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11 The Legal Regulation of Referral Incentives: Physician Kickbacks and Physician Self-Referral

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Introduction: Referral Incentives and the Law

The regulation of private health care has become a central issue in Canadian health policy. The specific issue that has attracted the most attention is whether physicians and patients may opt out of the single payer system for physician services and set up a parallel private system. Although the prohibition of opting out is not a condition for federal-provincial transfer payments under the *Canada Health Act*,¹ a recent paper notes that all provinces have enacted prohibitions and disincentives to curtail opting out by physicians and patients.² In addition, the Supreme Court of Canada has recently found unconstitutional under the *Canadian Charter of Rights and Freedoms*³ the prohibition on private health insurance in circumstances under which individuals cannot access care within a reasonable time frame within the public system.⁴

By contrast, there has been relatively little discussion of the regulation of independent health facilities (IHF), even though they are, for the most part, privately owned, for-profit entities, and are assuming increasing prominence in the landscape of health care institutions. IHFs provide a range of diagnostic and therapeutic services, such as physiotherapy and laboratory testing. IHFs provide services on a fee-for-service basis to individuals, who may pay out of pocket or may have coverage from private health insurance companies or provincial health insurance plans. Because of the multiple sources of payment, IHFs, unlike many other health care providers, operate simultaneously within the public and private health care systems. There may be as many as 1,000 IHFs in Ontario alone.⁵

As with other health care facilities, IHFs depend on physician referrals for patients. Because IHFs bill on a fee-for-service basis, physician referrals ultimately determine revenues and profitability. This raises two important issues for public policy. First, as experience in the United States has shown, institutional providers such as hospitals and IHFs have often compensated physicians for patient referrals. If physicians are compensated for making referrals, they may be placed in a financial conflict of interest, because referral incentives may overwhelm their clinical judgment. This may threaten cost-containment efforts and quality of care, as patients may receive unnecessary testing and treatment or as patients are referred to a provider who is not necessarily selected on the basis of the quality of care that he or she provide. Moreover, inducing a larger volume of referrals to particular providers may compromise access for those patients who actually need it, particularly in areas with limited physician and other resource availability. Second, experience in the United States has also shown that similar incentives can exist when physicians refer to IHFs in which they have an investment interest, giving rise to similar problems. Indeed, both kickbacks and self-referral were regarded as serious enough to prompt federal regulatory intervention in the United States.⁶ Despite the worrisome American evidence and the spread of IHFs in Canada, kickbacks and self-referral were not mentioned either by the report of the Senate Standing Committee on Social Affairs, Science and Technology (*Kirby Report*)⁷ or by the final report of the Royal Commission on the Future of Health Care in Canada (*Romanow Report*).⁸ Moreover, the topic has generated limited scholarly commentary in Canada.⁹

The potential for both kickbacks and self-referral to give rise to financial conflicts of interest raises the question of what the existing regulatory framework is, if any. To be sure, financial conflicts of interest that involve physicians are regulated by the common law.¹⁰ But in this chapter, we review provincial laws and regulations to determine whether they adequately protect patients against conflicts of interest arising from referral incentives. These rules take the form of rules of professional conduct for physicians. Our conclusion is mixed; in some respects these rules adequately protect patients, but in others they do not.

This lack of adequate regulation of referral incentives is of concern as provincial governments increasingly look to IHFs as a means to achieve greater efficiencies in delivering publicly insured health care services and to create the incentives for greater private capital investment in the health care infrastructure. Moreover, physician investment in IHFs is

likely to grow as well. Physician investment may be motivated by a mixture of objectives, such as enhancing access to care, increasing physician income by circumventing billing caps and other limits on physician revenues, and providing better control over quality. The growth of alternate payment mechanisms that cover the range of currently insured services may also encourage physicians to seek other revenue streams. In short, IHFs are likely to become a more important part of the landscape of health care institutions, underlining the need for adequate regulation. Following our review of existing regulation, in this chapter we propose regulatory models to be implemented before the further proliferation of IHFs. Indeed, given that conflict of interest guidelines are currently under review in Ontario,¹¹ this is an opportune time to explore the issue across Canada.

Defining Kickbacks and Self-Referral

An IHF and a referring physician may have two kinds of financial relationships. The first is a *kickback*, whereby a physician receives financial compensation for referring patients to a particular IHF for health-related services. In many markets, client referrals are compensated since they are of economic value to the party receiving the referral. Accordingly, we should not be surprised to see similar forms of compensation emerge in markets for health care, as has happened for many years in the United States.

Compensation can flow from IHFs to referring physicians or from specialists to primary care physicians, where the payment of kickbacks is often referred to as *fee-splitting*. Moreover, compensation can take many forms. In some cases, it may consist of a simple cash payment for each patient referred, or a percentage of the billings resulting from the referred patient. Complicated arrangements may consist of more favourable terms for office space, leases for medical equipment, or business loans, if the referring physician is a tenant or landlord, an equipment lessee or lessor, or a borrower or lender.

In many markets, compensation for referrals is unobjectionable. However, in health care this is ethically problematic because it creates a potential conflict of interest between physicians' financial self-interest and their duty to advise patients solely on the basis the patients' health needs. That is, the best interests of patients, not the financial interests of physicians, should guide decisions to refer. If the opposite is true, physicians may make unnecessary referrals, which could mean that

patients will be subjected to medically unnecessary care. Moreover, even if a referral is necessary, a kickback could lead physicians to direct referrals to particular providers for reasons other than the quality or accessibility of care. Finally, the incentives to increase referral volume and to direct referral stream to particular providers may create inefficiencies, increase waiting times, decrease access, and potentially increase costs.

Similar considerations of cost and quality arise in cases of *self-referral*, where the IHFs to which physicians refer their patients are partly or completely owned by those physicians, or in which referring physicians hold some other kind of investment interest. Physicians benefit from self-referral not by receiving kickbacks, but through the revenues generated by the IHF. Self-referral has generated more controversy in the medical community than have kickbacks.¹² Some physicians have argued that physician-owned IHFs are merely extensions of physician practices, even if they are situated in a different location and even if the referring physicians do not personally provide services at those facilities themselves. For this reason, self-referral is fundamentally different from referral to other providers. Defenders of self-referral have also argued that ownership by referring physicians does not represent a financial conflict of interest because it is a warrant of quality. Indeed, because of their expertise, physicians are more likely to apprehend the need for new IHFs and to design innovative ways for delivering high quality care. In addition, physician-owners, because of their ethical obligation to promote patient well-being, would be less profit-oriented than non-physician owners; this would provide a guarantee of the quality of care that patients receive. These physicians might even be able to provide better continuity of care by referring to their own facilities. Therefore, far from jeopardizing the quality of care, some would argue that self-referrals further patient well-being and that restricting self-referrals hurts patients.¹³

The Relevance of the American Experience for Canada

In deciding how to address these concerns, Canadian regulators have much to learn from the experience of the United States. American lawmakers have taken it to be self-evident that kickbacks negatively affect quality and costs by altering physician behaviour. By contrast, probably driven by the ethical controversy over self-referral, a large body of empirical literature has attempted to assess the effects on quality and cost, if any, of physician self-referral to IHFs.

Taken as a whole, this research suggests that self-referral increases referral volume and health care costs. Mitchell and Scott¹⁴ studied the effects of physician ownership of physical therapy and rehabilitation facilities in Florida. They found that patients who received care in facilities jointly owned by physicians (joint-venture clinics) had 40 per cent more visits per year on average than patients treated in non-joint-venture centres. In addition, gross and net revenues per patient were 30 to 40 per cent higher in joint-venture facilities and their percentage mark-up (that is, net profit before taxes expressed as a percentage of total operating expenses) was almost two times higher (44.8 per cent versus 23 per cent). Similar results were found by Hillman et al., who compared the use of radiological tests (including chest x-ray, spine x-ray, and ultrasound) by physicians who had imaging equipment in their offices (self-referring physicians) with physicians who always referred their patients to radiologists for testing (radiologist-referring physicians). They found that self-referring physicians were 4 to 4.5 times more likely to obtain radiological investigations than radiologist-referring physicians, and they charged significantly more for tests of the same complexity.¹⁵

The impact of self-referrals on health care quality is less clear. Overall, although the evidence is limited, it would appear that facilities jointly owned by physicians provide care that is, at best, of equivalent quality to that provided by other facilities. Mitchell and Scott's study found that joint-venture physiotherapy facilities employ proportionately fewer licensed therapists, and these licensed individuals spend about 60 per cent less time per patient per visit treating patients than do licensed therapists in non-joint-venture facilities.¹⁶ Similarly, a study of radiation therapy clinics demonstrated that radiation therapists, who are the principal personnel involved in quality control for patients undergoing radiation therapy other than physicians, spent 18 per cent less time per patient in joint-venture clinics.¹⁷ While these results suggest that the use of unlicensed physiotherapists or less frequent use of radiation therapists is a marker of poor quality in joint-venture facilities, empirically it is unclear whether these factors have any appreciable consequences for more concrete patient outcomes such as satisfaction, morbidity, or mortality. In contrast, it is possible that the joint-venture physiotherapy clinics that schedule frequent patient visits, or the physicians with diagnostic equipment in their own offices who order tests more readily, may be doing so appropriately and therefore may be benefiting patients. This seems unlikely; nevertheless, there is an absence of evidence to support or refute these assertions.

These findings raise interesting questions for Richard Saver's position (chapter 12, this volume) in which he advocates physician gainsharing. Saver argues that financial incentives analogous to those created by kickbacks and self-referral relationships may allow for the achievement of efficiencies in health care delivery that may not jeopardize quality and that may, in fact, enhance it. In support, he cites the experience of the Medicare Participating Heart Bypass Center Demonstration Project in the United States. The data on self-referral demonstrate, however, that physician investment interests are likely to increase costs. The question for Saver is whether it is possible to design a regulatory regime that avoids or minimizes these difficulties while harnessing their potential benefits.

The substantial differences in the financing and organization of the American and Canadian health care systems counsel caution in drawing lessons from the United States, both with respect to observed behaviours of providers and of patients. However, the need for caution should not prevent Canadian regulators from identifying particular aspects of the American health care system that seem to map onto existing or emerging features of the Canadian health care system. In the United States, referrals to IHFs generated a set of financial arrangements (kickbacks and self-referrals) prompted a set of provider behaviours that have been regarded as inappropriate. As similar structural features emerge in the Canadian health care system, we should be concerned that they may create similar behaviours in Canada. Given the potential for kickbacks and self-referral to generate inappropriate physician behaviour in Canada, it is important to assess the adequacy of the current regulatory framework.

Legal Rules on Kickbacks and Self-Referral

General

In Canada, kickbacks¹⁸ and self-referrals¹⁹ are regulated by the rules of professional misconduct. These rules are generally found in by-laws and regulations promulgated pursuant to provincial laws governing the practice of medicine. Some of these rules have been enacted by provincial governments; in other cases, they have been generated by provincial medical licensing authorities themselves. In one province (British Columbia), the rule regarding self-referral is located in a statute. It is worth noting that provincial laws governing the structure and

financing of health insurance programs do not regulate referral incentives. By comparison, in the United States, kickbacks and self-referral are located in portions of the *United States Code* governing Medicare, Medicaid, and other federal health insurance programs.²⁰

The regulation of kickbacks and self-referral through rules governing professional misconduct has two important consequences. First, the responsibility for enforcing these rules falls to provincial medical licensing authorities and, therefore, provincial ministries of health are not involved in enforcement. That fact that provincial medical licensing authorities have traditionally been the line departments for enforcement may reflect how kickbacks and self-referral in Canada have historically been conceptualized as raising concerns regarding the quality of care and professional ethics as opposed to health system design and financing. By contrast, in the United States, both the Department of Health and Human Services and the Department of Justice are vested with primary responsibility for the enforcement of federal laws on kickbacks and self-referral, clearly reflecting concerns over cost. Therefore, in Canada, lack of regulation of kickbacks and self-referral by provincial ministries of health may be a case where the legal and institutional framework for regulation has not kept pace with the unintended evolution of the health care system (for example, the proliferation of IHFs) or its intended evolution (for example, an integrated health system that try to align incentives across providers).

The role of provincial medical licensing authorities as the bodies responsible for enforcement of the rules around kickbacks and self-referrals may also reflect an historical situation where there were relatively few incentives for physicians to engage in self-referral and relatively few pressures or incentives for the development of IHFs. Consequently, the licensing authorities have relatively little experience in detecting and determining conflicts of interest in relationship to kickbacks and self-referrals. This lack of experience raises questions about the capacity of provincial licensing authorities to effectively investigate and police these situations. Further, as the number of IHFs grows and the potential opportunities for conflicts of interest also grow, provincial licensing authorities may have insufficient resources to police these conflicts of interest. Finally, provincial medical licensing authorities may encounter practical difficulties in regulating referrals across provincial and international borders. For example, physicians could refer patients to IHFs in another province in which they have a financial interest.

A second and related point is that the sanctions that can be imposed by provincial medical licensing authorities are severe but limited in scope. For example, if it finds that a physician has committed an act of professional misconduct, the College of Physicians and Surgeons of Ontario (CPSO) may reprimand the physician; revoke or suspend the physician's licence to practice; or attach terms, conditions, and limitations to the physician's certificate of registration. The CPSO has a limited power to impose fines (up to \$35,000). By contrast, in the United States, violation of the anti-kickback provisions of the federal Social Security Act is a criminal offence, punishable by a fine of up to \$25,000 and/or imprisonment of up to five years.²¹ Physicians who violate the federal Stark Laws (which prohibit physician self-referral for Medicare and Medicaid patients) may be denied payment for insured services and may be required to refund payments already made.²² Moreover, physicians who violate the anti-kickback statute and the Stark Laws may face heavy fines for each individual violation (for example, each self-referral that contravenes the Stark Laws) or exclusion from federal health care programs.²³ The CPSO lacks these powers.

Kickbacks

Table 11.1 summarizes the rules of physician professional misconduct governing kickbacks. Eight provinces (Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Ontario, Quebec, and Saskatchewan) explicitly regulate kickbacks. The remaining two provinces (Nova Scotia and Prince Edward Island) do not explicitly prohibit kickbacks, although it is legally possible that the general prohibition on professional misconduct in those provinces could be interpreted to prohibit kickbacks. Furthermore, although the College of Physicians and Surgeons Nova Scotia has issued non-binding guidelines, these do not have legal force.

Anti-kickback provisions vary somewhat in the scope of the conduct they regulate. All eight provinces that regulate kickbacks regulate the *receipt* of compensation by physicians for referrals. Seven of these provinces categorically prohibit receiving any kickback. For example, Ontario prohibits 'receiving fees from any person to whom a member has referred a patient or requesting or accepting a rebate or commission for the referral of a patient.'²⁴

The Alberta provision is similar, but in addition to prohibiting the receipt of kickbacks, it also prohibits the solicitation of kickbacks: 'A registered practitioner shall not *seek* or accept any payment or benefit,

Table 11.1 Rules of Professional Misconduct and Physician Kickbacks

	Kickback Arrangement				What Is Regulated				How Kickbacks Are Regulated		Exceptions
	Physician as Payor of Kickback	Physician as Recipient of Kickback	Any Person as Payor of Kickback	Drug/Device Supplier as Payor of Kickback	Referrals to Physicians	Referrals to IHFs	Referrals to Pharmaceutical Suppliers	Referrals to Medical Device Suppliers	Disclosure	Prohibition	
Alberta	X	X	X		X	X	X	X		X	
British Columbia		X		X			X	X		X	
Manitoba ^b		X	X	X	X	X	X	X		X	X
New Brunswick	X	X	X		X	X	X	X		X	
Newfoundland		X		X	X	X	X	X		X	X
Nova Scotia ^c											
Ontario	X	X	X	X	X	X	X	X		X	X
Prince Edward Island											
Quebec ^d	X	X	X		X	X	X	X	X	X	
Saskatchewan	X	X	X	X	X	X	X	X		X	X

Sources: CPSA By-laws, ss. 48 and 51.1; B.C. *Medical Practitioners Act*; CPSM By-Law 1, CPSM 'General Ethical Statement 124'; Regulation 9, Nfld. *Medical Board Regulations (MBR)*; Nfld. s. 35; *MBR*, ss. 16 and 17; *Ontario Professional Misconduct Regulation*, s. 11; *Ontario General Regulation: Medicine Act*, ss. 15 and 16; and *Quebec Code of Ethics of Physicians*, ss. 73 and 79. (Full references in note 18 of the text.)

^a These exceptions allow for rental agreements at market value between physicians and parties (i.e., physicians, IHFs, pharmacies, medical device suppliers) to whom those physicians may make referrals.

^b Manitoba, Ontario, and Saskatchewan each have two provisions governing kickbacks. One provision prohibits kickbacks in general language whereas the second provision is also a wide-ranging provision, but has more specific rules. See text for more discussion.

^c Nova Scotia has issued guidelines that are not legally binding and are therefore not included in this table.

^d Quebec has two provisions governing kickbacks. One prohibits the receipt of kickbacks, but only if the kickback 'would jeopardize ... [the] professional independence' of a physician (no further definition of the amount or nature of such a kickback is provided). The other provision permits the physician to receive royalties for prescribing 'products having a benefit to health,' if those royalties are disclosed to patients. See text for more discussion.

directly or indirectly, for any service rendered to a patient by any other practitioner or person.²⁵

Quebec's provision, by contrast, only prohibits physicians from receiving 'any commission, rebate or material benefit that would jeopardize ... [the] professional independence' of a physician.²⁶ Unfortunately, the Quebec provision does not provide any guidance on what kickbacks would impair a physician's professional independence.

Rules in only five provinces (Alberta, New Brunswick, Ontario, Quebec, and Saskatchewan) expressly prohibit physicians from *paying* kickbacks for referrals to other individuals, including other physicians. For example, the Saskatchewan provision makes '[s]haring fees with any person who has referred a patient'²⁷ professional misconduct. By implication, in the remaining five provinces (British Columbia, Manitoba, Newfoundland, Nova Scotia, and Prince Edward Island), it is not professional misconduct for physicians to compensate persons for referrals or to offer compensation for referrals. The caveat here is that referring physicians would be prohibited from receiving such fees in three of these five provinces (British Columbia, and Manitoba, Newfoundland), providing for some kind of regulation.

Provincial rules vary with respect to the detail in which they specify the entity that pays the kickback to the physician for a patient referral. The rules of six provinces (Alberta, Manitoba, New Brunswick, Ontario, Quebec, and Saskatchewan) do not specify the entity that pays kickbacks. For example, the Manitoba provision states that physicians must 'not enter any agreement where a reward, direct or indirect, is associated with the volume of your work, your referrals, your orders, or your fees.'²⁸

These rules are broad enough to cover not only kickbacks paid by physicians, but also kickbacks paid by other health professionals who receive patient referrals from physicians such as physiotherapists. Moreover, they are broad enough to capture payments made by corporations, such as IHFs and pharmaceutical companies, as well as by individuals associated with those corporations (for example, directors, shareholders, and marketing representatives). Note, though, that these rules do not and cannot prohibit the making of such payments by non-physicians, because they are found in rules of physician professional misconduct. The rules of four provinces (British Columbia, Ontario, Newfoundland, and Saskatchewan) specifically refer to the payments of kickbacks by suppliers of pharmaceuticals and suppliers of medical goods and services, both of which benefit from referral streams. British Columbia's provision, for example, states: 'A member of the college

must not take or receive remuneration by way of commission, discount, refund or otherwise from a person who fills a prescription issued by the member or who makes or supplies appliances.²⁹

Since British Columbia does not have a provision identifying other persons as potential payors of kickbacks, it appears not to constitute professional misconduct in that province for physicians both to pay and to receive kickbacks for patient referrals (that is, to participate in fee-splitting). It also appears not to constitute professional misconduct for physicians to receive kickbacks from IHFs that do not supply appliances.

Four provinces (Manitoba, Newfoundland, Ontario, and Saskatchewan) have enacted identically worded exceptions to the prohibition on kickbacks, which allow for rental agreements between physicians and parties (for example, other physicians, IHFs, pharmacies, suppliers of medical devices) to whom those physicians may make patient referrals. The danger of rental arrangements is that they may be structured to disguise kickbacks, for example, by setting leases at below-market rates (where referring physicians are tenants) or above-market rates (where referring physicians are landlords), or by tying rental rates to the volume of patient referrals. Accordingly, in these four provinces, rental arrangements are permissible only if rent is set at market rates and contains no volume incentive for referrals.

Finally, Quebec permits physicians to receive royalties for prescribing 'products having a benefit to health,' if those royalties are disclosed to patients.³⁰ This provision is broad enough to cover pharmaceuticals and medical devices and could contradict Quebec's more general provision on kickbacks. Furthermore, it does not indicate on its face how it interacts with the general provision.

Physician Self-Referral

Table 11.2 summarizes rules of physician professional misconduct on self-referral. Seven provinces (Alberta, British Columbia, Manitoba, New Brunswick, Ontario, Quebec, and Saskatchewan) regulate self-referral to IHFs. Self-referral to health facilities is not expressly regulated in the remaining three provinces (Newfoundland, Nova Scotia, and Prince Edward Island), meaning that self-referral by physicians to facilities in which they or their family members have an investment interest does not constitute professional misconduct. However, there is considerably more variation in the regulation of self-referral than in the regulation of kickbacks.

The paradigmatic case of self-referral by physicians entails referrals

Table 11.2 Rules of Professional Misconduct and Physician Self-Referral

	Who Has Investment Interest			How Self-Referral Is Regulated				Exceptions		
	Physicians	Immediate Family ^a	Extended Family	Disclosure	Prohibition	Restrictions on Investment Interest ^b	Other	Otherwise Not Available/Community Need ^c	Medically Necessary ^d	Publicly Traded Corporation Not Closely Held
Alberta ^e	X				X	X		X	X	
British Columbia	X	X	X		X			X		
Manitoba ^f	X	X ^g		X		X	X			
New Brunswick	X				X					
Newfoundland										
Nova Scotia										
Ontario	X	X	X	X						X ^h
Prince Edward Island										
Quebec	X			X						
Saskatchewan	X	X	X		X				X	

Sources: SCPS By-laws, ss. 51(1)(f)(i) and 51(2)(n); CPSM By-laws, ss. 47 and 49; B.C. *Medical and Health Care Services Regulation*, ss. 38-40; B.C. *Medicare Protection Act*, s. 35(1); CPSM By-Law 1, s. 55; CPSM 'General Ethical Statement 124'; Regulation 9, Nfld. s. 36; *Ontario General Regulation: Medicine Act*; *Quebec Code of Ethics of Physicians*, s. 77; and SCPS By-laws, s. 51(1)(f)(v) (diagnostic facilities). (Full references in notes 18 and 19 of the text.)

^a Defined as a spouse, child, or parent.

^b The terms of investment cannot include a requirement that referrals be made or any volume incentive for referrals. Manitoba additionally requires that the investment be offered at fair market value, presumably to preclude the masking of volume incentives.

^c These exceptions require prior approval by a regulatory authority in order to apply.

^d Self-referral is permitted if it is medically necessary.

^e Alberta has two provisions. One prohibits self-referral except in cases of 'demonstrable objective medical benefit.' The other prohibits self-referral to IHFs except in cases of community need or where the practitioner provides care directly.

^f Manitoba has two provisions. One requires physicians to 'avoid inappropriate personal benefit' in self-referral, which may prohibit certain kinds of self-referrals. The other requires disclosure of a financial interest.

^g Refers to 'indirect ownership' interests, which probably encompass familial investment interests (at least by an immediate family member).

^h Ontario does not require disclosure if the physician does not have a controlling interest.

by physicians to facilities in which they hold a personal investment interest. Not surprisingly, all seven provinces that regulate self-referral to health facilities regulate physicians' investment interests. Since it would be easy to circumvent such rules by putting an investment interest in the name of a family member, three provinces (British Columbia, Ontario, and Saskatchewan) also regulate referrals to health facilities in which family have an ownership interest. In table 11.2, we define 'immediate family' as including a spouse, child, or parent and 'extended family' as including other family members.

These three provinces include both immediate and extended family within the scope of rules on self-referral. The definition of family in Saskatchewan's provision is representative: 'member of the physician's family' means anyone connected with her or him by blood relationship, marriage, or adoption. Here (1) connected by blood relationship means that one is the child or other descendent of the other or one the brother or sister of the other; (2) connected by marriage means that one is married to the other or to a person who is connected by blood relationship to the other; and (3) connected by adoption means that one has been adopted, either legally or in fact, as the child of the other or as the child or a person who is connected by blood relationship (otherwise than as a brother or sister) to the other.³¹

In addition, one of Manitoba's rules refers to 'indirect ownership' interests, which we interpret to encompass the investment interests of immediate family members. The remaining six provinces – the three with no regulations on self-referral at all (Newfoundland, Nova Scotia, and Prince Edward Island) and the three that limit the regulation of self-referrals to IHFs in which physicians are investors (Alberta, New Brunswick, and Quebec) – do not expressly prohibit physicians from referring patients to facilities owned by their family members.

Provinces regulate self-referral differently. Four provinces (Alberta, British Columbia, New Brunswick, and Saskatchewan) outright prohibit physician self-referral. This is the regulatory model in the United States under federal law.³² By contrast, the remaining three provinces that regulate self-referral (Manitoba, Ontario, and Quebec) simply require that referring physicians disclose investment interests to patients. Quebec's provision is an illustrative example:³³ 'A physician must inform the patient of the fact that he has interests in the enterprise providing the diagnostic or therapeutic services he prescribes for him.'

Some provinces that regulate self-referral provide for exceptions. Alberta and British Columbia, which both presumptively prohibit self-

referral, have a community need exception – that is, they permit self-referral in cases where an IHF that does not raise conflict of interest concerns is unavailable. This exception may be important in rural areas. Both provinces require prior approval by a regulatory authority for the community need exception to apply – in British Columbia this is the Medical Services Commission and in Alberta it is the Council of the College of Physicians and Surgeons of Alberta. Paradoxically, Alberta has another provision that permits self-referral in cases of ‘demonstrable objective medical benefit,’ which is difficult to reconcile with the strictly prohibitive nature of Alberta’s other provision on self-referral.³⁴ Saskatchewan also permits self-referral in cases of medical necessity as an exception to the general rule of prohibition.³⁵ Ontario, which permits self-referral with disclosure, does not require disclosure in cases where the physician and family members do not have a controlling interest in the IHF: [T]he facility is owned by a corporation the shares of which are publicly traded through a stock exchange and the corporation is not wholly, substantially or actually owned or controlled by the member, a member of his or her family or a combination of them.³⁶

Finally, Alberta and Manitoba regulate the terms of physicians’ investment interests in IHFs, regardless of whether a physician engages in self-referral or not. Both provinces prohibit physician investment in IHFs from including a requirement that patient referrals be made to the IHF or volume incentives for patient referrals. Manitoba additionally requires that the investment be offered at fair market value, presumably to preclude the masking of volume incentives. By implication, Ontario and Quebec, which allow self-referral with disclosure to patients, permit such terms to be included in the terms of investment, as do the three provinces (Newfoundland, Nova Scotia, and Prince Edward Island) where self-referral is not regulated.

Discussion and Policy Recommendations

Although some provinces have rules of professional misconduct governing kickbacks and self-referrals, these rules are often inadequate. As we argue below, there are several areas in which provincial rules could be improved. In particular, we suggest that self-referrals should be more tightly regulated, although they may be unavoidable in limited circumstances. Given that conflict-of-interest guidelines are currently under review in Ontario, such proposals are timely. More generally, we recommend that provinces without legally binding rules enact such

provisions, as opposed to relying on non-binding guidelines issued by provincial medical licensing authorities.

Lead Enforcement Institution

The approach in the United States to regulating kickbacks and self-referrals has been much more aggressive than that in Canada. In part, this aggressive approach may be a response to the presence of greater incentives for potential conflicts of interest in the United States, which in turn may be a result of the more entrepreneurial and market-driven approach to organizing and financing health care in that jurisdiction. However, contrasting the divergent regulatory approaches in the United States and in Canada identifies several weaknesses in the ability to police conflicts of interest in Canada under current arrangements. For example, provincial medical licensing authorities have limitations as the lead enforcement agency for referral incentives, including their limited experience and resources to deal with a potentially growing problem; their lack of power to administer strong disincentives such as exclusion from provincial health insurance programs; and their dependence on patient complaints to enforce rules of professional misconduct, which is problematic because kickbacks and self-referral are largely invisible to patients. In addition, issues of health care financing and system design fall outside the mandate of provincial medical licensing authorities, which more narrowly focus on professional misconduct. For these reasons, we suggest that the lead regulatory institution should be shifted from medical licensing authorities to provincial ministries of health.

Such a shift in responsibilities should strengthen the hand of provincial governments to combat kickbacks and self-referral. However, provincial medical licensing authorities should be involved in enforcement, because despite the limitations of self-regulation, patient complaints are a potentially useful source of information on kickbacks and self-referrals, and because provincial medical licensing authorities can revoke, suspend, or otherwise attach conditions to the licences of physicians. Thus, under our proposed arrangements, provincial licensing authorities would refer potential cases of kickbacks and self-referral to the ministries of health for investigation, and provincial ministries of health would refer cases where individuals have been found to be engaged in these practices for professional misconduct proceedings. Finally, it should be noted that shifting responsibility to provincial

ministries of health does not eliminate the potential problems associated with cross-border instances of conflict of interest. Resolution of these problems will require interprovincial cooperation.

Kickbacks: Recommendations

Although eight provinces prohibit physicians from receiving kickbacks, only five prohibit physicians from paying or offering to pay kickbacks. But as a matter of professional misconduct, the payment of kickbacks represents as much of a conflict of interest as does the receipt of kickbacks, because these payments seek to induce referrals regardless of patient health status. Moreover, the growing role of non-physician health professionals (for example, physiotherapists) who may refer patients to physicians strengthens the case for prohibiting the payment of kickbacks by physicians. We recommend that all provinces prohibit physicians from paying or receiving kickbacks, not only to physicians, but to any other person. We also recommend that all provinces designate offering to pay kickbacks as professional misconduct.

Self-Referral to Independent Health Facilities: Recommendations

Three provinces do not expressly regulate self-referral to IHFs at all. Furthermore, six provinces permit self-referrals by physicians to IHFs owned by members of their immediate family. Given the cost and quality concerns raised by self-referral, and the ease of circumventing restrictions on self-referral through placing investments in the names of immediate family, provincial rules should be amended as necessary, both to regulate self-referral and to include referral to IHFs in which immediate and extended family members are investors within the ambit of regulation.

Three provinces that regulate self-referral to IHFs merely require referring physicians to disclose their investment interest to patients. In our view, disclosure may effectively police financial conflict-of-interest in cases where disclosure is made to someone with the requisite expertise to make an independent judgment. For example, disclosure works well in the context of medical research, where the audience consists of other physicians. But disclosure in clinical contexts to relatively inexperienced patients does not work very well, particularly when those patients require treatment. Patients may also misinterpret disclosure, not as a warning to take care, but rather as a warranty of an IHF's quality.³⁷

Finally, patients may not wish to refuse the referral in order not to strain the physician-patient relationship.

We recommend that self-referral be prohibited. However, there should be a community-need exception, as is currently in force in Alberta and British Columbia, in situations where self-referral is unavoidable. Prior approval by a regulatory authority is a necessary safeguard for ensuring that this exception is not abused, perhaps through techniques similar to those employed to define underserved areas. A ban on self-referral would still permit physician investment in IHFs. Finally, a ban on self-referral, even with a community-need exception, would require reconsideration if governments encourage physicians to integrate financially with IHFs or hospitals (for example, through risk-adjusted capitation). The goal of financial integration is to align provider incentives and encourage providers to offer care as cost-effectively as possible. However, financial integration between physicians and IHFs would make self-referral difficult to avoid. In the United States, as a result of the tension between restrictions on self-referral and the financial integration of providers, a number of important exceptions have been created to the federal ban on self-referral.³⁸ Provincial governments would need to create similar exceptions in Canada.

If self-referral is permitted, the terms of physician investment must not create the incentive to either make referrals or to inflate the volume of referrals. Only two provinces impose such restrictions. When added to the four provinces where self-referral by physicians is prohibited, this means that at present these investment terms do not attract professional sanction in four provinces, where they should.

Conclusion

Physicians play a key role in Canada as gatekeepers to the health care system. Although some exceptions exist, patients are generally unable, without a doctor's prescription or referral, to access specialists, hospitals, x-rays, other diagnostic tests, and drugs. Patients, in general, rely on physicians not only to identify their health needs but also on what services they require to meet that need. Thus, the role of physicians in setting the boundaries of publicly funded Medicare – who gets what services and when – is critical. Unregulated kickbacks and self-referrals can potentially result in physicians sending patients for more tests and treatments than required by the standard of care.

Although provinces have enacted rules of professional misconduct

on kickbacks and physician self-referral, the current regulatory framework is inadequate. As independent health facilities proliferate further, provincial governments should review current rules to 'get in front' of the important regulatory challenges that IHFs pose to cost and quality of patient care. As a number of policy advocates suggest changes to the way that health care is financed, it will be important to keep in mind how these changes affect the providers of care and their ability to organize themselves to oversee provision. A recent report, for example, recommends that governments move from annual, global budgets for hospitals to service-based funding, in part to stimulate the creation of 'specialized, stand-alone facilities.'³⁹ It will be critical to consider the consequences of such reform in smaller communities where there may be few physicians capable of integrating with other providers of care and, thus, avoiding self-referrals in such situations may be especially difficult.

NOTES

This is a revised and expanded version of Choudhry et al., 'Unregulated Private Markets for Health Care in Canada? Rules of Professional Misconduct, Physician Kickbacks and Physician Self-Referral' (2004) 170 *Can. Med. Assoc. J.* 115.

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3 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

4 *Chaoulli v. Québec* (Attorney General), [2005] S.C.C. 35. See also Patrick J. Monahan and Stanley H. Hartt, 'The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians,' C.D. Howe Institute Commentary 164 (May 2002), <http://www.cdhowe.org> (accessed 27 March 2004) and Colleen M. Flood, Kent Roach, and Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate on Private Health Insurance* (Toronto: University of Toronto Press, 2005).

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- 14 Jean M. Mitchell and Elton Scott, 'Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics' (1992) 268 *J. Am. Med. Assoc.* 2055.
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- 17 Jean M. Mitchell and Jonathan H. Sunshine, 'Consequences of Physicians Ownership of Health Care Facilities: Joint Ventures in Radiation Therapy' (1992) 327 *New Eng. J. Med.* 1497.
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- 19 CPSA By-laws, *ibid.* ss. 47 and 49; *Medical and Health Care Services Regulation*, B.C. Reg. 426/97, ss. 38–40; *Medicare Protection Act*, R.S.B.C. c. 286, s. 35(1); CPSM, By-Law 1, *ibid.*, s. 55; CPSM, ‘General Ethical Statement 124,’ *ibid.*; CPSNB, Regulation 9, *ibid.*, s. 36; *General Regulation: Medicine Act*, *ibid.*, s. 17; *Code of Ethics of Physicians*, *ibid.*, s. 77; SCPS By-laws, *ibid.*, s. 51(1)(f)(v) (diagnostic facilities).
- 20 See *supra* note 6 and accompanying text.
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- 22 *Ethics in Patient Referral Act*, *supra* note 6.
- 23 Paul Kalb, ‘Health Care Fraud and Abuse’ (1999) 282 *J. Am. Med. Assoc.* 1163.
- 24 *Professional Misconduct Regulation*, *supra* note 18, s. 11.
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- 27 SCPS, By-laws, *supra* note 18, s. 51(2)(n).
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