

Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral

Sujit Choudhry, Niteesh K. Choudhry, Adalsteinn D. Brown

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The regulation of private health care has become a central issue in Canadian health policy. The legality of private markets for medical services already available under public health insurance has attracted attention.¹ However, there has been little discussion of the regulation of independent health facilities (IHF).² IHFs are privately owned, for-profit entities that provide therapeutic and diagnostic services, such as physiotherapy and laboratory testing, and operate both within and outside the public system. There may be 1000 IHFs in Ontario alone.²

IHF depend on physician referrals for patients. This raises 2 important issues. First, IHFs can compensate physicians for patient referrals (a kickback), a practice that can potentially distort clinical judgement. Second, physicians can make referrals to IHFs that they themselves own, raising similar concerns. Both problems have occurred in the United States and have prompted regulation.^{3,4} But, in spite of the US experience, kickbacks and self-referral were not mentioned in the Kirby⁵ and Romanow⁶ reports and have generated limited scholarly commentary in Canada.⁷

Financial conflicts of interest involving physicians are regulated by common law, which imposes a fiduciary duty on physicians toward patients.^{8,9} Canadian courts have stated that physicians fulfill this duty by disclosing conflicting interests to patients.^{10,11} Unfortunately, in most clinical settings disclosure provides inadequate protection for patients.

The courts acknowledge that the professional regulatory bodies such as the provincial colleges of physicians and surgeons may have the greatest expertise in governing conflict of interest.¹² Therefore, we review the rules governing financial relationships between physicians and IHFs as found in provincial codes of professional conduct for physicians. In some respects, these rules adequately protect patients; in others, they do not. We propose regulatory models to be implemented before the further proliferation of IHFs.

Defining kickbacks and self-referral

The term *kickback* refers to the financial compensation of physicians for patient referrals. Compensation can flow from IHFs to referring physicians, or from specialists to primary care physicians (*fee-splitting*). Compensation can

consist of cash payments for each referral, discounted office space or leases for medical equipment, or business loans at below-market rates.

Compensation for referrals is unobjectionable in most markets, but is problematic in health care in view of the potential conflict between physicians' financial self-interest and their duty to advise patients solely on the basis of health needs. Kickbacks have the potential to entice physicians to make unnecessary referrals, or to refer patients to particular providers for reasons other than the quality or accessibility of care. Moreover, incentives to increase referral volume and to direct referral streams may create inefficiencies by increasing waiting times, decreasing access and potentially increasing costs.

The term *self-referral* refers to a situation in which physicians own the IHFs to which they make referrals and thus stand to benefit financially from the IHFs' profits. This practice has generated more debate than kickbacks have.¹³ Some physicians argue that physician-owned IHFs are simply extensions of physician practices in a different physical location, whether or not the referring physician personally provides services at those facilities. Defenders of self-referral also argue that ownership by referring physicians may be a warrant of quality.¹⁴

US data suggest that physician ownership of IHFs increases the number of referrals and leads to higher costs.¹⁵ Physicians who owned and operated diagnostic imaging equipment in their offices were up to 7 times more likely to obtain radiologic examinations than were physicians who always referred patients to radiologists.^{16,17} In addition, the charges per episode of care were significantly higher for self-referring physicians. Moreover, the existing data on quality suggest that the purported benefits of self-referral for quality may not exist. For example, licensed physiotherapists spent significantly less time per visit treating patients in physician-owned facilities than in other facilities.¹⁸

Rules of professional conduct

To determine the regulatory framework in Canada, we reviewed provincial laws and regulations (rules) governing the practice of medicine listed in an electronic legal database (Quicklaw) and on the Web sites of provincial med-

ical licensing authorities. For kickbacks, we coded rules according to whose conduct is regulated, what conduct is regulated, how that conduct is regulated and whether exceptions are permitted. For self-referrals to health facilities, we coded rules according to whose conduct is regulated, how the conduct is regulated and whether exceptions are permitted.

Kickbacks

Table 1 summarizes rules of physician professional misconduct governing kickbacks. Eight provinces explicitly regulate kickbacks. Although 2 provinces (Nova Scotia and Prince Edward Island) do not explicitly prohibit kickbacks, a general prohibition on professional misconduct could potentially be legally interpreted to prohibit kickbacks.

Provisions against kickbacks vary in their scope. Seven provinces prohibit receiving any kickback, whereas Quebec prohibits the receipt of kickbacks only if the kickback “would jeopardize ... [the] professional independence” of a physician,²⁶ without further definition. Seven provinces regulate referrals to physicians, IHFs, pharmaceutical suppliers and medical device suppliers, often through general language that does not distinguish among different kinds of referrals. In contrast, British Columbia regulates only those referrals made to suppliers of pharmaceuticals and medical devices.

Four provinces allow for rental agreements between physicians and parties (e.g., other physicians, IHFs, phar-

macies and medical device suppliers) to whom those physicians may refer. Rental arrangements can disguise kickbacks 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 referral volume. Rental arrangements are therefore 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.²⁷ This provision is broad enough to cover pharmaceuticals and medical devices and could contradict Quebec’s more general provision on kickbacks.

Physician self-referral

Table 2 summarizes rules of physician professional misconduct on self-referral. Seven provinces regulate self-referral to IHFs in which referring physicians have personally invested. In addition, 4 provinces regulate referrals to health facilities in which “immediate” family members have invested, since it would be easy to circumvent such rules by putting investments in the name of a spouse, child or parent. Three provinces also regulate referrals to IHFs in which “extended” family members have invested. Although 3 provinces (Newfoundland, Nova Scotia and Prince Edward Island) do not expressly regulate self-referral, a general prohibition on professional misconduct

Table 1: Extent of regulation of physician kickbacks, by province*

Variable	BC ¹⁹	AB ²⁰	SK† ^{21,22}	MB† ^{23,24}	ON† ^{25,26}	QC‡ ^{27,28}	NB ²⁹	NL ³⁰
Party to kickback arrangement								
Physician as payor of kickback		X	X		X	X	X	
Physician as recipient of kickback	X	X	X	X	X	X	X	X
Any person as payor of kickback		X	X	X	X	X	X	
Drug/device supplier as payor of kickback	X		X	X	X			X
Which referrals are regulated?								
To physicians		X	X	X	X	X	X	X
To IHFs		X	X	X	X	X	X	X
To pharmaceutical suppliers	X	X	X	X	X	X	X	X
To medical device suppliers	X	X	X	X	X	X	X	X
How are kickbacks regulated?								
Disclosure						X		
Prohibition	X	X	X	X	X	X	X	X
Exceptions§								
Market value rentals and no volume incentive			X	X	X			X

Note: IHFs = independent health facilities.

*Nova Scotia and Prince Edward Island have no specific regulations on physician kickbacks and are thus excluded from this table.

†Saskatchewan, Manitoba and Ontario each have 2 provisions governing kickbacks. One provision prohibits kickbacks in general language. The second provision is also wide-ranging but has more specific rules.

‡Quebec has 2 provisions governing kickbacks. One provision prohibits the receipt of a kickback, 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,” provided those royalties are disclosed to patients.

§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.

could potentially be legally interpreted to prohibit kickbacks.

Provinces regulate self-referral differently. Four provinces prohibit self-referral, whereas 3 provinces simply require that referring physicians disclose investment interests to patients. Four provinces permit self-referral in limited circumstances, such as in communities where there is no IHF that does not raise conflict-of-interest concerns. (This may be important in rural areas.)

Finally, 2 provinces prohibit physician investment in IHFs to include volume incentives for referrals. In contrast, volume incentives are permitted in 2 provinces that allow self-referral with disclosure, and in the 3 provinces where self-referral is not regulated.

Discussion and policy recommendations

Although some provinces have rules of professional conduct governing kickbacks and self-referrals, these rules are often inadequate. Regardless, all provinces should enact clear provisions.

Kickbacks

Although 8 provinces prohibit physicians from receiving kickbacks, only 5 prohibit physicians from paying or offering to pay kickbacks. But paying kickbacks represents a conflict of interest in that this action seeks to in-

duce referrals regardless of patient health status. Moreover, the growing role of nonphysician health care professionals (e.g., physiotherapists) who may direct patients to physicians strengthens the case for prohibiting the payment of kickbacks by physicians. All provinces should prohibit physicians from offering to pay, paying or receiving kickbacks — not only to physicians, but also to any other person.

Physician self-referral

Three provinces do not expressly regulate self-referral to health facilities. Furthermore, 6 others 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.

Three provinces that regulate self-referral merely require disclosure by referring physicians to patients of their investment interest. Although disclosure may effectively police financial conflict of interest if such disclosure is made to someone able to make an independent judgement (e.g., to physicians in the case of medical research), disclosure to relatively inexperienced patients does not work, particularly when they require treatment. Patients may also interpret disclosure not as a warning to take care, but rather as a warranty

Table 2: Extent of regulation of physician self-referral, by province*

Variable	BC ^{31,32}	AB† ³³	SK ³⁴	MB‡ ^{24,35}	ON ³⁶	QC ³⁷	NB ³⁸
Who has investment interest?							
Physicians	X	X	X	X	X	X	X
Immediate family§	X		X	X‡‡	X		
Extended family	X		X		X		
How is self-referral regulated?							
Disclosure				X	X	X	
Prohibition	X	X	X				X
Restrictions on investment income¶		X		X			
Other				X			
Exceptions							
Otherwise not available / community need**	X	X					
Medically necessary††		X	X				
Publicly traded corporation not closely held					X§§		

*Nova Scotia, Prince Edward Island, and Newfoundland and Labrador have no specific regulations on physician self-referral and are thus excluded from this table.

†Alberta has 2 provisions governing self-referral. One prohibits self-referral except in cases of “demonstrable objective medical benefit.” The other provision prohibits self-referral to IHFs except in cases of community need.

‡Manitoba has 2 provisions governing self-referral. One requires physicians to “avoid inappropriate personal benefit” in self-referral, which may prohibit certain kinds of self-referral. The other provision requires disclosure of a financial interest.

§Defined as a spouse, child or parent.

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

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

††Self-referral is permitted if it is medically necessary.

‡‡Refers to “indirect ownership” interests, which probably encompasses familial investment interests (at least by an immediate family member).

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

of an IHF's quality.¹³ Finally, patients might not wish to refuse the referral, for fear of straining the physician-patient relationship.

Self-referral should be prohibited. However, there should be a "community-need" exception, perhaps employing techniques such as those used to define underserved areas. Prior approval by a regulatory authority would prevent abuse. 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 them to financially integrate with IHFs or hospitals (e.g., through risk-adjusted capitation). The goal of financial integration is to align providers' incentives in order to encourage them to provide care as cost-effectively as possible. However, financial integration between physicians and IHFs would make self-referral difficult to avoid. Provincial governments would need to create exceptions to the prohibition on self-referral, as has happened in the United States.³⁸

If self-referral is permitted, the terms of physician investment must not create incentives either to make referrals or to inflate referrals. Only 2 provinces impose such restrictions at present.

Conclusion

Although provinces have attempted to regulate against physician kickbacks and self-referral, the current regulatory framework is inadequate. As IHFs proliferate, provincial governments should review current rules to "get in front" of the important regulatory challenges that IHFs pose to cost and quality.

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From the Faculty of Law, University of Toronto (S. Choudhry); the Joint Centre for Bioethics (S. Choudhry); the Departments of Medicine (N. Choudhry) and of Health Policy, Management, and Evaluation (Brown), Faculty of Medicine, University of Toronto, Toronto, Ont.; the Department of Medicine, University Health Network (N. Choudhry), Toronto, Ont.; and the Department of Medicine, Brigham and Women's Hospital, Harvard Medical School and the PhD Program in Health Care Policy, Harvard University, Boston, Mass. (N. Choudhry)

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Correspondence to: Prof. Sujit Choudhry, Faculty of Law, University of Toronto, 78 Queen's Park, Toronto, ON M5S 2C5; fax 416 978-2648; sujit.choudhry@utoronto.ca