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News

by Kevin Wilson

Physician, regulate thyself

Can private-sector doctors be the guardians of public health care?

No problem, say your health authority and the provincial government.

Every so often, Dr. Peter Huang receives a letter from Dr. Peter Huang.

Letter *recipient* Peter T. Huang is a Calgary ophthalmologist. He and his brothers hold shares in Enterprise Universal, a private company contracted by the Calgary Regional Health Authority to provide eye, nose, throat and foot services.

Letter *sender* Peter T. Huang is the Calgary Regional Health Authority's division chief for ophthalmology. In the missives, he advises himself of the number of cataract surgeries that he has been allocated, according to a scheme that he himself introduced.

Some might think it difficult for Dr. Peter Huang, public official, to avoid being influenced by the concerns of Dr. Peter Huang, businessman.

Some critics argue that it's not only difficult for Dr. Huang and some of his colleagues to avoid conflicts of interest – it's impossible. At least one important independent observer of Alberta's health-care system – the province's auditor general – shares some of their concern.

Doubling up to save health care

Albertans are used to being on the cutting edge of experiments with the Canadian health-care system, experiments ostensibly organized to prevent the collapse of that system under its own financial weight. Their provincial government has gone further than any other to promote the idea that financial savings can be realized through judicious use of private service-providers. So Albertans aren't surprised when their premier announces, as he did earlier this month, that he plans to further challenge the interpretation of the Canada Health Act, based on the recommendations of the as-yet-unreleased Mazankowski report.

Citizens of the province are also growing used to their health-care system being a work in progress, one that reflects enthusiasm for immediate

change more often than it does caution. In the new world of medical services, for example, doctors who run their own medical businesses are being asked to lend their expertise to the running of Alberta's regional health boards, despite the potential for private interest to come into conflict with the public good.

The result, says Liberal health critic Kevin Taft, is that, particularly in Calgary, "There's certainly all the appearances and – I will say bluntly – the reality of conflict of interest." Moreover, he says, the situation is putting into senior management those who have "motivations that steer the health-care system toward a for-profit model."

Private maverick, public guardian?

His professional accomplishments notwithstanding, Peter Huang seems an odd choice to oversee the ophthalmology division of the Calgary Regional Health Authority, a position that seems to call for a certain amount of dispassionate objectivity. What gives one pause is not just his ownership of a private health company that does business with his public-sector employer; it's that in the battle to advance private-sector involvement in the provision of health care, Huang has positioned himself in the vanguard.

In 1995, as the provincial and federal governments wrangled over facility fees, Huang's clinic was chosen to perform all eye surgery for Calgary's Foothills Hospital as part of a pilot project, a possible "foundation for the future," one official said. (The Huang family has something of a habit of being on the scene when health-care history is made in Alberta. When Premier Ralph Klein casually revealed to a party convention in 1999 that his Tory caucus had decided to approve private surgery clinics, it came in reply to a question from Huang's brother John, who has served as a vice-president for the Calgary Varsity Progressive Conservative Association.)

Huang experienced a setback in 1996, however, when his subsequent bid to gobble up Calgary's eye surgery business was one of two rejected by the CRHA. Both failed bids took the interests of the city's other ophthalmologists insufficiently into account – "A strong sense of inclusion was missing," as the CRHA's chief executive put it.

The doctor had a better year in 1998, when he acquired the recently decommissioned Holy Cross Hospital from the CRHA and turned it into a private surgical clinic. In that same year, newly appointed as the CRHA's eye surgery division head, Huang instituted a plan to withhold 20 per cent of the cataract surgeries allocated to each of the city's clinicians. Twice a year, each doctor could earn back 10 per cent of the withheld cases if he or she could demonstrate service to the medical community via teaching or other work during the previous six months.

Opposition politicians from both the Liberal and the New Democrat parties

charged that this represented a conflict of interest since, they claimed, Huang stood to benefit from the reallocation via his Holy Cross operation.

Huang vehemently rejected the charge of conflict of interest. "I take real offense to the suggestion I'm doing all these things to benefit myself," he told the *Calgary Herald*, pointing out that he would not sit on the committee that determined how the cases would be reallocated. He also told the *Herald* that even if the city's two top ophthalmologists lost 20 per cent of their business, they would still see three or four times the number of patients treated by their colleagues; he claimed, in fact, to be correcting an imbalance that many of his fellow ophthalmologists found unfair.

The argument carries curious resonance today. In September 2000, Minister of Health and Wellness Gary Mar released a report outlining the rationale behind the issuance of contracts to private clinics. In that report, he revealed that the CRHA contracted ophthalmic work worth \$5 million to five Calgary providers. Four of those were issued contracts worth from \$370,000 to \$870,000. The fifth provider received contracts worth \$2.5 million, half of the total amount issued by CRHA. That provider was Holy Cross Surgical, co-owned by Peter Huang, the CRHA's division head for ophthalmology.

Not alone

The Huang case worries Kevin Taft.

"The essential concern I have," he says, "is that, particularly in Calgary, there are some senior officials within the public system who are on the public payroll who are also very closely tied as shareholders or directors of for-profit companies or who have immediate family members in those positions – companies that provide or want to provide health services in the region." These sorts of relationships wouldn't be tolerated in the private sector or in other ministries, he says, citing the hypothetical example of a roadbuilder trying to work for the Department of Transportation.

In a report prepared for two labour groups prior to his election to the legislature, Taft outlined the basis for concern when medical business owners works for health authorities:

n They "owe a fiduciary trust to both organizations," but "the interests of the organizations may be in basic conflict: the objective of the for-profit clinic is to maximize profits [...] while the objective of [the authority] is to provide necessary services at the lowest cost."

n They may have the opportunity to influence decision-making directly or indirectly.

n They have access to inside information.

Among the physicians whom critics suggest may have been in a position to benefit from their public posts:

n Dr. Kabir Jivrai, CRHA's vice-president and chief medical officer, holds shares in Surgical Centres, Inc., which has three contracts with CRHA. (Jivrai's shares are currently held in trust.)

n Dr. Stephen Miller held shares and worked for Health Resource Group, which sought contracts with CRHA, while he had some responsibility for orthopedics in the region.

n Edmonton radiologist Bill Anderson is both part-owner of Medical Imaging Consultants, which is contracted to do MRI work for CHA, and is CHA's director of diagnostic imaging. He came under scrutiny earlier this year because he appointed the officials who determined which patients would get refunds from the province for MRIs done at private facilities.

In the latter case, CHA spokesman Steve Buick was emphatic. Not only was there no conflict of interest, he told the *Edmonton Journal*, but the notion didn't bear thinking about. "It's an enormous stretch to even suggest there's an appearance of conflict of interest here."

Breaking rules is hard to do

The CRHA's current conflict-of-interest guidelines, similar to those of the CHA, seem fairly unequivocal. "Conflict of interest," it says, "occurs when there is a reasonable perception that the ability to exercise the official duty of a CRHA Officer has, is, or may be affected by the private interests of that Officer as well as family members or close associates of the CRHA Officer. Conflict of interest may be potential, perceived or actual."

The word "reasonable" is open to interpretation. When a conflict is perceived, however, the onus is on the affected official to report the conflict to supervisors for mitigation or resolution of the problem, although strict guidelines aren't spelled out. Neither the CRHA or the CHA has, at this point, any independent monitoring of conflict-of-interest situations.

Dr. James Gaa of the University of Alberta's School of Business specializes in business and professional ethics. Sometimes, he says, rules don't get decisively broken because the guidelines they impose are too flexible. He says that people tend to look simply at whether there's been a breach of the law. "In other words, is there anything within the health ministry's regulations to prevent people from doing this? If there aren't any specific rules, then they'll say there's no problem. But of course that doesn't mean there's no problem, it just means that there's no illegality. That doesn't mean there's no impropriety."

Having administrators appoint managers to make decisions isn't a

satisfactory way to insulate oneself from the appearance of conflict, since the managers know who appointed them. Self-reporting can be a workable solution only if the guidelines are clear enough, Gaa says.

Sometimes, he says, "A member of the board's welfare can be increased at the expense of other people and the chance of that happening is sufficiently high that we just want to safeguard ourselves by not allowing this sort of situation to exist."

"In this sort of situation," he says, "it puzzles me how a person can be getting these contracts and successfully convincing people that there's no problem."

Who needs them anyhow?

It's often assumed that it's necessary for medical businessmen to be involved at the highest levels of health authorities. In defending Anderson's role as CHA's diagnostic imaging director, CHA spokesman Steve Buick said "We have to rely on the advice of a professional like Bill Anderson in terms of when MRI services are appropriate."

Journalist Gillian Steward says it isn't so. "If you really have to contract out, which in itself is questionable, there's certainly a way of setting it up so that people in positions of influence – whether it's the chief medical officer or the head of ophthalmology or the head of orthopedics in a major hospital – can't take advantage of those positions."

Assuming that contracting out is unavoidable, Steward says that there are three ways to safeguard the public system. The first is to have officers put his private holdings in a blind trust or to divest them. "And that certainly happens in the private sector," says Steward. "People have to divest themselves if there's a conflict."

The second solution would require that regional authorities enter into contracts only with companies and doctors who have no public role. Doctors with private clinics, who take public posts, would forfeit their company's right to bid for contracts in that region.

The third solution would be to hire as public administrators only those doctors who work entirely in the public system.

The conflict for doctors embracing both sectors is easy to explain, says Steward: "What comes first: your responsibility to the public or your responsibility to your business partners to make sure your business makes money?"

"I just think if you're going to have a place as an officer of a regional health authority, it has to be clear who you're working for."

Alberta's Department of Health: teeth and will?

In addition to criticizing the Department of Health and Welfare's business and reporting practices – for its continuing failure to file business plans in timely fashion, for example – the auditor general called for the regional health authorities to expand those who are obliged to report their private holdings and to implement independent supervision of conflict cases.

The Minister has made a commitment to revisiting the conflict guidelines. (Taft wonders why the Health Authorities were each allowed to make their own conflict-of-interest guidelines when other provincial agencies fall under provincewide legislation.)

But how quickly will new guidelines be implemented? And will new conflict-of-interest rules be tough enough to satisfy critics?

Gaa warns that until stringent and unequivocal guidelines have been put in place, Albertans should have serious reservations about how their health care is being managed. "I think, particularly to the extent that we seem to be moving toward a system where the health authorities are contracting with private organizations and the private organizations are run by the people who run the health authority, we're asking for trouble."

Stewart is happy that the auditor general expressed some concern. "It means that at least someone in Alberta with authority is recognizing that this is not right." Nevertheless, she's skeptical that new guidelines will free the public system of the taint of private interest. "It's my impression, particularly in Calgary, that they actually want to encourage this kind of what I would call medi-business. In the minds of the people who run the health authority in Calgary, they want to encourage this. They don't see it as a problem."

To add insult to injury, Stewart says, "There's still no evidence that [contracting out] saves money or reduces waiting lists." She finds it a little amusing that even the auditor general says that he's unable to discern, from the figures he has been provided, whether there has been a saving. "So if *he* can't tell, well wouldn't they at least investigate that before they go ahead? Instead they're pushing it further without any evidence that it's helping anybody except the people who run the companies."

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