

# Physicians Gaming the System: Modern-Day Robin Hood?

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From childhood, people have considered the storybook character *Robin Hood* as a hero who stole from the rich to give to the poor. Even if we were all taught that stealing was something bad, in certain circumstances, we would consider it acceptable if the goal were laudable. Perhaps our hero is simply a petty thief. But what if the gold that Robin Hood stole had an impact on an entire village? What if the stolen gold was intended for all of the villagers in order to pay them for their yearly harvests, but because of the justifiable robbery, none of them could therefore be paid? Would we have as much sympathy for Robin Hood or accept his act of thievery? To a certain extent, the actions of doctors can lead us to consider them as the “Modern-Day Robin Hood”. Indeed, in order to help their patients, some physicians choose to break health care rules and regulations regarding access to care and/or reimbursement<sup>1</sup>, that is, *gaming* the system for the personal benefit of individuals in need.

Compared to fraud, gaming is essentially based on altruistic motives and is not primarily carried out from a perspective of self-interest. Those who use gaming will resort to such tactics as over-claiming (e.g. billing for an insured service while providing an uninsured service) or will misrepresent patient data (e.g. queue-jumping, misclassification — for example, exaggerating the severity of an individual patient’s condition to obtain more expeditious care or to help a patient secure coverage for required care).<sup>2</sup>

People’s opinions, with respect to gaming, vary greatly. Some believe that the practice of gaming indirectly promotes equity and quality in the allocation of health care resources by allowing doctors to offer required health care services to patients who otherwise would not receive such care. Furthermore, some physicians believe it is their role to determine priorities among their patients, even if they must

bypass the system in order to do so. To others, gaming renders the health care system susceptible to important repercussions, such as increased overall costs and a reduction of the quality of health care services.<sup>3</sup>

Should something be done about gaming? If so, what exactly? In this article, I will argue that, even if it sometimes appears to be praiseworthy, gaming is not a good practice in general, and its potential impact on the health care system is sufficiently significant to substantiate intervention. Thereafter, I will propose guidelines that should be implemented regarding such conduct. These guidelines must also be understood and combined with other topics, namely education and a user-friendly resources allocation revision mechanism. Even if gaming can also be executed by hospitals to the benefit of patients or by physicians to the benefit of hospitals — or to that of any other health care establishment — I will confine my remarks to the specific circumstance of physicians who carry out gaming to the benefit of their patients.

## ***The Necessity to Intervene Regarding the Practice of Gaming<sup>4</sup>***

Is gaming an acceptable or an unacceptable practice? The answer to this question often depends on one’s point of view or situation vis-à-vis the issue. Undeniably, gaming will be considered good practice to those who would not otherwise benefit from a particular type of care or other services. However, only considering this question, by focussing on potential individual benefits, gives us but a partial view of a vastly more complex issue. As our health care system is based on common social values such as universality, accessibility (based on people’s needs) and public administration<sup>5</sup>, gaming should be considered while taking into account its



impact on those values or principles. Examined in this way, we can understand that such a practice might have a negative impact on the entire health care system and, in the long run and if overly widespread, might even become a threat to its very existence. In the following treatise, I will firstly explain how gaming can diminish the confidence people have in the health care system by, most notably, upsetting equity and weakening solidarity values. Secondly, I will discuss how the practice affects the standard of care, and finally, I will present the potentially serious financial consequences on the system.

To begin, confidence in the health care system is essential as “the system will survive if people think it’s fair”.<sup>6</sup> Hence, the perception of equity is extremely significant. Behaviour such as gaming can have an impact on that fundamental value as it can cause the resource allocation system to stray from its main objective: fair distribution, that is, distribution based on needs. Indeed, if such a practice becomes prevalent, patients, whose physicians refuse to do so, will be penalized and see their chances to receive care, even if greatly needed, diminished as other patients illegitimately<sup>7</sup> benefit from it. Additionally, physicians may have a natural tendency towards gaming when those requiring care are friends or family<sup>8</sup>, or when the patients are more capable or forceful in their requests for such practices<sup>9</sup>. There is a risk of creating “second-class” patients comprised of individuals without such privileged acquaintances or who are unable to adequately request care<sup>10</sup>. In short, gaming could become an extremely penalizing practice to those who do not benefit from it and may even ultimately become futile by requiring physicians to “standardize” such procedures to ensure the very services they wish to procure for their patients. Thus, the practice of gaming is unfair with respect to the aforementioned objective of distribution based on the priority of needs and therefore risks hindering confidence in the health care system, eventually leading to the rejection of the system as a whole.

In addition, the loss of confidence in the health care system can possibly lead to — or be driven by — an important lack of solidarity which is essential to ensure the system’s continued existence. Otherwise, if there is to be perceived inequity within the system, the necessity to maintain it will be lost. As Haavi Morreim justly underlined, if scarce resources are to be distributed fairly, all must cooperate.<sup>11</sup> Knowing that a select few, but not all, benefit from gaming, who will accept sacrificing himself or herself in order to maintain the ideal of, or the illusion of, an equitable health care system? As it is inequitable anyway, people will most likely try to convince

their physician to contravene the rules for their own benefit, or will “shop around” until they find one ready to do so.

A second, but equally important, consideration is that gaming can also influence the quality of care. Practices such as queue-jumping undoubtedly affect the quality of care as care will no longer be attributed to the result of priorities based on needs. Consequently, those who should have received services first will receive belated care, sometimes with less effective results. Also, this kind of illegitimate self-regulation can perpetuate unwise policies as it does not allow the health care system to properly identify deficient practices or it provides incorrect indications about adjustments that should be performed on such practices<sup>12</sup>. In brief, it can lead to the loss of important data that could be used to improve the system, thereby diminishing its capacity to adjust to ever-evolving needs so vital to the system’s long-term survival. This type of “band-aid” strategy gives the illusion of solving serious problems, but all the while, it limits the possibilities of getting to the very source of shortcomings by falsifying facts and figures related to the health care system.

Lastly, although it is at present impossible to provide precise figures on excess costs created by gaming practices in the health care system, as no such exhaustive studies have been carried out<sup>13</sup>, it is undeniable that any additional attribution of resources implies additional costs. Also, such diverted resources limit the possibility of investing in other important health care priorities, such as, medical or pharmaceutical research and home-care. If one were to establish a parallel with fraud in the health care sector, based on conclusions from certain American studies on the subject, estimates on additional costs run between three billion and ten billion Canadian dollars per annum<sup>14</sup>. These figures do not specifically address gaming, however, they give a general idea of the magnitude of possible financial impacts related to the phenomenon if no measures are taken to correct the situation. Such practices can lead to the creation of a parallel resource allocation system whereby inappropriate and unnecessary spending would occur, thereby affecting the health care system as a whole.<sup>15</sup>

Consequently, considering the possible effect of gaming on the health care system, which shall be proportionate to the prevalence of the trend, I believe that it is necessary to act in order to avoid or curtail such practices. Therefore, in the following section of this paper, I consider the different possibilities available to do so.



## **The Options to Avoid or Curtail Gaming**

To limit the development of the gaming practice, I think that there is a need to focus on three options: (1) creating guidelines, (2) improving education of physicians and patients regarding this issue and, finally, (3) ensuring more user-friendly revision mechanisms for special requests related to resource allocation. In order to discuss these options, I will explain the underlying principles for each one and will give details about their relative importance. But before doing so, a better understanding of the reasoning used by health care providers to justify the use of gaming is helpful to get a more complete picture of the overall issue. This step is also important in order to properly address the physicians' concerns and perceived need to resort to gaming.

Many reasons, good or bad, can explain the need for — or the temptation to resort to — gaming. Some researchers indicate that the severity of patient illness, the complexity of the process of appealing insurance decisions, and the probability of a successful appeal are among such reasons<sup>16</sup>. Other factors can also have an influence on the physician's behavior, such as, the patient's request (or insistence)<sup>17</sup>, the desire to regain a certain amount of control over resource allocation<sup>18</sup>, the time pressure<sup>19</sup> and the belief that it is necessary to provide high-quality care<sup>20</sup> (a certain form of "ethical adaptation").

Hence, to respond to the perceived need of — or the temptation to resort to — gaming, as an important first step, guidelines must be created. Such an initiative should come from the Canadian Medical Association ("CMA"), as they regulate the practice of medicine at a pan-Canadian level. Considering the possible impact of gaming on the health care system as a whole (a possible concern to all Canadians) it would be preferable that a pan-Canadian organization consider such an issue, although entities such as the provincial physicians' associations could thereafter establish their own particular guidelines. In any case, the issue will have the advantage of being discussed on a larger scale and consensus will hopefully be gained. Accordingly, such guidelines could be added to ethics codes in health care establishments in order to positively influence employees in general, notably, care givers and administrators. The Canadian Medical Protective Association ("CMPA")<sup>21</sup> would also likely be an important actor due to its influence on the practice of medicine in Canada and its role of prevention with respect to

practices that could have legal implications<sup>22</sup>. The important resources of this association, as well as its contact with medical schools, their students and with practitioners throughout their careers, can result in effective dissemination of the guidelines and can facilitate cooperation from the physicians in their application of the guidelines.

Ultimately, the physicians' governing bodies could include guidelines in their code of ethics. The legal impact of the guidelines, as a regulation, would thereby be assured. However, the usefulness of proceeding with such a strategy will vary depending on the conclusions of further studies regarding the extent of the trend. For now, implementation of such far-reaching recommendations without further analysis would most certainly be premature.

The advantages of using guidelines as a method of limiting gaming are diverse. Firstly, guidelines highlight the existence of the issue, its actual or eventual importance, and improve awareness among those to whom they are intended. In addition, guidelines help to define professional standards and can be used by disciplinary committees or courts as references about what type of conduct should be expected from physicians. Even without having formal legal implications, guidelines provide indications about how to react in different situations involving gaming. Thus, they help the profession to maintain good standards of practice as well as to enhance apprehension among physicians related to the pursuit of actions which are opposed to those standards.

Another advantage related to the establishment of guidelines is, notably, the low cost associated with such an approach. The cost will be born by organizations which already have the mandate to develop professional standards and to keep physicians informed of such standards. No additional public funds are therefore involved or required. With regards to ethics codes in health care establishments, there would be no need to hire new resources as they already have an obligation, at least in the province of Quebec<sup>23</sup>, to have such codes and to keep them updated. Finally, in addition to this public-finance advantage, and in stark contrast with certain rules that are unilaterally imposed by government — which in itself is sometimes viewed by physicians as part of the problem — guidelines would be written by professionals who have in-depth knowledge of their field and who also have the advantage of being respected by their peers, which can contribute to physicians adhering to those guidelines<sup>24</sup>.

A second option to the gaming issue, education, is particularly relevant as it is a good vehicle to improve information.



Creating guidelines without, at the same time, educating people about the issue the guidelines are trying to highlight or remedy can, among other things, perpetuate incomprehension or ignorance with respect to the said issue. They must both work in tandem and be directed to physicians and to the population in general as this issue involves them both.

With respect to physicians, education may be geared towards issues related to gaming directly (e.g. what is gaming? Is gaming a good option? Are there alternate means? What are the consequences to such a practice? Etc.). Education may be quite effective in preventing gaming, given the lack of concern and discussion regarding this issue in academic literature and in empirical research<sup>25</sup>. Preoccupation surrounding gaming is a relatively new phenomenon and, to date, very little awareness training has been held surrounding this issue. The complexity and ambiguity of such practices need to be discussed as early as in training during medical school. Physicians will need some resources to deal with this difficult issue, and education is a significant tool to achieve this objective. In addition, since the practice of gaming can be related to factors such as the desire to regain control over resource allocation and the belief that it is necessary to provide high quality care and respond to patients' demands<sup>26</sup>, gaming emphasizes an incomprehension by some physicians regarding the limits of their role in certain circumstances. Thus, education with respect to this subject is also of use. Whereas physicians are traditionally trained to take into account the sole interests of their patients, a new requirement to take into account other interests, such as that of society as a whole, in the equitable allocation of resources, enters into play<sup>27</sup>. Just as physicians are not obligated to respond to all of their patients' requests, they must also recognize that there are limits to their powers to heal and to intervene. Consequently, the educational aspect related to gaming could allow physicians to consider the more general question of their role in the health care system.

Education of physicians about gaming could be a task shared between different organizations, including the ones mentioned in the guidelines option (CMA, CMPA, etc.,) as

well as others, such as, the continuing education committees in health care establishments.

Education destined to the general population is also important as the impact of the practice of gaming on the quality and the cost of care, if it were to spread, is, as we have explained previously, a common preoccupation. I think that patients and the public in general should be better informed of the cost related to health care. They should also be more implicated in the control of resource allocation. As a part of the solution, I believe that every user should have an annual summary of the care that they have received and the cost related to it. I don't see the need to maintain the actual state of the public's total ignorance on an individual basis. Such a practice could improve items such as transparency, accuracy, follow-up, participation and awareness.

The last proposed option to gaming is that of promoting a user-friendly revision mechanism for allocation in particular cases. With such a mechanism, physicians would likely be less tempted to game the system if they believed that those mechanisms were useful and fair<sup>28</sup>. Gaming, notwithstanding its inherent risks, emphasizes the need to maintain some form of flexibility in resource allocation. Overly strict resource allocation methods can have the undesirable side-effect of creating the need to manipulate rules and regulations in order to offer quality care<sup>29</sup>. It is unimaginable that a system of the magnitude of the health care system will not create, although unwillingly, some injustices in certain circumstances. That is notably the reason why provincial health care policies usually provide for the possibility of allowing physicians to prescribe exceptional treatment programs in some cases<sup>30</sup>. If such measures leave no other choice for physicians than to consider gaming, the measures have obviously failed and require change or replacement. Therefore, I believe that there should be additional study about the subject in order to poll physicians as to their perception of the existing mechanisms. The conclusions of such research would be important in the determination of the need, or the extent to which, allocation revision mechanisms would be changed.

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Eventually, it could be interesting to set up multidisciplinary committees in health care establishments in order to decide about individual requests for resource allocation that were initially refused or deemed uninsured. An annual budget could be allotted to such committees. Physicians themselves could submit requests and easy access to such committees could incite them to seek a committee's opinion. Furthermore, such committees could be set up based on the model used for clinical ethics committees<sup>31</sup> although all members should be health care establishment employees. Physicians would thereby benefit from the input of committee members and could also share the responsibility or burden of certain decisions. Useful annual reports on health care services provided, on a no-name basis, could be used to monitor the needs as well as weaknesses of the health care system. In order to ensure transparency, such a report could also be made available to the public. Nevertheless, this option would probably be useful only for physicians working in establishments.

However, opposing the practice of gaming may be easier in theory than in practice. In a concrete situation of important and sometimes vital requirement of care, many of us would probably try to influence our doctors to receive better or more expeditious service or care. On the other hand, physicians are the ones that have to deal with their patients frustration, anxiety, despair and sadness. Therefore, all three options that I have discussed appear to essentially limit the development of gaming. Along with a better understanding of the challenges facing the health care system, clear guidelines will provide practical solutions to actual problems as well as increased confidence in revision mechanisms.

In this article, I have had the opportunity of discussing the necessity of reacting to the practice of gaming and to propose options by which we could avoid or curtail such practices. It is my opinion that gaming must not be considered in the very narrow light of the benefits to a few individuals, no matter how compelling their individual cases may seem. The impact should rather be measured with respect to the underlying values and credibility of our health care system. This is, in my opinion, a question that impacts the very survival of such a system. In order to limit, or avoid altogether, the possible consequences of gaming on the system, it is necessary that swift action be taken. Therefore, the creation of guidelines, the continued improvement of education with regards to this issue, and the implementation of adequate allocation revision mechanisms which allows for flexibility in order to adapt to particular or exceptional circumstances appear to be necessary.

To conclude, as to the question *Physicians Gaming the System: Modern-Day Robin Hood?*, the answer may simply reside in someone who is only human, an individual with feelings, ideals and subject to diverse influences. In any case, an individual who must consider the many possible repercussions of his or her actions which may, at first glance, appear heroic or be of noble intent. As with all those subjected to the health care system, even the provider must, at some point, accept the limits of the health care system, in particular, and of modern medicine in general. Such acceptance is not an easy task given the ever-increasing "endless possibilities" of modern science, in which impossibilities, mistakes and failures are less and less tolerated. Perhaps therein lies the answer to the heroic intent of our Modern-Day Robin Hood. In any case, society as a whole, and not a chosen few, must decide on the limits that will apply to our health care system.

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1. N. K. Choudhry, A. D. Brown and S. Choudhry define "gaming" as the act when a provider intentionally breaks health care rules regarding access to care and/or reimbursement for self-benefit, see Niteesh.K. Choudhry, Adalsteinn D. Brown and Sujit Choudhry, "Health Care Fraud and Gaming" (2003) [unpublished] at 5
2. *Ibid.* at 9; E. Haavi Morreim, "Gaming the System: Dodging the Rules, Ruling the Dodgers" (1991) 151 *Archives of Internal Medicine* 443.
3. *Supra* note 1. I notice that both those who defend and oppose gaming agree on this point. Generally, quality of care is an over-used motive in the health care sector used to justify any request, from salary to employment conditions, to system restructuring. The need to carry out empirical research to evaluate the true impact on this issue is all the more important. I will follow up on this position in the following pages.
4. The extent to which gaming is prevalent is unknown and, as is mentioned in the text corresponding to note 24, few studies on the matter exist. However, one American study mentions that 39% of physicians have declared that they have resorted to at least one tactic "sometimes" or more often in the last year (Rachel M. Werner et al., "The 'Hassle Factor' What Motivates Physicians to Manipulate Reimbursement Rules?" (2002) 162 *Archives of Internal Medicine* 1134). The necessity to react to the practice therefore will propor-



tionately rise in relation to the extent of the trend. Notwithstanding the preceding, I believe that based on available data, the practice is potentially serious enough to warrant further review.

5. Based on the five criteria set out by the *Canada Health Act*, R.S.C. 1985, c.6 s.7, in order for provincial insurance to obtain federal funding.
6. Professor Sujit Choudhry (Remark made during a lecture in Conflicts of Interest, Faculty of Law, University of Toronto, fall 2003) [unpublished].
7. This comment does not mean that people that benefit from gaming do not need such care. The point is that gaming does not necessarily take into consideration the “priority of needs”.
8. Without relying on specific — and scientific — data, many of us have heard of someone who has benefited from more expeditious service, either for a blood sample, a room upgrade or less waiting time in the emergency room because he or she knew a physician or was a public personality.
9. Please refer to the following section, where it is indicated that it is a factor that can potentially influence gaming.
10. One can easily think that victims of such a system would, more often than not, be the elderly, those requiring psychiatric care, or those without family or external support.
11. E. Haavi Morreim, “Gaming the System: Dodging the Rules, Ruling the Dodgers” (1991) 151 *Archives of Internal Medicine* 443.
12. *Ibid.*; *supra* note 1.
13. *Supra* note 1.
14. *Ibid.*
15. *Ibid.*
16. Rachel M. Werner et al., “The ‘Hassle Factor’ What Motivates Physicians to Manipulate Reimbursement Rules?” (2002) 162 *Archives of Internal Medicine* 1134.
17. Notably, it is also indicated that it may stem from difficulty in confronting the patients’ requests or it may be less time-consuming than trying to explain to patients the nature of their requested interventions or their other alternatives, see *supra* note 11.
18. Physicians, notwithstanding an obligation of fidelity in the delivery of quality care, are progressively losing their accustomed control over the necessary resources, *supra* note 11. We could even argue that over the last years, physicians have gained in responsibility but lost in power. Gaming can therefore be a means by which to regain such power.
19. *Supra* note 16.
20. Victor G. Freeman et al., “Lying for Patients: Physician Deception of Third-Party Payers” (1999) 159 *Archives of Internal Medicine* 2263; *supra* note 1.
21. The association that represents more than 95% of physicians across Canada.
22. See the CMPA website : <www.cmpa.org>. This preventative role has taken on more and more importance over the years.
23. *An Act Respecting Health Services and Social Services*, R.S.Q. c. S-4.2, s. 233.
24. Linette McNamara, Erin Nelson and Brent Windwick, “Regulation of Health Care Professionals” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2d ed., (Canada: Butterworths, 2002).
25. See *supra* note 1; Matthew K. Wynia et al., “Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place” (2000) 283 *Journal of the American Medical Association* 1858.
26. See my previous remarks at the beginning of this section.
27. *Supra* note 11.
28. Among the factors that influence the practice of gaming, that of lack of confidence in the revision process was mentioned earlier.
29. *Supra* note 11. Obviously, this aspect will mainly have to do with reimbursement regulations as opposed to practices such as queue-jumping.
30. As an example, in the province of Quebec, physicians can fill out a form to request particular care. This form must then be sent to the Health Board (RAMQ) who will decide if they approve or not of the request. Such requests can be made on a priority basis.
31. Clinical ethics committees exist in various hospitals in Quebec. They are multidisciplinary and generally include a physician and an ethicist. Among their functions is responding to physicians who seek ethical advice. For more details concerning their mandate, composition and functioning, see Association des Hôpitaux du Québec, *Les comités d’éthique en centres hospitaliers: proposition et planification*, Montréal, Association des hôpitaux du Québec, 1987.

