

Medicare Benefits Schedule Review Taskforce

Supplementary submission

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation by Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce). This document represents a supplementary submission to the MBS Review.

We have been pleased to participate in the MBS Review and our supplementary submission focuses on issues that have either arisen in the work of the Taskforce to date, or are yet to be addressed (because the focus on allied health items is imminent).

We raised the way in which direct referral from a physiotherapist to a consultant medical specialist could improve value in our initial submission to the Taskforce. It is our view that it needs to be tackled prior to the completion of the work of the Taskforce.

We recommend the Taskforce support amendment of Explanatory Note GN.6.16 of the Medicare Benefits Schedule such that a referral can be made by a registered physiotherapist to specialists and consultant physicians within the physiotherapist's scope of practice; and that such a referral given by a participating physiotherapist is valid until 3 months after the first service given in accordance with the referral.

We raised concern about anomalies in the fees and benefits for patients in some cases of diagnostic imaging in our initial submission to the Taskforce. Patients receiving the same service need to receive the same fees and benefits.

We recommend the Taskforce support the removal of anomalies in the MBS with respect to fees and benefits paid for NR-type diagnostic imaging services, when compared to R-type diagnostic imaging services.

We raised the way in which physiotherapists, as a highly skilled workforce, are currently unable to assess and provide group-based services for the management of type 2 diabetes under the MBS.

We recommend the Taskforce support the inclusion of physiotherapists as a professional group able to assess a person's suitability for group services for the management of Type 2 diabetes (e.g. MBS item 81100) and then to provide group sessions (e.g. MBS item 81105).

Given the mounting evidence of the safety, efficacy and value of video-consultations between patients and their physiotherapists, we recommend the Taskforce support the inclusion of video-consultations as a form of consultation using Item 80100 as the precedent. This will assist to address inequities in access to services for people in rural and regional Australia, and for people with a range of conditions (e.g. neurological disorders) that create barriers to access to physiotherapy.

Members of the physiotherapy profession have raised concern about access to physiotherapy in the current approach to the Chronic Disease Management (CDM) items.

We recommend that the Taskforce support:

- the introduction of an assessment consultation under the CDM items, using the Level D item for general practice as a model;
- an increase in the number of exclusive physiotherapy services in any one year to five (in addition to five non-physiotherapy allied health services)

- payment of a fee/benefit when a physiotherapist participates in a case conference (including a discharge case conference) for which the GP or consultant medical specialist service is subsidised under the MBS.

Our members have also expressed concern about the inequitable way in which the needs of children in out-of-home care are addressed within the MBS, given the evidence that these children are likely to have a range of undetected and potentially chronic health conditions.

We recommend that the Taskforce support the inclusion of children in out-of-home care as a category of people eligible for health assessments and a GP Management Plan.

We support the role of the Medical Services Advisory Committee (MSAC) in appraising new medical services proposed for public funding, and advising Government. However, using the MSAC process can be very problematic, especially when the proposal being made is auspiced by a not-for-profit organisation.

We are concerned that there will be an ongoing problem with the provision of low value services, or an absence of high value services, while the MSAC continues to operate in its current form, and while any review of its processes occurs. This delay is a substantial concern to us, as we see a range of Australians whose care is suboptimal as a result.

To enable applications for long-term funding to be considered by the MSAC, we recommend the Taskforce support (as an interim measure for two years), the introduction of new MBS listings for:

- a pulmonary rehabilitation (PR) program for patients with chronic lung disease. The model of funding in Aboriginal communities through Aboriginal Community Controlled Health Services/Aboriginal Medical services to be reviewed on completion of the evaluation of the Breath Easy Walk Easy, Lungs for Life (BE WELL) program;
- a physiotherapy service for the assessment and treatment of pelvic floor disorders, restricted to physiotherapists who have undertaken specific post-entry education;
- a physiotherapy service for the management of complex lymphoedema, and an associated rebate for up to 10 sessions within a 12-month period, using the current Mental Health Care Plan as a model;
- an early intervention physiotherapy service for people at risk of persistent pain;
- an initial assessment for an interdisciplinary pain education and self-management program; and an interdisciplinary group service for pain management, and
- a physiotherapy orthopaedic screening service for patients with specific conditions (e.g. degenerative knees, degenerative rotator cuff), indicatively based on a Level D consultation, on referral from a GP or consultant medical specialist

We are concerned about the limitations the legislative and regulatory arrangements in the MBS have on the preparation of pre-entry physiotherapy students to be work ready for private practice. Current arrangements limit the engagement of supervised students with patients, constraining the ability of the professional to provide appropriate and quality preparation for the future workforce.

We recommend the Taskforce support a change of the relevant Determination such that physiotherapy students undertaking supervised clinical placements as a part of their pre-entry education can provide aspects of physiotherapy services described in the Medicare Benefits Schedule. This could include assisting or participating after the 20-minute

threshold for the item, where elements of the services as described in the MBS are still being provided.

We have become aware of the proposition that subsidies under the MBS which are currently directed to patients will be directed via general practices.

We recommend that the Taskforce make no recommendation that supports any shift of subsidising physiotherapy services under the MBS to a payment model to GPs or general practices.

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Introduction

The Australian Physiotherapy Association (APA) is pleased to provide this supplementary submission to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce).

We believe that a high-value health system needs to be both fair and sustainable; that it needs to be grounded in both the best available evidence and in a considered willingness to invest in emerging opportunities and technologies.

We have been pleased to participate in the MBS Review and our supplementary submission focuses on issues that have either arisen in the work of the Taskforce to date, or are yet to be addressed (because the focus on allied health items is imminent).

Direct referral to consultant specialists

We raised the way in which direct referral from a physiotherapist to a consultant medical specialist could improve value in our initial submission to the Taskforce. It is our view that it needs to be tackled prior to the completion of the work of the Taskforce.

One in 20 Australians lives in an area with severely reduced access to the services of a general practitioner (GP). In some of Australia's most underserved areas, only half the number of GP services per person are provided, compared with those provided to people living in metropolitan areas.¹

This means that the patients of physiotherapists in rural areas, who already have restricted access to consultant medical specialists, have an additional hurdle when accessing the most suitable medical practitioner.

Allowing for direct physiotherapy referral to specialist medical practitioners will better utilise the existing workforce, cut red tape and free up GPs to dedicate more time to complex clinical care.

The rationale for retaining GPs as the primary source of referral has been the importance of continuity of care. However recent research suggests that a significant proportion of general practice care is delivered away from 'usual' or home practices, with over one-quarter of the study's sample attending more than one practice in the previous year.² This has potential implications for continuity of care.³

Within their scope of practice, optometrists, dentists, midwives and nurse practitioners are able to make referrals directly to consultant medical specialists. The same principle needs to apply to physiotherapists.

The Transport Accident Commission (TAC) in Victoria has a Network Pain Management Program in Victoria that supports the principle of early intervention and enables physiotherapists to refer motor accident patients directly to pain medicine specialists. Benefits of this program include:

- a single approval, which facilitates early access to healthcare
- access to a coordinated team of healthcare professionals, and
- access to pain management usually within 4 weeks of approval.

In contrast, the MBS requires a GP referral to consultant medical specialists, when in selected cases a physiotherapist could safely and appropriately make the referral. This can create a circular referral pattern that delays necessary specialist treatment and generates unnecessary work.⁴ The use of interoperable information and communications systems

(including My Health Record) overcomes any sense of discontinuity between providers and patients.

Similar to referrals from one specialist to another, physiotherapy directed referrals could be limited to a three-month period from the date of first visit to the specialist, with copies of all referral and other relevant documentation sent to a patient nominated GP.

In 2013 the APA commissioned Griffith University's Centre for Applied Health Economics and the Deeble Institute to conduct an economic evaluation to determine the costs associated with referrals. The research found if physiotherapists were to receive Medicare rebates to directly refer to a range of specialist medical practitioners, there would be substantial savings:

Savings to the MBS:	\$13,641,362
Savings to patients:	\$2,175,407
TOTAL SAVINGS:	\$15,816,769 ⁵

As shown in the figures above, the current referral system can incur additional GP out-of-pocket costs for patients. The imposition of additional costs can lead patients to delay their care, or worse, fail to follow through on treatments, potentially creating a later acute episode. By changing current referral requirements, health policymakers will streamline patient care, facilitating faster diagnosis, improved patient outcomes, quality of life, work productivity and wider community benefits.

The APA Code of Conduct is binding on all members and requires physiotherapists to collaborate with colleagues to promote safe, quality care.⁶ This will often involve collaboration with a GP, which is normal practice within the profession.

In addition, the Physiotherapy Board of Australia has a code of conduct that requires physiotherapists to 'recognise and work within the limits of their competence and scope of practice.'⁷ This reflects the practice in the profession of referring patients to a GP if the aetiology of the presenting condition is unclear or outside a physiotherapist's scope of expertise. However physiotherapists, as experts in the management of musculoskeletal disorders, are well placed to determine the relevant pathways for patients.

Recommendation 1

We recommend the Taskforce support amendment of Explanatory Note GN.6.16 of the Medicare Benefits Schedule such that a referral can be made by a registered physiotherapist to specialists and consultant physicians within the physiotherapist's scope of practice; and that such a referral given by a participating physiotherapist is valid until 3 months after the first service given in accordance with the referral.

Equivalent fees and benefits for diagnostic imaging

We raised concern about anomalies in the fees and benefits for patients in some cases of diagnostic imaging in our initial submission to the Taskforce.

These inequities need to be removed. Patients receiving the same service need to receive the same fees and benefits. We understand that other such anomalies are being addressed by the Taskforce and are keen to have this anomaly addressed prior to the completion of the work of the Taskforce.

At present, physiotherapists can request R-type x-rays of the spine, hip and pelvis and their patients receive a rebate that is equivalent to that funded when the request is made by a

doctor. However, when physiotherapists request NR type x-ray and ultrasound items, the MBS subsidies for patients are *lower* than that funded when the request is made by a doctor.

Evidence suggests that physiotherapists are skilled at ordering clinically appropriate imaging. When magnetic resonance imaging (MRI) was used as the gold standard, the diagnostic accuracy of physiotherapists for clients with musculoskeletal injuries was found to be as good as that of orthopaedic surgeons and significantly better than that of non-orthopaedic providers.⁸

Recommendation 2

We recommend that the Taskforce support the removal of anomalies in the MBS with respect to fees and benefits paid for NR-type diagnostic imaging services, when compared to R-type diagnostic imaging services.

Extension of the diabetes education service items

MBS items 81100, 81110 and 81120 allow diabetes educators, exercise physiologists and dietitians to assess a person's suitability for group services for the management of type 2 diabetes. Assessment includes taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services. As a highly educated workforce, where assessment is a core element of safe, high quality, evidence based clinical care, physiotherapists are well equipped to undertake an assessment and make an eligibility determination.

Items 81105, 81115 and 81125 allow diabetes educators, exercise physiologists and dietitians to provide group diabetes education services for eligible patients. Physiotherapists are equally if not better qualified than exercise physiologists to provide evidence-based group exercise programs. Physiotherapists have comprehensive knowledge of the underpinning pathophysiology and use this knowledge to develop clinically appropriate diabetes education programs.

Recommendation 3

We recommend the Taskforce support the inclusion of physiotherapists as a professional group able to assess a person's suitability for group services for the management of Type 2 diabetes and then to provide these group sessions.

Video-consultations

In some circumstances (e.g. Item 2100), the MBS recognises video-consultations as an appropriate modality for clinical care delivery. Item 80100, for example, is for professional attendance for the provision of focused psychological strategies for an assessed mental disorder by a psychologist (in defined circumstances). The scope of therapies funded is time-limited, with up to ten planned sessions in a calendar year, up to seven of which may be provided via video conference.

However, at present, video consultations between patients and their physiotherapists are yet to attract a subsidy under the MBS.

The current need for in-person or face-to-face attendance with a physiotherapist can act as a barrier to ongoing care. This includes circumstances where the patient is in a rural or regional location and the treating practitioner is urban based. Video-consultations can lower

the barriers for patients to receive advice and support. This includes people living in rural locations, those who are homebound and older people with limited capacity to travel to a clinic.⁹

Telemedicine has been a focus of health service delivery funding in leading organisations such as the Veterans Health Administration (VHA) in the United States of America (USA) since 2000.¹⁰ There is a broad and rapidly increasing body of evidence that demonstrates that digitally-supported physiotherapy can be effective. The evidence-base for video consultations is rapidly expanding.¹¹

An Australian study demonstrated a 23% cost reduction in favour of the spinal assessment telehealth service (compared with the usual outreach clinic) with the greatest savings in travel costs, with no adverse events reported.¹² Another study in telehealth showed:

- a 25% reduction in numbers of bed days of care
- a 19% reduction in numbers of hospital admissions, and
- a mean satisfaction score rating of 86% after enrolment into the program.¹³

The cost to the insurer was substantially less than other non-institutional care and nursing home care. The authors report that sufficiently scaled home telehealth implementation is an appropriate and cost-effective way of managing chronic care clients in both urban and rural settings. In Australia, the hospital provider and non-hospital provider may be different, raising the question of how costs and benefits would be shared.

A systematic review that assessed the economic value of video communication found that:

- 61% of the studies found telehealth to be less costly than the non-telehealth alternative.¹⁴

In terms of health outcomes, this systematic review reported that:

- 33% of studies found improved health outcomes
- 58% of studies found outcomes were not significantly different
- 6% found that telehealth was less effective
- 3% found outcomes differed according to patient group.

Despite the fact that digitally-enabled services may value-add to, or substitute for other services, they receive little or no reimbursement from third-party funders.^{15 16}

The ways in which payment models are designed and reimbursement occurs represent a substantial barrier to adoption of digital health modalities.¹⁷ In a 2017 international study, 60% of health care decision makers listed payment models as a challenge to the introduction of digitally-supported healthcare.¹⁸ This suggests that payment models will need to adapt to the changing landscape.¹⁹

Recommendation 4

We recommend the Taskforce support the inclusion of video-consultations between a patient and their physiotherapist as a form of consultation using Item 80100 as the precedent.

Chronic Disease Management Items

We are keen to deliver on the nascent value within the Chronic Disease Management (CDM) items in the MBS.

We have a number of concerns about the model for the CDM items as currently enabled in the MBS. Our members report that their clients tell them that they have claimed all but one of their annual allocation of MBS-subsidised consultations with allied health professionals prior to the client's first visit to this physiotherapist. This creates a material barrier to their client attending for a sufficient 'episode' of physiotherapy care.

Our members report they are advised by GPs that referral to the physiotherapist is for a single session, as the four remaining four sessions available under the MBS are to be used by other allied health professionals (e.g. a dietician or occupational therapist).

As a part of our initiative to improve the CDM items, we sought data on claims for these services from the Department of Human Services (DHS). We are yet to receive this data; however, we anticipate it will assist in determining the nature of physiotherapy attendance (although we are aware that the MBS data cannot inform any causal link to the proposition of this 'single session' problem).

Our members report that the structure of the CDM items departs materially from their usual practice. Independent research, commissioned by us in 2017, indicates that initial consultations last, on average, 40.29 minutes. This is more than twice the threshold length of 20 minutes indicated for the service in the MBS. There is little variation in this reported average length between urban and rural clinics and between sole traders and group practices.

This research also indicated that over a third of physiotherapists in Australia offer a bulk-billed initial consultation on referral from a GP. Across the states, Western Australian (WA), Queensland (Qld), Victoria (Vic) and the Northern Territory (NT) have the highest rates of offering to bulk-bill (respectively). Although the base of respondents in the study was smaller, the Australian Capital Territory (ACT) and Tasmania (Tas) have very low levels of offering to bulk-bill. The study showed very little difference between urban and rural clinics and between with sole traders and group practices.

We are aware from other research on the costs of physiotherapy services that the fee/benefit for the CDM items is materially lower than the full average cost of providing the service on a sustainable basis. We anticipate there is an important financial barrier for patients when accessing physiotherapy subsidised by the MBS. In the context of people with chronic conditions, we anticipate this barrier is amplified as they are likely to need an episode of care. Financial barriers are further exacerbated by variable bulk-billing rates.

Our members also report, that despite the design of the CDM items pertaining to the management of chronic conditions, they do not receive referrals for the same person over multiple years. We have asked the DHS to provide time-series data to further explore referral patterns to physiotherapy (although we are aware that we cannot make causal links with this proposition). We have sought data on gender, age, and State/Territory of residence, to explore whether or not there are obvious differences in the rate of claiming based on these factors.

Items 735-758 should generally be undertaken by the patient's usual medical practitioner. This is a medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Our members report that there is a small number of GPs who consistently refer patients who would not, in the view of our members, otherwise be eligible for these services. Our members have been made aware that the decision is that of the GP and the regulatory framework is such that the decision is the GP's.

Services provided by GPs and consultant physicians, as participants in multidisciplinary case conferences or discharge case conferences, attract a fee/rebate under the MBS.

Professionals who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team, include physiotherapists.

When a physiotherapist provides a professional service by participating in such a case conference, their service does not attract a fee/rebate. This is a material barrier to their participation and is inequitable.

Recommendation 5

We recommend the Taskforce support the introduction of an assessment consultation under the CDM items, using the Level D item for general practice as a model.

Recommendation 6

We recommend the Taskforce support five exclusive physiotherapy services in any one year in addition to five (non-physiotherapy) allied health services.

Recommendation 7

We recommend the Taskforce support payment of a fee/benefit when a physiotherapist participates in a case conference (including a discharge case conference) for which the GP or consultant medical specialist service is subsidised under the MBS.

Children in out-of-home-care

Children in out-of-home care are four times more likely to have abnormal vision, seven times more likely to fail a hearing test and two to three times more likely to have difficulty with speech.²⁰ In a 2011 Australian study, over half of carers listed either no health concerns or one concern only for a child when presenting for a health check, whereas 70% of children required two or more referrals to a variety of health services.²¹

An Aboriginal and Torres Strait Islander Peoples Health Assessment is available to:

- Children between ages of 0 and 14 years
- Adults between the ages of 15 and 54 years (which, because of the lower age threshold would include some children of the same age as children who might be in out-of-home care).

Some children are included in existing target groups for health assessments, including:

- People who have an intellectual disability, and
- Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants.

The MBS provides rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM)

plans. The patient must have at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

A substantial proportion of children in out-of-home care are likely to have conditions that fit the criteria of being chronic conditions, however, the detection of those conditions is less likely. If children in out-of-home already had such a condition diagnosed, they would be eligible to be referred to allied health professionals.

Physiotherapists are concerned that the absence of access to a health assessment is inequitable and could increase the likelihood that health issues that can be addressed by physiotherapy will be overlooked.

Recommendation 8

We recommend the Taskforce support the inclusion of children in out-of-home care as a category of people eligible for health assessments and eligible for a GP Management Plan.

New items in the MBS

We support the role of the Medical Services Advisory Committee (MSAC) in appraising new medical services proposed for public funding. This includes the provision of advice to Government on the funding of new medical services.

We understand the importance of amendments and reviews of existing MBS funded services being considered by MSAC. However, using the MSAC process can be problematic, especially when the submission is auspiced by a not-for-profit organisation.

We are concerned there will be an ongoing problem with the provision of low value services, or an absence of high value services while the MSAC continues to operate in its current form, and while any review of its processes occurs. This delay is a substantial concern to us, as we see a range of Australians whose care is suboptimal as a result.

Precedents in the MBS Review

The Government's response to recommendations from the MBS Review Taskforce indicates that both the Government and the Taskforce are prepared to recommend and make changes where there is sufficient evidence and demonstrated need, without incurring the delay that the MSAC process involves.

For example, to improve access, from 1 November 2018, the Government is introducing a new MBS item to provide funding for the delivery of dialysis by nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers in a primary care setting in remote areas. Additionally, from 1 November 2018, the Government is introducing two new time-limited MBS items for 3D Breast Tomosynthesis and removing rebates for plain film tomography. These new items are an interim measure (for two years) to enable an application for long-term funding to be lodged by the sector and considered by the MSAC.

Pulmonary rehabilitation

Almost half (47%) of the potentially preventable hospitalisations in Australia in 2014–15 were due to five conditions, with chronic obstructive pulmonary disease (COPD) having the highest rate of potentially avoidable hospital admissions.²²

There is strong evidence that pulmonary rehabilitation (PR) is effective in improving exercise capacity, health-related quality of life and reducing symptoms. Indeed the Cochrane review of pulmonary rehabilitation is now closed because no more studies will change the evidence.²³ Importantly, pulmonary rehabilitation has been shown to decrease hospitalizations²⁴, as well as reduce the length of hospital stay, with consequent cost savings to the health system.²⁵

Indigenous Australians bear an unequal burden of disease in relation to COPD. Compared to non-Indigenous Australians, the prevalence of COPD is 2.5 times higher, with the death rate 3 times higher and the hospitalisation rate 5 times higher in Indigenous Australians.²⁶

We are aware of a National Health and Medical Research Council grant that is evaluating the roll out of pulmonary rehabilitation in partnership with Aboriginal communities through Aboriginal Medical Services/Aboriginal Community Controlled Health Services (the BE WELL program).²⁷

Recommendation 9

We recommend the Taskforce support the introduction of new MBS listings for a pulmonary rehabilitation program for patients with chronic lung disease.

We recommend the model of funding for pulmonary rehabilitation programs in Aboriginal communities through Aboriginal Community Controlled Health Services/Aboriginal Medical services be reviewed on completion of the evaluation of the BE WELL program.

Pelvic floor care

The prevalence of pelvic floor disorders (urinary incontinence, faecal incontinence, and pelvic organ prolapse) is high, with more than half the female population affected in South Australia.²⁸ Although the cost of managing urinary incontinence and pelvic organ prolapse surgically is potentially costly, there is high quality evidence for cost-effective conservative measures, particularly pelvic floor physiotherapy, for these conditions as first line therapy. One study found 80% of women will have a satisfactory outcome from pelvic floor physiotherapy and will not require surgical management for their urinary incontinence²⁷ Depending on the choice of healthcare site (e.g. repeated visits to general practice) and other supports (e.g. the use of pads), the costs may be incurred in the primary care sector.

A proposal for inclusion of services for pelvic floor care is included in Appendix 1.

Recommendation 10

We recommend the Taskforce support the introduction of new MBS listings for a physiotherapy service for the assessment and treatment of pelvic floor disorders, restricted to a physiotherapist who has undertaken specific post-entry education.

Lymphoedema management

Lymphoedema is swelling that occurs when lymph fluid builds up in the tissues under the skin, due to non-functioning of the lymphatic system in that part of the body. Without management, lymphoedema is progressive and incurable. Lymphoedema can be managed by Complex Lymphoedema Therapy (CLT), a one-to-one therapy delivered by a trained lymphoedema practitioner (including physiotherapists).

Secondary lymphoedema is the most common type developing following damage to the lymphatic system. The damage may occur as a result of cancer treatments including the

removal of lymph nodes, following radiotherapy to lymph node groups or with the progression of malignant disease. The incidence of cancer diagnoses in Australia is steadily climbing and is the greatest cause of health burden in Australia, accounting for one-fifth of the total disease burden.²⁹

One in five women (21%) who have had surgery develop breast cancer-related arm lymphoedema.³⁰ Lymphoedema following other forms of cancer is relatively unexplored, however initial estimates range between 28 to 35%, 37 to 45%, and 75 to 90% for melanoma^{31 32}, gynaecological,³³ and head and neck cancer,^{34 35} respectively.

Primary Lymphoedema in comparison to Secondary Lymphoedema is the result of a congenital condition that affects how the lymph vessels were formed. This form may be presents at birth (congenital), develop at the onset of puberty (praecox), or not become apparent for many years into adulthood (tarda). At birth, about one person in every 6000 will develop Primary Lymphoedema.³⁶

Access to regular assessment and management by qualified lymphoedema therapists (including physiotherapists) is crucial to reduce the risk of exacerbations and to implement early management of acute changes as required. The aim is to avoid unnecessary hospital admissions for cases of cellulitis.

Unstable lymphoedema requires an intense course of bandaging and manual lymphatic drainage (massage) to reduce limb size before prescription of a compression garment to maintain the size and shape of the limb. Proper fit of compression garments is crucial to ensure their effectiveness, requiring garment replacement every 3 to 6 months. Both interventions have high time and economic costs: an Australian study found the average out-of-pocket financial cost of breast cancer related-lymphoedema was \$977 per person per year.³⁷

We support the Australasian Lymphology Association (ALA) submission to the MSAC. Indicatively this would require an assessment service likely to be equivalent to a Level D consultation in general practice; and allow for up to 10 consultations within a 12 month period, indicatively equivalent to a Level C general practice consultation.

An overview of the issues is provided in Appendix 2.

Recommendation 11

We recommend the Taskforce support a physiotherapy service for the management of complex lymphoedema, and an associated rebate for up to 10 sessions within a 12-month period, using the current Mental Health Care Plan as a model.

We recommend that these listings be introduced as an interim measure (for two years) to enable an application for long-term funding to be considered by the MSAC.

We recommend MBS rebates are restricted to lymphoedema practitioners eligible to appear on the National Lymphoedema Practitioners Register (NLPR);

We recommend Lymphoedema treatment provided by lymphoedema practitioners attracts a rebate that reflects the level of expertise, complexity and resources required to provide Complex Lymphoedema Therapy (CLT).

Recurrent and persistent pain

Early intervention

One in five Australians under the age of 65 is affected daily by chronic pain, this rises to one in three in over 65 years of age.³⁸ Chronic pain costs the Australian economy approximately \$34 billion per year, the third most costly health burden in Australia and is the leading cause of early retirement and absenteeism in the workplace.³⁹

The Productivity Commission has recommended re-focusing of the health sector to focus on integrated and patient centred care. With some estimates saying this could save the economy \$140 billion over 20 years.⁴⁰

Whilst the burden of chronic pain does not sit exclusively with musculoskeletal disorders, a significant amount of the burden does arise from these. For example, the direct costs of low back pain have been estimated at \$4.8 billion per year in Australia. In addition the indirect costs have been estimated at over \$8 billion in Australia.⁴¹

There are well defined predictors of chronicity in the literature with respect to pain. These include high levels of initial pain, poor self-efficacy, poor pain-related beliefs and fear avoidance.⁴² Early intervention to address these predictors has been shown to reduce the risk of developing chronic pain and may help address the burden of disease and prevent chronicity.⁴³

Physiotherapy has been shown to be effective in the early intervention setting and lead to outcomes such as fewer sick days, shorter injury duration and decreased utilisation of the health care system.⁴⁴ Physiotherapists are well placed to employ a biopsychosocial approach to educate and promote best-practice approaches to pain including pain education and promotion of healthy movement, as well as being well placed to screen for co-morbid predictors of chronicity. Physiotherapy can help address the domains that are predictors of chronicity.⁴⁵

As a result, it is important for the MBS to include services that provide early intervention physiotherapy services for people at risk of persistent pain. The presence of these services provides a routine, accessible option for patients and GPs when the risk of persistent pain is identified. The presence of these services is likely to lead to high-value use of health care resources.

The proposed service is described in Appendix 3.

Recommendation 12

We recommend that the new MBS listing for early intervention physiotherapy services for people at risk of persistent pain be introduced as an interim measure (for two years) to enable an application for long-term funding to be considered by the MSAC.

Secondary and tertiary prevention

The burden of chronic pain to society is immense.

The evidence into pain management strongly endorses the use of inter-disciplinary teams as a cost-effective way of managing pain and disability. Current models (and Medicare items) are outdated, favour uni-modal and do not support the biopsychosocial model of intervention.

Recent trials in NSW into the provision of short pain management programs, run in a Primary Care setting, show favourable outcomes. These programs can be used as a model for the provision of such care.

There are already some existing models of chronic disease management involving group based programs (for example in mental health). An adaptation of these models into the provision of multi-disciplinary pain management programs would be appropriate.

There would need to be suitably streamlined ways for GPs to identify appropriate patients who require such services. There would also need to be adequate assessment of these patients by a physiotherapist and Clinical Psychologist. Pain programs would need to be facilitated by at least a physiotherapist and a Clinical Psychologist but could also have GP involvement under existing Medicare item numbers.

These service models have been present in other countries for some time.

The proposed services are described in Appendix 4.

Recommendation 13

We recommend the Taskforce support a new MBS listing for an initial assessment for an interdisciplinary pain education and self-management program; and an interdisciplinary group service for pain management be introduced as an interim measure (for two years) to enable an application for long-term funding to be considered by the MSAC.

Referral to physiotherapy prior to consideration for surgery

In hospital-based orthopaedic screening clinics, a musculoskeletal physiotherapist screens patients referred by GPs to an orthopaedic surgeon, filtering and treating patients who could benefit from conservative treatment and reducing the number of appointments on the orthopaedic wait list. An analysis of physiotherapy led orthopaedic and neurosurgery screening clinics Queensland found that 58% of the patients referred by a GP did not require surgical consultations at all and 83% were referred for conservative physiotherapy management rather than surgery. The same review found that patients, GPs and medical specialists had high levels of satisfaction with the clinics.⁴⁶

The work of the Taskforce to date, and available research suggests that variations in the provision of orthopaedic surgery, and the use of surgery not supported by the literature could be reduced, and that there could be a corresponding reduction in costs in the MBS related to this surgery.

For example, non-surgical rehabilitation of patients with back pain, degenerative knee conditions, degenerative rotator cuffs or with sub-acromial pain has equivalent outcomes to surgery at far lower cost and at significantly reduced risk to the patient. Surgery should be reserved and only selectively offered to patients after appropriate rehabilitation has been exhausted and failed.

Currently there is no requirement that GPs or surgeons follow this evidence based pathway. There have been suggestions with the Taskforce's work (e.g. in the review of spinal surgery – fusion for back pain) that rehabilitation should be considered prior to surgery. Where rehabilitation prior to surgery is considered an appropriate option, it would be beneficial to have defined pathways within the MBS to facilitate referral.

Recommendation 14

We recommend the Taskforce support inclusion of a physiotherapy orthopaedic screening service for patients with specific conditions (e.g. degenerative knees, degenerative rotator cuff), indicatively based on a Level D consultation, on referral from a GP or consultant medical specialist, as an interim measure (for two years) to enable the application for long-term funding to be considered by the MSAC.

The role of students in MBS-rebated consultations

We are concerned about the limitations the legislative and regulatory arrangements in the MBS have on the preparation of graduates to be work ready for private practice. The current arrangements limit the engagement of supervised student with patients, thus limiting the education and training opportunities available to physiotherapy students, and the ability of the professional to provide appropriate and quality preparation for the future workforce.

In March 2017, we sought the Department of Human Service's position on the role that physiotherapy students who were undertaking clinical placements as a part of their pre-entry education could take in consultations in which the patient was seeking a subsidy under the MBS. We received the following:

An allied health service under item 10960 must be provided to the person individually and in person. This requirement is stated in the item descriptor. Item descriptors are included in the legislation and Medicare has no discretion to overrule a legislative requirement.

A physiotherapy trainee therefore, cannot perform a physiotherapy service on behalf of the service provider. I suggest that you may request your professional association to lobby the Department of Health for an amendment to Medicare's legislative requirements and allow a trainee physiotherapist to provide services on behalf of and under the supervision of the physiotherapist.

Following mid-year discussions with the Council of Physiotherapy Deans Australia and New Zealand (CPDANZ), we were provided with a letter from the (then) Department of Health and Ageing, dated 13 July 2005, which appeared to suggest that students could be involved in care provided to patients who were claiming a rebate under the Medicare Benefits Schedule. We provided this information to the Department of Health.

In December 2017, we received the advice included as Appendix 5.

In early February 2018, the Department of Veterans' Affairs (DVA) confirmed that, although its public information might be read as allowing students to be involved in providing care to patients who were eligible under its programs, this was not the case. The DVA confirmed that it was altering the text of its materials and held the same position as the Department of Health.

We are concerned that regulation of the MBS is limiting educational opportunities and has the potential to significantly reduce the participation of private practices in contributing the preparation of the future workforce.

The Chair of the CPDANZ has provided information about the issues (Appendix 6).

Recommendation 15

We recommend the Taskforce support a change of the relevant Determination such that physiotherapy students undertaking supervised clinical placements as a part of their pre-entry education can provide aspects of physiotherapy services described in the Medicare Benefits Schedule. This could include assisting or participating after the 20-minute threshold for the item, where elements of the services as described in the MBS are still being provided.

Employment of physiotherapists by general practitioners

The proposal of re-directing funding for physiotherapy provided under the MBS to a model in which it was provided to general practices / GPs was mooted by the Chair of the Taskforce in a meeting with our National President.

We understand that it was also raised in the General Practice Clinical Committee.

The approach reflects a measure in the 2018-19 Federal Budget, in which the Government announced targeted financial incentives to encourage doctors to deliver services in rural and remote areas that have difficulty attracting and retaining doctors – the Workforce Incentive Program (WIP).

This measure, a part of the Stronger Rural Health Strategy, provides financial incentives to support general practices to employ or otherwise retain the services of nurses, Aboriginal and Torres Strait Islander Health Workers/Practitioners and allied health professionals, including physiotherapists. From 1 July 2019, the WIP will replace the Practice Nurse Incentive Program and the General Practice Rural Incentives Program.

This measure now applies more broadly so that eligible practices can choose to employ allied health professionals across Australia to support increased team-based care arrangements, particularly in rural and remote Australia, where the allied health workforce remains limited.

The Department of Health has advised that, under the WIP, payments for nurses, Aboriginal and Torres Strait Islander Health Workers/Practitioners and allied health professionals will be made through the WIP Practice Stream and payments will continue to be made directly to general practices. When a general practice is considering which health professional to engage they will need to take into account services already available in the community, whether through private practice or public health services. The practice will also need to consider how best to engage these services, whether by directly employing a health professional or otherwise retaining their services, for example through contractual arrangements.

Although we support innovations in the funding of physiotherapy to ensure that the best value is achieved, we are very concerned about the proposals in the WIP and MBS Review.

These proposals appear to reduce consumer choice – a hallmark of our MBS. Instead of the consumer making the choice of health professional, the choice would be determined by the GP / general practice. We are concerned that there is yet to be evidence that this choice by a GP / general practice would be better than that of the individual consumer.

The proposals appear to pre-empt evaluation of the Health Care Homes initiative. Evaluation of stage one of the Health Care Homes (HCH) initiative will be conducted over two years and is designed to examine:

- how the stage one rollout affects the quality of care and the experience of care for patients with chronic and complex conditions.
- the experience for practices of HCH, including changes to the scope of practice, quality improvement system development, models of care, service delivery and business models.
- the use of health services by patients, particularly potentially preventable hospitalisations.
- the cost of care for the government, providers and patients.

Overall, the evaluation will assess the suitability of the HCH program for different practices operating in a range of contexts, and will inform decisions on future rollout.

The proposals appear to privilege general practices in the local 'market' for physiotherapy services – regardless of whether there is a well-established physiotherapy service or not. This creates a distortion in the market where local physiotherapy services will need to compete with general practices to attract professional staff. This is likely to disperse local physiotherapists, despite the value of physiotherapy peer-support, supervision and quality improvement which occurs in multi-physiotherapist practices. It creates competition in day-to-day service provision, which has the strong potential to negatively affect sustainable practices in rural locations by reducing the client volume and undermining viability. It may, in this way, undermine existing collaborations between general practices and physiotherapy practices.

Salary as a model of funding health services has a number of limitations.⁴⁷ The degree to which these implications have been considered is unclear to us.

Our members have begun to report instances of referrals within general practices that our members consider to be driven by financial, rather than clinical imperatives. To date, there is no material safeguard in the proposed initiative to stem such growth of inappropriate decision-making. Our members point to perceived problems with GP after hours services and with the collocation of pathology services as indications that there needs to be some consideration of appropriate safeguards.

We would anticipate that such a model would extend to psychologists, when it appears that the role of Primary Health Networks has been superseded by items within the MBS for the subsidizing of important psychology services for members of rural communities – indeed, psychology has been availed of video-consultations to facilitate these services.

We are concerned that the model is a reversion to a 'master-servant' relationship (as employment is) when physiotherapy has established itself as a first contact profession and credible collaborator, on this basis, with Australian general practice.

We anticipate that, as with other parts of the MBS Review, there will be an opportunity for public and professional comment prior to the recommendation being made to Government. We have a range of potential options that we think could meet the desired outcomes, but without compromising the sustainability of existing practices that are working well. We would welcome the chance to consult further on these issues.

Recommendation 16

We recommend the Taskforce make no recommendation that supports a shift of subsidizing physiotherapy services under the MBS to a payment model to GPs or general practices until public and professional consultation has occurred.

Appendices

Appendix 1 – Pelvic floor care

The prevalence of pelvic floor disorders (urinary incontinence, faecal incontinence, and pelvic organ prolapse) is high, affecting 49.7% of older women.⁴⁸ Thirty per cent of women who have had a baby have urinary incontinence⁴⁹, with the prevalence increasing with age and 47.7% of women have pelvic organ prolapse requiring treatment.⁵⁰ The lifetime risk of needing surgery for prolapse for a woman is 19% in a Western Australian study⁵¹, with surgical failure rates up to 58%.⁵² The recent vaginal mesh debate highlights the potential costs, both personal and economic, associated with prolapse surgery. The subsequent prohibition placed on mesh repairs, requires a rethink of how women with pelvic organ prolapse can be managed, with consideration of prevention and early intervention. Faecal incontinence affects 12.9% of Australian women⁵³ and is a life changing condition, often resulting from childbirth trauma to the anal sphincter.

Pelvic pain is another pelvic condition, which is not included in the statistics on pelvic floor dysfunction, as its prevalence and impact have only recently been recognized and investigated. Pelvic pain affects one in 10 younger Australian women⁵⁴ and 8% of Australian males.⁵⁵ It is very commonly associated with over-activity of the pelvic floor muscles and is amenable to physiotherapy. Pelvic pain in women affects young lives, preventing them from completing schooling and education or fulfilling their potential to contribute productively to society.⁵⁶

Pelvic floor physiotherapists are widely recognized as an integral part of management teams for people with pelvic pain.⁵⁷

The economic and societal cost of pelvic floor disorders

The prevalence of pelvic floor disorders in the USA will increase from 2010 to 2050 by 46-59% due to demographic changes, with implications for public health and the field of gynaecology.⁵⁸ The cost of surgery for pelvic organ prolapse, without considering surgery for urinary incontinence, was estimated at US \$1,543 million in 2001.⁵⁹ The total costs of pelvic pain in women is estimated to be A1\$billion.⁶⁰

Economic benefits of physiotherapy management in primary care.

There are likely to be considerable economic benefits from facilitating the pathway to conservative management for all of these people with these conditions.

One study has demonstrated the costs and outcomes of physiotherapy in Australia for stress urinary incontinence with 80% of women able to avoid surgery.⁶¹

Research suggests that 72% of women with prolapse, managed with a pessary, were able to avoid surgery, with its attendant costs and risks of failure and complications.⁶²

In the public sector, a recent Australian study has highlighted the potential to make cost savings by having physiotherapists provide first line assessment and management of women with pelvic floor dysfunction instead of first-line gynaecology assessment. The benefit to women and the hospital was to reduce waiting lists for affected women.⁶³

Australian authors have stated that as “the burden of genital prolapse in general populations is higher than previously thought, there is justification for a stronger evidence base for prevention, early detection and intervention to reduce the personal and societal costs of these gynaecological conditions”.⁶⁴

Proposal

The International Consultation on Incontinence has recommended conservative measures particularly pelvic floor physiotherapy for these pelvic floor dysfunctions as first line therapy due to the strength of the evidence.⁶⁵

There is Level 1 evidence from multiple, high quality randomized controlled trials for the efficacy of pelvic floor muscle training, administered by a trained physiotherapist for urinary incontinence, providing the basis for a Grade A recommendation for its inclusion in clinical care pathways. There is similar Level 1 evidence from a number of recent RCTs and a Grade A recommendation for the conservative management of pelvic organ prolapse by trained physiotherapists.

Simple vaginal devices, made of medical grade silicone (i.e. support pessaries), have a strong evidence base in the management of pelvic organ support.⁶⁶ Until recently exclusively in the scope of gynaecology practice, pessary care can now be included in conservative management provided by women's health physiotherapists, thanks to a world-first qualification at the University of South Australia. This training for physiotherapists will increase the management options for women with prolapse. Women can be co-managed with their GP and women's health physiotherapist in primary care, thus reducing the need for escalation to specialist gynaecology services.

An initial, assessment consultation would be required. It is likely that this would need at least 40 minutes – indicatively equivalent to a Level D consultation in general practice.

Evidence suggests that for stress incontinence it would be useful to have 6 follow-up visits for treatment, however, there is likely to be a range of visits needed and it would be useful to be able to trigger a further group of visits based on a range of parameters, including assessed progress. Depending on complicating factors these may need to be equivalent to a Level C general practice consultation.

It is considered useful for there to be a mechanism that would fund equipment (e.g. muscle stimulators for weak pelvic floor muscles and pessaries).

Access to services for regional and remote Australians – a case for Telehealth

People with pelvic floor disorders are not clustered in the large urban centres, where services are predominantly located, but are scattered in rural and remote areas, with the attendant demands on their time and financial resources to access appropriate treatment. There are three universities training physiotherapists at postgraduate level to manage pelvic floor disorders, as the knowledge and skills are not acquired at undergraduate level anywhere in Australia (or worldwide as Australia is a world leader in this field). The Australian Physiotherapy Association is commencing a competency-based program as a career pathway option to train more pelvic floor physiotherapists to meet this need. However, these increases in trained physiotherapists will not be able to meet the needs of many rural and remote men, women and children. Telehealth is an obvious solution and can be effectively used to deliver many services, to review patient progress, ensure effective services are being delivered and provide motivation for effective management programs.

Example:

An 18-year-old boy with high functioning autism lives 4 hours' drive from the nearest centre, where services are available to treat his defaecation disorder. This requires the skills of a pelvic floor physiotherapist with advanced practice skills to retrain his pelvic floor muscles. He is unable to attend school regularly, as he spends many hours on the toilet

during the day trying to empty his bowels. This is not only time consuming, preventing his from engaging in education and life, but also emotionally distressing for him and his family. His mother has never been able to work, as she has had to be available to care for him, so the family is resource low. He travelled to the city for the initial face to face consultation and on three subsequent occasions for 'biofeedback' training but between these visits, weekly Skype follow up and discussion about his progress, revision of his training program and encouragement, have contributed to a successful outcome. The therapist has borne the cost of the Skype / telehealth services herself in order to provide an effective service and to help this young man achieve his goals. Such a service should not depend on the altruism of the provider but should be enabled by the provision of a telehealth item number.

Appendix 2 – Complex Lymphoedema Therapy

We recommend the Taskforce support a physiotherapy service for the management of complex lymphoedema, and an associated rebate for up to 10 sessions within a 12-month period, using the current Mental Health Care Plan as a model.

We recommend that these listings be introduced as an interim measure (for two years) to enable an application for long-term funding to be considered by the MSAC.

Background - About the service

Lymphoedema is swelling (oedema) that occurs when lymph fluid builds up in the tissues under the skin, due to non-functioning of the lymphatic system in that part of the body. It usually occurs in an arm or leg, but in some cases the trunk, head, or genital area.⁶⁷ Without management, lymphoedema is progressive and incurable.

Lymphoedema can be managed by Complex Lymphoedema Therapy (CLT), a one-to-one therapy delivered to a patient with lymphoedema by a lymphoedema practitioner. It can involve:

- assessment of the development and the staging of lymphoedema
- assessment of physical and functional impairment
- assessment of psychosocial impairment
- measurement (circumferential and volume) of the affected limb or body part
- skin assessment and care
- lymphoedema area specific manual lymphatic decongestive massage (MLD)
- multilayer compression bandaging
- instruction in exercise in compression
- use of equipment such as low level laser, sequential compression pumps
- education in self-management including self and carer massage technique (SLD)
- measurement, prescription, ordering and fitting of compression garments
- education in compression garment care and utilisation
- follow up to ensure compliance and effective maintenance of limb/body part size.

CLT involves multiple steps. It should be noted that the larger the limb volume, or greater the skin or limb changes, or multiple limbs/sites will impact on the required consultation times. Thorough patient assessment and limb measurement requires approximately one hour. Reduction of limb volume through bandaging depends on the volume of limb swelling. A standard application of a multi-layered bandage can take approximately 45 minutes plus the skin care and lymphatic drainage which occurs prior. To achieve an effective reduction the bandaging is repeated until the limb volume has stabilised. This may only be required two-three times but is dependent on limb volume.

Current MBS support is prohibitive for many individuals to undertake the adequate number of bandaging sessions to reduce their limb size. When the limb volume has plateaued, garment measurements are taken and a suitable garment prescribed. Compression garments are most commonly manufactured in Europe and can take two – three weeks to be delivered. Bandaging is generally required in order to reduce the limb again to fit the compression garment. Follow-up of the garments' effectiveness may occur four weeks post-application. Garments are recommended to be replaced after six months as the compressive strength reduces over time with wear. Therefore this process is required to take place twice per year. Variabilities in patient capacity to wear garments etc. will change the approach taken and alternate strategies such as compression pumps may be utilised.

We recommend Lymphoedema treatment provided by lymphoedema practitioners attracts a rebate that reflects the level of expertise, complexity and resources required to provide Complex Lymphoedema Therapy (CLT).

The second issue is that the current referral by the GP under a Chronic Diseases Care Plan to a general allied health profession does not ensure that the allied health professional is an appropriately trained lymphoedema practitioner. Lymphoedema care may be complex and long term so it is best provided by trained lymphoedema practitioners.^{68 69}

Under this proposal, MBS rebates would be restricted to lymphoedema practitioners eligible to appear on the National Lymphoedema Practitioners Register (NLPR).

Appendix 3 – Early intervention physiotherapy services for people at risk of persistent pain.

This service will be provided to a person by an eligible physiotherapist if:

- the service is provided to a person who has pain lasting less than 6 weeks
- the person is being managed by a medical practitioner who has identified that person as showing risk factors associated with prediction of non-recovery (*high VAS, DASS or OMPQ scores*)
- the person is referred to an eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and
- the person is not an admitted patient of a hospital nor enrolled in a pain management program at a tertiary institution; and
- the service is provided to the person individually and in person or via video consultation for rural and remote patients
- the initial consultation is of at least 45 minutes duration and includes use of:
 - psychosocial screening tools (e.g. DASS Orebro and TSK)
 - functional measures to demonstrate progression such as patient specific functional scales
 - site specific outcome measures (eg. DASH, ODQ, NDI)
- the follow-up consultations of at least 30 minutes duration and includes:
 - pain education
 - interventions targeted at addressing the barriers to recovery identified at the initial assessment
 - active strategies that encourage self-management
- after the first five (5) services, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in the third dot point, outlining the baseline measures of biopsychosocial and functional parameters and provides written demonstration of how the barriers to recovery have been addressed, as well as progressions in these measures over time
- the person has been shown to have made demonstrable progress in the report mentioned in the seventh dot point but has not yet shown complete resolution, a further 5 sessions may be recommended by the medical practitioner mentioned in the third dot point
- in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

These planned services are time limited being deliverable in up to ten planned sessions in a calendar year. Claims for this service may not exceed this maximal limit.

Appendix 4 – Interdisciplinary Pain Education and Self-Management Program

Initial Assessment for Interdisciplinary Pain Education and Self-Management program

An initial assessment will be provided by a member of an inter-disciplinary team for the purposes of ASSESSING a person's suitability for group services for the provision of pain education and the promotion of self-management of pain.

This service will be provided following referral by a medical practitioner who has ruled out the presence of red flags or serious pathology in the person's medical history. The initial assessment will include assessment of the person's language and cognitive skills to be able to participate in the education program. Assessment of psychosocial factors will be made via self-reported questionnaires, and a functional physical assessment will be undertaken.

- (a) the service is provided to a person who has pain lasting longer than 3 months, or who has been identified as being at risk of developing chronic pain (with the use of appropriate screening tools such as those included in the ePPOC data collection).
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or a GP Management Plan, or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan; and
- (c) the person is referred to one or more eligible allied health practitioners (and including a physiotherapist) by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital nor enrolled in a pain management program at a tertiary institution; and
- (e) the service is provided to the person individually and in person or via video consultation for rural and remote patients
- (f) the service is of at least 50 minutes duration; and
- (g) after the service, the eligible allied health provider gives a written report to the referring medical practitioner mentioned in paragraph (c) outlining the baseline measures of biopsychosocial parameters; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable once only for this Assessment for Group Services item as it relates to a pain education and self-management program.

Interdisciplinary Group Service for Pain Management Program

Interdisciplinary pain management program provided for a person by an eligible physiotherapist and clinical psychologist, as a GROUP SERVICE for the provision of pain education and self-management strategies if:

- (a) the person has been assessed as suitable for a pain education self-management group service under assessment item [number]; and
- (b) the service is provided to a person who is part of a group of between 6 and 12 patients inclusive; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible member of the interdisciplinary team; and or via video conference to a person in a rural or remote area
- (e) the service is of at least 90 minutes duration, consisting of input from each member of the team; and
- (f) after the last service in the group services program provided to the person under items [numbers], the eligible interdisciplinary team prepares, a written report to be provided to the referring medical practitioner outlining changes in outcome measures because of the program and a self- management plan developed in collaboration with the patient, and
- (g) an attendance record for the group is maintained by the eligible interdisciplinary team; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

to a maximum of 10 GROUP SERVICES in a calendar year. Individual revision sessions may be included under subsequent CDM plans.

Appendix 5 – MBS-rebateable services and students

The following rules apply to all MBS-rebateable services provided by eligible physiotherapists (Items 10960, 81335 and 82035):

- A physiotherapy service that attracts an MBS rebate can only be provided by an eligible physiotherapist, as defined in the Determination (see later);
- An eligible physiotherapist must provide all components of the MBS-rebateable service, as described in the relevant MBS item descriptors;
- There is no scope for another person who is not an eligible physiotherapist to provide a component of a physiotherapy service for which an MBS rebate would be payable; and
- The supervision of students is not a formal component of the MBS physiotherapy services, and such supervision cannot be counted toward the completion of an MBS-rebateable physiotherapy service.

Physiotherapists cannot bill patients using MBS items 10960, 81335 and 82035 (the three MBS items currently available for physiotherapy services) for supervising a student to treat eligible patients for the required period of time. A physiotherapy trainee therefore, cannot perform a physiotherapy service on behalf of the service provider.

Thus, a student may observe the service being undertaken (with the appropriate consent), but cannot assist or participate in the service provision. This includes assisting or participating after the 20 minute threshold for the item, where elements of the service as described in the MBS are still being provided.

Under the current regulatory framework applying to the CDM allied health service items, there is no discretion to vary the requirement that all components of the service, as described in the relevant item descriptors, be provided by health professionals who have achieved the required standard of professional competence and who are appropriately registered.

The Determination

Under the provisions of the Health Insurance (Allied Health Services) Determination 2014 (the Determination <https://www.legislation.gov.au/Details/F2013L02134>), a physiotherapy service may only be billed if it is provided by an eligible physiotherapist and the services is provided individually and in person by the physiotherapist.

For the purposes of the Determination (Schedule 1, Clause 14)

“A person is an allied health professional in relation to the provision of a physiotherapy health service if the person is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided”.

This excludes physiotherapy students who have not completed their training and who have not gained the appropriate professional registration in their State or Territory.

Supervision by a registered physiotherapist of a physiotherapy student would not fulfil the requirements of the Determination, and any service provided by a student would not be billable to Medicare. Likewise, a service only partly performed by a registered physiotherapist, with a component provided by a physiotherapy student, would not be billable.

Appendix 6 – Physiotherapy students clinically supervised in the private sector

(Statement from Council of Physiotherapy Deans of Australia and New Zealand, May 2018)

Made by Prof Sandra Brauer, President CPDANZ, University of Queensland

Approximately 67% of physiotherapists worked in the private sector in 2015 (National Health Workforce Dataset – Physiotherapy 2015). Physiotherapy is a profession that requires annual registration with AHPRA. Physiotherapy attracts high achieving students (ATAR rank ~98-99) similar to law or medicine. To qualify as a physiotherapist, students must complete at least 4 years of study – either a 4-year Bachelor program, a 4-year Bachelor plus a two year Masters degree or plus a 3 year extended Masters degree. Under AHPRA, the Physiotherapy Board of Australia appoints the Australian Physiotherapy Council to evaluate university programs of physiotherapy to assess if the physiotherapy program, and the university that delivers it, provides students with the knowledge, skills and professional attributes to practise physiotherapy. Graduates of accredited programs are able to be registered as physiotherapists in Australia. All universities in Australia with physiotherapy programs who have graduated students are accredited.

Physiotherapists are first contact practitioners – a medical referral is not required. New graduate physiotherapists can practice independently immediately on graduation without supervision. Access to clinical placements that provide students with adequate experience to enable them to work safely and effectively on graduation is crucial.

Scope of the issue

In 2016 / 2017 there were 8,537 physiotherapy students registered with AHPRA (Physiotherapy Board Annual report, 2017). This is a mix of undergraduate (4 year) and postgraduate (2 – 3 year) programs. Council of Physiotherapy Deans of Australia and New Zealand (CPDANZ) benchmarking data indicate that approximately 30% of students are in their final year, thus approximately 2560 students completing clinical placements annually. Students on average complete approximately 1,000 hours of clinical practice, thus in Australia, require approximately 2.56 million hours of placements (12,800 x 5-week placements). The APPlinkup data from 2017 (which has data for ~60% of students nationally) estimates that at least 29% of all physiotherapy placements occur in the private sector - ~13% in private practice, ~10% in private hospitals and ~6% in university clinics.

Safety and quality of placements

Physiotherapy students are well prepared, safe, and closely supervised on placement.

Pre-clinical

National standards of practice (Australian & NZ Physiotherapy Practice Thresholds, 2015) outline threshold competencies required for initial and continuing registration as a physiotherapist. All university programs must demonstrate how all competencies are attained within their program, including clinical and professional competencies. Students typically complete clinical placements in the final year of their degree. University rules will generally ensure students have passed all pre-clinical studies (theoretical knowledge and practical skills) prior to commencing clinical placements. Pre-clinical study includes practical roleplaying and simulated patient interactions that are assessed, with safety a key criterion. Program accreditation guidelines ensure students must have completed appropriate professional and ethical education prior to commencing clinical practice. All

physiotherapy students must be registered with AHPRA on commencing their physiotherapy degree.

Clinical placements

Students must pass clinical placements across a scope of practice fields to meet accreditation requirements. Clinical placements need to allow students to demonstrate the ability to assess clients, diagnose, make decisions, manage risk, implement management techniques and plans, all in a safe, professional, evidence-based, effective manner in order to pass a placement.

Students on placement in private practice and private organisations must always be supervised by a registered physiotherapist when performing physiotherapy specific activities such as assessment and treatment. Students must demonstrate their ability to analyse and plan through discussion with their educator and through their demonstrated clinical reasoning with every client. A 1:1 model of supervision is the most common model in private practice. Thus, there is close supervision of physiotherapy students, with the assessment and management plan implemented by a student requiring the approval of a registered physiotherapist. All physiotherapy students are evaluated using the same national criteria that include sections on safety and professionalism.

Safety-adverse events

Formal complaints lodged with AHPRA from 2011-2016 about physiotherapists have been recently investigated (Ryan, 2018). Physiotherapists had the lowest rate of complaints (per 1000 practice years) when compared with chiropractors (29 per 1000) and osteopaths (10 per 1000), with 70% of complaints against physiotherapists resulting in no regulatory action.

The predictors of complaints are being male, aged over 66 years and practicing in metropolitan areas. Physiotherapy students are predominantly female, aged <30 years and have placements across metropolitan, regional, and remote centres.

There have been no notifications lodged with AHPRA about physiotherapy students in 2016-2017, and only one in 2015-2016 (AHPRA Annual report 2016-2017, p49). In the last five years there have only been 6 notifications lodged about physiotherapy students (AHPRA Annual Reports).

There are very few clinical incidents reported on physiotherapy student placements.

Clinical educators must submit a hazard and incident report form to the university if a student is involved in an incident while on clinical placement. Gaida et al (2015) evaluated incident reports regarding physiotherapy students from Monash University from 2008-2011. They reported an incident rate of 9.0/100,000 student-hours for third-year students and 6.8/100,000 student-hours for fourth-year students. Only two incidents across 4 years were reported from an outpatient setting, which most closely approximates a private practice clinic. Incidents were lowest when the supervisor was in close proximity to the student.⁷⁰

Training of clinical supervisors/educators

Clinical supervisors who supervise physiotherapy students on clinical placement are typically senior clinicians with additional training to support their education role. Health Workforce Australia (HWA) have recognised the importance of clinical supervision and have developed a competency resource (2014) that universities and accreditation bodies use to guide the development of a high quality, sustainable clinical supervision workforce across a variety of settings, to meet the current and future challenges of developing

competent health practitioners for the Australian health system. This includes National competencies for supervisors to optimise safety and quality in clinical supervision.

A number of strategies are used to help clinical supervisors to meet these competencies.

Clinical supervisors are offered a variety of training opportunities to support them as clinical educators. This can include introductory and advanced continuing professional development sessions on clinical education – on both general topics (e.g. facilitation of learning) and physiotherapy-specific training, in a variety of modes. Universities employ staff whose role is to educate and support clinical supervisors and students. They regularly visit sites to work with supervisors in real time with students. Where possible, universities will seek out alumni as clinical supervisors in the private sector, knowing they have been educated through a particular program. Clinical supervisors (registered physiotherapists) direct the engagement of students with clients. They determine how much interaction students have with clients, their role (e.g. only providing one component of management), and can cease engagement with clients, and cease the placement if they have any concerns.

All universities have legal agreements in place with every placement provider, whereby each site agrees to provide clinical supervisors with appropriate expertise. National physiotherapy competency standards (Physiotherapy Practice Thresholds 2015) identify that physiotherapists have a role as an educator, thus in their entry-level training, physiotherapy students receive training in their role as a future educator. Furthermore, experience in education is an area of expertise that is included in physiotherapy career pathways both professional (e.g. Australian College of Physiotherapists, APA) and in enterprise bargaining agreements. Clinical supervision of physiotherapy students is the most common way physiotherapists can attain these professional targets, and the private sector should not be disadvantaged from this opportunity.

The APA have identified that one of 6 key features of successful practices of the future is that they will be a partner in teaching, training and research (In Practice 2025). It has been identified that the broader role of the physiotherapy private practice in the health system will combine with an increased number of entry level students and greater constraints on the public hospital system to increase the role of the practice of the future in education.

The APA anticipates that private practices will offer a greater range and number of clinical placement opportunities and there will be an emerging role for the clinical educator in private practice. It has not been anticipated that there might be limitations to supervising physiotherapy students in private settings.

Practice accreditation guidelines

The Australian Physiotherapy Association Standards for Physiotherapy Practices are consensus guidelines that permit private practices to be accredited with the APA. They include criteria to indicate quality standards for student clinical supervision. These include that practices will normally need to offer a formalised induction program for students followed by an incremental increase in the student's caseload as their knowledge and skills improve. Supervisors will need to offer sufficient opportunities for observation and discussion and accept a duty of care for physiotherapy provided under their supervision.

Appropriate use of health care

The supervision ratio and patient load managed by students limit the number of clients they can manage. Students are generally supervised in a 1:1 staff:student ratio in private practice, and up to a 1:3 ratio in private hospitals. Students will typically begin with

observation, and progress to a maximum of 5 patients / day. It is typical that students may take at least 1 hr with a new patient and at least 45 minutes with a follow up patient. At the end of a 5-week block placement, the typical number of patients one student may provide services for per week might be in the range of starting at 10 in weeks 1-2 and growing to up to 25 in weeks 4 or 5. Given the ratio of staff:students, and the number of patients a student can manage in a day there are clear limits on the number of potential patients that could be seen per day.

Supervision of students is anecdotally reported to increase practitioner workload, and therapists are not able to increase the number of patients seen with the addition of a student. Physiotherapists must adhere to a code of conduct that protects patients and ensures safe, effective practice. Quality supervision practices are encompassed by the code of conduct. The private sector is dependent on high quality service provision to maintain reputation. There would be a business risk if the quality of service declines due to inappropriate engagement of students (e.g. the quantity of patients seen by students compromises quality).

Models of supervision vary between practices. If there are limitations to student involvement in service delivery (e.g. they can only observe), there are fewer opportunities to demonstrate competencies in clinical practice (e.g. in-patient assessment, management).

If there is insufficient opportunity, then this location would not be a suitable clinical placement. If there are limitations to student involvement in clinical placements in the private sector, there is a real risk that the future workforce will be less prepared and experienced for work in the private sector.

If in future, we are faced with a less experienced and capable workforce who have completed fewer hours of clinical practice under supervision in the private sector, there is a risk of a higher number of notifications and clinical incidents. To ensure ongoing safety of the public, it is preferable for physiotherapy students to have their initial exposure to working in the private sector while under the supervision of experienced clinicians, than to experience this for the first time when working alone. Any unnecessary limitations on the ability of the private sector to be engaged in clinical supervision of physiotherapists will be a barrier to the future workforce and pose a potential risk to patient safety.

Australian Physiotherapy Association

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 26,000 members, some 70 staff and over 1,000 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website www.physiotherapy.asn.au.

References

- ¹ Duckett S Breadon P Ginnivan L. Access all areas: new solutions for GP shortages in rural Australia, Grattan Institute, Melbourne. 2013.
- ² Haggerty JL Reid RJ Freeman GK et al. Continuity of care: a multidisciplinary review. *BMJ*. 2003 Nov 22;327(7425):1219-21.
- ³ Wright M Hall J van Gool K et al. How common is multiple general practice attendance in Australia? *AJGP* May 2018;47(5):289-96.
- ⁴ Wright Hall van Gool et al. op cit.
- ⁵ Comans T Byrnes J Boxall A et al. Physiotherapist referral to specialist medical practitioners. Final Report. Griffith University Centre for Applied Economics and Deeble Institute. 2 September 2013.
- ⁶ Australian Physiotherapy Association (2017). APA Code of Conduct, p4, available at http://www.physiotherapy.asn.au/DocumentsFolder/APAWCM/The%20APA/Governance/Code_of_Conduct_V2013.pdf
- ⁷ Physiotherapy Board of Australia (2011). Code of Conduct for Registered Health Practitioners, p2, available at <http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx>
- ⁸ Daker-White G Carr AJ Harvey I et al. A randomised controlled trial: Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments. *J Epidemiol Community Health*, 1999. 53: p. 643-50.
- ⁹ Foley & Lardner LLP. 2014 Telemedicine Survey Executive Summary. Executive Summary November 2014. Chicago. USA. <https://www.foley.com/files/Publication/0585f5b1-1205-4be7-be5a-4e14602a4fac/Presentation/PublicationAttachment/39c25a9b-5ff1-4ee8-b861-4ea2d71718ae/2014%20Telemedicine%20Survey%20Executive%20Summary.pdf> (Accessed 1 October 2017)
- ¹⁰ Hill RD Luptak MK Rupper RW et al. Review of Veterans Health Administration telemedicine interventions. *Am J Manag Care*. 2010;16(12 Spec No.):e302-10
- ¹¹ Holland AE. Telephysiotherapy – time to get online. *Journal of Physiotherapy* 2017;63:193-95. <http://dx.doi.org/10.1016/j.jphys.2017.08.001>
- ¹² Beard M Orlando JF Kumar S. Overcoming the tyranny of distance: An audit of process and outcomes from a pilot telehealth spinal assessment clinic. *J Telemed Telecare* 2016;23(8):733-9. <https://doi.org/10.1177/1357633X16664851>
- ¹³ Darkins A Ryan P Kobb R et al. Care Coordination/Home Telehealth – the systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions. *Telemedicine and e-Health*. 2009 (January);14(10):1118-26. <https://doi.org/10.1089/tmj.2008.0021>
- ¹⁴ Wade VA Karnon J Elshaug AG et al. A systematic review of economic analyses of telehealth services using real time video communication. *BMC Health Services Research* 2010;10:233
- ¹⁵ Mechanic D. Rethinking medical professionalism – the role of information technology and practice innovations. *Milbank Quarterly* 2008;86(2):327-58.
- ¹⁶ Kruse CS Krowski N Rodriguez B et al. Telehealth and patient satisfaction: a systematic review and narrative analysis. *BMJ Open* 2017;7:e016242. doi:10.1136/bmjopen-2017-016242.
- ¹⁷ Coye MJ Haselkorn A DeMello S. Remote patient management – technology-enabled innovation and evolving business models for chronic disease care. *Health Affairs* 2009;28(1):126-35.
- ¹⁸ Foley & Lardner LLP. 2017 Telemedicine and Digital Health Survey – Telemedicine Surges Ahead As Providers, Patients Embrace Technology <https://www.foley.com/files/uploads/2017-Telemedicine-Survey-Report-11-8-17.pdf> (Accessed 1 December 2017)
- ¹⁹ Accenture Consulting. Technology for people – Digital Health Technology Vision 2017. <https://www.accenture.com/us-en/insight-digital-health-tech-vision-2017> (Accessed 1 September 2017).
- ²⁰ Nathanson D Lee G Tzioumi D. Children in out-of-home care: does routine health screening improve outcomes? *Journal of Paediatrics & Child Health* 2009, 45: 665-9.
- ²¹ Kaltner M Rissel K. Health of Australian children in out-of-home care: needs and carer recognition. *Journal of Paediatrics and Child Health* 2011;47:122-6.
- ²² Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare. The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC. 2017.
- ²³ McCarthy B Casey D Devane D et al. Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochran Database Syst Rev* 2015(2):CD003793.

- ²⁴ Puhan MA Gimeno Santos E Cates CJ et al. Pulmonary rehabilitation following exacerbations of chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews* 2016.
- ²⁵ Griffiths T Phillips C Davies S et al. Cost effectiveness of an outpatient multidisciplinary pulmonary rehabilitation programme. *Thorax* 2001;56:779-84.
- ²⁶ Alison JA McKeough ZJ Johnston K et al. Australian and New Zealand Pulmonary Rehabilitation Guidelines. *Respirology* 2017;22:800-19.
- ²⁷ Alison JA Jenkins C Maguire G et al. Implementing evidence into practice to improve chronic lung disease management in Indigenous Australians – the Breathe Easy, Walk Easy-Lungs for Life (BE WELL) project. *NHMRC/ Global Alliance for Chronic Diseases: Prevention and Management of Chronic Lung Diseases*.
- ²⁸ MacLennan AH Taylor AW et al. The prevalence of pelvic floor disorders and their relationship to gender, age, parity and mode of delivery. *BJOG*. 2000 Dec;107(120):1460-70.
- ²⁹ Australian Institute of Health and Welfare. Australia's health 2016. Cat. no. AUS 199, Australian Institute of Health and Welfare, Canberra.
- ³⁰ DiSipio T Rye S Newman B et al. Incidence of unilateral arm lymphoedema after breast cancer – a systematic review and meta-analysis. *Lancet Oncol*, 2013;14(6):500-15.
- ³¹ Cormier JN Askew RL Mungovan KS et al. Lymphedema beyond breast cancer – a systematic review and meta-analysis of cancer-related secondary lymphedema. *Cancer* 2010;116(22):5138-49.
- ³² Voss RK Cromwell KD Chiang YJ et al. The long-term risk of upper-extremity lymphedema is two-fold higher in breast cancer patients than in melanoma patients. *J Surg Oncol*. 2015;112(8):834-40.
- ³³ Hayes SC Janda M Ward LC et al. Lymphedema following gynaecological cancer – results from a prospective, longitudinal cohort study on prevalence, incidence and risk factors. *Gynae Oncol*. 2017;146(3):623-9.
- ³⁴ Deng J Ridner SH Dietrich MS et al. Prevalence of secondary lymphedema in patients with head and neck cancer. *J Pain Symptom Manage*. 2012;43(2):244-52.
- ³⁵ Ridner SH Dietrich MS Niermann K et al. A prospective study of the lymphedema and fibrosis continuum in patients with head and neck cancer. *Lymphat Res Biol*. 2016;14(4):198-205.
- ³⁶ Lymphoedema Framework: Best Practice for the Management of Lymphoedema. International Consensus. London: MEP Ltd, 2006. Document can be downloaded from <https://www.lympho.org/portfolio/best-practice-for-the-management-of-lymphoedema/>
- ³⁷ Boyages J Xu Y Kalfa S et al. Financial cost of lymphedema borne by women with breast cancer. *Psycho-Oncol*. 2017;26:849-55.
- ³⁸ Pain Australia 2018-2019 Pre-Budget Submission. December 2017. <http://www.painaustralia.org.au/static/uploads/files/painaustralia-budget-submission-18-19-color-wfbralgwytqg.pdf>
- ³⁹ Productivity Commission 2017, Shifting the Dial: 5 Year Productivity Review, Inquiry Report. <https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review.pdf>
- ⁴⁰ Productivity Commission 2017. op cit.
- ⁴¹ Productivity Commission 2017. op cit.
- ⁴² Picavet HSJ Vlaeyen JW Schouten JS: Pain catastrophizing and kinesiophobia: predictors of chronic low back pain. *American journal of epidemiology* 2002, 156(11):1028-1034.
- ⁴³ Ramond A Bouton C Richard I et al. Psychosocial risk factors for chronic low back pain in primary care—a systematic review. *Family practice* 2011, 28(1):12-21.
- ⁴⁴ Hallegraeff JM Krijnen WP van der Schans CP et al. Expectations about recovery from acute non-specific low back pain predict absence from usual work due to chronic low back pain: a systematic review. *Journal of Physiotherapy* 2012;58:165–72.
- ⁴⁵ Guzman J Esmail R Karjalainen K et al. Multidisciplinary rehabilitation for chronic low back pain: systematic review. *British Medical Journal* 2001;322(7301):1511-6.
- ⁴⁶ Raymer M Smith D O'Leary S. Physiotherapy screening clinic model improves neurosurgery and orthopaedic outpatient services, Queensland Government 2012.
- ⁴⁷ Robinson JC. Theory and practice in the design of physical payment incentives. *Milbank Quarterly* 2001;79(2):149-77.
- ⁴⁸ Nygaard I Barber MD Burgio KL et al. Prevalence of symptomatic pelvic floor disorders in US women. *JAMA* 2008;300(11):1311-6.

- ⁴⁹ Chiarelli P. Postpartum stress incontinence – prevention and rehabilitation. *International SportMed Journal* 2003;4(6):1-10.
- ⁵⁰ Swift SE. The distribution of pelvic organ support in a population of female subjects seen for routine gynecologic health care. *Am J Obstet Gynecol.* 2000;183(2):277-85.
- ⁵¹ Smith FJ Holman CD Moorin RE et al. Lifetime risk of undergoing surgery for pelvic organ prolapse. *Obstet Gynecol.* 2010;116(5):1096-100.
- ⁵² Whiteside JL Weber AM Meyn LA et al. Risk factors for prolapse recurrence after vaginal repair. *Am J Obstet Gynecol.* 2004;191(5):1533-8.
- ⁵³ Prevalence of faecal incontinence (Australian Institute of Health and Welfare Report, 2006).
- ⁵⁴ Faculty of Pain Medicine ANZCA. Pelvic Pain Report: The \$6Billion Woman and the \$600Million Girl. 2011. <http://www.drsusanevans.com.au/wp-content/uploads/Pelvic-Pain-Report-rfs-SECURE-final.pdf>
- ⁵⁵ Ferris JA Pitts MK Richters J et al. National prevalence of urogenital pain and prostatitis-like symptoms in Australian men using the National Institutes of Health Chronic Prostatitis Symptoms Index. *BJU International.* 2010;105:373-9.
- ⁵⁶ Faculty of Pain Medicine ANZCA. op cit.
- ⁵⁷ Engeler D Baranowski AP Borovicka J et al. European Guidelines on Chronic Pain (2014) https://uroweb.org/wp-content/uploads/26-Chronic-Pelvic-Pain_LR.pdf
- ⁵⁸ Wu JM Hundley AF Fulton RG et al. Forecasting the prevalence of pelvic floor disorders in U.S. Women: 2010 to 2050. *Obstet Gynecol.* 2009;114(6):1278-83.
- ⁵⁹ Hay Smith J Berghmans B Burgio K et al. Committee 12. Adult Conservative Management, in Abrams et al (Eds), 6th Edition 2017 International Consultation on Incontinence. pp. 1443-28. https://www.ics.org/Publications/ICI_4/files-book/comite-12.pdf
- ⁶⁰ Faculty of Pain Medicine ANZCA. op cit.
- ⁶¹ Beaumont T Goode K. Identifying the pathway to conservative pelvic floor physiotherapy in a tertiary public hospital in Australia – a retrospective audit. *The Internet Journal of Allied Health Sciences and Practice* 2017;23:15(2).
- ⁶² Coolen AWM Troost S Mol BWJ et al. Primary treatment of pelvic organ prolapse: pessary use versus prolapse surgery. *Int Urogynecol J.* 2018;29:99-107.
- ⁶³ Beaumont Goode op cit.
- ⁶⁴ Smith FJ Holman CD Moorin RE et al.
- ⁶⁵ Hay Smith J Berghmans B Burgio K et al. op cit.
- ⁶⁶ Coolen Troost Mol et al. op cit.
- ⁶⁷ Moffat C Franks P Doherty D et al. Lymphoedema: an underestimated health problem. *Q J Med* 2003;96:731-8.
- ⁶⁸ Queensland Health. Queensland Health lymphoedema clinical practice guidelines 2014. Queensland Health; 2014 Mar.
- ⁶⁹ International Society of Lymphology. “The diagnosis and treatment of peripheral lymphedema: 2013 consensus document of the International Society of Lymphology”. *Lymphology* 2013 Mar; 46(1):1-11.
- ⁷⁰ Gaida JE Maloney S Loa K. et al. Clinical incidents involving students on placement – an analysis of incident reports to identify potential risk factors. *Physiotherapy* 2015;101:219-25.