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Issues surrounding chiropractic fee negotiations in Saskatchewan†

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Chiropractic fee negotiations in Saskatchewan utilize the Chiropractic Compensation Review Committee with recourse to the Chiropractic Consultation Committee. Health care professionals who practise on a fee for service basis provide the government with a budgetary problem. Although the fees are set, the health care provider can determine his own income by deciding how many visit services he/she wishes to provide. In the fiscal years 1981–82 to 1990–91, chiropractors earned $699.00 per year more than one would expect given the increases in fee schedules. Each chiropractor earned $2,329.00 per year more than was necessary to make up for losses due to inflation. The allegation that unnecessary treatments were performed on patients is countered by analysis of the services per discrete patient values by mode of practice. The increased earnings of chiropractors was accomplished by treating an increasing percentage of the population who sought health care. Comparative information was obtained from the four western provinces.
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KEY WORDS: chiropractic fee negotiations, copayment, services per discrete patient, professional practice, physician's practice patterns, chiropractic, manipulation.

En Saskatchewan, les négociations des honoraires des chiropraticiens sont entreprises par le Comité de révision des rémunérations des chiropraticiens avec recours au Comité consultatif chiropratique. Les professionnels qui oeuvrent auprès du secteur de la santé et qui sont entièrement rémunérés par le gouvernement pour leurs services rendus, posent certains problèmes au niveau budgétaire de ce dernier. Quoique les honoraires reçus soient fixes, celui qui offre le service peut déterminer son revenu annuel en établissant le nombre de consultations qui sera requis pour un client donné. Pour les années d'exercise de 1981–82 à 1990–91, les chiropraticiens ont gagné 699 $ par année de plus que ce qui avait été prevu selon le barème d'augmentation des honoraires. Chaque chiropraticien a reçu 2 329 $ par année de plus que la somme qui serait normalement requise pour pallier aux pertes dues à l'inflation. Il y a des allégations qui suggèrent que les chiropraticiens s'affairent à prescrire, à plusieurs de leurs clients, des traitements qui ne sont pas nécessaires. Ces affirmations sont contredites par une analyse du nombre de visites par client selon le mode de pratique. L'augmentation des salaires des chiropraticiens est directement reliée à l'accroissement continuel du nombre de gens qui ont choisi de consulter un chiropraticien.
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MOTS-CLÉS : négociations des honoraires des chiropraticiens, copaiement, nombre de visites par client, chiropratique, manipulation.

Introduction

In 1985, Saskatchewan chiropractors (and all other health care practitioners) lost the right to charge fees that were higher than the negotiated fee schedule. While it is true that a practitioner may opt out of the government-funded plan if the service provided is readily available, in the Saskatchewan marketplace, where health care is considered by consumers to be "free", only a few practitioners of any type have taken this step. Patients are not reimbursed for services provided by a practitioner who has "opted out".

Chiropractic services in Saskatchewan have been paid by Medical Care Insurance of Saskatchewan Health (or its predecessor the Saskatchewan Medical Care Insurance Commission) since 1973. Funding for these services is not included in federal provincial transfer payments. Unlike many other provinces, there is no limit on the amount of services paid for by the health care system in Saskatchewan. Thus, one can obtain accurate

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statistical data about chiropractic care in the province. Saskatchewan is the only jurisdiction in the world where all visits to chiropractors are recorded in a central registry. In other jurisdictions, once a patient exhausts their insured limit, information about their care is lost to review until the next fiscal year.

This paper will describe the process for negotiation of chiropractic fees in Saskatchewan and the results of that process; that is, the changes in the cost of the program over a ten year period.

The negotiation process

Negotiation for chiropractic fees is essentially a two-tier process. Two committees, each with a different mandate, are established in the Regulations pursuant to Section 41 of *The Saskatchewan Medical Care Insurance Act*.[1] These Regulations are cited as *The Chiropractic Services Payment Negotiation Regulations*. The Regulations were last updated September 1988. The two committees are as follows:

i. The Chiropractic Compensation Review Committee, established pursuant to Section 3 of Regulations;
ii. The Chiropractic Consultation Committee, established pursuant to Section 5 of Regulations.

The Chiropractic Compensation Review Committee

This committee is composed of not more than fourteen members, seven appointed by the president of the Chiropractors' Association of Saskatchewan (CAS) and seven appointed by the Saskatchewan Deputy Minister of Health. This committee has the specific mandate to negotiate the general rates of payments made under *The Saskatchewan Medical Care Insurance Act*.

The Chiropractic Consultation Committee

This standing committee is composed of not more than six members, three appointed by the president of the CAS and three by the Deputy Minister of Health for Saskatchewan. This committee is designed to provide ongoing communication between the profession and the Department of Health.

If the negotiations in the Compensation Review Committee reach an impasse, or if specific items under negotiation are not resolved, these matters may be referred to the Chiropractic Consultation Committee. If the issue cannot be resolved, the Regulations provide for the appointment of a mediator. However, unless both parties agree that the mediator's report is binding, either party may choose to ignore the report.

The issue of utilization considered during fee negotiation

Evans[2] argues that doctors can control their income to a great degree by deciding just how busy they wish to be. In a fee for service practice, the greater the number of patient visits, the more income earned.

Once a fee schedule is determined for chiropractors, the government is obliged to pay for the services rendered no matter what the cost as long as the services were clinically necessary. The Medical Care Insurance Branch pays for care rendered to individual patients, not simply a certain wage to physicians (except in the community clinics).

After most labour-management wage negotiations, it is possible for management to accurately budget for expenditures based on the results of the wage (fee) settlement. However, the size of the chiropractic "labour" budget depends on decisions made by labour (chiropractors) not by management (government). The government has no control on actual expenditures for health care services.

The decision to consume health care services involves different considerations other than consumer purchase decisions.[2–5] When a consumer "wants" to buy a car, the decision to buy the car is based on available resources, balanced against competing uses for the resources. When a consumer "needs" to consume health care several other factors must be considered. When the "doctor" says that they must have a certain treatment, patients tend to follow suggested regimens of therapy at least initially when they are in some discomfort.[3–5]

Since 1985, Saskatchewan chiropractic patients have not been faced with an economic barrier in the consumption of chiropractic care, other than the cost of time spent in waiting in the chiropractor's office. Prior to 1985, those chiropractors unhappy with the negotiated fee schedule set their fees at a level higher than the negotiated amount and their patients paid a copayment to see them. The patients paid the greater fee and were reimbursed the equivalent of the negotiated fee by the Medical Care Insurance Commission.

One would assume that in a free market economy, the market functioned to keep fees at a reasonable level. If the fee was too high, fewer patients would attend the office for care and the income of the chiropractor would decrease. Since 1985, all Saskatchewan practitioners have been forced to accept the fee schedule or to "opt out" entirely, in which case those patients attending their office would not be reimbursed any of the cost of the visit service. Unlike medical doctors where only 2 to 4% of all billings for visit services involved a copayment, approximately 50% of Saskatchewan chiropractors utilized the copayment option prior to 1985.[6] For those chiropractors who charged patients more than the negotiated fee schedule, the unexpected drop in the fee charged to patients after 1985 would have caused a similar drop in income if they did not increase the volume of patients seen.

It is often implied at the negotiation table that the increased frequency of visits at many practitioners' offices was a consequence of practitioners telling their patients to return for what may be unnecessary treatments. In fact, the increase in patient services is more complicated than simply blaming the practitioners. Variations in the cost of care have been shown to result from other factors, including distance from available health care, socioeconomic or educational status and differences due to cultural background.[2]

Prior to 1985, 50% of the chiropractors charged their patients a copayment (know colloquially as "Extra Billing"). After the changes to the Medical Care Insurance Act, these practitioners

lost the ability to generate extra income using the copayment. Not surprisingly, the cost of patient care in these offices rose after 1985. This affords an opportunity to critically examine the suggestion that increased patient attendance is a result of chiropractors providing unnecessary treatments in order to increase their income. If the allegation regarding unnecessary care is true, one might expect to see the "extra biller" group increase the number of times that they saw their patients to recapture all of their lost income. One would expect to see that they would have a higher cost of care relative to the "control" group – those practitioners who are not affected by the reduction in fees. The "extra-biller" group and the "control" group were spread fairly evenly throughout city and rural practices, hence eliminating the confounding variable of ease of access.

The removal of a fee barrier has been shown to create increased compliance with suggested regimes of therapy.[2,4,5] Faced with an economic hardship, patients often accepted a sub-standard level of care as more pressing demands on economic resources overruled attendance at a level required for optimal recovery to health. Patients attended for treatments until they were recovered enough to function and then discontinued treatment. Thus, while the cost of care may be lower, the cost to society rises in terms of lower productivity as well as the increased discomfort experienced by the patient.[3–5]

Changes in chiropractic expenditures over time

The cost to the provincial health care plan for chiropractic services rose dramatically in the years after 1985. Part of this increase was a negotiated one, a concession by the government that half of the chiropractors would suffer economic difficulty with the abrupt change in billing procedure. Table 1 describes the actual amounts spent on chiropractic services in Saskatchewan. The fiscal amounts ranged from $4,756,000.00 in 1981–82 to $13,547,000.00 in the 1990–91 fiscal year.[8–19]

Chiropractors in Saskatchewan increased their earnings at an average rate of $699.00 per chiropractor per year more than the government negotiators had expected even after adjusting for fee increases and added practitioners. This calculation is shown on Table 2.

Table 3 compares the Chiropractic Fee Schedule for regular office visits to changes in the consumer price index.[6,20] In terms of purchasing power, chiropractors in Saskatchewan have gained on inflation $2,329.00 per year per practitioner over the ten year period. This calculation is shown in Table 4. Most of the difference lies in fee settlements in 1985 and 1986.

Figure 1 depicts how often Saskatchewan patients were treated by chiropractors in 1988–1989 fiscal year. Of the 117,155 people who saw a chiropractor, 18,663 people saw a chiropractor once, 14,812 saw a chiropractor twice, 12,178 three times and so on. The frequency of attendance diminishes rapidly, e.g. 3,509 patients were seen ten times while only 371 patients saw a chiropractor thirty times. Only 991 different people were seen more than 50 times; 217 people were seen more than 75 times and 53 people were seen more than 100 times.[21]

Table 1[8–20]
Fiscal Amounts Spent on Chiropractic Services in Saskatchewan, Number of Chiropractors, Average Payments to Chiropractors

Year	Annual fiscal for chiropractic services	Number of active chiropractors	Average payment per chiropractors
1981–1982	4,756,000	69	70,300
1982–1983	5,624,000	76	73,100
1983–1984	6,571,000	79	78,500
1984–1985	6,958,000	85	78,504
1985–1986	8,091,000	83	91,638
1986–1987	9,610,000	89	108,400
1987–1988	10,522,000	96	105,641
1988–1989	11,344,000	99	112,000
1989–1990	12,894,000	107	119,091
1990–1991	13,547,000	108	124,352

Active chiropractors include those earning more than $30,000/year ($40,000 for 1990–1991).

Fiscal totals include payment for all chiropractic services including payment for services rendered by chiropractors who earned less than $30,000 in the year under review.

Definitions

In order to understand the following analysis, several definitions must be explained.

Case mix

This term refers to the combination of diagnoses and severity of each condition found within a particular practice. For any diagnosis, there will be a range of severity of the problems, requiring varying amounts of treatment.[7]

Discrete patient

This term refers to the number of different patients that a practitioner sees in a certain time period, such as quarterly or yearly. If the same patient sees two different practitioners, that counts as a discrete patient for each of the practitioners.

Visit service

This refers to an attendance at a doctor's office by a patient.

Service per discrete patient

The average of all visit services divided by the number of discrete patients seen. This average figure provides an indication of a combination of the case mix in the practice and the individual clinician's approach to treatment.

Table 2
Increase in Chiropractic Budget Expected Due to Fee Increases

The chiropractic fee schedule increased from 1980–1981 to 1990–1991 by 70.6%. The number of active chiropractors increased from 69 to 108.

Correction for fee increases:		
$4,756,000 × 1.706	=	$ 8,113,736
Correction for additional practitioners:		
The average payment to chiropractors in 1981–1982 was $70,300		
$70,300 × 1.706 = $119,932		
39 chiropractors @ $119,932	=	$ 4,677,348
Adjusted for added practitioners and fee increases		$12,791,084
Actual expenditures on chiropractic services 1990–1991		$13,547,000
Difference		$ 755,916

Thus, in the ten years the revenue paid to all active chiropractors increased by $755,916.00 more than could be expected from fee increases. This is $6,999.22 per practitioner in total or $699.00 per practitioner per year more than could be expected due to fee increases.

Table 3[6,21]
Changes in CPI* and Chiropractic Fee Schedule

Year	CPI	CAS fee $	% increase
1981–1982	11.3	8.00	11.9
1982–1983	6.7	9.00	12.5
1983–1984	4.7	9.63	7.0
1984–1985	3.8	10.14	5.2
1985–1986	3.9	10.26	12.0
1986–1987	4.5	11.50	12.0
1987–1988	4.2	11.50	0.0
1988–1989	4.6	12.25	3.0
1989–1990	5.3	12.75	3.0
1990–1991	6.3	13.10	4.0
% change 1980–1991	51.4		70.6

* CPI = Change in Consumer Price Index relative to March 31 of the previous year.

Consideration of services per discrete patient includes some patients who saw more than one chiropractor in a year. These patients were counted as a discrete patient for each different chiropractor that they saw. On average, there were 2,288 more discrete patients than actual patients per year for the ten years ending 1989–1990.[21]

If a practitioner had 1,000 visit services in a year and he saw 100 discrete patients, his services per discrete patient figure would equal 10. Note that this figure is simply an average and that an individual practice would contain patients who were seen infrequently in a given year and some patients seen very frequently. Since a majority of patients were seen a few times, one can understand why the services per discrete value is so low.

Average service per discrete patient
The average of all practitioners in the group for a certain time frame.

Mode 3
These practitioners had "opted out" of the health care plan. That is, their fee was higher than the negotiated fee schedule. Patients paid this higher fee or copayment and were reimbursed the negotiated amount by the health care plan. All of the chiropractors in this analysis were in "active" practice. That is, they were paid more that $30,000.00 from the health care plan in the year in which they were analyzed.

Table 4
Increases in Chiropractic Budget Relative to Increases in Inflation

Toltal inflation 1980–1981 to 1990–1991 is 51.4%		
$4,756,000 × 1.514	=	$ 7,200,584
Correction for additional practitioners: and inflation:		
$70,300 × 1.514 = $106,434		
39 chiropractors @ $106,434	=	$ 4,150,934
Adjusted for added practitioners and inflation		$11,351,518
Actual expenditures on chiropractic service 1990–1991		$13,547,000
Difference		$ 2,195,482

Thus, in the ten years the revenue paid to all active chiropractors increased by $2,195,482.00 more than was necessary to keep pace with inflation. This is $20,328.54 per practitioner in total or $2,329.00 per practitioner per year more than inflation.

Mode 8

These practitioners practised "under the plan". In other words they accepted the negotiated fee schedule and thus patients were not charged anything for a visit service. The survey only includes chiropractors who were in "active" practice.

Results

Table 5 lists the average services per discrete patient figures by type of practice and fiscal year.[21] In order to decide whether there are any differences, the actual yearly services per discrete patient figures for each active chiropractor in Saskatchewan were subjected to an Analysis of Variance Test (ANOVA Test) and then to Fisher's LSD Test using the statistical package NCSS.[22] A 95% confidence level was used.

When comparing the average visit services of those chiropractors who charged their patients a copayment prior to 1985 (Mode 3) to those who did not (Mode 8), the statistically sigificant differences in services per discrete patient (SPDP) all occurred in the averages of those practitioners who had opted out of the plan (Mode 3). In the three years prior to 1985, the Mode 3 average SPDP was significantly smaller than the Mode 3 and Mode 8 average SPDP from 1985–1986 to 1988–1989. (95% level of confidence.)

For the two years following the removal of an economic barrier to those patients who were seeing a Mode 3 practitioner (previously charged a copayment to patients), the patients in the Mode 3 practices were seen on an increasingly more frequent basis per year. In the fiscal year 1983–1984, the services per discrete patient figure for Mode 8 practitioners was statistically significantly higher than the value for the Mode 3 Practitioners. (95% level of confidence.) This tends to suggest there may have been some economic barrier to those patients visiting the Mode 3 practitioners.

After 1985, the services per discrete patient figures of Mode 3 practitioners approached the level of the Mode 8 practitioners. The increased cost to the chiropractic program was a direct result of this change in policy – that is, the restriction of the copayment option. The suggestion that those practitioners who were outside the plan simply saw the same patients unnecessarily often is countered by this data. The services per discrete patient figures of the Mode 3 practitioners simply approached the levels of the Mode 8 practitioners. Although the Mode 3 values are slightly higher after 1985, the differences are not statistically significant.

It has also been suggested at the negotiating table that over time all practitioners have been seeing their patients more often. Again the data does not support this suggestion. When the Mode 8 values from 1980–1981 to 1984–1985 were compared to all of the service per discrete patient values after the restriction of copayment in 1985, **there is no statistical difference**. There has been no change in the services per discrete patient values in the nine years under review, after correcting for the confounding variable of a copayment charge to some of the patients seen by chiropractors prior to 1985.

Table 5[19]
Average Visit Services Per Discrete Patient Per Year

	MODE 8		MODE 3	
Year	Number chiropractors	Average SPDP	Number chiropractors	Average SPDP*
1980–1981	27	6.3244	32	6.2541
1981–1982	28	6.37	33	6.1176
1982–1983	34	6.57	38	5.9376
1983–1984	38	6.7581	41	5.7798
1984–1985	45	6.3919	40	5.7548
1985–1986	44	6.5543	40	6.7822
1986–1987	50	6.6491	39	6.9749
1987–1988	57	6.5521	39	6.7410
1988–1989	60	6.7545	39	6.8926

*SPDP = Service per Discrete Patient

Table 6[9–19]
Number of Discrete Patient Per Year Seen by Chiropractors

Year	Number discrete patients treated by chiropractors	Total beneficiaries	Percent of beneficiaries treated
1980–1981	82,692	982,257	8.2
1981–1982	88,301	990,746	8.7
1982–1983	92,349	1,000,667	9.0
1983–1984	98,054	1,014,496	9.4
1984–1985	99,325	1,028,965	9.5
1985–1986	105,321	1,039,249	9.9
1986–1987	111,656	1,041,358	10.5
1987–1988	112,628	1,045,440	10.5
1988–1989	117,155	1,044,151	11.2
1989–1990	120,491	1,036,862	11.6
1990–1991	124,424	1,029,352	12.1

The increase in expenditures for chiropractic services reflects the fact that more and more Saskatchewan patients go to see chiropractors each eyar. Table 6 shows the numbers of patients who visited chiropractors each year from 1980–1981 to 1990–1991. As well, the total number of Saskatchewan beneficiaries is shown. There has only been a net gain of 47,095 beneficiaries in the ten year period. In 1980–1981, chiropractors saw 8.2% of those Saskatchewan patients who consulted a physician for health care. By 1990–1991, this figure had risen to 12.1% of those who sought care.

This increased utilization reflects the fact that there are more

Table 7[18,20,25–28]
Data from Ontario and the four western provinces 1989–1990

	Ontario	Manitoba	Saskatchewan	Alberta	B.C.
Total patients in province	9,599,000	1,129,000	1,036,862	2,568,211	3,055,600
Total services by chiropractors	8,190,868	805,282	1,028,862	2,202,163	2,159,603
Discrete patients seen by chiropractors	835,866	158,989	120,491	275,363	415,000
Services per discrete patient	9.80	5.07	8.54	8.00	5.20
Number of chiropractors	1,498	96	113	353	428
Population: practitioner ratio	1:6,408	1:11,760	1:9,176	1:7,275	1:7,139
Percent of population seen	8.71	14.08	11.62	10.72	14.00

chiropractors in the province. The Chiropractors' Association of Saskatchewan suggests that an optimal practitioner:population ratio is about 1:5,500.[6,23] Currently, this figure is closer to 1:9,000.[19] In other words, there is an undersupply of chiropractors, particularly in the rural areas.

Data from Ontario and the four western provinces

Data was obtained from the provinces whose health care plans provide some coverage for chiropractic services. Table 7 outlines information about the total visits and the percentage of the population seen by chiropractors.[18,21,25–28] Manitoba and British Columbia chiropractors have been more successful at treating a greater percentage of the population. Ontario has a lower practitioner:population ratio, yet has the lowest percentage of the population seen by chiropractors and the highest services per patient ratio.

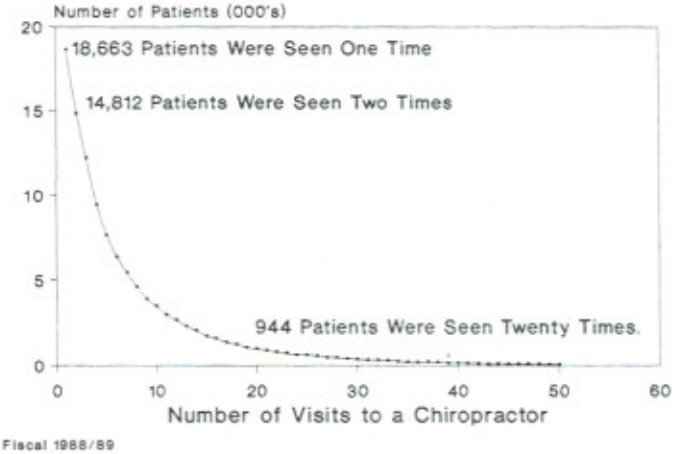
Conclusion

Because the market for chiropractic care is under serviced, the government should expect to see increases in the expenditures for chiropractic care as additional practitioners arrive. The allegation that chiropractors are seeking to improve income by asking patients to return too often is countered by the data presented above. On average, chiropractors see more of the population each year, but they do not appear to see them more frequently than in the preceding years.

More analysis of patterns of practice must be done to see if the provinces with the lower average service per patient values do treat their patients less often. Figure 1 shows that more than half the patients who consulted a Saskatchewan chiropractor were seen five or less times. Practitioners in Manitoba and British Columbia treat a larger percentage of the population and it seems reasonable to assume that many of these patients are treated less than five times, resulting in the lower service per discrete values. In addition, data analysis from all other provinces is hampered by the fact that once a patient uses up his or her insured services, the patient's treatment is lost to review until the next fiscal year.

Saskatchewan practitioners appear to treat their patients in a manner that is consistent with Alberta where a copayment exists. Similar percentages (10.7% and 11.6%) of the population see chiropractors. This would tend to negate the suggestion that the Mode 8 practitioners have always seen their patients more frequently to make up for a decreased income resulting from lower fees.

Figure 1 Number of Times Patients Seen



The two committee structure for negotiating Saskatchewan chiropractic fees and other issues calls for communication between the two chiropractic committees. Government negotiators may seek to delay or avoid issues by shuttling issues between the two committees. The chiropractic committee members must be conversant in the law defining the committee structure in order to use it to their advantage.

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