Australian Association of Massage Therapists

A submission on behalf of the Australian Association of Massage Therapists Ltd

First Stage of Human Services – Productivity Commission Public Inquiry

Identifying Sectors for Reform

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Massage Therapy Balances Health for Life

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1. Overview of human services

The roles for government in human services

REQUEST FOR INFORMATION

The Commission is seeking participants' views on what constitutes improved human services. Do the concepts of quality, equity, efficiency, responsiveness, and accountability cover the most important attributes of human services? If these are the most important attributes, how should they be measured or assessed?

As stated in the issues paper, human services help individuals develop their capabilities and maintain and improve their quality of life. Quality, equity, efficiency, responsiveness, and accountability are useful terms for measuring the delivery of human services. However, they do not adequately measure services, specifically from a recipient's or end user's point of view.

The first principle of helping people in need, is empathy – perceiving and understanding another person's physical and emotional circumstances and limitations. It goes to the core of preserving the dignity and self-worth of a person. Such understanding is developed through building long-term client-patient relationships[i] and can counter the dehumanising effect of quantitative measures for evaluating delivery such as efficiency.

While some empathy measures are considered in Box 2, 'The attributes of human service,' (Quality), they are described as intangibles. However, from an end-user's point of view they are in fact the most tangible and relevant measure they have of how the service has affected them.

Additionally, efficiency is often confused with effectiveness. It is often measured by the number of services provided, at a given cost, to achieve a given outcome. It can lead to an over-emphasis on the number of services delivered and tasks completed, at the expense of value or respect for a recipient's unique situation, strengths, weaknesses, and what is important to them.

An empathy measure places a greater focus on the need for fruitful client-patient relationships and is a useful qualitative measure to determine the true value of assistance and services provided from the recipient's point of view.[ii] Having a deeper understanding of the end user, would also help providers to deliver services in a manner that empowers the end user. Hence, it can help to determine if the solution provided or requested by an individual has addressed the underlying circumstances or cause of an individual's needs.

Quality, equity, efficiency, responsiveness, and accountability can also lead to the homogenisations of services and the perceived needs of individuals, and the over-simplification of recorded information for assessment purposes. The authors of the 2010 McKinsey and Co article,[iii] *'When and how provider competition can improve healthcare',* suggest that when introducing competition, it is also important that funding is linked to and follows each patient; otherwise providers have little reason to compete with each other for patients.

For example, let us consider a group of doctors sharing a round involving regular check-ups of the elderly living in an aged care facility who have a variety of mental and physical conditions. In any given week, it would appear more efficient and responsive for the doctors involved to split the rounds among them based on their availability and commitments at the time. As all are qualified health professionals, it would be easy to assume patients would receive largely the same level of medical attention, care and accuracy of diagnosis, and that outcomes of quality, responsiveness and accountability would be met.

However, the potential lack of continuity with patients, and poor quality assessments based on a narrow window of one-off visits by any given doctor would be high. In these circumstances, medical notes and records would be limited in depth and detail, because each doctor might see a patient on a sporadic or singular basis. In these circumstances, the practitioner's empathy for the patient and their circumstances would be limited. Hence, it is highly questionable if any medical practitioner who

meets or examines a patient for the first time or rarely, and for only a few minutes, could develop any real understanding of the patient's history or circumstances. Such regimes are flawed because it would be virtually impossible for the practitioner involved to create greater self-awareness and thereby seed behavioural changes that may improve the circumstances or conditions of the client or patient. An empathy measure could counter this.

2. The Commission's approach

REQUEST FOR INFORMATION

The Commission is seeking feedback on whether the factors presented in Figure 2 reflect those that should be considered when identifying human services best suited to the increased application of competition, contestability and informed user choice.

As a policy setting, accounting for the empathy experienced by the recipient is an important factor to consider when seeking to identify services best suited to reform. Empathy measures the nature of the relationship between the user and provider because it places the focus on the user or patient and as a measure can help service providers respond more effectively to the 'User characteristics' listed in Figure 2. Why? because empathy can improve the depth of data collected about individuals, which in turn can better inform the evolution and improvement of services provided, as well as better inform user choice.

This is particularly relevant in situations where an academic or technical understanding of a service or treatment cannot convey the actual experience or benefit. In such circumstances, first-hand experience by the user is required before they can make an informed choice on the service best suited to their needs.

The use of technology to improve the delivery of services is an important aspect of achieving efficiency gains. However, it is difficult to imagine how an online self-help menu that replaces human contact with screeds of support information and complex processes, forms and options, will convey any measurable sense of empathy with the end user and their needs. Such self-help services tend to be based on the assumption that the end user has a full understanding of the options and consequences of the choices they make; and has the time, and skill to become fully informed in order to make the wisest and most appropriate choices. The competency or computer literacy of the user with this technology can also affect value of the engagement, particularly with elderly clients.

Users are already willing to access and engage with massage service providers. However, due to the complexity of musculoskeletal and other chronic conditions, the benefits and the extent of the comparative benefits derived from bodywork/manipulation such as physiotherapy, osteopathy, massage or chiropractics, often varies between users or patients, and has yet to be accurately mapped or conclusively established through clinical trials. In these circumstances, a more empathetic people-focused diagnosis, delivery and performance evaluation regime is required.

3. Information on services best suited to reform

Scope for improving outcomes

REQUEST FOR INFORMATION

The Commission is seeking participants' views on which human services have the greatest scope for improved outcomes from the increased application of competition, contestability and user choice. Where possible, this should be supported by evidence from performance indicators and other information to show the extent to which:

- *current and expected future outcomes — measured in terms of service quality, efficiency, equity, accountability and responsiveness — are below best practice*
- *competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness.*

The Commission welcomes participants' views on how best to improve performance data and information in the human services sector.

Below best practice

Massage therapy is one response used in the treatment of musculoskeletal conditions. Massage is recognised as a legitimate treatment in Medicare subsidies under the chronic pain management system approved by GPs, and the 2013 Aged Care Funding Instrument (ACFI) Guidelines when provided by or under the guidance of Registered health professionals.

However, de-identified qualitative individual patient and clinician, measuring/comparing the end user experience and benefit of massage performed by these practitioners is not collected or measured because massage tends to be included as an adjunct service and not itemised as a standalone bodywork/manipulation service. Hence, the value of massage treatments in these settings is unclear.

For example, in the treatment or care of older people suffering from musculoskeletal conditions, massage is often administered, alongside other interventions, by nurses, physiotherapists or chiropractors in order to reduce pain and improve movement. The specific modalities and interventions used are not documented in the patient or client notes and are not part of any public record. Patient responses concerning how they feel; or evolution of techniques and modalities used are rarely gathered in detail, or measured or assessed through follow-up patient evaluation such as interviews. Hence, comparisons of effectiveness as a function of efficiency about the various body-work therapies, medications and interventions cannot be made.

Lack of competition and contestability

Registered health practitioners generally have considerably less massage training, qualifications in and experience of massage than degree and diploma-qualified massage therapists, yet the highly-qualified massage specialists, cannot provide unsupervised subsidised massage services under Medicare or the ACFI.

This contravenes best practice. Significantly, massage is most effective when combined with education and exercise, and when administered by a licensed therapist.[iv] Consequently, the value and contribution of massage in relation to patient outcomes in Human Services settings is potentially less because the quality of massage provided is potentially lower than it could be if administered by a fully-qualified and accredited massage therapy specialist. This, combined with a lack of data, also perpetuates the limited understanding of the benefits of massage for given conditions, which justify legislative barriers to government-subsidised health markets for highly-qualified massage therapists.

Around Australia, qualified health and allied health professionals and natural therapists who hold recognised massage qualifications practice remedial massage and myotherapy. Massage makes a

valuable contribution to the productivity of the health sector through employment, lower cost-musculoskeletal care, injury rehabilitation, chronic illness and aged care.

However, not all massage therapists, myotherapists, and Allied Health Professionals have the same qualifications, experience, or skill, which limits the beneficial outcomes that can be experienced by users. Given this, AAMT asserts that there are specific circumstances in which the judicious use of increased provider competition is likely to produce and improve the delivery of manipulation/bodywork service associated with musculoskeletal disease and a variety of conditions and chronic diseases.

The most obvious area where competition and contestability would provide benefit is in services where Allied Health Professionals such as nurses, osteopaths, physiotherapists and physical rehabilitation specialists, use massage as part of these services. Massage therapists have equivalent qualifications such as Bachelor Degrees in Health Science and at least 1,000 hours of training compared to nurses, physiotherapists, and osteopaths who can administer massage under Medicare, with as little as 200 hours of training and limited massage qualifications and experience.

Despite tertiary-qualified massage therapists having the professional skills and education to deliver the same or improved positive outcomes for patients in the areas of pain and stress relief, Federal legislation limits competition by not recognising the skills of tertiary-qualified massage therapists under Medicare provisions or the 2013 ACFI. The ACFI Guidelines exemplify the level of partiality in these policy and legislative arrangements because the recommendations for the administration of therapeutic massage for pain management require massage only under the directive of a registered nurse, medical practitioner, or allied health professional. However, all of these registered health practitioners usually have significantly less or no formal training in the massage speciality than tertiary-qualified massage therapists. This invalidates any assumed practice standard or quality assurance provided by their oversight. Additionally, chiropractors and other registered health professionals can administer massage or oversight the administration of massage despite having no formal training or qualifications in the massage speciality. The Medicare restrictions also translate to the *Safety Rehabilitation and Compensation Act* 1988 (SRCA) and the *Veterans' Entitlements Act* 1986, which do not recognise these higher-level massage qualifications. This is in contrast with Private Health Insurers and Workcover, where massage by remedial massage therapists is covered. The legislative barriers to competition in government-subsidised health markets such as primary care in hospitals, veterans, and aged care facilities are therefore groundless.

Improving performance data

Measuring empathy, through a provider self-assessment and client or patient assessments on how they feel or felt about given services, may provide further insights for comparing and improving services and actions available. Assessment by family or close friends involved may also provide useful insights. A considerable amount of work has already occurred in the area of empathy as performance and evaluation criteria. Researchers have attempted to categorise[v] these as follows:

- *Self-assessment – the assessment of empathy using standardised questionnaires completed by those being assessed.*
- *Patient-assessment – the use of questionnaires given to patients to assess the empathy they experienced among their carers.*
- *Observer-assessment – the use of standardised assessments by an observer to rate empathy in interactions between health personnel and patients, including the use of 'standardised' or simulated patient encounters to control for observed differences secondary to differences between patients.*

Additionally, a study[vi] that reviewed the procedures and instruments used in the assessment of services using Patient Centred Care (PCC) found that:

- four observational instruments described
- five for the assessment of physical space

- six aimed at discovering users' opinions; one which records family opinions, and five aimed at professionals
- as well as several qualitative tools for self-assessment of Centres.

The authors concluded that due to the diversity of instruments available for assessing PCC, and in order to avoid partial evaluations of attention, a combined strategy of assessment is recommended as well as integrating these measures into a broader service evaluation, which includes the different strands related to care quality.

Additionally, the 2016 study[vii] investigated reporting of research interventions applicable to a routinely practice-based context of non-pharmacological interventions. The authors note that in the field of manual medicine, where interventions are delivered with a high degree of individualisation and variability, poorly reported studies could compromise internal and external validity of the results. Their finding describes the Template for Intervention Description and Replication (TIDieR) as a tool that can be used to more effectively capture the details of what is being used in manual therapy interventions. Applying TIDieR tools to service delivery evaluations in order to identify what manipulation or body work intervention is actually being used would highlight when services are being delivered by physiotherapists or other allied health practitioners, when massage therapists would be more appropriate.

By including empathy as an evaluation factor in achieving improved user relationships and empowerment though person-centred care, qualitative data can be collected and measured to enable more detailed comparisons of interventions or services provided for musculoskeletal conditions, and by various health service providers. The inclusion of empathy, with built-in evaluation criteria and processes that are included in patient diagnosis, treatment and reporting criteria, would also help to ensure a more detailed evaluation of services, and augment the continuous improvement and categorisation of future services.

A current study by Endeavour College of Natural Health, investigating patient perceptions of empathy, empowerment, and patient-centred care in complementary medicine student clinics is due to present its results later in 2016. The aim of this project is to provide a preliminary examination of patient perceptions of the degree to which complementary medicine student practitioners employ a patient-centred approach during clinical consultation.

The project may shed further light on the value of empathy in bodywork and manipulation interventions.

Factors influencing potential benefits of increasing competition, contestability and user choice

User characteristics

REQUEST FOR INFORMATION

The Commission is seeking information on which human services have these characteristics:

- *service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient*
- *user-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed*
- *service recipients (or their decision-makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome*
- *outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.*

In the provision of 'hands-on' or 'body work' healthcare services for those suffering from musculoskeletal conditions, individuals can access a large number of options for the treatment of osteoarthritis. Depending on the definitions used, the ABS, National Health Survey describes around 19 actions taken by individuals to address these conditions, ranging from rest, physical manipulation or therapy (massage), pharmaceuticals such as anti-inflammatory and pain relief, weight loss and dietary supplements. There is little data available on the outcomes of these actions.

In bodywork/manipulation therapies, there are many administrative and legislative barriers to insuring recipients (or their decision-makers) have sufficient expertise to compare alternative services and providers. As a tactile hands-on therapy, the user's personal experience and benefits stand equally alongside the technical expertise of a provider and play a significant role in understanding the service options and appropriate service or treatment choices available. In response to the AAMT survey,[viii] therapists reported providing massage to alleviate pain and stress for the following conditions:

- Diabetes Effects Management
- Addictions Rehabilitation Support
- Cancer Treatment Issues
- Other Chronic Conditions
- Health and Wellness
- Motor Vehicle Accident and Rehabilitation
- Psychological Distress
- Joint Pain and Stiffness, including Arthritis
- Back Pain and/or Other Back Problems
- Repetitive Strain Injury Syndromes
- Neck/Shoulder Pain
- Other Acute Injury or Pain Conditions
- Sports Injury Management and Rehabilitation
- Headaches or Migraines.

However, as outlined previously in this document, patient choice is also limited, because current policy and legislative arrangements prevent many private and public patients from accessing the best possible massage therapy treatments for pain management and the relief of symptoms caused by musculoskeletal disease and other chronic diseases. This adds to the cost and inefficiency of many services involving bodywork/manipulation therapies, particularly in chronic disease and aged care.

Research shows that:

1. Patients whose general practitioner has additional complementary and alternative medicine training have lower health care costs and mortality rates than those who do not. Reduced costs come from fewer hospital stays and fewer prescription drugs.[ix]
2. When Person-Centred Care (PCC), is the focal point, and the processes for access to care, and continuity of and coordination of care in turn serves to enhance the delivery of PCC, practitioners perceived this as helping to reduce unnecessary walk-in clinic and emergency department visits, and facilitated a smoother transition from hospital to home.[x]

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The nature of service transactions

REQUEST FOR INFORMATION

For specific human services, the Commission is seeking information on the nature of service transactions based on these characteristics:

- *the nature of the relationship between the service user and the provider*
- *whether the service is used on a one-off, emergency or ongoing basis*
- *whether the service can be provided remotely*
- *the extent to which services to an individual can be unbundled*
- *whether there is a strong case for the provider to supply multiple services to an individual with complex needs.*

Nature of relationships

A key priority for AAMT is integrating massage further within conventional health. This includes improving the professional standing of massage therapists and the sector through higher education, improved standards of practice, clinical research and robust self-regulation.

As a tactile and kinetic treatment the nature of massage therapy, often involving close personal contact, relies on a high level of trust between patients and therapists because there is a greater sense of user vulnerability and perceived potential threat to personal safety.

Ongoing need

The ACFI Guidelines attests to the use of massage as one of the first line treatments of pain-related musculoskeletal problems on an ongoing basis. This is borne out in practice. In response to the AAMT survey,[xi] therapists reported that between 5% and 37% offered services for cancer treatment issues such as pain, lymphedema, distress, motor vehicle accident and rehabilitation, diabetes effects management and addictions rehabilitation support. Additionally, over 90% of respondents to the AAMT member survey reporting the top four 'reasons for therapy' as:

- neck/shoulder pain, back pain and/or other back problems
- maintenance of health and wellness
- improving health or functioning, and
- injury prevention, including stress and tension reduction.

Figure 1 below, shows how the number of sessions per week for the most frequently used therapy divides the respondents into five more or less equal groups: on average, 19% provide five sessions or less per week; 33% provide more than 20. This pattern changes for the second and third most frequently used therapies: on average, less than five sessions per week are offered by 41% of respondents for their second most frequently used therapy; 58% for the third.

The use of these therapies drops off drastically as the number of sessions increase. For example, only 12% of respondents provide their second most frequently used therapy more than 10 sessions per week; only 8% for the third most frequently used.

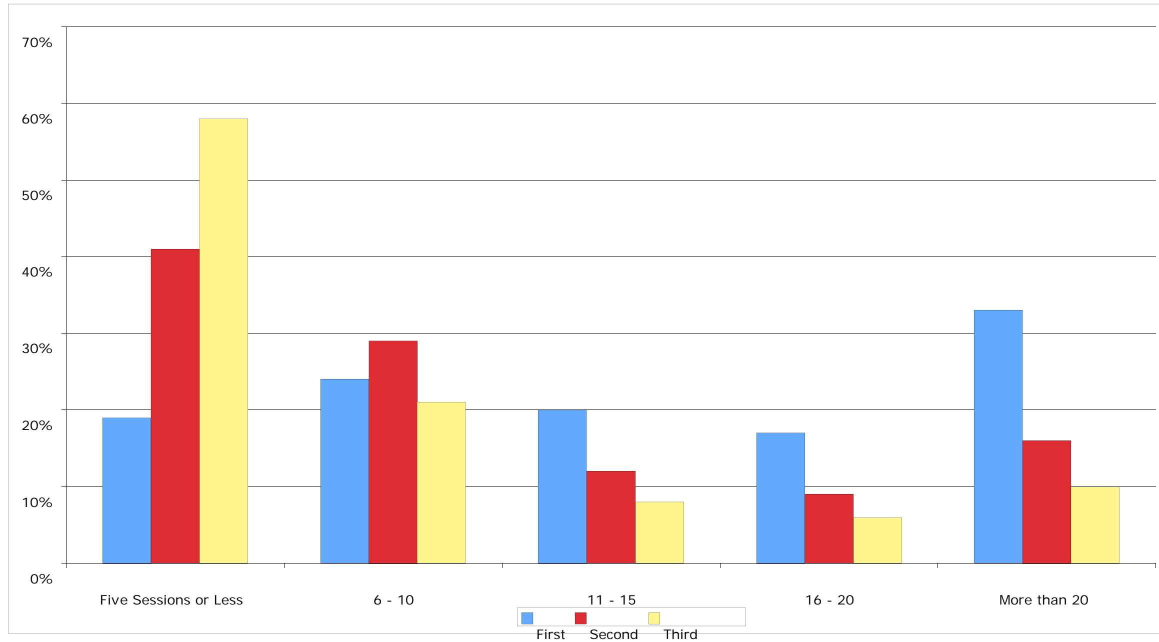

Figure 1. Number of sessions per week

Figure 2 shows that, of the practitioners who offer treatment for health and wellness, neck/shoulder pain and back pain and/or other back problems, between 10% and 23% report dealing with these reasons for applying therapy 'all or most of the time'; between 40% and 66% provide services in these areas from half to three-quarters of the time.

Respondents who treat the other problems surveyed spend 5% or less of their time in one specialised area.

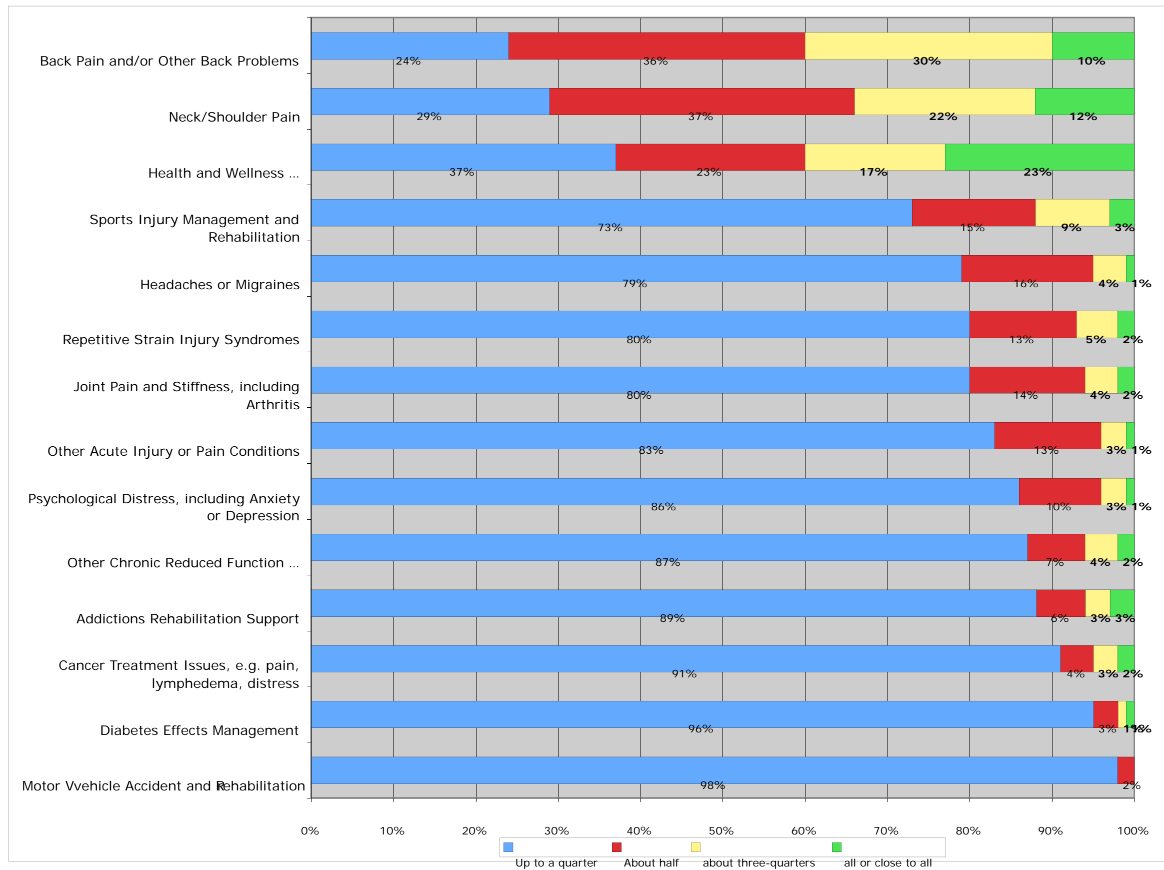

Figure 2. Specialisation by reasons for applying therapy

Supply characteristics

REQUEST FOR INFORMATION

The Commission is seeking information on the supply characteristics of specific human services including:

- *economies of scale and scope — in terms of costs and service quality — that may be lost by having a larger number of competing providers*
- *the potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance*
- *whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this*
- *technological change that is making competition and user choice more viable*
- *factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.*

Within the general massage therapy market, serviced by the private sector, user access and choice is not restricted. However informed user choice, access to private health insurance coverage and public sector services are.

However, increasing competition within the sector per se will not drive up quality nor address uncertainty, adverse selection, and the moral hazards associated with unscrupulous non qualified massage therapists.

As a sector, massage supply is already saturated with therapists holding a range of qualifications and experience. For example:

- massage therapists are believed to be among the largest group of CAM (Complementary and Alternative Medicine) providers, with Census data from five developed countries (US, UK, Canada, Australia and New Zealand) revealing that of nine CAM disciplines, massage therapists consistently accounted for the largest portion of the CAM workforce[xii]
- has grown by a rate of 62.3% over the past 10 years in Australia,[xiii] and created an additional 3,300 jobs in the past five years[xiv]
- jobs growth including turnover, during the five years between November 2014 and 2019 is expected to average between 10,001 and 25,000[xv]
- employs a high number of females, with a ratio of approximately 3:1 females to males;[xvi] or ratio of 2.5:1 AAMT's membership and provides a second income for many families.

Utilising the most skilled therapists

However, within these numbers there are many highly qualified and experienced massage therapists and myotherapists. For example, the ABS found that the massage sector officially employs around 15,500 qualified massage therapists nationally[xvii] with around 20% of massage practitioners[xviii] holding a bachelors degree. These therapists could be used more effectively in the delivery of human services and improve the equitable delivery of health services, contribute more significantly to the alleviation of symptoms, prevention, education and wellbeing of users suffering musculoskeletal and a variety of conditions and chronic disease. They could also contribute to improving health productivity and female workplace participation.

There are, however, limitations. The further integration of massage therapists into Human Services must be managed. The large influx of quasi-massage therapists under the 457 Visas and the 2011 provisions appears to coincide with the documented increase in the incidence of rape, sexual services, illegal prostitution, and human rights abuses of these workers. The increased level of competition

created by this influx of massage workers also encourages these transgressions, as massage shops seek to attract clientele.

Additionally, massage associations are largely funded through membership fees. Competition among Associations to secure members and hence funding creates a number of barriers that limit the sector's ability to provide adequate quality assurances that attest to the professionalism and skill of many massage providers. Competition for membership has led to:

- limited access to adequate funding for compliance auditing
- a conflict of interest between securing members and thoroughly vetting members, which also discourages the monitoring, reporting and persecution of delinquent members
- the ad-hoc delivery of industry standards and codes
- limited industry-wide cooperation
- a lack of transparency in membership registration, training, and management process.

An escalation in fraudulent claims in some market sectors has also seen Private Health Funds redefine eligibility for the Private Health Insurance Rebate for natural therapies and the erosion of the quality assurances this offered consumers about the professional competence of the attending remedial massage therapist. Despite this, these assurances still have some inherent relevance in the commitment and level of training required, and the encouragement for massage practitioners to become registered therapists in order to be eligible for the Private Health Insurance Rebate scheme. The standards, administered by voluntary membership associations such as AAMT, are de facto 'registration standards' in the absence of a statutory registration scheme similar to those administered by the Australian Health Practitioner Regulation Agency (AHPRA), however the value of this for insurers, regulators, complaint authorities and consumers has been eroded. The consequences of these developments are as follows:

- the reputations of legitimate highly-qualified massage therapists and myotherapists are sullied and thrown into question
- there is a lack of clear public demarcation between massage brothels and legitimate massage and myotherapy services
- potential customers are not using legitimate massage therapy and myotherapy clinics for fear of being seen to be associated with prostitution
- uncertainty about what constitutes a legitimate massage practice, and the associated education and quality assurance standards limits the opportunity for further integration of massage therapy and myotherapy into other health care services.

Combined with the high demand and need for massage and myotherapy services in Human Service provision, these issues pose an ongoing dilemma for health service regulators and insurers. On the one hand, many massage providers do not meet the education or professional quality assurance standards required to merit inclusion in government-subsidised services or Private Health Insurance Provider Status.

Importantly, there is a solution to this paradox and an opportunity to improve the delivery of human services associated with massage practices. Within the massage sector, there are many (20%) highly qualified and skilled massage professionals who can provide a more clinical massage service at a lower cost than those provided by Allied Health Professionals. These 20% of massage therapists and myotherapists who are tertiary-qualified offer an opportunity for bodywork service provision to be made more contestable because there are untapped skills and capabilities beyond the existing Allied Health pool of providers that would also improve the services provided.

The potential costs of increasing competition, contestability and user choice

REQUEST FOR INFORMATION

For specific human services, the Commission is seeking information on:

- *the costs that consumers would incur by becoming more active in selecting the services they receive, adapting to changes in how providers supply services, and switching services when a decision is made to do so*
- *the regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform users about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine-tune policies in response to any problems that emerge*
- *how the compliance costs faced by service providers will be affected by changes in government stewardship, and the adjustment costs that providers will bear in order to shift to a more user-focused model of service provision*
- *the extent to which such costs are one-off or an ongoing impost.*

The Commission welcomes information from participants on the costs faced by different types of providers, with different motivations and governance structures, when shifting to a more user-focused model of service provision.

The inclusion of massage therapists and myotherapists also promises considerable savings to the cost of human services, and an improvement in the quality of massage services delivered, without placing undue or excessive additional costs on massage and myotherapy providers.

To demonstrate the efficiency gains that could be made by including tertiary-qualified massage therapists in government-subsidised health services, AAMT offers the following information, which should allow the Productivity Commission to conduct further comparisons with the cost of Allied Health Services currently fulfilling the role of massage therapists, for the same conditions.

Potential efficiencies and cost saving

Table 1 provides the total number of chiropractors, physiotherapists and osteopaths reported in the 2014/15 AHPRA Annual Report; and the estimated number of degree-qualified massage therapists in Australia which could be included in the pool of professional manual manipulation therapists:

Table 1. Degree-qualified registered manual manipulation practitioners and unregistered massage therapists

Practitioner	Number
Chiropractors	4,998
Physiotherapists	27,543
Osteopaths	2000
Degree-qualified massage therapists	3000

AAMT does not have access to Human Services data, however, expenditure in the private sector involving private health insurance can provide an indicative comparison. Funding in this area is provided through premium insurance rebates from the Australian government ($4.3 billion), and insurance premium payments by members ($9.2 billion).[xix] Of the $9.2 billion non-hospital, non-medical treatments such as chiropractic, physiotherapy and osteopathic services account for 5.3% of this expenditure during 2012/13. Like degree-qualified massage therapists, all of these professions are trained in the diagnosis and treatment of musculoskeletal conditions such as back pain and neck pain. Similarly to AAMT massage therapists, the most common reasons given for seeking chiropractic and osteopathic treatment were back and/or neck pain, non-specific musculoskeletal problems and enhancement of general health and well-being.[xx]

A 2013 Study[xxi] found that excluding the Chronic Disease Management arm of the Enhanced Primary Care Program for patients with chronic medical conditions, growth in the use of each of these services continued to grow; an absence of practice guidelines for the chiropractic profession could account for the high average number of services provided per practitioner. This absence may have unwittingly led to the acceptance of a wide variation in the level of servicing among chiropractors in Australia. However, the problem is not unique to the chiropractic profession, and would therefore exist to some extent in both the physiotherapy and osteopathic professions.

Also, chiropractic services tend to take less time than massage or other bodywork services, which could also account for the discrepancy.

Direct cost saving can be achieved. Nationally, the average annual salary for all massage therapists is $47,000,[xxii] compared to physiotherapists $64,614 or occupational therapists $60,898.[xxiii]

Of AAMT’s 8,000-plus members, 6,000 of whom are qualified remedial massage therapists, the average annual salary is around $52,000 with an average hourly rate of $60 per hour. The average cost for the ‘reasons for applying the therapy’ in the AAMT members' survey, vary from an average of $64 for headaches or migraines to $70 for addictions rehabilitation support or psychological distress, including anxiety or depression. Median costs vary from $65 to $70 per hour, a very narrow range.[xxiv]

While there is considerable variation in the number of respondents who provide treatment for each of the ‘reasons for treatment’ surveyed, Table 2 shows great consistency in the fees charged per session and the average number of minutes allocated to each session, independent of the reason for treatment. The average number of minutes per session also falls into a narrow range: 50 to 58 minutes; there is no variation between the median number of minutes per session.

Table 2 Fees charged and minutes per session

	Fee Charged per Session		Minutes per Session	
Reasons for applying the Therapy	Average	Median	Average	Median
Sports Injury Management and Rehabilitation	$67	$70	53	60
Motor vehicle Accident and Rehabilitation	$69	$70	54	60
Addictions Rehabilitation Support	$70	$68	57	60
Joint Pain and Stiffness, Including Arthritis	$66	$65	53	60
Diabetes Effects Management	$66	$68	54	60
Cancer treatment Issues, e.g., Pain, Lymphedema, Distress	$68	$70	56	60
Back Pain and/or Other back Problems	$67	$70	55	60
Neck/Shoulder pain	$64	$65	51	60
Occupational Overuse Syndrome	$65	$65	51	60
Headaches or Migraines	$63	$65	50	60
Health and Wellness for maintaining, Improving Health or Functioning, and for Injury Prevention, Including Stress and Tension Reduction	$69	$70	57	60
Other chronic Reduced Function, Disability, or Pain Conditions, e.g. Fatigue	$68	$70	55	60
Other acute Injury or pain Conditions	$65	$65	52	60
Psychological Distress, Including Anxiety or Depression.	$70	$70	58	60

Table 3 shows that 'reason for applying the therapy' results in considerable variation in the number of sessions required, from four for headaches and migraines, to ten for diabetes effects management.

Table 3 Number of sessions

	Number of Sessions	
	Average	Median
Diabetes Effects Management	10	6
Addictions Rehabilitation Support	10	6
Cancer Treatment Issues	9	5
Other Chronic Conditions	9	5
Health and Wellness	9	5
Motor Vehicle Accident and Rehabilitation	8	6
Psychological Distress	8	6
Joint Pain and Stiffness, including Arthritis	8	5
Back Pain and/or Other Back Problems	6	4
Repetitive Strain Injury Syndromes	6	5
Neck/Shoulder Pain	5	4
Other Acute Injury or Pain Conditions	5	4
Sports Injury Management and Rehabilitation	4	4
Headaches or Migraines	4	3

To estimate the cost for each of the 'reasons for therapy' surveyed, the number of sessions and cost per session are combined in Table 4. Clearly, addictions rehabilitation support is the most expensive, on average $700 for a course of treatment. This is followed by a variety of conditions ranging in cost from $252 to $660, with headaches and migraines ($252), sports injury management and rehabilitation ($268) being the least expensive.

Table 4 Overall Cost of Treatment

Treatment	Cost of Treatment
Addictions Rehabilitation Support	$700
Diabetes Effects Management	$660
Health and Wellness	$621
Cancer Treatment Issues	$612
Other Chronic Conditions	$585
Motor Vehicle Accident and Rehabilitation	$552
Psychological Distress	$544
Joint Pain and Stiffness, including Arthritis	$528
Repetitive Strain Injury Syndromes	$420
Back Pain and/or Other Back Problems	$402

Other Acute Injury or Pain Conditions	$325
Neck/Shoulder Pain	$320
Sports Injury Management and Rehabilitation	$268
Headaches or Migraines	$252

Regulatory arrangement

Some massage therapists are highly qualified health professionals who deliver higher level and technically-skilled services in hospitals, clinical practices, and elite sports settings, while others offer base level wellbeing and relaxation massage. On the negative side of this ledger, massage is an unregulated health service, burdened with a prevalence of unqualified or poorly qualified therapists offering quasi-massage services.

To address this, a facility that harnesses the higher education, diversity, creativity, and professionalism of massage therapists, and maps the professional competencies, skills, and qualifications available to the health sector and patients is required. Being at the forefront of these issues, AAMT is developing professional standards and quality assurance, which will provide user-oriented, timely, and accurate information to compare services and providers.

Currently under development in collaboration with the industry, AAMT is establishing a new Quality Assurance Standard and Accreditation Scheme for massage and myotherapists which, differentiates formal massage qualifications and modalities from pseudo or poor-quality massage.

The new Accreditation Scheme describes the Quality Assurance Program for massage and myotherapists and offers a professional framework for consistent and reliable national Best Practice Standard (BPS) and Quality Assurance (QA) for the Australian massage industry that is monitored and reported. When completed, it will provide a national universal description of the skills, qualifications, and professional pathways for massage therapists and myotherapists including:

- formal recognition of compliance with an industry Code of Ethics;
- conformity to a Best Practice Standard;
- recognition of appropriate qualifications pertaining to specific modalities of massage
- a transparent, consistent process of auditing and collecting industry data
- protection of practice for Accredited massage therapists through international copyright and trademark.

In order to improve User choice, efficiency and the quality of outcomes for users and patients, the AAMT proposes opening government-subsidised bodywork/manipulation services to competition and contestability, by recognising degree and advanced diploma-qualified massage therapists, who have completed the new Quality Assurance Standard.

Cost to providers

Under the current self-regulatory framework for massage therapists AAMT is already bearing the cost of establishing the scheme.

The additional costs to providers are expected to be minimal and significantly less than those costs incurred by Registered Health Professionals.

While the Massage and Myotherapy Accreditation Scheme is similar to the Allied Health schemes that are under the administration of AHPRA, it is anticipated that the cost for massage providers will be significantly less than the cost to Allied Health Practitioners, who pay between $780 and $2,500 per year in association and registration fees.

A focus on empathy measures in data collection and reporting would enhance the technical information available, while the new Quality Assurance Standards and higher qualifications would

provide the assurance necessary to warrant the inclusion of these therapists in the professional sphere of Human Service - health service provision.

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