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The markets of private chiropractors and physiotherapists

Competition and Consumer Analysis 04

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Chapter 1
Summary and main conclusions

1.1 Background to the analysis

Well-functioning markets support high consumer welfare

A well-functioning market is characterised by efficient resource exploitation and a happy interplay between consumers and enterprises, for example. The Danish Competition and Consumer Authority is engaged in creating well-functioning markets and focuses in this analysis on the competitive and consumer conditions on the chiropractor and physiotherapist markets.

The services provided by these markets affect many Danes. In the past two years, four out of ten Danes have been treated by a chiropractor and/or a physiotherapist. For these services, they – together with public funds, the mutual health insurance company 'Sygeforsikringen "danmark"' and private health insurance schemes – have paid approx. DKK 5.4 billion altogether over the past two years.

Like other healthcare markets, the chiropractor and physiotherapist markets are subject to a number of societal considerations. These markets differ from the typical service markets in several respects: The vast majority of services provided by the two markets are provided by what is known as the practice sector. In the practice sector, chiropractors and physiotherapists practice under their respective collective agreements concluded with public authorities. When consumers buy services in the practice sector, they do not pay the full price of treatment because the services are subsidised. In addition, the rates of the practice sector are fixed centrally by the collective agreements. Both of these factors cause the traditional market mechanism, whereby pricing is based on supply and demand, to be suspended. To counter this, endeavours are made to regulate especially *the supply* of subsidised treatments.

In continuation of the government's competition policy proposal of October 2012 and the government's health policy proposal of May 2013, there are plans to give a number of areas in the practice sector a freer rein. By way of example, from the autumn of 2014 private players will be permitted to operate group practices And the government's task force on the potential for increased competition in the dentist sector suggested in May 2013, *inter alia*, maximum rates instead of fixed rates in the dentist sector as well as a relaxation of the regulations governing dental practice ownership. In addition, the task force on modernisation of the pharmacy sector will present proposals for a modernisation of the sector which furthers accessibility, patient safety and low rates with a strengthened incentive structure, for example by means of competition.

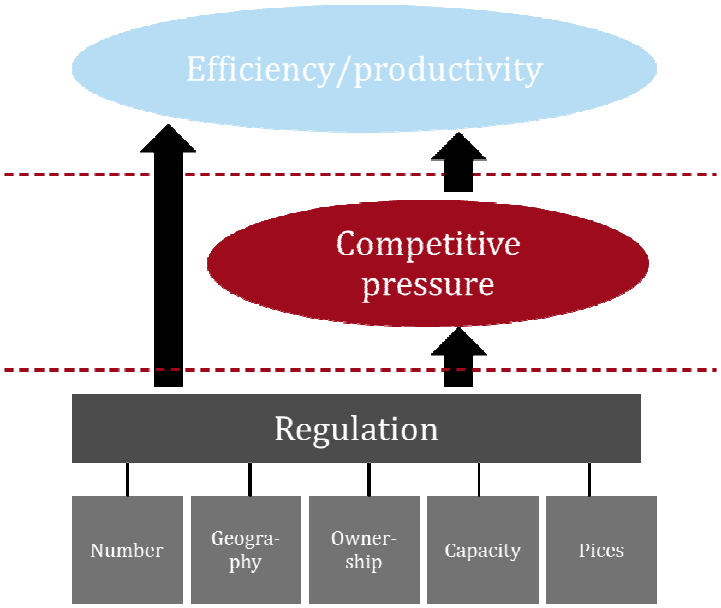
1.2 Summary and main conclusions

The regulation of the markets is intended to support several considerations
The regulation of the chiropractor and physiotherapist markets is intended to support a number of societal considerations, including considerations of health policy targets, considerations of public expenditure control in this sector and considerations of ensuring high consumer welfare. The analysis focuses primarily on competition, efficiency and consumer welfare.

The regulation prevents efficient and equal competition
The current regulation of the practice sector on the chiropractor and physiotherapist markets prevents efficient and equal competition between enterprises. It also contributes to a considerable loss to consumers and society.

In addition, certain parts of the regulation make it hard for chiropractors and physiotherapists to structure the operation of their practices efficiently and for the more efficient practices –the physiotherapists in particular – to grow at the expense of those less efficient, see Fig. 0.1.

Fig. 0.1 **Regulation and competitive pressure affect efficiency/productivity**



Source: The Danish Competition and Consumer Authority, based on the Productivity Commission.

The majority of treatments provided on the chiropractor and physiotherapist markets are subject to comprehensive regulation. Chiropractors and physiotherapists are subject to different forms of regulation. The main elements of the regulation are as follows:

Firstly the regions' and joint consultation committees' allocation of provider numbers (*ydernumre*) limits new healthcare providers' prospects of entering the market and physiotherapists' prospects of expanding their business (restriction of numbers).

Secondly the regulation makes it possible to determine where healthcare providers may set up business and whether they may relocate their practice. In addition, chiropractors are only allowed to practice from one address. As a main rule, the same applies to physiotherapists (geographical provisions).

Thirdly the regulation includes provisions to the effect that only healthcare providers who have acceded to the collective agreement are allowed to have private ownership of their practices and a controlling interest in companies (ownership provisions).

Fourthly the regulation includes control and information provisions intended to ensure that the general financial framework is complied with as well as provisions on how multiple physiotherapists may use the capacity of a provider number and who may use such capacity (capacity control).

Finally the regulation specifies the rates chargeable by the healthcare providers for their services and defines the contents of the services (fixed rates and rate structure).

Specifically, the regulation shields the practices in the practice sector against competition (restriction of numbers). In addition, the regulation creates a risk of local monopolies far from the nearest competitor (geographical restrictions). The regulation also prevents competition on prices, whereby more efficient practices may attract customers by means of lower rates (fixed rates). And the regulation prevents players with solely a business background from having a controlling interest in and operating practices (ownership provisions).

Furthermore, the regulation distorts the competition between healthcare providers in the practice sector and those outside (restriction of numbers). In fact, the structure of the system subsidises chiropractors and physiotherapists in the practice sector and creates unequal competition with healthcare providers on the free market. Healthcare providers allowed to provide treatment in the practice sector gain a certain competitive edge vis-à-vis healthcare providers outside the sector. On one hand, the price paid by patients for treatment in the practice sector is subsidised and thus significantly lower than the price chargeable by healthcare providers on the free market; on the other hand, the healthcare providers in the practice sector are ensured a certain automatic demand and income. This conclusion is supported by the fact that provider numbers have a value and are traded between healthcare providers.

In summary, the regulation impairs the healthcare providers' incentive to develop and offer high-quality services at low rates and to operate their practices more productively. In addition, the regulation of physiotherapists in particular prevents the most productive practices from growing at the expense of those least productive (restriction of numbers and capacity control).

Chiropractors and physiotherapists find that the regulation inhibits efficient operation and growth

The analysis shows that chiropractors and physiotherapists find that specific elements of the existing regulation restrict their potential for operating an efficient business and expanding their business.

The chiropractors find that especially their access to obtaining a provider number (55 per cent), the rate structure of the collective agreements (53 per cent) and the fixed rates (45 per cent) prevent them from operating their practices efficiently. Chiropractors also find that particularly their access to obtaining a provider number (55 per cent) and the geographical provisions (39 per cent) prevent them from expanding their business.

The physiotherapists find that especially the terms of the collective agreements concerning who may use the capacity of a provider number (Clause 17 employments) (67 per cent), the rules governing the use of substitutes[1] (63 per cent) and the access to obtaining an (additional) provider number (62 per cent) prevent them from operating an efficient business.

[1] The physiotherapist (or chiropractor) whom the substitute is replacing may not be present at the practice at the same time as the substitute.

In addition, the physiotherapists find that the regions' maximum limit on provider numbers (66 per cent), the provider number's/the regions' capacity requirements (65 per cent) and the geographical provisions (34 per cent) prevent them from expanding their business.

In addition to the regulation, the analysis shows that both chiropractors and physiotherapists find that the interaction with private health insurance schemes and the management companies of the health insurance schemes prevent them from operating an efficient business. This is the experience of 74 per cent of the chiropractors and 42 per cent of the physiotherapists. The impression is that the interaction is experienced as administratively cumbersome. The opinion of the healthcare providers should *inter alia* be seen in the light of the relatively large extent of private health insurance schemes: In 2011, 1.2 million Danes had private health insurance, and the gross cost of claims paid totalled DKK 1.2 billion, 20 per cent of which related to the cost of chiropractor and physiotherapist treatments (i.e. DKK 240 million in 2011).

In addition, several insurance companies require that all healthcare providers used by their policyholders have a provider number. This has several consequences: The requirement for a provider number means that approx. 20 per cent of the costs of chiropractic treatment and approx. 40 per cent of the costs of physiotherapy are publicly funded. This reduces the costs incurred by insurance companies in meeting their obligations to the insured. The insurance companies' requirements also contribute to supporting the competitive bias caused by the regulation between healthcare providers with provider numbers and those without, see also above.

In summary, based on the analysis, the Danish Competition and Consumer Authority finds that particularly the restriction of numbers, the capacity restriction, the fee system and, to some degree, the ownership provisions impair (i) the incentive to improve productivity to the benefit of the consumers and society, (ii) the potential for operating the practices efficiently and (iii) the potential for the more productive and efficient practices to grow at the expense of those less productive and efficient. The regulation hampers productivity growth on the markets, causing a substantial loss to consumers and society.

Large potential for more chiropractic treatment and physiotherapy for the same money
In order to elucidate the size of the socioeconomic loss caused by the regulation, the Danish Competition and Consumer Authority has made productivity and potential calculations, for example. The Authority has also focused on the expenditure development and the fee system.

Initially, we wish to point out that, in general, it is difficult to calculate potentials because it is difficult to measure how productively the healthcare providers exploit their resources. The Authority has defined productivity as how well a healthcare provider is able to exploit his resources in providing treatments to patients.

The Authority has chosen a methodology and designed two productivity indicators *"number of treatments per hour"* and *"number of treatments per patient"* with their inherent strengths and weaknesses. It is, for example, a strength that the measurements are based on data retrieved from actual transactions between the parties to collective agreements in the practice sector and that the measurements are economically intuitive and meaningful. Conversely, it is, for example, a weakness that the calculations do not allow for the quality aspect of the individual treatment and that no explicit allowance has been made for differences in patient mix and patients' different needs of treatment. However, we have tried to handle this in the measurement *treatments per patient*, where the healthcare providers are divided into three groups based on the specialties within which the patients are treated, for example whether it is ordinary or free physiotherapy. The grouping narrows the spread between top and bottom. It should also be noted that the Danish Competition and Consumer Authority is not aware of any specifications of the providers' actual working time or the actual time spent by the providers on the various types of treatment. Thus, there exist no data on how the patients'

needs and the patient mix affect the number of treatments per hour or per patient. The Authority has tried to calculate the average working time based on the capacities allocated for physiotherapists and on the assumption that chiropractors have a 37.5-hour working week.

On the whole, the Authority estimates that the productivity measurements can be used to illustrate how well the healthcare providers are able to exploit their resources in providing treatments to the patients. The Authority also finds that it is more valuable to try to measure productivity than to refrain from trying because of the uncertainties that will always be associated with productivity measurements.

Firstly the analysis shows that the development in real public expenditure per treatment for physiotherapists has increased by approx. 4 per cent in the period 2003 to 2012. For chiropractors, the real expenditure has decreased by approx. 12 per cent in the same period.

Secondly the analysis shows that there is a significant difference between the number of treatments per hour provided by the more productive and the less productive providers. The number of treatments indicates how well the providers exploit the treatment capacity allocated to them by the region. There are probably several reasons why providers exploit their capacities differently. To cite some of the reasons: Some providers give treatment both in the practice sector and on the free market; providers spend varying amounts of time in order to provide identical types of service according to the collective agreement; providers' working hours vary; and patients differ and therefore have different needs of treatment. Another reason could be that some providers are more productive than others and are able to give more treatments per hour. The indicator is therefore relevant to estimating the potential inherent in increasing the productivity.

The average chiropractor provides 3.8 treatments per hour. The average physiotherapist provides 2.4 treatments per hour. If half the providers, i.e. those with fewest treatments per hour, increase the number of treatments to the level of the average provider, this would result in a further 281,000 chiropractor treatments and 729,000 physiotherapist treatments at the current provider capacity. This corresponds to a 15 per cent increase in the number of chiropractor treatments at a value of DKK 91 million and a 10 per cent increase in the number of physiotherapist treatments at a value of DKK 160 million.

The calculations may be interpreted as the potential inherent in the average provider being allowed to grow and replace less productive providers. The Authority's calculations therefore indicate that society will benefit from allowing the more productive providers to grow. If the more productive providers were allowed to grow at the expense of those less productive, it would ensure a better allocation of resources in the practice sector. It would release resources that could create more value elsewhere in the sector or in society, and it would directly increase productivity in the sector even further. It should be noted that this is a calculated potential, which an amendment of the regulation could help to realise.

Thirdly the analysis shows that the number of treatments per patient differs greatly from the more productive providers to those less productive – as does the time it takes for providers to complete treatment of a patient. There may be several reasons why the number of treatments per patient differs from one provider to the next. To cite some examples: Some providers have a larger group of chronic patients or free-treatment patients needing a particularly high number of treatments; providers may have different patient mixes; or some providers are more productive and able to complete treatment of patients faster.

The chiropractors provide services both to individuals who are not chronically ill (specialty 53) and to the chronically ill (specialty 64). To allow for patients' different needs of treatment, the Authority has divided the providers into three groups based on their share of treatments of chronically ill patients. The average provider in the group of primarily non-chronic treatment providers provided 5.2 treatments per patient in 2012, while the average provider

in the group of mixed patients provided 5.5 treatments per patient. Finally, the average provider in the group with a larger share of chronically ill patients provided 6.5 treatments.

The physiotherapists provide both ordinary physiotherapy and free physiotherapy. To allow for the different treatment needs of patients receiving ordinary and free physiotherapy, the providers have been divided into three groups based on their share of free-treatment patients. In 2012, the average provider in the group that primarily provides ordinary physiotherapy gave nine treatments per patient, while the average provider in the group with mixed patients gave 13 treatments per patient. Finally, the average provider in the group with primarily free-treatment physiotherapy gave 22 treatments per patient.

If half of the providers, i.e. those with the highest number of treatments per chiropractor and physiotherapist patient, reduced the number of treatments to the level of the average provider, this is estimated to give scope for a savings potential. In the chiropractor sector, the annual savings potential is estimated at DKK 41 million for the consumers and DKK 8 million out of public funds. In the physiotherapist sector, the potential is estimated at DKK 72 million annually for the consumers and DKK 146 million annually out of public funds.

The calculations may be interpreted as the potential inherent in allowing the average providers to grow and replace those less productive. The Authority's calculations therefore indicate a societal benefit derived from allowing the more productive providers to grow. Today, a reduction in the number of treatments per treatment course and thus increased productivity would not be reflected in the rates stipulated in the collective agreements. In principle, the rates are regulated mechanically in the collective agreements irrespective of the providers' productivity. Any productivity benefit gained from realising this potential will therefore accrue to the consumers – in the form of a lower *total* price per treatment course – and to public authorities in the form of lower public expenditure. It should be noted that this is a calculated potential, which an amendment of the regulation could help to realise.

It should also be emphasised that the two potential estimates (treatments per hour and treatments per patient) are partial, so the results cannot be added up.

Fourthly the structure of the practice sector's current fee system does *not* support continual productivity improvements that accrue to society and the consumers. For one thing, there is no explicit requirement of productivity improvements linked to the bi-annual mechanical regulation of the providers' fixed fees. For another, the fee system remunerates the providers for the number of treatments instead of completed courses of treatment, for example. This may encourage higher productivity in the form of more treatments per hour. However, the way the system is structured today, such productivity benefits will typically accrue to the providers, see also the National Auditors' 2012 report. But public authorities – and the consumers – will not get a share of the benefits directly. However, part of the productivity benefits may benefit the consumers, since the regions and the municipalities have continually, in the collective-agreement negotiations, introduced requirements for handicap accessibility, IT systems etc. without the providers being compensated for this directly in the rates.

The consumers experience good service, short waiting times and accessibility among chiropractors and physiotherapists

The consumers cannot evaluate and compare the treatments of a chiropractor or physiotherapist *before* a purchase. An evaluation of the relation between the price and quality of a treatment is not feasible until the treatment has been provided. Treatments may therefore be considered an empirical benefit. Even after treatment has been completed, it is difficult for a consumer to evaluate the professional quality of the treatment. However, the consumers may evaluate the *perceived* quality and service provided.

Moreover, as a main rule the consumers do not pay the full price of either chiropractor or physiotherapist services. The vast majority of these services are subject to some form of

subsidy – be it by the National Health Service, by 'Sygeforsikringen "danmark"' or by a private health insurance scheme. It is against this background that consumers may evaluate the services provided to them by chiropractors and physiotherapists.

In addition, the consumers on the chiropractor and physiotherapist markets are patients whose demand for services are governed both by their needs and preferences and by the professional assessment of their treatment needs applied by a General Practitioner, a chiropractor or a physiotherapist, among others.

Generally, consumers are well satisfied with the treatments provided by chiropractors and physiotherapists:

Just about all chiropractor patients experience good/relatively good service (97 per cent). The same applies to nine out of ten patients treated by physiotherapists.

Accessibility is very important to the consumers. And, in the consumers' experience, both chiropractors and physiotherapists *are* accessible. More than eight out of ten chiropractor and physiotherapist patients find that the providers' opening hours are flexible/relatively flexible. And the vast majority of chiropractor patients (just under 90 per cent) and physiotherapist patients (84 per cent) find the waiting time for treatment short/relatively short. The actual waiting time for treatment was under one week for just above 90 per cent of chiropractor patients and 66 per cent of physiotherapist patients. Approx. 25 per cent of the physiotherapist patients waited 1-2 weeks for treatment, while 10 per cent waited more than two weeks.

Almost all patients find it easy to go to the chiropractor (95 per cent) and the physiotherapist (97 per cent).

Finally, based on figures obtained from the Danish Health and Medicines Authority and complaint data from the National Agency for Patients' Rights and Complaints, the evaluation is that the safety of treatments provided by chiropractors and physiotherapists is high: In March 2013 one physiotherapist and no chiropractors were to be found on the list of disciplined healthcare providers issued by the Danish Health and Medicines Authority. In 2012, there were 15 complaints about chiropractors and physiotherapists out of a total of 3,059 complaints about healthcare providers filed with the Disciplinary Committee of the Danish Health and Medicines Authority.

Box 0.1
Main conclusions

The regulation excludes efficient and equal competition on the markets

The regulation excludes efficient competition between healthcare providers in the practice sector:

- Restrictions on access to obtain a provider number – and thus access to provide treatment in the practice sector – shield the existing practices in the sector against competition from new providers.
- Restrictions on the geographical locations where the healthcare providers may set up practice shield the healthcare providers in the practice sector against competition from other providers.
- Restrictions on multiple physiotherapists using the capacity of one provider number impair their prospects of expanding their business and thus their incentive to compete.
- Fixed rates exclude competition on prices between healthcare providers in the practice sector.
- The ownership provisions exclude market players with solely a business background from having a controlling interest in and operating practices.

The regulation creates unequal competition conditions between healthcare providers in the practice sector and those outside despite the fact that all the providers are authorised by the Danish Health and Medicines Authority:

- The price paid by the patients for treatment in the practice sector is subsidised and thus significantly lower than the price chargeable by providers on the free market.
- Healthcare providers in the practice sector are ensured a certain demand and income.
- Altogether, this gives healthcare providers with provider numbers a competitive edge – and, in fact, subsidies – compared to providers whose sole option is to provide treatment on the free market.

The regulation prevents the more productive providers from expanding their business and replacing those less productive on the market. This applies, in particular, to the physiotherapists.

Chiropractors and physiotherapists find that the regulation prevents efficient operation and growth

Chiropractors and physiotherapists find that the regulation prevents them from operating an efficient business and expanding their capacity and activities:

- The physiotherapists find that especially the capacity control and the restriction of numbers prevent them from operating their practices efficiently and expanding their business.
- The chiropractors find that especially the restriction of numbers, the fixed rates and the rate structure stipulated by the collective agreements prevent them from operating their practices efficiently.

Restrictions on the potential for efficient operations and growth can cause a decline in productivity growth on the markets and thus a socioeconomic loss.

Large potential for more chiropractic treatment and physiotherapy for the same money

The Danish Competition and Consumer Authority's productivity and potential calculations indicate that the current regulation causes a societal loss to consumers, healthcare providers and public authorities, which is illustrated in the following:

- If providers with average productivity (measured by treatments per hour) are allowed to grow and replace the less productive providers, estimates show an annual potential of approx. 281,000 chiropractor treatments and approx. 729,000 physiotherapist treatments more with the current treatment capacity in the practice sector.
- If half of the providers, i.e. those with the highest number of treatments per patient, reduced the number of treatments to the same level as the average provider, estimates show a savings potential in chiropractor services of DKK 41 million for the consumers and DKK 8 million out of public funds, and an annual savings potential in physiotherapist services of DKK 72 million for the consumers and DKK 146 million out of public funds.

In addition, the current fee system of the practice sector does not support continual productivity improvements that accrue to society and the consumers.

Consumers experience good service, short waiting times and accessibility among chiropractors and physiotherapists

- Chiropractor patients experience good service in the practices (97 per cent), flexible opening hours (84 per cent), short waiting times (90 per cent) and easy access to the practices (95 per cent).
- Physiotherapist patients experience good service in the practices (90 per cent), flexible opening hours (81 per cent), short waiting times (84 per cent) and easy access to the practices (97 per cent).

Well-functioning markets support high consumer welfare. This analysis points out that the chiropractor and physiotherapist markets are not as well-functioning as they could be – and, in consequence, the consumer welfare is not as high as it could be. Box 1.2 presents the Danish Competition and Consumer Authority's thoughts on the structure of the regulation.

Box 0.2

The Danish Competition and Consumer Authority's thoughts on the structure of the regulation

The analysis points out that the Danish people could get more chiropractic treatment and physiotherapy for the same money if the regulation was structured more appropriately. This must be done with consideration for the following general principles, which the Authority finds to be compatible:

» Consideration for the health policy targets, and consideration for the need to control public expenditure.
» The possibility of efficient and equal competition.
» The possibility of efficient operations, and the possibility of the more efficient providers growing at the expense of those less efficient.

The analysis particularly gives reason to consider whether the restriction of numbers, the capacity restrictions (particularly for physiotherapists, the fee system (the fixed rates and the rate structure) and the ownership provisions are expedient.

Thoughts on evaluating the restriction of numbers should *inter alia* be seen in the light of their being based on the assumption that the consumers would demand more treatments if the capacity was higher and the access to treatment therefore easier. However, the analysis does not indicate a potential excessive demand from the patients. The analysis shows, for example, that, in the past two years, less than 1 per cent of the consumers have declined treatment despite needing it because of long waiting times.

In 2010, Sweden opened the way for free establishment to chiropractors and physiotherapists; concurrently there has been a shift towards a higher degree of demand control instead of supply control, for example by means of regionally fixed restrictions on the number of treatments. The experience gained from this shows that, on one hand, new players have entered the market; on the other hand, the right of free establishment has not resulted in an increase in public expenditure.

Thoughts on evaluating the fee system should *inter alia* be seen in the light of the National Auditors' 2012 report on the practice sector, including that today the benefits of productivity improvements typically accrue to the healthcare providers.

Thoughts on evaluating the ownership provisions should *inter alia* be seen in the light of other areas in the health sector having opened the door to (considering) lifting the restrictions on who may own practices etc. This applies to doctors and dentists, for example.

1.3 Analytical approach

The main issue of the analysis is whether the consumers and the government get as much chiropractic treatment and physiotherapy as possible for the money available with the current structure. The analysis focuses on the problems and possible reasons for this, but does not offer any solutions.

It should be noted that the analysis does not consider the potential competition between professional groups, such as chiropractors, physiotherapists and doctors, nor how much the variations in a patient's own share of expenses affect the consumers' choice between the different types of healthcare provider.

Initially, Chapter 2 focuses on the markets in a healthcare policy and socioeconomic context, the regulation and the market players. Subsequently, Chapter 3 analyses whether it is possible to identify any signs of a potential for making the markets function better than they do today and thus a potential for even higher consumer welfare. Chapter 4 then analyses possible

reasons why a potential for better-functioning markets may not be realised. Finally, Chapter 5 focuses on how consumers experience the consumer welfare on the current markets – measured by service and waiting time, for example.

Annex 1 presents the experience gained in Sweden and the Netherlands, while Annex 2 summarises the methodology and the surveys conducted for the analysis.

The analysis also includes a separate Appendix 1 listing the productivity and potential calculations of the analysis and an Appendix 2 comprising the questionnaires and response breakdowns of the analysis.