Self-referral by physicians is a source of frequent debate. In some circumstances, self-referral can result in better continuity of care, speedier diagnoses, and improved timely access to health care services. From an ethical and legal perspective, however, self-referral is often criticised because it can result in a conflict of interest between a physician’s primary legal and ethical duty to act in the best interest of his or her patient and the financial incentive associated with making the referral. From a public policy perspective, self-referral is also viewed with some suspicion because self-referral practices tend to be correlated with higher use of insured diagnostic procedures, which, in addition to being potentially inappropriate for patients, may be costly for the public health care system.

This article begins by describing some common types of self-referral and by outlining some frequently cited concerns about the practice. The sections that follow outline various ways in which self-referral practices are regulated across Canada. The most common method is through professional regulation. As highlighted in this article and by other authors in the literature, there is substantial variation across the provinces in terms of how conflicts of interest related to self-referral are regulated as a matter of professional conduct.

In addition, many jurisdictions have introduced measures aimed at curbing high rates of utilization of specific insured health services in response to concerns over rising public health care costs. These types of measures tend to focus on and limit access to and reliance on specific publicly insured services that may be more susceptible to inappropriate or over-use, such as diagnostic testing services, in order to control costs and improve “appropriateness.”
The experience of some jurisdictions appears to indicate that, where thoughtfully implemented, such measures can help to improve quality and ensure more appropriate care rather than simply punish all professionals who self-refer.

What Is Self-Referral? Why Is It Criticised?

This article refers generally to two types of self-referral. In the first, the physician (often a specialist) orders a test and then performs it him or herself (or through a delegate) at his or her office and is compensated for the referred test (“in-office self-referral”). In the second, the physician refers his or her patients to an outside facility in which they have a direct or indirect financial interest (“off-site self-referral”).

Key concerns often raised with regard to self-referral include the following:

1. Self-referral (or the prospect or potential of self-referral) can give rise to conflict of interest between the financial incentive associated with making the referral and the physician’s duty to act in the best interests of his or her patient.

2. Instances of self-referral have been shown to be correlated with higher rates of use of certain therapeutic and, in particular, diagnostic procedures, which may be inappropriate for the patient and costly to the health care system at large.

These concerns, while valid, do not mean that all financial investments or instances of self-referral by physicians will be abusive. While a direct or indirect proprietary or financial interest in in-office diagnostic equipment or another health-related business or facility may, in some circumstances, give rise to an unresolvable conflict of interest situation, this will not always be the case.
Further, where the physician has a conflicting secondary interest, it may be possible to address the conflict in a way that still fulfils his or her fiduciary duty to the patient. The courts have indicated that, at minimum, adequate disclosure to the patient of a competing financial interest will be required. Most provincial regulatory bodies for physicians have additional rules for avoiding or managing (or both) conflicts of interest generally, and many have specific rules relating to off-site self-referrals.

Self-referral is also cited as a contributor to rising rates of diagnostic testing (particularly diagnostic tests such as CT and MRI scans and echocardiography), which are, in turn, an increasingly large cost source for the public health care system. A number of studies (primarily from the U.S.) have demonstrated a correlation between self-referral and higher rates of test ordering. Whether done consciously or unconsciously, it appears that physicians who have their own diagnostic imaging equipment or own or have an interest in another business or facility tend to be inclined to order more tests.

With that said, self-referral appears to be only one of many factors contributing to this trend. A recent report on diagnostic imaging utilization released by the Canadian Agency for Drugs and Technologies in Health, for example, identified numerous factors including (1) an aging population, (2) increased availability of and patient demand for access to these technologies, (3) the practice of defensive medicine to avoid malpractice claims, (4) gaps in knowledge of the ordering physician, (5) excessive wait times for the most appropriate test, and others.

**How is Self-referral Regulated?**

**Overview**

Self-referral is primarily regulated in Canada through professional regulation. Medical professional regulatory bodies are tasked with regulating the professional and ethical conduct of their physician members, including in respect of conflicts of interest. Physicians are generally subject to a prohibition on practising while in a conflict of interest unless the conflict can be addressed or resolved in some way. A proprietary or other financial interest in a separate health business or facility, for example, may in some circumstances give rise to a conflict of interest. Regulatory regimes often outline specific instances that will be deemed to constitute a conflict of interest (e.g., off-site self-referrals). The regime may also describe how the conflict of interest should be avoided or managed. In addition, even if a particular form of self-referral is not expressly regulated, the physician’s legal and ethical requirements may still be enforced by the regulator through broader prohibitions on professional misconduct.

In some jurisdictions, rising costs have prompted additional regulation of both in-office and off-site self-referral practices through rules linked to reimbursement of publicly insured health services. For example, governments (as administrators of the provincial health insurance plans) may prescribe limits on who can claim for certain insured services and in what circumstances, including limits on when a professional may claim a fee for a service that was self-referred. While such rules will often directly or indirectly address conflicts of interest and self-referral, the underlying intent tends to be slightly different from that of professional regulation. The focus here tends to be on managing utilization of insured health services to reduce unnecessary testing (or improve “appropriateness”), thereby controlling costs.

Finally, while not the focus of this article, it is worth reiterating that financial conflicts of interest for physicians are also regulated by
common law, which imposes a fiduciary duty on physicians that is owed to patients. The case law in Canada is not completely settled on the issue, but courts have indicated that prior disclosure of the interest may be sufficient to fulfil the physician’s duty to the patient from a common law perspective.

**Professional Regulation**

The sections that follow summarize various ways in which self-referral is regulated as a matter of physicians’ professional conduct, including (1) how professional regulatory bodies define the scope of self-referral practices that will be regulated and (2) how conflicts of interest arising from circumstances of self-referral are to be avoided or managed.

In addition to the specific rules (outlined below) that apply in the case of certain types of conflicts, physicians are subject to various overarching ethical obligations, including

- considering the well-being of the patient first and foremost;
- resisting any influence or interference that could undermine the physician’s professional integrity;
- recognizing and disclosing conflicts of interest arising in the course of carrying out professional duties and activities and resolving them in the best interest of patients;
- refraining from exploiting patients for personal advantage; and
- recommending only those diagnostic and therapeutic services that the physician considers to be beneficial to the patient.

In-office self-referral practices tend not to be explicitly addressed in provincial professional conduct rules, though physicians engaging in such practices would be subject to compliance with the above obligations and other general rules regarding professional conduct.

**Scope of the Conduct That Is Regulated**

Of the provinces that have conflict-of-interest rules specifically addressing self-referral practices, there is variation in how self-referral is defined and regulated. For example, Manitoba’s regulator considers that a self-referral conflict of interest arises when a patient is referred to “any goods or services, including but not limited to drugs, medical appliances, diagnostic procedures, or other forms of therapy or treatment, from a Facility in which the physician has an interest.” “Facility” is similarly broadly defined. As a result, these provisions capture a broad spectrum of diagnostic, therapeutic, and any other goods or services to which the physician may refer his or her patient.

By contrast, Saskatchewan’s rules regarding self-referral only address referrals for diagnostic testing and broadly exempt from the definition of a conflict of interest a referral for any diagnostic test that is “medically necessary.” Other provinces fall along this spectrum at various points.

Most conflict of interest rules provide that both direct and indirect financial or proprietary interests can result in a conflict where self-referral will or could occur. Generally, though not always, referrals to family members or facilities or business owned by such family members are addressed by such self-referral rules.

The extent or quantum of interest in the facility or business may also be a relevant consideration. In Ontario, for example, the definition of conflict of interest excludes self-referrals to a facility where the proprietary interest in question (direct or indirect) consists of less than a controlling interest in shares of a
publicly traded corporation. By contrast, other proprietary interests (e.g., any interest in a private company) would be caught and must be disclosed to the patient. Most other provinces address financial or proprietary interests more generally, without reference to a minimum materiality threshold.

How Self-referral Conduct Is Regulated

Prohibition

In some provinces, certain forms of self-referral are prohibited outright, although exceptions generally exist. British Columbia generally bars a physician from referring his or her patient to a facility or business in which the physician has a financial interest except (1) in the case of a community with demonstrated need or (2) where in the interest of continuity of care, the patient is being referred to another College-accredited facility, the referring physician himself or herself will be performing the procedure. Many provincial regulators that permit self-referral (or permit it in certain circumstances) impose rules governing how the conflict of interest arising from the self-referral is to be managed or avoided. These types of rules are summarized below.

Regulating the Patient Disclosure

Basic disclosure. Where self-referral is permitted, disclosure of the physician’s interest to the patient is generally a minimum requirement. Even in the absence of a professional standard or regulation obliging such disclosure, the case law indicates that disclosure of the interest is likely a minimum requirement to avoid a breach of the physician’s legal fiduciary duty (in addition to his or her ethical obligations).

It is generally acknowledged, however, that mere disclosure of a conflict will not always be sufficient to fulfil the physician’s duty to his or her patient (e.g., where a patient was not given sufficient information to understand the implications of what was disclosed). In light of this, some regulators provide more specific rules or guidelines to their members regarding the content of, and method for, delivering proper disclosure and ensuring that a patient has given informed consent to the service being delivered in spite of the conflict. This can include more general requirements for the physician to “(i) make full, frank and timely disclosure of the conflict of interest to the patient, and (ii) obtain the informed consent of the patient before providing any medical advice or treatment to the patient” (as is the case in Alberta). Alternatively, physician members may be required to post signs in a facility in which a physician has an ownership or proprietary interest stating their name and interest in the facility (as is the case in Manitoba and Nova Scotia).

Non-directive referral forms. Another practical way to help patients to feel comfortable seeking out alternate providers is to require physicians to supply patients with a prescription or referral form that can be used at any facility of their choice (rather than one that must be used at or directs the patient to a particular facility—this is sometimes known as a “non-directive” prescription or form). In Manitoba and Nova Scotia, for example, where a physician has an ownership or proprietary interest in another facility, he or she must provide the patient with a written non-directive prescription or referral, as the case may be, to be used at a facility of the patient’s choice.

Requirements to provide patients with information about alternative providers. Other regulators go a step further and actually require members to provide patients with information about alternative providers. The clearest
example of this can be found in British Columbia, where, in addition to basic disclosure, a physician must also provide his or her patient with accurate information about the wait times for alternative facilities to the extent possible and appropriate in the circumstances. In Quebec, physicians may also be obliged to provide a patient with names of alternate providers, but only if this information is first requested by the patient.

Regulating the Financial Arrangements

**Limits on the structure of financial investments.** Some provincial regulators impose limits on the manner in which physicians may invest in other businesses or facilities to which the physician may refer patients. In British Columbia, Alberta, Manitoba, and Nova Scotia, if the physician will or may refer patients to the facility or business (and assuming that the investment is otherwise permitted), the investment must be structured so the return on the physician’s investment is based on an equity or similar interest in the facility and is not in any way linked to the volume of patient referrals made by the physician.

Manitoba and Nova Scotia regulators also specifically prohibit any arrangements that include a requirement for the physician to make referrals or otherwise generate professional business for the Facility as a condition to entering into such an agreement. In addition, both provide that the terms of the agreement “must not differ significantly from terms which fully informed parties negotiating at arm’s length would regard as fair for the ownership or proprietary interest which is the subject of the agreement.”

**Prior approval of arrangements.** Another approach is to require that the physician receive prior approval from his or her professional regulatory body before investing in another business or facility that could end up being the recipient of referrals from that physician. Alberta’s regulator prohibits its physician members from having a direct or indirect interest in a health care business to which the physician refers a patient, or to which a patient may be expected to attend due to geographic proximity or necessity, unless the physician’s particular arrangement has received the permission from the Registrar of the College.

**Notification requirements.** Rather than requiring prior approval, Ontario requires physicians to inform the College if the physician member or a member of his or her family has any proprietary interest in a facility where diagnostic or therapeutic services are performed (not only interests in businesses and facilities where the member may end up referring patients). The standard conflict of interest notification form requests relatively detailed information about the facility, such as the following: name of the facility, nature of the ownership interest, nature of the services provided, method of notifying patients of the interest/ownership, relationship of any family member with a proprietary interest, and additional “optional” questions regarding the availability of alternative services in the community, distance to nearest facility offering comparable services, and comparable accessibility of the facility.

Combining Mechanisms to Build a Regulatory Regime

Professional regulatory bodies can and do draw on a combination of these various mechanisms to develop a regime to govern conflicts of interest resulting from self-referral. As a result, there is significant variation in the way that self-referral ends up being regulated across Canada. In British Columbia, for example, the general prohibition on physicians’ referring patients to
businesses or facilities in which the physician holds a financial interest is subject to certain exceptions in the case of demonstrable community need or in the interest of continuity of care. Where an exception applies, the College imposes requirements limiting how the referring physician’s investment may be structured and prescribing basic requirements for patient disclosure (including a requirement to give information about alternative facilities).

In Manitoba and Nova Scotia, physicians are generally permitted to invest in other businesses and facilities and to refer patients to such businesses and facilities without requirement for prior approval or notification; however, physicians must comply with certain requirements in terms of the structure of their investment arrangements in addition to certain disclosure requirements (i.e., in relation to signage disclosure, non-directive referral forms and prescriptions, and refraining from disparaging comments about competing facilities).

A final example is Ontario, where self-referral is also generally permitted, but the interest must be disclosed to the patient unless the physician has less than a direct or indirect controlling interest in a corporation that is publicly held. Notification to the College of all proprietary interests in therapeutic and diagnostic facilities is required, but no prior College approval is necessary before making any such investments.

Restrictions on Self-referral of Insured Health Services

As noted earlier, diagnostic testing has been identified as a growing source of cost strain on the public health care system. In this context, regulation of self-referral may take the form of measures aimed at saving costs and/or ensuring appropriate use of these insured health services. These types of restrictions tend to be focused on self-referral with respect to insured health services (i.e., uninsured services are generally not caught by these restraints) and may take the form of fee reductions in the case of self-referral and/or the development of quality assurance standards that are linked to reimbursement and often limitations on who may bill for certain diagnostic tests and procedures.38

Prohibition on self-referral. In the United States, a source of frequent and ongoing debate is the “Stark Law,” which prohibits physicians from referring Medicare and Medicaid patients to certain types of “designated health services” with which they (or their immediate family members) have a “financial relationship.”39 There are exceptions, including for certain forms of in-office self-referral; however, some argue that these exceptions have been susceptible to potential over-use.40

Fee reduction (where self-referral has occurred). Ontario recently attempted to use this type of policy lever. In mid-2012, the Ontario government announced that it would reduce OHIP fee payments by 50 per cent for certain diagnostic tests where self-referral had occurred. The announcement was met with significant criticism, and ultimately, the fee cut was retracted later that year as part of an overarching agreement between the government and the Ontario Medical Association.41

Limiting access to specialist fee codes. Another approach that some jurisdictions have taken is to limit physicians’ access to fee codes for certain insured diagnostic tests to only those closely related to their specialty.42

Credentialing and quality assurance programs linked to reimbursement. Many U.S. insurers require credentialing and enable the development of quality assurance standards that are subsequently linked to reimbursement.
These types of measures, if implemented properly, may have the potential to improve quality and appropriateness in addition to achieving desired cost reductions.43

For example, Kouri et al. describe the experience of a large north-eastern health maintenance organization (HMO) in the United States. The HMO established a multi-global/advisory committee that was tasked with developing professional guidelines for in-office imaging performed by physicians based on each specialty. The HMO then evaluated the technical quality of the imaging, using inspections and questionnaires (including evaluating the soundness of the equipment, outputs and doses to the patients, patient safety programs, etc.). The program identified significant deficiencies in technical quality in non-radiologists who were performing testing in their offices. In evaluation, the program was reported to have resulted in “a significant decrease in the proportion of imaging performed by self-referrers and in the overall number of radiologic examinations.”44

British Columbia uses a more direct mechanism to restrict self-referrals for insured diagnostic services. The Medicare Protection Act provides that the services performed at certain diagnostic facilities will not be insured (i.e., will not be paid for by the provincial Medical Services Plan) unless the facility is approved. In turn, the facility will not be approved unless certain prescribed conditions are met, including that health professionals holding a material investment in the facility do not have a conflict of interest.45 Facilities and physicians operating diagnostic testing equipment are also required to undergo specific credentialing in order to be eligible for reimbursement from the Medical Services Plan.

Similarly, the Ontario Assistive Devices Program (ADP) limits participation to Registered Vendors and Registered Authorizers who meet the requirements of the ADP and who have an executed agreement with the Ministry of Health and Long-Term Care. It is a breach of the ADP Authorizer or ADP Vendor Agreements “to sell, dispense or authorize the use of Assistive Devices where the Authorizer or Vendor has a Conflict of Interest.”46 The ADP Conflict of Interest Policy defines a conflict of interest to include when “an Authorizer or Vendor has commitments, relationships or interests, financial, family or otherwise, that interfere with her or his abilities to exercise unbiased and impartial judgement relating to authorizing or selling Assistive Devices to Clients” or where “there is a financial relationship or any other relationship of influence between an Authorizer and Vendor.”47 If, as a result of a compliance review, the Authorizer or Vendor is found to be in contravention of its ADP Agreement (including being in breach of these conflict of interest rules), disciplinary action may be taken up to and including de-registration from ADP.48

Analysis

The challenge of how best to regulate and manage the utilization of diagnostic and other health care services is increasingly relevant in Canada, especially in light of growing investments in non-hospital, community-based health care delivery.49 In Ontario, it is estimated that 50 per cent of independent health facilities are already owned or controlled by physicians.50 There is no reason that such investments should necessarily be discouraged, provided that appropriate measures are in place to promote ethical conduct and appropriate care while regulating to protect the public and the health care system from abusive behaviour.
While an increasingly important policy objective is to control escalating rates of diagnostic testing, effective policy measures to address these concerns will likely need to take aim at the myriad of factors that contribute to the problem, as opposed to singling out and punishing only certain types of self-referral. Up-to-date quality assurance standards, coupled with credentialing, appear to be a promising option if they can be properly implemented (which is undoubtedly a challenging task). In this respect, the lessons from other jurisdictions will be of assistance. There is likely a strong role for professional regulatory bodies to lend their expertise to the development of quality assurance standards and credentialing programs.51

Professional regulation also has an important role to play in regulating conflicts of interest in relation to insured and uninsured physician services alike. Rules for managing conflicts arising from self-referral should be clear and understandable. At minimum, they should insist on disclosure of any conflict and should be consistent with other applicable requirements for conflicts of interest prescribed in respect of their delivery of insured health services.

In some instances, it would be helpful if greater guidance was given as to what the content of the disclosure should include. For example, requiring non-directive referral forms seems to make good sense not only as a means of regulating self-referral but more generally as a means of protecting patient choice. One way to facilitate better compliance with this type of requirement would be to establish provincial standardized non-directive referral forms, such as those currently used for laboratory requisitions in Ontario.52 As we move towards great adoption of electronic medical records, standardized electronic referral forms would appear to be a logical next step.

Requiring physicians to provide patients with information about alternative providers and applicable wait times is another way to empower patients to make informed choices. Ideally, this type of requirement would be accompanied by a commitment by the relevant government or regulator to collect and make these data available as opposed to placing the onus on individual physicians to collect and presumably verify this information on an ongoing basis.

Like most difficult questions, the path forward on physician self-referral will require a thoughtful and nuanced approach and likely call on a combination of regulatory mechanisms tailored to target abusive behaviour across both the public and private system without unduly punishing physicians or restricting patient access.

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1 Although “self-referral” is a broad term that captures similar conduct across other health professions, here the term is used to describe the practice of a physician ordering tests or other procedures for a patient, which are, in turn, performed by that same physician or at a facility in which the physician has a financial interest.


3 Irfan Dhalla gives a common example of this type of self-referral: A respirologist receives a referred patient for shortness of breath that could be asthma or chronic obstructive pulmonary disease. The respirologist, after performing a family history and physical examination, may perform a spirometry test (as recommended by applicable practice guidelines) and interpret the results in order to help to make or confirm the diagnosis. See Irfan Dhalla, “Punishing All Self-referral Is Not the Solution,” HealthyDebate.ca (May 30, 2012), <http://healthydebate.ca/opinions/punishing-all-self-referral-is-not-the-solution> (“Dhalla”).

4 See, for example, College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines,


The medical practitioner, like the lawyer or other professional adviser, is bound, then, to see to it that in no circumstance will he allow his professional duty to come into conflict with his personal interests. And when a patient consults his physician he is entitled, in equity, to assume that this adviser has no pecuniary interest in the surgical operation he advises or in the choice of the surgeon or in the amount of the proposed surgeon’s fee. If the medical adviser has a pecuniary interest—and a fee-splitting arrangement is such an interest—he must disclose it or fail in the discharge of his duty to his patient, and by failing in that way he acts illegally, in my opinion. His conduct does not amount to a crime under the provisions of The Criminal Code of Canada, it is true, but it is illegal none the less. And I am unable to see how the provision of the general by-laws which required the physician to disclose the arrangement to his patient after the event removed the illegality.

6 In Canada, for example, it has been estimated that as many as 30 per cent of CT scans are inappropriate or contribute no useful information for diagnosis and treatment. See Health Council of Canada, Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada (September 2010): 31, <http://www.healthcouncilcanada.ca/rpt_det.php?id=154>; Canadian Association of Radiologists, Do you need that scan? (Ottawa: CAR, 2009), <http://www.car.ca/uploads/news%20publications/car_cat_scan_eng.pdf>. Inappropriate use of testing such as diagnostic testing can also potentially be a patient safety concern, particularly when it results in unnecessary exposure to ionizing radiation (i.e., CT and PET/CT scans).


9 There is some debate about the most appropriate place to set out the rules regarding conflict of interest. Self-regulating professionals generally have by-law or regulation-making power that is subject to ministerial approval—once approved, these have the force of law. Colleges also issue policies and guidelines. While guidelines and other similar instruments do not necessarily have the force of law, Colleges and their discipline committees can consider the interpretations and principles in determining whether the regulations have been complied with and standards of practice have been maintained.

10 See Choudhry, supra note 2 at 1115.

11 In Henderson, supra note 5, the Ontario High Court confirmed that where a medical adviser has a pecuniary interest “he must disclose it or fail in the discharge of his duty to his patient.” This could be interpreted to imply that disclosure satisfies a physician’s duty to his or her patient from a common law perspective, though such a view should be cautiously applied. In Henderson, the court did not expressly state that disclosure would be sufficient to fulfill the physician’s duty to his patient, only that without disclosure, such a duty was certainly not met. See also Moe Litman, “Self-referral and Kickbacks: Fiduciary Law and the Regulation of ‘trafficking in patients.’” CMAJ 170, no. 7 (March 30, 2004), <doi:10.1503/cmaj.103195> (“Litman”). Both Choudhry and Litman refer to problems in relying solely on disclosure, including the fact that disclosure can often be misconstrued as a positive endorsement of the referral (see Choudhry, supra note 2 at 1117–1118; Litman at 1119).


13 See also note 39 regarding the debate around regulating in-office self-referral in the United States under the Stark Law.

14 Provinces that have specific self-referral rules include British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia. Newfoundland and Labrador does not appear to have any specific rules relating to self-referral, though it has general rules governing conflicts of interest. Prince Edward Island has specific rules for self-referral in relation to physician dispensaries, but not for other types of self-referral (Physician Dispensary Regulations, P.E.I. Reg. EC617/87, s. 7 [PEI Regulation]).


16 Regulatory By-laws of the College of Physicians and Surgeons of Saskatchewan, s. 9.1(f) [SK Standard].

17 For example, see BC Standard, supra note 4; Alberta (College of Physicians & Surgeons of Alberta, Standards of Practice, Standard 29 [AB Standard], Ontario (O. Reg. 114/94, s. 17 [ON Regulation]).

18 The scope of family members may also vary. Some refer only to immediate family members (e.g., children, parents, siblings, or a spouse) while others refer to more extended familial relations (e.g., in-laws, grandchildren, grandparents). The BC Standard acknowledges that a conflict of interest may occur in the context of other relationships as well, such as in the case of a close friend or business partner. In their 2004 review of provincial professional regulatory conflict of interest provisions, Choudhry et al. recommended that inclusion of family member interests is particularly important in light of the potential influence of this type of competing interest as well as the relative ease of putting a business interest in, for example, a spouse’s name in order to avoid complying with the various requirements associated with conflicts of interest. This would appear to be consistent with the interpretation of “indirect interest” in other contexts (e.g., Baillargeon v. Carroll, [2009] O.J. No. 502, 56 M.P.L.R. (4th) 161 (Ont. Sup. Ct.).

19 Some exceptions include Alberta (AB Standard, s. (3)), Quebec (Code of Ethics of Physicians, ch. M-9, r. 17, s. 77 [QC Standard]), and New Brunswick (New Brunswick, Medical Act, s. 7.1(2) and Regulation 9, s. 36 [NB Medical Act]), which refer only to interests in another facility/business that the physician himself or herself holds.

42
Alberta and New Brunswick refer to "indirect interests" that may capture interests of family members.

ON Regulation, supra note 17, s. 17.

For example, see BC Standard, supra note 4 and AB Standard, supra note 17. As we discuss in further detail later on, British Columbia regulates self-referral more generally through professional standards and also specifically through restrictions on ownership in certain types of diagnostic facilities under the Medicare Protection Act, RSBC 1996, c. 286, and its regulations. With respect to diagnostic facilities, the minimum investment is 10 per cent to be considered "material." For professional obligations (including diagnostic, therapeutic, and other types of facilities), there is no minimum threshold.

Provinces with prohibitions include British Columbia (community need and continuity of care exceptions; see BC Standard, supra note 4), Alberta (only with prior approval of the College; AB Standard, supra note 17, s. (3)(b)), and Saskatchewan (prohibited in respect of related diagnostic facilities only unless the test is medically necessary; SK Standard, supra note 16, s. 9.1(10)). In New Brunswick, any self-referral is arguably prohibited based on s. 36 of Regulation 9 (prohibition on having a conflict of interest) and s. 7.1(2) of the NB Medical Act that defines a conflict of interest as "the member or associate member receiving a financial or other benefit in their direct or indirect ownership of an interest in a commercial enterprise that provides a product or service that may be prescribed or recommended by them for a patient or in their practice of medicine." While some commentators have advocated broad prohibitions on physician off-site self-referral, most agree that some exemptions are necessary (e.g., where there is a community need in rural and underserved areas). See Choudhry, supra note 2 and Littman, supra note 11. See NB Medical Act, supra note 19.

BC Standard, supra note 4 at 2.

For example, in Ontario, where a physician orders a diagnostic or therapeutic service from a facility in which he or she has a proprietary interest, the conflict can be addressed if the proprietary interest is disclosed to the patient before providing the service (see ON Regulation, supra note 17). Quebec has similar provisions (see QC Standard, supra note 19). Other provinces such as British Columbia and Alberta also require disclosure, but the requirement is accompanied by additional obligations that must be fulfilled to discharge the physician's duty (see BC Standard and AB Standard, supra note 17).

For example, in Prince Edward Island and Newfoundland and Labrador, where there are no general conflict of interest provisions regarding self-referral (except in Prince Edward Island in the case of physician dispensaries. See notes 14 and 28).

Adam Saporta and Barbara E. Gibson, "Ethics of Self-referral for Profit: Case Example of a Physician-Owned Physiotherapy Clinic," Physiotherapy Canada 59, No. 4/2007 (University of Toronto Press: 2008): 266–271. See also College of Physicians & Surgeons of Nova Scotia, Competent Care and Ethical Practice, "Conflict of Interest Guidelines" at 3 [NS Standard]; the College specifically acknowledges that "[s]imple disclosure of a conflict does not necessarily resolve a physician's conflict of interest."

AB Standard (supra note 17), for example, provides that where a conflict of interest is unavoidable or if the Registrar has given permission to the physician to remain in a conflict of interest, the physician must (1) make full, frank, and timely disclosure of the conflict of interest to the patient and (2) obtain the informed consent of the patient before providing any medical advice or treatment to the patient. In all cases, members are reminded, the consent of a patient cannot vitiate the obligation of the physician to act other than in the best interest of the patient.

MB Standard, supra note 17.


See MB Standard, supra note 15 and NS Standard, supra note 26. Although a somewhat different circumstance, in Prince Edward Island, a physician who operates a physician dispensary is obliged to explicitly offer a prescription to the patient so that the patient can go elsewhere to fill their prescription. PEI Regulation, supra note 14, s. 8.

See BC Standard, supra note 4. Choudhry et al., (supra note 2) and Saporta and Gibson (supra note 26) recommend that the requirement to provide information about reasonable alternatives should generally be a feature of all self-referral provisions in conflict of interest standards and regulations. In a similar vein, although the MB Standard (supra note 15) and the NS Standard (supra note 26) do not place a positive obligation on physicians to disclose alternate referral locations, both prohibit member physicians from making disparaging comments to their patients about other facilities that compete with the facility in which they have an interest. See QC Standard, supra note 19.

See BC Standard, supra note 4; AB Standard, supra note 17; MB Standard, supra note 15; NS Standard, supra note 26. While these restrictions help to guard against disguised kickbacks, query whether this distinction between permitted and non-permitted arrangements is so clear when a facility or business is wholly or substantially owned by a physician (or his or her family members). In such a situation, returns on investment would, presumably, be closely linked in any case to the number of referrals made and revenues generated therefrom.

MB Standard, supra note 15 and NS Standard, supra note 26. It is unclear what particular arrangements would constitute a “significant” departure from arm’s length terms; one might ask also why these provisions do not simply require all such arrangements to be on fair market value terms.

See AB Standard, supra note 17.

See ON Regulation, supra note 17, s. 17(2).

CPSO, Conflict of Interest Form (Jan 2011), <http://www.cpsso.on.ca/uploadedFiles/CTAs/External_CTAs/policies/ConflictofInterestFORM.pdf>.

The public interest here is distinct from simply ensuring the professional conduct of physicians. As administrators of public health insurance plans, provincial governments may also be motivated to regulate self-referral conduct as it relates to utilization of insured diagnostic and therapeutic health services (i.e., costs to the health care system).

“Designated health services” include clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and
outpatient hospital services; and outpatient speech-language pathology services. See 42 USC § 1395nn (h)(6).

The latest U.S. federal Budget (in spring 2013) proposed to end this exemption, noting the following:

"[t]he in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely performed on the same day as the related physician office visit. Additionally, evidence suggests that this exception may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2015, this proposal would seek to encourage more appropriate use of select services by excluding radiation therapy, therapy services, and advanced imaging from the in-office ancillary services exception to the prohibition against physician self-referrals (Stark law), except in cases where a practice meets certain accountability standards, as defined by the Secretary."


In particular, the fee cut was criticised as unfairly punishing all self-referral rather than targeting abusive conduct. The cut narrowly focused on self-referral as a primary culprit for excessive use of certain insured health services; however, information was lacking as to what reasonable rates of self-referral would be and whether the instances of self-referral in Ontario were, in fact, excessive at that time. See: Auditor General’s Report, supra note 8. See also: Dhalla, supra note 2.

Kouri, supra note 7.

Ibid.

Ibid.

Material is defined as more than 10 per cent; the Medicare Protection Act provides for an exception where there are no other options without a conflict of interest occurring (with approval).


Ibid., s. 6.

Ibid., ss. 13–14.

For example, the Ontario Minister of Health and Long-Term Care indicated in her 2012 Action Plan for Health Care that a key priority will be to move procedures out of public hospitals and into community health clinics and not-for-profit independent health facilities.

Auditor General’s Report, supra note 8 at 151.

See, for example, the key role that the College in British Columbia plays in administering the Diagnostic Accreditation Program, <http://www.dap.org/Default.aspx?p=14>.

This option was recommended for Ontario Independent Health Facilities by the Auditor General of Ontario in his 2012 Annual Report. See Auditor General’s Report, supra note 8 at 169, but standardized non-directive referral forms could also be implemented more broadly.

The regulation of health care is a controversial topic in many countries, including Canada. Buzzwords such as “universal health care,” “private health care,” and “health insurance” get a lot of attention. But what do these terms actually mean, and how do they apply in Canada? In this article, we will explore the basics of health care regulation in Canada and, in so doing, consider the role of the private sector in this important industry.

Health care in Canada is regulated by a patchwork of legislation at both the federal and provincial levels. Each provincial or territorial government develops, administers, and funds its own health insurance plan for residents. These various insurance plans have many features in common, because the federal government, while not directly involved in the administration or delivery of health care services, does play a role in directing health care policy. Specifically, through a “carrot and stick” approach, the federal government encourages provincial and territorial governments to develop insurance plans that meet a variety of national standards, including free and universal access to health care services. As a result, publicly administered and funded health care has become the prevailing model in Canada. That said, the private sector does play an important role in both supporting and supplementing this system, particularly in the delivery of health care services, but also, albeit in a more limited way, in funding such services.
“Private” versus “Public”

There tends to be much confusion and inconsistency in the use of the terms “private health care” and “public health care.” This confusion likely stems, in part, from the fact that the health care systems in most westernized countries engage, to varying degrees, both the public and private sectors. Therefore, it can be misleading, and an oversimplification, to characterize any one system as being exclusively “public” or “private.” Further, the concepts of delivery of services and funding of services are often conflated in discussions on the topic when, in reality, these elements are often treated differently in many systems with respect to public versus private sector involvement.

For example, the Canadian system is often described as a “public” health care system. While it is true that health care in Canada is regulated, administered, and (perhaps most importantly) funded by government entities, the private sector does play an important role in this system. Specifically, it plays a major role in the delivery of health care services in Canada and also has a role, albeit a more limited one, in funding these services. Therefore, reference to the Canadian system as a “public” one means, more precisely, that it is a health insurance system funded and administered predominantly by the government.

Role of the Public Sector in Canadian Health Care

Division of Powers

In Canada, the Constitution Act, 1867 sets out the distribution of powers as between the federal and provincial/territorial governments. For the most part, health care is a matter that falls under provincial/territorial jurisdiction, which means the federal government cannot specifically dictate or control how it is regulated. But the federal government does have another tool at its disposal for influencing health care policy—namely, its spending power—and it uses this tool to give effect to a national standard. In other words, the federal government will provide the provinces or territories with full funding for health care services so long as the health care system they create meets specific requirements or standards set at the national level.

The Canada Health Act

The vehicle through which the federal government communicates its mandate is the Canada Health Act (the “Act”). Section 3 of the Act states that the “primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” The Act purports to achieve that objective by setting out various criteria, as well as some restrictions, that a province or territory must adhere to in order to receive federal funding for health care.

Criteria

Specifically, in order for any province or territory to receive a “full cash contribution” from the federal government for health care, it must establish (for its residents) an insurance plan that meets various criteria summarized below:

- **Public Administration**: the plan must be operated on a non-profit basis by a public authority that is accountable to the provincial/territorial government. (This is referred to as a “single payer system.”)
- **Portability**: the plan must cover “residents,” even while they are
temporarily absent from their province/territory or from Canada.

- **Universality**: the plan must entitle all insured persons of the province/territory to insured health services on uniform terms and conditions.

- **Accessibility**: the plan must provide for uniform and reasonable access to insured health services by all insured persons.

**Comprehensiveness**: the plan must cover all “insured health services provided by hospitals, medical practitioners, or dentists.” The term “insured health services” is defined in the Act as “hospital services, physician services and surgical-dental services provided to insured persons.” The definitions of “hospital services” and “physician services” turn on the services being, respectively, “medically necessary” or “medically required.” Taken together, the effect is that the provinces and territories must develop insurance plans for their residents that cover health services provided by a physician or in a hospital that are medically necessary.

**Prohibitions**

The Act also includes certain provisions designed to discourage seeking financial contributions from patients. Specifically, the Act requires that the provincial and territorial insurance plans prohibit the use of “extra-billing” and “user charges.”

The term “extra-billing” refers to charging a patient who is insured under a public insurance plan more than that plan would pay for the service in question. In other words, where a physician has received or will receive a payment from the provincial or territorial health insurance plan in respect of a procedure, the physician may not receive any additional payment for that procedure (from, for example, the patient or a patient’s insurance company).

Beyond what can be recovered through the government.

The term “user charge” refers to ancillary charges connected to the primary service provided. Specifically, it refers to additional charges to the patient for services arising out of, or related to, the use of an insured health service that is not payable under the plan. For example, a fee imposed by a provider to cover the costs of things like supplies, overhead, and nursing constitutes a user charge and, therefore, is prohibited.

If user charges or extra billing are permitted in any province or territory, the Act provides that the federal government can hold back funding from the offending jurisdiction. By incorporating these prohibitions, the government is attempting to ensure that costs for insured services cannot exceed the coverage provided by the government.

**Compliance**

Technically, compliance with the above criteria and prohibitions is voluntary, but the federal government can hold back funding if a province or territory fails to give effect to these principles. Therefore, there is a strong incentive for compliance. To that end, the provincial and territorial governments each have created their own publicly funded and administered health insurance plans, and these plans are, unofficially, collectively referred to as “Medicare.”

**The Role of the Private Sector in Canadian Health Care**

The principles set out in the Act mandate significant government involvement in health care. But, does that mean that the private sector is entirely excluded from this industry? The answer is, unequivocally, no. In fact, as described below, the private sector plays an
important role in the delivery and even, to some extent, the financing of health care services.

**Delivery of Health Services**

It is important to note that the Act focuses on the *funding* of health care; it is silent on the issue of *delivery* of such services. It “does not prevent private, or for-profit, providers from delivering and being reimbursed for publicly insured health services, so long as private payment by patients (through user charges and extra-billing) is not involved.”

Accordingly, the Canadian system is one in which government funds the majority of health care services, through Medicare, while the private sector is primarily responsible for the *delivery* of these services on either a for-profit or a not-for-profit basis.

For example, Medicare is coverage for insured services provided by physicians or at hospitals. But physicians are not employed by the government and instead generally operate privately on a for-profit basis. Further, even though physicians bill the government, not the patient, on a fee-for-service basis when providing services covered by Medicare, they “enjoy clinical autonomy, *i.e.* they are largely free to determine what services to supply to which patients and at what time.”

In addition, due to advancements in medical technology, many diagnostic and even some surgical procedures formerly performed in hospitals are now being delivered in private clinics, though the approach taken to such clinics varies across the country. In Ontario, private clinics can apply to the provincial government, pursuant to the *Independent Health Facilities Act* [IHFA], for a licence to deliver certain diagnostic or surgical services outside of a hospital setting. At these private clinics, physicians providing medically necessary services receive compensation through the Ontario Health Insurance Plan “fee for service” structure. Further, since these procedures are either complex or too costly to perform outside of hospitals without the support of a hospital global budget, the IHFA permits the Ontario Minister of Health and Long-Term Care or another “prescribed person” to provide owners of the clinics with funding for the operating costs of the clinic.

Generally speaking, even public hospitals in Canada, though heavily dependent on government funding, have historically been privately governed, usually through not-for-profit corporations (often linked to religious or charitable organizations) with management being overseen by a board of directors independent from the government. That said, while this model still applies in some jurisdictions, in others, hospital boards have now been abolished, and hospital operations are instead under the control of regional or provincial health authorities.

It is important to note, however, that while these various providers are technically part of the private sector, they are not operating in a purely “private” manner since they are still subject to significant regulation from the government. For example, physicians who bill to Medicare do not determine the amount to charge for the insured services but instead are limited to charging the fees that have been approved by the government authority funding the service. With respect to public hospitals, even where they are “privately” owned, the relevant provincial or territorial government is still heavily involved in their governance and operations and can even have legislative authority to appoint a supervisor to take over all responsibilities of the hospital’s board if deemed to be in the public interest. In fact, the close relationship between the government and public (but privately governed) hospitals was clearly
brought into focus when the Supreme Court of Canada, in a decision about whether a Canadian hospital was required to fund translation services for deaf patients, determined that the hospital’s activities in this regard were sufficiently “governmental” in nature to attract scrutiny pursuant to the Canadian Charter of Rights and Freedoms.  

There are some limited situations in which the government does directly administer health services. For example, both the federal and provincial/territorial levels of government are responsible for protecting and promoting “public health,” which is an effort to “respond to threats that have no regard for international or provincial boundaries.” These entities are involved in matters such as the prevention and control of infectious diseases, immunization, and water sanitation. The federal government is also responsible for ensuring delivery of care to Canada’s First Nations communities.

**Funding of Health Services**

Medicare is funded by the federal and provincial/territorial governments. So what role does the private sector play, if any, in the funding of health care services in Canada? It has been said of Canada “[a]cross the country, private insurance starts, for those who can afford it and who are not otherwise excluded, where government funding ends.” In other words, once a health care service is outside the scope of the public insurance system, the various restrictions on funding set out in the Act (and the related provincial/territorial legislation giving effect to same) do not apply. The private sector can deliver these services at market rates, and private insurance can be used without restriction. Therefore, any discussion about the role of the private sector in funding health care services must start with an assessment of where Medicare “ends.”

**The Limits of Government Funding**

Medicare does not cover all health-related services. There are a variety of ways in which a service can be outside the public insurance system.

**Not a Service Provided in a Hospital or by a Physician**

The Act speaks just to those health services that are provided by physicians or in hospitals. There are many health services that do not fall into either of these categories, such as vision care, ambulance services, home care, podiatry, psychology services, and chiropractic care, as well as pharmaceuticals and dentistry services provided outside hospitals. The Act does not apply to such services, and, therefore, the provinces/territories are not required to cover such services through their respective insurance plans in order to receive federal funding (though in some cases they choose to cover some of these services in any event).

**Excluded Services**

Even where a service is provided in a hospital or by a physician, it still may not be covered by Medicare, as only “medically necessary” hospital services and “medically required” physician services are covered by the Act.

The Act does not define “medically necessary” or “medically required,” which means the provincial and territorial governments have significant discretion in determining what should, and should not, be covered by their respective insurance plans. Typically the provincial/territorial governments will determine which services should be eligible for public funding through consultation with their respective medical associations. Although there are some discrepancies between the jurisdictions regarding which health services are covered, examples of health services **typically**
not considered medically necessary include most cosmetic surgery, telephone advice, experimental treatments, circumcision of newborns, fertility treatments, and semi-private or private accommodations (as compared to ward accommodation) in a hospital.

Further, in certain circumstances, services which would otherwise be considered medically necessary are excluded from coverage due to the circumstances in which they arose. For example, in the Act, “insured health services” is defined as “hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers’ or workmen’s compensation” [emphasis added]. Accordingly, if a health service is provided as a result of workplace injury, it is the provincial or territorial worker’s compensation insurance that will fund the associated costs, not Medicare. As another example, in Ontario, any assessment or examination, such as an MRI, relating to an injury arising out of a motor vehicle accident is excluded from coverage under OHIP. Instead, the motorist’s insurance company funds the costs.

Private Insurance

If a health service does not qualify for coverage under the Medicare plans, then a patient must fund the related costs personally or through private insurance. Contrary to popular belief, private funding for health care services (i.e., by patients or private insurers) is not expressly prohibited in the Act. Therefore, a privately paid-for service will not, in and of itself, contravene any provision of the Act. But the legislative framework in Canada, taken as a whole, does limit the potential for private funding of health care services to situations where the service at issue is not eligible for Medicare.

Services Eligible for Medicare

The Act does not prevent physicians from “opting out” of the provincial or territorial health insurance plan and receiving payment personally from patients. At the provincial or territorial level, some governments have effectively prohibited this practice, while others have not. Therefore, in theory, a provider could, in certain jurisdictions, elect not to accept funds from the public system and then instead charge patients for medically necessary services without any of the limitations imposed by the public insurance scheme on fees. But “[i]n practice, few physicians leave the public system because it is hard to attract a sufficient number of patients who want to pay full health care costs when they also have access to the public system.”

If, however, the costs for medically necessary services could be shifted from the patient to a private insurer, providers might be more likely to opt out of the public system. This could, in theory, raise access issues for the public system. Some believe that if a large number of providers decide to operate outside of Medicare and instead receive funding through private sources, this could lead to a shortage of providers in the public system.

Under the current legislative framework

[private insurance for medically necessary services is discouraged, by both federal and provincial legislation. The Canada Health Act requires provincial health care insurance plans to be accountable to the provincial government and to be non-profit, thereby effectively preventing private insurance plans from covering medically required services.]

Furthermore, certain provinces, including British Columbia, Alberta, and Ontario, go even further by expressly prohibiting the use of
private insurance for services eligible for Medicare.

Quebec formerly had an absolute prohibition on private insurance for such services, but there was a successful court challenge to it in Chaoulli v. Quebec (Attorney General) on constitutional grounds. In this decision, Madam Justice Marie Deschamps, writing for the majority of the Supreme Court of Canada, stated:

Even if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system’s integrity.

To date, this decision (released in 2005) has not had the far-reaching effect that was initially expected. As such, generally speaking, private insurance is still not available for services eligible for Medicare coverage. That said, there are legal challenges currently working their way through the courts that are very similar to the Chaoulli case, so this is still very much a live issue.

Services Not Eligible for Medicare

Any services outside of Medicare have to be funded by the patient either out of their pocket or through private insurance. Private, for-profit clinics exist in Canada to provide health services that fall outside of Medicare. For example, there are private clinics in Canada that provide services to injured workers or members of the armed forces as well as to patients who are willing to pay out of pocket for faster access to a diagnostic procedure than is deemed “medically necessary.”

The various restrictions in the public insurance scheme regarding fees do not apply outside of that context, so providers are free to determine the fees for their services without legislative restriction. Unlike the scenario discussed above, in which private insurance for Medicare services is severely restricted by government action, private insurance for non-Medicare services is commonplace in Canada. Many Canadians, often through their employment, have private insurance for health care services, such as prescription drugs, dental care, vision care, medical equipment and appliances, paramedical services, chiropractic services, and massage therapy.

Opportunities for the Private Sector in Canadian Health Care

Even in Canada’s “public” health care system, there are many opportunities for the private sector—predominantly, in the realm of delivery of services but also, to some extent, in funding. Between the current trend towards delisting services historically covered by Medicare—resulting in more and more services falling outside the scope of the public insurance system—and the various legal challenges underway to prohibitions on private insurance for publicly insured services, there is reason to believe that opportunities for the private sector in health care will only increase with time.

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1 The Constitution Act, 1867 (UK), 30 & 31 Victoria, c 3.
3 Ibid., s. 3.
4 Ibid., ss. 7–12.
5 The definition of “insured persons” set out in the Act is defined at s. 2 as residents of the province, with the
exception of members of the Canadian Forces and prisoners, who receive coverage from the federal government through separate federal programs. As well, the Act excludes from coverage those residents who have not completed the prescribed minimum period of residence or waiting period for entitlement to insured health services.

The “surgical-dental services” referred to in the Act must be performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures. Since such procedures are not common, in this article, the focus will just be on hospital services and physician services.

Act, supra note 2, s. 2.
Ibid.
Ibid., s. 15(1).

For example, the Kensington Eye Institute in Ontario is a not-for-profit private corporation that specializes in eye surgery, such as cataract surgery, glaucoma surgery, retina surgery and corneal transplants. Kensington has been licensed by the Ontario Ministry of Health and Long-Term Care as an Independent Health Facility pursuant to the IHFA.

IHFA contemplates IHFs being either for-profit or not-for-profit entities, the government currently in place in Ontario has demonstrated a preference for such clinics to be not-for-profit.
R.R.O. 1990, Reg. 552, s. 24(1) 8.2.
For example, see Alberta, Nova Scotia, and New Brunswick.
See e.g., the Ontario Public Hospitals Act, R.S.O. 1990, c. P.40, s. 9.
Ibid. at 14.

As described by Health Canada: “Provinces and territories may also offer "additional benefits" under their respective health insurance plans, funded and delivered on their own terms and conditions. These benefits are often targeted to specific population groups (e.g. children, seniors, social assistance recipients), and may be partially or fully covered. While these services vary across different provinces and territories, examples include prescription drugs, dental care, optometric, chiropractic, and ambulance services”. Health Canada, “Canada Health Act - Frequently Asked Questions” (19 August 2011), online: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/faq-eng.php#i3

Flood, supra note 11 at 22.

Except for in the province of Quebec, though according to a recent report, the Quebec Health Minister is currently reviewing this policy: “Health Minister Considers Changes to IVF Spending,” CTV News, May 14, 2013, <http://montreal.ctvnews.ca/health-minister-considers-changes-to-ivf-spending-1.1281930>.

Act, supra note 2, s. 2.

Supra note 15.

But see discussion below regarding Chaoulli v. Quebec (Attorney General), infra note 32.

For example, Ontario, through the Commitment to the Future of Medicare Act, 2004, S.O. 2004, c. 5, s. 10.3.

For example, British Columbia, through the Medicare Protection Act, R.S.B.C. 1996, c. 286.


Ibid.
Ibid., para. 74.

• CHALLENGES FACED BY HOSPITALS WHEN DETERMINING WHEN AND WHAT TO CHARGE PATIENTS •

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Hospitals face the challenge of providing appropriate care to the communities they serve while balancing the ever-increasing costs associated with providing that care. At the same time as some hospitals are finding their operational and capital funding to be insufficient, new technologies are driving up costs and putting pressure on the already strained global budgets of hospitals. Hospitals are grappling to determine whether such new advanced surgical supplies, equipment, and services are insured services and therefore must be funded through their global budget or whether patients can be charged directly for the associated costs.

This article explores some of the legal issues that arise when hospitals try to determine whether the services or supplies provided are insured and therefore cannot be charged to patients. Hospitals are, understandably, looking for opportunities to reduce their costs and earn additional revenue by providing and charging for uninsured services. The following questions are discussed below: first, can patients be charged for enhanced or improved supplies, or are hospitals required to provide all supplies at no charge? Second, if patients can be charged, does it have to be on a cost-recovery basis? The article uses the Ontario legislative framework governing insured services to highlight the legal complexities hospitals face when seeking revenue-generating opportunities, but the broad legal issues are relevant throughout Canada. Determining whether equipment, a supply, or service is insured can require consideration of intricate legislative and policy questions. It would be impossible to provide a comprehensive analysis of all of the potentially insured and uninsured services in this article. Hospitals seeking to generate ancillary revenue or reduce the costs that must be funded from their global budget should conduct an in-depth legal and policy analysis before charging patients for specific services or supplies. Such an analysis will be fact and situation driven and must take into account the specific service or supply and the circumstances surrounding its provision.

Legislative Funding Framework

Government funding of Canada’s health care system is shared between federal and provincial governments, but it is the individual provinces that are responsible for the management and delivery of health services, including determining which services will be funded by the provincial government (i.e., which services will be “insured”).

The majority of spending on Canadian health care is public spending. According to the Canadian Institute for Health Information:

- Provincial and territorial government spending on health accounted for 65.2% of total health expenditure in 2010. Another 5.3% came from other parts of the public sector: federal direct government, municipal government and social security funds. The private sector was made up of three spending categories, the largest of which was out-of-pocket spending (14.5%), followed by private health insurance (11.7%) and non-consumption, which accounted for 3.3% of total health spending.

Although hospital spending as a share of the total amount of spending on health has been decreasing, hospital spending still accounts for a large share of health spending. In 2010, this amounted to $56.3 billion representing 29.1 per cent of total health expenditure. Almost 90 per cent of the funding for that spending came from provincial and territorial governments.
The Constitution Act 1867 at s. 92(7) gives to the provinces the exclusive authority to make and administer laws for the “Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.”

The overarching legislation related to federal funding of health care is the Canada Health Act [CHA] that governs the funding relationship between the federal and provincial governments.

The CHA contains the following definition of “insured health services”:

“insured health services” means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers’ or workmen’s compensation [emphasis added].

The CHA defines hospital services as:

any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,
(b) nursing service,
(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,
(d) drugs, biologicals and related preparations when administered in the hospital,
(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
(f) medical and surgical equipment and supplies,
(g) use of radiotherapy facilities,
(h) use of physiotherapy facilities, and
(i) services provided by persons who receive remuneration therefor from the hospital

Publicly funded health care services include physician services and medical care in hospitals and the funding of the corresponding requisite medical and surgical equipment and supplies. The definitions of “hospital services” and “physician services” in the CHA refer to the provision of such services by a hospital or physician that are “medically required.” However, the CHA does not define what is meant by “medically required,” and this has been left to the provinces to determine.

The vagueness of the phrase “medical necessity” combined with the fact that the provincial governments determine what will be included in the Fee Schedule and how much will be paid for each inclusion, based on negotiations with physicians, leads to disparity between the provinces. Health care services listed in the Fee Schedule and considered to be insured or medically necessary in one province may not necessarily be such in another province.

As William Lahey points out in the text Canadian Health Law and Policy:

Federal acceptance of different answers to the question of what is medically necessary would seem to mean either the application of a variable standard across provinces or the consistent application of the lowest common denominator that is not mentioned in the Act [the CHA].

Each province administers its health insurance plan within its territory in accordance with the general framework and the prescribed provincial obligations established by the CHA. The CHA stipulates that in order for a provincial government to receive the “full cash contribution” from the federal government, the province must establish a health care insurance plan that meets specified criteria of (1) public administration, (2) comprehensiveness, (3) universality, (4) portability, and (5) accessibility in respect of all insured health services. The provinces then fund physician and hospital services through a combination of their own revenue and the cash and tax transfers they receive from the federal government. It is the
“comprehensiveness” criterion that requires provinces to fund all of the insured services provided in hospitals. Provinces generally fund hospitals by providing hospitals with an allocated global operating budget.\(^\text{10}\)

The *CHA* does not create any offences, and no one can be charged with violating the *CHA*. The federal government’s only enforcement mechanism under the *CHA* is the authority to withhold all or part of the federal government’s cash contribution.

In most provinces in Canada, the provincial government has implemented some sort of regionalization structure that gives a responsibility for distribution of health care funding within a specific region of the province in order to provide some administrative centralization to the delivery of health care. In Ontario, Local Health Integration Networks (LHNs) receive funding from the Ministry of Health and Long-Term Care (the “Ministry”) and are responsible for co-ordinating care and funding for hospitals within their geographical region. A hospital’s global budget will be determined by the LHIN from, among other things, the services it provides, the demographics of the patients within its geographic region, the funding it received in the previous year, and the total funding available to the LHIN from the Ministry. As such, it is the LHIN, not the individual hospitals themselves, that has responsibility for determining the amount of funding each hospital within its geographic region will receive.

**Health Insurance Act and Commitment to the Future of Medicare Act**

Every Canadian province has a health insurance act and a health insurance plan. In Ontario, the Ontario Health Insurance Plan (OHIP) is governed by the *Health Insurance Act [HIA]\(^\text{11}\)* and any regulations made under the *HIA*.

Section 12 of the *HIA* provides that every insured person is entitled to payment for insured services in the amounts and subject to any conditions and co-payments that are prescribed in the regulations. Subsection 11.2(1) of the *HIA* sets out the following services that are insured services for the purpose of the *HIA*:

1. Prescribed services of hospitals and health facilitates rendered under such conditions and limitations as may be prescribed.
2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed.\(^\text{12}\)

Section 7 of the General Regulation under the *HIA* (the “Regulation”)\(^\text{13}\) provides that insured persons are entitled without charge to certain defined “in-patient services”:

1. Accommodation and meals at the standard or public ward level.
2. Necessary nursing service, except for the services of a private duty nurse who is not engaged and paid by the hospital.
3. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.
4. Drugs, biologicals and related preparations that are prescribed by an attending physician, oral and maxillofacial surgeon, midwife or registered nurse in the extended class in accordance with accepted practice and administered in a hospital, but not including any proprietary medicine as defined from time to time by the regulations made under the *Food and Drugs Act* (Canada).
5. Use of operating room, obstetrical delivery room and anaesthetic facilities, including necessary equipment and supplies [emphasis added].\(^\text{14}\)

Section 8 of the Regulation provides that insured persons are entitled without charge to certain defined “out-patient services”:
1. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations.

2. The use of radiotherapy facilities where available in a hospital in Canada when prescribed by a physician.

2.1 The use of occupational therapy and physiotherapy facilities where available in a hospital in Canada when prescribed by a physician or a registered nurse in the extended class.

3. The use of speech therapy facilities where available in a hospital in Canada when prescribed by a physician, by an oral and maxillofacial surgeon or by a registered nurse in the extended class.

4. The use of diet counselling services when prescribed by a physician or a registered nurse in the extended class.

5. The hospital component of all other out-patient services, including the use of an operating room and anaesthetic facilities, surgical supplies, necessary nursing service, meals required during a treatment program and the supplying of drugs, biologicals and related preparations that are prescribed in accordance with accepted practice by a physician on the medical staff, a midwife on the midwifery staff, an oral and maxillofacial surgeon on the dental staff or a registered nurse in the extended class on the extended class nursing staff of the hospital and that are administered in the hospital, but not including,

i. the provision of any proprietary medicine as defined from time to time by the regulations made under the Food and Drugs Act (Canada),

ii. the provisions of medications for the patient to take home,

iii. diagnostic services performed to satisfy the requirements of third parties such as employers and insurance companies, and

iv. visits solely for the administration of drugs, vaccines, sera or biological products.

6. Use of home renal dialysis medications where available in a hospital in Canada and prescribed by a physician on the medical staff of that hospital.

6.1 Use of home renal dialysis equipment and supplies where available in a hospital in Canada and prescribed by a physician on the medical staff of that hospital or by a registered nurse in the extended class on the extended class nursing staff of that hospital.

7. Use of home hyperalimentation medications where available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital.

7.1 Use of home hyperalimentation equipment and supplies where available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital or by a registered nurse in the extended class on the extended class nursing staff of that hospital.

8. The provision to haemophiliac patients, for use in the home, of equipment and supplies for the emergency treatment of, or the prevention of, haemorrhage where the equipment and supplies are available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital.

8.1 The provision to haemophiliac patients, for use in the home, of equipment and supplies other than blood products where the equipment and supplies are available in a hospital in Ontario and prescribed by a registered nurse in the extended class on the extended class nursing staff of that hospital [emphasis added].

Subsection 9(1) of the Regulation states that, subject to s. 10 and subs. 11(1), an insured person is entitled to in-patient and out-patient services without charge in a hospital that is listed in Schedule 2 to the Regulation or has been graded as a Group A, B, C, E, F, G, J, or R hospital. The term “in-patient” is defined as a person admitted to and assigned a bed in a hospital in-patient area. The term “out-patient” is defined in the Regulation as “a person who receives out-patient services and is not admitted to an in-patient area.” Although the definition of out-patient is not particularly clear, it would seem that the intention of the Regulation is that “out-patient services” are services that are provided to patients of a hospital who are not admitted as in-patients. Therefore, any in-patient or out-patient of a hospital will be entitled, without charge, to everything as set out in ss. 7 and 8 of the Regulation, including necessary services, equipment, and supplies. As such, these services and supplies must be funded through a hospital’s global budget (or otherwise) and cannot be charged to a patient.

Additionally, subs. 10(5) of the Commitment to the Future of Medicare Act, 2004 [CFMA] provides that no person or entity may charge or
accept payment or other benefit for an insured service rendered to an insured person except as permitted under s. 10 (which does not apply here) or unless permitted to do so by the regulations in certain prescribed circumstances and on certain prescribed conditions. The regulation to the CFMA\(^1\) provides in s. 4 that a hospital may charge or accept payment for private or semi-private accommodation except in certain circumstances and may charge co-payments as permitted under the Regulation to the HIA. An “insured service” for the purposes of the CFMA is defined in s. 8 as an insured service under the HIA. Therefore, no one (including Ontario’s public hospitals) can charge in-patients or out-patients for any services, equipment, or supplies to which the patients are entitled without charge by virtue of the Regulation.

Discussion

Determining whether a specific supply would be considered insured for the purposes of the HIA and the CFMA is one of the challenges facing hospitals and requires a detailed analysis. The HIA does not define the terms “necessary equipment and supplies” used to deliver in-patient services or “surgical supplies” that are a component of out-patient services.\(^1\) Nonetheless, these are the equipment or supplies that are, according to the HIA, publicly funded. As a result, a hospital must cover the costs of the equipment and supplies within its global budget and cannot charge patients (or third-party payors) for them. It is this lack of clarity that causes confusion when hospitals are faced with the decision of whether to pass the costs associated with new, more expensive advanced equipment or supplies onto their patients.

Although, in most instances, it may be safe to assume that standard and customary supplies that have traditionally been insured are considered “necessary” and therefore are insured, this is less obvious when new enhanced or upgraded supplies become available. Ontarians have grown accustomed to being charged when receiving enhanced supplies such as aircast walking braces or fibreglass casts instead of traditional plaster casts. The author is not aware of these practices being challenged by the Ministry. Further, neither the Ministry nor OHIP has issued any guidelines or policy statements as to how a determination of necessity is to be made in the case of supplies.

Laurel Montrose, in her book Medicare in Ontario: A Legal Reference Guide has written as follows:

> [the medical necessity requirement used in section 11.1 of the Health Insurance Act is interpreted as referring to a specific service in a specific patient’s circumstances, rather than referring to a generic test.\(^1\)]

Although the Ministry has no published criteria or policies, some evidence of how it may judge whether equipment or supplies are “necessary” may be drawn from Ministry correspondence and the single OHIP bulletin regarding billing patients for intraocular lenses for cataract surgery.\(^2\) This bulletin stated that when a foldable or rigid intraocular lens was implanted in conjunction with a surgical cataract extraction performed in a hospital or certain other locations, the provision of the lens [was] part of the insured service and its cost [could] not be billed to the patient. Hospitals or physicians [could] not bill patients for the difference in cost between the foldable and rigid lenses.

This is because the foldable lens was found by the Ministry to provide tangible medical benefit.\(^2\)

In 2007, the Assistant Deputy Minister of Health sent a memorandum to all hospital CEOs entitled Cataract Surgery Conditionality 2007/08. In the memorandum, he stated:

> Cataract surgery as funded by the Wait Time Strategy includes the insertion of a foldable lens implant, which is to be provided to the patient free of charge by the institution in which the surgery is performed. If a patient
elects to have an added feature lens, the institution may provide such a lens to the patient with the patient paying the difference in the cost between the standard and added feature lens directly to the institution. In such a circumstance, written documentation of the discussion regarding lens options and informed consent must be retained on the patient’s chart. There should be no additional fees charged to the patients for this discussion as well as the lens implantation—both considered to be insured services under OHIP.22

The above memorandum demonstrates the Ministry’s view that intraocular lenses that also provide better refractive results (e.g., implants that correct presbyopia or astigmatism) do not provide a medical benefit, merely a “lifestyle” benefit, and therefore, this implant is not a necessary supply. As such, a hospital may provide such a lens to a patient at a charge. However, the hospital may only charge the patient the difference in the cost between the standard (foldable) and the upgraded lens. By analogy, if a supply provides only a lifestyle benefit, it seems the supply will likely not be considered necessary, and a hospital may charge a patient for the upgraded supply.23

Unfortunately, the Ministry documents relating to intraocular lens implants appear to be the only bulletins that the Ministry has issued with regard to “upgraded” or “enhanced” supplies. Therefore, they offer the only guidance as to how the Ministry may determine in future whether an upgraded supply is a “necessary” supply. When dealing with questions about specific equipment and supplies, hospitals may have regard to the principles outlined in these bulletins; however, in the absence of a bulletin regarding a specific supply in which a hospital is interested, the bulletins cannot be viewed as definitively articulating the Ministry’s view. Further, as Montrose noted, the definition of medical necessity depends on the specific circumstances of specific patients. A survey of available decisions of the Health Services Appeal and Review Board (HSARB) show the central issue considered by the HSARB was whether a particular service qualified as an “insured” service. The few cases available are heavily focused in terms of the specifics of each case and do not include an objective list of criteria to be considered before rendering a decision about whether a service was necessary; more often than not, the decision hinged on whether a particular service was listed in the OHIP Schedule of Benefits.24

Other Sources of Ancillary Revenue

Along with non-insured services that hospitals (or their foundations) have traditionally turned to in order to augment the funding received from government, such as parking operations, coffee shops, and gift shops, hospitals are beginning to offer to patients, at a charge, complementary uninsured health services. These are services that are not insured services in any instance and that include such things as (1) emergency response systems that will detect if a subscriber of its services is in distress and needs emergency medical care, (2) chiropractic care, and (3) orthotics and chiropody services. Because these types of services are not insured, hospitals can be confident that they may charge patients directly for these services. However, some hospitals are leveraging their existing insured services to expand the services provided by the hospital to include additional services for a fee. For example, a hospital may already have in place a Botulinum Toxin (“Botox”) clinic to provide Botox for insured services (such as cleft palate repair) and then expand the clinic’s service offerings to include non-insured services such as cosmetic Botox injections. Some hospitals that provide physiotherapy and occupational therapy services to in-patients and out-patients (an insured service) have begun to offer physiotherapy and occupational therapy services for a fee to patients who are neither in-patients nor out-patients of the hospital.
Before a hospital decides to expand the services it offers, it should ensure that the circumstances in which the services will be offered and the individuals to whom it will be offering the services will not create a circumstance where the services are in fact insured services. Charging non-hospital patients for services that are insured in some circumstances requires careful consideration of a number of factors. A hospital must determine whether the patients who will receive the services fall under the definition of either in-patient or out-patient. If so, are the services to be offered insured hospital services? If the answer to both questions is yes, hospitals will likely not be able to charge individuals for these services. If the answer to either question is no, hospitals will likely be able to charge for the services.

Although these questions sound simple, determining under what circumstances individuals are in-patients or out-patients and determining which specific services are insured can be complex. Prior to expanding the service offerings provided by a hospital, the hospital should undertake a comprehensive analysis of which services will be offered to which patients and the context of the delivery of the services.

**Cost Recovery or Mark-up?**

If a hospital determines or is confident that a supply falls outside of the insured regime and, therefore, that it can charge a patient for an upgraded or enhanced supply, the hospital will have to determine how much it will charge the patient. Can the hospital charge the full cost of the supply? Can the hospital charge a mark-up over and above the cost, thereby earning revenue from the enhanced supply? Or must the hospital charge the patient merely the difference in the cost between the standard insured supply and the enhanced supply. In its bulletins and correspondence related to upgraded intraocular lens implants, the Ministry was clear that hospitals or physicians were only to charge the difference in the cost between the standard foldable intraocular lens and the enhanced upgraded intraocular lens. However, as discussed earlier, the Ministry has not produced any other bulletins or policy statements with respect to enhanced supplies, so it is difficult to know whether this policy would apply for all enhanced supplies or whether it is specific to this one instance. It seems unlikely that hospitals are charging patients the difference in cost between a plaster cast and a fibreglass cast, given the difficulty in making an accurate cost analysis. Further, although this is the stated Ministry policy with respect to intraocular lenses, it is unclear where the Ministry derives the authority to stipulate that such charges for enhanced intraocular lenses must be restricted to cost recovery.

**Conclusion**

As stated in the opening of this article, technological advances are leading to more expensive and advanced equipment and supplies being available for treating patients. However, such improved equipment and supplies often come with much greater costs than traditional or current equipment or supplies. As hospitals explore whether there are opportunities to pass those additional costs on to patients (or their third-party insurers) directly instead of paying for them out of already strained global budgets or whether there are opportunities to generate ancillary revenue, the legal framework for the funding of insured services must be considered. This environment, while creating new ways to earn revenue and stretch funding dollars as far as possible, can also create legal pitfalls. As can be seen from the discussion above, when hospitals attempt to determine which services are definitively insured services and which may be services or supplies that fall outside the insured funding framework, there are complex
legal issues to be considered requiring a specific, fact-driven analysis.

All of this leads to the question of whether hospitals (or anyone else for that matter) should be charging patients for enhanced or upgraded supplies or patients, under our universal insured system, should be entitled to all surgical supplies provided in hospital. Does charging patients directly for the costs of more advanced or superior supplies create a two-tier health care system, or is it just one more contribution to the two-tier system that already exists? Examples supporting the assertion that a two-tier system exists include the fact that (1) patients can pay a fee and be accommodated during their hospital stay in a private room (instead of at the public ward level), (2) patients who require casts can pay an upgrade to get the fiberglass casts instead of plaster casts, and (3) patients undergoing cataract surgery can purchase added-feature intraocular lenses that correct for presbyopia and astigmatism instead of standard intraocular lenses. As technology advances, it is reasonable to assume that more and more such enhanced products will be available and that hospitals will have to decide whether to absorb those costs as part of their global budgets or pass those costs along to the patients. Does our universal health care system mean that patients are entitled to the best health care available, or does it mean that insured persons are entitled to quality health care but that patients with the ability to pay can receive better or different health care? Hospitals will want to take into account when deciding whether to charge patients for enhanced equipment, supplies, or additional services that there is a risk that the hospital would be viewed as charging patients for services or supplies that the public may see as necessary regardless of whether the services or supplies are actually insured. This is a reputational risk, not a legal one, and each hospital will have to make its own assessment in any given situation.

[Editor’s note: Cathi Mietkiewicz is an associate in the Fasken Martineau DuMoulin’s Health Law Practice Group and Business Law Section. She has a practice that focuses on advising clients regarding general corporate and commercial matters, corporate governance, and regulatory compliance and disciplinary matters.]

1 The rules governing the circumstances in which patients may be charged for drugs are even more complex than the rules surrounding supplies, and they may differ according to which drug is involved and in what circumstance. A discussion of the drugs funding is outside the scope of this article.
2 “Non-consumption expenditure includes a number of heterogeneous components, such as hospital non-patient revenue, capital expenditures for privately owned facilities and health research.”
4 Ibid. at 42.
5 The Constitution Act, 1867 (UK), 30 & 31 Victoria, c 3, s. 92(7).
7 Ibid., s. 2.
8 Jocelyn Downie, Timothy Caulfield, and Colleen M. Flood, eds., Canadian Health Law and Policy. 4th ed. (Markham, ON: LexisNexis Canada, 2011), 40.
9 “Cash contribution” means the cash contribution in respect of the Canada Health Transfer that may be provided to a province under ss. 24.2 and 24.21 of the Federal-Provincial Fiscal Arrangements Act, R.S.C. 1985, c. F-8.
10 In certain circumstances, provincial governments may provide additional funding in addition to a hospital’s global budget for specific health care services.
12 Note that “prescribed” is defined in s. 1 of the HIA as “prescribed by the regulations.”
14 “In-patient” is defined in the Regulation, s. 1, as “a person admitted to and assigned a bed in a hospital in-patient area”.
15 “Out-patient” is defined in the Regulation as “a person who receives out-patient services and is not admitted to an in-patient area.”
17 General, O. Reg. 288/04.
18 It is interesting to note that the Regulation states that the equipment and supplies to which in-patients are entitled must be “necessary” but does not place this same requirement on surgical supplies for out-patients in order to be insured. Nonetheless, it seems unlikely that it is the intent of the Regulation that in-patients are only insured for medically necessary supplies but that out-patients are insured regardless of whether a supply is necessary.


21 The fact that a foldable lens requires a smaller incision results in less post-operative pain, fewer restrictions on post-operative activities, and more rapid visual recovery: all these were considered by the Ministry when determining if the foldable intra-ocular lens provided a medical benefit.

22 An “added-feature” lens could include intraocular lenses that correct for presbyopia or astigmatism or both.

23 In 2010, the Ministry released *Info Bulletin 4521* that confirmed the view of the Ministry that patients may be charged only the difference in cost between the medically necessary lens and the upgraded lens.

24 The HSARB cases all involved patients and fees charged by individual practitioners to provide specific services to the patient; none of the cases considered costs for equipment or supplies.

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