Opportunities in palliative care and end of life care

A submission on behalf of the Massage & Myotherapy Australia

Second stage of Human Services—Productivity Commission Public Inquiry

Identifying Sectors for Reform

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Prepared: February 2017

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Acknowledgements

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Overview

This submission provides information to support extending the role of massage therapy and massage therapists in a variety of end-of-life and palliative care settings.

Already providing a vital service, Massage and Myotherapy Australia believes that further integration of massage therapy will contribute positively to creating greater contestability and competition, alongside improving affordable user access and choice.

User choice, anecdotal evidence, and a growing body of scientific evidence provide a solid basis on which to extend massage therapy services.

Often, massage fills the gap when patients seek alternatives to medications and other therapies; choosing massage because they feel it is more appropriate to their needs.

As a lower cost complementary or allied health option that is known to relieve pain and stress, the massage workforce already has highly skilled therapists practiced in palliative care settings, and the speciality is provided by education and professional development providers in various training settings.

Extending services will also enable the conduct of more detailed high quality research studies and further our understanding about the efficacy, physical and emotional benefits of massage for given conditions.

Choice and access

Consumers consistently choose massage therapy when the choice is available to them.

Massage therapy already occupies a valuable place in an integrated approach to palliative and end-of-life care in some settings. For example, at Eastern Palliative Care Victoria 37% of clients were referred to the massage program during 2016 and 33% of clients were referred to the massage program during 2015.

Importantly, massage does not compete with other options such as physiotherapy or medications, it fills an intervention gap where patients have found these therapies no longer effective, or are seeking an alternative that is more appropriate to their needs.

Consequently, massage therapists are active in end-of-life care, involving the last 12 months of life, in both private and public settings. Massage therapy has the capacity to play an even greater role in both these settings.

The presence of massage in palliative and end-of-life care, in private and public settings, has occurred largely on an ad-hoc basis as organisations either respond to consumer demand or the availability of massage therapy has been championed by key personnel within the organisation. The effectiveness of massage therapy as evidenced in the scientific literature or anecdotal and personal experiences related by patients are the primary motivations for these champions.

Access is available through therapists, accredited individually in such settings who provide fee-for-service therapy. This is expanding, with large metropolitan hospitals actively establishing massage services in a hospice setting, involving contractors or employed staff.

A more formally funded and integrated approach, overseen at a federal and state level may augment what is already happening in day or inpatient hospice, hospital, or community-based health services, and in-home settings. This should involve employed massage therapists, or contract therapists on a case-by-case basis.

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.

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. As a sector, massage supply is already well supplied 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[i]
- the use of massage in health care has grown by a rate of 62.3% over the past 10 years in Australia,[ii] and created an additional 3,300 jobs in the past five years[iii]
- jobs growth including turnover during the five years between November 2014 and 2019 is expected to average between 10,001 and 25,000[iv]
- the massage sector employs a high number of females, with a ratio of approximately 3:1 females to males;[v] or ratio of 2.5:1 of the Massage & Myotherapy Australia membership and provides a second income for many families.

Building greater capacity, consistency and access

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.[vi] Within health care and social assistance occupations, around 25.5% have tertiary qualifications or a Cert III and Cert IV[vii] qualification, which suggest that around 3,000+ people employed in providing massage have tertiary qualifications.

	Postgraduate Degree	*Graduate Diploma/ Graduate Certificate*	*Bachelor Degree*	*Advanced Diploma/ Diploma*	Certificate III/IV	*Total*
Health care and social assistance	*6.4%*	*9.3%*	*3.9%*	*4.2%*	*1.7%*	*25.50%*

These more highly qualified and skilled massage professionals can provide a more clinical massage service and offer an opportunity to improve contestability.

There are, however, limitations. The further integration of massage therapists into Human Services must be managed in consultation with industry leaders

Massage associations are majority 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 robust, transparent compliance auditing
- a conflict of interest between securing members and thoroughly vetting members. ,
- the previous ad-hoc delivery of industry standards and codes
- limited industry-wide cooperation

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.

Combined with the high demand and need for massage services in Human Service palliative and end-of-life care provision, there is an ongoing need to monitor, or limit the inclusion to those massage therapists who hold recognised qualifications in massage with a palliative care specialisation.

While the number of those practicing massage is increasing overall, numbers of well-trained palliative or end-of-life care massage therapists are small, with demand outstripping supply in many settings.

Access to education and training in Australia to facilitate professional development is available through a small number of specialist Palliative Care Massage or Oncology Massage training programs.

Other options include online education, for example, international specialist massage programs, PCC4U, or individual component subjects available through institutions such as the Australian Centre for Grief and Bereavement or university programs in Australia or overseas. There are increasing numbers of therapists entering these programs.

Being at the forefront of these issues, Massage & Myotherapy Australia is developing a new professional standards and quality assurance scheme in order to harness the higher education, diversity, creativity, and professionalism of massage therapists, and map the professional competencies, skills, and qualifications available to the health sector and patients.

The new Certification Program will provide user-oriented, timely, and accurate information to compare services and providers through public education and the marketing and communication initiatives of Certified therapists. Importantly, it will also differentiate formal massage qualifications and modalities from pseudo or poor-quality massage.

The Certification Program 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 Certified massages therapists through international copyright and trademark.

In order to improve user choice, efficiency and the quality of outcomes for users and patients, the Association proposes opening the opportunity for government-subsidised bodywork services to competition and contestability, by recognising degree and advanced diploma-qualified massage therapists, specialist palliative and aged care therapists and those who have completed the new Quality Assurance standard.

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

Recognition in policy and regulatory reform would ensure that only those therapists with the appropriate end-of-life and palliative care training who can meet the professional standards as defined in the Certification Program would do much to protect end users and ensure a high quality of massage care.

Unfortunately, competition, between-groups such as physiotherapy, osteotherapy, or General Practitioners seems to limit productivity and integration to the detriment of meeting the needs and desires of patients. Given this, there is considerable opportunity to develop an integrated approach that recognises that massage therapy offers an alternative or crossover on care issues such as oedema, mobility, anxiety, social isolation, and pain management.

This offers capacity to contribute to continuity of care in the context of a multi-disciplinary approach to care (the normative model in end-of-life care). Collaboration with other providers is a path forward, where massage therapists can also offer some like services, perhaps less expensively.

This needs to include a system that enables health providers to build a shared understanding of the circumstances where massage therapy delivers positive patient outcomes for symptoms and quality of life issues. This includes less pain medication being accessed or preventing hospital admissions for cellulites for example.

Importantly, defining what a palliative care massage therapist does is central to expanding the role of this important care option.

While there is minimal reporting in the literature of adverse outcomes from massage, comprehensive preparation for engaging with the complex and changing needs of the palliative population is indicated. Preparation for this specialisation requires:

- development of high-level discipline-specific skills beyond training in remedial or relaxation massage, skills in other modalities— for example, lymphoedema management or reflexology— combined with strategies and practices to support patients and families in self-management such as relaxation techniques, caregiver massage or self/simple lymphatic drainage
- an understanding of the principles of the palliative care approach
- knowledge of disease processes, both malignant and non-malignant, likely treatment pathways, and their possible side effects, and an understanding of the 'whole person' impacts of a life limiting illness. Such knowledge informs the therapist of the technique modifications required to ensure a safe, comfortable and effective therapy
- professional and therapeutic communication skills and familiarity with common assessment tools
- awareness of grief, bereavement and cultural needs
- cultivation of both reflective practice (informally or through formal supervision) and self-care strategies to strengthen the capacity of the therapist to maintain a responsive and compassionate presence.

Access to education and training in Australia to facilitate professional development is available through only a small number of specialist Palliative Care Massage or Oncology Massage training programs. Other options include online education, for example, international specialist massage programs, PCC4U, or individual component subjects available through institutions such as the Australian Centre for Grief and

Bereavement or university programs in Australia or overseas. There are increasing numbers of therapists entering these programs. This provides opportunities for Registered Training Organisations to develop massage training packages to meet the growing demand for these specialised services.

Competition and contestability

There are number of factors, including regulations and policies, which limit competition and contestability.

Registered health practitioners generally have considerably less specific massage training, qualifications and experience of massage than degree and diploma-qualified massage therapists, yet these highly qualified health professional cannot provide unsupervised publicly-funded or subsidised massage services under Medicare or the Federal Aged Care Funding Instrument (ACFI).

This contravenes best practice. Significantly, massage is most effective when combined with education and exercise, and when administered by a licensed therapist.[viii] Consequently, the value and contribution of massage in relation to patient outcomes in end-of-life 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 federally-subsidised palliative care markets for highly qualified massage therapists.

Around Australia, qualified health and allied health professionals and natural therapists who hold recognised massage qualifications practice massage and myotherapy. Given this, Massage & Myotherapy Australia asserts that there are specific circumstances in which the judicious use of increased provider competition is likely to produce and improve the delivery of bodywork service associated with end-of-life-care and palliative care.

Areas where competition and contestability would provide benefit is in services where Allied Health professionals such as nurses, osteopaths, physiotherapists and physical rehabilitation specialists, use or refer to massage as part of these services or as adjunct or extension of palliative and end-of-life care.

This does not mean that massage therapists or therapy should depose the role of Allied Health services, but it does provide another known and recognised end-of-life care option that is underutilised and underfunded, in comparison.

Massage therapists who provide specialist palliative care, who have recognised qualifications such as Bachelor Degrees in Health Science, Advance Diploma or Diploma, undertake at least 1,000 hours of speciality training compared to nurses, physiotherapists, and osteopaths who can administer massage under Medicare, with as little as 200 hours of massage training and limited massage qualifications and experience.

Federal legislation limits competition by not recognising this level of experience and qualifications.

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 for example, require massage only under the directive of a registered nurse, medical practitioner, or allied health practitioner such as a dentist or dietician. Such professionals usually have significantly less understanding or no formal training in the massage speciality. This invalidates any assumed practice standard or quality assurance provided by their oversight. Additionally, the Medicare restrictions also translate to the *Safety Rehabilitation and Compensation Act* 1988 (SRCA) and the *Veterans' Entitlements Act* 1986. This contrasts Private Health Insurers and Workcover, where massage by remedial massage therapists is covered.

The legislative barriers to competition in government-subsidised palliative and end-of-life care, in hospitals, veterans, and aged care facilities are therefore groundless, and provide considerable opportunity for reform in the palliative care space.

Effectiveness

> *'The perception is that massage has the capacity to provide comfort in a general sense, a meaningful goal of care in this context. However, it may be less well known that evidence supports the targeted intervention of Massage Therapy in addressing a broad range of specific symptom and quality of life issues across the physiological, psychosocial, emotional and spiritual domains of care.'*
> R. Moore Palliative Care Specialist.

Appendix 2. Case study—Finding safe refuge through positive touch provides further insight into a role that massage therapists can plan at end of life.

Massage therapy is an innovative service that adds value through improving the well-being and quality of life for those in need of palliative end of life care.

For example, Eastern Palliative Care Association Inc., (EPC) works on an interdisciplinary model of care with all disciplines and programs coming together in a team approach. The Allied Health Therapies program is a core component of its service. The EPC website services page[ix] describes massage therapy as a proven and dynamic therapy.

Practitioners may use many styles and techniques to benefit the client.

- *Some of the massage techniques being used in palliative care to release aches, pains and discomfort in the body and limbs and for stress release are:*
- *Therapeutic massage—for better blood circulation and back, neck and shoulder problems*
- *Lymphoedema massage—to minimise fluid retention in arms, legs, feet or ankles*
- *Shiatsu massage—pressure point massage to relieve stress and discomfort in the whole body*
- *Reflexology—stimulating various pressure points associated with different body organs.*

While sporadic research occurs, currently the availability of data, be it in the number of patients choosing massage, quality of patient outcomes, and clinical efficacy of massage therapies limits our knowledge and understanding of the value of massage in an integrated end of life setting.

What we do know is that the surveying that is available, seems to support the view that if the user has informed choice, that is, knows how massage therapy may contribute to their wellbeing and that it is available, massage therapy is readily chosen.

Additionally, the growth of massage therapy in aged care homes and in-home care, while not the same as end-of-life care, is seeing massage therapy services offered on a fee for service basis, by many of the agencies active in that space.

The complexity of evaluating massage therapy in this space rests on the wide diversity of symptom applications for which massage therapy can be applied. Paradoxically, this makes massage the perfect contributor to palliative and end-of-life care, which aims to provide symptom management across physical, psychosocial, and spiritual domains of care, as well as seeking to optimise quality of life.

However, it does make it quite difficult to comprehensively describe and assess what exactly massage therapy is doing. For example, massage with relaxation intent may well result in reduced pain for one person and better managed anxiety or breathlessness in another, or ameliorate social isolation for another patient.

Importantly the use of assessment tools in palliative care is extensive, and massage therapists well trained in palliative care will be familiar with the use and usefulness of such tools.

There is a steadily growing number of pilot and empirical studies, systematic reviews, trials and research reports adding validity and strength to the clinical experience, and the self-reporting by patients, of the ameliorating or moderating impact of massage therapy across an array of quality of life and symptom issues, including:

- Anxiety, depression, distress/stress (Moyer, 2004)
- Pain (Wilkie, 2000, Kutner, 2008)
- Skeletal-muscular impairment (Smith, 2010)

- Fatigue (MacDonald, 2014)
- Nausea (Cassileth, 2004)
- Oedema/lymphoedema (Williams, 2002)
- Constipation (Hodgson, 2000)
- Sleeplessness (Sagar, 2007)
- Shortness of breath (MacDonald, 2012)
- Disrupted body image (Bredin, 1999)
- Existential suffering (Bilhult, 2007, Wilkinson, 2007)
- Social isolation and caregiver burden (Collinge, 2013).

(Also see Appendix 1. List of papers on massage research)

While we do not yet fully understand the mechanistic links between the manipulation of soft tissue of the body (massage) and the corresponding relief of a broad range of symptoms, the sense of touch and its role in whole body physiology is the least examined and understood of the senses.

What is known indicates a complex interplay between biomechanical, physiological, neurological, and psychological pathways. Some suggested underlying mechanisms include:

- A moderating effect via manipulation of skin, fascia, muscle, and peripheral nerves on autonomic nervous system activity, affecting the release of endogenous hormones. For example, the increased levels of oxytocins, known to occur in response to massage, are associated with lowered cortisol levels, stress relief and pain reduction, giving rise to 'The Relaxation Response', the direct physiological opposite to the stress response. (Sagar, 2007)
- Stimulation, through slow, light touch, of unmyelinated C-tactile neural fibres evokes direct connection to brain centres involved in emotional regulation and social connection. (Campbell, 2006)
- Potential promotion of local vascular and lymphatic circulation through biomechanical means. (Hughes, 2008 Franklin, 2014)
- Alternate sensory stimuli overriding pain signals (Kutner, 2008), Ongoing research in areas such as neuroscience may deliver a deeper and more coherent understanding of the 'feeling better' response to massage. In the interim, 'feeling better' remains, in the palliative context, a sufficiently valuable goal and outcome.

Improving performance data

Given this, there is a great need to collect more qualitative information on individual patient and clinician experiences that measure and compare the end user experience and benefit of massage performed by qualified therapists.

This has its challenges 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, 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, high value comparisons of effectiveness as a function of efficiency about the various bodywork therapies, medications, and interventions cannot be made.

Measuring performance through client or patient assessments on how they feel or felt about given services, may provide further insights for comparing and improving services. 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[x] 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[xi] that reviewed the procedures and instruments used in the assessment of services using Patient Centred Care (PCC) found that:

- four observational instruments were 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[xii] 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 capture the details more effectively 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.

A current study by Endeavour College of Natural Health, investigating patient perceptions of empathy, empowerment, and patient-centred care in complementary medicine student clinics will provide a preliminary examination of patient perceptions of the degree to which complementary medicine student practitioners employ a patient-centred approach during clinical consultation. This project may shed further light on the value of empathy in bodywork and manipulation interventions.

Efficiency and productivity

Massage therapy costs less than other end-of-life health services, but it is not particularly time efficient as compared to say physiotherapy or medication.

Being a whole system approach, massage therapy tends to involve spending longer with each client—both a strength, and a limitation. However, the additional time may well be a contributing factor as to why patients tend to choose massage therapy when it is available. Pain relief, and the positive psychological/physiological effects of touch and human interaction, make massage an efficient and effective service to improve life quality at end-of-life, if only for a short time, in all settings.

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 potential efficiency gains from including higher-qualified massage therapists in government-subsidised health services, we offer 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.

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. Higher qualified registered manual manipulation therapists

Practitioner	Number
Chiropractors	4,998
Physiotherapists	27,543
Osteopaths	2,000
Higher-qualified massage therapists	3,000 plus - estimate

The Association 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).[xiii] 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.

In this setting, the Association contends that direct cost saving can be achieved. Nationally, the average annual salary for all massage therapists is $47,000,[xiv] compared to physiotherapists $64,614 or occupational therapists $60,898.[xv]

Of the Associations 8,000-plus members, 6,000 of whom are qualified remedial massage therapists or myotherapists, 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 Massage and Myotherapy Australia 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.[xvi]

While there is considerable variation in the number of respondents who provide treatment for each of the 'reasons for treatment' surveyed, Table 22 below 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 numbers 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, Lymphoedema, 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 the '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

	Number of Sessions	
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.

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

Appendix 1. List of massage research papers post-1999

Note: Many more papers were published prior to 1999

Smith, J et al, 2010, 'Massage Therapy: more than a modality', *NZ Journal of Physiotherapy*, vol. 38 (2) pp 444

Kutner, J et al, 2008, 'Massage Therapy versus Simple Touch to Improve Pain and Mood in Patients with Advanced Cancer', *Annals of Internal Medicine*, vol. 149 (6), pp 369–379

Cassileth, B et al, 2004, 'Massage Therapy for Symptom Control: Outcome Study at a Major Cancer Center', *Journal of Pain and Symptom Management*, vol.28 (3),pp 224–236

Beck, I et al, 2009, 'To find inner peace: soft massage as an established and integrated part of palliative care', *International Journal of Palliative Nursing*, vol. 15 (110, pp 541–559

Falkensteiner, M et al, 2011, 'The Use of Massage Therapy for Reducing Pain, Anxiety and Depression in Oncologic Palliative Care Patients: A Narrative Review of the Literature', *ISRN Nursing*, vol. 2011, ID 929868.

Cho, Y et al, 2004, 'The effect of acupressure with massage on fatigue and depression in patients with end-stage renal disease,' *Journal Nursing Research*, vol. 12 (1), pp 51–59

Sagar, S et al, 2007, 'Research on Therapeutic Massage for Cancer Patients: Potential Biologic Mechanisms', *Journal of the Society for Integrative Oncology*, vol. 5 (4), pp 155–162

Cronfalk, B et al, 2009, 'Inner power, physical strength and existential well-being in daily life: experiences of receiving soft-tissue massage in palliative home care', *Journal of Clinical Nursing*, vol. 18, pp 2225–2233

Gorman, G et al, 2008, 'Massage for Cancer Pain: A Study with University and Hospice Collaboration', *Journal Hospital Palliative Nursing*, vol. 10 (4), pp 199–197

Lee, S et al, 2015, 'Meta-analysis of Massage Therapy on Cancer Pain', *Integrated Cancer Therapies*, vol.14 (4), pp 297–304

Cassileth, B et al, 2010, 'Integrative and behavioural approaches to the treatment of cancer related neuropathic pain', *Oncologist*, vol.15 (2), pp 19–23

Billhult, A et al, 2007, 'Massage relieves nausea in women with breast cancer who are undergoing chemotherapy,' *J. Altern. Complem.Med*, vol. 13, pp 53–57

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Appendix 2. Case study—Finding safe refuge through positive touch

Finding Safe Refuge Through Positive Touch
A Case Study

"The wholeness in us serves the wholeness in others." Rachel Naomi Remen

Ronna Moore Massage Therapist

Case Presentation

Our case describes Mrs A, a 75 year old woman with metastatic infiltrating squamous cell carcinoma in the region of the left axilla, for which she has received surgery, including axillary clearance, chemotherapy, and radiotherapy, but without current active treatment. She has an open ulcerating wound proximal to the axilla, at the anterior aspect of the left chest wall, for which she is receiving daily wound management provided by RDNS. Mrs A was referred by her oncologist and initial treating physiotherapist for management of lymphoedema of her left arm, secondary to axillary clearance and radiotherapy, and for assistance with pain management.

On examination, lymphoedema was confirmed as moderate to severe, the left arm measured 6cm greater than the right arm at most levels, with soft pitting oedema and a taut, but intact, skin surface. Movement at the left shoulder was restricted to 10-20% range and associated with pain on both active and passive movement. Mrs A had trialled the wearing of tubigrip compression, but this was abandoned as exacerbating, with difficulties in donning related to a previous history of spinal surgery resulting in restrictions in mobility.

In applying a modified LYMQOL assessment tool (Keeley, 2010), Mrs A rated high negative impact on each category assessed: appearance, function, symptoms (pain, heaviness) and associated mood.

Treatment

It was evident that modifications to the guidelines for lymphoedema management (ILF2010) were required. The proximity of the wound, pain, and impaired shoulder function constituted significant impediments to the introduction of either compression bandaging or the wearing of a garment. Thus, management was limited to initial intensive provision of manual lymphatic drainage (MLD) three times per week, the introduction of simple exercises and skin care. After the initial phase, MLD was continued on a weekly basis and Mrs A was encouraged to self-apply simple lymphatic drainage massage whenever possible.

Outcome of treatment

- A noticeable improvement was observed after the initial intensive period, with continuing progression over the following weeks to the present day, where the volume reduction is significant and comparative arm measurements are close to equivalent, apart from at the elbow where there continues to be a degree of swelling. Whilst the feelings of pressure and heaviness associated with the oedema have lessened, pain and range of movement has only improved slightly, indicating that the wound at the axilla may be the primary source of pain and restriction to movement.
- LYMQOL impact scores now rate significantly lower for appearance and mood, with Mrs A's anxiety and apprehension related to the lymphoedema largely resolved. Function scores reflect persistent impairment, as does the rating for pain. Active and passive movements of the arm and shoulder continue to generate pain, however comfort at rest has improved, possibly due to the reduction in load. Improved pharmacological pain management is also now in place.

Extended treatment

It was notable that the provision of MLD, a specialised gentle massage technique, was having beneficial outcomes for Mrs A beyond the reduction in oedema, with respect to other issues: anxiety, generalised pain and physical discomfort. As a result, it was agreed that the treatment plan would be adjusted to include gentle massage sequences to the whole accessible body to support other quality of life needs, musculoskeletal health and general physical and psychological well-being. This treatment approach was combined with a range of breathing, guided imagery and relaxation techniques which were introduced to support Mrs A in finding comfort, not only during the course of the treatment session, but also in establishing strategies for ongoing self-regulation of pain and anxiety.

Mrs A, who has a medical background, has been motivated to participate in this study by a desire to communicate the value of the holistic approach to care and to articulate the benefits such care has conferred upon her. Her wish is that such care be readily available to all people experiencing similar circumstances.

"I look forward to the treatment, it has been physically comforting, the touch is very gentle. The lymphoedema has gone, and really, it went quite quickly once we started the massage treatment, which was amazing as the arm was extremely, frighteningly, swollen all the way to my fingers. I was very anxious about what would happen to me if it kept swelling. The massage has been enormously helpful, supporting me physically, psychologically ,emotionally, lifting my spirit. Being able to have the time in this relaxed way, quietly, with the music playing, or freely and safely talking about things, like anxieties, apprehensions and life, and to have some techniques to keep me moving, help me to manage my pain and to relax, has been very beneficial."

Conclusion

This case study describes the benefit of the massage therapist bringing responsiveness and flexibility in the approach to care of a person with a life limiting illness. For Mrs A, the most important referral issue for the treating massage/lymphoedema therapist to address, initially, was the presence of lymphoedema. Once effective management of this issue had been achieved, it was possible to adjust the treatment care plan in response to other identified needs, namely, to support generalised physical comfort and well being, to moderate anxiety and also to provide an opportunity for emotional expression and meaning finding. Mrs A has generously attested to the value of this approach. Through the provision of gentle positive touch, combined with compassionate presence, the massage therapist has the capacity to cultivate an atmosphere of comfort and safety from which significant quality of life benefits may flow.

Acknowledgements: Alex Bridge Design and Maree O'Connor Physiotherapist

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