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

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.

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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.

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.

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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.

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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.

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 "Heath 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.

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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 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.