



A C H I E V I N G  
T O G E T H E R

#### **OUR NEW VISUAL IDENTITY**

The publication of our 2007 Annual Report introduces a new visual identity for the Institute for Work & Health, based on an expression of our organization's well-known abbreviation, IWH. The bold square formed by the letter H conveys stability and integrity and the plus symbol is a metaphor for the counting and measuring that is the basis of much of our research. Energy and discovery is conveyed by the bright dot above the letter I.

#### **THE INSTITUTE AT A GLANCE**

The Institute for Work & Health (IWH) is an independent, not-for-profit research organization. Our mission is to conduct and share research that protects and improves the health of working people and is valued by policy-makers, workers and workplaces, clinicians, and health & safety professionals.

#### **WHAT WE DO**

Since 1990, we have been providing research results and producing evidence-based products to inform those involved in preventing, treating and managing work-related injury and illness. We also train and mentor the next generation of work and health researchers.

#### **HOW WE SHARE OUR KNOWLEDGE**

Along with research, knowledge transfer and exchange is a core business of the Institute. The IWH commits significant resources to put research findings into the hands of our key audiences. We achieve this through an exchange of information and ongoing dialogue. This ensures that research information is both relevant and applicable to stakeholder decision-making.

#### **HOW WE ARE FUNDED**

Our primary funder is the Ontario Workplace Safety and Insurance Board (WSIB). Our scientists also receive external funding from major peer-reviewed granting agencies.

#### **OUR COMMUNITY TIES**

The Institute has formal affiliations with four Ontario universities: McMaster University, University of Toronto, University of Waterloo, and York University. The Institute's association with the university community and its access to workplaces and key sources of data have made it a respected advanced training centre. Over the last several years, IWH has hosted a number of international scientists. Graduate students and fellows are also associated with the Institute. They receive guidance and mentoring from scientific staff and participate in projects, which give them first-hand experience and vital connections to the work and health research community.

# We

are pleased to report on the accomplishments of a pivotal year at the Institute for Work & Health in 2007. We had spent the year 2006 looking back, with a five-year review of our activities over the period from 2002 to 2006. In 2007, it was time to think of the future. We created a new strategic plan to guide our activities from 2008 to 2012. We also had another productive year, completing many successful projects. In this report, we have chosen to profile eight examples that reflect the scope of our research, knowledge transfer and exchange efforts, and collaborations with our partners in 2007.

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A MESSAGE FROM THE CHAIR AND PRESIDENT



Dr. Cameron Mustard & Dr. Roland Hosein

A TIME OF RENEWAL

In 2007, the Institute's Board of Directors and staff devoted time and energy into defining our strategic goals for the next five years. In last year's annual report, we described the recommendations from the report of the international five-year review panel that assessed the Institute's work over the period 2002-2006. The panel's recommendations – and the views of our stakeholders – were prominent in our strategic planning over the past year.

We asked ourselves, where do we want the Institute to be in five years? We engaged Institute staff in a number of sessions where we shared our ideas, debated and discussed them, and set out a vision for the Institute's next five years. Our goals and our vision appear in a new strategic plan for the Institute for 2008-2012.

We have also refined our mission statement to emphasize the importance of producing relevant, useful research for our occupational health and safety colleagues who use our findings. The plan sets out values that we will strive to achieve, and the principles that will govern our relationships and activities.

The strategic plan affirms our research focus in two key areas: primary prevention of work-related injury and illness, and work disability prevention and management. In addition, the plan emphasizes our ongoing commitment to knowledge transfer and exchange (KTE), to the training of highly-qualified research personnel, to organizational excellence and to our future sustainability as an organization.

In addition to strategic planning, 2007 was also a year of many scientific accomplishments and active strengthening of our relationships with our partner agencies and organizations in Ontario. In this year's annual report, to showcase the diversity and relevance of our work, as well as our partnerships, we present eight examples of projects from 2007. These projects represent a fraction of the work that goes on at the Institute.



**OUR NEW MISSION STATEMENT**

The Institute for Work & Health conducts and shares research that protects and improves the health of working people and is valued by policy-makers, workers and workplaces, clinicians, and health & safety professionals.

IWH scientists published 39 studies in peer-reviewed journals and made 84 presentations at conferences or to professional groups over the year. KTE staff held seven meetings with stakeholders for our systematic prevention reviews program and we created two new clinical networks in addition to five existing networks. Interest in our work remains high among occupational health and safety professionals. There were almost 2,500 downloads of the *Seven Principles for Successful Return to Work* in 2007. The number of articles about IWH in trade media more than doubled over the previous year. We also began work to make our communication products even more accessible to our audiences, with a fresh new look for some of our products and our website.

For all their hard work, and for their contributions to developing our strategic plan, we would like to express our appreciation to Institute staff in research, knowledge transfer and exchange, library services, information systems and administration.

We would also like to acknowledge the support of our main funder, the Workplace Safety and Insurance Board.

We look forward to another year of working closely with our partners, to achieve our collective goals of preventing injury and illness in workers and in helping injured workers recover and return to work.

Read our strategic plan online at [www.iwh.on.ca/products/strategic\\_plan.php](http://www.iwh.on.ca/products/strategic_plan.php)

Dr. Roland Hosein  
Chair, Board of Directors

Dr. Cameron Mustard  
President



A C H I E V I N G  
T O G E T H E R

TWO OVERARCHING GOALS MOTIVATE OUR EFFORTS

in occupational health and safety (OHS). For some, the focus is on finding ways to prevent injury and illness in workers. For others, the priority is to help injured workers recover and return to work, and to prevent the injury from becoming a permanent disability. Achieving these goals requires ongoing, concerted efforts by employers, workers, OHS and health-care professionals, policy-makers and researchers. In 2007, the Institute for Work & Health (IWH) has continued to conduct studies and deliver research results to help our partners achieve both of these goals.



**IN 2007, IWH DELIVERED** research results to help our partners achieve the two main goals in occupational health and safety: to prevent injury and illness in workers, and to help injured workers recover and return to work.

In prevention, our research has explored the injury risks among groups of workers who may be more vulnerable, such as immigrants and young workers out of high school. This type of research can help target prevention efforts. Our research has contributed evidence on the effectiveness and economic benefits of workplace injury prevention programs.

To keep our prevention efforts relevant, IWH has continued to work with groups who use our research. For instance, we engage clinicians, policy-makers and OHS professionals in our systematic reviews. We participate on the Occupational Health and Safety Council of Ontario (OHSCO). Members include senior decision-makers in Ontario's prevention system, including the Ministry of Labour, the Workplace Safety and Insurance Board (WSIB) and Ontario's health and safety associations.

For the goal of improving recovery for injured workers, we have been active in many areas as well. As contributors to the work of the Neck Pain Task Force, IWH scientists helped produce a series of reviews and studies that provide guidance on assessing, classifying and treating neck pain. In return to work, our researchers completed a unique study of injured workers and identified strategies that are crucial for successful early return to work. Another study involving injured workers pinpointed factors that can complicate a work-related compensation claim.

We also continue to interact with those who care for injured workers. For instance, through our clinical networks, we have been creating new tools to help clinicians in their practice. In collaboration with our knowledge transfer and exchange staff, the physio-therapist network produced *Practice Perspectives*, a commentary on the clinical applications of an IWH review on back pain.

For IWH, therefore, 2007 marked another productive year. And there have been successes to report in Ontario. The Ministry of Labour announced that there has been a 20 per cent reduction in work-related injuries in Ontario since 2004.

But even one injury is too many, especially for the worker affected. So the efforts to achieve our collective goals continue. The WSIB has set its own fairly ambitious targets for a 35 per cent reduction in lost-time injury rates and in the number of traumatic fatalities between 2007 and 2012. The WSIB also aims to improve its services to injured workers for a better recovery and return to work.

At IWH, we remain committed to producing relevant, applicable research and to working with our partners to unravel the complexity behind these goals and to help meet these targets.





## Preventing injuries and illness among workers

### → VULNERABLE WORKERS FACE DIFFERENT INJURY RISKS

Some types of workers may be exposed to higher injury risks, making them more vulnerable to injury. Risk factors among young workers, who are one example of vulnerable workers, have been studied by IWH researchers. Dr. Curtis Breslin has led research showing that young workers who were out of high school were three times more likely to be injured on the job than those who were still in school. The study was published in the *Canadian Journal of Public Health*. "This finding suggests that we need to target work injury prevention resources outside of school," says Dr. Breslin, an IWH scientist. "We need to find other ways of reaching these young workers."

From 2006 to 2007, Institute President Dr. Cameron Mustard was a member of an Action Group appointed by the Ontario Minister of Labour. The Action Group recommended a number of approaches to preventing workplace injuries in workers under age 25 and not in school. One recommendation was to target locations where these young workers spent time, such as youth employment centres, as a way to communicate safety messages to them.

To better understand these young workers, Dr. Breslin has initiated work on a research project in co-operation with the Ontario Association of Youth Employment Centres. The project will identify the injury hazards young workers out of school have encountered, compare

their experiences to Ontario youth in general and describe the kind of safety training the youths receive at their workplaces. This knowledge will inform prevention efforts for these young workers.

Another special population of interest is workers who are new to Canada. Each year, more than 200,000 immigrants arrive in Canada. While many studies have been done on the labour market earnings of immigrants, less is known about their work experiences and occupational health and safety issues.

Scientist Dr. Peter Smith has begun several studies to explore these questions. Are there differences in immigrants' working conditions or injury rates compared to Canadian-born workers? The answers to these questions may have implications for prevention specialists, policy-makers, as well as immigrant settlement agencies, immigrant workers and their employers.

### → TWO APPROACHES REDUCE INJURIES IN HEALTH-CARE WORKERS

In Ontario, musculoskeletal disorders (MSDs) – including low-back pain – account for more than 40 per cent of all lost-time claims. From 1996 to 2004, three million working days were lost due to MSDs, which amounted to more than \$380 million in benefits paid, health-care treatments and lost productivity.

Certain workplaces pose a higher risk of injury than



**AN IWH REVIEW** identified two approaches to help prevent soft-tissue injuries in health-care workers: exercise training and a three-part patient handling program.



others, due to the nature of job tasks and hazards. Health-care workers fall in this group, and they consistently report high levels of back pain. In 2007, IWH researchers completed a systematic review that looked at findings from studies of MSD prevention programs for health-care workers.

This review identified two approaches that had beneficial effects: exercise training and a multi-component patient-handling program.

“Most health-care workers lift or handle patients every day,” says Dr. Benjamin C. Amick III, the Institute’s Scientific Director. “These activities can place high biomechanical loads on the low back, which can lead to pain and discomfort.” The review was conducted by Dr. Amick and colleagues from the Institute for Work & Health, the University of Texas at Houston and several other organizations.

The multi-component program reduced injury rates in health-care workers. The three components were:

- a worksite policy change such as zero-lift policies
- patient handling equipment
- training for health-care workers in the use of the equipment.

Practitioners from Canada and the United States provided valuable input and feedback for this review. Representatives from hospitals, nursing homes, government agencies, professional associations,

insurance companies and lift-manufacturing companies described what kind of information and questions would be useful and relevant in their practices.

“We know which questions should be considered as we link the workplaces and workers to the research questions that need to be asked,” notes Joseline Sikorski, President and CEO of the Ontario Safety Association for Community & Healthcare (OSACH). Staff from OSACH, which is the province’s health and safety association for that sector, participated in the review. “Stakeholders and researchers have to work together to make sure the results are timely and valid for all involved.”

Sikorski says the three-component program makes perfect sense. “Without the worksite policy and the education component, the patient lifting equipment would likely be sitting in a corner.”

In addition, the review showed exercise programs targeted at workers with pain also had a positive effect. “These training programs were intense—usually two to three sessions a week over several weeks and some exercise programs included intermediate outcomes such as improvement in cardiovascular health,” says Dr. Jessica Tullar of the University of Texas, a co-author of the review.

“The benefits to both cardiovascular health and musculoskeletal health are a double bonus,” adds Dr. Amick.



YOUNG WORKERS

out of high school were three times more likely to be injured than those in school, suggesting the need for injury prevention efforts outside of schools.



This review's findings are important because it offers organizations an approach to prevent these costly and burdensome conditions. However, Dr. Amick says organizations must understand that the evidence supports using all three components together. "There are no simple fixes," he adds.

#### ➔ ECONOMIC BENEFITS OF WORKPLACE PROGRAMS

It's not only important to show employers or other decision-makers that OHS programs are effective: if they are thinking of investing resources in such programs, they want to know if the benefits are greater than the costs.

But often, studies of the health benefits of OHS programs haven't included an evaluation of their resource implications. Scientist Dr. Emile Tompa has headed a series of projects to further develop the evidence for economic returns of workplace interventions.

"Economic evaluations are important in any area where you need to make a decision about resource allocation, so that you can answer the question 'Is it worth implementing this alternative rather than another one?'" says Dr. Tompa.

In 2007, Dr. Tompa and IWH colleagues completed a systematic review of economic evaluation studies of OHS programs. This review showed that there was strong evidence for the economic benefits of disability



management programs across sectors, and ergonomic programs in the manufacturing and warehousing sectors.

Dr. Tompa was also part of a research team, led by the Centre of Research Expertise for the Prevention of Musculoskeletal Disorders (CRE-MSD). The researchers completed an economic evaluation of an injury prevention program based on participatory ergonomics (PE) in a manufacturing setting. PE is an approach that involves workers, supervisors and managers in planning and organizing tasks and workspaces to prevent injury. While the program did not lead to a lower injury rate, it did reduce the duration of sick leave and the duration of disability insurance claims. The program was found to be cost-effective.

Also in 2007, Dr. Tompa and colleagues completed a methods text on the economic evaluation of workplace interventions. The book, which will be published in 2008 by Oxford University Press, provides guidance on how to conduct and assess economic evaluations of OHS studies. The textbook is aimed at practitioners, workplace researchers, applied economists and policy-makers at compensation boards and in government.

The systematic review has spawned a practical tool for workplaces in the form of an economic evaluation workbook. "The workbook will help walk employers and other decision-makers through the steps of an economic evaluation of an OHS program," says Dr. Tompa.



**THE REVIEW FOUND** emerging evidence that the use of mass media communications can influence attitudes and behaviours surrounding occupational health and safety.

**→ SOCIAL MARKETING CAN PROMOTE  
WORKPLACE SAFETY**

Encouraging safer workplace practices often requires changing people's attitudes, to convince them that preventing workplace injuries is actually possible.

"Recent polls have shown that roughly half of workers and employers believe workplace injuries are inevitable," says Dr. Cameron Mustard, IWH President and Senior Scientist. "Changing these fatalistic views is an important goal of workers' compensation boards' investments in social marketing."

Advertisers have long made use of mass media to influence consumer purchasing decisions. Social marketing uses similar marketing techniques to influence social attitudes and behaviours with the goal of improving problems in society.

An IWH review showed that mass media communication can enhance workplace safety, particularly when combined with education programs, consulting services or targeted inspections. The review assessed studies on the effectiveness of campaigns with high quality evaluations from countries such as Germany and Australia.

"The review found emerging evidence that the use of mass media communications can influence attitudes and behaviours surrounding occupational health and safety, especially if integrated with other programs," says Dr. Mustard.

The success of anti-smoking campaigns has shown the power of an integrated social marketing approach. Legal restrictions on tobacco use, government taxation, and advertising have worked to promote changes in attitudes and behaviours about smoking.

Several Canadian workers' compensation boards, noting the successes of social marketing campaigns in public health, have been using these methods to influence the way people think about workplace safety. "It's a credit to the compensation boards that they have taken this role," says Dr. Mustard. "Public insurance agencies have both the mandate and the means to change attitudes and beliefs."

## 2

## Improving recovery for injured workers

### → TASK FORCE PROVIDES GUIDANCE ON TREATING NECK PAIN

When workers are injured, their first step to recovery often involves a visit to a health-care professional. Understanding the effectiveness of clinical treatments is crucial to enabling early recovery from an injury.

One common problem among workers is neck pain. It can be caused by a motor vehicle collision, resulting in whiplash, or by ongoing strain due to awkward work positions.

An international team of researchers and scientist-clinicians was assembled to build consensus around the best ways to prevent, diagnose, and manage neck pain. In 2007, the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders completed work on a series of reviews and studies.

“Neck pain is not a simple condition, so it really requires the attention of multiple perspectives,” says Dr. Sheilah-Hogg Johnson, a senior scientist at IWH and a task force member. “The task force supplied those perspectives by drawing together international experts from different methodological backgrounds.”

The task force considered nearly 32,000 research citations and did critical appraisals of more than 1,000 studies. A synthesis of the best available evidence and several original research studies appeared in the

January 2008 editions of *Spine* and the *European Spine Journal*.

“The collaboration, generosity and cooperation of the administration and the researchers at IWH were invaluable to the success of the task force,” says Dr. Scott Haldeman, president of the task force’s administrative committee.

The task force’s work produced several key findings. One recommendation is for clinicians to classify neck pain into one of four grades, according to severity.

There is neither one cause nor one “best” treatment option for less serious types of neck pain (Grades 1 and 2), which are the most common. Different treatments appear to work, specific to the grade and the nature of the injury.

“One of the things the evidence tells us is that much can be learned from taking a good patient history,” says Dr. Hogg-Johnson. “Another is that patient choice should be a factor in treating neck pain. There isn’t a single best treatment, so patients might have to try a number of different things before discovering what works for them.”



PATIENTS WITH NECK PAIN

should have a say in which treatment they prefer, as there are several possible treatment options, an international task force found.



**IN ONTARIO**, six in 10 workers received a work accommodation offer from their employer a month after injury. However, about 20 per cent of those workers declined the offer.



#### CRITICAL FACTORS FOR EARLY RETURN TO WORK

In recent years, IWH research has helped show the approaches that lead to a more successful return to work for an injured worker.

To develop a deeper understanding of these approaches, Scientist Dr. Renée-Louise Franche and colleagues studied the experiences of more than 600 injured workers in Ontario.

They found that 60 per cent of workers who were off work because of a musculoskeletal disorder had received a work accommodation offer from their company within 30 days after injury. This study was published in the *Journal of Occupational and Environmental Medicine* in 2007. This rate represents an important improvement from the mid-1990s, when only about 25 per cent of workers reported receiving an offer of accommodation within 30 days.

Yet approximately 20 per cent of workers declined an offer to return to work under an accommodated work arrangement.

“Workers reported that the main reason they didn’t accept the offer was that they weren’t physically ready to return to work,” says Dr. Franche. “We now need to understand what will make offers more acceptable to the workers – for instance, this could be related to the timing of the offer, the type of work offered, or the manner in which it is offered.”

This Readiness for Return-to-work Study also showed that when a health-care provider advised the workplace on how to prevent re-injury, workers were off for shorter periods. “The key finding here is that it is not only the presence of the interaction between the workplace and health-care provider that counts, but more importantly its content,” says Dr. Franche.

Another set of findings from the study, published in the *Quality of Life Research Journal*, also highlighted the issue of recurring work absences. Six months after their injury, 38 per cent of workers who had attempted a return to work had at least one additional work absence.

The findings show that a first return to work does not mean that the worker has fully recovered from an MSD.

“Recurrence of work absence can be harmful for both the worker and the workplace, as it can erode the initial goodwill from both parties,” says Dr. Franche. “We need to start thinking about recurrence prevention. But employers also have to understand that recurrences may happen. We must work with employers to prevent them, anticipate them and manage them.”



#### UNDERSTANDING LONG-TERM CLAIMS

In most disability insurance systems around the world, about 20 per cent of disability episodes are responsible for 80 per cent of all costs. In recent years in Ontario,





there has been a concern that the duration of long-term disability episodes may be increasing. The implication is that the average disability benefit cost of long-term claims is rising.

To understand the complex factors that may be driving this trend, IWH researchers embarked on two different projects. One involved interviews with injured workers who had long-term claims, as well as their peer supporters and service providers. In the other study, researchers examined the characteristics of long-term claims over an 11-year period to identify the factors that may be responsible for the increasing duration of long-term claims.

Workers who have long-term claims – ones that lasted longer than anyone expected – face challenges as they go through the health-care and compensation systems and attempt to return to work. When the challenges add up, they can prolong their claim, according to a study completed in 2007 by Dr. Ellen MacEachen, and colleagues.

“Many workers we interviewed seemed to be typical workers, but they got what we called a ‘toxic dose’ of more than one problem,” says Dr. MacEachen, an IWH scientist.

The researchers interviewed 69 injured workers, peer supporters and service providers from across Ontario. They aimed to identify some common problems or issues that could lead to complicated claims, based

on participants’ experiences with their workplaces and the health-care and compensation systems.

The issues that emerged were not surprising:

- Miscommunication among all the players involved.
- Having an unsupportive employer.
- Workers feeling that they could not refuse work that was not properly modified for them.
- Relying on doctors at walk-in clinics to fill out medical forms, because they didn’t have a family doctor.
- Having “invisible” injuries to soft tissues that called for additional medical reports before a claim entitlement decision could be made.

And the list went on.

What was surprising about the findings was how workers were caught in administrative situations over which they had little control. This challenges policies and decision-making systems that assume workers are in charge of the circumstances of their workers’ compensation claim, Dr. MacEachen notes.

Often these complications would affect the “other 18 hours” of a worker’s life. For instance, if a worker had limited personal savings, then any delays or complications in determining claim eligibility could be devastating. With no benefits coming in, they would drain their own resources or borrow money from family and friends.

As a practical way of addressing the issues that can arise in the return-to-work process, and in the systems



**IWH RESEARCHERS** are developing a tool to help service providers identify and deal with “red flags” – situations that complicate injured workers’ compensation claims.

that workers encounter, Dr. MacEachen and colleagues are developing a tool for service providers. The tool would help identify “red flags,” which are the toxic situations or process-related roadblocks that could complicate a claim. If a red flag is identified in a worker’s situation, the service provider would need to look into the particular context to address issues that might be overwhelming the worker. “Green lights” identify providers’ helpful practices in return to work.

#### → **THE INCREASING DURATION OF LONG-TERM CLAIMS**

Motivated to improve outcomes for injured workers, IWH researchers and colleagues at Ontario’s WSIB have collaborated to identify factors that may be responsible for the increasing duration of long-term claims.

Dr. Sheilah Hogg-Johnson and Dr. Emile Tompa led the IWH contributions to this project. The goal, says Dr. Hogg-Johnson, was to ensure that the compensation system was functioning as it should. “Our hope is to improve outcomes for workers, and their ability to return to work,” she says.

At the invitation of WSIB colleagues, Drs. Hogg-Johnson and Tompa helped to identify key indicators in the data that could be used to assess long-term claims. They tested four possible explanations for the increased duration of lost-time claims. They questioned whether the increase reflected a change in statistical analyses, in the labour market, in the individual

characteristics of claimants, or in the way that claims were managed following the legislative move from Bill 162 to Bill 99 in 1998.


Bill 99 replaced the former Worker’s Compensation Act with the Workplace Safety and Insurance Act. Among the many changes associated with the bill, the WSIB modified practices associated with the review and adjustment of loss of earnings benefits (LOE).

When subject to testing, the move to Bill 99 stood out from the other three hypotheses as the most probable explanation.

“Bill 99 and the ensuing policy changes seem to have had an effect on the duration of long-term claims,” says Dr. Tompa. “But it’s not a simple story. There are many factors affecting persistence, and they’re all interwoven.”

Dr. Tompa attributes some of the study’s success to the collaborative relationship between WSIB and IWH. “It would have been difficult to know what was behind the data without talking to people at the WSIB who administer and adjudicate the different programs.”

The study represents a first foray into long-term claim duration for Dr. Hogg-Johnson and Tompa. They have received a grant from the WSIB’s Research Advisory Council to continue this research for two years.



THE YEAR IN  
NUMBERS

STAFF

Total staff: 88 (74 full-time; 14 part-time)

Adjunct scientists: 36

STUDENTS

PhD students: 5

Post-doctoral students: 2

Completed PhDs: 1

PROJECTS

Active projects: 52

National/provincial project  
collaborations: 22

International project collaborations: 4

National/provincial policy  
advisory roles: 13

International policy advisory roles: 11

FUNDING

Research grant funding: \$2,069,258

Workplace Safety and Insurance Board  
funding: \$4,864,232

PRESENTATIONS & PUBLICATIONS

Articles in peer-reviewed journals: 39

Completed systematic reviews  
on the effectiveness of prevention  
interventions: 1

Book chapters: 3

Memberships on scientific journal  
boards: 3

Editorships of scientific journals: 2

Presentations to conferences &  
professional groups: 84

A U D I T O R S '  
R E P O R T

TO THE DIRECTORS OF  
INSTITUTE FOR WORK & HEALTH

We have audited the balance sheet of Institute for Work & Health as at December 31, 2007 and the statements of operations, net assets and cash flow for the year then ended. These financial statements are the responsibility of the organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement.

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. In our opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at December 31, 2007 and the results of its operations and cash flow for the year then ended in accordance with Canadian generally accepted accounting principles.

*Stern Cohen LLP*

CHARTERED ACCOUNTANTS  
LICENSED PUBLIC ACCOUNTANTS  
TORONTO, CANADA  
MARCH 3, 2008

## Statement of Operations

For the year ended December 31,	2007	2006
<b>Revenue</b>		
Workplace Safety and Insurance Board of Ontario	\$ 4,864,232	\$ 4,864,232
Other (Note 6a)	2,019,225	2,614,929
Interest	50,033	59,543
	<b>\$ 6,933,490</b>	<b>\$ 7,538,704</b>
<b>Expenses</b>		
Salaries and benefits	\$ 5,316,956	\$ 5,889,233
Travel	133,456	180,847
Supplies and service	127,225	132,583
Occupancy costs	538,227	534,737
Equipment and maintenance	196,408	129,657
Publication and mailing	71,078	86,719
Voice and data communications	44,009	44,822
Staff training	47,740	44,471
Outside consultants (Note 6b)	267,564	270,644
Other	128,566	130,541
Amortization of capital assets	106,711	170,333
Amortization of deferred rent	(45,264)	(45,264)
	<b>\$ 6,932,676</b>	<b>\$ 7,569,323</b>
<b>Excess (deficiency) of revenue over expenses for the year</b>	<b>\$ 814</b>	<b>\$ (30,619)</b>

See accompanying notes.

## Statement of Net Assets

For the year ended December 31,	2007		2006	
	Invested in capital assets	Unrestricted (Note 6c)	Total	Total
Beginning of year	\$ 197,468	\$ 546,002	\$ 743,470	\$ 774,089
Excess (deficiency) of revenue over expenses for the year	(106,711)	107,525	814	(30,619)
Investment in capital assets	\$ 53,876	\$ (53,876)	\$ —	\$ —
<b>End of year</b>	<b>\$ 144,633</b>	<b>\$ 599,651</b>	<b>\$ 744,284</b>	<b>\$ 743,470</b>

See accompanying notes.

## Statement of Cash Flow

For the year ended December 31,	2007	2006
<b>Operating activities</b>		
Excess (deficiency) of revenue over expenses for the year	\$ 814	\$ (30,619)
<b>Items not involving cash</b>		
Amortization of capital assets	106,711	170,333
Amortization of deferred rent	(45,264)	(45,264)
Deferred revenue	(410,309)	(187,798)
Working capital required by operations	\$ (348,048)	\$ (93,348)
Net change in non-cash working capital balances related to operations	(109,205)	(7,211)
Cash required by operations	\$ (457,253)	\$ (100,559)
<b>Investing activities</b>		
Purchase of capital assets	\$ (53,876)	\$ (55,871)
Short-term investments	272,635	(115,383)
	\$ 218,759	\$ (171,254)
Change in cash during the year	(238,494)	(271,813)
<b>Cash</b>		
Beginning of year	545,903	817,716
<b>End of year</b>	\$ 307,409	\$ 545,903

See accompanying notes.

## Balance Sheet

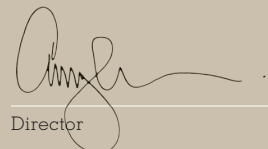
As at December 31,	2007	2006
<b>Assets</b>		
<b>Current assets</b>		
Cash	\$ 307,409	\$ 545,903
Short-term investments (Note 2)	774,376	1,047,011
Accounts receivable (Note 3)	744,585	681,120
Prepaid expenses and deposits	64,800	133,670
	\$ 1,891,170	\$ 2,407,704
Capital assets (Note 4)	144,633	197,468
	\$ 2,035,803	\$ 2,605,172
<b>Liabilities</b>		
<b>Current liabilities</b>		
Accounts payable	\$ 312,500	\$ 427,109
Deferred revenue (Note 5)	933,755	1,344,064
Current portion of deferred rent	45,264	45,264
	\$ 1,291,519	\$ 1,816,437
Deferred rent	—	45,265
	\$ 1,291,519	\$ 1,861,702
<b>Net Assets</b>		
Invested in capital assets	\$ 144,633	\$ 197,468
Unrestricted	599,651	546,002
	\$ 744,284	\$ 743,470
	\$ 2,035,803	\$ 2,605,172

Other information (Note 6)  
See accompanying notes.

Approved on behalf of the Board:



Director



Director

## Notes to Financial Statements

December 31, 2007

The Institute for Work & Health was incorporated without share capital on December 20, 1989 as a not-for-profit organization.

The Institute is a knowledge based organization that strives to research and promote prevention of workplace disability, improved treatment, optimal recovery and safe return-to-work. The Institute is dedicated to research and the transfer of research results into practice in clinical, workplace and policy settings.

The Institute is predominantly funded by the Workplace Safety & Insurance Board of Ontario (WSIB) up to the Institute's approved WSIB budget. Other revenues are generated through research activities and certain interest earned.

### 1 / Significant accounting policies

#### (A) Amortization

Capital assets are stated at cost. Amortization is recorded at rates calculated to charge the cost of the assets to operations over their estimated useful lives. Maintenance and repairs are charged to operations as incurred. Gains and losses on disposals are calculated on the remaining net book value at the time of disposal and included in income. Amortization is charged to operations on a straight-line basis over the following periods:

Furniture and fixtures – 5 years  
Computer equipment – 3 years  
Leaseholds – term of the lease

#### (B) Revenue recognition

The Institute follows the deferral method of accounting for contributions. Restricted contributions, which are contributions subject to externally imposed criteria that specify the purpose for which the contribution can be used, are recognized as revenue in the year in which related expenses are incurred. Unrestricted contributions, which include contributions from the WSIB, are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. Revenue in excess of expenditures from fee for service contracts is recognized at the completion of the contract.

#### (C) Lease inducements

The lease inducements, consisting of cash, are deferred and amortized over the term of the lease.

#### (D) Short-term investments

Short-term investments are recorded at fair value.

### 2 / Short-term investments

	2007	2006
GIC	\$ 518,659	\$ 400,859
Ontario Savings Bonds	—	384,906
Corporate notes	255,717	261,246
	<b>\$ 774,376</b>	<b>\$ 1,047,011</b>

The GICs earn an average interest of 4.2% and mature in 2009, 2010 and 2011. The Corporate notes earn an average interest of 3.8% and mature in 2008 and 2012.

### 3 / Accounts receivable

	2007	2006
The Foundation for Research and Education in Work and Health Studies	\$ 92,726	\$ 158,297
Other	651,859	522,823
	<b>\$ 744,585</b>	<b>\$ 681,120</b>

### 4 / Capital assets

	Cost	Accumulated amortization	Net	
			2007	2006
Furniture & fixtures	\$ 602,462	\$ 554,958	\$ 47,504	\$ 64,738
Computer equipment	1,235,012	1,158,524	76,488	98,329
Leaseholds	503,131	482,490	20,641	34,401
	<b>\$ 2,340,605</b>	<b>\$ 2,195,972</b>	<b>\$ 144,633</b>	<b>\$ 197,468</b>



## 5 / Deferred revenue

	2007	2006
CAN	\$ 23,270	\$ 34,574
CIHR	304,314	358,150
MOHLTC	6,230	374,156
NIOSH	44,027	13,446
OCA	12,403	36,081
WDMB – Special Project	—	80,000
Worksafe BC	76,362	70,290
WSIB – Contract	2,141	63,000
WSIB – RAC	416,380	214,054
Other	48,628	100,313
	\$ 933,755	\$ 1,344,064

## 6 / Other information

## (A) Other revenue

	2007	2006
CAN	\$ 8,663	\$ 50,309
CIHR	437,246	538,412
MOHLTC	375,750	583,920
NIOSH	9,787	97,668
OCA	23,678	42,554
Ontario Neurotrauma Fund	17,758	42,772
Pfizer	—	124,509
University of Maryland	20,098	42,131
University of Saskatchewan	30,161	49,245
WDMB – Special Project	85,700	—
Worksafe BC	93,857	53,310
WSIB – Contract	67,859	—
WSIB – Pilot	345,000	386,749
WSIB – RAC	489,890	468,840
Other	13,778	134,510
	\$ 2,019,225	\$ 2,614,929

## (B) Outside consultants

	2007	2006
University co-investigators	\$ 124,239	\$ 144,521
Other project related services	109,674	79,206
Other services	36,147	46,917
	\$ 270,060	\$ 270,644

## (C) Unrestricted net assets

Unrestricted net assets are not subject to any conditions which require that they be maintained permanently as endowments or otherwise restrict their use.

	2007	2006
Total assets	\$ 2,035,803	\$ 2,605,172
Invested in capital assets	(144,633)	(197,468)
	\$ 1,891,170	\$ 2,407,704
Liabilities	(1,291,519)	(1,861,702)
Unrestricted net assets	\$ 599,651	\$ 546,002

## (D) Commitments

The Institute is committed under a lease for premises which expires July 31, 2009 with annual rents, exclusive of operating costs, as follows:

Year	Amount
2008	\$ 200,000
2009	\$ 116,000

## (E) Pension

For those employees of the Institute who are members of the Hospitals of Ontario Pension Plan, a multi-employer defined benefit pension plan, the Institute made \$308,504 contributions to the Plan during the year (2006- \$286,063).

## (F) Change in accounting policy

Effective January 1, 2007, the Institute adopted CICA Handbook section 3855 for the recognition and measurement of financial instruments and accordingly, the Institute's investments are included on the balance sheet at their fair value.

The cost of the Institute's investments approximated their fair value as at December 31, 2006.

## (G) Financial instruments

The organization's financial instruments consist of cash, short-term investments, accounts receivable, and accounts payable. It is management's opinion that the Institute is not exposed to significant interest, currency or credit risks and that the fair value of financial instruments is approximated by their carrying value.

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