Ontario Legal Clinics'
WORKERS' COMPENSATION NETWORK
Réseau d'échange des cliniques juridiques
de l'Ontario sur la loi des accidentés du travail

Reply c/o: Rexdale community Legal Clinic, 500 Rexdale Boulevard, Toronto, Ontario M9W 6K5
Tel: 416 741-5201 Fax: 416 741-6540

January 31, 2012

The Honourable Dalton McGuinty
Premier of Ontario
Legislative Building, Queen's Park
Toronto, Ontario
Canada M7A 1A1

Dear Premier McGuinty:

Re: KPMG VALUE FOR MONEY AUDIT

We are writing to provide our review of the KPMG Report, and again ask that you decline to implement its recommendations. The WSIB should not take its policy directives from private consultants at KPMG. Changes of this magnitude are properly the subject of a Green Paper and legislative public hearings

Our first and most central objection to KPMG's work is that it went well beyond the proper scope of an independent value for money audit by making specific policy recommendations and even suggestions about possible statutory reforms.

Our second objection is closely related: KPMG failed to appreciate basic legal principles about the workers' compensation system and the statutory principles of the *Act*. Since KPMG exceeded its mandate by making substantive recommendations for policy and legal reform, its misunderstandings about the statute and the law are fatal to the credibility of its Report. If the WSIB actually adopted KPMG's suggested policy recommendations, it would likely be violating its constituting statute. The WSIB cannot introduce policies that reduce workers' statutory entitlement to compensation for recurrences and aggravations that arise out of and in the course of employment.

Thirdly, KPMG's analysis in matters arguably within its expertise is poor and should be given little weight. It concluded that a drastic reduction in benefits was proof of improved "quality and consistency" of decision-making. Where KPMG looked to outside sources of information and expertise, such as the guidelines of the controversial American College of Occupational and Environmental Medicine, it did so without considering various other available sources of expertise.

Finally, we note that KPMG's Report - and much of the WSIB's own work in recent months and years - is animated by the idea that workers' compensation should operate like a private insurance scheme, with cost containment through early "closure" and "resolution" of cases as its main objective. This understanding is wrong. It ignores the rights entrenched in the statutory scheme and the historic trade-off where workers sacrifice their right to sue in exchange for fair

compensation. Instead, proponents of the private insurance model focus on factors external to the statute's primary goals, mainly reduction of costs to employers and principles like “insurance equity”.

Please find enclosed our submission which sets out some of our concerns in more detail. We would be pleased to meet with your office to discuss our submission.

Thank you for your consideration of this matter.

Yours truly,

Jayne Mallin
Director of Legal Services
Rexdale Community Legal Clinic

On behalf of the Worker’s Compensation Network

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SUBMISSION

Introduction

In the past two years, the WSIB has retrenched benefits to injured workers and undermined performance of its statutory objectives in order to contain costs. The ratcheting down of benefits is obvious in the Board's statistics: a 31.3% drop in the number of permanent impairments awards from 2010 to 2011; a 28.6% reduction (which the WSIB terms an "improvement") in the amount of money permanently impaired injured workers receive when their benefits are locked-in.[1] These austerity measures should stop. Instead, it appears that the WSIB is going to continue to cut benefits, this time through policy changes based on the opinion of private consultants at KPMG.

Overview of Opinion

A. KPMG exceeded its mandate and the requirements of an independent value for money audit

While value for money, or performance, auditing is an accepted manner for assessing the performance of government programs, they should be limited to the role of an examination of the economy, efficiency and effectiveness of the areas being studied. Unfortunately, KPMG, in its audits of the WSIB has overstepped the appropriate boundaries of value for money audits and strayed into proposing extensive policy and legislative changes. This is well beyond the role, or proper duties, of an independent auditing agency. It also certainly exceeds the mandate given to the auditor by the request for proposal.

By doing so KPMG has ignored the warnings in several standards and guidelines for performance auditing. For example the International Standards of Supreme Audit Institutions standards and guidelines for performance auditing based on INTOSAI's Auditing Standards And Practical Experience specifically indicates that "however, the moment auditors start asking whether the public commitment itself is feasible at all they will also have to be cautious not to go beyond their mandate by crossing the borderline into political territory". And further on "political decisions and goals established by the legislature are in general the frame of reference, which form the basis of the audit criteria used in performance auditing. It is not the role of the SAI (Supreme Auditing Institution) to questions these decisions and goals".

While a performance auditor may criticize the merits of existing policies if goals are too vague, or in conflict with other objectives, or based on insufficient information, and they may also

[1] WSIB Second Quarter 2011 Report to Stakeholders, p. 3.

criticize existing policies as not achieving the government objective, they are not to criticize the legislative objective itself.

Specifically for example, when looking at a social welfare program, they may look at whether the existing program or aspects of it meet the stated government objectives; however, as stated by INTOSAI, “thus performance auditing does not for example question the level of compensation in a social welfare system”. It is submitted that by suggesting that injured workers are over compensated in cases of recurrences and being compensated for age rather than workplace injury KPMG is doing exactly that.

The performance audit manual from the federal auditor general also warns of performance auditors second guessing government policy, “special care is required when audit findings touch on government policy. As officers of parliament, we are not to be seen to be second guessing the intentions of parliament when it approves legislation or of cabinet when it selects a certain policy direction”. While this is aimed at government auditor generals it is submitted as also apt in cases of independent performance audits.

The same document indicates it is generally understood that audits are useful to examine the implementation rather than development of policy and they are not to question the merits of the governments programs and policies. Yet this is exactly what KPMG has done in the audit of the WSIB Adjudication and Claims Administration (ACA) Program.

A performance or value for money audit certainly may suggest that current policies did not meet the objectives of a specific program and may suggest that alternate policies be considered however they should not actually suggest what those alternate policies ought to be.

Value for money audits also should be done by auditors which are truly independent from the organizations they are auditing. One might question whether repeated use of the same consultants may erode the true independence of the auditor. This was pointed out when looking at the UK National Audit Office and value for money audits, that there was a risk of politicization and association with the organization, not seen as independent, and a danger of being overly dependent on contractors.

Unfortunately, it appears that the lead auditor in this case went into the audit with set goals and did not approach it in an unbiased manner. At a worker-side stakeholders meeting where a representative from IAVGO was present, he indicated that they had “drunk the Kool-Aid” and suggested that the workers' compensation system was perpetuating disability among injured workers. He also implied that senior Board management would follow his recommendations, even if these recommendations were for whole-scale legal and policy change in the system. This raises serious and troubling questions about whether or not this was a proper value for money audit at all.

It could also be questioned whether the auditors have sufficient expertise to deal with medical issues to conclude that it is necessary for injured workers to return to work in essence before they are medically ready to and also that the effects of factors such as age outweigh the contribution of work to injuries and deteriorating medical conditions over time. These are far outside the scope of a value for money audit and the expertise of the auditors.

It appears that KPMG had decided to do a lot more than a value for money audit and in effect attempted an evaluation of certain aspects of the WSIB. However, program evaluation involves different skills and processes beyond a value for money audit. KPMG has neither the expertise nor the mandate to do that.

In conclusion, KPMG overstepped the proper boundaries and standards for a value for money audit by straying into the areas of policy recommendation and commenting on things that they had neither the background nor expertise to do. Also there are troubling indications that this was not a proper independent, unbiased audit but an exercise entered into by a lead auditor who with a set agenda and preset notions of what was going to be recommended prior to commencing the process. By accepting their recommendations, the management of WSIB has overstepped its bounds by taking its policy directives from KPMG rather than the government.

B. KPMG is wrong about basic legal principles

KPMG claims that the only goals of workers' compensation are return to work and recovery

A value for money auditor must become thoroughly familiar with the background of the policies and organizations it is examining. While the KPMG Report cites the fact that the workers' compensation system began in 1914, in its review of the legislation is dealt only with the post-1990s situation and in particular the 1998 Act. The auditor lost sight of - or perhaps never knew - the original purpose of the system.

Indeed, KPMG purports to discuss the goals of workers' compensation without ever mentioning the statutory goal of compensation of injured workers and survivors.[2]

KPMG appears to be labouring under the misapprehension that the originating and only goals of the workers' compensation system in Ontario are recovery and return to work. In its report, KPMG states, "Historically the principles of recovery and return to work have been paramount to the operation of the system." It states that recovery and return to work are the "first principles" of the system. KMPG also muses that a "shift in focus" to securing benefits though litigious means is undermining the main principles of recovery and return to work.[3]

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[2] The WSIA's stated purposes are:

- to compensate injured workers and survivors;
- to facilitate return to work and recovery of injured workers;
- to facilitate retraining and re-entry into the labour market of injured workers; and
- to promote health and safety and reduce injuries.

[3] KPMG Report, p. 13, 50.

KPMG is wrong on its facts. The "first principle" of workers' compensation in Ontario is compensation of injured workers. In 1913, Sir William Meredith's vision in creating the system was a compensation law that would "provide for the injured workman and his dependants and … prevent their becoming a charge upon their relatives or friends, or upon the community at large."

Recovery and return to work were not even features of the statute when the system was first created. Over the years, the statute's purposes have reflected an evolving understanding of what it means to compensate and restore injured workers to their pre-accident situation, and so the statute has been amended to include these additional goals. The ultimate purpose of the system remains the same: to ensure that employers – not workers, their families or society at large - pay for the costs of the injuries their industry creates.

KPMG's approach to the system's goals also suggests that it views the workers' compensation system as centrally an insurance system for employers, the real clients. This is not accurate. Workers' compensation is social insurance, and differs from private insurance in significant ways. This misunderstanding led KPMG to treat injured workers as "customers" of the compensation system rather than clients served by it. It also caused the auditor to subordinate the interest of injured workers to those of employers who they seem to see as the real clients of the WSIB system.

KPMG makes policy recommendations that would fall afoul of the statute

KPMG says that WSIB should revise the Aggravation Basis and Recurrences policies to curtail the "expansion of entitlement"[4] and benefits "beyond what was envisioned"[5] due to pre-existing age-related degenerative changes or conditions. The allegation appears to be that older workers are more vulnerable to having worse injuries, and it is possible that their injuries will take longer to resolve and may reoccur in part because of their age. KPMG claims that older workers are therefore getting more benefits then the law intends and are overcompensated. They suggest that the Board consider revising both the Aggravation Basis and Recurrences policies to reduce such alleged "overcompensation" and even suggest that the WSIB introduce a time limit for claiming a recurrence.[6]

Following KPMG's recommendation on policy reforms would cause the WSIB to fall afoul of its constituting statute, which states that workers are entitled to compensation where their injuries arise "out of and in the course of his or her employment". Well-established law means that the statutory language "arising out of and in the course of his or her employment" in the general entitlement provision of the Act includes:

[4] Page 28 of the KPMG Audit Report.

[5] Page 23 of the KPMG Audit Report.

[6] KPMG Report, p. 28.

- Entitlement for recurrences (re-activation or worsening of workplace injury symptoms) because recurrences are simply the result of the original compensable injury. [7]

- Entitlement for aggravations (where a workplace accident exacerbates or increases the progression of a pre-existing disability) is required by the statute if the work accident advances the pathology of a pre-existing condition.[8]

- Entitlement whenever the work accident is a significant contributing factor to the worker's condition, even if it is not the only factor or even the predominate contributor. [9]

- Entitlement regardless of a worker's pre-existing vulnerability, such as age - the "thin skull" principle. In addition to the Tribunal's pronouncement in the foundational *Decision No. 915*, the relevance of the thin-skull principle to workplace compensation was articulated by Justice Cromwell (now of the Supreme Court of Canada) in *Logan v Nova Scotia (Worker's Compensation Board*):

> It is well-established that something akin to the common law "thin skull" principle applies in workers' compensation law. That is, generally the fact that a particular worker was more susceptible to injury or was more seriously injured than most people would have been in the same circumstances does not break the necessary causal link between the accident and the injury.[10]

KPMG's recommended policy revisions fall afoul of all of these requirements of the statute. The WSIA requires the WSIB to compensate workers regardless of their pre-existing conditions or disabilities, if the workplace injury significantly contributes to their ongoing injury. Full entitlement is warranted even if a worker's condition is more serious or lasts longer than it might have for a younger worker. This is the essence of the thin skull rule.

It is clear that KPMG views the aging workforce as a financial problem for the WSIB. However, its comments and recommendations concerning entitlement for aggravations and recurrences are without legal merit and contradict well-established law. It is little surprise that KPMG made such mistakes because they are not equipped with the skills or expertise to make specific policy recommendations in workers' compensation law.

C. KPMG's Work is Sloppy

We identify below our specific concerns with KPMG's conclusions and recommendations. However, as a whole, KPMG's approach is sloppy, and its analysis is facile. A few examples are particularly troubling and worthy of note at the outset.

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[7] See *Decision No. 746/08* at para 19; *Decision No. 1623/99*; *Decision No. 360/94*.

[8] See Decision No. 2446/09; See *Decision No. 1592/01* at para 21; *Decision No. 2341/08* (September 17, 2009).

[9] See *Decision No. 705/04* at para 17; *Decision No. 101/90*; Decision No. 2062/01R.

[10] As per Cromwell JA (as he then was) in *Logan v Nova Scotia (Workers' Compensation Board),* 2006 NSCA 88 at para 86.

Exclusive reliance on a controversial and biased American body

The KPMG's first statement of "Fundamental Principles & Objectives" is that the WSIB should adopt "key principles" of disability prevention found in the guidelines of the American College of Occupational and Environmental Medicine (ACOEM) on Disability Prevention.[11]

KPMG's reliance on the ACOEM guidelines is troubling. A value for money auditor who elects to look to outside sources of information or expertise must do so in an unbiased way that examines 'both sides' of the issue at stake. KPMG suggested the WSIB adopt the ACOEM guidelines without examining any other research into return to work. For example, KPMG failed to even mention the extensive research on return to work done by Institute for Work & Health scientists in Ontario.

Further, ACOEM is a controversial body that has come under significant criticism in academic literature. It has been criticized in the *International Journal of Occupational and Environmental Health* as a professional association "in service to industry" - it represents the interests of its company employed physician members and, as such, provides them a vehicle to advance the agenda of corporate sponsors.[12] The ACOEM has been criticized for working closely with insurers and employers to limit financial risks, and for not disclosing conflicts of interest in the creation of an "evidence-based" statement on mould (which has been used by attorneys and expert witnesses in mould litigation to invalidate claims).[13] KPMG relies on this controversial College as the sole source of its principled approach to so-called "disability prevention." It does not even reference the presence of a large body of literature created in Ontario about safe and efficient return to work.

Unquestioning conclusions based on inadequate data

KPMG also fails to engage in a meaningful analysis of the actual success of the claims adjudication and administration process in accomplishing the Board's statutory goals. A value for money audit is intended to assess the efficiency, effectiveness and economy of a scheme in fulfilling its statutory goals. The assessment is not supposed to look solely at whether a governmental organization is successfully reducing costs. Rather, it is supposed to assess how well the organization is accomplishing its goals.

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[11] KPMG Report, page 15.

[12] Ladou J, Teitelbaum DT, Egilman DS, France A, Kramer SM, Huff J. "American College of Occupational and Environmental Medicine (ACOEM): a professional association in service to industry." *Int. J. Occup Environ Health*. 2007 Vol 14, No 4.

[13] Kramer S, Perez J. "Association of Occupational and Environmental Clinics (AOEC): Pediatric Environmental Health Specialty Units. Int. J. Occup Environ Health. 2007; 13: 427-430. The authors states: "It is of grave concern that occupational-physician associations such as ACOEM and AOEC, which work very closely with insurers and employers to limit financial risk, are being given such a significant role in furthering the understanding of environmental illness in children."; Craner J. "A Critique of the ACOEM statement on mold: undisclosed conflicts of interest in the creation of an "evidence-based" statement. Int. J. Occup Environ Health. 2008 Vol 14, No. 4.

But, time and again, KPMG confused reduced benefits and reduced costs as proof of the WSIB achieving its statutory goals.

For example, KPMG notes a significant increase in denial of initial entitlement, from 7.9% to 11.3% of claims from 2009 to 2010. KPMG notes that this increase in denials is attributable to more specialized adjudicators and more management oversight, leading to better quality and consistency in decision-making. While these are possible reasons for the increase in denials, KPMG needed to consider other possible explanations, including whether managers and adjudicators were being pressured by the Board's financial situation to deny claims that they might in the past have allowed.

KPMG also asserts that LOE lock-in decisions are being "improved" because 27.6% fewer workers received full LOE at the lock-in in 2010 versus 2009.[14] This analysis is even more facile that its conclusions about initial entitlement denials. Workers who have benefits locked-in are, as KPMG acknowledged, those with the most so-called "complex" claims (meaning workers who are the most seriously injured and vulnerable). Not even KPMG can claim that the 27.6% reduction in workers receiving full LOE means that 27.6% more workers are returning to work and thus only suffering a partial wage loss and only needing partial LOE. It should have been obvious to the auditors that the primary reason for the precipitous drop in benefits at the lock-in was more restrictive decision-making and likely management reversals of front-line decisions. So, the auditors should have asked whether this more restrictive decision-making was efficiently serving the WSIB's statutory mandate, which includes compensation of injured workers, recovery and return to work. If KPMG had engaged in this honest analysis, it would have been clear that the WSIB's ratcheting down of benefits to workers who are unemployed has served only one goal: reduction of costs to employers. This cannot lead to a conclusion that they are delivering value for money.

And, KPMG stated that reduction in the time "on benefits" at 3, 6, 12 and 24 months post-injury is evidence of improved return to work and recovery.[15] KPMG went so far as to say that workers are returning to work more quickly.[16] In fact, the statistics KPMG used appear to show only that workers received fewer benefits, not that they actually returned to work. It is possible that return to work improved (versus decision-making being made more restrictive), but the available data does not prove that. At very least, KPMG needed to consider the various possible explanation for the changing benefit levels, and explain its preference for one likely explanation over another.

Recommending changes with the sole objective of benefit reduction

KPMG recommended some significant changes to the benefit scheme solely based on prospects for cost reductions, without any consideration of the WSIB's statutory goals.

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[14] KPMG Report, p. 41.

[15] KPMG Report, pp. 45, 65.

[16] KPMG Report, p. 45.

For example, KPMG recommended that the WSIB create its own rating schedule for NEL awards, solely on the reasoning that Ontario's average NEL awards are higher than the average in some other provinces.[17]

NEL Awards

The Lead Auditor does not like the use of the American Medical Association Guide to the Evaluation of Permanent Impairment 3rd edition (hereinafter the AMA guides). He states on page 36 of the report:

> Existing policy is found to provide for adequate guidance and direction as related to the rating of PIs. However current regulation requires the use of the AMA guide third edition to conduct PI assessments, which presents a number of issues. The guide is:
>
> - Paragraph 15+ years old and medically out of date
> - Not user-friendly or easily understood by nonmedical professionals
> - Nonspecific to occupational injuries

However this is not the only reason for disliking the use of the guides. This is clear from statements on page 37 of the report where he states:

> Outcomes in Ontario with respect to PRA's are not consistent with Peer organizations. In particular Ontario grants:
>
> - A higher proportion of NEL awards relative to lost Time injuries compared with the WSIB Peer organizations
>
> - A higher average NEL award percentage compared to the WSI Diese peer organizations (Ontario: 14.6%; Alberta: 9.6%; BC 5.1%; Québec: 8.7%)
>
> The difference is between Ontario and peer organizations appear to relate more to the use of the AMA guide third edition into the severity of the injury. The WSIB should consider creating its own reading shuttle, much like other provinces have done. This would bring great greater consistency, transparency and fairness to the rating of PIs.

Clearly the main reason for disliking the AMA guides is not because they are out of date, or not user friendly, or not specific to occupational injuries, but because they appear to grant higher percentages to injured worker. Changing the schedule may provide consistency, transparency and fairness to someone, but it will also result in less money for injured workers for their permanent impairments.

Firstly we feel that this recommendation overstates the generosity of the AMA guides and the generosity of the NEL system. Second, the report has no understanding of the history behind the adoption of the AMA guides and if one understands the history of its adoption, one will understand why going to an internal policy would not serve the interests of injured workers or the system.

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[17] KPMG Report, p. 37.

The analysis with respect to the generosity of the NEL system in comparison to other Workers' Compensation Boards in Canada is suspect. The conclusion that the lead auditor draws is that the system gives NEL awards that are too generous because the average NEL percentage is higher in Ontario than in three other provinces.

The use of the averages is suspect because of the nature of the workforce covered in Ontario, Quebec, BC and Alberta. As of 2009 Ontario only had 73.4% of its workforce covered; this is one of the lowest rates of coverage in Canada.[18] For the same year Alberta had 91.84% of the workforce covered, BC had 93.34% of the workforce covered and Quebec had 93.32% of the workforce covered. This difference in coverage would have a profound impact on the average NEL award in Ontario versus in Alberta, BC and Quebec since the 25% of the workforce not covered are primarily white collar workers. The workforce that is covered is dominated by Construction, Mining, Forestry, and Manufacturing. These industries produce more accidents and more serious accidents than you would see in the predominantly white collar industries that are not covered in Ontario. This would lead to more NEL awards as a percentage of accidents than you would see in provinces that had more universal coverage. This would also lead to higher average awards than you would see in provinces with more universal coverage.

Even with the higher average percentage, this does not lead to a more generous NEL award than in other provinces. For an injured worker, the important part of the NEL award is not the percentage awarded but the amount of Cash awarded. When you use this perspective, the Ontario system does not seem as generous as other provincial systems. For a 45 year old worker in Ontario, the base NEL benefit would be $57096.10; a 10% NEL would pay that injured worker 5706.91.[19] In Alberta that same worker would get $8340.18; in Quebec he or she would get $7075.30.[20] The Ontario worker would get a significantly lower NEL benefit than workers' in other provinces. When you look at all of Canada of the 9 provinces and territories that give benefits that are analogous to a NEL award, the average 10% award for a 45 year old worker would be $6991.54. Clearly Ontario has below average NEL awards.

Because of this stark difference in the NEL base, even the average awards are not as generous as is first seen. An average NEL for a 45 year old worker in Ontario would be $8332.09. The average NEL for a 45 year old worker in Alberta would be $8006.58 and the average NEL for a 45 year old in Quebec would be $6144.91. These differences are not as stark as would be suggested by looking simply at the average NEL awards.

In any event a comparison of NEL awards in Ontario with similar awards to other provinces misses a fundamental point about Workers' Compensation in Ontario. Workers' Compensation is not about being generous to the workers that our economy injures and kills on the job. Injured workers traded their right to sue their employers in order to get compensation speedily. If an injured worker still had the right to sue his or her employer for injuries on the job, then the

[18] Source: Association of Workers' Compensation Boards of Canada

[19] The use of a 45 year old worker is necessary as both Ontario and Quebec give different base awards depending on the age of the worker at the time of the injury. They appear to be the only provinces to do so. Source: association of Workers' Compensation Boards of Canada.

[20] British Columbia does not pay a NEL award. Their permanent disability award is based on a percentage of the worker's pre-injury earnings and is paid as a pension. If this were converted to a lump sum it would be significantly higher than any NEL award or its equivalent.

analogous award in Tort would be the general damages award. The base general damages award would be approximately $350,000.00; 10% of that would be $35,000. Discussions about the generosity of the NEL system in Ontario should take, as its starting point, the fact that injured workers get roughly ¼ of the money that they gave up in giving up their right to sue.

The history of the NEL award and the implementation of the AMA guides also give us some idea of why we should not be adopting some internally generated rating schedule.

The current dual award system started in 1990 with the adoption of Bill 162. The NEL award was a small part of the compensation for injured workers with permanent impairments; the major part of the compensation was through the Future Economic Loss award which paid income loss benefits during the time of the income loss until age 65.[21]

Prior to 1990, injured workers with permanent impairments received a pension for life for their permanent impairment. The award was based on the injured workers pre-accident earnings and the percentage was based on an impairment award. All injured workers with similar impairments received similar awards, regardless of the impact of their permanent impairment on their ability to earn.

The rating schedule used to rate permanent impairment under this scheme was the ''Ontario Rating Schedule''; it is still used to rate injured workers for their impairments based on pre 1990 injuries and can be found in policy 18-07-02. In the injured worker community the Ontario Rating Schedule was colloquially referred to as the "Meat Chart".

The Meat Chart was neither transparent nor user friendly. One of the results of Decision 915 was that the Meat Chart, as a matter of law, could only be understood by the few Workers' Compensation doctors who actually performed ratings. No other doctor could comment on the appropriateness of a rating making an appeal of a pension rating hopeless; this made the Meat Chart unfair.

Bill 162 changed that. By moving away from the Meat Chart, the legislature clearly intended to move away from Board generated policy document that could only be understood by Board employed doctors.

The Workers' Compensation Board did, in 1991, try to develop an alternative rating system. They commissioned a study that they claimed was the largest such study of permanent impairments at they time. This study included a large survey of people for their opinions on permanent impairments and the percentages that they ought to generate. The Workers' Compensation Board rejected the results of the study because they felt that the NEL awards that would be granted as a result of the survey would be too high. The 3rd edition of the AMA Guides was adopted instead for physical impairments.[22]

While the AMA guides are not simple, they can be learned by non-medical people. The training to understand them takes about an afternoon. This relative simplicity is much preferred to the

[21] The dual award system changed with Bill 99 in 1998; the general scheme of the wage loss system remained unchanged and the income loss benefit was renamed the Loss of Earnings Benefit.

[22] Psychological impairments and Chronic Pain Disorder used "psychological and behavioural disorders rating schedule", an internally generated Board Policy.

opaqueness of the Meat Chart which **as a matter of law** could only be understood by Board Doctors. It is also unclear why the fact that it is not specific to occupational injuries would matter. Suppose that a person had occupational induced asthma with specific results for FEV1 and FCV1 testing. Would that person's disability be any different because it was occupationally induced than someone else with Asthma with the exact same FEV1 and FCV1 readings?

Reviewing other Jurisdictions rating schedules, you can see that they are using variants of the old Ontario Rating Schedule. This is most clearly seen in looking at the ratings for hand impairments. Alberta, Manitoba and New Brunswick use the identical rating for hand impairments as the Ontario Rating Schedule. Manitoba's rating for spinal impairments is identical to the Ontario Rating Schedule. Compensation for psychological disability is very similar throughout Canada, with the exception of Newfoundland which does not appear to give permanent disability awards for psychological disability.

Many other provinces appear to be using the same schedule that Ontario's Legislature rejected over 20 years ago. We feel that it would be a rejection of the intent of the legislation to go back to a rating schedule that had similarities to this schedule. While a return to the days of the pre-non-economic loss award pension rating system might be more administratively efficient off for the WSIB, it would be inherently unfair for injured workers as they could do nothing about a decision that they were unhappy with as they would there would be no opportunity whatsoever to challenge the adequacy at the award. While the AMA guides third edition may be out of date it is at least something that persons who were not WSIB doctors can examine, they compare the rating to the medical reporting and determine whether the rating itself is consistent with the rating guides.

Representation of Injured Workers

The injured workers represented by community legal clinics are mainly former low wage earners from small and non-unionized workplaces who are permanently disabled and come to us for assistance after their workers compensation benefits have been cut. Often, they have limited education, job experience and English language skills. Most, are surviving on social assistance or with the support of family. A significant proportion suffer from post injury psychological symptoms such as depression related to being disabled, being unable to work and living in poverty, unable to support themselves and their family.

KPMG offends these clients by stating that the "WSIB's legislative and policy framework … gives rise to multiple opportunities for … adjudicative reviews … undermines administrative efficiency and … creates a "faint hope" moral hazard" (page 14) is offensive. These injured workers need hope in a slow, bureaucratic decision making process that may permanently deny them compensation for their injury without the injured worker ever having met or spoken to anyone in the workers' compensation decision making process. They need an appeal process that will allow them an opportunity for a fair hearing.

The report alleges at page 14 that "The WSIB stakeholder environment includes a large representative community … with conflicting interests and perspectives on the role of the WSIB, the economic entitlements of injured workers and the responsibilities of employers. This has

driven stakeholder demands that have resulted in a broadening of the WSIB mandate …" This suggestion that representatives have managed to broaden the mandate of the WSIB is mistaken. The WSIB's mandate comes from the legislation and is limited by the legislation. It is clear that KPMG would like to see workers' compensation much more restricted than it is now, but it is ridiculous for KPMG to claim that representatives have forced the WSIB to exceed its statutory mandate. Again, this critique by KPMG that "[t]his expanded mandate creates a social dependence that makes it more difficult to bring closure to individual cases" (page 14) demonstrates a lack of appreciation that the WSIB is a social institution, established in return for injured workers giving up their legal right to sue in the courts for compensation for permanent injury, and upon which many injured workers will have to depend upon for the rest of their lives.

Management Oversight & Performance Monitoring

The Value for Money auditors conclude that although significant progress has been made by the WSIB in the area of management oversight mechanisms, it is important that the WSIB develop a comprehensive framework covering its critical decision making functions and identifies opportunities to formalize timelines and broaden the level of oversight across the entire claim lifecycle.

Two recommendations were advanced in this regard:

Recommendation #9: WSIB should assess its timelines with respect to all critical adjudication activities to ensure appropriate review deadlines have been established to support timelier decision making with respect to recovery and return to work.

Recommendation #10: WSIB should strengthen its management oversight by developing a formal review and approval framework for key decisions, including referrals for PI Assessments.

WSIB Management has responded to these recommendations by agreeing with each of them. With respect to Recommendation #9, the WSIB has established and begun installing operational benchmarks (process measures) that describe all critical adjudication activities with corresponding management measures and targets for all phases of a claim. With respect to Recommendation #10, the WSIB states that has established manager reviews and touch points, and will establish an oversight and approval framework to ensure an appropriate level of quality consistency and risk management in relation to key decisions, including all referrals for permanent assessments.

As legal representatives of injured workers, the Ontario Legal Clinics' Network raises the following concerns and comments with respect to these two recommendations:

Recommendation #9:

Timelier decision making with respect to recovery and return to work is a very important goal which has the potential of providing a benefit to injured workers, so long as the timelier decision making results in improved service to injured workers. Improved service requires truly improved recovery times and successful return to work. Simply reducing decision making times with the aim of terminating claims sooner so as to reduce costs does not improve those decisions.

Important decisions should be made more quickly. However, pressing injured workers to return to work before they are ready in order to meet WSIB's operational benchmarks and targets will result in the opposite proposed impact of increased efficiency and effectiveness. Several research studies have demonstrated that forcing seriously injured workers to return to work increases the risk of re-injury and has not resulted in sustainable employment.
The Ontario Network urges the Board to consider the many studies including *Red Flags/Green Lights: a Guide to Identifying and Solving Return-to-Work Problems,* and MacEachen et al, *A deliberation on 'hurt versus harm' logic in early-return-to-work policy* prior to implementing management measures and targets in any phase of the claim but most importantly with respect to decisions relating to recovery and return to work. The risk of true harm to injured workers as a result of pre-mature, forced return to work is great and an inappropriate risk in furtherance of reducing the duration and thus the cost of claims.

Recommendation #10:

This recommendation appears to be clearly aimed at reducing the costs with respect to the claims of workers with serious injuries that result in permanent impairment and thus significant loss in their ability to restore earnings. The recommendation supports a redoubling of management oversight of key decisions with no guidelines to ensure *better* decisions.

In addition, the WSIB's Management Response that it will establish an oversight and approval framework to ensure an appropriate level of quality consistency and risk management in relation to key decisions risks breaching the Board's duty of fairness in its decision making capacity.

The administrative law duty to be fair in decision making applies to the WSIB, as a public authority whose decisions affect the rights and interests of injured workers, their survivors and employers.[23] The Supreme Court of Canada has ruled that the purpose of the duty of procedural fairness is:

> "to ensure that administrative decisions are made using a fair and open procedure, appropriate to the decision being made and its statutory, institutional, and social context, with an opportunity for those affected by the decision to put forward their views and evidence fully and have them considered by the decision-maker."[24]

The majority of the Court in *Baker* went on to say that the more important the decision is to the lives of those affected and the greater the impact on that person, the more stringent are the procedural protections that will be mandated. The court cited the example of the right to continue one's profession or employment being at stake and the "grave and permanent consequences" of those decisions on a professional career.[25]

Such are the serious consequences of the decisions which the WSIB is charged to make respecting recovery, return to work and other key decisions relating to benefits and assessments of injured workers. Canadian law mandates that injured workers are entitled to

[23] Jones, David Phillip and de Villars, Anne S. *Principles of Administrative Law, Fifth Edition,* 2009 at page 255.
[24] *Baker v. Canada (Minister of Citizenship and Immigration* (1991) 14 Admin L.R. (3rd) 173 (S.C.C.) p. 192-94
[25] Ibid

have decisions affecting their rights, interests or privileges made using a fair, impartial and open process which is appropriate to the statutory, institutional and social context of the decision being made. We are concerned as representatives of injured workers that the recommendations accepted by the WSIB will infuse these decisions with inappropriate considerations of reducing duration and cost of claims, most notably those which result from serious injury. This is in violation of the duty to be fair that the Board owes injured workers.

In addition, the audit fails to calculate the additional bureaucratic cost of this increased management oversight, both in terms of actual dollar cost and in terms of delay that a more complex decision-making scheme, with several "reviews and touch points", would necessarily entail. The KPMG Report posits that positive effects will result in the sense that the Board will achieve savings in both benefits and long term liabilities. It is assumed that the increased bureaucratic costs will be recovered through the process of reducing benefits to injured workers, shouldering them thusly, and unjustly, with the costs of these initiatives.

Policy Renewal Framework

KPMG recommends as a leading practice that there be "ongoing review and renewal of policies to give clear, concise and consistent direction to WSIB staff and stakeholders."(p. 17) The report concludes that the present "policy suite" is too complex and limits the ability to "bring resolution" to a claim in a timely fashion. It bemoans the fact that there are multiple avenues for reconsideration and/or appeals of decisions within the current policies. (p. 51)

KPMG goes on to address several specific policies which it recommends changing in order to "optimize recovery and early and safe return to work" which it sees as the filter through which all policies should be assessed.

KPMG recommends:

1. revising the aggravation basis policy because it is too difficult to separate out the work-related impairment from age-related impairments.
2. revising the recurrences policy because it can allow coverage of increased symptoms related to the aging process
3. revising the work disruption policy because in practice it can act to the advantage of an injured worker over a non-injured worker.
4. changing the CPP offset policy to require that worker's apply for CPP disability benefits and that these be taken into account even after the 72 month lock-in period
5. changing the reimbursement for health care travel policy because it over-compensates workers

The Network in principle, does not find the idea of regularly reviewing policies and of making them clear and consistent objectionable. However, the recommendation to minimize consultation is objectionable. We suggest that it is better to uncover problems with proposed changes in policy through the consultative process rather than through repeated appeals which are frustrating for all parties involved.

KPMG does not consider all of the purposes of the Act as set out in the legislation when looking at policies in general. It ignores the fourth purpose of the Act which is to provide compensation and other benefits to workers and talks only about return to work and re-entry into the labour market of workers in viewing policies. Clearly the recommendations have the aim of reducing benefits payable to workers.

KPMG appears to be ignorant of several well-established principles of law surrounding workplace injuries such as the *thin skull principle* and the *significant contributing factor* test as established through WSIAT case law. Several of the changes they recommend would be subject to being set aside by the Tribunal as being policies which are contrary to the substance of the Act.

Specifically the report appears to target older workers as workers whose compensation should be limited. To deny an older worker compensation for a recurrence or an aggravation of a pre-existing condition due to factors related to his or her age for example would on its face be contrary to the Human Rights Code of Ontario and subject to challenge.

This also attempts to negate the medical connection between the work performed and the condition developed by the injured worker. For someone who has a pre-existing condition, a workplace injury may have more long lasting consequences and this is reflected in the present policy. The condition might never have become disabling without the contribution of the work injury or process. There is nothing unfair about compensating an injured worker for the consequences of a workplace accident or disease because he or she had a pre-existing condition that made him or her more vulnerable to ongoing disability. This is an appropriate application of the well-established *thin skull principle.*

The recurrences policy requires either clinical compatibility with the original injury or disease and the current condition or a combination of clinical compatibility and continuity of symptoms. It recognizes that injuries often have ongoing consequences which may become worse at times and may require both treatment and lost time at later dates. This policy recognizes that all of the effects of an injury may not be immediate and that a worker who has had an injury is more vulnerable to having ongoing problems related to that injury apart from any aging process.

The work disruption policy recognizes that a worker who has a workplace injury is in a much worse position when having to seek new employment than someone without the limitations which may exist due to that injury. Research has confirmed that a permanently injured worker is at a distinct disadvantage in the general marketplace. This policy attempts to provide extra assistance to workers who find themselves out of work due to disruptions because they are not in the same position as others.

KPMG cites reimbursement for health care travel as an example of a policy which over-compensates injured workers but gives no explanation for this statement. Section 32 of the Act includes extraordinary transportation costs as part of the definition of health care. The health care travel policy compensates for extra expenses that a worker would not have incurred but for the workplace injury.

By making specific recommendations to amend or revise policies in order to reduce compensation to injured workers, KPMG has gone beyond the scope of a value for money audit.

Specifically they were engaged to look at the efficiency and effectiveness of adjudication decision making and claims administration. By questioning the merits of specific policies, KPMG goes beyond its mandate. It suggests some changes that would require legislative amendments and not just policy change. Extensive consultation should take place before any such fundamental change is contemplated. This is not something which should occur as the result of a value for money audit report.

The 6 Year Lock-in

KPMG recommends that the "WSIB should examine the value of the six year lock-in window…and develop an options paper … to be provided to the government." (Recommendation #5)

Scope

The "six year lock-in window" refers to the provisions to s.44 of the *Workplace Safety and Insurance Act* which provide the opportunity for the Board to review, vary or discontinue payment for loss of earnings benefits for six years after the injury. At that point any benefits being paid continue to age 65. This provision was put in the legislation to balance the interests of the WSIB in adjusting the level of compensation during a period when it is likely to fluctuate, and the interests of injured workers who will not be motivated to try to obtain better paying employment if every gain is clawed back by the WSIB.

This topic has no place in a value for money audit. It is a direct attack on the current legislation. This appears to be an attempt by WSIB management to 'sneak' its dissatisfaction with the current legislation into the public discourse under the guise of an audit. This does not show good faith or transparency.

No Claims Statistics

The KPMG report expresses concerns that the proportion of claims that were being locked-in at 72 months post-injury is increasing and that the level and frequency of permanent awards is increasing since 1998 (page 7). Since these numbers are not published by the WSIB or provided by KPMG, this comment is shielded from discussion. Our understanding is that the number of locked in claims has decreased, and that the average permanent impairment award has decreased by year of injury since 1998. A lack of transparency in the statistics affects the credibility of this report.

Targeting the Permanently Disabled

The injured workers who are locked in to receive some level of ongoing compensation are the most badly injured, the most significantly disabled of the workers who are served by our workers compensation system. Despite receiving more than 250,000 claims a year, only about 13,000 per year are accepted by the WSIB as having some degree of permanent impairment.

The numbers provided on pages 39 and 40 indicate that an average of 457 injured workers per year have been locked in at some level of compensation for loss of earnings. Of those, about 205 injured workers have been locked in every year at full loss of earnings as unemployable.

Only a small proportion of WSIB claims result in permanent impairment, and less than 4% of those are locked as having a long term loss of earnings. Less than two percent are locked in at full loss of earnings as unemployable. This strikes us as a relatively small number. The amount of resources devoted by KPMG and the WSIB to target these injured workers and to beat down that number appears harsh and uncaring. These few people are the ones most in need of the full range of benefits and services of the workers' compensation system.

No Return to Work Statistics

The KPMG report frequently uses 'return to employment' as a euphemism for 'cut off benefits.' For example, at page 45: "Improved work reintegration efforts in longer duration claims resulted in a reduction of the proportion of claims requiring full LOE benefits at lock-in. In 2009, 42% of lock-ins were awarded full wage loss while only 30% required full wage loss for cases locked-in in 2010."

The reduction in these claims cannot be attributed to work reintegration. The WSIB does not keep any data on injured workers returning to employment, it only keeps data on the number of injured workers who are cut off benefits. The WSIB cuts off benefits when injured workers are deemed able to return to work, without regard to whether they do return to employment. The WSIB makes no record of what happens to those injured workers. When KPMG surveyed injured workers for the 2009 audit of the LMR Program, they found that more than 50% of injured workers were still unemployed after successfully completing their retraining program, being deemed able to return to employment, and having their benefits cut. The KPMG report is misleading in its reference to statistics regarding injured workers returning to employment because there are no such records.

Regarding the above referenced reduction in claims locked in on full loss of earnings benefits in 2010, we saw what happened in 2010 to the injured workers who were not locked-in at full benefits. We represented many of those injured workers. The WSIB adopted an institutional position that refused to recognize that some injured workers are not competitively employable. It launched a major review of injured workers that had been determined to be unemployable but not yet locked in. It required management approval of decisions locking in full loss of earnings benefits. It became easier for adjudicators to deem injured workers capable of returning to work than to have to face their manager and seek approval to pay full loss of earnings benefits. We recall that the WSIB told 50 – 100 of these injured workers that they were capable of returning to work and they were not going to be locked in to receive full loss of earnings benefits. Hence the reduction in 2010 lock-in statistics.

We believe that most of these decisions were appealed. In many of our cases, the decisions were so obviously wrong that they were reversed before reaching the appeal level. But the initial adjudication levels continue to challenge injured workers. For example, recently a clinic was approached by a worker who is 64 years old and permanently disabled and unable to return to his pre-accident job. The WSIB has decided to cut his loss of earnings benefits because he should be able to perform a menial job in some other field.

Refusal To Acknowledge Some Are Not Competitively Employable

The refusal of the WSIB to acknowledge that some permanently disabled injured workers are no longer competitively employable not only wastes WSIB resources in dealing with re-adjudication of those decisions but also creates huge life disruption for the injured workers which exacerbates their disability and leads to higher social and medical costs.

The KPMG report suggests that the higher rate of lock-ins among Schedule 1 claims compared to Schedule 2 is because of financial incentives for Schedule 2 employers to re-employ injured workers. These employers pay directly and indefinitely for every cent that goes to injured workers. We doubt that explanation. As noted above, the WSIB records termination of benefits not returns to employment. We only know that Schedule 2 employers have a higher proportion of termination of benefits without lock-in. Schedule 2 employers have a permanent financial incentive to "manage claims" but in our experience this involves aggressive claims management actions such as appeals against entitlement and requesting premature return to work before healing, resulting in the termination of benefits of injured workers who follow their doctor's advice not to return to work.

If there is greater rate of return to work in Schedule 2 workplaces, it is likely due to the different nature of the employers in each schedule. Schedule 1 includes all small business and self employed workers. Schedule 2 is primarily large corporations and government services which have a much higher degree of unionization and larger workforces with more flexibility for workplace accommodations.

Comments on Experience Rating Undermine Funding Review

KPMG suggests expanding the Experience Rating incentives for Schedule 1 employers to improve return to work. By inviting KPMG to advise on Experience Rating at this time, the WSIB is encroaching on the mandate of the WSIB Funding review and undermining the credibility for the Funding Review Report which is expected to review and make recommendation on this very topic.

There is absolutely no evidence that experience rating improves return to work for injured workers. Research shows that financial incentives lead to non-reporting and miss-reporting of injuries through inappropriate claims management by employers to obtain rebates or avoid surcharges by preventing payment of wage loss benefits.

Extending experience rating will cut off most injured workers

Extending the experience rating window to 6 years will enable the system to cut off most injured workers from receiving workers compensation benefits. Employers will have a financial incentive to keep injured workers busy for 6 years at regular wages doing concocted jobs that do not contribute to the employer's productivity. As soon as the worker is locked in to age 65 at no loss of earnings, the employer will restructure, the concocted job will disappear and the injured workers will be unemployable. The employer will have no compensation costs, and possibly a rebate, and the injured worker will have no job and no compensation. This is what happens now when the experience rating window closes at 3 years after the injury. At least

now, the injured worker has an opportunity to obtain compensation for the loss of earnings before being locked in. That opportunity will be eliminated by extending the window to six years.

Across the Board Benefit Cuts

It has been our observation as caseworkers meeting with injured workers during 2010 and 2011 that the WSIB has been engaged in an 'across the board' cost cutting exercise that has featured widespread denials of benefits that were previously paid. Injured workers tell us 'the WCB is trying to nickel and dime me to death.' They have to fight simply hang on the compensation benefits that they were receiving. Nothing has been spared. Medications and health care aids such as surgical stockings that were once paid are now rejected at the pharmacy counter. We see encouragement for more of that approach in the KPMG report. For example, the recommendation to review and revise the policy on reimbursement of health care travel expenses (page 59.)

A more blatant example of the WSIB grasping to reduce compensation to the permanently disabled workers is the recommendation to get around the 6 year lock-in when it comes to offsetting CPP disability benefits. Currently, if an injured worker has been accepted by the WSIB to be unemployable (a small number, as noted above) and, before the 6 year lock-in, that worker receives Canada Pension Plan Disability benefits for the same condition, the relevant portion of the CPP(D) will be offset from the WSIB loss of earnings benefits. If the CPP benefits begin after the lock in, it has no effect on LOE benefits. The KPMG claims this is a financial incentive to delay applying for CPP benefits. In our experience, late applications or decisions happen very rarely. Generally, injured workers pursue every option for financial support and they have no control over how long the CPP decision process takes.

Downloading Costs to Other Public Systems

KPMG wants to be able to claw back CPP disability benefits awarded after the lock in, if there is a retroactive payment reaching to a date before the lock-in date. Up to now, thee has been clarity – which should be valued in a value for money audit of the decision making process. Now, it is clear that benefits received before the lock in are offset, benefits received after the lock-in are not. It is incredible that, for the sake of clawing back a few dollars from the most disabled injured workers, the WSIB is asked to bring in a new policy that skirts the 6 year lock-in and introduces a complicated recalculation process that will generate more appeals and administrative expenses.

The fact that this is purely a financial claw-back from injured workers is apparent because the report expresses no interest in flexibility of the six year lock in when it could mean increased compensation for the injured worker. Often a worker is locked in at six years with no loss of earnings compensation because they happen to be employed at the time of the six year review. But if they can't continue working a few months later because that job was never suitable or sustainable, the WSIB relies on the closure of the 6 year limit.

KPMG further suggest requiring injured workers to apply for Canada Pension Plan benefits if they believe they cannot return to work. This is simply trying to download the cost of workplace injuries off of the employers who pay for the workers' compensation system and onto the public.

This is the exact opposite of the position taken by Sir William Meredith, the founder of our workers' compensation system, that a just compensation system would provide financial support for the injured worker so that he does not become a burden on the community.

KPMG appears intent on promoting that Ontario should race to the bottom of the workers' compensation scale. They note that Ontario is the only jurisdiction in Canada that has a lock-in provision. KPMG claims that while the original intent was to bring finality, return to work has often become a secondary objective and securing long term benefits has become a primary objective. To the extent that this observation has any basis in fact, it is a direct result of the WSIB's campaign to deny that any injured worker is unemployable. When the WSIB's position is that no injured worker is unemployable, it is impossible to have any dialogue about the employment prospects of a particular case.

Conclusion

The KPMG recommendation to consider eliminating the 6 year lock-in and WSIB management's agreement (page 58) is shocking and reflects a complete disrespect for the fundamental principles of workers' compensation. In his final report, which was the foundation for our workers' compensation system, Sir William Meredith recommended that compensation should continue as long as the disability lasts.

When Professor Paul Weiler proposed the wage lost system to replace the permanent disability pension system in his 1980 green paper, he failed to include a lock-in provision. This shortcoming was immediately noticed. For example, law professor Terence G. Ison, stated that this "would be almost like a sentence of perpetual probation." (Commentary on the report entitled "Reshaping Workers' Compensation in Ontario" by P.C. Weiler, 1981, exhibit 122 of the Standing Committee on Resources Development, 1983, Legislature of Ontario, p. 16.) The government responded by the addition of the 6 year lock-in provision in the legislation. The KPMG report appears duplicitous in touting finality with reference to stopping benefits and closing files, but opposing finality with reference to decisions to continue paying compensation.

High Risk Claims

KPMG defines "high risk claims" as those where the injured worker has not returned to work within 3 to 6 months of the injury, and/or those claims where there is likely to be a determination of a permanent impairment (Executive Summary, pg 12). KPMG states that the Board's adjudication and claims administration has been less effective in dealing with certain high risk complex claims, namely from the three injury types – low backs, shoulders and fractures – that contribute close to 50% of total claims costs. KPMG finds that these claims take a disproportionate amount of WSIB staff resources and have poorer recovery and return to work outcomes (Executive Summary, pg 11)

KPMG concludes that the lack of a high risk claims management process impacts on length of benefits paid, and recommends the implementation of an assessment and triage function so that the best practices of disability prevention are used to facilitate return to work and to minimize the likelihood of a permanent impairment (Report, page 47).

KPMG's recommendations specific to high risk claims are that the WSIB should:

1. develop a comprehensive risk assessment framework to identify high risk claims, and then to manage these claims more quickly to improve recovery and return to work outcomes and to reduce benefit duration;
2. establish a new work model within long term case management to differentiate between cases where only maintenance activity is required from "high leverage cases" (Report, page 47).

The Network believes that the KPMG recommendations stray from suggestions for process improvement into the realm of substantive changes that can only be affected through legislative and regulatory changes. As such, these recommendations should not be found in any part of a value for money audit.

The idea that benefit duration can and should be limited for certain types of claims is an issue that was dealt with squarely by the Supreme Court of Canada. In the Martin and Laseur cases (***Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Laseur,*** *2003 SCC 54, [2003] S.C.J. No. 54 (QL))*, the SCC found that any attempt to limit benefits based on type of injury was unconstitutional. KPMG's suggestion of reduced benefit duration for high risk claims is no different than the attempt to limit benefits for injured workers with chronic pain that was struck down by the SCC.

Injuries, such as those to low backs, shoulders, and fractures, do have a high likelihood of permanent impairment because these injuries are often serious in nature, and despite medical treatment often result in a permanent physical or functional abnormality or loss. This likelihood of permanent impairment can not be negated or prevented by a return to work. This is a medical question, not a benefits duration question.

The only way to reduce the likelihood of permanent impairments resulting from workplace injuries is to reduce the number and severity of workplace accidents. KMPG's report is notable for having no focus the (in) effectiveness of the WSIB's accident prevention mandate.

KPMG's references to focussing the work of case managers on cases of "highest risk and highest return", and the euphemism of "earlier case resolution" is repugnant and is a total retrenchment of the historical principles underlying worker's compensation, as it is suggesting an arbitrary benefit reduction for injured workers with complex serious injuries. The probability of a wage loss associated with a permanent impairment is very high, because a permanent loss of function or physical/psychological abnormality will almost certainly compromise the injured worker's ability to be employed in the same manner as pre-injury. Wage loss benefits must continue to be paid as long as the injured worker suffers a wage loss resulting from the compensable injury.

Forcing seriously injured workers back to work is, according to research, counterproductive (i.e. high risk of re-injury) and does not result in sustainable employment, as noted by McKinnon, IAVGO Reporter, <u>Early and Unsafe Return to Work: Research Shows Return to Work After Injury May be Dangerous to Your Health:</u>

> Information began to emerge from research in the 1990s which found that early return to work did not necessarily result in sustainable employment. A 1995 study by Butler, Johnson and Baldwin looked at Ontario WCB data of 11,000 injured workers with

> permanent partial disabilities from injuries between 1974 and 1987. This was the first to analyze work absences that occur after the first return to work.[26] They found that the rate of successful returns to employment, measured by first return to work, is 85%. However, the rate of success evaluated over a longer time period is only 50%. A most striking statistic in this research is the re-injury rate: "Almost 60% of those who returned to work had one or more subsequent injury related work absences."[27]
>
> ….in the Johnson, Butler and Baldwin study noted above, a most striking statistic was that about 32% of the injured workers who had been employed at the one year mark (i.e. D1) had become unemployed by the three year post-injury point (i.e. R1). This indicates that about one third of the workers who had returned early to work were not able to sustain it.

KPMG report fails to include relevant Ontario research on the costs of returning injured workers to work too early, including research from the Institute for Work and Health such as Red Flags/Green Lights: a Guide to Identifying and Solving Return-to-Work Problems, and MacEachen et al, A deliberation on 'hurt versus harm' logic in early-return-to-work policy. As such, any recommendations on process changes are suspect.

Adjudication and Claims Administration

KPMG observes that current claims registration processes are limited and cumbersome. Electronic reporting of injury is hampered by the limitations of the existing form for Employer's Report of Injury. Auto-adjudication is limited to certain types of claims. KPMG states that auto-adjudication could be expanded if supported by simpler adjudication rules (Executive Summary, page 13). KPMG suggests reallocating resources from claims processing activities to more high value decision making and case management activities (Executive Summary, page 17).

While admitting that there is no authoritative leading practice for the design of an adjudication and claims administration program, KPMG makes several suggestions for such a program, including the automation of routine administrative tasks (Report, page 17), redesigning the e-Form 7, expanding auto-adjudication to a greater number of "uncontested injury claims", creating incentives to encourage electronic claims registration, and discontinuing the primary adjudication function (Report, page 24). The recommendation is to improve registration time by enhancing electronic registration, expanding auto-adjudication and increasing the administrative penalty for late reporting by employers (Report, page 56).

It is the opinion of this network that this actually ***is*** a subject that would be envisioned by a value for money audit – namely recommendations for improving WSIB internal processes.

Provision could be made for workers to file the Form 6 electronically, in advance of having a claim number established. Currently, the e-Form 6 can only be completed if a claim has already been registered at the WSIB by the employer. While injured workers can submit a manual Form 6 without waiting for a claim number, e-filing is not available. Mailing/faxing the Form 6 creates

[26] Managing Work Disability: Why First Return to Work is Not a Measure of Success, Industrial and Labor Relations Review, Vol. 48, No. 3.
[27] Above, p.467.

a delay that e-filing could eliminate. That is, injured workers should have an ability to have an electronic Form 6 submitted to start the registration of a claim.

Conclusion

In conclusion this Network strongly urges you to recognize the serious flaws in this value for money audit, namely: acting outside the scope of a value for money audit; the lack of expertise in the substantive areas of workers' compensation; failing to consider all available sources of expertise in arriving at some of its conclusions around decision-making; failing to appreciate basic legal and statutory principles; and the obvious encroachment into areas better left for the legislature and workers' compensation experts and we implore you to appreciate the serious undermining of the legislative progress that would happen should the WSIB not retract its intention to implement many of these recommendations despite the Auditors having clearly overstepped their authority and have not acted in accordance with objective standards at the professional, provincial, and international levels.

The Network urges you to immediately contact the WSIB to express your concerns and demand that they cease implementation of the recommendations until further public consultation and appropriate legislative enquiries have been undertaken.

All of which is respectfully submitted by, January 26, 2012

The Workers' Compensation Network