Australian Physiotherapy Association
Submission

SIRA NSW Model of Care for the Management of Low Back Pain

Submission by
Australian Physiotherapy Association (APA)
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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

About Australian Physiotherapy Association (APA)

The APA is the peak body representing the interests of Australian physiotherapists and their patients. We are a national organisation with state and territory branches and specialty subgroups. The APA represents more than 32,000 members.

The APA's vision is that the whole community recognises the full benefit of physiotherapy, and we believe that all Australians should have access to high quality physiotherapy to optimise health and wellbeing. We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health for all Australians.

Acknowledgements

The APA would like to acknowledge the contribution of the physiotherapists who provided expert clinical guidance and evidence regarding the fidelity of the SIRA NSW Model of Care for Low Back Pain relative to evidence based practice. The APA and its New South Wales Branch would also like to acknowledge the contribution of our national speciality subgroups whose consult and collaboration was sought including APA Titled and Specialist physiotherapists in the Advanced Practice, Musculoskeletal, Occupational Health, Pain, and Sports and Exercise committees. The APA thanks the Royal Australian College of General Practitioners (RACGP) for their letter of endorsement.

Contents

1. Executive Summary

The seemingly innocuous removal of the term 'physiotherapist' from the primary care team and from the clinical care pathway is not evidence-based. The substitution of the physiotherapist with non-Ahpra regulated, limited scope exercise providers underestimates the complex and considered evidence-based care and clinical acumen that patients with acute low back pain deserve access to and represents an unsafe over-simplification of guideline-based care at the level of implementation. Unfortunately, the change not only represents a step away from evidence-informed care, but a step towards insurer managed care, in a model facetiously positioned as 'Value Based Health Care'.

Patients with acute low back pain require clinical attention at the highest level of qualification possessed by the Australian health system. SIRA's Low Back Pain Model of Care (LBP MoC) eclipses such assurance from the clinical pathway in a concerning display of reform which has prioritised dollar value for the insurer over value for the patient.

Recommendations:

The APA Recommends that:

Recommendation 1: In SIRA NSW Model of Care for the Management of Low Back Pain, p.1, the primary care team members should re-include 'the physiotherapist' explicitly.

Recommendation 2: In SIRA NSW Model of Care for the Management of Low Back Pain, replace the term 'physical therapies' with 'physiotherapy' or 'physiotherapist' in Pathway A (Non-specific acute low back pain, p.8) under Medium and High risk patient categories, and Pathway C (Acute low back pain and leg pain, p.10) under Medium and High risk patient categories. This recommendation is endorsed by the Royal Australian College of General Practitioners (RACGP).

Recommendation 3: In SIRA NSW Model of Care for the Management of Low Back Pain, p.3, under Principle 6: Active physical therapy encouraged, amend "Physical therapies will be primarily a 'hands off' approach" to "Physical therapies will prioritise a patient-centred active approach, with or without evidence based and individualised manual therapy."

Recommendation 4: The Clinical Advisory Group (CAG) make representations to SIRA regarding inadequacy of reform processes which are performative, hasty, lacking in transparency, and which allow amendments to clinical pathways based on vested interests alone; whether that be those of a lobby group or those of a funder.

Recommendation 5: The Clinical Advisory Group (CAG) make representations to SIRA regarding the role of SIRA regulatory powers to direct service within the Low Back Pain Model of Care; the regulator should not utilise phrasing or terminology within the model of care alone as evidence with which to justify SIRA directed care at the level of any individual practitioner or patient. Such directed care requires more than the evidence afforded by the LBP MoC high level summary document; this caveat should be included as an explicit note on model of care documentation.

Recommendation 6: SIRA engage with APA on true reform towards Value Based Health Care for patients with acute low back pain. The APA welcomes the opportunity to co-design and pilot strong, safe models of care for patients which enable evidence-based access, outcome retrieval and measurement, development of educational resources for practitioners and patients, and adherent implementation of true Value Based Health Care across physiotherapists and their patients with acute low back pain.

Given APA Recommendations 1, 2, 3, and 5, and RACGP endorsement that the term 'physical therapies' be replaced by the words 'physiotherapy' or 'physiotherapist', should the LBP MoC be implemented without these recommendations, the statement 'consensus was reached on all advice provided in this guide' (SIRA 2023a:2) is now false and must be removed from the MoC Summary document.

2. Background

The removal of the term 'physiotherapist' from SIRA's model of care is beyond an issue of semantics and will have direct consequences on the care outcomes of patients with acute low back pain.

The case for value

In Australia, the lack of strong and strategic primary care for patients with low back pain has left an open goal into which the increasing burden of disease keeps scoring. The burden of disease related to musculoskeletal conditions is the number one cause of years lived with disability (YLD), with LBP responsible for 44% of these YLD (De Luca et al. 2022), resulting in 4.73% of Australia's total health loss via disability adjusted life years (DALYs) (Institute for Health Metrics and Evaluation (IHME) 2019). For Australian adults, low back pain is typical for most, but incorrigible for some (De Luca et al. 2022), with the latter enduring the brunt of the burden: pain, physical impairment, sleep disturbance, time off work, secondary psychological morbidity, and reduced ability to participate in activities of daily living (Makris et al. 2017) — all ultimately impacting the ability to live a life that they value.

The LBP burden places significant demand on the Australian health system, where annual expenditure for back problems is approximately $3.4 billion, largely (62%) sustained by hospital services (Australian Institute of Health and Welfare (AIHW) 2023), whereby back pain is the 8th most common of all diagnostic presentations to Emergency Departments (AIHW 2022). Low back pain is the most common musculoskeletal presentation to general practice (GP) (Wheeler et al. 2018), and primary care sustains 21% of Australia's expenditure on back pain, predominantly via expenditure on the Pharmaceutical Benefits Scheme (PBS) (44%) and GP (40%), with 10% of expenditure associated with allied health (AIHW 2023). Weak primary care has been an incriminated factor in the pursuit of outcomes for people with low back pain and thus the focus of reform objectives across many schemes (Cruz et al. 2020), including SIRA.

SIRA model of care for low back pain

SIRA's Low Back Pain Model of Care is originally sourced from an Agency of Clinical Innovation (ACI) 2016 model (ACI 2016), but rebranded under the auspices of Value Based Health Care,

with little change since 2016 except conspicuous removal of 'physiotherapy' and 'physiotherapist' in May 2023 (SIRA 2023a). The change was made without consensus or consult from the APA and, worryingly, without exposed source, methodology, or evidence to support this major change—in direct contradiction of evidence-based practice.

The vague terminology in SIRA's LBP MoC is of further concern within context of the strong regulatory powers possessed by SIRA, who have recently become legislatively enabled to make directions to health practitioners to provide health services in a SIRA specified way (SIRA 2023b), and SIRA can now unilaterally decide to exclude providers who do not comply with such direction (SIRA 2023b). The APA has already expressed concern that SIRA's strong directive powers will result in insurer interference in patient care and the undermining of the autonomy of qualified health providers to make clinical decisions based on expertise, something SIRA is not qualified to do (APA 2022). Any terminology in the LBP MoC can be utilised to enable insurer directed or 'managed' care and used as a rationale to exclude providers whose clinical decisions or patient preferences opposed such direction.

Paradoxically, whilst SIRA's Clinical Advisory Group reaps the benefit of physiotherapist insight (the only allied health included on this expert advisory), and physiotherapists are deemed qualified to be engaged as independent consultants on behalf of SIRA and are the only physical allied health appointed by SIRA to issue certificates of capacity, patients subject to this revised model will not be entitled to the expertise of a physiotherapist (SIRA 2023a). This contrary positioning of the physiotherapist as capable and competent when on the side of SIRA but somehow not included on the side of the patient reveals a gap in value which patients are being deprived access to, and certainly calls into question that when it comes to low back pain, SIRA are somehow unaware of the core role of a physiotherapist as a primary care provider.

SIRA have confirmed to APA that the replacement of 'physiotherapy' with 'physical therapies' is to allow non-Ahpra regulated exercise physiologists (EPs) to substitute the physiotherapist. Such ill-considered doctoring of the ACI model of care to remove explicit inclusion of physiotherapists has significant ramifications for the health outcomes of patients with acute low back pain.

For patients with acute low back pain (ALBP) under SIRA's scheme, this now means that physiotherapists have been removed from their 'Primary Care Team', which was previously listed as the GP, Nurse and Physiotherapist (ACI 2016), and is now listed as the GP, Nurse and 'treating allied health providers' (SIRA 2023a:1). Patients with ALBP with or without leg pain and deemed medium or high risk of poor prognosis by the GP, could be referred directly to an EP within 2 weeks of the claim or injury as the very first point of care, even in these circumstances of medium to high risk and dubious prognosis (SIRA 2023a). The broad 'allied health' terminology alongside the 'hands off' policy in the MoC provides the facade required for the SIRA direction of care towards a SIRA choice of practitioner who have no evidence as first contact allied health practitioners in general, let alone for ALBP.

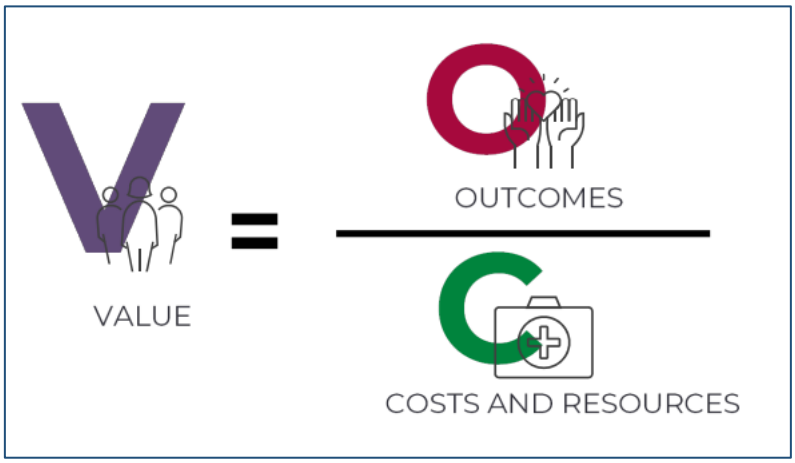
The APA repeatedly requested evidence from SIRA which supports the role substitution of physiotherapy by exercise physiologists in acute low back pain management for medium to high risk patients and have received no such evidence. APA's extensive literature search didn't retrieve any empirical evidence for EP in acute low back pain, and even Exercise and Sport Science Australia's (ESSA) own submission into consultation on this model of care provides no such evidence (ESSA 2023a). The APA is extremely concerned regarding patient access to appropriate, qualified, safe, evidence-based care for patients with acute low back pain.

Reform towards Value Based Health Care

Value Based Health Care (VBHC) must improve both outcomes and costs and must not be used as an excuse to cut costs (Porter and Teisberg 2006). Proposed by Michael E. Porter and Elizabeth O. Teisberg in 2006 as a solution to the overflowing costs amid ambivalent outcomes within United States of America's (USA) health system (Porter and Teisberg 2006), the American import of VBHC has been adopted in the rhetoric of Australian health reform, including in NSW Workers Compensation and Motor Accident Injury Schemes (SIRA 2021).

Whilst there are many complexities in the implementation of VBHC theory in practice, at the high-level, the 'value' metric which VBHC intends to improve is captured by SIRA's VBHC Framework (SIRA 2021), see Figure 1.

Figure 1. The 'value' metric in Value Based Health Care



(SIRA 2021:6)

Thus, a convenient way to increase the VBHC 'value' metric is to reduce costs alone, an approach appealing to some funders who can then reframe cost cutting as improved 'value' based on this specific metric. This approach is not only cautioned, but admonished by the inventors of VBHC who say this shortcut will inevitably lead to poorer quality healthcare for patients (Porter and Teisberg 2006:35). The use of VBHC in monopoly systems (such as under SIRA) is also cautioned as such systems do not allow patients to choose or change funder and thus are 'fatal' environments for patient value which empower hegemonic cost cutting methods (Porter and Teisberg 2006:88-89). Note that SIRA's LBP MoC implementation currently does not even include health outcome measurement to assist determination of the 'value' metric.

Ultimately, the substitution with poorer quality resources inevitably leads to increased long term costs — 'Lower quality does not save money in health care, nor does it in most industries' (Porter and Teisberg 2006:24). The exchange of a physiotherapist with an allied health provider without an evidence-based in ALBP is not true VBHC and does not empower quality. This trade-off is not valuable for patients with ALBP and is in no way reform towards sincere Value Based Health Care where value for the funder must not be retrieved at the cost of outcomes to the patient (Porter and Teisberg 2006).

3. Physiotherapists in the Primary Care Team

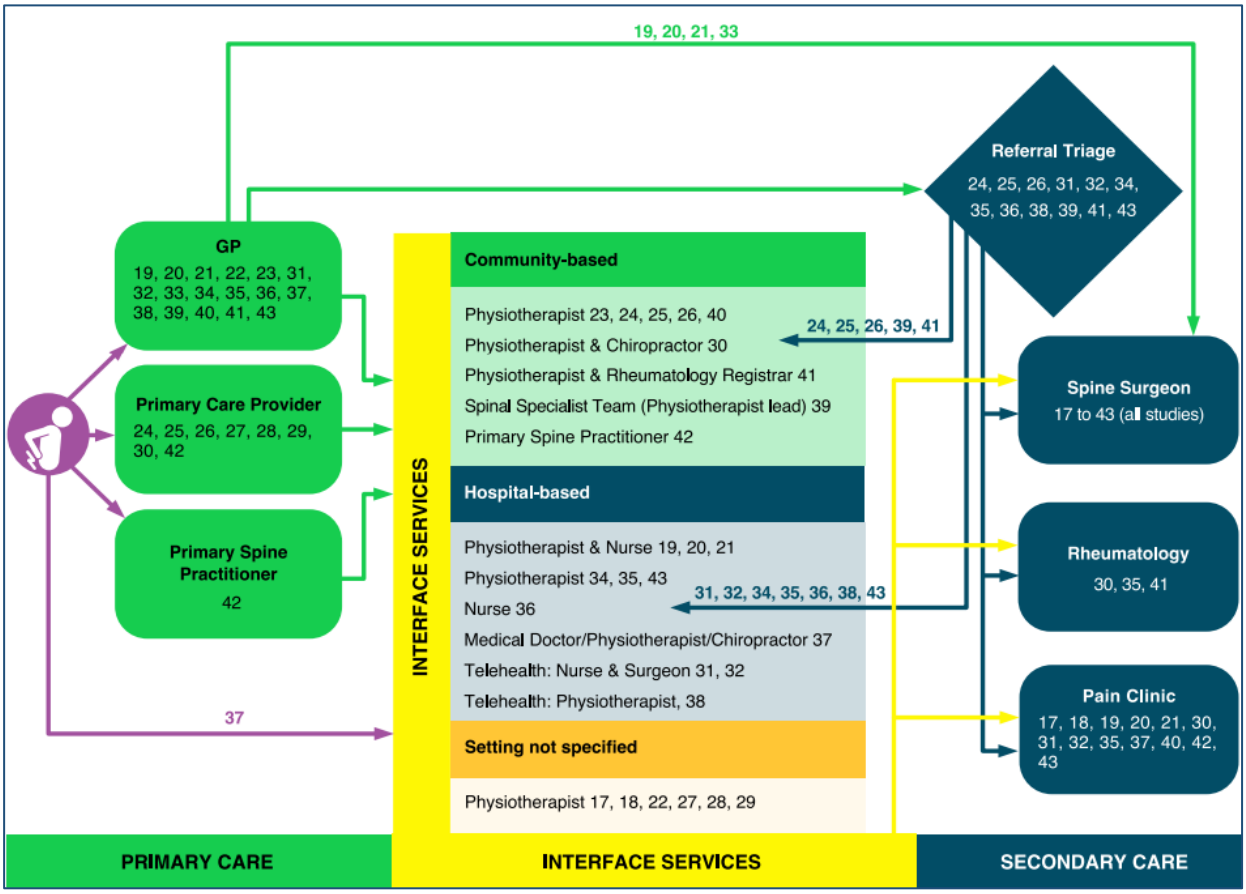
Excluding physiotherapy management is not evidence-based

Physiotherapists are an evidence-advocated, qualified member of the core primary care team in musculoskeletal care for patients with low back pain (ACI 2016; Wan Wambeke 2017; Sahin et al. 2018; Protheroe et al. 2019; Coombs et al. 2021; Bodenheimer et al. 2021; Coeckelberghs et al. 2021; Demont et al. 2022; Murphy et al. 2022; Vader et al. 2022). The scope of practice and knowledge of a physiotherapist enables clinically meaningful medical integration of allied health with General Practice (Bodenheimer et al. 2021), and physiotherapists are the profession who lead management of low back pain in the interface involving the GP and the surgeon or specialist (Protheroe et al. 2019; Murphy et al. 2022). Physiotherapists are formally qualified to perform this role autonomously (Physiotherapy Board of Australia (PhysioBA) 2015), and are the only allied health qualified to do so across all healthcare settings including hospitals (Murphy et al. 2022) and emergency departments (Coombs et al. 2021).

SIRA's removal of the physiotherapist from the primary care team for patients with acute LBP is at odds with broader health reform which, indeed, is trending towards even greater access to physiotherapists for musculoskeletal conditions — exemplified by England's National Health Service (NHS) reform towards First Contact Physiotherapy (FCP) whereby physiotherapy for musculoskeletal conditions will be publicly funded in primary care without a GP referral, for all adults, by 2024 (NHS England 2023). The FCP model has been evaluated as improving outcomes for patients with musculoskeletal concerns (such as back pain) and reducing the load on GP (Goodwin et al. 2021; Stynes et al. 2021) and highlights the perplexing nature of SIRA's approach which could remove the physiotherapist—a clinician who should be promoted not demoted in the management of low back pain (Bornhoft et al. 2019; Bodenheimer et al. 2021; Vader et al. 2022).

Figure 2 provides the infographic output of a recent systematic review of clinical pathways for low back pain which reviewed literature on LBP clinical pathways from 2006 to 2021 and provided evidence of the primary clinicians in the care team (Murphy et al. 2022).

Figure 2. The primary care team in low back pain clinical pathways



(Murphy et al. 2022)

Physiotherapists are overwhelmingly the referred to clinician as well as the major 'Primary Care Provider' in the literature which had non GP first contact (Murphy et al. 2022). In this review, the only other allied health evidenced in the clinical pathway for LBP is a chiropractor (North American literature) (Murphy et al. 2022). This shows that for those referred from GP service, physiotherapists are the main evidence-based choice (Murphy et al. 2022).

Patients with acute low back pain deserve access to physiotherapists — clinicians who understand the complexity of LBP management and that the full scope of care and clinical consideration cannot be replaced by any pre-determined treatment modality.

Recommendation 1: In SIRA NSW Model of Care for the Management of Low Back Pain, p.1, the primary care team members should re-include 'the physiotherapist' explicitly.

4. Physiotherapy and Physical Therapies

SIRA's patients require more consideration, not less

The minimising of the role of a physiotherapist to 'physical therapies', alongside the conflation of physical therapies with general exercise undermines the complexity of care required for patients with acute low back pain, especially those deemed medium to high risk of poor prognosis – the subjects of the changes to SIRA MoC (SIRA 2023a). The exchange in terms indicates that, once screened a single time for 'red flags', the only technical consideration required is the design and delivery of an exercise program. Unfortunately for patients with ALBP, this is not evidence-based (Karlsson et al. 2020; Ijzelenberg et al. 2023).

Amplifying APA concern is the lack of consideration for the specific patient group subject to this model — people who have sustained a workplace or transport accident injury (SIRA 2021). This patient group are known to have poorer outcomes (Royal Australian College of Physicians (RACP) 2022) and poorer satisfaction with the health system (Compton et al. 2019) than those outside a compensable scheme. Injured workers have higher rates of psychological comorbidity (Gray et al. 2023), with the pursuit of workers' compensation coverage itself deemed a risk factor towards mental ill-health (Gray et al. 2019) and increased self-harm (King et al. 2023). For compensation claimants with low back injury, there are even links to higher all-cause mortality (Martin et al. 2020), and higher cause-specific mortality related to increased opioid use (Martin et al. 2020). Evidence advocates for an enhanced and early role of a physiotherapist for compensation claimants (Johnston and Beales 2016; Donovan et al. 2021; St-Georges et al. 2022; Khorshidi et al. 2023) —patients who should not be denied the clinical consideration of a physiotherapist.

Guideline based care and physiotherapy

SIRA's LBP MoC states that it is consistent with the Australian Commission on Safety and Quality in Health Care's (ACSQHC) standard (SIRA 2023a: 2); a set of quality statements which are not inclusive of the full set of clinical considerations required (Maher et al. 2023). That is, one cannot simply pledge allegiance to the ACSQHC standard and then forgo their medical or physiotherapy qualifications — which are in and of themselves standards for healthcare

excellence in Australia. Whilst guidelines and standards for care are a common tool of reform aimed specifically to elucidate care at the 'zoomed out' high level (O'Connell and Ward 2018; Guerra-Farfan et al. 2023), models of care (MoC) aim to elucidate the clinical pathway at the level of clinical encounter and health service (Parambath et al. 2023). These tools (guidelines, standards, models of care) are not direct equivalents of each other (Parambath et al. 2023), and certainly not the equivalent of a physiotherapist or medical qualification. The clinical pathway should be more specific and defined than general guidelines (Rotter et al. 2019). Words appropriate for use at the non-specific high level (such as 'physical therapies') should not be cut and paste into the downstream health service paradigm. As Figure 2 displays, peer-reviewed clinical pathways specifically state referral to 'physiotherapist', not 'physical therapies'.

The implementation of guidance such as ACSQHC's standard relative to SIRA's LBP MoC should be flexible to patient preference (Andri 2021), as well as clinical judgement (George et al. 2021), rather than miss-wielded to refer all patients directly to exercise — representing ecological fallacy which eclipses options for high-value precision in patient-centred care. Because the reduction of low value is often incorrectly positioned as increasing high value, it may be helpful to think of the following analogy — a ten-pin bowler utilising the bumpers (guidelines) is protected from bowling a gutter ball (the lowest value), but this bowler is not any closer to a 'strike' (the highest value), which relies on the training and acumen of the bowler, regardless of the presence of such guidelines. Guidelines should be implemented in such a way that doesn't reduce access to individualised high-value patient-centred care (Van Dulmen et al. 2013) and access to the most qualified clinicians in the care of acute low back pain.

High value care for patients with acute low back pain

Physiotherapy is evidence-based 'physical therapies'

For patients with ALBP, physiotherapists provide a core role compatible with objectives of high value, and first line care should include early referral to physiotherapy to reduce chronicity (Bailly et al. 2021). Physiotherapists are experts in non-pharmaceutical, non-invasive management ('physical therapies') for low back pain and provide patients access to the full scope of consideration and options for evidence-based physical therapies, which, within the context of 'low value' healthcare gives physiotherapists a keystone role in achieving true VBHC. Commonly

dissuaded low value care for low back pain includes over-prescription, over-imaging, over-injecting, unnecessary surgery (Buchbinder et al. 2020), and any therapy which institutionalises the patient in ongoing 'healthcare' with low yield of result or even disutility (Scott et al. 2021). It should be noted that even 'active therapies' such as exercise, when unnecessarily institutionalising of the patient in-rooms (e.g. as opposed to independent exercises) can also be low value care (Zadro et al. 2020). No specific 'physical therapy' modality gets the high value 'blank cheque' and whether or not a certain 'physical therapy' is outcomes-focused is a clinical decision which incorporates an understanding of the evidence base, physiotherapist expertise, and importantly, customisation to the relevant patient presentation.

Patient access to diagnostics

Whilst common discourse frames 'value' in terms of what treatments should be reduced, such discourse neglects that VBHC reform specifically highlights what healthcare should be increased— diagnostic rigour (Porter and Teisberg 2006:26). Diagnostic accuracy is identified as one of the top 'under treatments' which in lieu leads to costly low value healthcare, with harmful ramifications for patients (Porter and Teisberg 2006:26). Diagnostic errors (missed diagnosis, wrong diagnosis or delayed diagnosis (Al-Khafaji et al. 2023)) are the most common, costly and catastrophic of medical errors (Armstrong Institute for Patient Safety and Quality 2023) leading to misclassification of patients who then receive both too much of the wrong care and too little of the correct care (Porter and Teisberg 2006:24).

For low back pain, physiotherapists are autonomously qualified to screen patients and diagnose (PBA 2015) thus affording the interdisciplinary (GP and physiotherapist) assurance of strong diagnostics in the clinical pathway for those with ALBP. In low back pain, commonly missed diagnoses include vertebral fractures (Prost et al. 2021) and ankylosing spondyloarthritis (Riis et al. 2023). The inclusion of the physiotherapist in low back pain management provides a strong care pathway for patients and alleviates the risk of missed, wrong or delayed diagnosis. It also avoids an approach that would see a percentage of patients sacrificed for assumptions related to the broad aggregate.

Physiotherapists are qualified to resolve more for the patient than a binary understanding of back pain as either specific or non-specific (Allegri et al. 2016) and can provide more insight for patients than one-size fits all management. Physiotherapists can provide bio-anatomical insight

(Allegri et al. 2016) (noting that 'anatomise' does not mean 'pathologise' or 'catastrophise'), functional insight (RACP 2022:161), psychosocial insight (Otero-Ketterer et al. 2023), and goal-directed care relative to patient specific needs. It is important that SIRA patients are not deprived of physiotherapist knowledge—

> 'Lack of knowledge or recognition of the common structure specific pain referral patterns, poor clinical reasoning, inappropriate referral and predilection for popular management approaches also contribute to mis-diagnosis and mis-management.' (Monie et al. 2016).

The ability of the physiotherapist to elucidate patient specific pain and functional presentation without use of radiological investigation sincerely enables LBP MoC Principle 3: Only image those with suspected serious pathology (SIRA 2023a:3).

Access to non-pharmaceutical analgesia

In SIRA's LBP MoC, Principle 7 (Begin with simple analgesic medicines) and Principle 8 (Judicious use of complex medicines) recommend pharmaceutical pain management (SIRA 2023a:4). However, Principle 6 includes a 'hands off' policy, reducing options for non-pharmaceutical pain relief, in direct contradiction to enabling care away from over-reliance on pharmaceutical management. For LBP, all drugs should be considered second line management (Bailly et al. 2021), whereas physiotherapy is first line management (Bailly et al. 2021). It is noted that pharmaceutical pain management is funded outside SIRA (via the PBS) whereas manual therapy would be funded at SIRA's expense —this should not be the rationale to exclude options for non-pharmaceutical pain relief for patients with acute LBP in SIRA's scheme.

The censorship of manual therapy from management in acute LBP care is not evidence based (Gianola et al. 2022) — this MoC is unique in removing manual therapy whilst enabling pharmaceuticals and the following guidelines recommend manual therapy for acute low back pain:

- National Institute for Health and Care Excellence (NICE) Low back pain and sciatica in over 16s Guideline: 'Consider manual therapy (spinal manipulation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but

only as part of a treatment package including exercise, with or without psychological therapy' (NICE 2016).

- Australian Commission on Safety and Quality in Health Care (ACSQHC) Low Back Pain Rapid Review Report (the basis for the high-level ACSQHC Standard): 'Using manual therapy' is recommended as 'Consensus' when used as an adjunct therapy (ACSQHC 2020).

Whilst physiotherapy pain management is well beyond manual therapy, within the context of SIRA regulatory powers to direct care, terminology such as 'hands off' could be used to exclude patients from manual therapy care options and thus methods for non-pharmaceutical pain management (Gianola et al. 2022) — strengthening a bias in this MoC policy towards pharmaceutical pain management.

Exercise therapy for acute low back pain

Physiotherapists are experts in exercise (World Physiotherapy 2019) and have been the leaders of therapeutic culture towards active physical therapy, both as major producers of such literature as well as operationalising an active approach in the clinical setting. Such work has led the way for a number of complementary exercise therapists; for example exercise physiologists and clinical pilates professionals, both often working in tandem with a physiotherapist to deliver the exercise program. Physiotherapists devise a management plan which is informed by a clinical impression synthesised from a bio-psychosocial assessment, supported by actively educating the patient and strengthened by a goal directed approach (such as one related to activities of daily living and return to work). Indeed, physiotherapists are the only allied health professional qualified to complete the physical capacity assessment for return to work and certification in SIRA NSW Scheme (SIRA 2022).

However, it is important that the need to reduce low value reliance on passive therapies is not confused with presumptions that exercise will always be appropriate in the acute stage and have no side-effects (Karlsson et al. 2020). For patients post motor vehicle accident or workplace injury, due consideration should be given to their presentation rather than hasty referral straight to exercise programing. Even the ACI 2016 model cautions—

> 'During the initial stage of recovery, guiding the person to resume their normal physical activities should be the physical therapy focus without a separate structured exercise program. There is some evidence that exercise can delay recovery when commenced in the early acute phase'. (ACI 2016)

Active physical therapies constitute more than graded exercise therapy, and for acute LBP, a recent Cochrane review concluded that for ALBP, according to the evidence base, exercise therapy is no better than sham/placebo therapy and no better than no treatment at all (Ijzelenberg et al. 2023). This is not to say that physiotherapists should not utilise exercise management for ALBP, but it is to caution a dogmatic understanding of acute low back pain management which centres around presumptions in what physical therapies are 'evidence based'.

A qualified physiotherapist will be able to take the evidence base as a whole and customise the active management plan relative to their informed clinical impression and the goals of the specific patient.

Precedent exists — changing 'physical therapy' to 'physiotherapy'

If the APA recommendation to re-include 'physiotherapy' is adopted within SIRA LBP MoC, this will not be the first time in which clinical guidance was revised from broad terms such as 'physical therapy' to explicitly state 'physiotherapy' in order to strengthen rigour and meaning in clinical policy. In the recently published 2022 update on the ASAS-EULAR recommendations for the management of axial spondyloarthritis (Ramiro et al. 2023), the guidelines changed from recommendation of 'physical therapy' to 'physiotherapy', with the below cited reason —

> 'The task force under-lined that *physiotherapy* should not be an umbrella term also used for interventions that are not widely tested or have proven benefit' (Ramiro et al. 2023)

And —

> 'After discussion, the task force concluded that 'physiotherapy' is a more appropriate term than 'physical therapy' as used in the previous version of the recommendations and therefore this small change was incorporated' (Ramiro et al. 2023)

This change highlights that ambiguous terms, even those such as 'physical therapy' which are associated with the American equivalent of the physiotherapy qualification (George et al. 2021), leave room for misinterpretation and misrepresentation of the true recommended care.

Confusion regarding broad terminology of 'physical therapy' also underpinned rationale for the international organisation World Physiotherapy to change names from 'World Confederation for Physical Therapy' to 'World Physiotherapy' in 2019 (World Physiotherapy 2023).

Physiotherapy and the physiotherapy evidence base is not an umbrella category for all 'allied health practitioners' (as used in SIRA's revised MoC (SIRA 2023a:1)), of which there are 27 distinct types (Allied Health Professions Australia 2023). No other allied health provider has the evidence, experience and qualified role in low back pain management which physiotherapists and physiotherapy has, regardless of how similar other nomenclature may sound. There is more required in low back pain management than having a name which gets confused with physiotherapy. The terminology of 'physical therapies', a SIRA initiated revision (SIRA 2023a) of ACI's model of care (ACI 2016), risks missorientation of patients, misappropriation of physiotherapy scope, and ultimately the misleading (and potential misdirection) of patients to inappropriate non-evidence based care with consequential impacts for health outcomes and safety.

Recommendation 2: In SIRA NSW Model of Care for the Management of Low Back Pain, replace the term 'physical therapies' with 'physiotherapy' or 'physiotherapist' in Pathway A (Non-specific acute low back pain, p.8) under Medium and High risk patient categories, and Pathway C (Acute low back pain and leg pain, p.10) under Medium and High risk patient categories. This recommendation is endorsed by the Royal Australian College of General Practitioners (RACGP).

Recommendation 3: In SIRA NSW Model of Care for the Management of Low Back Pain, p.3, under Principle 6: Active physical therapy encouraged, amend "Physical therapies will be primarily a 'hands off' approach" to "Physical therapies will prioritise a patient-centred active approach, with or without evidence based and individualised manual therapy."

5. Clinical Safeguards and Patient Safety

In the exchange of 'physiotherapist' with 'physical therapies' in SIRA's LBP MoC, the biggest 'red flag' is the fact that the weakening of terminology also directly weakens access to the protection of patient safety and rights by the Australian Health Practitioner Regulation Agency (Ahpra). Unlike physiotherapists, exercise physiologists are not registered with or regulated by Ahpra and are not even acknowledged under New South Wales law as health practitioners (New South Wales Government 2023). Patients subject to this model are those who have suffered a transport accident or workplace injury with resulting medium to high risk back pain (SIRA 2023a). These patients deserve the right to a 'physical therapies' provider held to the standard of care ensured by Ahpra regulation.

Ahpra is the national regulator for those recognised under law as health practitioners and their main objective is patient safety (Ahpra 2023b). Ahpra ensures that Australia's registered practitioners are suitably trained, qualified and safe to practice, and provide the patients the ability to make complaints and have practitioners investigated for unsafe practice or non-compliance with Ahpra's rigorous Code of Conduct (Ahpra 2023b). Ahpra is completely independent to the APA, whereas exercise physiologists are self-regulated by ESSA (ESSA 2023b). Notwithstanding independent regulation by Ahpra, the APA also advocates that physiotherapists practice within the competency of their qualification (APA 2023a).

As qualified health practitioners, ethically, one of the most important considerations for patient safety is the ability of a health practitioner to discern —'when does this patient need to be seen by someone else?' The ability to know the limits of one's scope assists patients to navigate the health system in a way which retrieves outcomes, prevents lapses in care, and promotes safety. Physiotherapists are medically integrated across all settings and are trained to screen patients, be clinically suspicious of medical masquerades and refer to qualified specialists. Exemplifying an understanding of the importance of scope within physiotherapy, the APA has developed a 'Scope of practice tool' which allows physiotherapists to 'self-test' that their practice is indeed in line with their qualification and competence, for the betterment of patient safety (APA 2023b).

ESSA's submission into SIRA's consultation regarding the LBP MoC states that exercise physiologists should be included in the list of musculoskeletal specialists (ESSA 2023a). The qualification of 'Specialist' is a protected title achieved formally via additional qualification and

its misappropriation and misuse can mislead patients and have serious implications for safety and quality (Ahpra 2023a). In SIRA's LBP Model of Care, 'Musculoskeletal Specialists' are defined as —

> 'Specialist physiotherapists, rheumatologist, spine surgeon or pain or rehabilitation physician. Cognitive behaviour therapy trained physiotherapist and/or clinical psychologist may also be considered for those with medium to high risk (SIRA 2023a:11).'

For patients with ALBP under this MoC, Musculoskeletal Specialists are who the patient is referred to if there is no improvement or worsening symptoms at 6 weeks (SIRA 2023a:4). The definition of Musculoskeletal Specialists within SIRA LBP MoC should remain as it is currently defined to ensure access to the appropriate care at the appropriate time, for the betterment of patient outcomes and safety.

The change of the term 'physiotherapy' to 'physical therapies' within SIRA LBP MoC may seem subtle, but significantly impacts the ability of the clinical pathway to retrieve outcomes for patients in acute low back pain. Patients with ALBP deserve clinical consideration at the highest level of qualification and deserve physiotherapists as part of their primary care team. Health reform should centre value for the patient which provides customised therapeutic attention beyond direct referral to any treatment modality and prioritises diagnostic rigour and patient safety. The APA is passionate about true reform towards value and welcomes further consultation with SIRA towards sincere, outcomes focused, evidence-based Value Based Health Care.

Recommendation 4: The Clinical Advisory Group (CAG) make representations to SIRA regarding inadequacy of reform processes which are performative, hasty, lacking in transparency, and which allow amendments to clinical pathways based on vested interests alone; whether that be those of a lobby group or those of a funder.

Recommendation 5: The Clinical Advisory Group (CAG) make representations to SIRA regarding the role of SIRA regulatory powers to direct service within the Low Back Pain Model of Care; the regulator should not utilise phrasing or terminology within the model of care alone as evidence with which to justify SIRA directed care at the level of any individual practitioner or patient. Such directed care requires more than the evidence afforded by the LBP MoC high level summary document; this caveat should be included as an explicit note on model of care documentation.

Recommendation 6: SIRA engage with APA on true reform towards Value Based Health Care for patients with acute low back pain. The APA welcomes the opportunity to co-design and pilot strong, safe models of care for patients which enable evidence-based access, outcome retrieval and measurement, development of educational resources for practitioners and patients, and adherent implementation of true Value Based Health Care across physiotherapists and their patients with acute low back pain.

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