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Parallel Lines do Intersect: Interactions between the Workers' Compensation and Provincial Publicly Financed Health Care Systems in Canada

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Abstract

This paper uses a case study approach to document and analyze the interactions that arise between two health care payers in Canada: the provincial public health care insurance plans and the provincial Workers Compensation Boards. Through a documentary review and semi-structured key-respondent interviews, the study identified a set of policy events and decisions undertaken by each payer that had consequences for the other. These events, which included changes to governance, funding, and service delivery within each system, generated interactions transmitted through the political environment, the institutional environment, the economic environment (primarily through competition for the same resources) and cross-system learning. The two payers currently lack a formalized process by which to consider such spillover effects and to coordinate policy between them. These interactions and their associated consequences for both payers raise important policy challenges and provide insight into the dynamics of parallel system of health care finance more generally.

I. Introduction

It is commonly believed that Canada has only a single payer for medically necessary physician and hospital services: provincial public insurance plans. This belief, in fact, is false: Canada has several parallel payers for medically necessary physician and hospital services. The federal government, for instance, finances health care services for aboriginal peoples, the RCMP, the military, and federal prisoners (who are excluded from the CHA's definition of insured persons); and workers' compensation boards finance health care required to treat workplace-related injuries and illness (which are excluded from the CHA's definition of insured services). Individuals covered by these parallel payers can access health care services on terms and conditions different than can those who rely solely on provincial health insurance plans. The existence of distinct, parallel payers alongside the provincial insurance plans raises a number of important policy issues, foremost of which is the nature of the interactions between them.

This paper examines the interactions that arise between the provincial public health insurance plans and one of Canada's parallel payers: worker's compensation boards (WCBs). The WCBs present an interesting case study of parallelism because the 13.1 million workers covered by workers' compensation are simultaneously eligible for health care through provincial public plans and, if injured in the workplace or ill as a result of an occupational disease, through the WCBs. The payer depends only on whether the illness or injury is work-related.

Workers' Compensation in Canada long predates Medicare. It was established in the early part of the 20th century as a system of social insurance (financed by employers) as part of an "historic compromise" in which workers gave up the right to sue employers for workplace-related injuries and illness in return for defined levels of no-fault benefits (Ison 1989). WCBs ensure worker access to needed health care services through a variety of arrangements, including direct provision at WCB facilities and contractual arrangements with both public and

private providers. Although WCB health care spending is small relative to total health care spending in Canada (in 2003, workers' compensation health spending equaled approximately 1.5% of total provincial health care spending, or about 3.8% of provincial health care spending on the working age population (Canadian Institute for Health Information 2005), it is concentrated in areas of particular policy concern such as orthopaedic services and diagnostic imaging.

II. Methods

The study employs a case-study approach in which we gathered data through a documentary review followed by semi-structured interviews with key informants. The documentary review identified events and policy decisions emanating from either the WCB or the provincial health care system that would likely have generated spillover effects for the other payer. The review was conducted using the LexisNexis Academic database. (Table A.1 lists the search terms.) Separate reviews were conducted for nine of the ten provinces (Quebec was excluded for reasons of language). All retrieved newspaper and newswire articles were assessed for relevance in terms of potential for creating important cross-payer effects, and relevant articles were used to construct, for each province, a policy timeline from 1990 to the present that included events and decisions that potentially created interaction between the WCB and the provincial plan.

The semi-structured, key-informant interviews, conducted by telephone between September 2006 and February 2007, were designed to provide an in-depth understanding of the nature of the interactions between the two systems. The interviews were limited to four provinces -- British Columbia, Alberta, Manitoba, and Ontario -- chosen on the basis of the richness of the set of events identified through the documentary review. Twenty-two individuals were interviewed, with 8, 6, 3, and 5 individuals from BC, Alberta, Manitoba and Ontario

respectively (Table A.2). The interviewees were identified through multiple sources, including media reports of selected policy events, research team knowledge of individuals with current and/or past policy participation in either the workers' compensation or provincial health care sectors in the provinces under study, and the key-informants themselves. The key-informants included past or current members of provincial WCBs, provincial ministries of health, regional health authorities, researchers, and physicians. All interviews were audio-recorded, transcribed and checked for accuracy; each participant had the opportunity to review their transcript prior to coding and to review draft study papers (Appendix A includes a summary of the interview instrument).

The interviews varied from 30 to 90 minutes in duration and were divided into two parts. Respondents first reviewed the list of policy events identified for their province through the documentary review, commented on the accuracy and completeness of the listing, and identified any missing events. In the second part, respondents were asked to select two events or policy decisions from the list provided *or* based on their own experience and to answer a series of questions regarding the rationale, goals, implementation, and consequences (intended and unintended) of each event, as well as its implications for both systems. All transcripts were independently reviewed and coded by the research coordinator (DP) and the principal investigator (JH) and then discussed by the full research team at study meetings.

III. Interactions between the WCB and the Publicly Financed System

III.1 The Policy Events and Decisions Identified by Respondents

Table 1 lists the policy events and decisions judged by respondents to be associated with important interactions between the WCB health systems and the provincial health care systems. Some events were identified by multiple respondents. The events vary along a number of dimensions. Although most were WCB initiatives, they also include actions undertaken by the

federal government, provincial governments, regional health authorities and medical associations. They include changes in governance, especially the change to regionalized systems of governance, changes to the methods and levels of health care funding and changes in delivery arrangements (Lavis et al. 2004). Many of the events are linked. Funding cutbacks to the provincial plans in the mid-1990s, for instance, and the associated growth in wait times was one catalyst that impelled WCBs to develop new funding and delivery relationships with providers.

III.2 Key Types of “Interaction” Between the WCB and Provincial Plans

Interactions between the two payers arose most often because actions by one payer affected the broader environment in which both systems operate. Interactions generally work through the political environment, the institutional environment, the economic environment (especially in the competition for shared resources), and cross-payer learning.

Interactions in the Political Environment

A recurring theme in the interviews was that the “politics of medicare” imposed constraints on WCBs’ ability to act in ways that were legal but perceived by government to have unacceptable political ramifications. One respondent noted, for example, that:

But it’s [WCB] artificially restrained from doing that [providing appropriate health care at the right time for the best possible recovery for injured workers]because of the public image or the politics around the public health care system . . . they [governments] don’t want contrasting systems.

The WCB initiatives of most concern were strategies to expedite care for workers by sending patients out-of-province (including the United States), contracting with private for-profit clinics, and contracting for “excess” capacity within the publicly funded infrastructure. Such initiatives had political impacts because they implied that Canada has “two-tier” health care. Faster care for workers also served as a reminder that the public system was not delivering timely care. This not only creates political difficulties for a provincial government but, some argued, could more generally erode support for publicly financed health care:

. . . when they [WCB] started to maneuver some of their clients through the system quicker . . . a bit of a black cloud was going to hang over the organized system for the rest of the population. . . a number of commentators went to great lengths to flag this as a mark of the deteriorating capacity of the public system and the great advantages that this semi-privatization model . . .

The political responses to these concerns range from moral suasion, quietly asking WCBs not to pursue such strategies, to limiting the nature of certain contractual relationships between public facilities and WCBs, to outright prohibition. The Ontario WCB, for instance, was prevented from transferring orthopaedic surgical services to specialty clinics located in community-based teaching hospitals because the services were sufficiently similar to those obtained (after extended wait) by the general public and as such would invite direct comparison:

“when you start dealing with cartilage operations on knees or things like that, it has a direct, comparable issue with general public health care . . . where the hand program or the prosthetic program and other things, nobody saw a direct parallel very clearly.”

Interactions through the Institutional Environment

Changes to institutional arrangements for governance, funding and delivery in one system can have consequences for the other system. Because of its more dominant role, changes to the provincial system more often have consequences for the WCBs. The change to regionalized governance within the provincial health care systems, for example, reduced transactions costs for the WCB and led to greater consistency and coherence of policy across hospital sites by dramatically reducing the number of organizations with which it had to contract:

We [the WCB] had been interacting essentially with each individual entity in the province. And what's begun since 1997 . . . is us moving to interacting with just the six health authorities or processes . . . trying to rationalize things through the six health authorities instead of going through two hundred hospitals and god knows how many long-term and short-term clinics and centres.

Changes to the regulatory framework and delivery systems can similarly generate spillover effects. The Regulated Health Professions Act (RHPA) in Ontario, for example, facilitated WCB contracting by defining recognized health professions and thereby delineating the providers eligible for WCB reimbursement. Bill 11 in Alberta, which for the first time allowed

non-hospital overnight-stay facilities, expanded the range of services for which the WCB could contract with private clinics. WCBs can also benefit from primary care reform within provincial plans and the move from predominantly solo or small group family practices funded by fee-for-service to larger, multi-professional primary care practice funded through blended arrangements. These reforms provide greater scope for interested family physicians to develop occupational health specializations.

Interaction in the Economic Environment: Competition between Payers

Competition among payers for the same scarce resources is one of the most-debated aspects of parallel arrangements. WCB initiatives to expedite care for injured workers, such as incentive payments for physicians to treat injured workers more quickly and contracting with private for-profit clinics and contracting with hospitals for after-hours use are of particular concern in this respect. (Hurley et al. (2007) provides a detailed discussion of these strategies.) Supporters argue that such initiatives can increase access to services in the provincial plan by injecting additional funding into the system and removing WCB cases from queues in the provincial plans. This is most likely to hold when the WCB uses resources that would otherwise be unavailable to individuals in the provincial plan such as an after-hours MRI or an orthopaedic surgeon with limited operating time. Detractors counter that such initiatives often simply divert resources from the provincial plan, resulting in the same number of cases being treated but with preferential access for workers. The ultimate impact depends on several factors, including the most binding resource constraint among the resources required to produce a service. Even if a surgeon has operating time available for treating patients outside the provincial plan, if another surgical input is in short supply it can still have a consequences:

. . . we have private centres using local resources, so using anaesthetists who work here, it's been a diversion of resources from the public and into the private sector. . . we've had an anaesthesiologist shortage which at least has been exacerbated by the existence of those private efforts.

WCB revenue is increasingly attractive to cash-strapped hospitals. In providing services to WCB cases, hospitals allocate treatment and management resources toward WCB cases:

If there's a scarce resource, hospitals, if they had the choice of having the physios or OTs work in a revenue-generating or a non-revenue-generating area, you can imagine which one they'd choose . . . that might be true too about MRI/CAT scans . . . hospitals certainly have the financial incentive to make sure that their scarce resource of radiology technologists do the paid work

Competition between WCBs and the provincial plans for the same resources puts upward pressure on resource prices, reducing the real ability of each system to provide services with a given budget. Respondents from both WCBs and Ministries of Health recognize this potential impact of WCB bonuses and incentives for physicians:

With orthopaedic surgeons, we [WCB] pay a significant premium . . . and so that may cause the government some grief. We have to work closely with them to ensure that we're not setting them up to be levered by our fee structure into raising their rates generally.

The docs, as is their want . . . began their negotiation season by doing a deal with the WCB in which WCB paid ten percent above our going rate, which put a lot of pressure on us.

The impact of WCBs' purchasing initiatives on the provincial plans can also extend beyond the specific services the WCB purchases. WCB contracts can increase the financial viability of private clinics for which the individual private-payer market alone is insufficient or too risky. Larger volume WCB contracts can cover the fixed costs, creating a platform from which a clinic can enter the individual private-pay market.

Cross-System Learning

Cross-system learning, whereby innovation in one system is adopted by the other, can arise at both the managerial and clinical levels. At the management level, for instance, some of BC's regional health authorities built on the WCB contracting experience to introduce their own form of contracting with the private clinics in an effort to reduce wait times in the provincial plan. The Ontario WCB hoped that Ontario's provincial plan might adopt a variation on a WCB nurse-practitioner-based "pathway" management program designed to help an injured worker navigate

the complexities of the health care system to obtain appropriate services. The Alberta WCB's quality initiatives embodied in its preferred provider arrangements can potentially generate changes in practice that benefit all patients of these providers. More generally, because many providers treat both WCB-financed injured workers and public patients, clinical initiatives such as evidence-based practice guidelines in one system can have spillover effects to the other. Finally initiatives such as the integration of WCB claims into the BC Linked Database and the work of work-related research institutes such as the Institute for Work and Health can enhance cross-system learning (see, e.g., Brown et al. (2007)).

The Missing Interaction: Lack of a Formal Policy Coordination Across the two systems

One of the most striking findings was the absence of mechanisms through which to consider spillover effects or to coordinate policy development between WCBs and Ministries of Health. While regular communication occurs at the operational level where the two systems share infrastructure (e.g., the billing system), and *ad hoc* communication takes place at a higher political level between WCB CEOs and Ministers of Health (though this tended to depend on a personal relationship between individuals), we consistently found gaps in planning and coordination at the Deputy Ministry, Assistant Deputy Ministry and Director levels. The following comment with respect to WCB initiatives to expedite care typifies what we heard throughout the interviews:

I recall no discourse at all in the planning . . . there was no formalized way of communication. . . . all [discussions have] been directly with the institutions themselves. Even now we have very little direct contact with the Ministry.

IV. Discussion

Interaction between parallel systems is inevitable when they draw on the same pool of resources. Interactions arise at all levels, from high-level political concerns down to the activities of individual clinicians and patients. Some of them depend on the relative sizes of the two systems, but many do not. From a political perspective, for instance, the mere existence of a

parallel payer (regardless of its size), creates political challenges because it invites comparison. It does not matter whether the comparisons are fair or appropriate because such details become lost in the public debate. A small system's effects can be disproportionately large when activity is concentrated in selected areas, as is the case for WCBs, and when that activity is leveraged by other system stakeholders as private clinics have with WCB contract work.

It is inevitable that health system stakeholders, and providers in particular, will exploit the presence of parallel payers to pursue their objectives. Physicians in recent years, for example, have striven to increase their income opportunities through new fees, higher fees, and new service opportunities with the WCBs. Unfortunately, some of the very conditions necessary for sound management of a publicly financed health care system – a keen eye on costs, accountability, adoption of evidence-informed practices -- are precisely the conditions that make options attractive to providers and provider organizations.

Parallel systems inevitably generate both efficiency and equity effects. Parallel systems, for example, can compromise efficiency by reducing the overall health generated with society's limited health resources and increase transactions costs for patients and providers as people navigate back and forth across and within the systems. Transactions costs associated with adjudication costs, appeal costs, and establishing and maintaining a claim may be particularly important in the workers' compensation system. Parallel payers, some argue, can foster greater innovation and, especially in the case of workers compensation, increase efficiency of the broader economy by improving productivity. The full set of potential efficiency effects is too complex and subtle to explicate here but their consideration is central to an assessment of parallel finance.

The equity effects of parallel finance are transparent: individuals accessing care through one system are seen more quickly or receive care of different quality than an identical individual accessing care through the other. Who gets preferential access depends on the nature of the

parallel system. In the case of WCBs, the distinction rests solely with the place of injury or cause of illness: if it occurs at work or can be linked to work, then access is through WCBs; if not, one must rely on the provincial plan. The preferential treatment of workers is increasingly questioned by some (Commission of the Future of Health Care in Canada 2002; Office of the Auditor General of Ontario 2006). Within the current legislative framework, of course, WCB strategies to expedite care for injured workers are fully legal and, indeed, WCB's have a legal obligation to employers and workers to obtain the care necessary to return a worker to work as quickly and safely as possible. A policy review therefore would have to confront the more fundamental question of whether there continues to be a convincing policy rationale for the exclusion of workers' compensation from Medicare's regulatory framework.

Finally, although the WCBs and the provincial plans are distinct, both serve the public interest and there appear to be unrealized opportunities to improve policy and practice in both systems through better coordination and communication. Fragmented policy making by multiple payers each considering only their own interests leads to "ricochet effects" – unanticipated effects on other payers active in the same arena – that can ultimately harm the interests of both payers (Gildiner 2001). Better policy coordination between the WCBs and the provincial plans, however, requires creation of institutional structures through which to carry-out this all-important work.

Parallel Lines do Intersect: Interactions between the Workers' Compensation and Provincial Publicly Financed Health Care Systems in Canada

Table 1: Respondent-identified Policy Events and Decisions that create Interactions between WCBs and the Public Provincial Health Insurance Plans				
	Governance	Funding, Payment Policies and Financial Incentives	Delivery Arrangements	Other
BC	<ul style="list-style-type: none"> Provincial public plan establishes regionalized system of governance 	<ul style="list-style-type: none"> WCB in 1990s takes a more proactive, independent (from provincial health plan negotiations) approach to negotiations with BCMA Lack of a fee schedule based on a validated relative value scale Federal government decreasing transfers to provinces for health care in 1980s WCB offers physicians incentive payment to expedite care for workers 	<ul style="list-style-type: none"> WCB implements novel delivery arrangements, including in-house delivery and visiting clinics, to expedite care for injured workers 	<ul style="list-style-type: none"> WCB establishes a relationship with UBC Centre for Health Services and Policy Research regarding integration of WCB claims data with BC linked database to facilitate research
AB	<ul style="list-style-type: none"> Provincial government passes legislation to allow care provision in non-hospital surgical facilities 	<ul style="list-style-type: none"> Provincial government cuts funding to provincial health plan in 1990s WCB establishes its own fee schedule and begins direct negotiation with Alberta Medical Association WCB's uses a combination of financial incentives and standards of care to expedite care for workers. 	<ul style="list-style-type: none"> WCB explores alternate service delivery models to expedite care for injured workers Private interests establish private, for-profit MRI clinics Selected Regional Health Authorities create separate, expedited care streams for WCB clients WCB establishes contractual arrangements with health care professionals and facilities to define standards of business (e.g., accreditation) practice and standards of care through preferred provider relationships 	
MN		<ul style="list-style-type: none"> WCB begins direct negotiations with Manitoba Medical Association WCB pays financial incentives to private clinics for expedited care 	<ul style="list-style-type: none"> WCB establishes contractual arrangement with (public) Pan Am Clinic for expedited care 	
ON	<ul style="list-style-type: none"> Historical exclusion of WCB from Canada Health Act Lack of independence of WCB from political process Provincial government passes the 1991 Regulated Health Professions Act 		<ul style="list-style-type: none"> WCB establishes new service delivery models to facilitate early access and treatment for workers WCB, in collaboration with health professionals, introduces "Programs of Care", which provide evidence-based treatment plans for various worker injuries WCB introduces nurse practitioner-based case management program to ensure timely, appropriate care for workers WCB devolves care from WCB Downsview Rehabilitation Centre to community-based clinics through contractual relationships 	<ul style="list-style-type: none"> Workplace Safety and Insurance Board establishes the Institute for Work and Health to provide independent research evidence

Appendix A: Study Methods

This study employed a case-study approach that gathered data through a documentary review and semi-structured interviews with key informants. The purpose of the documentary review was largely instrumental: to identify key events and policy decisions emanating from either the WCB or the provincial public plan that would likely have generated spillover effects for the other, especially in terms of timeliness, access, or quality of care. Using the LexisNexis Academic database, we retrieved and reviewed newspaper and newswire articles using the search terms ‘workers’ compensation’ and ‘Province’ in combination with each of the terms listed in Table A.1. We also replicated the searches substituting the term ‘workers’ compensation’ with ‘workers!’. Use of the exclamation mark expanded the search so that all combinations of terms with the phrase preceding the character were recovered.

<ul style="list-style-type: none"> ○ health ○ health care ○ health services ○ third party ○ third party payment ○ chiropractors ○ diagnostic ○ clinics ○ public health insurance ○ provincial health insurance ○ OHIP (acronym or key words from other provinces) 	<ul style="list-style-type: none"> ○ health policy ○ clinics ○ rehabilitation ○ physicians ○ physiotherapists ○ fees ○ surgeons ○ medical association ministry of health ○ ministry of labour ○ ministry of finance ○ automobile insurance
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Separate reviews were conducted for nine of the ten provinces (Quebec was excluded for reasons of language). All retrieved articles were reviewed for relevance (defined in terms of potential for creating important cross-system effects), and relevant articles were used to construct a policy timeline for each province for the period 1990-present that identified a set of events and decision that potentially created interaction between the WCB and the provincial plan.

The purpose of the semi-structured, key-informant interviews, which were conducted by telephone between September 2006 and February 2007, was to gain an in-depth understanding of the nature of the interactions between the two systems. The interviews were limited to individuals in four

provinces -- British Columbia, Alberta, Manitoba, and Ontario -- chosen based on the richness of the set of events identified through the documentary review. A total of 22 individuals were interviewed, with 8, 6, 3, and 5 individuals from BC, Alberta, Manitoba and Ontario respectively (See Table A.2).

Table A.2: Interview Subjects

Characteristics	Province				Overall
	ON	BC	MB	AB	
WCB	4	6		4	14
Health Ministry		1			1
Regional Health Authority		1	2	1	4
Researcher			1	1	2
Hospital Sector	1				1
Physician					
Total Sample	5	8	3	6	22

The interviewees were identified through multiple sources, including media reports of selected policy events, research team knowledge of individuals with current and/or past policy participation in either the workers' compensation or provincial health care sectors in the provinces under study, and the key-informants themselves. The study sample was comprised of individuals who were past or current members of six groups including provincial workers' compensation boards, provincial ministries of health, regional health authorities, researchers, and physicians. We were unable to speak to any individual from the Manitoba WCB as it made an organizational decision not to participate. All interviews were audio-recorded, transcribed and checked for accuracy; each participant had the opportunity to review their transcript prior to coding and analysis and to review draft study papers (See Appendix A for a summary of the interview instrument). The interview instrument included a series of semi-structured, open-ended questions and was divided into four main parts. The first part of the interview focused on the listing of potential interactions between the workers' compensation and provincial plans under study. Participants were asked to comment on the accuracy and completeness of the listing and to identify any missing events/policies/initiatives.

During the second part of the interview, participants were asked to identify two interactions (either from the listing *or* from their own experience) and to answer a series of 10 follow-up questions regarding each interaction. These questions focused on the rationale, goals, implementation, and consequences (intended and unintended) of each event, as well as its implications for both systems.

The third part of the interview included one question about each of the following four topics/issues (asked only if it was relevant to the participant's area of expertise and not addressed during the preceding discussions): expedited care for WCB clients; the establishment of private, for-profit clinics; the impact of alternate payer systems for health professionals; and the existence of any important events/policies/initiatives originating in the public health system that either facilitated or hindered the WCB's ability to provide high quality health care services to injured workers.

The final section of the interview provided participants with an opportunity to make any additional comments/observations and to identify other potential key informants

All transcripts were independently reviewed and coded by the research coordinator (DP) and the principal investigator (JH) and then discussed by the full research team at study meetings.

Interview Guide

As you know, the purpose of today's interview is to identify your thoughts and insights on the major areas of interactions between the provincial workers' compensation and the provincial health insurance systems in (province). We're particularly interested in those interactions that influence the quality, accessibility, and sustainability of health care services for both workers and the public more broadly.

To facilitate this task, we have provided you with a listing of events that we think demonstrate an interaction between these two health systems. These events were identified through an extensive analysis of publicly available documents (such as newspaper articles, press releases, and websites).

The interview itself is divided into two parts.

During the first part, you will be asked to provide some general feedback on the listing.

During the second part of the interview, you will be asked to select two events, that you think demonstrate an important interaction between the two systems, from either the listing or from your own experience, and then answer a series of follow-up questions regarding these events.

If you have not already done so, please take a few moments to review our list.

A. Reaction to our listing of events/initiatives/decisions

A1 Have we identified the main events or policy decisions in both the WCB and the publicly financed health system that represent an important effect by one system on the other (province)?

A2 Have we missed any major events/decisions?

- For example, where the status quo was explicitly reconsidered but ultimately maintained?

A3 Are there any events listed that did not have a significant impact for either the WCB or provincial health care systems in terms of quality, accessibility or sustainability?

B. Discussion of Specific Events

Please identify two events, either from this listing or from your own experience, that you think demonstrate a major interaction in terms of quality, accessibility, and/or sustainability.

The first few questions are intended to give us a better understanding of the nature and scope of the policy/initiative/event.

The remaining questions address the interactions between the two health systems that occurred as a result of this policy/initiative/event.

- B1 What was the rationale for the timing of this policy/initiative/event (e.g., commissions, economy, new government, opinion polls)?
- B2 What were the explicit and implicit goals associated with this initiative?
- B3 Was this initiative fully implemented?
- B4 Were the intended effects of this initiative achieved?
- B5 Were there any unintended consequences?
- B6 Was the initiative (and its intended effects) sustained over the long-term?
- B7 What factors constrained or facilitated the implementation of the policy/initiative/event?
- B8
 - a. What were the implications of this policy/initiative/event for the WCB (Or: for the provincial health system)?
 - b. Were these implications considered before the policy/initiative/event was undertaken? If so, how?
 - c. (If not addressed) Were there any formal or informal mechanisms for facilitating communication or collaboration between the WCB and the provincial health system with respect to this type of policy/initiative/event?
 - d. If yes, describe.
- B9 Can you identify any key lessons or learnings associated with this initiative in terms of clinical practice or system management (within either the WCB–financed and/or the provincial health care system)?
- B10
 - a. Would you link this event to an overall planned policy trajectory.
 - b. If yes, identify.
- B 11 What strategies has the WCB explored in order to deliver more timely access to health care services for injured workers?
- B 12 For Delivery Arrangements only: How has the establishment of private, for-profit clinics facilitated or hindered the WCB's ability to provide high-quality health care services to injured workers. Or How has the establishment of private, for-profit clinics facilitated or hindered your organization's ability to provide health care services to the general population?
 - Diagnostic
 - Surgical
 - Rehabilitation
 - Community-based primary care practitioners

B13 If no events originating in the public health care system are identified: Can you think of any events or issues that originated in the public health care system that facilitated or hindered the WCB's ability to provide high-quality health care services to injured workers?

Ex:

- Physician salary caps
- De-listing of insured health care services
- De-listing of drugs from provincial drug formularies

B15 If respondent is health professional or WCB person who has selected this issue as one of the two events: To what extent are WCB cases onerous for health professions because of requirements such as validating work status?

B16 (If time permits, interviewee can identify additional events)

- Repeat B1-B10

C. Additional Comments or Observations

C1 Do you have any additional comments or observations regarding our listing of policies/initiatives/events and/or the relationship between WCB health care services and the public health care system?

D. Other Key Informants

D1 Is there anyone else that you think we may want to contact because of his or her knowledge of the workers' compensation and provincial health insurance systems in (province)?

Thank you for your collaboration and your time.

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