THE HEALTH WORKFORCE

Presented to the Productivity Commission

Prepared by the

Australian Physiotherapy Association

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Authorised by

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EXECUTIVE SUMMARY

Physiotherapy patients encounter multiple barriers to accessing the right care at the right time. Some barriers relate directly to shortages in the physiotherapy workforce while others are the result of outmoded funding systems and practice restrictions.

Substantial system efficiencies can be gained from relatively minor adjustments to health professional roles and the Medicare Benefits Schedule (MBS). This submission contains a series of recommendations to reform MBS and maximise the capacity of the physiotherapy workforce.

A critical constraint on the expansion of the physiotherapy workforce is the lack of public funding for physiotherapy education. Inadequate funding levels have precipitated a crisis in clinical education in Queensland and the APA predicts the same problems will arise elsewhere unless funding is increased as a matter of urgency.

The role of physiotherapy and other health professions in the delivery of primary care must be acknowledged. Private physiotherapists provide well in excess of 10 million patient services per annum— this is a massive contribution to primary care yet their role is largely ignored by health bureaucrats and doctor groups. Primary care is not restricted to services provided within in general practice so decisions regarding the funding and delivery of primary care services must me bade in light of this fact.

Special attention is needed to the health workforce in rural and remote areas. Programs focusing only on doctor recruitment fail to acknowledge community need and the reality that health professionals value the support of colleagues from diverse disciplines. In order to be successful, rural and remote recruitment programs must be broadened.

Health workforce shortages in the community at large exacerbate recruitment problems for Indigenous services, but problems are compounded by funding systems that do not target a wide range of health professional skill. Attention is needed to the development of funding systems to support the provision of a wide range of health professional services via Indigenous health organisations.

The APA contests the view that healthcare needs can be met by professionals with a smattering of skills from a range of disciplines. The community needs high quality services provided by clinicians who can adapt to changing technologies and care needs. The APA suggests that Australia needs adaptable professionals willing and equipped to take on new roles, devolve roles that do not require their skill level, and work collaborative with professionals who possess different but complementary skills to their own.

RECOMMENDATIONS

Recommendation: The APA urges the Commission to conduct a close analysis of workforce reforms in the National Health Service of the United Kingdom.

Recommendation: That enhanced scope physiotherapy practitioner roles be formalised as a mechanism to maximise the utilisation of physiotherapists' skills and reduce workforce attrition.

Recommendation: That the physiotherapy assistant role, formalised through the Australian Qualifications Framework, be promoted as a mechanism to increase physiotherapy workforce capacity.

Recommendation: That physiotherapists be approved as first contact practitioners by third party payers.

Recommendation: That the Commission endorse the recommendations in the Physiotherapists' Diagnostic Imaging Referral Patterns report, 2004[1].

Recommendation: That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.

Recommendation: That patients being referred by medical specialists to physiotherapists be eligible for a MBS rebate.

Recommendation: That new MBS items be introduced for the management of specified conditions by specified practitioners where there is evidence of the effectiveness and cost effectiveness of the intervention.

Recommendation: That physiotherapy undergraduate courses be placed in the same funding cluster as undergraduate medicine.

Recommendation: Funding should be allocated to develop, pilot, and evaluate innovative models of clinical education for physiotherapy to improve system capacity in this area of severe shortage. To facilitate this, the Department of Education, Science and Training should fund a collaborative project involving schools of physiotherapy, the Australian Council of Physiotherapy Regulating Authorities, and the APA.

Recommendation: To ensure that structures are in place to facilitate knowledge and skill update, evidence of participation in a continuing professional development program should be a requirement of registration as a physiotherapist.

[1] A copy of the report is provided in Attachment 3 to the APA Comments on the Commission's Issues in Brief, May 2005.

Recommendation: Divisions of General Practice should be transformed into Divisions of Primary Care to promote better co-ordination and delivery of multidisciplinary healthcare.

Recommendation: Existing programs focused on the GP workforce must be extended to include all health professionals whose skills are needed in that location.

Recommendation: That funding options be explored to increase the capacity of Aboriginal community controlled health services to engage physiotherapists and other health professionals to better meet the primary healthcare needs of Indigenous clients.

INTRODUCTION

The APA appreciates the huge task taken on by the Productivity Commission. We understand that the Commission is seeking to make recommendations on mid-level reforms that alleviate pressure on the health workforce. Further, the APA acknowledges that there are cultural sensitivities, both within the health workforce and in health departments, that must be addressed gradually meaning that radical reform is impractical. In our initial submission we highlighted the lack of understanding, and recognition, of physiotherapy by policy makers and the concomitant misuse of human and financial resources.

Our central message is that a huge proportion of health services today are provided by health professionals other than medical practitioners, who are often not aware that the services are being provided. These services are generally undervalued and the skills of many service providers are underutilised. The Commission needs to acknowledge that a substantial proportion of health services are provided by professionals other than medical staff. A lack of recognition of the capabilities of other health professional and the value of their services results in the underutilisation of their skills and diminished productivity. The APA understands that the Commission is not reviewing the health system as a whole and is therefore not intending to make recommendations on major reforms.

In this submission the APA has endeavoured to make targeted recommendations regarding the reforms we contend are needed to ameliorate health workforce shortages. Our submission errs on the side of brevity: the APA would be pleased to provide details regarding any aspect of the submission.

This submission should be read in conjunction with the APA preliminary submission to the enquiry.

ROLE REDESIGN

The APA strongly supports role redesign in physiotherapy practice. There are tasks currently performed by physiotherapists that do not require the skill and knowledge of a physiotherapist, and there are physiotherapists leaving the profession because they are unable to apply the depth of their abilities. These facts in combination with critical workforce shortages have informed the APA's decision to encourage the development of physiotherapy assistant and enhanced scope physiotherapy practitioner roles.

In our preliminary submission we stressed the growing importance of specialisation in physiotherapy practice. Specialisation is not only a clinical necessity; it plays an important role in defining career pathways thus improving workforce retention. The APA will continue to develop and promote specialist pathways and to support skill development by providing continuing professional development activities in specialist disciplines.

The APA strongly supports evidence based practice and therefore physiotherapy research. The APA contends that physiotherapy research roles should not be confined to universities: hospitals and the private sector should develop physiotherapy clinical researcher roles to promote growth in the body of knowledge and provide another career path for physiotherapists.

NHS Workforce Reforms

The APA attached to its preliminary submission a report on physiotherapy led clinics in the United Kingdom. The report results from initiatives that have come out of the workforce reform undertaken by the National Health Service (NHS). The APA contends that there are lessons for Australian workforce planners from the NHS reforms. The Commission may wish to note the substantial reductions in waiting lists resulting from the physiotherapy initiative described in the report, and also the effectiveness of substituting orthopaedic surgeons consultations with physiotherapy assessments.

Recommendation: The APA urges the Commission to conduct a close analysis of workforce reforms in the National Health Service of the United Kingdom.

Enhanced Scope Practice

One of the NHS reforms that has both maximised the use of physiotherapists' skills and reduced attrition is the development of enhanced scope physiotherapy practitioner roles. These roles facilitate workforce substitution and allow physiotherapists to fully employ their clinical reasoning abilities. They reduce the pressure on the specialist doctor workforce, reduce the number of consultations a patient has before receiving an intervention, and provide career paths for physiotherapists thus providing more options and making the continuation of clinical practice more attractive.

The roles involve application of advanced clinical reasoning skills, which constitutes a higher level of practice rather than an extended scope of practice. The roles may involve extended duties such as referral for ultrasound, CT scans etc., waitlisting patients for other interventions, prescribing pharmaceuticals, and giving injections.

These roles are being trialled in some Australian hospitals, which is a positive step, but there are some barriers to the wide-scale development of these roles. As indicated in the preliminary submission, the APA considers that there are legal barriers in some jurisdictions to expanding the scope of practice to include functions such as limited prescribing and injecting pharmaceuticals. We are also aware that several of the key peak bodies representing medical practitioners oppose workforce substitution in these areas. The APA contends that such opposition is based on perceived self-interest rather than an assessment of the clinical skill of physiotherapists and the potential benefits to the healthcare system.

Recommendation: That enhanced scope physiotherapy practitioner roles be formalised as a mechanism to maximise the utilisation of physiotherapists' skills and reduce workforce attrition.

Physiotherapy assistants

The APA is confident that a physiotherapy assistant (PTA) qualification will be included in the new Health Training Package. The APA will encourage its members to work with PTAs to increase the capacity of the physiotherapy workforce. We are confident that the roles will be taken up in the public sector, but are concerned that payment issues may be a barrier to efficient take up of this role in the private sector. In particular, we are concerned that third party payers such as private insurers and workers' compensation authorities will not pay for services delivered by PTAs under the supervision of the physiotherapist.

Recommendation: That the physiotherapy assistant role, formalised through the Australian Qualifications Framework, be promoted as a mechanism to increase physiotherapy workforce capacity.

WORKFORCE SAVINGS

There are a great many workforce savings to be made by acknowledging that care should be provided by the most appropriately skilled practitioner, and that this is not always a medial practitioner. Savings are possible in reducing duplication services caused by placing GPs in 'gatekeeper' roles and in workforce substitution where different kinds of services can be provided to manage the same condition (see for example Evidence-based access to the MBS for patients of physiotherapists, below).

The issue of GPs being used as fiscal gatekeepers needs urgent attention because it is a false economy. Third party payers such as accident compensation authorities seek to limit costs by funding physiotherapy care only on GP referral. Not only does this generate unnecessary GP visits, it also contributes to delays before the initial consultation which can have negative clinical consequences[2]. Physiotherapists are first contact practitioners and the APA contends that there is no reason why they should not have first contact status in cases where payment for services is made by a third party.

Physiotherapists routinely diagnose and refer patients for further investigation or specialist services if the patient's condition would not benefit from physiotherapy management. They would continue to do so if awarded first contact status by third party payers. There is no evidence that costs are

[2] See for example Zigenfus GC, Yin J, Giang GM and Fogarty WT(2000): Effectiveness of early physical therapy in the treatment of acute low back musculoskeletal disorders. *Journal of Occupational & Environmental Medicine* 42(1):35–39. Where the results show that injured workers in the early physiotherapy intervention had more favourable outcomes than those in the two comparison groups.

contained by this GP gatekeeper role. The APA contends that, particularly in relation to the management of musculoskeletal injury, system costs and workforce pressure would be reduced if compensation authorities and the Department of Veterans' Affairs removed from GPs the burden of acting as gatekeepers.

The APA supports its members in the provision of quality physiotherapy services and encourages them to consider the cost benefit of services provided. Accordingly, the APA has a position statement on Clinical Justification and Outcome Measures[3] which states that:

> *The progressive evaluation of physiotherapy treatment outcomes is an integral part of professional accountability … a clinical justification for physiotherapy services would routinely include the use of … outcome measures.*[4]

The APA contends that physiotherapists are more open to accountability than most other professionals and that they deserve to be accorded first contact status by third party payers.

Recommendation: That physiotherapists be approved as first contact practitioners by third party payers.

MBS

As the cornerstone of health funding in Australia, arrangements under the Medicare Benefits Schedule (MBS) impact significantly on the health workforce. The funding only of medical practitioner interventions has unduly increased public reliance on these interventions to the detriment of the health workforce and indeed the health of the public. Patients are forced to consult doctors for conditions that are better managed by other practitioners, leaving the medical workforce with the overwhelming burden of care.

The APA understands that there are a great many conflicting interests to be considered in discussions regarding the reform of the MBS and therefore proposes incremental reform. On that basis, listed below are targeted reforms that will deliver economic and workforce savings. The only potential barrier to these reforms is that some GP groups may oppose them on the grounds that it encroaches on their 'turf'. The APA is aware that the Federal health bureaucracy is unduly influenced by doctor organisations, but would hope in this instance they would be swayed by weight of argument rather than historical allegiances.

The Commission is aware that there is now one physiotherapy item providing patients with chronic and complex illness (who have a multidisciplinary care

[3] Available at https://apa.advsol.com.au/staticcontent/staticpages/position_statements/public/ClinicalJustification&Outcome%20Measures.pdf
[4] Ibid.

plan prepared by their GP) access to an MBS rebate for up to five physiotherapy services. The program, which has been in operation for one year, has already had 108 267[5] physiotherapy services rebated under the scheme. Given the complexity of the Enhanced Primary Care program, and the resistance of GP groups to it, this figure clearly demonstrates that there is an unmet need for physiotherapy services.

Diagnostic imaging

In its preliminary submission the APA draws the Commission's attention to its research into diagnostic imaging patterns. The research demonstrates that existing referral arrangements, where by patients receive a higher rebate on GP rather than physiotherapist referral for some X-ray services, can lead to the waste of over $1 million and 10 000 hours of GP time per annum.

Recommendation: That the Commission endorse the recommendations in the Physiotherapists' Diagnostic Imaging Referral Patterns report, 2004[6].

Physiotherapist referral direct to medical specialist

A conservative estimate of the number of services private physiotherapists provide per annum is $10 million. This figure is based on private health insurance rebate information and accident compensation statistics. Most of these consultations involve the physiotherapist assessing, diagnosing, and managing the patient's condition. However, on some occasions, the physiotherapist diagnoses a condition that requires surgical intervention. The physiotherapist advises that patient that they must see a specialist, but in order to attract a Medicare rebate for the specialist's services, a GP referral is required. Naturally the patient attends the GP, although there is no clinical reason to do so. Therefore, the patient's and GP's time is wasted and an MBS consultation is billed unnecessarily.

There is no clinical reason why the patient should not receive a rebate on the physiotherapist's referral. In fact, it can lead to a delay in the patient receiving the required intervention. Reforming the referral arrangements requires only minor legislative change and will result in workforce and cost savings.

Recommendation: That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.

Medical specialist referral direct to physiotherapists

Medical specialists such as orthopaedic surgeons regularly refer patients directly to private practitioners for physiotherapy following surgery or for non-

[5] HIC website: http://www.hic.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml Query on item number 10960.

[6] A copy of the report is provided in Attachment 3 to the APA Comments on the Commission's Issues in Brief, May 2005.

surgical management of a range of conditions. However, many patients are unable to afford private care, and public services are virtually inaccessible unless that patient has had surgery at a public hospital.

In many cases the specialist refers the patient for physiotherapy instead of undertaking a surgical procedure. In such cases physiotherapy intervention is the best available care for the patient, it is substantially cheaper than surgery, and places less pressure on the health workforce. If hospitalised, the patient will require the services of the surgeon, an anaesthetist, nursing staff, and health support workers as well as occupying a hospital bed. It is also highly likely that the patient will require post-operative physiotherapy rehabilitation. If physiotherapy management is available to substitute for surgical management, clearly there are workforce advantages and cost savings.

Funding physiotherapy on specialist referral will reduce hospital admissions and surgery costs.

Recommendation: That patients being referred by medical specialists to physiotherapists be eligible for an MBS rebate.

Evidence-based access to the MBS for patients of physiotherapists

In its preliminary submission and in discussions with the Commission, the APA has provided evidence that physiotherapy interventions for the management of certain conditions are as effective and more cost effective than many medical and surgical interventions. A further example is the physiotherapy management of female stress urinary incontinence. There is a substantial body of evidence of the efficacy of physiotherapy in continence management, the most recent of which was published in the Australia and New Zealand Journal of Obstetrics and Gynaecology. The study found that 82 per cent of women were cured of stress urinary incontinence after one episode of physiotherapy care[7].

A further study, which has been accepted for publication in the *Australia and New Zealand Journal of Public Health*[8], found that physiotherapy management of female stress urinary incontinence costs on average $302.40 while surgical management costs between $4668 and $6124.

In addition to being less cost effective, surgical management also requires a substantially greater workforce contribution by more highly trained staff. For example, the surgeon would be a sub-specialist urogynaecologist who would have a minimum of 15 years training, a specialist anaesthetist who would have a minimum of 12 years training plus nursing and health support workers while the continence physiotherapist would have four years undergraduate training with two or more years additional training or experience.

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[7] Neumann PB, Grimmer KA, Grant RE and Gill VA (2005): Physiotherapy for female stress urinary incontinence: a multicentre observational study. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 45(3): 226–232.

[8] Personal communication with author.

There are many such interventions in a range of disciplines. It is a demonstrably false economy for such interventions not to be funded by the MBS.

The APA does not believe that Medicare should be extended to provide unfettered access to all health professionals' services. Instead the APA contends that interventions for which there is evidence of effectiveness and cost effectiveness should be funded under the MBS.

A possible mechanism for determining which interventions should be added to the MBS schedule would be via an assessment committee that operates somewhat like the PBS committee. There could be lessons learned from the operation of that committee, so the 'Health Intervention Evaluation Committee' (HIEC) could operate more efficiently. For example, the HIEC brief could state that no new intervention for the management of a condition should be added unless an existing intervention is removed.

Recommendation: That new MBS items be introduced for the management of specified conditions by specified practitioners where there is evidence of the effectiveness and cost effectiveness of the intervention.

The APA contends that minor changes to the existing MBS schedule will yield workforce and cost savings. We are cognisant of the fact that state/federal funding complexities mean that it is likely that expenditure in one jurisdiction will yield savings in another but an assessment of cost effectiveness must be based on the entire system not any single jurisdiction.

EDUCATION

Education is critical to the practice of physiotherapy. As stated in the preliminary submission, the APA supports the recommendations in the AUTC report on learning outcomes and curriculum development in physiotherapy education. We reiterate that support and encourage the Commission to endorse the recommendations.

We also reiterate our concerns regarding the lack of co-ordination between the health and education sectors and call for the establishment of a single, national health education agency.

Funding for physiotherapy education

On page 19 of the Issues Paper, the Commission mentions that some health professional graduates are not viewed as job ready. The AUTC report indicates that employers are by and large satisfied with the work readiness of physiotherapy graduates. This job readiness comes at a cost, and within in current funding arrangements is unsustainable.

There is a huge amount of pressure placed on public hospital physiotherapy departments to provide undergraduates with the experience they need to be job ready. The system largely functions on the good will of clinicians and is unsustainable. The demands of clinical education contribute to clinicians' stress levels and therefore to professional burn out. The APA contends that professional burn out is a significant attrition factor in the public sector and that this is one of the costs of providing job ready physiotherapy graduates.

As evidence of the unsustainability of the system, we draw the Commission's attention to the current situation in Queensland. Clinicians employed by Queensland Health have traditionally taken responsibility for supervising and assessing physiotherapy students. These roles are not part of clinicians' position descriptions and supervision creates additional work for which relief personnel are not provided. Like all hospital physiotherapy departments in Australia, departments in Queensland are under-funded and understaffed, thus the additional workload created by the presence of students places further stress on the system.

For the first time in Australia, physiotherapists have refused to take undergraduate students due for clinical placement. The clinicians feel that they are no longer able to sustain the extra workload. Consequently, a group of final year students have been unable to gain their clinical experience they require to become competent practitioners. Until the students undertake the required clinical placements they will be unable to register and will therefore be unable to practice.

Although these problems have come to the fore in Queensland, the same pressures are present nationally.

Additional pressures are placed on the system by the increasing number of students requiring placements (both local and overseas students) while funding for physiotherapy departments is not increasing. The capacity of the public hospital sector is at breaking point and the university sector does not have sufficient funds to explore other options for the delivery of clinical education. As the AUTC report attests, schools of physiotherapy are stretched to the limit and have no additional funds to commit to the exploration of innovative models of clinical education.

The physiotherapy profession strongly refutes the comments of some commentators that the profession is stifling innovation. Physiotherapy educators are enthusiastic to explore innovations such as clinical simulation in clinical education and the APA private practice group has volunteered to assist in developing models that will lead to increased system capacity to provide placements. The profession is willing and wanting to foster innovation, what is lacking is the funding to do so.

The need for this funding is not open ended. The APA will, on request, produce costed proposals for the development and evaluation of a range of new models of clinical education.

Recommendation: That physiotherapy undergraduate courses be placed in the same funding cluster as undergraduate medicine.

Recommendation: Funding should be allocated to develop, pilot, and evaluate innovative models of clinical education for physiotherapy to improve system capacity in this area of severe shortage. To facilitate this, the Department of Education, Science and Training should fund a collaborative project involving schools of physiotherapy, the Australian Council of Physiotherapy Regulating Authorities, and the APA.

Mandatory continuing professional development

In its preliminary paper, the APA discusses the value of continuing professional development (CPD) for up skilling physiotherapists and allowing them to utilise new technologies and clinical advancements. The APA contends that CPD is critical to ensure that the workforce is adaptable and able to meet emerging needs.

The APA provides a CPD program which is entirely funded by participants in the CPD courses. The need for this program was identified by the profession and is funded and managed by the profession. Without the APA CPD program, the profession would have no mechanism to adapt to changing needs and technologies.

APA members are required to participate in the program, but there is no such requirement for non-members. The APA contends that CPD is critical to the adaptability of the physiotherapy workforce and that all physiotherapists should be required to participate in a CPD program.

Recommendation: To ensure that structures are in place to facilitate knowledge and skill update, evidence of participation in a continuing professional development program should be a requirement of registration as a physiotherapist.

PRIMARY CARE AND PREVENTION

The Commission acknowledges that preventive care is likely to reduce the burden on the healthcare system of the future. There is also broad acknowledgement that there is a need for an increased focus on primary management of chronic disease to reduce morbidity and acuity. Therefore primary and preventive care are important factors in managing the need for health services. The APA strongly supports an increased focus on preventive interventions and primary care service delivery.

The APA submits that new models of primary care service delivery are needed in both the public and private sectors. At present the bulk of primary care is delivered in the private sector. The APA notes with interest the Victorian proposal for the development of super clinics. On balance that APA considers that this is a sound proposal, provided the clinics include

physiotherapists, psychologists, podiatrists, and other health professionals who make a major contribution to primary care and chronic disease management.

In the private sector, the APA supports the development of multidisciplinary group practices. Such practices provide a one-stop-shop which is convenient for patients and deliver clinical and administrative efficiencies. For instance support staff overhead costs are shared, there is increased capacity to utilise healthcare assistants, clinicians benefit from collegiality and there are a range of benefits of a single patient record. The APA would be pleased to work with other professional associations to develop new models and tools to support clinicians in transforming their practices.

There are also existing structures that could be employed to increase primary care capacity in the private sector. Divisions of General Practice provide support to GPs and receive funding to increase the delivery of a range of primary care and workforce services. At present, most divisions restrict their governance and activity to GPs. The APA contends that the Divisions model is a good mechanism to support general practice, but that broader support is needed to increase private practice capacity. Some divisions have already been renamed Divisions of Primary Care and the APA supports this change. However, greater reform is needed, including opening up the governance and membership of divisions to physiotherapists and other health professionals, changing the mandate of divisions to supporting all primary care providers, and increasing the capacity of divisions to facilitate the delivery of preventive care services.

Recommendation: Divisions of General Practice should be transformed into Divisions of Primary Care to promote better co-ordination and delivery of multidisciplinary healthcare.

RURAL AND REMOTE

As the Commission is no doubt aware, there is an extensive array of initiatives to promote medical workforce recruitment in rural and remote areas. The vast bulk of these initiatives focus solely on doctor and nurse recruitment, despite evidence that retention is improved where there is a team of health professional in the town or region. A rare exception is the North West Queensland Allied Health Service (NWQAHS) project which was funded by the Commonwealth to attract allied health professionals to provide services in remote Queensland. The project has attracted and retained 53 staff to Mt Isa and APA members speak highly of the project. It is the project most regularly cited by members when they are asked to provide examples of what works in terms of recruitment and retention. Unfortunately it is a rare and notable exception. The APA urges the Commission to examine the project report which is available at
http://www.health.qld.gov.au/rhac/documents/PSD_Report.PDF

Members also reliably comment on the value of positive experiences during rural clinical placements as a recruitment tool. Other positive factors cited by members include: management and support from allied health professionals; marketing the innovative nature of rural work; good networks between health professionals; service delivery models that provide professional support; and understanding that face to face time is only a small component of outreach work.

Recommendation: Existing programs focused on the GP workforce must be extended to include all health professionals whose skills are needed in that location.

INDIGENOUS ACCESS TO PHYSIOTHERAPY

In relation to Indigenous communities, members state that visiting clinics are the most effective means of care delivery and visits should be conducted in teams, with a diversity of gender, age, and cultural background. Some members have found a drop-in policy to be effective in towns.

The APA has recently completed a small study on Indigenous utilisation of physiotherapy services in three regional locations. The major findings of the report are that Indigenous Australians have virtually no access to private physiotherapy services and that physiotherapy services are best delivered to Indigenous people via Indigenous health services. A copy of the report is provided in Attachment 1.

Recommendation: That funding options be explored to increase the capacity of Aboriginal community controlled health services to engage physiotherapists and other health professionals to better meet the primary healthcare needs of Indigenous clients.

ADAPTABILITY

There is much debate in the literature about the need for workforce flexibility, the benefits of generalist verses specialist skill sets and professional boundaries. The APA submits that much of the debate is a distraction from the real problems of increasing demand for diverse healthcare services and inefficient funding and service delivery models. The APA has addressed funding and service delivery models in this and its preliminary submission so comments here are restricted to the concept of flexibility.

The APA contends that what is needed is a workforce that is trained to adapt. As we explained in our preliminary submission, physiotherapists are trained to be adaptable because of their broad based education. The APA has fostered a culture of adaptability by providing CPD courses to meet the emerging needs of patients, disseminate research evidence, and to allow clinicians to become proficient in new techniques and in the use of new technologies.

Physiotherapists are willing and able to take on new roles, including the supervision of trained PTAs who can increase workforce capacity.

The APA rejects outright that flexibility is one individual fulfilling multiple workforce roles or that there is any benefit in health professionals with generic training. Generic skills do not deliver the standard of care required by patients or indeed by common law. Professionals need to be adaptable, and understand the role of other professionals, but they cannot be flexible enough to fulfil multiple professional roles. As an example, how could one individual fulfil roles in physiotherapy, psychology, and audiometry? While there are common elements in their training, their professional skill and knowledge is in completely different fields.

The APA strongly supports inter-professional education where by physiotherapists can share a class with medical students, podiatry students, and any other health professional educated at the same institution. There are efficiencies to be gained and clinical benefits from professionals learning to work together before they commence clinical practice. Subjects that could be co-taught across virtually all health professions would include ethics, Indigenous culture, communication skills, and legal responsibilities. Other examples may be restricted to certain disciplines: for instance at present many institutions co-teach anatomy to physiotherapy and medical students. Whereas audiology and podiatry students would clearly have different needs. There is, however, no benefit in entire courses devoted to the development of low-level, generic skills.

The APA encourages the Commission focus of professional adaptability. The community needs high-level skills in physiotherapy, optometry, nursing, and all the other health professions. Professionalism cannot be substituted without endangering the public. Attempting to gain flexibility by downgrading skill levels would be tantamount to reckless endangerment of the public. A focus on adaptability will provide for the embracing of new technologies and techniques without compromising safety and quality.

Adaptable professionals will be willing and equipped to take on new roles, devolve roles that do not require their skill level, and share responsibilities with other health professionals working at their level.

CONSULTATION

Historically, consultation with health professionals has been restricted to doctors and nurses. For any broad scale reform to succeed, all stakeholders must be consulted. The APA appreciates that this potentially involves a huge number of stakeholders. The APA recommends that professions be advised that only one organisation will be consulted per profession. This will reduce the number of stakeholders and provide individual professions with the impetus to develop one voice.

The APA was quite satisfied with the consultation process for developing the *National Health Workforce Strategic Framework*. It could have been improved by providing a mechanism of input to the first draft, and by altering the balance of representation at the consultative forum to reflect the broad profile of the health profession workforce. Specifically, medical representation could be reduced to attain a better balance amongst the representative group.

WORKFORCE RESEARCH

In many submissions the APA has highlighted the need for the collection of data on the physiotherapy workforce and development of projections on the need for physiotherapy services. The APA is somewhat frustrated by the lack of action in relation to this matter. It appears that the Australian Institute of Health and Welfare, the logical group to conduct the supply side analysis, is severely under-funded and therefore unable to conduct the necessary research.

The *National Health Workforce Action Plan*[9], which underpins the *Health Workforce Strategic Framework,* includes a strategy to conduct an allied health workforce planning study. It recommends an in depth study into either the physiotherapy or podiatry workforce yet as far as the APA is aware there has not even been a decision made as to which workforce to investigate. The recommendation has elevated expectations and the APA is most disappointed by the lack of progress.

CROSS-OVER WITH OTHER SECTORS

The skills many physiotherapists apply in the health sector are the same as or similar to those applied in other sectors. Certainly their basic training is the same so when the need for physiotherapy skills in health is assessed, there must be due consideration of the needs of other sectors. For example, physiotherapists work in disability, aged care, education, and in industries as diverse as fitness and mining.

In considering course content and curricula, the needs of these other sectors must also be taken into account. Additionally, the professional skills, ethics, and attributes of the profession cannot be ignored. A physiotherapist is not just a set of clinical skills. Physiotherapists have a unique complement of skills, attitudes, and values that allow them to fill diverse roles and to make a positive contribution to the community. The APA is proud to uphold the values of the profession and contends that the values instilled in physiotherapists through their education and experience are as important to the community as their clinical skills.

[9] Released in July 2004.

ABOUT THE APA

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups.

The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 10 000 members, some 60 staff, and over 300 members in volunteer positions on committees or working parties. The APA is governed by a Board of Directors, elected by representatives of all stakeholder groups within the Association.

The APA mission is to support its members to deliver world's best practice physiotherapy and its vision is to improve the health of Australians by supporting world's best practice physiotherapy.

The APA has a Platform[10] and a Vision for Physiotherapy 2020[11] and all its submissions are publicly available via the APA website: www.physiotherapy.asn.au

[10] Available at: https://apa.advsol.com.au/ScriptContent/foryou_public_platform.cfm?section=foryou
[11] Available at: http://apa.advsol.com.au/staticcontent/download/APA_vision.pdf