PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY:

APA COMMENT ON THE ISSUES IN BRIEF

Prepared by the

Australian Physiotherapy Association

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Authorised by

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SUMMARY COMMENTS ON TERMS OF REFERENCE

There is little known about factors affecting the supply of and demand for physiotherapists. Governments have traditionally shied away from responsibility for the physiotherapy workforce, with the Commonwealth asserting that it is a state responsibility and states only undertaking piecemeal projects and failing to co-ordinate nationally to analyse the need for physiotherapy services.

Physiotherapists are highly efficient and effective practitioners who work from a strong and growing evidence base and who are prepared to be accountable through the use of outcome measures and voluntary practice accreditation. Funding arrangements for payment for physiotherapy services are inefficient, with much cost shifting between state, local, and federal authorities, and between the public and private sectors. Furthermore, the structure of the system leads to inefficient use of other health resources such as GP services and diagnostic technologies.

There is no linkage between healthcare needs and the number or allocation of physiotherapy education placements. Physiotherapy education is vastly under funded; a fact that fails to acknowledge the importance of the discipline to primary healthcare in Australia.

In addition to the need for increased funding for physiotherapy services and education, there is a need for role redesign in physiotherapy. Pleasingly there are positive developments in expanding the scope of physiotherapy practice and in the formalisation of physiotherapy assistant roles. The major barriers to this reform are inadequate remuneration for higher levels of skill and the protectionist approach of some other professions.

Indigenous Australians would arguably benefit more from physiotherapy than most other Australians, because of the prevalence of chronic disease and the need for preventive exercise/lifestyle programs. However, a study by the Australian Physiotherapy Association (APA), yet to be published, demonstrates that Indigenous Australians in rural areas have virtually no contact with private physiotherapy services and no access to primary physiotherapy services via Indigenous health services and public hospitals. Their only contact with physiotherapy services is via tertiary hospitals, usually when it is too late, for an example, after the diabetic has had a leg amputated.

INTRODUCTION

To assist the Productivity Commission in developing an issues paper, the APA has endeavoured to respond to each question in the preliminary areas of interest section of the Commission's issues in brief document. Responses are listed under the headings from the brief, with answers recorded below the relevant question.

The APA wishes to make some opening remarks.

The physiotherapy workforce is Australia's largest contributor to healthcare after nurses and doctors. The knowledge and skill set of physiotherapists and the changing care needs of the population mean that their contribution must increase to fulfil community needs. This expansion has to occur in a context where many policy makers, particularly at a federal level, do not understand the role of physiotherapists, let alone what the demand will be for their skills in the future. The health policy environment is dominated by the medical profession. Policy makers understand what doctors and nurses do, doctors and nurses have a loud public voice, and the funding climate encourages patients to rely principally on doctor services. Existing Medicare arrangements perpetuate public reliance on doctor services, even when the services of other health professionals may be more effective and efficient in the management of the patient's condition.

The physiotherapy profession in Australia relies heavily on research evidence to guide its practice. The evidence base for physiotherapy practice has grown exponentially in recent years and continues to grow rapidly. PEDro, the physiotherapy evidence database contains 6093 trials, reviews, and guidelines.[1] Some of the evidence demonstrates not only clinical effectiveness but also cost effectiveness. At present, however, this evidence does not influence health funding arrangements. The extract below from the *British Medical Journal* is an example of research evidence supporting the cost effectiveness of physiotherapy as opposed to GP care, where GP care is funded and physiotherapy care is not.

> In the treatment of neck pain, manual therapy, a physiotherapy modality, was not only found to be the most effective treatment, but also the cheapest at a third of the cost of GP care. Manual therapy cost €447 compared to GP care that cost €1379 (Korthals-de Bos et al, 2003).

As our population ages and experiences a higher prevalence of chronic disease, there will be an increasing need for physiotherapy services relative to other healthcare services. These services will be required at the population health/preventive level, and in primary and tertiary care.

[1] PEDro (2005): http://www.pedro.fhs.usyd.edu.au/index.html (accessed 12 May 2005).

Examples of the increasing need for physiotherapy skills
Australian and overseas studies of community dwelling older people have identified that approximately one in three people aged 65 years and over fall each year, with 10 per cent having multiple falls, and over 30 per cent experiencing injuries requiring medical attention[2].

Australian physiotherapy researchers lead the world in falls prevention research and effective physiotherapy interventions are available to prevent falls[3]. As the population ages and more people remain at home, more physiotherapists will be needed to assess falls risk and design appropriate interventions to prevent falls. Interventions may be delivered one on one, in groups, or by physiotherapy assistants.

According to results from the 1995 National Health Survey, arthritis is a major cause of disability and chronic pain in Australia[4]. Now that certain classes of drugs are no longer available to arthritis sufferers because of their side effects, physiotherapy management is the only pain management option for many patients. Furthermore, as chronic disease rates increased, the incidence of co-morbidity will also increase making the less invasive physiotherapy interventions (i.e. where pharmaceutical management is impossible because of contraindications, physiotherapy may be needed) critical in the management of the pain and debilitation caused by arthritis and other musculoskeletal disorders. The National Health Priority Areas' Arthritis and Musculoskeletal conditions website recommends physiotherapy as a treatment for arthritis, yet the Department of Health and Ageing does not fund access to physiotherapy services for the general population.

Cardiovascular disease causes more deaths than any other disease, accounting for 50 797 deaths (40 per cent of all deaths) in Australia in 1998[5]. Physiotherapists contribute to cardiovascular health through preventive care, primary management, tertiary intervention, and rehabilitation.[6] Particularly in tertiary management, specialised physiotherapy skills are essential to the provision of best practice care. At present there is a critical shortage of appropriately skilled cardiothoracic physiotherapists in Australia, yet the Commonwealth provides no support for postgraduate education for these professionals. Furthermore, there is little financial incentive to undertake expensive further education because specialist skills in cardiothoracic physiotherapy are often not remunerated at a higher level. Although there is limited recognition of higher skills in the public sector, there is no recognition within the private sector. Third party payers (i.e. insurers, workers' compensation authorities, Veterans' Affairs, and road accident authorities) do not reward greater expertise. This is a significant impediment to skill growth

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[2] See http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-injury-falls-index.htm (accessed 13 May 2005).
[3] See the APA position statement on Falls Prevention (2005): https://apa.advsol.com.au/staticcontent/staticpages/position_statements/public/FallsPrevention.pdf
[4] See http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pq-arthritis-index.htm
[5] See http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pq-cardio-index.htm
[6] The APA has just completed an evidence-based position statement on physiotherapy and cardiovascular health. It will be available shortly.

that the market alone cannot overcome. Government intervention is needed to provide an incentive to skill acquisition.

The examples above briefly illustrate the growing need for physiotherapy services and allude to some of the structural barriers to meeting growing needs. A recent West Australian work value study elegantly describes the changes in demand for physiotherapy services: a copy is attached and we specifically draw attention to pages 18–20 (Attachment 1).

Workforce planners and policy makers must be made more aware of the vital role that physiotherapy services currently play, and the expanded roles they will play in the future. The monopoly of medicine (both in workforce planning and Commonwealth funding) must end if Australia's health service workforce of the future is to meet the community's healthcare needs. Radical change to the planning, structure, education, funding, and remuneration of the health workforce is essential.

The APA will expand on these themes in its next submission to the Productivity Commission's health workforce study. In the interim, we would be please to address specific issues or provide further information on request.

Unless otherwise stated the responses below relate only to the physiotherapy workforce.

RESPONSES TO ISSUES IN BRIEF

Workforce planning

- **What is the underlying rationale for workforce planning in the Australian context?**

There is no national workforce planning in physiotherapy. There is no universal data collection and the last report on the physiotherapy workforce is of 1998 data (Australian Institute of Health and Welfare: 2001). Higher education places are set by institutions largely based on profit rather than planning motives.

Some state health departments are coming to terms with the need to plan the physiotherapy workforce. The Victorian Department of Human Services is to be commended for funding a study into attrition and retention factors in physiotherapy.

- **Do current arrangements facilitate the identification of, and planning for, Australia's health workforce priorities in the medium and long term as well as in the short term?**

No. The absence of planning outside the nursing and doctor workforces means that neither short, medium, nor long-term proprieties are adequately identified.

- **What are the main problems with current planning arrangements? To what extent do they consider the structure or funding of the health system? Can they take adequate account of such matters as ageing and technological advances that are likely to change demand for, and the nature of, the health workforce in coming years? What provision is, or could be made, for potential future skill needs (e.g. for robotic technicians)?**

Current planning arrangements focus on projected need for doctor and nurse services—they do not account for the fact that millions of episodes of care are provided annually by other health professionals. They also assume that health professional roles will remain static. Changing healthcare needs and technologies demand a flexible workforce, with planners mapping needs against skill sets to meet those needs. It is noteworthy that in different populations the same needs will be met by different skill sets and even among the same populations, different consumers will chose different skill sets to manage the same needs. At present, consumer choice is extremely limited in this regard by anticompetitive funding models which privilege doctor services.

In that planning and funding arrangements both focus on doctor services, they consider only one aspect of healthcare in Australia. Arrangements that do not even acknowledge the current reality that not all health services involve doctors, nurses, and pharmaceuticals cannot possibly be responsive to changing needs. Although millions of episodes of care are provided annually by physiotherapists, psychologists, podiatrists, dietitians, and other health professionals, it is difficult to definitively state minimum data such as the number of professionals currently practising. The dearth of data is echoed by an absence of workforce planning.

Provision for future skill needs must be made in the underpinning training of health professionals. Physiotherapists receive education in the basic biological and psychosocial sciences that underpin clinical practice. In combination with the clinical reasoning and communication skills they acquire, this equips them to readily apply new technologies, following participation in appropriate professional development activities. Despite the pressure of growing curricula, physiotherapy courses must continue to deliver the high level of basic sciences that underpin the acquisition of clinical skill.

Structures are needed to tap this flexibility. For instance, governments need to work with professional groups to design and implement new health roles and support must be provided for health professionals to acquire the new skill and knowledge needed to take on new roles or utilise new techniques or technologies.

The physiotherapy profession has a history of adaptation and changing scope. A comprehensive report has recently been completed on changes in the physiotherapy profession from 1989 to 2004. It outlines the growth in the profession's scope of practice and developments in physiotherapy specialisation. The document was prepared as part of a work value study in Western Australia and it thus uses local examples. Notwithstanding, it clearly documents the evolution of the profession and demonstrates the flexibility of Australian physiotherapists. A copy of the report, Increased Work Value, the Case of Physiotherapy, is attached (Attachment 1).

Even now the profession, led by the APA, is pursuing role redesign to maximise the capacity of the physiotherapy workforce. The APA supports further development of physiotherapy assistant roles, an expanded scope of physiotherapy practice and the development of enhanced scope practitioner roles.

- **Are adequate data available to facilitate effective workforce planning?**

No.

- **Is health workforce planning sufficiently well co-ordinated across services and jurisdictions? How well is it linked with the education and training of healthcare workers and the delivery of healthcare services? How might co-ordination and integration between each of these areas be improved?**

A single national health education agency is needed with responsibility for projecting future healthcare needs, mapping the services/skill sets necessary to meet those needs, and commissioning and purchasing health education. Consideration also needs to be given to skills required for care in disability sector as there are crossovers with the health sector.

The education system has demonstrated an inability to be responsive to health skill needs, and creating the necessary links between health and education departments only creates opportunities for cost/blame shifting so a single health education agency, under the control of the Federal health department but with representation from all jurisdictions, should have full responsibility.

- **What lessons emerge from past attempts to improve health workforce planning? Have the high priority issues been targeted? Are there particular examples where planning has worked especially well? What can be learnt from workforce policies and outcomes in other countries and their efforts to improve planning arrangements?**

A major lesson to learn is the peril of focusing too closely on one or two sectors of the workforce to the detriment of others.

Regarding the overseas experience, the APA is particularly impressed by recent development in the National Health Service of the United Kingdom. In particular, the NHS resolve to drive policy in partnership with carers appears to be yielding excellent results.

Massive reform is underway in the NHS and we are loathe to take on the task of documenting and reviewing the process. We are assuming that the Productivity Commission will access this information from elsewhere. The APA would be pleased to address any questions specific to physiotherapy.

Briefly, physiotherapists have taken on screening roles in orthopaedic and musculoskeletal clinics. This has resulted in a reduction in waiting time for first specialist appointment by two-thirds. There has also been in increase in conversion to surgery rates from 20–30 per cent to 70–80 per cent meaning that the orthopods' skills are being used more efficiently. The flow on effect has been a reduction in the wait for elective surgery.

We attach for your information 'The role of physiotherapy-led screening clinics in managing wait lists and hospital demand for musculoskeletal/orthopaedic services,' by Dr Leonie Oldmeadow. It is a report of her study tour of the NHS examining vertical streaming in physiotherapy. In particular we draw your attention to the efficiencies gained by removing from the orthopaedic surgeon responsibility for triage. The report of the study tour is only available in print and will be forwarded by post.

Education and training

Unlike some other professions, the APA is seeking an increase in the number of physiotherapists. Our Vision for Physiotherapy 2020 calls for there to be 16000 full-time equivalent, practicing physiotherapists by that time. High ENTER scores are required to enter physiotherapy programs within the universities. Strong competition from prospective students for a place in a physiotherapy course has resulted in generally only students in the top two per cent being admitted. The limitation on the present system is lack of funding.

Physiotherapy is a clinical discipline and it is not funded accordingly. On graduation, physiotherapists are eligible for unconditional registration. Therefore, their clinical education must prepare them to practice independently and safely in all settings. Without funding as a clinical discipline this is becoming increasingly difficult. At present the Commonwealth Course Contribution for physiotherapy is $7392 per student, while universities receive $15 422 for each medical student. The education requirements, including laboratory classes, dissection, and clinical placement do no vary materially yet physiotherapy schools are expected to make do with less than half of the resources.

We draw to the Commission's attention the recently released Australian Universities Teaching Committee (AUTC) report on physiotherapy education. A copy is attached (Attachment 2). It is the only comprehensive study of physiotherapy education in Australia. The report makes 10 recommendations, including increasing funding for physiotherapy education. The APA commends the report and strongly recommends it to the Commission. The recommendations relating to clinical education are:

1. Federal Government should review the Commonwealth Course Contribution Schedule and reclassify physiotherapy as a clinically based medical science.
2. A feasibility study be instigated to explore the merits of a regulated preceptorship/mentoring system for new graduates in the workplace that recognises that new graduates require support during their first year of employment. (McMeeken et al, 2005)

The lack of funding is placing economic pressure on institutions to offer physiotherapy as a graduate-entry course. Graduate entry masters courses are full-fee paying courses and therefore more economically viable than the cash-strapped HECS places. There is a place for graduate-entry programs, but their introduction should be based on educational need rather than economic imperative.

The APA is gravely concerned that entry-level courses masters courses may replace bachelor degrees. There are three levels of concern regarding this possibility: workforce implications; research; and equity.

Graduates of entry-level masters will have amassed a substantial study debt. For example, a student with a science degree from the University of Sydney will have a HECS debt of $54 720 (based on 2005 fees and without indexation). The current full time fee for a Master of Physiotherapy at the same institution is $17 184, meaning that, on obtaining an entry level physiotherapy qualification, the student will have a debt of at least $89 088.

Thus wage expectations will be higher and the chances of attracting physiotherapists to important but lower paid roles in areas such as aged care and disability would be diminished.

As the proportion of graduate entry masters qualifications increases, the pool of potential researchers will decrease. Physiotherapy academics have observed that graduate entry masters students do not continue into research. The reasons for the trend are unclear but the trend itself is apparent and will lead to a dearth of researchers in Australia. As Australia currently leads the world in physiotherapy research, this would have international implications.

Finally we would be concerned that the costs involved in obtaining the graduate entry qualification may be a barrier to socioeconomically disadvantaged persons.

- **How effective are current education and training arrangements (whether undergraduate, graduate, VET, or clinical training)?**

In respect of entry-level physiotherapy education, please refer to the AUTC report in answer to this question.

  - **Is there adequate co-ordination between the various entities involved in this area—governments, hospitals, educational institutions, and professional groups—and agreement on common goals?**

Communication and co-ordination vary across the country. In some instances, lack of funding actively prevents co-ordination. For example, because there is inadequate funding to allow universities to support substantial numbers of clinical placements in the private sector, public hospitals remain the principle site of clinical placement. Growing numbers of students are increasingly putting pressure on the number of places available, forcing universities to compete for clinical education places. Thus rather than working together to maximise clinical placement opportunities, institutions compete to provide their students with the clinical experience they need to practice.

In respect of workforce planning, there is no co-ordination of post-entry level education. The APA provides a professional development program for its members and has pathways for the recognition of specialist expertise. However, there is no entity that assesses the need for specialist skills and there is no support for physiotherapists seeking to develop their expertise or a higher level of remuneration for physiotherapists with specialist knowledge and clinical skills.

The need for and extent of specialisation in physiotherapy is generally poorly understood within the community. Probably the most recognised physiotherapy speciality is sports physiotherapy. Physiotherapists recognised as having specialist skills have qualifications or experience at the level of a clinical masters. There are now a broad range of clinical areas where graduate level skills and knowledge are inadequate to meet the clinical needs of the population served. The APA has the following clinical special groups, all of which have defined specialisation pathways, or are in the final stages of defining those pathways:

- Aquatic physiotherapy;
- Cardiothoracic physiotherapy;
- Continence and women's health;
- Occupational health physiotherapy;
- Gerontology;
- Musculoskeletal physiotherapy;
- Neurology;
- Paediatrics; and
- Sports physiotherapy.

It is difficult for those not closely associated with the physiotherapy profession to understand what specialisation means. Recently the National Cardiothoracic Group of the APA completed a discussion paper on competency expectations of new graduate physiotherapist in cardiothoracic physiotherapy. The purpose of the document is to identify what a new graduate physiotherapist should be competent to do in the area of cardiothoracic physiotherapy. The document coincidentally provides good examples to illustrate the distinction between physiotherapy practice and specialist cardiothoracic physiotherapy practice. Some examples are listed in Table 1 below.

Table 1. Extract from the National Cardiothoracic Group Cardiothoracic Curriculum Committee Discussion paper on competency expectations of new graduate physiotherapist in cardiothoracic physiotherapy.

Competency expectation of new graduate physiotherapist			
	Independent	Will require initial supervision /assistance	*Will require further supervised training and experience and/or postgraduate training*
Breathing pattern and control	Recognition of normal, spontaneous breathing patterns and variations resulting from pathology or work of breathing		*Assessment of control of breathing and central components of ventilation (e.g. sleep studies)*
Oxygen therapy, metered dose inhalers and humidification	Principles, issues, and common equipment	Specific equipment	*Recommendation for domiciliary oxygen* *Administration and management of domiciliary oxygen*
Management of artificial airways	Artificial airways—recognition of different types, principles and issues associated with different airways either temporary or permanent		*Tracheostomy weaning procedure including cuff deflation/ tracheostomy changes, downsizing etc*
Assisted ventilation techniques			*Principles of supported ventilation and indications for use (theoretical understanding of different types and levels of support including invasive and non-invasive methods)* *Non-invasive ventilation techniques and approaches* *Assessment and management of ventilated dependent patients (ICU)*

The right hand column indicates the type of competencies a specialist cardiothoracic physiotherapist must possess. Additional education and experience is required to master these competencies. Specialist physiotherapists also develop a higher level of clinical reasoning skills. A combination of post-entry level competencies and high level clinical reasoning is required to practice in a specialist field.

While clinical specialisation is essential in a range of work settings, remuneration rarely reflects this fact. The lack of recognition is placing pressure on workforce development in important clinical areas. Most notably in the gerontology area: specialist skills are required but not only are those with special skills not paid more than those without, physiotherapists in

gerontology are generally paid less than those in other areas of practice. There is already a shortage of physiotherapists in gerontology: unless measures are put in place to provide a viable career path as a matter of urgency, our rapidly ageing population will have very limited access to essential physiotherapy services.

There is agreement on the goals of entry-level education by virtue of the physiotherapy competency standards currently under review by the Australian Council of Physiotherapy Regulating Authorities (ACOPRA).

In the VET sector, there is agreement that the existing Certificate III in Allied Health Assistance is too generic to be of any use. The APA is working with the Community Services and Health Industry Skills Council to develop new competencies for a Certificate IV in Physiotherapy Assistance. Support will be needed from hospitals and other employers to train and remunerate assistants at a higher level.

- **Is the balance in the numbers of training places in particular fields appropriate? If not, what is required to deliver a better balance in the future?**

This is difficult to answer definitively because of a lack of data. Certainly more physiotherapists are needed (whether needs can be met via retaining the current workforce and re-attracting qualified physiotherapists is unknown) and, as indicated above, the APA contends that there is a growing demand for specialist skills. Anecdotally there is a clear need for funded postgraduate positions in cardiothoracic, paediatric, gerontological, musculoskeletal, and neurological physiotherapy.

As previously mentioned there is a need for more appropriately qualified physiotherapy assistants. The need cannot realistically be met until the new competencies are in place but once they are, industry will need to invest in the training of assistants.

- **Is education and training occurring in the best institutional settings and is it providing the skills and knowledge base required for effective delivery of healthcare services? Is the balance between public and private sector training appropriate?**

Broadly yes, but the APA is concerned regarding the cost of entry-level and postgraduate physiotherapy education.

- **Is education and training responsive to changing healthcare needs? More specifically, is curriculum development responsive to changes in medical practice and technology?**

As discussed above, physiotherapists are very good at adapting to new demands by virtue of their comprehensive basic science and clinical reasoning education. The APA continuing professional development (CPD) program for graduate physiotherapists is responsive to changes in practice and technology. The undergraduate competencies are under review and future needs are considered in the review process. There is a long lead-time on the provision of qualified physiotherapy assistants but once the new competencies are established the APA believes that persons trained will be responsive to changing needs. If necessary, the APA will investigate a CPD program for physiotherapy assistants.

The responsiveness of the profession is due to and driven by the profession. To date there has been little external support for physiotherapists in meeting changing demands. As pressures on the profession increase, facility will need to be made to ensure that the responsiveness can continue to adequately meet the demands.

- **How effective are current arrangements that provide short-term retraining to allow health professionals to return to work, and training to those needing to upgrade their skills?**

Physiotherapy re-entry education programs are severely lacking in all jurisdictions. Significant investment is needed both in re-entry education (which the APA could supply, if funded to do so) and programs to encourage non-practicing physiotherapists back to the profession.

A number of registration boards have introduced recency of practice provisions and it should be noted that provision is being made for re-entry programs in some jurisdictions.

- **What role do professional organisations play in the development and content of training courses? Are these arrangements delivering good outcomes?**

Undergraduate physiotherapy training programs
The APA contributes to the direction of entry-level physiotherapy education through its representation at the Australian Council of Physiotherapy Regulating Authorities (ACOPRA), which accredits all entry level programs, and also through representation at many of the individual program advisory committees at the Schools of Physiotherapy. The APA is also active in contributing to the development of standards for the assessment of entry-level physiotherapists (e.g. 2005 Review of Physiotherapy Competency Standards).

Post-Graduate physiotherapy courses
The APA contributes to the development of postgraduate coursework programs at universities in a number of ways. There is a rigorous course

review process for postgraduate qualifications that enable members to submit for recognition as Titled Members (e.g. 'Sports Physiotherapist') under the APA Specialisation Framework. This review process evaluates the program against the Professional Practice Standards considered appropriate under the APA's Charter of Educational Standards. Many of the Schools of Physiotherapy have an APA representative on their post-graduate Advisory Committee. There has also been a recent trend to incorporate (or give credit for) APA Professional Development activities as part of a Masters program. For example, the Masters in Sports Physiotherapy at La Trobe University has as part of its curriculum the APA Level One and Level Two courses in Sports Physiotherapy.

Continuing Education for Registered Physiotherapists
The APA is by far the biggest provider of Professional Development activities for physiotherapists, running some 400 events nationally each year. Many of these events are aimed at supplementing/consolidating the pre-vocational education of recently qualified physiotherapists, while others are intended to enable experienced practitioners to keep abreast of developments in their field and to maintain their standard of clinical practice. The genesis of most professional development events is through the interest groups within the APA (e.g. 'Cardiothoracic Physiotherapy', Musculoskeletal Physiotherapy', etc.) and is delivered through a combination of volunteer physiotherapists, paid presenters and APA staff (each state branch of the APA employs a professional development officer to assist the National Groups with the administration of professional development events).

The professional development events provided by the APA vary enormously, from one hour lectures, to weekend hands-on (practical) courses, to large scientific conferences. All courses are subject to a rigorous accreditation process, to ensure that the quality of the course is consistent and that it has been designed in accordance with the stated rationale and learning objectives. All course participants are asked to complete a comprehensive course evaluation questionnaire, which is used in the further development of each particular course, and may be used by the accreditation committee to suggest improvements. Professional development is also tied to three levels of recognition in the profession, the highest of which is the Specialist category conducted by the Australian College of Physiotherapists.

Regulation of the health workforce

- **Are current regulatory arrangements broadly conducive to appropriate outcomes? To what extent do they increase the cost of and/or reduce access to services?**

- **What influence do registration procedures and professional rules have on workplace or professional mobility, or the ease of re-entry to the workforce after an absence?**

- **Would relaxing current restrictions in some areas improve the effectiveness, accessibility and financial sustainability of service delivery without endangering safety and quality objectives? Are there areas where more regulation would be desirable? How do Australia's regulatory arrangements compare with those in other countries?**

The questions above are answered concurrently.

State based regulation restricts movement between states and creates barriers to educational opportunities. Although national mutual recognition legislation provides for cross-border recognition of registration, clinicians are still required to complete the paperwork and pay the fee for each state in which they wish to work. The APA canvassed the problems in its submission to the Commission in March 2003 on mutual recognition.

In summary, the APA believes that nationally consistent, nationally portable registration is essential to remove barriers to workforce flexibility.

In its investigations of enhanced scope physiotherapy practice, the APA has encountered a legal question that remains unanswered. While it is likely that most registration acts present no barrier to expanded practices such as injecting, it is unclear whether barriers may exist by virtue of other legislation, such as drugs and poisons acts. Further investigation is needed to determine whether there are legislative barriers to extending the scope of physiotherapy practice. The APA recommends that a national study be conducted to investigate legal barriers to expanded scope of practice for all registered health professionals.

Workforce participation

- **To what extent is participation in the health workforce influenced by short term cyclical conditions in the economy rather than longer term structural factors?**

Data collection regarding the physiotherapy workforce is so poor that it is difficult to comment.

- **What are the key influences on workplace participation and job satisfaction?**

- **For example, how important are remuneration, conditions (including hours of work, job design and access to training), and workplace pressures?**

Hard evidence in relation to this question is severely lacking. The Victorian Department of Human Services is collaborating with the APA on a study to identify retention and attrition factors in physiotherapy. A literature search has been commissioned and will be complete before the Commission's report is finalised. The APA will endeavour to provide the Commission with an analysis of the findings.

Information from members leads the APA to conclude that lack remuneration and career paths are a major factor in attrition from physiotherapy practice. The APA specialisation framework provides the basis for a career path yet most employers and third party payers have failed to recognise and remunerate higher levels of skill.

Physiotherapy Business Australia (PBA) is a group of the APA representing physiotherapists in private practice, many of whom own and operate physiotherapy practices. PBA cites lack of career path in private practice as an attrition factor. An example is that of a 23-year-old physiotherapist, only three years out of university, who has already reached his maximum earning potential in the private sector.

Workplace injury is also a known attrition factor. One in six physiotherapists moved within or left the profession as a result of work related musculoskeletal disorders (Cromie, 2000).

- **Apart from their impact on work satisfaction, do features of job design in the healthcare area detract in other ways from effective workplace outcomes—through, for example, inhibiting efficient work allocation and affecting the scope for mobility and re-entry?**

The high proportion of independent healthcare practitioners means that 'job design' does not adequately capture the organisation of work in healthcare. A discussion of the systems in which care is delivered is necessary.

A range of work practices that arise from both the historical role of doctors as the centre of healthcare and existing health funding arrangements lead to system inefficiencies. System inefficiencies result in unnecessary consultations, inappropriate utilisation of skill and unnecessary expenditure. More importantly for the patient though, efficiencies can mean inappropriate care and sub-optimal outcomes.

Referral arrangements under the Medicare system are a perfect example. The only research available to the APA relates to diagnostic imaging referral in physiotherapy. The study found that because of referral arrangements, 9460 hours of unnecessary GP consultations were occurring per annum, at a cost to the taxpayer of $1 040 567. Thus a change in the system of referral could save nearly 10 000 hours of GP time and over $1 million per annum. A copy of the report is attached (Attachment 3).

Other examples relate to the fact that if physiotherapists refer a patient to a specialist, the patient is not eligible for a Medicare rebate. This means, for example, that a patient has to see a GP in order to get a referral to see an orthopaedic surgeon. Physiotherapists are appropriately qualified to give the referral, but because they do not have referral rights, the patient wastes their time by attending an unnecessary consultation with the GP. Given the shortage of GPs, the GPs time could also be better spent. There are efficiencies to be gained by granting physiotherapists the right to refer patients for Medicare rebated consultations with specialists such as orthopaedic surgeons and obstetricians and gynaecologists.

Other limitations of the current funding arrangements result in suboptimal care.

Examples

Annie is a single parent with two boys, Stevie and Michael, who have Batten's Disease. It is a degenerative brain disorder and usually results in death at 10 to 15 years of age. Stevie and Michael are both bed ridden and require tube feeding. They require regular suction to remove fluid from their lungs. Stevie was recently admitted to hospital with pneumonia. He was discharged from hospital and Annie was told that he must have pulmonary physiotherapy at home. The hospital advised her to contact community services, which she did and was told that physiotherapy services are for adults only. Community services advised her to contact DADHC who said they do not provide physiotherapy. She returned to the hospital and was told they only provide in hospital physiotherapy services. She went to her GP who told her that Stevie needs physiotherapy – a fact of which she was well aware. Annie wants to keep her boys at home; she said 'there's only so many days left that I can cuddle my boys'.

Annie's case is a real case with changed names. The lack of ready access resulted in sub-optimal care for Stevie and also caused Annie much angst and frustration, particularly at having to spend so much time on the phone attempting to arrange services rather than being with Stevie. Stevie is now dead and Annie is facing the same frustration in arranging care for Michael.

Samantha is the twenty three year old mother of Rani. They are supported by Angelo who earns $25 000 a year working on a production line. Yesterday at school Rani fell and twisted her knee. The school nurse confirmed that

nothing was broken, but said it would be sore for some time and Rani would benefit from seeing a physiotherapist.

Samantha cannot afford a private physiotherapist and the community health services only provides physiotherapy to pensioners so she goes to her GP. The GP says she can provide painkillers or a referral to an orthopaedic surgeon but there is nothing else she can do. Samantha asks about the public hospital but the GP says the waiting list is so long Rani would be in high school before she was seen.

Rani has not received the care she needs and GP time and Medicare dollars have been wasted because our funding system provided only doctor care, and not the most appropriate care for that particular patient.

Due to their high level of knowledge and ability, as evidenced by their high ENTER scores and comprehensive education, physiotherapists have significant untapped capacity to contribute to the healthcare system. Review of the Medicare system should occur in order to, not only meet patient needs, but also to ensure that outdated historically based approaches as to which profession can be funded does not prevent physiotherapists being used to their full potential.

Currently there are limited or no financial rewards for physiotherapists who develop and utilise higher skills. The APA contends that if promotional opportunities are available, physiotherapists will take it upon themselves to develop the skills needed to fulfil the requirements of expanded roles.

As stated previously, due to their high level of knowledge and ability, as evidenced by their high ENTER scores and comprehensive education, physiotherapists have significant untapped capacity to contribute to the healthcare system. These experienced professionals often experience a high level of frustration at the artificial barriers placed in their way to providing the care their patients need and for which they have the skills to provide. Anecdotal evidence tells us that this frustration and lack of challenge in the workplace roles impacts on retention of skilled clinicians in physiotherapy. Workplace redesign, such as has occurred in the NHS, should overcome much of this frustration and ensure that physiotherapists are able to undertake roles for which they clearly have the capacity and skill.

- **What other practical, financially-responsible, measures might reduce the rate of attrition in particular health professions and facilitate re-entry into the workforce?**

As previously mentioned, access to re-entry courses is an issue and the APA would be prepared to conduct appropriate courses if financial support were available for the development and delivery of appropriate courses.

The other factor that requires attention is the rate of injury of physiotherapists. The APA has identified the need for manual handling guidelines for the

movement of patients for therapy purposes. The guidelines may, in part, reduce the high rate of attrition of physiotherapists due to injury. Further research is needed to identify ways to reduce the rate of injury and concomitant workforce loss.

Migration issues

- **Should recruitment of overseas trained healthcare workers continue to supplement local healthcare resources? Should such recruitment mainly be used to address short term gaps, including in rural and remote areas, or is there scope to meet some ongoing needs in this way? Should ethical considerations limit the future role of overseas trained workers in the Australian healthcare system?**

- **Do current regulatory and training arrangements facilitate the effective use of overseas trained health workers?**

The APA is concerned that current examination requirements for overseas-trained practitioners are a disincentive for 'working holiday' physiotherapists. Limited registration has been introduced in many jurisdictions but is unavailable in Queensland and Western Australia. Where it has been introduced, there are indications that problems may arise at the end of the period of limited registration. For example, a practice in one State has employed a UK trained physiotherapist for nearly 12 months. At the end of the 12 months limited registration will expire. The practice is happy with the physiotherapist and has asked the physiotherapists' registration board how at 365 days the physiotherapist can be deemed competent to practise and at 366 days no longer be able to practise.

Where limited registration is unavailable, the applicant must complete a three-stage assessment process before being able to register. This involves assessment of qualifications, a written examination and a clinical examination. Obviously this is impractical for holidaymakers. Protection of the public is of paramount importance but presumably what is safe in one jurisdiction is safe in another. The APA strongly supports a nationally consistent approach to the assessment of overseas-trained physiotherapists for both permanent and holiday employment.

- **What are the implications for the Australian workforce of competing demand from other countries also facing health workforce shortages?**

Australia should aim to independently produce the skills it needs to care for its own population. Ethically we should not be recruiting from underprivileged nations but in reality there is a global marketplace of health practitioner skills and there is very little Australia can do to influence that market.

Productivity

The APA contends that existing Medicare arrangements are anti-competitive and stifle productivity by creating an artificial market for GP services. GP services are of course critical to healthcare in Australia but other health professionals are better trained to manage many conditions for which patients currently consult GPs because funding for other services is unavailable. Opening up Medicare would allow health professionals to apply their skills in their area of expertise (thus providing better patient outcomes) and open up the healthcare market to competition.

- **How should the productivity of the health workforce be measured? On currently available indicators, how does productivity in Australia compare to health workforces in other countries? Is there significant variation within Australia across jurisdictions and health fields, or between the public and private sectors?**

The APA supports the use of outcome measures in clinical practice[7]. We therefore contend that productivity ought to be measured in respect of the outcome for the patient. However, in the case of preventive care, outcomes must be measured over a long period of time.

The APA contends that waiting lists and patient access to services should be indicators of productivity because early intervention in most conditions leads to better outcomes.

Australian physiotherapists are well regarded internationally. We have no data on relative productivity, but we do know that Australian physiotherapists are targeted by international recruiters (not good for our workforce but it does speak of the quality of Australian physiotherapists) and that Australian physiotherapy researchers are internationally renowned. Physiotherapy practice is of high quality throughout Australia and in all work settings.

- **Beyond the various avenues canvassed above, what options are available to improve the productivity of the health workforce? For example:**
  - **What contribution can e-health make?**

Better communication between members of healthcare team is an important role IT can fulfil. It is vital that initiatives include access for all practitioners, not

[7] The APA position statement on outcome measures is available at https://apa.advsol.com.au/staticcontent/staticpages/position_statements/public/ClinicalJustification&Outcome%20Measures.pdf

just doctors. This is essential to ensure that communication between members of multidisciplinary teams is efficient and effective.

- **Is there scope to reduce the total costs of service delivery by greater investment in labour saving technologies (such as robotics)? Are there any particular impediments to such investment and how might they be addressed?**

The APA contends that the potential for cost reduction lies in the ongoing development and funding of preventive and patient self-management programs rather than technology. System efficiency is also important, for example as discussed above by reforming the referral system.

The APA also contends that service delivery costs can also be reduced by ensuring that the appropriate service is available and affordable for the patient. Examples exist for all allied health disciplines but a clear example exists in mental health. Many patients who would benefit from cognitive behavioural therapy with a psychologist (an evidence-based therapy), are forced instead to consult a psychiatrist because psychiatry is covered by Medicare where as psychology is not covered. Relevant physiotherapy examples have been covered earlier in this submission.

- **Would less restrictive delineation of work responsibilities within and between professional groups allow better use to be made of the health workforce? Are there particular regulations, education and training or workplace constraints that prevent or hinder this from happening now?**

Yes—a number of examples have been covered earlier in this document including Medicare referral arrangements, extended scope of practice and the need for Medicare to be expanded to include services provided by other health professionals for which there is evidence of effectiveness and cost effectiveness.

In regard to regulation, as discussed above the APA is unclear as to whether there are any legislative barriers to expanded scope of practice. There are no educational barriers to physiotherapists providing care or referrals under Medicare. Physiotherapists are appropriately skilled now to take on these roles. The only educational barriers that exist are in relation to undertaking postgraduate study to fill specialised physiotherapy roles. These barriers relate to the cost of postgraduate education, particularly given the lack of financial reward for undertaking further study.

Demand

- **Are recent assessments of future demand for healthcare services and workers, and the specific impacts of factors such as ageing and advances in medical technology, *broadly* appropriate?**

Yes, clearly an ageing population with a higher prevalence of chronic disease will need more healthcare services. In the APA's assessment, ageing and chronicity place a proportionally greater demand on physiotherapy services than these of most other disciplines.

- **Will future growth in demand have different implications for workforce needs and policies in particular healthcare fields and/or geographical areas?**

Yes. A different skill mix required will be required to manage chronic illness and deliver preventive health programs. The evidence strongly supports the role of allied health in the management of chronic illnesses such as chronic obstructive pulmonary disease and chronic heart failure. More allied health professionals will be required to work in ambulatory care to manage these and other chronic illnesses and to minimise resultant hospital admissions.

The role of physiotherapy in areas such as pre and post surgical intervention and management is increasing. Programs such as 'Get Fit for Surgery' maximise the physical condition of a patient prior to surgery ensuring a short as possible length of stay in the acute facility and a shorter recovery period post discharge.

Further, enhanced scope of practice and taking on responsibilities such as triage in emergency departments will also increase the demand for physiotherapy.

Physiotherapy assistants will take on greater responsibility and will be required in increased numbers in both community and hospital settings.

Regional, remote and Indigenous issues

- **What particular workforce issues arise in relation to the delivery of services to people living in regional and remote areas and to Indigenous Australians? Are there issues specific to Indigenous Australians living in urban areas?**

Like all health workforces, physiotherapists are vastly under-represented in rural, remote, and Indigenous communities.

There are two reports on required levels of service in remote communities. The North West Queensland Area Health Service has produced a report on allied health staffing level benchmarking. It focuses on the needs of populations of less than 5000 (Next Challenge Consultancy, 2005). The extensive project report recommends six guidelines for minimum service levels. The minima are low yet they are unmet in most communities. A summary of the guidelines is reproduced below.

Guideline A
At least 125 days of service (DOS) from a team of three or more allied health professions per annum (total contact and non-contact time).
Guideline B
Frequency of at least two visits per year per discipline with additional off site service provision.
Guideline C
Clinical and non-clinical split in the DOS (Guideline A) will vary depending on the service delivery model and distance from the base.
Guideline D
Allied health services need to use a range of service delivery methods that are planned in line with communities needs and consistent with best practice models of service delivery.
Guideline E
A team of allied health professionals are required to deliver services to sites.
Guidelines F
Travel time must be added to the calculated DOS staffing time required to service a community.

The second body of work was developed by a group of expert physiotherapists with extensive experience working in rural and remote work settings. The group's recommended minimum physiotherapy workforce for remote contexts is reproduced below. This level of service is being trialled for physiotherapists and other allied health professionals in the Katherine region of the Northern Territory.

Recommended Minimum Physiotherapy Workforce for Remote Contexts

The calculation of minimum physiotherapy workforce requirements for remote regions is achieved using the following criteria:-

1. There must be a capacity for a minimum of monthly visits from a physiotherapist to all remote communities with a population of over 100 residents.
2. The minimum length of stay for each visit is determined by the size of population of each community using the following formula:
   - Community population of 100–300 = 1 day visit (minimum)
   - Community population of 300–800 = 2 day visit (minimum)
   - Community population of 800—2000 = 3 day visit (minimum)

1. One day of work on-site in a remote community generates an average of one day of non-clinical activity; that is, time spent on travel, report writing, equipment ordering, service meetings, health education planning, communications, etc.
2. This formula may also apply to other allied health professions focusing on aged/disability care in remote areas; eg occupational therapy, speech, audiology, podiatry. Physiotherapy goals are much enhanced when shared with AHP colleagues in their work with clients and carers.

These four requirements enable clear calculation of the minimum workforce required for any given remote region; eg Katherine, Arnhem Land, the Gulf, Cape York, the Kimberly, Central Australia, Far West NSW, etc. However, there is no stipulation that all the required workforce be provided through the public sector. There may be opportunities for the purchase of private services by non-government providers. Furthermore, the proposed formula only provides a means of establishing a minimum workforce level – higher levels will be desirable in many remote districts according to variable rates of need over time and associated with differing population demographics.

Recommended Model for Remote Physiotherapy Practice

Once the relevant minimum workforce numbers have been established the key issues for remote physiotherapy practice are associated with the model chosen for service delivery. The following guidelines for model development are proposed:-

- Physiotherapists must work in close collaboration with other allied health professionals and service providers involved in aged and disability care in the name of co-ordinated care.
- Physiotherapists must give priority to the development of positions for local remote community residents to work in aged and disability service provision. This enables effective partnerships in primary healthcare service delivery.
- Priority must be given to the development of information technologies and resources which enable effective communication of therapy information and ideas over distance
- The concept of Community Based Rehabilitation be should be explored and developed by physiotherapists for application in the remote Australian context.

The most significant barrier to working with Indigenous communities is lack of funding. There are very few positions funded for physiotherapists and allied health practitioners in Indigenous communities, despite the demonstrable need for healthcare. Indigenous people do not access private physiotherapy services and they only access public services via tertiary hospitals. Hospital physiotherapy services commonly provide care for conditions such as cardiovascular disease, complications resulting from diabetes and chest infections/pneumonia. There is little on no system capacity for preventive programs and there is no capacity for primary care physiotherapy services such as continence management, musculoskeletal care or asthma management. Indigenous health services unanimously stated a need for physiotherapy services but cited lack of resources as the reason why those services are not provided.

- **Are these issues mainly related to the attraction and retention of staff? Or are the appropriate mix of service providers and the skills that specific providers must have, different from those required by other groups?**

The shortages principally relate to recruitment and retention but Indigenous communities need a higher level of service and a different skill mix to metropolitan communities. There is also clearly inadequate workforce (ie funded positions) in rural and remote Australia. It is well documented8 that the health of the Indigenous population is poorer than that of non-Indigenous populations. Aside from a shamefully low life expectancy—21 years less for males and 20 years for females, compared with the total population (Australian Bureau of Statistics 2002)—there is also a significantly higher level of morbidity, particularly due to chronic disease and injury. The APA contends that there is therefore a greater need for health services and a significantly greater need for preventive healthcare programs for Indigenous communities as compared to the remainder of the population.

- **To what extent could system-wide initiatives to promote better workforce outcomes assist Indigenous Australians and those living in regional and remote areas? What more focused initiatives are required? What is the potential for telemedicine to improve services for these groups?**

A recent APA research project on Indigenous utilisation of physiotherapy services found that health services for Indigenous people are best delivered by Indigenous controlled health services. Ten Indigenous services need access to physiotherapy and other allied health professionals to provide clinical and preventive services. The APA contends that targeted initiatives

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[8] See for example the National Indigenous Health Survey series produced by the Australian Bureau of Statistics: http://www.abs.gov.au.

developed in conjunction with local communities are essential to improve the health of Indigenous Australians. Therefore, workforce initiatives must be tailored to individual community needs.

The only systemic changes likely to be of assistance are increasing Indigenous participation in health professional education and mandating the inclusion of Indigenous cultural awareness content in all health professional curricula.

After hours GP services adjacent to acute care hospitals

Physiotherapists are skilled in the primary management of soft tissue injuries. Many injuries presenting to GPs after hours, particularly at weekends following sport are amenable to early physiotherapy intervention.

After hours clinics should not be GP only but instead be a true primary healthcare service where physiotherapists work with GPs as part of a multidisciplinary service to provide expert care in this area. This would ensure high quality care and free GPs for work requiring the skills of a medical practitioner.

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ATTACHMENTS

Attachment 1: Increased Work Value: The Case for Physiotherapy 2004.

Attachment 2; Australian Universities Teaching Committee (2005): report on learning outcomes and curriculum development in Australian physiotherapy education.

Attachment 3: Australian Physiotherapy Association (2004): Physiotherapists' Diagnostic Imaging Referral Patterns.

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