Physiotherapy practices and third party payers: issues in professional ethics in Quebec

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Report presented to the

Ordre professionnel de la physiothérapie du Quebec (OPPQ) and

Fédération des cliniques privées du Quebec

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Préambule (en français)

Ce rapport, rédigé en anglais, présente les résultats d'un sondage pancanadien à l'aide de vignettes cliniques visant à dresser un état de la distribution des services en physiothérapie. Ce préambule résume les grands éléments du rapport. Dans ce rapport, nous présentons les résultats principaux pour la province du Québec et pour le Canada en général. Un rapport complet en anglais par province est accessible à l'adresse suivante : https://www.facebook.com/PERN.ca/.

L'objectif de ce sondage était de déterminer si des facteurs liés au patient (caractéristiques personnelles) et la source de financement des services (différents types de couvertures d'assurances) ont une influence sur la distribution des services en physiothérapie au Canada dans les réseaux de santé publiques et privés. Une analyse secondaire a également été réalisée pour décrire les modèles de prestation de services des physiothérapeutes canadiens en clinique externe auprès de patients adultes ayant des problèmes musculosquelettiques.

Des professionnels canadiens en physiothérapie ont reçu une vignette clinique (description d'une histoire de cas d'un patient fictif), parmi 24 différentes vignettes. Chaque patient fictif avait la même condition médicale (douleur lombaire aigüe), mais avec différentes caractéristiques personnelles (âge, sexe, statut socio-économique) et différentes sources de financement (aucune assurance, assurance privée ou assuré par la commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) ou son équivalent provincial) qui, en les combinant, formaient au total 24 différentes vignettes cliniques. Après avoir reçu au hasard une vignette clinique, les participants ont répondu à un sondage en ligne qui contenait un questionnaire de 40 questions recueillant leurs perspectives et comportements en lien avec ce patient fictif. La distribution des services en physiothérapie était mesurée à l'aide de trois paramètres : 1) le délai de prise en charge (soit le temps requis pour voir un physiothérapeute après avoir été référé), 2) la fréquence des traitements et 3) la durée totale de traitement.

Les participants devaient être des physiothérapeutes ou thérapeutes en réadaptation physique ayant le droit de pratiquer au Canada, travaillant présentement avec une clientèle adulte en musculo-squelettique et ils pouvaient être des cliniciens ou gestionnaires.

Les caractéristiques personnelles d'un patient fictif avec une douleur lombaire aigüe ont démontré n'avoir aucune influence sur la distribution des services en physiothérapie au Canada et au Québec. Au Canada spécifiquement, en ce qui concerne les sources de financement, un patient fictif ayant subi un accident de travail et couvert par l'équivalent provincial de la CNESST recevrait une plus grande fréquence de traitement comparativement à un patient couvert par

une assurance privée ou sans couverture. Les résultats montrent aussi que dans le secteur privé, les patients fictifs sans couverture d'assurance attendaient plus longtemps que les autres avant d'être vus en physiothérapie pour la première fois. Au Québec, un patient couvert par la CNESST recevrait aussi une plus grande fréquence de traitement comparativement aux autres patients fictifs couverts par une assurance privée ou sans couverture.

Ainsi, il s'avère que les normes de pratique en physiothérapie sont étroitement liées aux sources de financement associées aux paiements des traitements. Cependant, lorsque les participants sont questionnés directement à savoir si l'âge du patient, la source de financement ou la chronicité de la condition d'un patient affecteraient leur jugement clinique sur la distribution des services de physiothérapie, ceux-ci ont répondu par la négative. Ceci implique l'existence d'un biais implicite qui défavorise les patients sans couverture d'assurances. Il est impossible avec notre devis de déterminer si ce biais est associé uniquement au professionnel de la physiothérapie ou également à la structure collective de soins.

Au Canada, de manière générale, le patient fictif avec douleur lombaire attendrait plus communément deux semaines avant d'être vu par un professionnel de la physiothérapie. Il serait suivi de deux à trois par semaine pour une période de un à trois mois. L'évaluation initiale et le temps de traitement se situeraient entre 31 et 60 minutes. L'échantillon de professionnels québécois avait une plus grande proportion de participants disant que le patient fictif attendrait plus de trois mois ou n'obtiendrait jamais de rendez-vous comparativement à l'échantillon de professionnels canadiens. L'évaluation initiale et le temps de traitement étaient aussi plus longs comparativement à l'échantillon de professionnels canadiens.

Les résultats de cette étude mettent en évidence des inégalités au Canada par rapport à l'accès et à la distribution des services de physiothérapie. Il a été démontré que les sources de financement créent des incitatifs puissants qui influencent les comportements des professionnels de la physiothérapie. Ce type de biais implicite est souvent inconscient et la première étape est de l'identifier clairement. Il faut également partager ces résultats avec l'ensemble de la communauté des professionnels en physiothérapie afin de générer une discussion et commencer à trouver des solutions. Cette étude, contribuant à la formation d'une éthique professionnelle collective, pourrait servir de tremplin à l'élaboration des politiques nationales et provinciales pour assurer que la population canadienne ait un accès et une allocation des ressources en physiothérapie équitables.

Final report

Project

Physiotherapy practices and third party payers: issues in professional ethics

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Introduction

During a 4-month period, July 2nd 2014 to November 1st 2014, Canadian physiotherapy (PT) professionals were solicited for participation in an empirical cross-sectional online survey questionnaire. Our research team was interested in exploring the ethical challenges encountered in the interactions between PT professionals and third party payers. Analysis of the survey will be disseminated through scientific publications.

The purpose of this report is to give detailed results relevant to your provincial association.

Methodology

An online survey containing clinical vignettes (i.e., case scenarios) along with a 40-item questionnaire was used to collect data on the practices of PT professionals. The objective was to evaluate whether the source of funding for PT services, as well as specific patient-related characteristics, influence wait time, the frequency of treatment and the duration of treatment. A secondary objective was to describe the current patterns of service delivery of Canadian PT professionals working in adult musculoskeletal outpatient practice.

In total, 24 vignettes were developed and distributed across 10 Canadian provinces and 3 territories. Each vignette described a patient treated in PT with the same musculoskeletal problem (lower back pain) but with variations in certain patient characteristics (age, gender, socio-economic status (SES)) and in insurance coverage (private insurance, Workers Compensation Board (WCB) or none). Figure 1 illustrates the different possible combinations used to construct the 24 vignettes. The complete clinical vignette can be found in Appendix 1.

PT professionals participating in the study received one randomly selected vignette with the accompanying questionnaire through a personalized weblink. The questionnaire included: 1) demographic questions and 2) questions about service provision to the patient described in the vignette, such as patient prioritization, treatment frequency and total treatment duration. The inclusion criteria to participate in the survey were:

1) Be a physiotherapist or a physical rehabilitation therapist (PRT) with the right to practice in Canada
2) Currently working with an adult clientele
3) Currently working with a musculoskeletal clientele
4) Be a clinician or manager

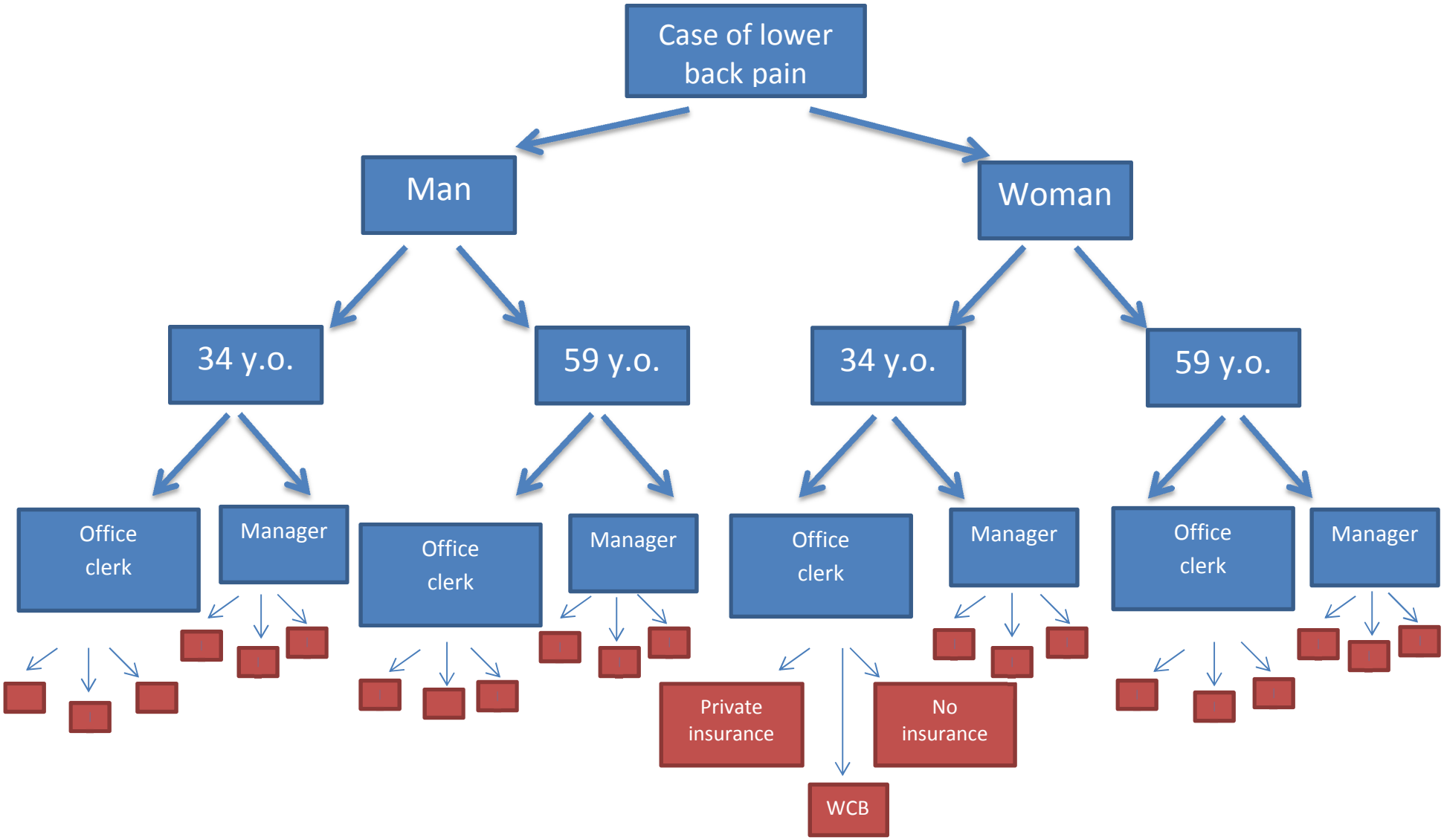
Case of lower back pain
Man
Woman
34 y.o.
59 y.o.
34 y.o.
59 y.o.
Office clerk
Manager
Office clerk
Manager
Office clerk
Manager
Office clerk
Manager
Private insurance
No insurance
WCB

Figure 1

General descriptive statistics

846 individuals were included for analysis (9.8% of the predicted Canadian respondent pool).

Please note that the following information is a descriptive overview of the results from surveys completed by PT professionals from your province. These findings are not necessarily statistically or clinically significant.

Table 1 focuses on the descriptive statistics of our responding professional sample of professionals from the province of Quebec compared to the overall Canadian respondents.

The professional sample in Quebec is comparable to the overall professional sample. As expected, the Quebec professional sample has more PRTs. Also, there seems to be a slightly higher proportion of clinicians (as opposed to having dual roles of manager and clinician) working in public settings compared to the overall sample.

Category	Subcategory	Canada N (%)	Quebec N (%)
Role at work	Clinician	644 (76.1)	294 (79.9)
	Manager	25 (3.0)	9 (2.5)
	Both	177 (20.9)	65 (17.7)
Sector of practice	Private	388 (45.9)	148 (40.2)
	Public	353 (41.7)	180 (48.9)
	Both	105 (12.4)	40 (10.9)
Training *	Physiotherapist	734 (86.8)	258 (70.1)
	Physical rehabilitation therapist (postsecondary diploma)	112 (13.2)	110 (29.9)
Sex (CAN: n=845 QC: n= 367)	Women	669 (79.2)	293 (79.8)
	Men	176 (20.8)	74 (20.2)
Age (CAN: n=845 QC: n= 367)	18-25 y.o.	62 (7.3)	45 (12.3)
	26-35 y.o.	233 (27.6)	103 (28.1)
	36-45 y.o.	228 (27.0)	91 (24.8)
	46-55 y.o.	205 (24.3)	93 (25.3)
	56-65 y.o.	108 (12.8)	33 (9.0)
	>66 y.o.	9 (1.1)	2 (0.5)
Highest level of education (CAN: n=845 QC: n=367)	CEGEP/Community college	107 (12.7)	99 (27.0)
	Bachelors	509 (60.2)	193 (52.6)
	Masters	223 (26.4)	75 (20.4)
	PhD or equivalent	6 (0.7)	0 (0)
Years of experience	0-5 years	174 (20.6)	85 (23.1)
	6-10 years	115 (13.6)	46 (12.5)
	11-15 years	119 (14.1)	57 (15.5)
	16-20 years	120 (14.2)	49 (13.3)
	21-25 years	100 (11.8)	55 (15.0)
	26-30 years	81 (9.6)	32 (8.7)
	> 30 years	137 (16.2)	44 (12.0)
Place of work**	Rehabilitation center	84 (9.9)	44 (12.0)
	Long-term care center	95 (11.2)	49 (13.3)
	Hospital	255 (30.1)	107 (29.1)
	Private clinic	462 (54.6)	170 (46.2)
	School	26 (3.1)	11 (3.0)
	Home care services	146 (17.3)	74 (20.1)
	Other	50 (5.9)	16 (4.3)
Main clientele**	Children and adolescent	128 (15.1)	42 (11.4)
	Adult	769 (90.9)	324 (88.0)
	Older adults	352 (41.6)	155 (42.1)
Type of clientele**	Cardiorespiratory	107 (12.7)	45 (12.2)
	Musculoskeletal	803 (94.9)	347 (94.3)
	Neurological	243 (28.7)	100 (27.2)
	Other	74 (8.8)	38 (10.3)
Status of employment (CAN: n=845)	Full time	631 (74.7)	267 (72.6)
	Part time	214 (25.3)	101 (27.5)

Table 1 – Descriptive Statistics for Canada (n=846) and the province of Quebec (n=368)

** Physiotherapists are trained at the university level (bachelor's or master's degree), whereas physical rehabilitation therapists are trained at the community college level (post-secondary diploma)*

***Some sections could have multiple answers (place of work, main clientele and type of clientele) explaining total percentage higher than 100% in these sections*

Factors influencing PT service provision

The primary purpose of the project was to explore whether patient-related characteristics (age, socio-economic status and gender) and circumstances of insurance coverage (private insurance, WCB or none) were associated with wait time, frequency and duration of treatment. Table 2 indicates that insurance status is a statistically significant factor related to wait time and treatment frequency in Canada. Moreover, in the province of Quebec, WCB patients were also seen more frequently than patients with private insurance or no insurance.

We found no differences in wait time, frequency or duration according to SES, age and gender. However, respondents stated that older patients are seen more frequently ($p=0.04$) and for a longer duration ($p=0.04$) in Ontario. Insurance status was a significant factor in the overall Canadian sample: those with no insurance wait longer in the private sector ($p=0.002$) and those who are covered by WCB are seen more frequently (Canadian sample: $p<.001$; Quebec sample only: $p<.001$).

Interestingly, even if insurance status is a statistically significant factor related to wait time and treatment frequency in Canada, when we asked all participants if their answers would differ depending on a change in insurance status, the vast majority stated it would make no difference in their service provision.

Table 2 presents wait times, frequency and duration of treatment, time for initial evaluation and time for treatment for a patient covered by private insurance, the WCB or no insurance at all in the Quebec and Canadian professional samples.

Overall in Canada, based on the vignette responses, a patient with LBP would most commonly be seen within 2 weeks, 2 to 3 times per week and for a period of 1 to 3 months. The initial evaluation and the treatment time would be between 31 and 60 minutes. The treatment frequency was similar in private settings regardless of the patient's insurance status, except for patients covered by the WCB who were likely to be seen more frequently (4 to 5 times a week). This tendency is accentuated in Quebec. Also, the Quebec professional sample had a higher proportion of respondents stating that the vignette patients would wait for their first appointment for more than 3 months or would never get an appointment compared to the Canadian professional sample. The initial evaluation and the treatment time are also longer compared to the Canadian professional sample.

Table 2– Service provision parameters for the Quebec and Canadian professional sample of a low back pain vignette

		Wait time (CAN: n=841, QC: n=364) %					Frequency (CAN: n=796, QC: n=337) %				Duration (CAN: n=816, QC: n=351) %				Time for initial evaluation (CAN: n=822, QC: n=356) %			Average time for treatment (CAN: n=821, QC: n= 355) %		
		<2 weeks	2-4 weeks	1-2 months	>3 months	Never	≤1 /week	2-3/week	4-5/week	Varies	0-4 weeks	1-3 months	>3 months	Varies	≤30 min	31-60 min	>60 min	≤30 min	31-60 min	>60 min
QC	**Private insurance**	52.1	17.1	12.0	6.8	12.0	24.3	57.0	13.1	5.6	15.3	56.8	15.3	12.6	1.8	82.9	15.3	35.1	61.3	3.6
	WCB	55.8	8.9	10.6	14.2	10.6	22.1	35.6	31.7	10.6	14.0	58.9	18.7	8.4	12.6	66.7	20.7	35.8	59.6	4.6
	No insurance	55.2	17.9	7.5	12.0	7.5	21.5	61.5	8.5	8.5	16.5	62.4	14.3	6.8	0.7	85.1	14.2	28.1	68.9	3.0
	Total	54.4	14.8	9.9	11.0	9.9	22.8	52.8	17.2	7.1	15.4	59.5	16.0	9.1	4.8	78.7	16.6	32.7	63.7	3.7
CANADA	**Private insurance**	61.6	12.3	11.6	6.2	8.3	18.0	58.6	16.9	6.5	16.6	61.1	12.8	9.4	6.0	83.5	10.5	50.8	47.4	1.9
	WCB	61.3	11.2	10.4	9.7	7.4	18.2	47.8	26.5	7.5	13.6	65.1	15.1	6.2	9.9	75.7	14.4	47.1	49.8	3.1
	No insurance	61.5	17.2	6.1	9.5	5.7	24.1	59.2	9.9	6.7	17.4	62.8	14.0	5.8	3.4	86.7	9.9	44.6	54.1	1.4
	Total	61.5	13.7	9.3	8.4	7.1	20.2	55.4	17.5	6.9	15.9	63.0	14.0	7.1	6.3	82.1	11.6	47.4	50.5	2.1

Recommendations

As healthcare professionals working in a diverse society, it is our duty to ensure that patients receive proper and high quality care, regardless of financial or social background. The Canada Health Act (CHA) shares similar values as its primary objective is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers".

This research suggests that unfortunately there are disparities in Canada with respect to access to PT services and in PT service provision, especially in relation to the insurance status of patients.

Based on this descriptive study using a clinical vignette, there appears to be important differences in the way that professionals provide PT services. The results highlight the need to pay attention to differences in how professionals *perceive* their service provision as compared to how *in practice* they provide service, with special attention to the role of insurance status and gender.

Biases are often unconscious and the first step toward addressing them is that they be clearly identified. Sharing these findings with members of PT associations, managers and PT professionals is necessary to generate a discussion and begin finding solutions to improve equity of care.

Discrepancies in service provision based on insurance status can be a result of structural or institutional features. PT professionals also need to examine how policies and institutional structures shape their clinical practice. These considerations warrant careful scrutiny as systemic and structural issues often lead to decisions about how often people are seen and how quickly treatment is initiated.

Conclusion

This study makes a significant contribution to our understanding of the provision of PT services. It is part of a broader research project investigating issues related to ethics and equity related to the distribution and provision of care. Study findings will inform stakeholders (managers, third party payers, private insurers) regarding how insurance status and social factors may influence professional practice and provide guidance for where to begin in seeking to improve the accessibility and equity of PT services for the Canadian population.

This report and subsequent publications can be found at this address: https://www.facebook.com/PERN.ca/

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Appendix – Clinical vignette

A (34/59 y.o.) (man/woman) who works as a (senior manager/office clerk) comes to your clinic for a consultation. He/she says that he/she suffers from low back pain which started 6 years ago but his/her condition has gotten worse in the last few months after a fall. For almost a year, in addition to his/her usual pain in the lower back, he/she now feels the pain radiating down his/her buttock, thigh and left leg which causes him/her much discomfort. Flexion of the spine is very painful and the patient cannot endure long hours sitting in his/her office anymore. His/her work station does not provide optimal ergonomics and has not for several years now. (text from one of the 3 following coverage options)

1) Private insurance: The pain being too intense, the patient has been off of work for the last four weeks. He is covered by a private insurance ($50/treatment, limit of $750 a year for physiotherapy).
2) Workers' Compensation Board: The pain being too intense, the patient has been off of work for the last four weeks and is compensated by the equivalent of the Workers' Compensation Board.
3) No insurance: The pain being too intense, the patient has been off of work for the last four weeks. He is not covered by private insurance for physiotherapy coverage and is paying out of pocket for treatment.

He was referred to physiotherapy for lumbar rehabilitation by a doctor who suspects a discal protrusion at the level of L4-L5. The physician noted on the referral that the patient had hypoesthesia to pain and to touch in the L5 dermatome. The patient complains of pain 3/10 in the lumbar region and 5/10 in the leg.