairment, expressed as a percentage of impairment of their whole body.

The WSIB has made significant changes to the personnel who determine the severity of permanent impairments. When NEL awards were first established, the level of impairment was rated by an independent physician in the community. The WSIB kept a roster of physicians who had the requisite expertise to assess various types of injuries, and workers could choose from among them which physician they wanted to do the assessment. The physician personally examined the worker, rated the worker's level of impairment against the legislated rating schedule,⁶² and sent a report to the WSIB that formed the basis of the amount of the NEL benefit.

In 2008, the WSIB began moving away from the use of independent physicians, and began sending workers to the WSIB's Regional Evaluation Centres (RECs) for an examination. In some cases, the WSIB dispensed with an examination altogether and allowed its adjudicative staff to rate the level of impairment themselves, using the health information already in the claim file.

We know (from an internal document the WSIB disclosed to the Standing Committee on Government Agencies), that in "2011-2012" the WSIB implemented a "[m]ore aggressive approach to the determination of Permanent Impairment (PI) using health information in the worker's file."⁶³

The WSIB's response to IAVGO's data requests suggests that this "more aggressive approach" has eliminated almost entirely the role of independent assessors in the determination of NEL ratings. In response to our request for the

The WSIB's "more aggressive approach" has eliminated almost entirely the role of independent assessors in the determination of NEL ratings.

number of NEL assessments conducted by RECs and independent roster physicians, the

⁶² The WSIB uses the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 3rd edition, as the rating schedule for determining the degree of permanent impairment; *WSIA*, supra note 4 at s 47(2); O Reg 175/98, s 18.

⁶³ *Orientation: Permanent Impairment Branch* supra note 12 at 3540.

WSIB replied that this “[d]ata [is] not available.... [the] current NEL process does not involve referral to a REC and Roster physician referrals only occur if the ‘by file’ method cannot be conducted.”⁶⁴

As result of its changes in 2011-2012, then, the assessment of the size of permanent impairments was placed almost entirely in the hands of the WSIB’s adjudicative staff. These employees are subject to their management’s imperative to reduce the unfunded liability by solving its “serious expense problem,” are generally not medically trained, and never meet, let alone conduct a medical examination of, the injured worker.

ii. Discounting NEL awards for asymptomatic pre-existing conditions

In 2012 (again, the year in which most of the reduction in the average NEL size was achieved) the WSIB began a new practice of discounting (or “apportioning”) the NEL ratings of workers with pre-existing conditions, even where the worker had no pre-accident symptoms or impairment.

The consultant said that the WSIB should not include any assessment for degenerative processes associated with aging and genetics. The Board implemented this recommendation – even where conditions were asymptomatic.

In early 2012, the WSIB hired a consultant to conduct a review of the NEL system and devise

recommendations for a different way to rate these awards (despite the legal requirement that the Board use the third edition of the *AMA Guides*).⁶⁵ The consultant recommended, among other things, that the WSIB should not include any permanent

⁶⁴ DR2032 *supra* note 17 at 7.

⁶⁵ See note 59, *supra*.

impairment assessment for “degenerative processes associated with aging and genetics.”⁶⁶

The WSIB immediately implemented the consultant's recommendation and, without any change in official policy, started apportioning the NEL benefits of workers with pre-existing conditions, even where those conditions were asymptomatic.

Particular attention was paid to injuries of the back and neck. In May 2012, the WSIB's Permanent Impairment Branch issued an internal document directing NEL assessors (who by this point were almost exclusively the WSIB's own employees) to reduce awards whenever diagnostic or other medical reports show the presence of underlying

Apportioning NEL awards for asymptomatic pre-existing conditions has been the WSIB's standard practice ever since – even though the Appeals Tribunal has repeatedly ruled this is not permitted.

or pre-existing conditions. The most common of these were identified as Degenerative Disk Disease (DDD), degenerative changes of the posterior elements, spinal stenosis and spondylolysis.⁶⁷ The document includes a table advising assessors how to apportion where there is evidence of DDD.

The apportioning of NEL awards for asymptomatic pre-existing conditions has been the WSIB's standard practice ever since, even though the Workplace Safety and Insurance Appeals Tribunal has ruled, often and repeatedly, that this is not permitted by the *WSIA* or official WSIB policy.⁶⁸ But even

⁶⁶ Brigham & Associates, *Permanent Impairment Advisory Service: Executive Summary*, (4 April 2012) at 7 (included in the WSIB's disclosure to the Standing Committee on Government Agencies July 31, 2012 at 1065).

⁶⁷ Ontario, Workplace Safety and Insurance Board, *Spine and Pelvis: Permanent Impairment Branch*, May 7, 2012 (included in the WSIB's disclosure to the Standing Committee on Government Agencies, July 31, 2012, at 3549-3581).

⁶⁸ *Workplace Safety and Insurance Appeals Tribunal Decision No. 204/14* (12 February 2014); *Workplace Safety and Insurance Appeals Tribunal Decision No. 588/14* (7 April 2014), *Workplace Safety and Insurance Appeals Tribunal Decision No. 607/14* (2 June 2014), online: <<http://wsiat.on.ca/Decisions/2014/607%2014.pdf>>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 10/15* (16 April 2015), online: <<http://>

people who accept the validity of the WSIB's actions would have to agree that the resulting reduction in NEL awards does not reflect an improvement in workers' health. It is self-evidently a cut in benefits, legitimate or otherwise.

iii. Using asymptomatic pre-existing conditions to rescind ongoing entitlement to benefits

Midway through 2012 (the year which saw the first significant decrease in the incidence of permanent impairments) the WSIB changed the way it considers asymptomatic pre-existing conditions when determining ongoing entitlement to benefits—including entitlement to a NEL award.

More specifically, the WSIB began regularly rescinding ongoing entitlement in claims where workers did not recover from a strain or musculoskeletal injury within the “expected recovery time” and their test results showed any pre-existing degenerative findings.

This practice has resulted in a reduction in the incidence of NEL awards in two ways. First, as described in the section on Specialty Clinics above, adjudicators have begun pre-emptively closing claims prior to the conclusion of treatment, based on the Clinic's advice about the “expected recovery time.” As a result, unless the worker contests the decision to close her claim, WSIB staff simply do not turn their minds to whether the worker has reached maximum medical rehabilitation with a permanent impairment.

wsiat.on.ca/Decisions/2015/10%2015.pdf>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 946/16* (19 April 2016), online: <<http://wsiat.on.ca/Decisions/2016/946%2016.pdf>>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 313/16* (28 April 2016), online: <<http://wsiat.on.ca/Decisions/2016/313%2016.pdf>>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 558/16* (11 May 2016), online: <<http://wsiat.on.ca/Decisions/2016/558%2016.pdf>>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 392/16* (17 May 2016), online: <<http://wsiat.on.ca/Decisions/2016/392%2016.pdf>>. *Workplace Safety and Insurance Appeals Tribunal Decision No. 462/16* (1 June 2016), online: <<http://wsiat.on.ca/Decisions/2016/462%2016.pdf>>.

Second, in cases where the existence of a permanent impairment is addressed, the WSIB actively seeks out ways of attributing the impairment entirely to non-work-related causes. To support this new approach, the WSIB created an adjudicative advice document titled “Determining a Permanent Impairment when there is a Pre-existing Factor: Permanent Impairments for Work-Related Injuries.”⁶⁹ The document says that regardless of whether the worker has a pre-existing condition or a pre-existing disability, in assessing entitlement to a permanent impairment award, the case manager should “determine which diagnoses and symptoms are related to the work injury and which ones are non-occupational.”⁷⁰ In our experience, this type of guidance has resulted in adjudicators routinely denying PI awards to injured workers, because they feel licensed to find that *any* ongoing injury relates to age-related degenerative changes.

In IAVGO’s view, the practices the WSIB adopted in 2012 to screen out PIs from entitlement to NEL award breach the *WSIA*. But improper or not, the resulting reduction in the incidence of NEL awards is hardly evidence of an improvement in workers’ health. Like the reduction in the size of NEL awards, it is a cut in benefits, legitimate or otherwise.

⁶⁹ Ontario, Workplace Safety and Insurance Board, *Determining a Permanent Impairment when there is a Pre-existing Factor: Permanent Impairments for Work-Related Injuries* (April 2012) (included in the WSIB’s disclosure to the Standing Committee on Government Agencies, July 31, 2012, at 3587).

⁷⁰ These guidelines were effectively adopted as formal WSIB policy in November 2014, in a new policy, 15-02-03 *Pre-existing Conditions*, and in amendments to an existing policy, 11-01-05, *Determining Permanent Impairment*.

VI. CONCLUSION

As a means of reducing its unfunded liability, the WSIB's transformation over the last six years has been a remarkable success: the WSIB is on track to eliminate it completely six years ahead of schedule,⁷¹ even while granting Schedule 1 employers a substantial reduction in premiums.⁷²

For injured workers, the evidence is that the transformation has resulted in cuts to benefits. A dramatic decrease in spending on prescription drugs is the result of thousands of workers per year being excluded from the WSIB's drug benefits program.

Direct health care services—that is, health services provided to workers by physiotherapists, chiropractors and the like—have been transformed into programs that integrate benefit cost control measures with treatment. And—the unkindest cut of all—the reduction in the incidence and size of permanent impairment awards, which the WSIB cites as evidence of improved health outcomes for workers, are in fact the product of the WSIB's aggressive use of pre-existing conditions to deny and reduce benefits.

For injured workers, then, the supposed benefits of the transformation are an illusion, so no one feels them. The cuts, by contrast, hurt because they are all too real.

⁷¹ Ontario, Workplace Safety and Insurance Board, *2015 Economic Statement*, undated, at 6, 7.

⁷² Ontario, Workplace Safety and Insurance Board, News Release, *WSIB Announces First Premium Rate Reduction Since 2001* (September 14, 2016), online: <http://www.wsib.on.ca/WSIBPortal/faces/WSIBDetailPage?cGUID=WSIB068550&r=&_afLoop=1321465151788000&_afWindowMode=0&_afWindowId=4o7y6ri1g_1#%40%3FcGUID%3DWSIB068550%26_afWindowId%3D4o7y6ri1g_1%26_afLoop%3D1321465151788000%26r%3D%26_afWindowMode%3D0%26_adf.ctrl-state%3D4o7y6ri1g_29>.

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