ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/348155979

Overcoming Overuse Part 4: Small Business Survival

Article *in* Journal of Orthopaedic and Sports Physical Therapy · January 2021

DOI: 10.2519/jospt.2021.0101

CITATION
1

READS
197

6 authors, including:

Adrian Traeger
The University of Sydney
84 PUBLICATIONS 1,621 CITATIONS

SEE PROFILE

Jason Soon
The Royal Australasian College of Physicians
11 PUBLICATIONS 38 CITATIONS

SEE PROFILE

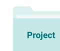
Mary O'Keeffe
The University of Sydney
94 PUBLICATIONS 1,262 CITATIONS

SEE PROFILE

Joshua Robert Zadro
The University of Sydney
73 PUBLICATIONS 336 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



Chronic pain in families View project

'Do Something Different' for chronic low back pain View project

All content following this page was uploaded by Joshua Robert Zadro on 04 February 2021.

The user has requested enhancement of the downloaded file.

ADRIAN C. TRAEGER, PT, PhD[1,2] • JASON SOON, BEc (Hons)[1,3] • MARY O'KEEFFE, PT, PhD[1,2]
SIMON DÉCARY, PT, PhD[4-6] • ZOE A. MICHALEFF, PT, PhD[7] • JOSHUA R. ZADRO, PT, PhD[1,2]

Overcoming Overuse Part 4: Small Business Survival

Clinicians in the private sector are often remunerated according to the number of consultations they provide. It is easy to see how this fee-for-service payment model could drive overuse: it incentivizes service providers to do more, not less. This payment model may also influence the type of care provided by remunerating some providers differently according to the specific services they provide in the consultation.

In the "Overcoming Overuse" series, we have discussed how overuse can happen,[14] what clinicians can do to identify it in practice,[8] and its many and complex drivers.[10] In this editorial, we focus on economic factors that could drive overuse in the private sector. We do not attempt to provide answers for any one health system. Rather, we propose ideas for small business leaders that demand further investigation.

Supplier-Induced Demand, Unwarranted Variation, and Overuse

Supplier-induced demand[9]—a surplus in demand for a health service beyond what would be expected had the consumers of the service (patients) been fully informed—can help explain the economics of overuse. Patients use more health services than they need because (1) they have incomplete information about benefits and harms of care options, (2) they have easy access to clinicians in their region, and (3) the clinicians in that region need to maintain a target income. In this environment, suppliers of health care can "induce" demand through various means of persuasion, including during consultations or through advertising.

Measures of variation in health care are widely viewed by policy makers as hallmarks of potential waste in the system. The most well-known examples are in surgery: if you break your hip, where you live does not tend to influence the likelihood that you will have hip surgery.[2] In contrast, where a person lives might substantially influence the likelihood of having a spinal fusion operation for low back pain. A person living on Bruny Island, Australia—a regional area that, apart from its exceptional cheese, is similar to other Australian regional areas—is 7 times more likely to have spinal fusion surgery than a person living in the regional area of New South Wales.[1] Supplier-induced demand can explain some of these variations insofar as they cannot be explained by differences in the need for clinical services in different areas.

There is also evidence of geographic variation in physical therapy. A person living in the Northeast region of the United States has a greater number of physical therapy visits per episode of care compared with someone living in the West region of the United States (7.8 visits per episode in the West versus 10.8 visits per episode in the Northeast).[7] In Germany, there was substantial geographic variation in physical therapy utilization even after controlling for patient "need" (eg, the number of people with disabling osteoarthritis in a region).[11] Variation in care is not direct evidence of overuse; lower numbers in a given region could be explained by underuse of appropriate care, for example, due to lack of access.

Economic theory suggests that the number of clinicians in an area should

SUMMARY: The challenge of overuse raises important questions for those in the business of musculoskeletal health care. What is the right number of physical therapy visits for a given condition? Can a practice provide "less" but still be profitable? In this, the editorial on overcoming overuse of musculoskeletal health care, we consider the economic drivers of overuse in the private sector. We propose actions that could support small business leaders to overcome overuse and build profitable, high-quality services. *J Orthop Sports Phys Ther 2021;51(1):1-4. doi:10.2519/jospt.2021.0101*

KEY WORDS: *medical economics, musculoskeletal, overuse, physical therapy*

[1]Institute for Musculoskeletal Health, The University of Sydney and Sydney Local Health District, Sydney, Australia. [2]School of Public Health, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia. [3]Menzies Centre for Health Policy, The University of Sydney, Camperdown, Australia. [4]Centre de recherche sur les soins et les services de première ligne de l'Université Laval, Quebec, Canada. [5]Canada Research Chair in Shared Decision Making and Knowledge Translation, Université Laval, Quebec, Canada. [6]Department of Family Medicine and Emergency Medicine, Faculty of Medicine, Université Laval, Quebec, Canada. [7]Institute for Evidence-Based Healthcare, Faculty of Health Sciences and Medicine, Bond University, Robina, Australia. No funding was received for this editorial. The authors certify that they have no affiliations with or financial involvement in any organization or entity with a direct financial interest in the subject matter or materials discussed in the article. Address correspondence to Dr Adrian Traeger, Level 10 North, King George V Building, Royal Prince Alfred Hospital, PO Box M179, Missenden Road, NSW 2050 Australia. E-mail: adrian.traeger@sydney.edu.au Copyright ©2021 JOSPT, Inc®

not influence the number of services provided per person, unless people are receiving more services than they need. Ten out of 12 countries had a positive linear relationship between surgeon supply and spine surgery rates.[3] However, a more recent study in the United States found a wide geographic variation in rates of knee and shoulder arthroscopy but no relationship between orthopaedic surgeon supply and geographic variation.[6]

Funding Arrangements to Promote Quality and Support Small Businesses

Similar patient outcomes can be achieved with fewer consultations.[8] For a business to be profitable with fewer consultations per episode, the equation appears simple: increase the number of patients a practice services, not the number of visits per episode. The **TABLE** shows our suggestions for how private physical therapy businesses could foster a culture of quality over quantity. Below, we discuss actions from governments, private health insurers, and consumers that could support the less-is-more approach we advocate.

Action From Governments

Reducing barriers to direct access; increasing primary contact responsibilities of physical therapists, including case management in workers' compensation; and reorienting the workforce (eg, the ratio of physical therapists to general practitioners to specialists) based on need are examples of government actions that could help the private sector compensate for reducing low-value care (**FIGURE**). The net effect would be more episodes of care diverted to the private physical therapy sector to meet clinically appropriate needs and less incentive to bill for visits per patient.

Governments could shift funds currently spent on ineffective therapies to packages of evidence-based physical care that include quality indicators.[13] In Australia, the government currently pays for ineffective spine surgeries (at up to A$53700 per operation), but not for an evidence-based exercise program provided by a physical therapist (the government pays for a maximum of 5 physical therapy visits annually, for selected patients, at a cost of A$311).[12] Clearly, this needs to change.

Action From Insurers

Systems based on fee for service have higher visit numbers than those where clinicians are paid a fixed salary (so-called "capitation" models).[5] The capitation model has worked well in the United Kingdom, where the quantity and costs of care for a given health condition are substantially lower than in countries with fee-for-service payment systems. To move away from fee for service, insurers could fund packages of evidence-based physical therapy care (eg, progressive resistance training and education for knee osteoarthritis).

Moving away from fee-for-service models could remove the incentive to overservice, because payment for an episode is fixed. Of course, there is potential to exploit package-based funding; some patients and clinicians may feel that they need to use all allotted sessions, which leads to more care rather than less. Other limitations of package-based care include third-party payers having strong influence on the number of sessions a physical therapist can provide, irrespective of a patient's progress. A focus on outcomes and quality indicators is therefore essential, as is ongoing evaluation of any new funding scheme.

Action From Consumers

Consumers play an important role in addressing overuse by demanding care that is evidence based. Shared decision making will be important but is unlikely to solve such a complex problem. It may, however, empower consumers to look critically at the care they are paying for. Physical therapy is often associated with substantial out-of-pocket costs. As more consumers become aware of the concept of value in health care, clinicians and their patients should be asking themselves, "Do the benefits of this care justify its cost?" The answer becomes difficult when care is discretionary, in the "gray zone,"[8] or when the payer is not an individual but a faceless insurance company.

TABLE Ideas for Fostering a Culture of Quality in Small Physical Therapy Businesses[a]

- If not already doing so, pay staff a fixed salary rather than have their remuneration be dependent on the number of consultations
- Dedicate paid or protected time for staff to read and engage in research
- Hold regular meetings to discuss complex patients
- Lead by example by having senior staff offer fewer sessions for a given episode of care
- Collect, audit, and reflect on practice measures of care quality, for example, components of a model of care provided
- Reflect on marketing practices. Does the service have a solid evidence base?
- Provide extended consultations when the evidence suggests it might be necessary, for example, coordinating multidisciplinary care for a person with chronic low back pain
- Train staff to discuss requests for low-value care with their patient
- Train staff to use a shared decision-making approach
- Develop strong, trusting relationships with referrers to ensure a collaborative approach to care
- Develop new models of care delivery, such as telerehabilitation
- Explore additional services, such as physical activity coaching

[a]*Some of these ideas are based on successful approaches implemented by accountable care organizations in the United States. Organizations that focused on collaborative, evidence-based approaches to care; paid staff salaries; and had a strong focus on patient outcomes appeared to have less overuse and better patient outcomes than organizations with financial incentives to provide more care.[4] Although these were large corporations, we believe that many of the principles could be applied to small businesses.*

CONCLUSION

Efforts to address overuse in the private sector need not destroy small businesses. In theory, the

solution is simple: replace low-value services with high-value services. This requires a substantial redesign of systems: funding arrangements, clinical responsibilities, referral patterns, and access to physical therapy. Rigorous and ongoing evaluation of any policy to address theoretical drivers of overuse would ensure that physical therapy in the private sector may remain as valuable as possible. We hope this editorial serves as a call to better understand and overcome the economic drivers of overuse. ◉

STUDY DETAILS

AUTHOR CONTRIBUTIONS: All authors conceived the idea. Dr Traeger wrote the first draft. All authors contributed intellectual content, assisted with revisions, and approved the final version of this editorial.

DATA SHARING: There are no data in this editorial.

PATIENT AND PUBLIC INVOLVEMENT: Patients and the public were not involved in the design or writing of this editorial.

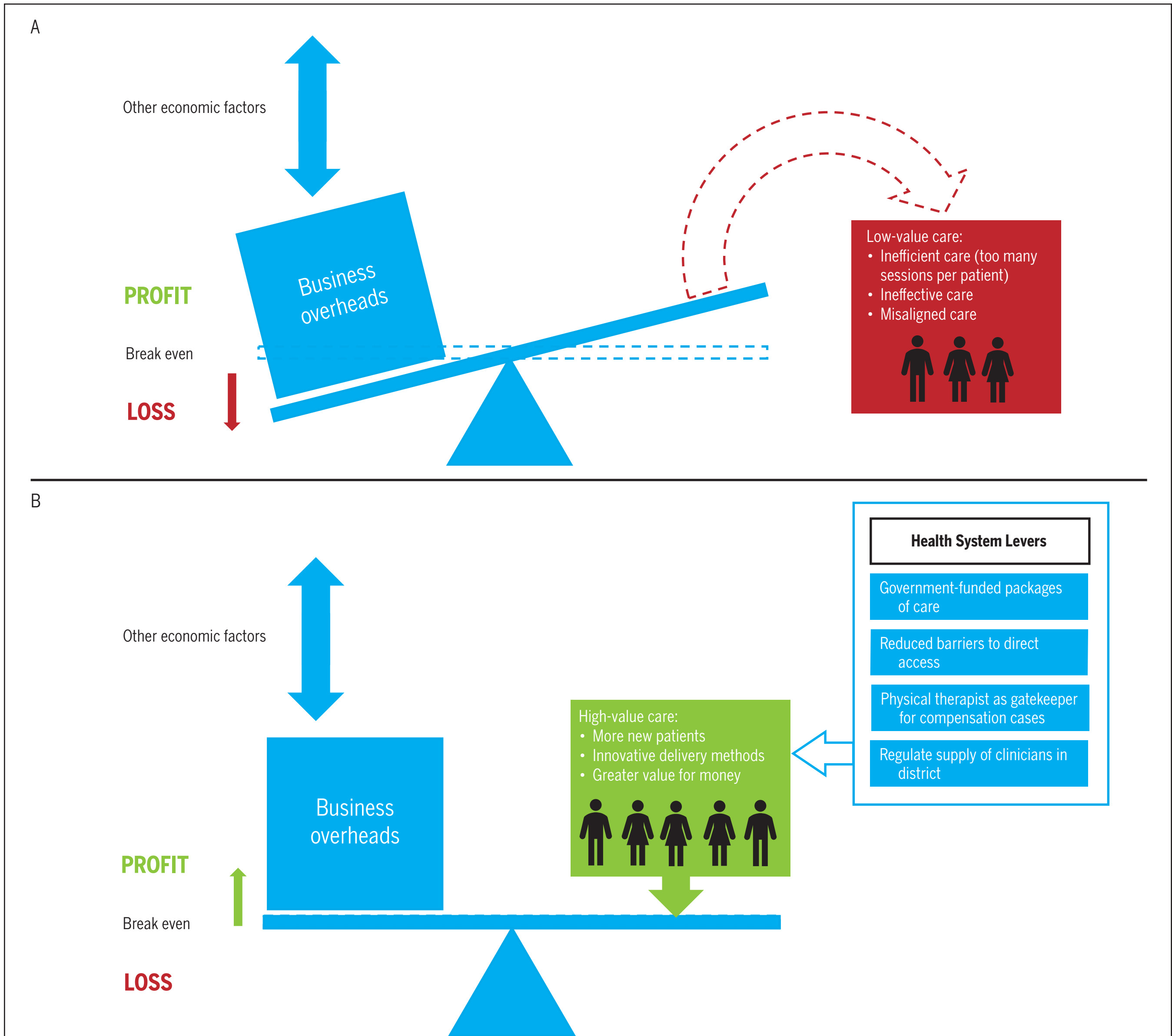


FIGURE. Actions to support profitable, high-value care in the private physical therapy sector. Precise estimates of the amount of low-value care provided in private physical therapy practices are not available. We assume that a proportion of physical therapy care could be of low value (A). A practice that audited care and chose to reduce all low-value consultations might experience a loss of revenue (A). Lost revenue could be easily replaced if practices had an increase in new consultations with patients in need (B). Health system levers to support profitable, high-value care could include government funding of evidence-based packages, regulating the supply of clinicians in a region, shifting compensation cases from general practitioners to physical therapists, and reducing barriers to direct access (B).

REFERENCES

1. Australian Commission on Safety and Quality in Health Care. The Second Australian Atlas of Healthcare Variation. Sydney, Australia: Australian Commission on Safety and Quality in Health Care; 2017.
2. Birkmeyer JD, Reames BN, McCulloch P, Carr AJ, Campbell WB, Wennberg JE. Understanding of regional variation in the use of surgery. *Lancet*. 2013;382:1121-1129. https://doi.org/10.1016/S0140-6736(13)61215-5
3. Cherkin DC, Deyo RA, Loeser JD, Bush T, Waddell G. An international comparison of back surgery rates. *Spine (Phila Pa 1976)*. 1994;19:1201-1206. https://doi.org/10.1097/00007632-199405310-00001
4. Gawande A. The cost conundrum. *The New Yorker*. June 1, 2009. Available at: https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum
5. Gosden T, Forland F, Kristiansen IS, et al. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians. *Cochrane Database Syst Rev*. 2000:CD002215. https://doi.org/10.1002/14651858.CD002215
6. Jain NB, Peterson E, Ayers GD, Song A, Kuhn JE. US geographical variation in rates of shoulder and knee arthroscopy and association with orthopedist density. *JAMA Netw Open*. 2019;2:e1917315. https://doi.org/10.1001/jamanetworkopen.2019.17315
7. Machlin SR, Chevan J, Yu WW, Zodet MW. Determinants of utilization and expenditures for episodes of ambulatory physical therapy among adults. *Phys Ther*. 2011;91:1018-1029. https://doi.org/10.2522/ptj.20100343
8. Michaleff ZA, Zadro JR, Traeger AC, O'Keeffe M, Décary S. Overcoming overuse part 2: defining and quantifying health care overuse for musculoskeletal conditions. *J Orthop Sports Phys Ther*. 2020;50:588-591. https://doi.org/10.2519/jospt.2020.0109
9. Mulley AG. Inconvenient truths about supplier induced demand and unwarranted variation in medical practice. *BMJ*. 2009;339:b4073. https://doi.org/10.1136/bmj.b4073
10. O'Keeffe M, Traeger AC, Michaleff ZA, Décary S, Garcia AN, Zadro JR. Overcoming overuse part 3: mapping the drivers of overuse in musculoskeletal health care. *J Orthop Sports Phys Ther*. 2020;50:657-660. https://doi.org/10.2519/jospt.2020.0111
11. Rommel A, Kroll LE. Individual and regional determinants for physical therapy utilization in Germany: multilevel analysis of national survey data. *Phys Ther*. 2017;97:512-523. https://doi.org/10.1093/ptj/pzx022
12. Traeger AC, Buchbinder R, Elshaug AG, Croft PR, Maher CG. Care for low back pain: can health systems deliver? *Bull World Health Organ*. 2019;97:423-433. https://doi.org/10.2471/BLT.18.226050
13. Westby MD, Klemm A, Li LC, Jones CA. Emerging role of quality indicators in physical therapist practice and health service delivery. *Phys Ther*. 2016;96:90-100. https://doi.org/10.2522/ptj.20150106
14. Zadro JR, Décary S, O'Keeffe M, Michaleff ZA, Traeger AC. Overcoming overuse: improving musculoskeletal health care. *J Orthop Sports Phys Ther*. 2020;50:113-115. https://doi.org/10.2519/jospt.2020.0102

View publication stats