RESTORING THE BALANCE

A WORKER-CENTRED APPROACH
to Workers' Compensation Policy

A Report to the Board of Directors
Workers' Compensation Board of BC

March 31, 2018

Paul Petrie

TRANSITION TOWARDS A WORKER-CENTRED APPROACH

Introduction

This report has been prepared for the chair of the Board of Directors of the Workers' Compensation Board[1] (Board). The terms of reference for this review asked that I review the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) and any other matters the chair may request including:

- assess in relation to other Canadian jurisdictions whether the current Board benefit levels fully reflect the financial losses suffered by injured workers;

- consult with external stakeholders including members of the Policy and Practice Consultative Committee (PPCC), representatives of the Workers' Advisers Office and Employers' Advisers Office, representatives of the Board's administration, and other parties that the chair may indicate; and

- recommend possible changes to the RSCM II policies to ensure a worker-centred approach wherever practicable.

The contract commenced on January 8, 2018 with the final report to the chair due on or before March 31, 2018. Given the limited timeline for the report, this is not a comprehensive review of claims policy. In order to identify the issues of greatest concern to representatives of the worker and employer communities I consulted widely with these stakeholders as part of this review. Between January 26 and March 8, 2018, I held 69 consultation meetings with members of the Board of Directors (9); Board staff (9); employer representatives (12); worker representatives (19); Ministry of Labour (4); other (5).

I also had an opportunity to meet with the 40+ employer representatives who attended my presentation to the Employers Forum on February 23 and the 9 members of the BC Federation of Labour compensation committee who attended my February 5 session. In almost all cases I met at the workplace of the person consulted. Appendix A contains a list of individuals I consulted in this review. It was on the basis of these consultations

[1] now operating as WorkSafeBC. The Act refers to the Workers Compensation Board as the legal entity under the Act and I refer to the WCB or "the Board" to identify the overall workers' compensation system covered by the Act. "The Board" is also the common term used in the *Rehabilitation Services and Claims Manual* to refer to the Workers' Compensation Board and the WorkSafeBC administration.

that I identified the issues addressed in this review and developed the policy proposals for the consideration of the Board of Directors.

I wish to recognize the willingness of representatives of both the worker and employer communities to share their carefully considered views and proposed solutions. I also acknowledge the full cooperation of the Board's administration in providing information, analysis, insights and cautions to ensure that my efforts have the benefit of their experience and knowledge. While I fully appreciate the many contributions I have received in the course of this time-limited review, any oversights, errors or omissions are wholly my responsibility.

The focus of this review is on identifying policy options within the bounds of the current legislation for consideration by the Board of Directors to ensure a worker-centred approach that maximizes recovery from the workplace injury or disease and restores injured workers to safe, productive and durable employment.

I have organized the issues addressed in this review into the following general topic areas:

The Historical Context

My terms of reference direct me to assess whether the current Board benefit levels fully reflect the financial losses suffered by injured workers. To some degree Board benefit levels are determined by the provisions in the legislation and legislative considerations are not before me in this policy review. It is important to consider the degree to which the current adjudication of claims restores the financial losses suffered by injured workers in the historical context to provide some perspective on this issue.

The Historic Compromise which is the foundation of the workers' compensation system is based on a balance between worker and employer interests. Workers gave up their rights to sue negligent employers in exchange for no fault compensation funded collectively by employers and administered independent of government outside the court system. Maintaining the balance in the workers' compensation system that retains the confidence of both the employer and worker community is essential to the system's long-term survival. Where system changes upset the balance of interests between workers and employers, steps must be taken to restore that balance.

Maintaining the balance in the workers' compensation system has historically relied on periodic royal commissions to provide an independent review and to make recommendations to government to ensure the viability of the system. The last royal commission was carried out by Mr. Justice Gill who delivered the Royal Commission Report[2] on Workers' Compensation in British Columbia - *For the Common Good* - in January 1999. In that report he concluded that:

> The commission determined that, while deserving praise for fiscal responsibility, the Workers' Compensation Board of British Columbia has failed in its mandate to administer fair and equitable benefits to all injured workers, often those most in need of assistance. (page xix)

He also identified: "...severe shortcomings in leadership, lack of defined goals, poor performance evaluation and deficient accountability structures and processes." (page xx)

Following the Royal Commission Report, the newly elected Liberal Government commissioned a Core Services Review[3] of the workers' compensation system to review the law and policy which was carried out by Alan Winter. In addition, the government commissioned a second "Service Delivery Review" carried out by Allan Hunt from the US based Upjohn Institute[4]

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[2] FOR THE COMMON GOOD Final Report of the Royal Commission on Workers' Compensation in British Columbia, Judge Gurmail S. Gill Commission Chairman, Oksana Exell Commissioner, Gerry Stoney Commissioner

[3] Core Services Review of the Workers' Compensation Board, 2002

[4] "Why Not the Best", Service Delivery Review by H. Allan Hunt PhD of the US Based Upjohn Institute

The Winter Core Services Review provided the basis for Bill 49 introduced by the Liberal Government in 2002 to bring major changes to the British Columbia Workers' Compensation System. These changes were in response to strong advocacy from the employer community based on the contention that the Workers' Compensation Board had become economically unsustainable. The British Columbia economy had been through a down turn in the 2000-2001 recession, impacting the Board's investment portfolio that resulted in a projected unfunded liability.

The former government introduced Bill 49 to address the concerns advanced by employers. During the May 16, 2002 second reading of Bill 49 the Minister of Skills Development and Labour raised concerns about the financial impact on the Board of the continuation of the benefits levels then in place and outlined the following goals of Bill 49:

> The goals of this bill are to restore the system to financial sustainability by bringing costs under control, to make the system more responsive and to maintain benefits for injured workers, which are among the highest and best in Canada, while ensuring fairness for workers and employers. (Hansard, Volume 8, No. 3 at page 3547)

The primary purpose of the amendments to the Act that became effective on June 30, 2002 was to reduce the costs of workers' compensation benefits to address what the government had concluded was required to achieve a more financially sustainable system in the future. Interestingly the Board had an operating surplus of $571 million in 2002.

The changes enacted by Bill 49 and subsequent initiatives included:

- A dramatic reduction in loss of earnings pensions by limiting access to only exceptional cases.

- A major reduction in resources devoted to vocational rehabilitation assistance to help workers return to work.

- A new limitation in lifetime permanent impairment pensions to age 65 unless the Board was satisfied that the worker would have retired at a later date.

- A reduction in compensation benefits from 75% of gross earnings to 90% of net earnings resulting in a general reduction in wage loss benefits.

- The reduction in the Consumer Price index to the CPI rate less 1% with a cap at 4%.

- Increased restrictions on the manner of determining a worker's wage rate.

- A 75-day limit on the ability to review and re-adjudicate prior decisions even if subsequent evidence challenged the validity of that decision.

- The imposition of binding policy to limit decision makers' ability to exercise discretion on the basis of the merits and justice of the case.

- Elimination of the Board's Appeal Division that applied remedial jurisdiction to resolving appeals and the creation of the external Workers Compensation Appeal Tribunal that was bound by Board policy.

- Introduction of a computer-assisted case management system that focused more on the application of policy to claims adjudication and less on the merits and justice of the individual worker's case.

In 2010 the Board again retained H. Allan Hunt to assess the Board's progress on the recommendations he made in his 2002 review in light of the legislative changes introduced in 2002. His May 2010 report[5] summarized evaluation of a range of service delivery measures including benefit adequacy, return to work outcomes and timeliness of claim processing. He noted significant problems with the launch of the computerized claims management system which he attributed to implementation challenges that would likely be resolved with time. Hunt also reviewed the Board's progress with his prior service delivery recommendations and concluded:

> WorkSafeBC has successfully transformed itself into a customer-oriented service organisation in the past decade. In my opinion, this is due primarily to the consistency of the leadership at WorkSafeBC and the unwavering focus of that leadership on the goal of service quality. The transformation may not be 100 percent complete yet, but the contrast with the organisation that I first encountered in 1991 is very striking indeed.

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[5] Service Delivery Core Review: A Reappraisal, May 2010, H. Allan Hunt, PhD W.E. Upjohn Institute, Michigan, USA

Hunt qualified his findings somewhat by noting that the context in which his 2010 review was carried out covered the period 2002 to 2008 when the British Columbia economy was in a strong growth phase with unemployment dropping from 8.5% in 2002 to 4.6% in 2008. During that period the Board's operating surplus averaged approximately $500 million. However, the world-wide recession that occurred in 2008 saw the unemployment rate rise from 4.6% to 7.6% in 2009. He indicated his review concentrated mainly on the 2002-2008 period.

The Board also commissioned a series of studies with the Canadian Institute for Work and Health to review the impact of Bill 49 on benefit adequacy and equity.[6] The study reported on post-accident earnings and benefits adequacy and equity of long- and short-term disability claims. The methodology compared the benefits injured workers received under the pre-Bill 49 policy with the benefits they would have received under the Bill 49 changes. The study looked at the impact of three changes introduced under Bill 49: the change to 90% of net earnings, the reduction in the application of CPI, and the limitation of loss of earnings pensions to only those cases considered "exceptional". On the basis of these three factors, the authors concluded that for long term pension benefits:

> Overall, the move to Bill 49 resulted in reduced benefits. For the entire sample the reduction was 15%.

The greatest impact was to injured workers in the 50-59 age bracket with the earnings replacement rate at 82% well below the target rate of 90% of their pre-injury earnings. The authors indicated this age bracket was the most vulnerable to the changes introduced in Bill 49. The authors did not factor in the impacts of the inclusion of Canada Pension Plan benefits, and the limitation of loss of function pensions to age 65. They pointed out that these impacts, especially for older injured workers, would show even greater loss of benefits.

The authors recommended a more worker-centred approach with greater consideration of individual experiences of these workers and contextual factors that affect them, since injured workers with similar impairment levels may have dramatically different earnings recovery patterns.

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[6] "WorkSafeBC Study Report I: The Impact of Bill 49 on Benefits Adequacy and Equity," July 2011; Emile Tompa et. al., Institute For Work and Health.

The Board conducts quarterly surveys of both employers and workers to gage the level of their "overall experience" with the Board. Approximately 80% of surveyed workers rate their overall experience with the Board as good or very good. This has improved from 74% in 2011. Approximately 83% of employers rate their satisfaction as either good or very good.

These indicators suggest that the Board is meeting the expectations of a large majority of workers and employers. A majority of the claims are being handled well. However, there is still a significant percentage of both employers and workers for whom the Board is not meeting their expectations. The Board's senior staff acknowledge that there is still a significant number of workers and employers where the Board could be doing a better job at providing the necessary supports to maximize recovery and restore the injured worker to safe, productive and durable employment.

Comparison of benefits with other jurisdictions

The terms of reference directed me to assess whether the current Board benefit levels fully reflect the financial losses suffered by injured workers in relation to other Canadian jurisdictions. Inter-jurisdictional comparisons are challenging, since each province has its own legislation and policy for interpreting and applying that legislation. The Association of Workers' Compensation Boards of Canada (AWCBC) provides the most carefully developed inter-jurisdictional comparisons with explanatory notes where comparisons require qualification.

Appendix B contains some of the key comparisons based on data collected and analyzed by the AWCBC. Calculation methodology for these measures are detailed on the AWCBC website. It is beyond the scope of this time-limited review to go beyond the readily available information on comparative benefit levels.

Table 1.1 provides inter-jurisdictional comparisons of the incidence of time loss claims, injury frequency rates, average claims duration, and permanent impairment ratings. The following summarizes the information in that table.

Time loss frequency rates:

- British Columbia has the 2nd highest injury frequency rate at 2.20 claims per 100 person years of employment.

Average duration of claims:

- British Columbia has the 4th highest composite duration of time loss claims of the nine jurisdictions reporting at 70.9 days.

Average permanent impairment rating:

- British Columbia ranks 8th (9.6%) out of the 11 jurisdictions reporting on the average impairment rating for permanent disabilities with Ontario and Quebec showing a higher average rating.

Table 1.2 includes a comparison of:

Maximum insurable earnings for 2016:

- BC has the 4th highest insurable earnings at $78,600. Manitoba has no maximum and Alberta and Northwest territories ranks second and third.

Basis for calculating earnings benefits:

- All provinces and territories now base earnings benefits on a percentage of net earnings. Of the eleven jurisdictions reporting, six including British Columbia base earnings benefits on 90% of net earnings. Five base earnings benefits on 85% of net or lower.

Permanent disability benefit limits:

- British Columbia has the third highest maximum amount ($4,486) for total permanent disability benefits for the seven jurisdictions reporting. Four provinces have no minimum for permanent disability. British Columbia has the lowest minimum ($1,428.70) of the four provinces that have established a minimum for permanent total disability.

Vocational Rehabilitation/Duty to Accommodate:

- Table 2 (page 77) provides an inter-jurisdiction comparison of return to work - duty to accommodate provisions contained in the statutes of different jurisdictions. British Columbia is the only major province that does not have a statutory duty to accommodate injured workers. Northwest Territories and Nunavut also do not have a statutory duty to accommodate in their legislation. This has implications for some of the key recommendations in this review.

An overall assessment based on this data shows that the British Columbia Workers' Compensation Board is generally in the middle of the pack when comparing benefit lev-

els and structures with other jurisdictions. The current benefit levels are rooted in the statutory changes enacted in 2002 by the previous government.

The changes enacted in 2002 focused primarily on reducing the costs resulting from injury and illness and has succeeded in achieving this fiscal objective. The successes have been achieved largely through a policy-driven case management system. While this approach has apparently worked for the average claim where there are no complications, it has not always worked well for more complex claims that do not fit the expected profile for the particular diagnosis being adjudicated. In those cases, the worker's recover is expected to fit into the established profile and when it does not, the supports needed for the worker's recovery are often not provided and that worker is left behind by the system.

It is apparent from the research provided by the Institute for Work and Health that the changes introduced in 2002 have impacted some groups of workers more than others. These vulnerable workers have experienced a disproportionate burden of the impacts of the cost-savings initiatives. This is not an unexpected result of a policy driven case management system that is designed to provide average justice based more on adjudicating the diagnosis and less on considering the relevant circumstances of the individual worker.

The available evidence indicates the current case management system does not fully compensate some injured workers for the losses resulting from the injury or disease. This is particularly the case for older workers with permanent disabilities that significantly impair their earning capacity. I address this issue in the next section of this report.

A WORKER-CENTRED APPROACH TO DECISION MAKING

The second provision in my terms of reference is to recommend possible changes to the *Rehabilitation and Claims Services Manual* (RCSM II) policies to ensure a worker-centred approach to policy issues wherever practicable. A worker-centred approach for injured and disabled workers is one that takes into consideration the worker's individual circumstances in applying policy and making decisions about benefit entitlement and rehabilitation measures. It is designed to maximize the worker's recovery from the injury or disease and to restore as close as possible the worker to his pre-injury employment status without a loss of earnings.

The Merits and Justice of the Case

Section 99 of the Act provides the foundation for all decisions made under the Act. That section states:

> **99** (1) The Board may consider all questions of fact and law arising in a case, but the Board is not bound by legal precedent.
>
> (2) The Board must make its decision based upon the merits and justice of the case, but in so doing the Board must apply a policy of the board of directors that is applicable in that case. [7]
>
> (3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

Subsection 99(2) is the pivotal provision for considering a worker-centred approach. Bill 49 amended section 99 in 2002 by adding the phrase: "but in so doing the Board must apply a policy of the board of directors that is applicable in that case." The purpose of that addition was to bring a greater degree of consistency to decision- making. Following the statutory change the Board brought in a new policy manual to address the

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[7] the citation of section 99(2) in policy #2.20 has a minor typographical error. Section 99(2) in the Workers Compensation Act states that: "The Board must make **its** decision based upon the merits and justice of the case...". The policy misquotes section 99(2) to read, "The Board must make **a** decision based on the merits and justice of the case..."

changes in the legislation and to place a greater emphasis on the application of policy and the direction to Board officers to carry out that policy.

For example, with respect to referrals of a claim for permanent disability consideration, the pre-2002 policy #96.20 provided discretion to the decision-maker to refer a claim for assessment of a "potential permanent disability" to the Disability Awards Department for an assessment based on the evidence of the worker and/or the evidence of the treating physician. The disability awards officer would arrange for a medical examination and then decide whether there was a permanent disability based on the permanent functional impairment assessment.

In the current version of the RSCM II, policy #96.20 has been completely removed from the manual. The replacement policy #96.30 now simply reads:

> The Board determines whether an actual or potential permanent disability is accepted on a claim.

This may result in a greater degree of consistency in referrals to disability awards, but it does not specifically require the Board to take into consideration the evidence of the worker who experiences the impact of the disability and the evidence of the treating physician who has direct clinical evidence of the nature and extent of the worker's impairment resulting from the injury.

Policy #2.20 in the RSCM II indicates that:

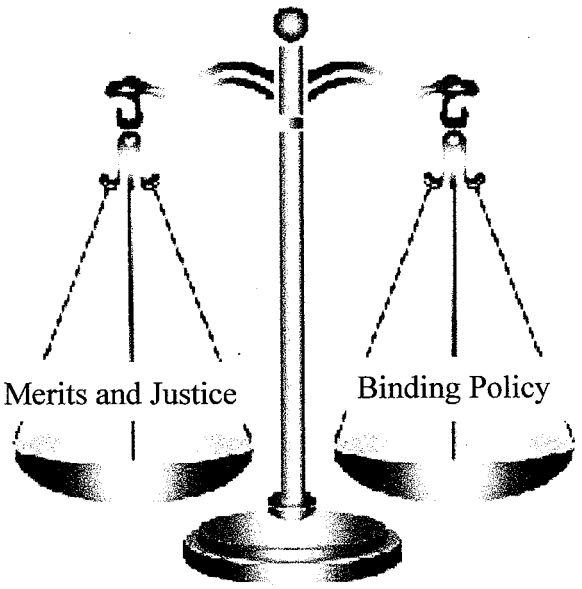
> Each policy creates a framework that assists and **directs** the Board in its decision-making role when certain facts and circumstances come before them. If such facts and circumstances arise and there is an applicable policy, **the policy must be followed**. (Emphasis added).

While the policy still provides for the Board to take into account the relevant facts and circumstances, the change to section 99(2) has made policy binding and has placed a greater emphasis on the application of the policy and relatively less emphasis on consideration of the facts and circumstances. This approach is reinforced in policy #2.20 as follows:

> All substantive and associated practice components in the policies in this Manual are applicable under section 99(2) of the *Act* and must be followed in decision-making.

Prior to 2002 Board policy provided "adjudicative guidance" and so the individual circumstances - the merits and justice of the case - could provide a basis for exercising a greater degree of discretion. The introduction of binding policy has reduced the ability of decision-makers to apply the merits and justice of the case to the decision-making process. Binding policy also facilitates the use of a computerized case management system to guide claim investigation and decision-making, sometimes without sufficient consideration of all the circumstances from the worker's perspective.

Restoring The Balance



There is no specific reference in policy #2.20 to the requirement in section 99 that, "The Board must make its decision based on the merits and justice of the case." This provision in the legislation is at the heart of a worker-centred approach to the application of policy in a fair and compassionate way that is responsive to the worker's circumstances. Therefore, to provide a greater focus on a worker-centred approach:

1. **I recommend that the Board of Directors consider amending policy #2.20 to explicitly incorporate the requirement in section 99(2) that,**

"the Board must make its decision based on the merits and justice of the case." That amendment can provide for the adequacy of the investigation of the relevant facts and circumstances of the issue to be decided and take into consideration the evidence of the worker in all cases.

The focus on managing the claim primarily by reference to policy requirements rather than identifying the broader objective of determining what is needed to restore the individual worker to safe, productive and durable employment has left too many workers without a suitable job to return to and without adequate financial compensation to cover the loss where that employment is not reasonably available.

Providing the necessary supports to promote maximum recovery and achieve safe, productive and durable employment requires a more worker-centred approach to managing the claim especially for the more complex cases that don't fit neatly in the case management system. The inability of the case management system to fully identify and address the individual barriers that are impacting the injured worker's ability to return to a job that restores his or her pre-injury earnings often results in a disputed claim and a resort to the more adversarial appeals system. The delay in resolving the matter in dispute often means that finding a timely, workable solution is lost.

A case management system is an important component of an efficient workers' compensation system to ensure a level of consistency to decision-making. However, where that system does not have sufficient flexibility to consider the merits and justice of the individual worker's case, it erodes the principle of fairness and equity that is integral to the worker community's confidence in the system. When the workers' compensation system fails to provide fair and equitable compensation benefits, especially to the most seriously injured and vulnerable workers, corrective action is required. Incorporating a more worker-centred approach within the case management system is the most effective approach to address these inequities.

MEDICAL EVIDENCE AND EVALUATION OF DISABILITY

The foundation of entitlement to workers' compensation benefits is medically confirmed disability arising out of and in the course of employment or due to the nature of the worker's employment. Section 5(2) of the Act provides for compensation where the worker is disabled from the work at which he or she is employed. This determination is made initially by the worker's treating physician or qualified medical practitioner on the Board's Form 8 and Form 11. For most cases with a straight-forward diagnosis, this is sufficient to process a short-term wage-loss claim.

Some employers express concern that the medical evidence provided by treating physicians is insufficient to document the limitations and restrictions resulting from a compensable injury and that the physician often serves as an advocate for the patient, simply repeating the worker's position. They also contend that it is difficult for a physician to provide a thorough evaluation in the short time allotted to medical treatment under the Medical Services Plan.

Worker representatives contend that the worker's physician is in the best position to identify the nature and extent of the disability based on their clinical evaluation. They express concern that the Board medical advisors often substitute their opinion over that of the treating physician without the benefit of an in-person examination or direct clinical evaluation.

The Board recognizes that it is important to secure quality medical evidence to ensure a fair and objective adjudication. The Board's chief medical officer has recently developed an accredited one-hour in-service training session for treating physicians with a focus on principles of disability management and safe return to work. The Board is also currently reviewing and revising the Form 8 and Form 11 to improve the utility of the medical information provided by treating physicians. There is recognition, however, that for the more serious injuries and complex diagnoses more information than can be provided on the basic forms would enhance the reliability and fairness of the decision-making process.

Ontario has addressed the issue of the availability and adequacy of trained community-based medical practitioners with expertise in occupational medicine by establishing a number of Occupational Health Clinics for Ontario Workers (OHCOW) in Hamilton, Toronto, Windsor, Sudbury, Sarnia, Thunder Bay and Ottawa. For over 25 years these clinics have provided medical diagnostic services for workers who may have work-relat-

ed health problems and are funded through the Ontario Ministry of Labour. The clinics are staffed by an inter-disciplinary team of nurses, hygienists, ergonomists, researchers, client service coordinators and contracted physicians.

These clinics provide a community-based, worker-centred approach to medical evaluation that is lacking in British Columbia. The mission of the OHCOW clinics is "to protect workers and their communities from occupational disease, injuries and illnesses; to support their capacity to address occupational hazards; and to promote the social, mental and physical well-being of workers and their families." In my view, British Columbia has much to learn from this model and the Board of Directors may wish to consider implementation of a similar model in BC.

The Ontario Workplace Safety and Insurance Board (WSIB) has introduced a functional abilities form (FAF) paid for by the WSIB that provides a more detailed evaluation of the worker's abilities and limitations. The clinical evaluation derived from this form provides a more reliable basis for determining the nature and extent of the impairment and resulting disability. It also provides a more substantial basis for determining what alternate duties the worker can perform when the injury prevents a return to the pre-injury job.

I propose a somewhat similar "Abilities and Limitations Form" be adopted by the Board. Such a form would not be necessary in the large majority of cases with a straight forward diagnosis with little or no time loss. However, for complex injuries and challenging diagnoses, the completion of this form would provide the most cost-effective clinical medical evidence at the outset of the claim to guide treatment and provide an informed basis for determining appropriate return to work options. The case manager would be in the best position to determine when this enhanced clinical evaluation is required. The payment for this more thorough clinical evaluation could be made under BCMA fee code 19907 or other code item the Board considers appropriate.

A copy of the form could be provided to the worker by the physician at the time of the clinical evaluation. The Board could provide the employer with necessary information from the form to guide placement in suitable alternate duties where the worker is unable to return to the pre-injury employment.

In order to provide a more complete clinical evaluation in appropriate cases and to guide return to suitable employment:

2. **I recommend that the Board of Directors support development of an "Abilities and Limitations Form" for completion by the treating physician at the request of the Board on a timely basis in appropriate cases to be paid out of the accident fund.**

Timely resolution of medical disputes

Prior to 2002 Medical Review Panels (MRP) under section 63 of the Act provided a process for resolution of medical disputes in complex and difficult cases at any adjudicative level within the decision-making process. The access to a MRP required a physician to certify a bona fide medical dispute and resulted in an appointment of a 3-person panel of physicians from a list of independent specialists: one chosen by the worker, one chosen by the employer, and a chair appointed by the Board. The MRP would examine the worker and provide a certificate of findings to resolve the dispute. The process was administratively complex, and it routinely took over a year to get a certificate of findings from the MRP. The medical findings were binding on the Board.

As a result of legislative changes in 2002 section 63 of the Act was repealed and no general provision was made for resolving medical disputes. The legislature did provide a mechanism under section 249 of the Act authorizing the Workers' Compensation Appeal Tribunal (WCAT) to provide assistance from an independent health professional (IHP) from a list established by the chair of WCAT. A WCAT panel may request a report from an IHP with terms of reference and questions to address the medical issue under consideration in the appeal. The panel will consider the IHP report when making its decision after providing the parties to the appeal an opportunity to make submissions on the report.

While the IHP process works well for WCAT in addressing medical issues in question, it does not offer a mechanism for resolving medical issues in dispute at other levels of decision-making. It is generally left to the parties when a medical dispute arises to secure a medical-legal opinion from a physician of their choice. When the worker or employer is able to obtain such an opinion, it is most often considered at the WCAT level long after the medical issue in dispute arose. This forces the parties in an adversarial process and delays timely adjudication of the issues in question.

The adversarial process is generally a non-therapeutic method of resolving medical issues in dispute often to the detriment of the worker and the recovery process. Securing

a medical legal opinion is also expensive and often difficult for an unrepresented worker to obtain.

Under the current case management approach, standardized return to work guidelines are used to support the management of claims and Board medical opinions often rely to some degree on these guidelines in formulating medical opinions.[8] Prior to the reliance on the case management system, Board medical advisors would more regularly conduct in-person examinations to provide a clinical evaluation as the basis for their opinions.

A medical dispute most often arises when the opinion of a Board medical advisor or consultant differs from the opinion of a treating physician or specialist. This dispute is compounded from the perspective of the worker and his or her treating physician where the medical advisor's opinion is made without the benefit of an in-person clinical exam. In my view the merits and justice of the case are best determined where there is reliable clinical evidence to support the opinion.

Where a clear medical dispute exists and a worker's physician provides sufficient reasons to clearly identify the basis for that dispute, an independent medical examination (IME) can provide a mechanism to resolve that dispute without the delays and adversarial stances that attend the review and appeal process. An early resolution of these disputes wherever possible can build confidence in the decision-making process and minimize the non-therapeutic consequences of the adversarial process. Like the IHP reports, the IME would not be binding on the decision-maker, but would provide persuasive clinical evidence to consider in resolving the issue in dispute.

This approach has some challenges. It would need to be administered in a way that is seen to be reasonably independent of the claims decision-making process. It would also need to be time-sensitive to provide an IME within 45-60 days of a decision in dispute to enable the case manager to consider whether it provided a basis for reconsideration of that decision.

The issue of where to locate the administration of the IME is a challenging one. This matter bears further review with involvement of the Board's Policy, Regulation and Research Division and the Board's chief medical officer. The organization in the workers' compensation system with the most experience and expertise on independent medical evaluation is the Workers' Compensation Appeal Tribunal (WCAT) on the basis of its di-

[8] The Board uses The ODG return to work guidelines to guide adjudicative practices.

rect involvement in the IHP process under section 249 of the Act and should be consulted on this issue. The resolution of the location of this process requires further consultation to explore the available options and to identify the most suitable and available one.

A roster of physicians prepared to conduct IMEs on an expedited basis could be compiled with assistance from the University of British Columbia (UBC) medical experts familiar with occupational medicine in consultation with the Board's chief medical officer. The goal of an IME process is to provide a mechanism to resolve established medical disputes, avoid unnecessary appeals and restore a greater degree of confidence in a fair decision-making process.

To achieve this goal:

3. I recommend that the Board of Directors consider establishing an independent medical examination (IME) process to assist in resolving established medical disputes.

Preliminary determinations and expedited medical treatment

The Board currently has policy #96.21 which provides income support where there is a significant delay in determining the eligibility of a claim where the delay is not the fault of the worker. That policy specifies that "health care benefit bills will not be paid under a preliminary determination."

In my view, there should be some discretion in this policy to provide expedited medical treatment where the claim qualifies for a preliminary determination and the medical evidence indicates that the worker is at risk for a significant deterioration without timely and appropriate medical attention.[9] This flexibility in policy could be particularly important for workers with a claim for a mental disorder under section 5.1 of the Act where the medical evidence indicates timely treatment intervention is needed to avoid a significant deterioration of the condition and to reduce the risk of prolonged disability without that intervention.

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[9] Available research indicates that early intervention should be based on medical evidence in the individual case. For example see: National Institute for Clinical Excellence. Post-traumatic Stress Disorder (PTSD): The Management of PTSD in Adults and Children in Primary and Secondary Care.2005. (NICE Clinical Guidelines, No. 26.) 7, Early interventions for PTSD in adults.); Kearns, M. C., Ressler, K. J., Zatzick, D. and Rothbaum, B. O. (2012), EARLY INTERVENTIONS FOR PTSD: A REVIEW. Depress Anxiety, 29: 833–842. doi:10.1002/da.21997; also see: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1107447

Where the conditions for a preliminary determination are met:

4. **I recommend that the Board of Directors consider a method for approval of medical treatment on an expedited basis where clinical medical evidence indicates the worker is at risk of a significant deterioration without that treatment.**

VOCATIONAL REHABILITATION AND RETURN TO WORK SUPPORT

Early return to safe, productive and durable work is recognized as a key principle of the workers' compensation system. In his 1966 Royal Commission Report Mr. Justice Tysoe stated:

> The prime mission of those who administer workmen's compensation and the prime purpose of the Act is not to furnish financial benefits, but to promote and encourage measures for the prevention of injury to workmen in the course of their work and, should any be so unfortunate as to become disabled as a result of such injury, means for their rehabilitation and return to useful employment as soon as possible.[10]

Restoring an injured worker to suitable employment with the injury employer at the level of his or her pre-injury earnings is at the heart of a worker-centred approach and is the primary focus of this review.

British Columbia is the only province in Canada where there is no legislative requirement in its Act for employers to rehire injured workers (See Table 2 page 77 in Appendix B for details).[11] The question I must consider in this review is whether there are policy options available that will ensure a worker-centred approach to return to work. I believe there are.

Section 16 of the Act provides:

> To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

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[10] Commission of Inquiry Workmen's Compensation Act, 1966; pp 18-19

[11] The Northwest Territories and Nunavut also do not have a statutory obligation to re-employ/ rehire injured workers.

This legislation gives the Board wide latitude to enact policy to restore injured workers to suitable employment that is safe, productive and durable to minimize any financial losses that the worker will incur as a result of the compensable disablement.
The *British Columbia Interpretation Act also* directs that "every enactment must be construed as being remedial, and must be given such fair, large and liberal construction and interpretation as best ensures the attainment of its objects". My recommendations are guided by this approach.

Duty to Accommodate

While the Act is silent on a duty to accommodate, employers have the duty to accommodate to the extent of undue hardship under the BC Human Rights Code.[12] And during the Board's vocational rehabilitation process employers, workers and unions are expected to comply with Human Rights legislation and associated policies.

There has been a new development in the law on this matter. In a February 1, 2018 unanimous decision of the Supreme Court of Canada (*Quebec v. Caron)*[13], seven judges of the court relied on the duty to accommodate in Human Rights legislation in Quebec and ruled that "...Quebec employers have a duty under the province's injured workers' legislation to reasonably accommodate those injured in the workplace — even though that duty is not expressly mandated by the statute."[14] (emphasis added)

Whether that decision will have a direct impact on the BC Board's obligation to support a "duty to accommodate" under Human Rights legislation is a matter for the courts to decide. However, the reasons in the SCC judgement offer compelling guidance to speak to this issue in Board policy. The Board has a clear commitment under section 16 of the Act to support measures to restore injured workers to safe, productive and durable employment with whatever measures and expenditures from the accident fund it considers necessary and expedient.

The first lesson from *Caron* is to reinforce the principle and goal of restoring the injured worker to long-term employment with the injury employer at no loss of earnings or em-

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[12] Human Rights Code [RSBC 1996] Chapter 210

[13] Quebec (Commission des normes, de l'équité, de la santé et de la sécurité du travail) v. Caron; 2018 SCC 3 -Case number 36605

[14] Supreme Court 'integrates' duty to accommodate into Quebec's injured workers' legislation, February 01, 2018

ployment status wherever possible. The term "accommodation" is generally used to refer to a durable placement that is not transitory. This is contrasted with what is often referred to as light duty or selective employment which is a transitory process to a temporarily disabled worker although it may also assist that worker in securing accommodation to suitable and durable employment in the long term.

The second lesson from *Caron* is that it is important for the Board to respect the jurisdiction of the Human Rights Tribunal while at the same time meeting its own responsibility to workers under section 16 of the Act. The Human Rights Tribunal has a primary responsibility and the appropriate tools to adjudicate the duty to accommodate under their legislation and the Board should not infringe on that jurisdiction. The Board must respect the rights and obligations of employers and workers under the Human Rights legislation and must be transparent in articulating that respect.

The final point I take from *Caron* is that the Board's support to employers and workers in meeting their obligations under the duty to accommodate should harmonize to the extent possible with that obligation under the Human Rights legislation without infringing on it or interfering with it. This approach is consistent with the Board's current commitment under section 16 of the Act. It can also assist the worker and employer in achieving a just accommodation in a way that avoids a protracted and expensive adversarial dispute before the Human Rights Tribunal.

In light of *Caron*, it is important for the Board to explicitly recognize the duty to accommodate under the Human Rights legislation while respecting the separate jurisdiction of the Human Rights Tribunal to enforce its legislation without interference from the Board.

Board Policy for Vocational Rehabilitation (VR)

Board policy for VR is set out in Chapter 11 of the RSCM II. Given that the Board has broad discretion under section 16 of the Act, it is helpful if these policies as a whole promote VR practices which support key goals noted above. I make recommendations regarding specific VR policies as follows:

Policy C11-85: Principles and Goals

Board policy C11-85.00 provides a general overview to the Board's commitment to quality rehabilitation and outlines the principles and goals of vocational rehabilitation under section 16 of the Act.

In order to emphasize the importance of establishing a more worker-centred approach to this policy I offer the following recommendations for the Board of Directors' consideration under policy C11-85.00:

5. **I recommend that the Board of Directors consider enhancing the Board's approach to "Quality Rehabilitation" by amending policy C11-85.00 emphasizing an approach which may be summarized as follows:**

   Quality rehabilitation recognizes that a safe and early return to work that maintains the dignity and productivity of a worker plays an important role in the worker's rehabilitation and recovery. The Board is committed to timely intervention to assist the worker and the employer achieve a successful return to work with the injury employer wherever possible including provision of accommodation supports and services where needed.

   Where a return to work with the injury employer is not possible, the Board will provide the necessary supports and services to assist in restoring the worker to suitable and available employment at the pre-injury earnings level wherever possible. Where re-employment results in a significant loss of earning capacity, rehabilitation services will assist the worker in securing compensation benefits that will minimize the losses resulting from the disability.

   The Board recognizes that there is a "duty to accommodate" injured workers under the BC Human Rights Code. The Board will carry out its responsibilities respecting the jurisdiction of the Human Rights Tribunal in addressing issues arising under the Human Rights Code.

6. **I also recommend that the Board of Directors consider amending the section entitled "Quality Rehabilitation" in policy C11-85.00 to include a commitment to support early return to safe, productive and durable work that minimizes financial loss to the worker and incorporates the duty to accommodate as much as possible.**

7. **I recommend that the Board of Directors consider amending the "Principles" in policy C11-85.00 to include a principle that vocational rehabilitation assistance may be initiated without delay in conjunction with medical treatment and physical rehabilitation where there is evidence of barriers to return to work with the injury employer.**

8. **I recommend that the Board of Directors consider including a principle that sufficient vocational rehabilitation supports will be provided to ensure that workers can successfully compete when they return to employment.**

Policy C11-85.00 also includes a section on "Goals" which could be amended to emphasize the Board's overriding commitment to support durable, long-term employment with the injury employer wherever possible. In support of this objective:

9. **I recommend that the Board of Directors consider including an overall goal for the Board's vocational rehabilitation program to provide the necessary supports and services to workers and employers to achieve durable, long-term employment with the injury employer wherever possible and, where return to suitable work with the injury employer is not possible, provide the necessary supports and services to assist in securing suitable alternate employment that restores the worker's pre-injury earnings where possible.**

It is not only important for the Board to articulate its commitment to recognize and respect the jurisdiction of the Human Rights Tribunal, but also to defer to that jurisdiction in appropriate circumstances. This is a complex and sensitive matter and should be carried out in a manner where the Board retains its responsibilities to continue to support the worker under section 16 of the Act.

It should also be recognized where the employer and the union are parties to an accommodation arrangement under the Collective Agreement, the same "duty to accommodate" issue may be addressed through the grievance/arbitration process. Although a decision by an arbitrator or the Labour Board does not oust the jurisdiction of the Human Rights Tribunal, it frequently renders it unnecessary.

Therefore, as a practical matter, it seems reasonable for the Board to adopt the same approach for all accommodation disputes, whether the dispute arises at Human Right Tribunal or through a grievance/arbitration proceeding.

One of the options the Board of Directors may wish to consider is that where a dispute regarding the "duty to accommodate" is established, either under the Human Rights legislation or under a collective agreement, that the Board make a "preliminary determination" on a rehabilitation plan under section 16 and Board policy #96.21. The Board could then base the rehabilitation plan on the accommodation if one is offered and on the lack of an accommodation if one is not offered. This approach would allow for review and reconsideration of the preliminary determination once the accommodation dispute is resolved without infringing the 75-day rule in section 96(5).

Policy C11-88.00 - Nature and Extent of Programs and Services

It is well established that maintaining the employment connection following an injury improves the likelihood of securing a suitable accommodated position with the injury employer. To facilitate this connection policy C11-88.00 could be amended to reinforce "early intervention" support:

10. **I recommend that the Board of Directors consider amending the "Early Intervention" section in policy C11-88.00 state that vocational rehabilitation assistance will be available to the worker to restore the employment connection with the pre-injury employer where possible as soon as the worker is medically able to participate in his or her own vocational future.**

Vocational rehabilitation plan

In keeping with the guidance regarding durable accommodation in the *Caron* judgement and where possible to limit the worker's loss of earnings:

11. **I recommend that the Board of Directors consider amending the "Vocational Rehabilitation" section of policy C11-88.00 to include the overall vocational goal of restoring the worker to safe, productive and durable suitable employment as close to his or her pre-injury earnings as possible.**

12. **I also recommend that the Board of Directors consider amending this section to include a commitment that the plan have a reasonable probability of achieving and sustaining the vocational goal over the long term.**

To provide a measure of flexibility with the vocational plan to ensure that the plan can be adjusted to the changing needs of the worker:

13. **I recommend that the Board of Directors consider amending this section of policy C11-88.00 allow the VR plan to be amended where there are significant developments in the vocational rehabilitation process, indicating the vocational goal is unlikely to succeed.**

Lastly, some confusion may arise in policy C11-88.00 as a result from the inclusion of the provisions for wage loss equivalency under the heading "Discontinuation of Vocational Rehabilitation Services" in this policy.

To support the VR goals in this policy, it is helpful to state what is often the practice - that there is a continuity of wage-loss equivalency where there is a significant gap between the discontinuation of temporary disability benefits and completion of permanent disability entitlement. Therefore:

14. **I recommend the Board of Directors consider adding a new heading "Payment of Wage Loss Equivalency Benefits" to this policy.**

15. **I also recommend that the Board of Directors consider amending policy C11-88.00 to specify that wage loss equivalency benefits may apply after temporary wage loss benefits have been concluded and suitable employment is not available while the worker is awaiting permanent disability assessment under section 23 of the Act or is awaiting or undertaking specific vocational programs.**

Policy #115.30 provides for exclusions for some types of claim costs from consideration under the employer's experience rating charges. For example, injuries covered by policies C11-88.10, *Work Assessments*, C11-88.40, *Training- on-the-Job*, and C11-88.50, *Formal Training* attract relief under section 42 of the Act.

The rehabilitation costs associated with restoring an injured worker to suitable employment with the injury employer are often far less than the cost of providing the training and supports necessary to place a worker with a different employer in a different occupation. The injury employer also incurs its own costs as part of meeting their accommodation responsibilities. A safe, durable accommodation by the injury employer can be considered a win, win, win situation:

- the worker gains the benefit of retaining his or her connection with the workplace and co-workers;
- the employer retains an experienced employee;
- and the Board benefits by reduced costs to the accident fund and reduced demands on staff resources.

To encourage and support the timely accommodation of an injured worker with the injury employer:

16. **I recommend that the Board of Directors consider provision for relieving the employer of the rehabilitation costs associated the accommodation under policy #115.30 so long as the accommodated employment is durable and long term. The employer should be relieved of the costs if the accommodation is considered successful 12 months after its inception.**

My recommendations for enhancing the level of engagement for vocational consultants in the system will require additional resources to accomplish this successfully. It will take more than additional positions to succeed. The Ontario WSIB undertook a similar initiative in 2012 that has been very successful. Ms. Evie DoCouto, WSIB Vice President, Return to Work Program, attributes Ontario's success to three factors: strong support from the WSIB leadership; collaboration with the workplace partners; and a professional vocational rehabilitation staff.

The WSIB utilized the disability standards developed by the National Institute for Disability Management and Research (NIDMAR) to build a cadre of capable vocational rehabilitation professionals to deliver their services. I would recommend that the BC Board continue to collaborate with the WSIB to gain insights from their successes and their delivery model.

Certified Disability Management Professionals have played a key role in the WSIB program's success particularly in handling complex cases. WSIB supports all their return to work specialists in achieving the internationally recognized CDMP certification through NIDMAR. The Board of Directors may wish to consider a similar commitment to professional certification.

Light duty and return to work

Section 5(2) of the Act provides:

> Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable under this Part from the first working day following the day of the injury.

The payment of compensation is based on medically confirmed evidence of disability, and where the Board receives medical evidence that the worker is unable to continue at the work at which he was employed, compensation is payable. Selective/light employment is a subset of section 5(2) and does not automatically displace it because there is an offer of light duties.

It is generally accepted that the earlier a worker is able to return to safe and productive employment following an injury, the more likely he or she is to retain employment with the injury employer when full recovery or maximum medical improvement is achieved.

The offer of light duties by the employer often occurs immediately following the injury so long as the work is medically appropriate and productive. It has the advantage to the worker of continuing his or her wages without interruption. The employer gains from this arrangement because there is no payment of wage loss benefits to impact the employer's experience rating. The Board gains because the administration of a claim with no wage loss benefits is less complex. These "wins" are dependent on whether the light duty employment is safe and productive for the worker and will not slow the recovery or worsen the resulting disability.

When fairly administered, suitable light duty employment can play an important role in a worker's recovery and recognizes the value of maintaining an injured worker's positive connection to the workplace.

The current policy requires that:

- The worker must be capable of undertaking some form of suitable employment.
- To be suitable, the employment must be safe and must not risk further harm to the worker or slow his or her recovery.
- The work must be productive. Token and demeaning tasks are considered detrimental to the worker's recovery.
- Where the forgoing requirements are met within reasonable limits, the worker must agree to the light duty arrangement.

Where the worker and/or the worker's physician disagree that the light duties meet these policy requirements, the Board is required to investigate and determine the safety of the work after considering the medical evidence and other relevant information. The Board may initiate the investigation in response to notification by the worker or the employer or may initiate its own investigation where it considers further inquiry is indicated.

The policy specifies that the Board's evaluation will be based on, but not limited to, a detailed description of the employment being offered, including the physical requirements and detailed medical information outlining the workers medical restrictions, physical limitations and abilities. The Board officer then determines whether the light duty offer meets the policy criteria outlined above.

The current employer's report of injury (Form 7) asks the employer if modified or transitional duties are available to the worker and if so to provide a description of these duties in a 2-3 inch square box on the form. It would be more appropriate in light of policy #34.11 to request the employer provide a copy of the light duties that have been offered to the worker and ask if a copy of that offer has been provided to the worker. This will ensure that the Board has reliable information on which to initiate an investigation if one is required. Where a copy of the light duty offer has been provided to the worker, the Form 7 should also indicate whether the worker has been asked to provide that offer to his or her treating physician for approval of those duties.

Many large employers have well established disability management programs that provide suitable light duty employment on a proactive basis. The success of these programs depends on the employer's commitment to provide safe productive employment in accordance with available medical evidence and the worker's individual circumstances. Cooperation with the workplace partners including a union where one is available provides the basis for building a trust relationship for this program. Larger employers often have a greater degree of flexibility in arranging light duties. Medium and smaller employers don't always have this flexibility.

To assist medium and smaller employers with accommodating the injured worker in suitable light duties I recommend that the employers report of injury contain a new question after the question, "Have any modified or transitional duties been offered to the worker?" to read, "If no, can the Board be of assistance to the employer in arranging suitable employment for the worker?"

The Abilities and Limitations Form outlined in recommendation #1 provides a valuable supplementary source of clinical evaluation for determining the suitability of light duties offered by the employer. Where the physician's report of injury (Form 8/11) does not contain sufficient information to determine whether the light duty offer is safe and will not delay the worker's recover or worsen the condition, the board officer can provide the treating physician with the employer's light duty description and request an evaluation of the worker's suitability for those specific duties. In appropriate circumstances the Board can ask the physician to complete an Activities and Limitations Form to provide a more detailed clinical evaluation of the suitability of the physical requirements.

Policy #34.11 states:

> Should the Board determine that the worker's refusal is unreasonable, benefit entitlement is determined under section 30 of the *Act*. For example, the worker does not provide the selective/light duties to the attending physician or the worker refuses to return to work after the physician has determined the duties are suitable. Benefit entitlement will be adjusted effective the date the selective/light employment was suitable and available, as determined by the Board.

This policy is clear on how cases are handled where the worker unreasonably refuses to cooperate with the employer's effort to arrange light duty employment that complies with policy #34.11. In that case, the light duty is deemed to comply with section 30 on the date it was offered and benefits, if any, are paid accordingly. However, in my view this policy does not adequately address the situation where the worker has a reasonable basis to believe that the policy requirements have not been met. What is unclear in policy #34.11 is whether the worker continues to receive wage loss benefits while the investigation on the reasonableness of his or her refusal is carried out.

A worker-centred approach would not penalize the worker for raising a reasonable concern with respect to whether the light duty offer meets the policy requirements that was

sufficient to initiate an investigation. In my view, where the worker provides a reasonable concern about the viability of a light duty position and there is medical evidence confirming that the worker is disabled from the work at which he or she was employed, then wage loss should continue to be paid while the investigation is carried out. That is consistent with the requirements of section 5(2) of the Act and the requirements in policy #34.11. However, where the worker unreasonably refuses to cooperate with the employer's efforts to establish a viable light duty position that complies with policy #34.11, then deeming the light duty position when it was formally offered is appropriate and in accordance with the Act and the policy requirements.

This approach puts the onus on the Board to initiate and complete the investigation without delay. Where a reasonable dispute arises regarding the compliance of a light duty offer, the first step is for the employer to provide the Board with a detailed description of the employment being offered either at the initiative of the employer, or at the request of the Board officer where it is not otherwise provided by the employer. Where the medical evidence provided by the treating physician is not sufficient to resolve the matter, the Board officer can request that the physician carry out a thorough examination and complete the "Abilities and Limitations Form" as detailed in the "Medical Evidence and Evaluation of Disability" section of this report.

Where further investigation is required, it is up to the Board officer to determine the nature and extent of the investigation and to arrive a fair resolution for all parties. In my view, this is a critical point in the claim. The Board's initiative and support can determine whether the worker is accommodated by the employer or whether the Board's involvement will focus on assisting the worker in finding alternate employment with a different employer. The latter course is more uncertain, challenging and difficult for the worker, and incurs greater expense borne by the accident fund and ultimately the employer. The Board's involvement at this point can make the difference between a successful re-employment outcome with the injury employer or an ongoing Board engagement with the worker to find alternate employment, often accompanied by disputes, appeals and the non-therapeutic adversarial process.

To facilitate a successful non-adversarial resolution of a reasonable dispute over the suitability of light duties:

17. **I recommend that the Board of Directors consider amending policy #34.11 to provide for a careful investigation of the dispute and where appropriate engage a vocational rehabilitation consultant or occupa-**

tional therapist to meet face to face with the parties to facilitate an accommodation acceptable to both the worker and the employer where so directed by the case manager or requested by the employer or worker.

18. **I also recommend that the Board of Directors consider amending this policy to indicate where there is medical evidence that the worker is disabled from the work at which he or she was employed during the investigation process, the Board continue to pay wage loss benefits to the worker while the investigation is concluded.**

19. **Finally, I recommend that the Board of Directors consider a further amendment to indicate that where a successful accommodation is achieved after investigation, that the costs associated with vocational rehabilitation expenditures and with the associated wage loss payments while the investigation is being carried out be borne out of the accident fund generally and not charged to the employer's experience rating account. The authority for this cost adjustment is found in section 42 of the Act.**

Claim Suppression

During the course of my consultations some representatives of the worker community expressed concerns about what they consider to be misuse and in some cases abuse of light duties and in some cases bordering on claim suppression. These concerns included:

- threats of dismissal if the worker filed a claim for wage loss;
- assigned to non-productive "work" in the lunchroom;
- punch in on time clock then allowed to go home for the day;
- use of mandatory drug testing when reporting an injury as a means of suppressing a claim.

One representative contended that, "the difficulties people have in applying for compensation...had the effect of suppressing claims." Another representative submitted, "suppression comes more from the case managers, vocational rehabilitation consultants and [Board medical advisors]... than employers." I have included a first-hand case study in Appendix C which was submitted by a third representative to illustrate this point. The

case study of this firefighter with a PTSD condition also has relevance for two recommendations I make later in this review.

Some representatives urged me to meet with individual workers to investigate and confirm these abuses. I declined to do so. I consider engagement with and investigation of individual cases is beyond the scope of my mandate. However, I do not consider it appropriate to dismiss their concerns without comment.

It is contrary to section 177 of the Act for an employer to pressure a worker from reporting a claim to the Board. That section provides:

> An employer or supervisor must not, by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede or dissuade a worker of the employer, or a dependant of the worker, from reporting to the Board
> (a) an injury or allegation of injury, whether or not the injury occurred or is compensable under Part 1,
> (b) an illness, whether or not the illness exists or is an occupational disease compensable under Part 1,
> (c) a death, whether or not the death is compensable under Part 1, or
> (d) a hazardous condition or allegation of hazardous condition in any work to which this Part applies.

Interfering with a worker's statutory right to entitlement to compensation is a serious violation of the Act and may attract penalty consideration under section 196 of the Act. The Board has a statutory duty and fiduciary trust to workers to protect their right to make a claim free from interference by employers.

Section 13 of the Act also prohibits workers from agreeing to waive or forgo any benefit entitlement under the Act. That section states:

> A worker may not agree with his or her employer to waive or to forego any benefit to which the worker or the worker's dependants are or may become entitled under this Part, and every agreement to that end is void.

Policy # 94.20 addresses the employer and supervisor prohibitions under section 177 of the Act and the possibility of an administrative penalty that may be calculated on the basis of the criteria in item D12-196-6 in the Board's *Prevention Manual.* What appears to

be missing in policy #94.20 is adjudicative direction and guidance on what steps a board officer is to take when an allegation of a violation under section 177 of the Act is raised. Given the seriousness of a violation of section 177 of the Act and the complexity of the possible remedy under section 196 of the Act:

20. **I recommend that the Board of Directors consider amending Policy #94.20 to indicate where an allegation of a violation under 177 of the Act is raised, the Board officer will document that allegation and refer it to the Board's Legal Services Division for direction and guidance.**

The issue of claim suppression is fraught with allegations that are difficult to document. The very fact that these activities are not openly practiced is because they are prohibited by the Act. Where there are serious allegations of violations of section 177 of the Act, the Board has a duty to respond. However, the Board's response should be proportionate to the nature and extent of the problem. Determining the nature and extent of the problem is the challenge.

This problem has been addressed systematically by other workers' compensation boards. For example, the Manitoba Workers Compensation Board released a comprehensive report[15] that indicated claim suppression occurs in approximately 6% of workplace injuries, which represents approximately 1,000 claims per year. This empirically based study reported on four separate survey measures indicating that employer "overt claims suppression" ranged from 6.0% up to 29.8%. These findings led to measures taken by the Manitoba WCB to address this issue.

Given the importance of this issue and the difficulty in evaluating the nature and extent of this problem on an anecdotal basis:

21. **I recommend that the Board of Directors consider initiating an independent review of this issue by a qualified organization with a scientific methodology to determine whether and to what extent claims suppression is a significant issue in the BC workers' compensation system.**

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[15] "Claim Suppression in the Manitoba Workers Compensation System", Nov. 2013; Prism Economics and Analysis.

PERMANENT DISABILITY ENTITLEMENT

Referral for Permanent Disability Evaluation

The transition from temporary disability benefits to permanent disability benefits is a critical period in the claim for the injured worker. This transition typically occurs at "plateau" when the medical evidence indicates the worker has reached maximum medical improvement from the compensable injury and the remaining conditions have reached a plateau of recovery.

Under current policy, there is little guidance regarding decision-making procedures at this important point in the claim. The current practice is that the Board officer consider possible permanent disability entitlement at the time of plateau. It is the responsibility of a case manager to determine what permanent conditions are accepted on the claim and whether the claim should be referred to the disability awards department to assess the worker's entitlement for these accepted conditions under section 23(1).

If permanent conditions are accepted, the Board officer will also usually adjudicate whether the worker can return to his pre-injury job without assistance or whether there should also be a referral to vocational rehabilitation (VR) to explore employability options. Finally, at the time of plateau, the Board officer may or may not adjudicate whether the worker is entitled to a loss of earnings (LOE) assessment, based on whether his loss of earnings from his injury is "so exceptional". In practice, early LOE decisions may or may not be included in plateau decisions.

Ideally, prior to the termination of temporary disability benefits, the Board will have had an opportunity to determine whether the worker can return to work with the injury employer either to the pre-injury job or to some accommodated position with the injury employer. Where the worker is able to return to the pre-injury job, full-duties or with an accommodation, that is an indication that the worker may not need a referral to VR or may not be entitled to an LOE assessment. Where there is a clear indication prior to the plateau date that the worker is unable to return to work with the injury employer, an early referral to the vocational rehabilitation consultant to initiate a rehabilitation plan should be initiated if this has not already been done to avoid delays in the pension assessment process.

Prior to the changes to the statute in 2002, then policy #96.20 in the RSCM I offered guidance to Board officers regarding the approach used to refer cases to the disability

awards department for assessment of permanent disability or potential permanent disability. That former policy provided:

> To ensure consistent referrals of all cases where there is a potential disability, the Board officer is required to send the file to the Disability Awards Department for further evaluation where any of the following guidelines apply:
>
> 1. Where a medical report indicates that a permanent disability exists or that there is a possibility a permanent disability exists.
>
> 2. Where a worker indicates there is a permanent disability as a result of the compensable injury, or states there is an inability to return to employment as a consequence of the injury.
>
> 3. Where there is any other indication of a permanent disability or potential permanent disability.
>
> If there is any doubt about the existence of a permanent disability, these claims are referred to the Disability Awards Department for final consideration. Board officers, however, are expected to exercise discretion and common sense in deciding whether to refer a worker's claim to the Disability Awards Department, it is up to the Board officer to clearly delineate by memo the status of the claim and to confirm what conditions have been accepted.

Policy #96.30 in RSCM I also specified:

> It is the responsibility of Disability Awards Officers and Adjudicators in Disability Awards to determine whether a worker's injury or occupational disease has caused a permanent disability. They then decide the extent of the disability and calculate the worker's permanent disability award entitlement. Policy also provides that Disability Awards Officers and Adjudicators in Disability Awards must accept the final decision of the Board officer as to what conditions are accepted under the claim.

In 2004 a Board discussion paper 16 advanced a new approach and recommended that policy #96.20 be amended to read:

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16 See the Board's 2004 "Discussion Paper: Referral to Disability Awards."

> The Board officer determines when temporary total disability or temporary partial disability benefits are concluded, and whether an actual or potential permanent disability is accepted on the claim. These decisions are generally made on the basis of information supplied by a treating physician, qualified practitioner, consulting specialist or and/or the injured worker. Treating physicians and qualified practitioners are required to send periodic reports to the Board outlining the worker's condition. These reports include a question which asks specifically whether there will be any permanent disability resulting from the injury.
>
> In those situations where a Board officer determines that an actual or potential permanent disability does not exist, and this decision is contrary to the attending physician's opinion or the worker's own opinion on the matter, then a decision is to be provided to the worker, setting out the status of the claim. If the worker is not satisfied with the Board officer's determination, a review of the decision may be requested.
>
> If an actual or potential permanent disability is accepted on the claim, the Board officer will refer the file to the Disability Awards Department for an assessment of the extent of the disability.

In the current version of the RSCM II, policy #96.20 has been completely removed from the manual and specific reference to the evidence of the worker and the treating physician has been eliminated from the policy. Policy #96.30 now simply reads:

> The Board determines whether an actual or potential permanent disability is accepted on a claim.

The changes to policies #96.20 and #96.30 reflect the changes in Board practice, not just about who makes the permanent disability decision but also on what basis or evidence it is made. Under the current policy (#96.30), the Board officer makes this decision but there is no specific policy direction to seek the input of the worker or the treating physician on this decision. It is at this critical point in the claim when it is important to have policy direction on the nature and extent of the investigation to be carried out. Failure to ensure that all relevant evidence is considered prior to the Board officer making this important decision can lead to unnecessary reviews, appeals and referrals back to the Board for further investigations.

The lengthy delay to go through the appeal process just to have the evidence of the worker and treating physician fully and fairly considered takes an inordinate toll on the worker. The legal maxim "justice delayed is justice denied" applies. More importantly, the non-therapeutic impact on the worker to be forced into the adversarial process only to have the worker's evidence and the treating physician's evidence and opinion considered is the contrary to what a worker-centred approach should provide.

The evolution of policy #96.20 where the evidence of the worker and the treating physician were given a significant role to the current approach where the policy does not specifically refer to the role of the worker and physician's evidence is the difference between a worker-centred approach and a strict case management approach under the current policy.

In order to restore a more worker-centred approach to this important decision and to fully consider the evidence of the worker and the treating physician in making a decision to refer the claim for permanent disability for assessment:

22. **I recommend that the Board of Directors consider a new policy #96.20 to indicate that when the worker's injury is reaching maximum medical improvement and there is some evidence of a potential permanent disability, the Board officer will request that the treating physician or specialist complete an Activities and Limitations Form (ALF) with a copy to the worker and give the worker an opportunity to provide any further evidence regarding the existence of an actual or potential permanent disability.**

Where the worker continues to be disabled from performing the full duties of the work at which he or she was employed at the time of injury, this may be an indication that there is a level of ongoing disability from the injury.

23. **I also recommend that the Board of Directors consider amending policy to indicate that the Board officer will consider the evidence of the worker and the worker's physician and where there is substantial evidence from the treating physician and from the worker that the worker has a potential permanent disability, this evidence will be given significant weight unless there is conclusive evidence to the contrary. Where the Board officer determines that the worker has a permanent disability, the**

Board officer will refer the worker's claim to Disability Awards for an assessment of that disability under section 23(1).

Loss of Earnings Assessment

The mandatory method for determining a worker's permanent disability entitlement is contained in section 23(1) of the Act. As pointed out in policy # 39.00 the percentage of disability determined for the worker's condition under section 23(1)(a), is intended to reflect the extent to which a particular injury is likely to impair a worker's ability to earn in the future.

Section 23(3) of the Act provides the Board with a discretionary method to determine whether the assessment of disability under section 23(1) appropriately compensates the worker for the impact of the disability on the worker's ability to earn in the future. The addition of a new section 23(3.1)and (3.2) to the act in 2002 introduced a new prerequisite for considering a loss of earnings pension under section 23(3) of the Act. The provisions of section 23(3), (3.1) and (3.2) are reproduced below to provide reference for my consideration of this issue.

Section 23(3) of the Act provides if:

(a) a permanent partial disability results from a worker's injury; and
(b) the Board makes a determination under subsection (3.1) with respect to the worker;

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and (d) whichever of the following amounts the Board considers better represents the worker's loss of earnings:
(i) the average net earnings that the worker is earning after the injury;
(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of injury and the worker's disability resulting from the injury is so exceptional

that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of injury or to adapt to another suitable occupation.

The provisions in the Act may be summarized as follows:

First, there is an assessment of the worker's entitlement under section 23(1) of the Act to determine the nature and extent of the disability resulting from the injury.

Next, the Board makes a determination under section 23(3.1) as to whether the impact of the worker's disability on his or her ability to continue in the pre-injury occupation is "so exceptional" that the amount determined under section 23(1) does not appropriately compensate the worker for the injury. The "so exceptional" test, under section 23(3.2) requires the Board to consider the ability of the worker to continue in his or her occupation at the time of injury or to adapt to another suitable occupation.

If, and only if, the combined effect of the worker's occupation and the worker's disability resulting from the injury is so exceptional (under sections 23(3.1) and (3.2)) that an amount determined under section 23(1) of the Act does not appropriately compensate the worker for the injury, will the Board consider possible loss of earnings entitlement under section 23(3) of the Act.

The determination of the worker's disability resulting from the injury under section 23(1) is integral to the application of section 23(3.1) and (3.2) and logically precedes it. A plain reading of the Act does not require an application of the "so exceptional test" before the section 23(1) assessment of the nature and degree of the permanent disability. In fact, the reference in section 23(3.1) to "the worker's disability from the injury" is an indication that the determination of the assessment of the nature and extent of the worker's injury under section 23(1) should precede the application of the so exceptional test.

The two-step process for section 23(3) consideration

The Board has somewhat different policy requirements for each of the two steps involved in the determination of a loss of earnings pension under section 23(3), using pol-

icy #40.00 for determining matters under sections 23(3.1) and (3.2) and then policy #40.12 for determining matters under section 23(3). The use of different policies effectively creates a "two-step" adjudicative process for the worker, leading to complexity and delay. The actual terms of policy #40.00 at the first step have also been the source of numerous challenges at WCAT and in the courts.

The expansive role of policy #40.00 in the first step under section 23(3.1) and (3.2) was addressed at length in the BC Court of Appeal judgement in *Jozipovic v. British Columbia (Workers' Compensation Board)* 2012 BCCA 174. Following that judgement, the Board made some adjustments to policy #40.00 in response to the court's concerns.

More recently, in the BC Supreme Court judgement in *Shamji v. WCAT* (2016 BCSC 1352) Justice Voith detailed a range of concerns with respect to the Board's application of section 23(3.1) and (3.2) in determining the worker's loss of earnings pension and the amount of that pension. His first concern is that the first step in the assessment process - the decision on eligibility for an LOE pension can be negated in the second step on the "assessment" of that pension under section 23(3). Justice Voith observed:

> This is particularly curious, and I would say irrational, when the very issue of eligibility is predicated on a finding that an injured worker's loss of income is "significant" or his or her circumstances are "so exceptional" that an assessment of that loss is necessary or appropriate. [105]

He also observed:

> ...that the present process, or the way the process is implemented, has the prospect of excluding potentially meritorious claims for an LOE pension. It is equally possible that a worker would not meet the stage one eligibility threshold based on average incomes or figures, but would have done so if that worker's actual income had been used. [106]

Justice Voith went on to state:

> While these separate inquiries may be logical, the fact remains that, in combination, the overall scheme is unwieldy, inefficient, and cumbersome. This is particularly so when one considers that the Act is intended to serve injured workers. [109]

In a March 1, 2018, judgement the BC Court of Appeal [*Shamji v. Workers' Compensation Appeal Tribunal*, 2018 BCCA 73] three justices upheld the judgement below noting:

> The reviewing judge, expressing concern about the implications of his conclusion on the two- stage process, questioned why a worker would have to establish eligibility for an LOE assessment based on one set of figures, only to be subsequently told that he had no right to such a pension where the decision maker on that assessment chose to use different figures. He also questioned why a worker should go through these different stages given the length of time this matter had taken, with multiple hearings at each stage. [64]
>
> I certainly appreciate the observations of the reviewing judge. As this case demonstrates, the compensation system in the Act can be slow, cumbersome and frustrating to workers. However, part of this stems from the nature of a process that evaluates a worker's disability, provides vocational rehabilitation where appropriate, and assesses what losses have resulted from an impairment of earning capacity. An initial assessment of functional impairment under s. 23(1) is not made until a worker's injury has "plateaued". It is only after this has been done that consideration can be given to an LOE under s. 23(3). [67]

The BCCA judgement also acknowledged that a two-step process was permissible under the Act consistent with the prior BCCA judgement in *Preast v. Workers' Compensation Appeal Tribunal,* BCCA (September 9, 2015). The concerns of the court reflect some of the same concerns for a worker-centred approach.

In 2017 the Board's Workers' and Employers' Services Division initiated a review of the decision-making process for the section 23(3) loss of earnings. This initiative arose from recognition that there were inconsistencies in the decision-making process that were resulting in a high volume of reviews and appeals and a high rate of appellate returns that required further investigation and new decisions. In addition to the impact of the resulting delays for the worker, these returns were resulting in a significant amount of rework for vocational rehabilitation consultants.[17]

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[17] For example, the Division estimates there are approximately 3,000 vocational rehabilitation plans per year and approximately 1,000 LOE awards expected. There are also approximately 1,400 Review Division reviews per year in relation to vocational rehabilitation plans and section 23(3) decisions. A review of 846 Review Division decisions had a return rate of 42% for further information or investigation.

The Board is in the process of rolling out an improved decision-making process for section 23 loss of earnings cases following review of WCAT and Supreme Court decisions, discussions with Review Division representatives, and information from Board staff. The following recommendations are intended to complement and supplement the Board's initiative to develop a "Comprehensive Framework for Quality Decision Making" under section 23(3) of the Act. This "Framework" provides an important step forward to bring a more transparent and proactive approach to the decision-making process that will improve consistency to section 23(3) decisions and hopefully reduce appeals from these decisions.

Application of policy in section 23(3) appeals

The two critical terms to consider in the application of current policies are "suitable occupation" and "appropriate compensation." Clear and consistent definitions of these terms are necessary for adjudicative direction and guidance for implementing this very important provision of the Act that affects the most seriously disabled workers. It is also important that the two policies be consistent and integrated, to avoid the adjudicative difficulties and the barriers to workers noted by the courts.

"Suitable Occupation"

With respect to "suitable occupation," policy #40.12 outlines the considerations that the Board must take to arrive at a conclusion of employment that the worker could be expected to undertake over the long term including medical evidence of the limitations imposed by the disability as documented by the permanent disability assessment under section 23(1). As noted earlier Policy #40.00 provides a more general definition of suitable occupation.

In order to provide consistency in policy with respect to the determination of a suitable occupation:

24. I recommend that the Board of Directors consider amending the definition of suitable occupation in policy #40.00 to indicate that a suitable occupation is one that the worker has the physical ability to perform, has the necessary knowledge and skills to be competitively employed in that occupation given all the worker's circumstances, and actual employment in that occupation is reasonably available to the worker in the long term. It would also be helpful to reference policy #40.12 which

provides detailed guidelines in determining suitable and reasonably available occupations for a worker.

Appropriate Compensation/ "Significant Loss of Earnings"

Policy #40.00 provides that section 23(1) may not appropriately compensate a worker where the worker cannot continue in a suitable occupation with a "significant loss of earnings".

Policy #40.00 also provides that in determining whether a worker is experiencing a significant loss of earnings, the Board takes into consideration the difference between the worker's pre-injury earnings and the combined total of the worker's post-injury earnings and the amount awarded under the section 23(1) method of assessment. However, the policy does not provide a specific percentage of loss that would constitute a "significant" loss. That is left to policy directive C6-2 which states that the Board:

> ...recognizes that a "significant loss of earnings" exists where the difference between the worker's pre-injury earnings against the combined total of the post injury earnings and the amount in the section 23(1) award is at least 25%.... [and] "does not exist where the calculated result is 5% or lower.

That practice directive, which is not a policy of the Board of Directors, acknowledges that a lower figure than 25% may represent a significant loss of earnings. The practice directive indicates that a 10% difference in the pre and post-injury earnings may represent a significant loss in some circumstances.

It is important to keep in mind that the workers' average earnings are already discounted by 10% based on the 90% of net calculation. In addition, the Board includes the amount the award of the section 23(1) assessment in the calculation of the post- injury earnings. The inclusion of CPP benefits and the general age 65 retirement date also impacts the worker's entitlement. Permanently disabled workers are further disadvantaged by their reduced capacity to compete in the general labour market. They face the uncertainties of fluctuations in the economy that leave disabled workers more vulnerable to unemployment than workers without a disability.

To provide a greater degree of consistency in the application of sections 23(3.1) and (3.2) and a more worker-centred recognition of the significant impact of the permanent disability on the worker's future earning capacity:

25. **I recommend that the Board of Directors consider amending policy #40.00 to recognize that a "significant loss of earnings" exists where the difference between the worker's pre-injury earnings against the combined total of the post injury earnings and the amount of the section 23(1) award is at least 10% and also to recognize that a significant loss of earnings does not exists when the calculated result is 5% or lower and further, where the evidence shows that worker's individual circumstances indicate that a loss between 5% and 10% is significant for that worker the Board may determine the worker's entitlement under section 23(3).**

Finally, there is no compelling reason why the determination on the so exceptional test (under section 23(3.1) and (3.2)) cannot be made at the same time as the decision on the loss of earnings decision (under section 23(3)). This would remove the confusion often arising from the separate two-step process. Further, it is important to have the adjudications in the two inter-related decisions made on a consistent basis, for the reasons set out by the court, unless there is compelling evidence to the contrary.

In order to streamline and rationalize the Board's consideration of possible loss of earnings entitlement under section 23 of the Act and to make the assessment process more worker-centred:

26. **I recommend that the Board of Directors consider amending policy to indicate where the Board determines that the worker satisfies the requirements of sections 23(3.1) - that the worker's disability is "so exceptional" - the Board will make a determination in the same decision regarding the worker's entitlement to a loss of earnings pension under section 23(3) and use the same findings of fact as the basis for both decisions.**

Chronic Pain

There are no sections of the Act specific to chronic pain: the condition is adjudicated under policies #22.00 and #39.02. Policy #39.02 defines permanent chronic pain as pain which persists longer than six months and is either disproportionate to the injury or is non-specific. Under this policy, chronic pain is rated as a non-scheduled award at 2.5% impairment.

This policy states:

> Entitlement to a section 23(1) award for chronic pain may only be considered after all appropriate medical treatment and rehabilitation interventions have been concluded.

Policy #22.00 provides that, in "all" cases of (temporary) chronic pain (i.e. after six months), a multidisciplinary assessment must be undertaken. The purpose of this assessment is to assess causation and to provide an opinion on treatment. However, the policy also states that where chronic pain is considered to be "permanent" (i.e. after six months), it may be considered for disability benefits under section 23 of Act.

Policy #39.02 (for permanent chronic pain) also indicates that where the claim has been referred for a permanent disability assessment, the Board may arrange a multidisciplinary assessment to consider the worker's history, health status, the impact of the pain on physical functioning, psychological state, behaviour, ability to perform the pre-injury occupation and the activities of daily living to be used for determining acceptance of the claim.

Neither policy indicates that all necessary medical treatment and supports be identified before the assessment of the permanent disability evaluation is carried out. Rather, the definition of both temporary and permanent chronic pain as being "pain after six months" means that at the point that chronic pain is diagnosed, it may also be considered to be permanent.

There are many emerging treatment options that can assist the worker in coping with chronic pain. It is in the interest of the worker, employer and the Board to ensure that the worker has achieved maximal medical improvement for the chronic pain condition before the permanent disability assessment is carried out. This approach will maximize

the chances of a successful return to work once the recommended and appropriate treatment has been carried out.

27. **I therefore recommend that the Board of Directors consider an addendum to policies #22.00 and #39.02 to ensure that all necessary treatment to maximize the worker's ability to return to safe productive and durable employment has been carried out, before the worker is referred for a permanent disability assessment for chronic pain.**

In the course of my consultations I heard a wide range of concerns about how the 2.5% flat rating for all chronic pain conditions has failed to recognize the impact of this sometimes debilitating condition on workers. This "one size fits all" policy was raised time and again to illustrate the failure to recognize the merits and justice of the individual worker's case where significant chronic pain is identified by the treating health professionals. I was urged to recommend adoption of the Ontario model which compensates some chronic pain related diagnoses up to 90%. Others urged me to consider implementing the recommendation in the 2002 Core Review to provide a range of 0 - 20% for chronic pain.

The Board's Policy, Regulation and Research Division (PRRD) recently initiated a review of chronic pain policies and has embarked on an extensive pre-consultation process with stakeholders. A significant amount of information about the Board's policies and practices has been provided through this process. It is evident that the medical understanding and treatment of pain and chronic pain conditions have evolved significantly in the past 15 years. The PRRD is planning to include involvement of an expert panel as well as the stakeholders in its consultation process.

The Board is to be commended on its initiative to undertake a full review of this important issue. However, the PRRD review process is expected to take some time and the issue I must consider is whether there are some steps the Board of Directors can consider taking on an interim basis to provide a greater degree of fairness to the evaluation of chronic pain, particularly for the more serious cases.

The approach offered by Alan Winter in the Core Review has some merit. It utilized four categories for assessing permanent chronic pain:

- Mild 0-5%;
- Moderate 10%;

- Moderately Severe 15%; and
- Severe 20%.

This approach could be useful in distinguishing varying levels of disability from a chronic pain condition where a distinction is made between impairment and disability using a "biopsychosocial" model.[18] The approach advocated by some uses "activity limitation" as a basis for assessment rather than strict impairment.

I gave serious consideration to recommending this approach to the Board of Directors as an interim policy while the PRRD carries out the chronic pain policy review. The experience from such an interim policy could provide useful data and valuable information for the application of a more flexible approach that considers the experience of the worker.

In the end, however, I decided this option was not practicable. While it could provide a greater degree of fairness for individual workers who experience chronic pain going forward, its development and implementation would take time and it could take resources and focus away from the PRRD review while it was being implemented. The period following its full implementation would be limited.

The other issue arising under policy 39.02 that merits some consideration is the impact of the accepted chronic pain condition on the worker's ability to continue in the pre-injury occupation or to adapt to another suitable occupation. Typically, a low PFI (such as 2.5%) does not indicate a serious impact on employability. However, in the case of chronic pain, the single flat rate of 2.5% does not always reflect the impact it can have on the worker's employability, particularly for the more severe cases.

One way to address this inequity as an interim measure, particularly for the most serious chronic pain conditions, is to make provision in policy to allow for a loss of earnings assessment where the chronic pain condition meets the so exceptional test in sections 23(3.1 and 3.2) of the Act. No new program needs to be developed and no significant increase in Board resources would be required for this. This issue can be further addressed by the PRRD review and the experience from this addition can provide useful evidence when the PRRD considers this issue.

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[18] "Assessing Pain and Disability in the Pain Patient"; Feinberg,S.; Brigham, C.; Ensalada, TL.. In AMA Guides Newsletter, Jan./Feb. 2016 (available online at: http://www.coa.org/2016/presentations/qme/HenryAMAGuides.pdf)

28. I recommend that the Board of Directors consider including a reference in policy 39.02 to indicate that in more serious chronic pain cases where it is established that the disability resulting the chronic pain condition is so exceptional that the section 23(1) award does not appropriately compensate the worker, the Board may consider the claim under section 23(3) of the Act.

Duration of Permanent Disability Pensions

Section 23.1 of the Act makes provision for the payment of compensation for permanent disability entitlement under section 23.1 up to age 65 unless the Board is satisfied that the worker would retire at a later date. Section 23.1 specifically provides:

> Compensation payable under section 22(1), 23(1) or (3), 29(1) or 30(1) may be paid to a worker, only
>
> (a) if the worker is less than 63 years of age on the date of the injury, until the later of the following:
> (i) the date the worker reaches 65 years of age;
> (ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board, and
>
> (b) if the worker is 63 years of age or older on the date of the injury, until the later of the following:
> (i) 2 years after the date of the injury;
> (ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date the worker would retire, as determined by the Board.

The Act does not provide any specific direction on how best to project the date when the worker would likely retire. That matter is left to the Board to determine through Policy. Policy #41.00 states:

> Where the Board is satisfied a worker would retire after reaching 65 years of age, section 23.1 permits the Board to continue to pay benefits to the age the

> worker would retire after the age of 65 **if the worker had not been injured**.
> (emphasis added)

The policy goes on to specify:

> When determining whether a worker would retire after age 65, the circumstances under consideration are those of the individual worker as they existed **at the time of injury.** (emphasis added)

The policy also requires evidence that is verified by an independent source to confirm the worker would work past age 65.

A search of WCAT decisions for "age 65 and 23.1" shows over 1,000 appellate decisions on this issue. There are also ten noteworthy decisions attempting to provide adjudicative guidance to appellate decision makers who have to wrestle with these sometimes difficult cases. WCAT noteworthy decision 2014-03091 provides a comprehensive summary of the legislative background informing section 23.1 of the Act and policy item #41.00 and is helpful in understanding the complexity of this issue and its application.

Policy #41.00 clearly limits the evidence which the Board may consider in a decision under Section 23.1. The policy does not provide clear rationale for these limitations.

I am particularly concerned about the policy requirement to limit consideration to evidence involving the circumstances of the individual worker **as they existed at the time of injury**. This by definition precludes consideration of the possible impact of the injury and resulting permanent disability on the worker's retirement options.

In my view the application of section 23.1 should be considered through the lens of section 23 as a whole and the overall purpose of the Act. The purpose of section 23 of the Act is to estimate **the impairment of earning capacity from the nature and degree of the injury** and provide compensation for 90% of the estimated loss of average net earnings resulting from **the impairment.** The impact of the injury and the resulting disability on earning capacity is at the heart of section 23 of the Act. It is difficult to see how the impact of the injury on the worker's retirement age is not a relevant consideration in determining the worker's date of retirement.

Further, this policy limitation disadvantages younger workers, who are less likely to have made clear retirement plans at the time of injury. A young, injured worker who has lost a limb for life, may well feel aggrieved when he or she receives the decision that the compensation for that injury will be terminated at age 65 while they must endure the impact of that impairment for life. Few young workers will have established verified evidence that they would have retired past age 65. Many will be living from pay check to pay check and may be entertaining dreams of retiring at age 55. For a young worker with a family and a mortgage, the chances of paying off the mortgage by age 65 may not be possible **as a direct result of the injury**.

29. **I therefore recommend that the Board of Directors consider amending policy # 41.00 to allow consideration of all relevant evidence regarding the actual impact of the injury on the worker's likely retirement date, including relevant evidence after the date of injury.**

One additional issue relating to retirement date merits comment. When the Board officer refers the issue to the Disability Awards Department, the evidence of the likely retirement date, particularly if the impact of the injury and resulting disablement is taken into account, is at best thin.

Because this issue is often of considerable important to the worker, who is facing a lifetime of disability, there is a tendency to almost automatically appeal these decisions and to make efforts to gather additional evidence. This is understandable in these circumstances. Failure to do so within 75 days means that decision is final and binding and not open to further review.

However, from a worker's perspective, the Board's decision on the retirement issue comes at a critical time when the worker is often involved in the vocational rehabilitation process and sometimes in the process of consideration of possible entitlement to a loss of earnings pension under section 23(3). The intrusion of an appeal at this stage when the worker is involved in vocational rehabilitation assistance does not assist the rehabilitation process. An appeal at this important time in the claim and in the worker's life can add to and often compound the frustrations that navigating the workers' compensation system can involve. It can have a significant non-therapeutic impact, especially when the appeal is opposed adding the further element of the adversarial process into the mix.

It would be more appropriate in my view to determine the likely retirement date as a preliminary determination under policy #96.21 at the time of the section 23(1) of the Act with a commitment to review that determination two years after all outstanding decisions relating to permanent disability entitlement are made. That will allow the worker an opportunity to provide all necessary information and sufficient evidence for the Board to make a final decision on this issue with confidence. The worker's long-term employment prospects and the impact of the injury on those prospects will be more available and more reliable at that point. This approach will require some added provision in policy #96.21 or a new related policy in #41.00 to provide the basis for a preliminary determination.

30. **I therefore recommend that the Board of Directors consider amending applicable policies to provide for a preliminary determination to be on the issue of the worker's likely retirement age under section 23.1 of the Act with a review of that determination two years after all outstanding decisions relating to permanent disability entitlement have been made.**

Payment of Interest

The issue of interest arose on a regular basis during the course of my consultations mainly from representatives from the worker community. They noted some delay in routine decisions, and frequent significant delays in implementing appellate decisions. One representative documented a 9-year delay in implementing a worker's pension entitlement for a chronic pain condition accepted under her claim and said, "She was denied interest on her delayed payment while the Board earned interest on her money in their investment portfolio." Another submission noted a worker who had to pay interest on borrowed funds to meet his financial obligations while the Board collected interest on his unpaid benefits.

The Workers' Advisers Office provided a detailed submission on this issue. They contend that under current policy, every time a benefit should be paid to a worker but is for one reason or another delayed for a significant period of time, the worker is essentially forced to make an unpaid loan to the Board. He or she may be forced into expensive borrowing while the Board has use of these funds. When the delayed benefit eventually is paid there is no adjustment for the effect of inflation, borrowing costs, or lost opportunity. They submit that payment of interest encourages prompt, complete and accurate decision-making.

The Act currently provides for the payment interest:

- Where survivor's benefits under section 19(2)(c) were incorrectly terminated; and

- Where payments resulting from Review Division decisions are deferred under section 258 pending an appeal to the WCAT.

Prior to November 1, 2001, policy #50.00 provided that the Board also paid interest to workers where:

- the wage-loss or pension was for a condition which was previously overlooked, or for which the Board had previously decided that no payment was due; and

- the effective date for payment of the restored benefits was more than one year prior to the date on which the retroactive benefits were processed.

The interest period was not capped, and interest was compounded and paid at a rate equal to the average return on the Board's investment portfolio for the preceding year, updated annually.

In 2001, the interest policy was changed to adopt the blatant Board error test that provided interest payments only where a Board officer made an "obvious and overriding" error. The issue of interest was considered by the courts in several cases without a clear resolution[19].

In 2012 the WCAT chair issued a decision under section 251 of the *Act* that the blatant Board error test was so patently unreasonable that it was not capable of being supported by the *Act.* The chair also found that the Board of Directors has the authority under section 82 of the Act to make policies for payment of interest in circumstances beyond those prescribed by the Act. The Board of Directors affirmed their policy as viable under the Act and directed the WCAT to apply the policy. Following further consultation[20] with the stakeholder communities, the Board of Directors removed any further provision to

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[19] for example *Johnson v. WCB* 2007 BCSC 1410 ; *Johnson v. British Columbia (Workers' Compensation Board*), 2011 BCCA 255; *Lockyer-Kash v. WCB* 2016 BCSC 2435

[20] "Interest on Compensation" August 2012. A Board discussion paper for consultation with stakeholders.

pay interest on compensation claims other that the two provisions specified under the Act.

As pointed out by the Supreme Court of Canada in *Pasiechnyk,* [21] the four fundamental principles of the Workers Compensation Legislation are:

(a) compensation paid to injured workers without regard to fault;
(b) injured workers should enjoy security of payment;
(c) administration of the compensation schemes and adjudication of claims handled by an independent commission, and
(d) compensation to injured workers provided quickly without court proceedings.

Policy considerations on the payment of interest

(1) Security of payment and timely payment of compensation are foundational to the workers' compensation system.

(2) Payment of interest restores some of the "lost opportunity" from delayed payment.

(3) Payment of interest provides a "quality function" by providing a financial account-ability for delayed payments.

(4) Payment of interest encourages correct decisions in the first instance rather than through appeals.

(5) The confidence in the workers' compensation system is eroded when the Board fails to meet its financial obligations in a timely manner.

(6) There is an onus on the worker to file a claim on a timely basis and to file a re-quest for review or appeal within statutory time limits. There is no such statutory obligation on the Board to make timely decisions.

There are therefore some compelling reasons to consider the payment of interest when there has been a significant delay in the payment of due compensation.

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[21] *Pasiechnyk v. Saskatchewan (Workers' Compensation Board)* [1997] 2 SCR 890

It addition to the foregoing reasons, there is an equity issue with respect to the payment of interest. Where entitlement to a payment is due but not paid, the board retains control of those funds and they are included in the Board's investment portfolio and the Board realizes a return on that investment at a higher rate than what the Board would pay on "simple interest"[22] which is the current method used where the Board now pays interest. When the Board pays no interest on delayed payments it receives a "benefit" in the form of the amount returned on investment for those funds.

The accident fund therefore retains those funds where the Board does not pay interest. Even where the Board does pay interest on delayed payments, the Board still gains the difference on amount earned through the Board's investment portfolio and the amount the Board pays in simple interest. An equitable approach to this issue in my view is for the Board to consider applying some of these accrued funds on investment to the payment of interest.

There are many policy options for the payment of interest on compensation and the payment of interest also involves administrative issues. The policy options are complex as illustrated by the wide variety of interest policies in the jurisdictions where interest is paid. It is beyond the scope of this time- limited review to craft a specific policy option for consideration by the Board of Directors. That requires administrative and actuarial considerations following carful investigation and analysis.

However, an equitable worker-centred approach to the payment of compensation merits consideration of an interest policy that is fair to workers and equitable to employers.

31. **I recommend that the Board of Directors initiate a review if the issue of interest with a view to establishing an equitable interest policy that recognizes the losses experienced by injured workers as a result of delays in the payment of due compensation where the delay is within the control of the Board or results from decisions that are overturned on review or appeal.**

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[22] Simple interest is calculated based only on the principal, while compound interest is calculated based on both the principal and previous interest accrued.

OCCUPATIONAL DISEASES

Evidence and decision making

Policy #97.00 provides adjudicative direction and guidance for investigating claims and weighing evidence in the decision-making process. While this policy also applies to occupational diseases, its focus is primarily on investigation and adjudication of injury claims. Policy #26.23 provides adjudicative direction and guidance for investigating occupational disease claims. These claims are often more complex from an evidentiary perspective around exposure issues and the determination of a diagnosis.

Some recent court cases have offered judicial guidance for occupational diseases. For example, the Supreme Court of Canada in *British Columbia (WCAT) v. Fraser Health Authority* 2016 SCC 25 ("Fraser Health") found that the Board has a jurisdiction to decide causation by making inferences from the evidence, even though scientific proof is lacking.[23] This is consistent with the guidance in *Snell v. Farrell* [1990] 2 SCR 311.

The Supreme Court of B.C. in *McKnight v. Workers' Compensation Appeal Tribunal* 2012 BCSC 1820 found that "diagnosis" is a finding of fact and the adjudicator must apply a legal standard, not a medical standard, for a finding regarding a diagnosis. Under the Act, the legal standard is "as likely as not" under section 99(3), which may be different than a medical standard.

Policy #26.23 could be strengthened by incorporating these same principles.

32. I recommend that the Board of Directors consider incorporating the principles regarding the onus of proof and medical evidence arising from recent judicial decisions into policy #26.23.

Date of Disablement

Section 6 of the Act provides that compensation for an occupational disease is only payable if a worker is "disabled from earning full wages at the work at which the worker was employed".

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[23] The relevant quote from the judgement: *"The law in Canada requires a broad approach to the evidence, which, together with a pragmatic, common sense consideration of the evidence, enables inferences of causation to be drawn even though scientific proof is lacking."*

Policy #26.30 "Disabled from Earning Full Wages at Work" lists some examples of what constitutes disabled from earning full wages at work, including missing part of a shift or not working full hours. Currently, the policy lists "the need to change **jobs** due to the disabled effects of the employment". Equating the provision in the Act - disabled from earning full wages at the work at which the worker was employed" with "disabled from earning full wages at work" has resulted in some ambiguity in adjudicating this issue.

In one case, a pulp mill worker had a sulfur dioxide exposure at work and developed permanent reactive airways disorder. The employer accommodated him so other than attending the emergency room and some medical appointments, he never missed work due to his disability. The Board found that although his injury was compensable, there was no referral to Disability Awards for his significant permanent impairment because he was not disabled from earning full wages, under policy #26.30.

The Board interprets section 6 to indicate that where a worker accepts light duties or modified pre-injury duties they are not disabled from earning full wages at work. Yet the worker is disabled "from the work at which he was employed", otherwise modified duties would not be required.

This ambiguity can be resolved by simply indicating in policy #26.30 the need to change **job duties** at the work at which the worker was employed is sufficient to comply with section 6(1) for compensation purposes. This would ensure that workers who take alternate duties to avoid missing time at work will not be penalized.

33. I recommend that the Board of Directors consider amending policy #26.30 to recognize that the worker is disabled for purposes of paying compensation where the occupational disease disables the worker from performing his or her regular job "duties."

A related problem arises on time limits for making an application in policy #32.55 "Time Limits and Delays in Applying for Compensation." That policy now indicates that the one-year deadline for filing an occupational disease claim starts running from the date of disablement. WCAT cases have confirmed that the "date of disablement" must be treated as the date of the occurrence of the injury for section 55 purposes (*WCAT #2005-03633* - Noteworthy Decision re Red Cedar Dust Asthma). There is no "date of disablement" for s. 55 purposes if the worker has not taken time off work (*WCAT-#2014-01931* Noteworthy Decision).

This can be resolved by recognizing in policy #32.55 the same principle for time limits for injuries under section 5 of the Act in policy #93.22. That policy recognizes special circumstances in a situation where a worker with a minor physical injury was not disabled from work and did not require medical treatment. The Board of Directors may also wish to consider a minor policy amendment in policy #32.55 to address that issue.

Activity Related Soft Tissue Disorder (ASTD) claims

I received many submissions regarding ASTD claims. The Board receives a high volume of these claims. They often make their way into the appeal process. Policy #27.00 - #27.32 provides detailed adjudicative direction and guidance for these claims for specific conditions. The first step in the adjudication process is to determine whether the claim is to be adjudicated under section 5 of the act as a personal injury or under section 6 as an occupational disease. Diagnosed conditions recognized through regulation or listed in schedule B are normally adjudicated under section 6 unless the condition arises from a specific incident or trauma, a series of trauma or the onset occurs during a specific shift.

Policy #27.00 2. addresses in general terms the distinction between an ASTD claim that is considered an occupational disease and one that is considered a personal injury. Often the diagnosis of an ASTD condition is unclear at the outset of the claim and it is difficult to determine which section of the Act should be used for adjudication. In the past, the ASTD *Practice Directive* provided guidance on what section of the Act (section 5 or section 6) to apply for different conditions and circumstances and stated that where there was a "working diagnosis only", an ASTD should be adjudicated under both section 5 and section 6. The current *Practice Directive* does not contain this provision nor does the ASTD policy.

This means that simple diagnostic issues - unclear or conflicting or delayed or multiple diagnoses, which are not uncommon for ASTDs - can lead to ASTD claims being adjudicated under the wrong section, under the wrong policy and having the wrong causation tests applied at the Board and on appeal. If the worker must seek additional decisions under the other section of the Act, there will be a significant delay in compensation benefits and a fragmentation of the Board's adjudication, often causing problems of jurisdiction on appeal. A clear statement in policy #27.00 to indicate that, where there is some evidence that the ASTD could be considered under either section 5 or section 6,

both issues be adjudicated at the same time to avoid unnecessary appeals and resulting delays.

34. I recommend that the Board of Directors consider an amendment to policy #27.00 2. to indicate that, where there is no clear diagnosis and there is some evidence that the ASTD could be considered under either section 5 of section 6, the decision include consideration of the claim under both sections.

ASTD adjudication policies provide specific direction regarding risk assessment for these conditions. *Practice Directive* C4-2 which is not Board policy, is relied on extensively to adjudicate ASTD claims. Labour representatives contend that the guidelines in *Practice Directive* C4-2 are outdated and rely primarily on research that is over 20 years old. They argue that, "The numbers are mostly derived from individual studies cited in the NIOSH 1997 Systematic Literature Review *Musculoskeletal Disorders and Workplace Factors - A Critical Review of Epidemiologic Evidence for Work-Related Musculoskeletal Disorders of the Neck, Upper Extremity, and Low Back.* "

I was referred to *WCAT-2011-02371* that provides a detailed analysis that documents the limitations of P*ractice Directive* C4-2 in adjudicating ASTD claims. That directive contains "pre-conditions" that preclude the exercise of discretionary decision-making as set out by policy. Many of the numeric values establish standards which are equal to or higher than the risk factor thresholds set out in Schedule B. The Vice-Chair noted that the "one-size-fits all" prescriptive approach set out in Appendix 1 of the *Practice Directive* essentially defeats the purpose of the legislation and binding policy, which both provide for flexibility to consider the particular circumstances of the case and the exercise of judgement consistent with section 99 of the Act.

The impact of lack of discretion exercised by decision-makers can be seen in the judicial review of *WCAT-2013-03319* in *Rutter v. WCAT 2015 BCSC 862.* In this case the court found that WCAT had narrowed the work-related risk assessment to one of "repetition" and imposed a higher standard of causation for this single factor than provided for by policy. More importantly, the court found that WCAT was patently unreasonable when it virtually ignored the worker's right shoulder disability as a "risk factor" for developing a left shoulder ASTD. The court stated that although favouring one's shoulder is not expressly identified as a risk factor in Board policy, it was required by the general language of policy #27.00 and section 250(2) of the Act and was "clearly called out for" in the circumstances of the case.

In light of the high number of appeals arising out of the application of *Practice Directive* C4-2 and the court's judgement on the importance of affirming consideration of all of the relevant circumstances:

35. I recommend that the Board of Directors consider an amendment to policy #27.00 further emphasizing the importance of identifying all of the relevant risk factors that exist in the particular case and base the decision on a careful evaluation of the evidence in accordance with Board policy and taking into consideration the merits and justice of the individual case.

Worker representatives also submit that the Board's *Occupational Health and Safety Regulation* (Regulation) and published guidelines provide more up-to-date guidance addressing risk factors for preventing musculoskeletal injuries and these factors should be incorporated into the *Practice Directive* to guide adjudication of these conditions. Sections 4.46-4.53 of the Regulation address "Ergonomic (MSI) Requirements" where "MSI" means a "*musculoskeletal injury*" or injury or disorder of the muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissue including a sprain, strain and inflammation that may be caused or aggravated by work.

The guidelines for this section of the Regulation set out how to assess risks using MSI Risk Factor Identification Worksheet A and MSI Risk Factor Identification Worksheet B. This data may be relevant to the adjudication of claims in some cases.

36. To ensure that relevant risk factors in the workplace are fully considered in the adjudication of ASTD claims, I recommend that the Board of Directors consider an amendment to policy #27.00 5. that the use of relevant risk analysis data from the workplace be considered in the adjudication of these claims.

With the changing nature of work and the integration of computers in the workplace, many of the issues arise from ASTD claims from workers with intense typing, keyboarding and mousing tasks. These claims are often denied on the basis that the single risk factor of repetition cannot result in an ASTD type injury. Yet this is not consistent with the Board's approach to ergonomic issues for computer use, under the Regulation and guidelines.

37. I recommend that the Board of Directors consider developing an ASTD policy specific to the risk factors consistent with the ergonomic requirements in the Regulation and guidelines.

One union that represents diagnostic imaging workers advise they have assisted 29 members appeal ASTD decisions based on the C4-2 guidelines. They point out that of the 29 members, appeals were allowed in 26 of the cases with additional evidence from a professionally-trained ergonomist. They argue that many of the ASTD appeals now clogging the appeal system could be avoided if the Board carried out standardized ergonomic assessments using more up-to-date environmental risk factors. It is apparent from the evidence presented that professional ergonomic assessment is the best available evidence to resolve the ASTD issue. It would be more effective from a worker-centred approach for the Board to apply this ergonomic expertise at the first level of decision-making to get it right without the negative impact involved in forcing the worker into the appeal system.

38. I recommend that the Board of Directors consider what steps are necessary to ensure that there is adequate expertise at the Board level to fairly and efficiently adjudicate ASTD claims without resorting to review and appeal levels wherever possible.

The union also argued that their record of successful appeals supports consideration of an industry presumption under schedule B for diagnostic medical imaging technologists. I make no recommendation on this, since it is beyond the scope of my terms of reference. Prior to 2002, the Board had an Occupational Disease Standing Committee with a mandate to review the Board's occupational disease policies and make recommendations for changes and additions to the Board. That Committee provided the Board with a mechanism to determine whether there was a basis to recognize a probable relationship between a disease and an occupational activity and make recommendations about additions to Schedule B.

MENTAL DISORDERS

Policy C3-13.00 sets out decision-making principles for determining a worker's entitlement to compensation for a mental stress injury, under section 5.1 of the Act. In consultations, it became clear that the majority of mental disorder claims arose from occupations that involve work related traumatic events and stressors, such as first responders. It also appears to be the case that the majority of these claims are not accepted.

There is no doubt that section 5.1 imposes special restrictions on mental disorder claims, compared to other types of injuries. However, in a worker-centred compensation system, Board policy should not raise the bar to compensation higher than the legislation provides. In my view, policy C3-13.00 creates further barriers to compensation for work-related injuries in this area in two main ways.

First, the policy guides a decision-maker to seek a definition of "traumatic events" and "significant stressors" using workplace norms as an objective standard. The policy defines "traumatic events" as being an emotionally shocking event "which is generally unusual and distinct from the duties and interpersonal relations of a worker's employment" and a significant "work-related stressor" as one which is excessive compared to the "normal pressures or tensions". This policy guidance strongly indicates that traumatic events or stressors which are NOT unusual do not qualify under this provision, excluding the very type of event which is likely to be involved in a mental stress injury for these occupations.

In effect, these policy provisions import an element of an old "assumption of risk" doctrine in that the "normal" or "usual" job duties are objectively non-compensable (the worker assumes the risk) and only "unusual" events are compensable. Normal work is effectively exempted from compensation for mental stress. This barrier is not required or sanctioned by the legislation. At the same time, it is clear that the legislation did not want to endorse a "causative significance" test for these type of injuries.

It would be helpful if policy permitted both a subjective and objective element to the definition of "traumatic event" and "significant stressors", by removing the provisions requiring that the events or stressors be "unusual" or outside the "normal" and instead, offering another standard. A "traumatic" event could be one which in all the circumstances was reasonably likely to have traumatized the worker.

39. I recommend that the Board of Directors consider amending the definitions of "traumatic event" and "significant work-related stressor" to remove the requirement that events or stressors be "unusual" and to include a subjective element to the definitions.

Secondly, the policy offers little guidance, other than what is in section 5.1(1)(c) the Act, for situations which will be excluded from consideration, what is known as the "labour relations exclusion".

It would be helpful if the policy clarified that this provision only excludes mental disorders that are a direct reaction to the employer decision itself. Everything a worker does in a workplace is ultimately decided at some level by the employer and if read too broadly, this policy could exclude some claims not intended by the legislation. The provision of examples would be particularly helpful. For example, if a worker hears that several co-workers are being laid off, his or her reaction to the employer's decision is not compensable, however traumatic, due to this provision. However, if a worker is forced to work long hours in stressful conditions due to her employer's downsizing, a resulting mental disorder that is due to the impact of these negative working conditions should not be excluded from consideration on the basis of the "labour relations exclusion" without consideration of all the relevant facts.

40. I recommend that the Board of Directors consider amending policy C3-13.00 clarify that application of section 5.1(1)(c) of the Act, the "labour relations exclusion" is to be applied to reactions to the employers' actual decisions, not workplace conditions as a whole.

The final issue to consider is the sensitivity and compassion that these claims require. Appendix 3 contains a brief case summary where the worker's interaction with the Board was problematic and from the worker's perspective clouded with suspicion. The nature of these conditions requires special sensitivity to not worsen the condition. The Board's Department of Special Care Services provides support for psychologically fragile workers when those cases are referred to them, but this is not always the case before cases are referred to them.

This is particularly problematic where there is some doubt on the Board's part about the validity of the claim. I heard several concerns expressed regarding the use of video surveillance to investigate some cases involving psychologically fragile workers.

Video Surveillance

Currently, there is no policy governing the Board's use of video surveillance to gather evidence on injured workers. The *Practice Directive* #C 12- 7 provides some guidance but is not binding.

This is a difficult subject. Ideally, video surveillance should be the "tool of last resort", used only when there are "reasonable grounds" to suspect misrepresentation or fraud on the part of the worker and safeguards for using this tool should be carefully adhered to, especially for psychologically fragile workers. This was not the information I received in my consultations.

I believe that video surveillance is an area where there needs to be substantial changes in Board practice, informed by clear Board policy. In effect, video surveillance should be a tool used to determine if a worker has engaged in serious misconduct. It should be used with clear procedural guidelines and protections and should not be used as a simple adjudicative tool for difficult files. There is also a disturbing pattern of claims which are denied or terminated on the basis of video surveillance, but which, on appeal, are found to not be substantiated by the video surveillance.

Important principles for a new policy on video surveillance could include:

- A request procedure which requires:
  - clear and substantive reasoning and is not just a subjective opinion from a claim owner; and
  - Approval by a person independent of the claims adjudication process, based on clear criteria. This is the path used for Prevention investigations.

- Guidelines that video surveillance is a tool of last resort. Where there is a concern about the consistency of a worker's presentation, claim owners should attempt to attain additional assessments or evidence prior to a request for surveillance.

- A requirement that when the video surveillance is obtained, it is examined for its probative value by a qualified examiner. *WCAT-2003-03300* provides helpful key questions for the assessment of video surveillance.

- That if there is a consideration of adverse decisions after the surveillance is completed and examined, that the worker or his representative will be provided with the surveillance evidence and given a reasonable time to respond.

- If criminal charges are contemplated, then the procedural protections afforded by the Charter in a criminal context apply. In the context of an investigation, these are set out in *R. V. Jarvis* [2002] 3 S.C.R.

41. **I recommend that the Board of Directors consider implementing a policy for the appropriate use of video surveillance to meet Board responsibilities without causing unintended harm to the worker.**

CONCLUSION

At the heart of workers' compensation in British Columbia is the need to share a joined commitment on the part of workers and employers to maintain a fair and equitable workers' compensation system. The sustainability of the system depends on maintaining a balance of interests between these primary stakeholders consistent with the principles of the historic compromise. Failure to maintain this balance can undermine the integrity of the system and invite its demise.

As Mr. Justice Tysoe pointed out in his 1966 Royal Commission Report, the overriding purpose of the system is to protect workers from injury and disease by maintaining safe and healthy workplaces. Where workplace injury and/or disease occurs, the system must support the worker's maximum recovery and restore the worker to safe and productive employment at no loss of earnings wherever possible and equitable compensation where that goal is not achieved.

Employers carry the responsibility of maintaining sufficient funding of the system to ensure that injured and disabled workers receive the necessary supports to achieve maximum recovery, return to safe, productive and durable employment, and adequate compensation benefits to replace the financial losses they suffer as a result of the injury.

Workers bear the heavier burden of dealing with the pain and suffering resulting from the injury, the disruption to their lives and livelihood, and the financial stresses that often accentuate the resulting disablement. To be equitable, the funding from employers must be sufficient to provide the necessary supports and services to fully restore injured workers to their pre-injury employment status and provide compensation benefits needed to replace their losses.

The 2002 changes to the Act were based on a fear largely on the part of employers and the new government that the existing benefit levels were unsustainable based on a predicted unfunded liability. That projected unfunded liability was based on assumptions rooted in the experience from the economic downturn in 2000-2002 and never materialized. As previously noted the Board ended up with a surplus of $571 million in 2002.[24]

Since, 2002, employers have received a 15% reduction in average assessment rates while workers benefits have been frozen at the reduced levels introduced in 2002. In 2015 the Board reported a surplus of $927 million and in 2016 a surplus of $471 Million.

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[24] H. Allan Hunt, Service Delivery Core Review: A Reappraisal, 2010, Page 14.

This has resulted in a significant imbalance between the adequacy of benefits to workers and the sufficiency of the accident fund for employers. Restoring that balance in benefit levels is mainly a legislative issue and is beyond the scope of this policy review.

My task in this review has been to identify policy options for consideration by the Board of Directors to restore a worker-centred approach.

The first step in restoring this balance in policy is to incorporate the requirement in section 99 of the Act to consider the merits and justice of the individual case when applying a policy of the Board of Directors. This requires adequate investigation of the facts and circumstances of the case with particular attention to the worker's evidence before making a decision. This emphasis must not only be incorporated into the words of policy, it must become an essential part of the Board's case management system. Treating workers with dignity and respect is an integral part of a worker-centred approach and must be a hallmark of the Board's interaction with workers.

The focus of my recommendations in this review is on restoring injured workers to safe, productive and durable employment as soon as the medical evidence indicates that is appropriate in the circumstances of the case. I have also provided policy options that reinforce the key goal of returning injured worker to the injury employer wherever possible. This is not only an emerging legal imperative, it also makes good sense for both the worker who maintains an established attachment to the pre-injury workplace, and of value to the employer who retains a trained and experienced worker.

Perhaps most important, retaining the injured worker with the injury employer minimizes the need to engage in complex and sometimes expensive retraining and re-employment supports to place the injured worker with a new employer. The cost associated with increased vocational rehabilitation benefits in the early stages of the claim to confirm attachment with the injury employer, result in significant savings in the later stages of the claim where placement with a different employer is costly and sometimes results in loss or earnings consideration.

The challenge for a renewed vocational rehabilitation commitment in the early stages of the claim is first the need for additional vocational service delivery capacity and second, and equally important, that the additional staff have the necessary training and experience in disability management to delivery this support efficiently and effectively using established disability management tools and strategies. Ontario has pursued this strategy for six years with considerable success in both restoring workers to productive em-

ployment with their injury employer, but also achieving significant cost savings. They attribute their success in part to their commitment to require and support certified professionalized training for the return-to-work specialists who carry out this work.

A secondary area of focus in my recommendations is to identify policy options to prevent unnecessary appeals. There is a high level of appeal activity around light duty reemployment and around pension and loss of earnings issues. I have recommended policy options to provide a greater worker-centred approach in these areas, with the intent of reducing unnecessary appeals that often delay and sometimes disrupt the return to work efforts. The Board's new "Comprehensive Framework for Quality Decision Making Sec 23(3)" is an example of a proactive approach now being taken by the Board.

I have attempted to address key areas of concern raised by employer and worker stakeholders. However, there are many additional areas that merit attention that I was unable to investigate and fully consider within the nine-week time frame of this review. It is my hope that where there are other issues in which stakeholder representatives and the Board's administration feel that significant improvements can be made, or where my recommendations can be improved, I urge them to bring these to the attention of the director of the Board's Policy Regulation and Research Division for consideration and where appropriate to the Board of Directors.

Based on my experience with this review, I believe the employer and worker stakeholder communities appreciate the need to correct the imbalance that has occurred in the system over the last 15 years and to restore that balance with a worker-centred approach to ensure that the British Columbia workers' compensation system is sustainable over the long term.

ACKNOWLEDGEMENTS

In the course of this review I have had the privilege of meeting with and hearing the ideas, concerns, and recommendations of representatives of the employer and worker communities. On the basis of my consultations I believe there is a willingness to work together to improve the system where it is found lacking. I am greatly indebted to each and every representative that took the time to share their views and their vision of a fair and equitable system.

Alan Winter and Janet Patterson provided some sage advice and guidance as I navigated challenging legal issues. Janet was especially instrumental in providing me with a grounding in the many judicial decisions that provide guidance for the system. I especially appreciate the insights and ideas that Doug Alley from the Employer's Forum and Nina Hansen from the BC Federation of Labour shared. They very ably represented the views of their respective communities.

I also want to express my appreciation to the leadership of the Board's administration who were generous with their time to review some of my proposals and offer valuable advice. I am especially grateful to Trevor Alexander, Senior Vice President of Worker and Employer Services and his leadership team whose guidance was invaluable to me. I believe they have the expertise and commitment to make support the transition to a more worker-centred approach. Lori Guiton, Director of the Board's Policy, Regulation and Research Division was especially helpful in providing background information and analysis.

I was very impressed with the commitment of the Workers Advisers Office and the Employers Advisors Office not only to serve their constituent communities, but to also work toward solutions that benefit the workers compensation system as a whole. I believe they can and will play an important role in promoting and supporting a worker-centred approach that is equitable to workers and employers.

I had an opportunity to meet with each of the members of the Board of Directors and I am impressed with the calibre of the leadership they convey. I am particularly indebted to Lynn Bueckert, the director representative of workers, and Lillian White, the director representative of employers, who serve as co-chairs of the Board of Directors Policy Committee. Together they met with me at critical junctures in this review. While they ably represent their constituent communities, they together demonstrate the commitment to cooperation needed to achieve a balanced system that serves the employers

and workers of British Columbia. I also thank Board chair Ralph McGinn for giving me the opportunity and the privilege of participating in this important project.

Finally, I must thank my good friend and colleague Donna Hanson for her invaluable assistance, patience and support for making it possible for me to compile and deliver this report on time.

Appendix A

Name	Title	Organization
Alexander, Trevor	Senior Vice-President, Operations	WorkSafeBC
Alley, Doug	Managing Director	Employers' Forum
Bains, Hon. Harry	Minister of Labour	Ministry of Labour
Blakely, John	Executive Director	Ministry of Labour, Labour Policy and Legislation Division
Boddez, Angela	Director, Fair Practices Office and Registrar	WorkSafeBC
Buck, Brad	Manager, Safety Advisory Services	BC Public Service Agency
Bueckert, Lynn	Board of Director	WorkSafeBC
Chauhan, Sam	Manager, Occupational Health & Safety	City of Surrey
Corwin, Lucas	Director	Ministry of Labour, Workers' Advisers Office
Cooke, Alan	Board of Director	WorkSafeBC
Dehek, Lani	Manager of OH Disability Management	BCNU
Dhillon, Baltej	Board of Director	WorkSafeBC
DoCouto, Evie	Vice President, Return to Work Division	Workplace Safety & Insurance Board
Earle, David	President & CEO	BC Trucking Association
Farquhar, Alec	Director	WAO, Ontario MOL
Fournier, Kim	Manager, Law and Policy	Ministry of Labour, Employers' Advisers Office
Gravelle, Joyce	Vice-President, Administration	National Institute for Disability Management and Research
Guiton, Lori	Director, Policy, Regulation & Research	WorkSafeBC
Hanna, Janice	Claims Adjudicator, WCB Disability Awards	Retired
Hansen, Nina	Director, Occupational Health and Safety	BC Federation of Labour
Haralds, Dave	Executive Director	Ministry of Labour, Employers' Advisers Office
Harder, Brian	OH&S Representative	United Steelworkers
Harrison, Rolf	Lawyer	Harrison O'Leary Lawyers
Hartmann, Chris	Director, Return to Work Services, Voc Rehab & Disability Awards	WorkSafeBC
Hughes, Trevor	Deputy Minister	Ministry of Labour
Hunt, Stephen	District Director	United Steelworkers District 3 Western Provinces and Territories
Hynes, Susan	Chief Review Officer	WorkSafeBC
Ishkanian, Vahan	Barrister and Solicitor	
Jackson, Alex	Rehabilitation Consultant	
Jobe, Jim	WCB Advocate	Health Sciences Association
Kawa, Leah	EDMP Administrator, Labour Relations Officer	Health Sciences Association
Kilby, Jeannie	President	CUPE 402
Laurie, Michelle	Staff Representative	United Steelworkers
Leyen, Jennifer	Director, Special Care Services	WorkSafeBC
Loftus, Lee	Board of Director	WorkSafeBC

Name	Title	Organization
Love, Kevin	Barrister and Solicitor	Community Legal Assistance Society
Lowes, Larry	Manager, Health and Safety	London Drugs Limited
Luck, Susannah	WCB Case Manager	Morneau Shepell
MacDonald, Iain	Staff Representative	BCGEU
MacDonald, Pamela	Regional Manager	Workers' Advisers Office
McDonald, Todd	Vice-President, Claims Services	WorkSafeBC
McGinn, Ralph	Chair, Board of Directors	WorkSafeBC
McKenna, Tom	National Representative	CUPE
McMillan, Grant	Strategic Adviser	Council of Construction Associations
McNeil, Margaret	Board of Director	WorkSafeBC
Miles, Diana	President & CEO	WorkSafeBC
Morrison, David	Regional Manager	Workers' Advisers Office
Nicholls, Rob	Manager, Safety, Security and Emergency Management	Metro Vancouver
O'Donnell, Merrill	Workers Advocate	BC Building Trades
O'Leary, Sarah	Lawyer	Harrison O'Leary Lawyers
Parhar (MD), Dr. Gurdeep	Executive Association Dean	Clinical Partnerships Faculty of Medicine, UBC
Parker, Jim	WCB Officer	BCNU
Patterson, Brooks	Board of Director	WorkSafeBC
Patterson, Janet	Barrister and Solicitor	
Pendray, Andrew	Chair	Workers Compensation Appeal Tribunal
Picotte, Adam	Barrister & Solicitor - WCB Advocate	Health Sciences Association
Pongracic-Speier, Monique	Lawyer	Ethos Law
Rogers, David	Rehabilitation Consultant	
Rothfels, Dr. Peter	Director, Clinical Services and Chief Medical Officer	WorkSafeBC
Schmidt (PhD), Dr. James	Neuropsychologist	Schmidt Trentadue & Associates
Schnoff, Niki	Staff Representative	Move Up Together
Shaw, Ian	Senior Vice- President & General Counsel	WorkSafeBC
Startup, Mark	President	Retail Council of Canada
Stoffman, Larry	Consultant	United Food and Commercial Workers Union (UFCW) Local 1518
Tanner, Michael	Director	Ministry of Labour, Labour Policy and Legislation Division
Taylor, Alex	Regional Manager	Workers' Advisers Office
Teschke, Kay	Board of Director	WorkSafeBC
Wainwright, Helga	LRO	Health Sciences Association
White, Lillian	Board of Director	WorkSafeBC
Williams, Blake	Past Director	Workers' Advisers Office
Wilson, Greg	Director, Government Relations	Retail Council of Canada
Winter, Alan	Barrister and Solicitor	Harris and Company
Wolfgang Zimmerman	President & CEO	Pacific Coast University for Workplace Health Sciences
Young, David A.	Regional Director, Worker and Employer Services Division	WorkSafeBC

Appendix B

Table 1 Lost time, Duration and Impairment data (source AWCBC KSM 2016)

	total lost time claims	lost time Injury frequenty	Average composite duration of claims	Average impairment rating	% of claims awarded impairment benefits
British Columbia	51,044	2.2	70.90	9.6	11.1%
Alberta	24,380	1.25	65.75		11.22%
Saskatchewan	8,589	2.11	N/A	7.43	6.75%
Manitoba	14272	2.89	77.40	4.86	6.82%
Ontario	57,386		N/A	9.92	5.97%
Quebec	68,537	1.8	N/A	10.27	26.66%
New Brunswick	4,516	1.33	92.3	7.1	14.92%
Nova Scotia	6,087	1.93	110.32	7.93	23.94%
Prince Edward Island	1,010	1.47	74.3	6.28	20.52%
Newfoundland and Labrador	3,589	1.72	117.07	15.18	14.09%
Yukon	464	2.1	30.76	8.56	8.09%
Northwest Territories and Nunavut	826	2.03	49.94	9.4	13.5%

Table 1.2 Compensation Benefits by Province (source AWCBC)

	Maximum comp earnings	% of earnings benefits are based on	Waiting Period	Permanent Disability maximum: PTD	Permanent disability minimum: PTD
British Columbia	$78,600.00	90% of net	no	$4,486.22	$1,691.85
Alberta	$95,300.00	90% of net	no	$5,152.42	$1,428.70
Saskatchewan	$65,130.00	90% of net	no	$4,884.75	$2,124.74
Manitoba	No Maximum	90% of net	no	$5,901.85	$1738.70
Ontario	$85,200.00	85% of net	No	N/A	N/A
Quebec	$70,000.00	90% of net	no	N/A	N/A
New Brunswick	$60,900.00	85% loss of earnings	3/5 of weekly benefits	$3,285.66	no minimum
Nova Scotia	$56,800.00	75% 1st 26 weeks then 85% of net	2/5 weekly benefits	N/A	no minimum
Prince Edward Island	$52,100.00	85% of net	2/5 weekly benefits	lump sum	no minimum
Newfoundland and Labrador	$61,615.00	80% of net	2/5 weekly benefits	$3,121.32 based on 80% net earnings	some minimum rules apply
Yukon					
Northwest Territories and Nunavut	$86,000.00	90% of net	no	$1138.25 northern residents	no minimum

Return-to-Work/Duty to Accommodate

	Obligation to Re-Employ	Legislation	Policy & Procedure	DTA Details	RTW Details
British Columbia	No	N/A	N/A	Employers encouraged to rehire at Phase II	No requirement under WCA for employers to rehire injured workers
Alberta	Yes	S.88.1(1) & (3)	Draft 04-05 Appl. 2-5	Wkr empl 12 months No exemption for small empl.	DTA unless undue hardship
Saskatchewan	Yes	S.51, 5.3 & 101 (1b)(ii)	POL 08/96 POL 01/07	To the point of undue hardship	Obligation of employer to cooperate
Manitoba	Yes	S.49 (3)	Policy 43.20.25	Applies where 25+ workers 12 continuous months	Reinstatement in original job where possible
Ontario	Yes	S.41 – 43 Reg 35/08	19-02-02 Respons. of wkr/empl.	To the point of undue hardship Exception for construction	Obligation to reemploy 20+
Quebec	Yes	S.32 S 234 – 251 S. 176	Policy 3.01 3.02	Commission may reimburse cost of accommodation	Right to reinstatement within 1 year where 20+ workers
New Brunswick	Yes	S.42.1	Policy 21 - 413	Required to re-employ > 10 exempt 10-19 1 year 20 + 2 years	Duty to communicate DTA from human rights – obligation 1 year
Nova Scotia	Yes	S.89 – 101	Policy on re-employment	Empl with less than 20 exempt 1 year empl	To the point of undue hardship
Prince Edward Island	Yes	S.86.1 – 86.12	Policy 93 RTW	20+ workers 1 year Const. exempt	To the point of undue hardship
Newfoundland/ Labrador	Yes	S.89 – 89.4	Policy 33.00 – 43.00	20 + workers 1 year empl.	To the point of undue hardship
Yukon	Yes	S.41 (1)	Policies 04-06 07-1-3 08	20 + workers Empl 1 yr	Mandatory accommodation
Northwest Territories & Nunavut	No	S.46	Policy 04.14	No DTA	VR Services

Appendix C

Firefighter case study - PTSD

(the following case study was provided by a firefighter who agreed to include this in my report)

About 4 years ago, in December sometime in the morning, I went to a call for a sick child. When we arrived, we quickly realized that this child (I believe he was under 18 months) was way sicker than we thought. He wasn't breathing and had no pulse. The scene quickly escalated. The family panicked, and screaming everywhere, I personally picked up the infant and began our cpr protocols in my arms. (the child was on a bed, so we had to transfer to a flat surface). The ambulance arrived shortly after us, and began the airway control and had us continue the cpr. Anyways...long story short, I did CPR on this child all the way to the hospital, with the majority of it occurring in my arms. It was awful. The child didn't make it.

This call happened on our first day shift. I didn't feel like coming to work the next day and called in sick. I called in sick for my night shifts too. (3 sick days) Those 3 days off, I hung out with my friends and family, sought professional help, had a beer or two, and went into the mountains to snowboard and clear my head. It was the perfect rehab for me. When I returned to work, I felt great about things.

Approximately 2-3 months later, [my captain who is responsible for Health and safety] approached me and asked whether I took those days off sick because of that call, and I replied yes. He wanted me to make a claim with WCB. I agreed. I was going to try and claim back my 3 days of sick time.

I'm not sure how it all got started, but I received a call from a WCB case agent. This was an intake person before I was assigned my actual person....This person knew the story from what I had claimed, but phoned to get some information from me, start my claim, inform me of the process, and to ask about the incident. I recounted the incident to her and re-lived all the emotions that came with it. It was awkward to pass this story on to an intake person, but assumed that she'd understand. She took my story, and said she would pass on my claim to a case manager and that I would receive a call within a certain time period..(can't remember how long it was)

Fast forward a couple weeks. [My case manager] gave me a call to introduce himself, explain the process and hear the story. I recounted the story to him, relived the emotions, and now was frustrated that I had to repeat this story again. [He] agreed that "it must have been stressful" and that it certainly warrants a WCB claim. [He] went on to say how as firefighters were expected to "weather a certain amount of expectational stress" (as in, this kind of stress is considered expected for our job, whereas it wouldn't be for other jobs). I had no idea what

else to say to him. I asked a few questions, and then left it at that. He was going to start my claim process and get back to me.

A week or so later [he] calls back. He asked how I was doing, and explained what was going to happen next. But first, he wanted me to talk about the incident again. I wasn't too thrilled on telling the story again, so I left out some of the major details and told him the basics, as he already knew the whole story...right? After the basics were done, [he] wanted to know more about the stuff I left out this time, so he probed, and asked for some more of the details, and basically made me tell him all the story again. I felt at this point that they did not believe me, and that the reason I was telling the story over and over and over was to see if it was the same each time – like they were trying to find a gap in the story or something like that. It stressed me out.

IN order for me to have my claim accepted, I would have to go see one of their doctors for an evaluation. Fine I thought...whatever. ...but then he said "in order for your claim to be accepted, our doctors will have to diagnose you with an accepted mental disorder....like one in the big book of medicine...on the list of mental disorders..." Once I was diagnosed, then my medical records would be passed on to my employer and my claim would be accepted. I didn't like the sound of that. I was really stressed now. I told him that I would call him back, but that I didn't like the sound of that.

I called [my captain] to discuss what he wanted me to do. I had now been dealing with this call for way too long, re-lived it way too many times, and told [my captain] I was more stressed now then I was after the call. I wanted to drop the claim and he agreed.

I called [the case manager] back and told him I was going to drop the case. I told him what I thought about the process and left it at that. I was done.

It was an awful experience mostly because I felt like they didn't believe me at all. It honestly felt like such an uphill battle against someone who has NO IDEA what it is like to do my job...let alone CPR on a child, in front of the family, at Christmas.