Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Response to the Medicare Benefits Schedule Review Taskforce Consultation

Presented to the MBS Review Taskforce

November 2015

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation on the Medicare Benefits Schedule Review (the Review).

The APA believes that all Australians should have access to safe, high quality physiotherapy in order to optimise the health and wellbeing of individuals, families, communities, and the nation as a whole.

Given the range of review currently occurring and the complexity of the structures and responsibilities in health, the APA strongly recommends that a whole-of-system perspective be taken when proposing improvements *within* the MBS, with a view to creating arrangements that can be mirrored in other schemes.

Maintenance of universal access and the principles of modern regulation need to guide the Review.

The APA recommends that three rules applying to the whole of the MBS be reviewed and amended. The requirement for a GP referral in order to be able to claim a rebate for a consultation with a consultant medical specialist should be removed, allowing physiotherapists to refer to a range of consultants. The inequities in rebates for some physiotherapist-referred diagnostic imaging need to be removed. The requirement for personal attendance in consultations needs to be reviewed in light of technology that allows synchronous audio-visual contact without personal attendance.

The APA recommends that judicious use of requirements in MBS item codes and descriptors be used to guide quality health practice overall and not only medical practice. For example, the MBS could be reformed to include preclusions, where clinically appropriate, for claiming on some surgery items until such time as the patient has first attempted conservative management of their condition through physiotherapy.

The APA considers it important for a distinction to be made between unexpected variation resulting in rates of claims that are low compared with health need, and those which are unexpectedly high and cannot be justified by health need. Where unexpected variation arises for low access compared with health need, consideration needs to be given to measures that will facilitate improved access.

The APA supports clinician-led reviews of pooled claims data to assess variations in MBS items claimed for similar services, absent of variations accounted for by comparative health need.

The impact of the Review might be measured by reference to the following:

- cost-savings to the health system – a health care system that encourages high-value choices and minimises unnecessary expenditure
- more effective use of health services within the system - conservative management saves money to the hospital sector, reduces waiting lists for surgery.
- decreased patient out-of-pocket expenses at a population level – as a result of direct access to the right health professional, instead of multiple occasions of service.

GP Management Plans are currently low-value because they are overly complex and appear to inconsistently fill their intended role – as part of a process, not a process in themselves. The APA recommends that Treatment Plans should be simplified, and written by the most appropriate care provider (which does not necessarily need to be a GP). Health assessment items also have the potential to represent high-value patient care.

The APA supports a transparent process that incorporates clinical input from a range of health disciplines through the clinical committees being formed as a part of the Review.

Introduction

The Australian Physiotherapy Association (APA) believes that all Australians should have access to safe, high quality physiotherapy in order to optimise the health and wellbeing of individuals, families, communities and the nation as a whole.

The APA believes that this access needs to be both fair and sustainable; that it needs to be grounded both in the best available evidence; and that it needs to be grounded in a considered willingness to invest in emerging opportunities and technologies.

In April 2015, the Commonwealth Minister of Health and Sport announced a program of work to ensure that Australians continue to receive the high quality care and appropriate care they need, as efficiently as possible through the Medicare system. This included the establishment of a Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce).

However, Australia's health system is a complex set of structures and services, in which all levels of government are involved. The different levels of government have different, sometimes shared roles in funding and service delivery, policy formulation and regulation. Australia's health system is comprised of a number of health financing and funding arrangements in addition to the MBS. These include those in Aboriginal and Torres Strait Islander Health, private health insurance, compensable insurance schemes (such as those for Australians who are injured in their workplace or in motor vehicle accidents), national schemes such as the scheme for Australian veterans, and state/territory funded and/or provided health services, including those for people in prison.

The current review of federal/state responsibilities in health offers an opportunity to create a more rational allocation of roles and responsibilities for health that plays to the strengths of each level of government. In the view of the APA, a key role of this review should be to ensure that the operation of the resulting funding programs ensures that Australians do not 'fall through the gaps' between the various programs, and that there is an equity in the way Australians are treated across these programs. The APA believes that it is important for reform to identify aspects of the funding models that work well; and to support their adoption in other schemes so that there is consistency *across* the financing/funding schemes.

As a result, the APA strongly recommends that a whole-of-system perspective be taken when proposing improvements *within* the MBS, with a view to creating arrangements that can be mirrored in other schemes.

Although the focus of the APA's submission to the Taskforce is on improvements *within* the MBS that will facilitate more reliable, just and cost-effective access for Australians who would benefit from physiotherapy, the APA takes the view that the principles that underpin its submission to the Taskforce are applicable to the other financing/funding schemes for health in Australia.

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 12,000 members, some 70 staff and over 300 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.

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Response to the Medicare Benefits Schedule Review Taskforce Consultation

1. Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

The APA supports a review of the MBS.

Some rules and regulations that apply to the whole of the MBS are out-of-date and need review. The APA's position on these will be outlined later in this response. Some descriptors for, and rules that apply to, individual MBS items are also out-of-date, leading to concerns about the value these items have for Australians claiming rebates under the MBS. The APA's position on these will be outlined later in this response.

2. Are there any other principles that must guide the Review?

The maintenance of universal access is the first principle that must guide the Review.

In addition, the principles of modern regulation[1] must guide the Review. These principles include:

- **cost-effectiveness** (e.g. the Review and the structures that it sets in place need to support evidence-based conservative treatment, such as physiotherapy for lower back pain which can lead to a reduction in surgery rates, while achieving good health outcomes)
- **an outcomes-focus** (e.g. the Review and the structures that it sets in place need to support the achievement and reporting of optimal health outcomes and eliminate wasteful expenditure in healthcare)
- **access and relevance** (e.g. the Review and the structures that it sets in place need to provide access to rebates under the MBS and be available when a patient is referred directly from a physiotherapist to a consultant medical specialist)
- **targeted and informed** (e.g. the Review and the structures that it sets in place need to be informed by changes in clinical practice; by review of under/over-use of items; and physiotherapists should provide input to changes in the MBS through clinical committees)
- **transparent and accountable** (e.g. the Review and the structures that it sets in place need to ensure that reviews of MBS claims data are informed by valid and reliable data; clear to the parties involved; and clinician-led)
- **proportionate and responsive** (e.g. the Review and the structures that it sets in place need to ensure that sanctions are fair, and that the MBS responds to innovation)
- **consistent and fair** (e.g. the Review and the structures that it sets in place should allow patients to claim rebates for attendance at group sessions with physiotherapists, as they can for sessions with Exercise Physiologists
- **collaboration and cooperation** (e.g. the Review and the structures that it sets in place should maintain the collaborative model of the current review, such that small changes to specific item numbers can be made without high levels of 'red tape')
- **monitoring and review** (e.g. the Review and the structures that it sets in place should establish streamlined mechanisms for feedback and review).

3. Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

The APA recommends that three rules applying to the whole of the MBS be reviewed and amended – those pertaining to:

- the requirement for a GP referral in order to be able to claim a rebate for a consultation with a consultant medical specialist
- the inequities in rebates for some physiotherapist-referred diagnostic imaging, and
- the requirement for personal attendance in consultations.

Specialist referral

Since the 1970s, physiotherapists have been recognised by private health insurers, compensable schemes and hospitals as primary contact professionals.

The Transport Accident Commission (TAC) has developed a new 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 specialists. This can create a circular referral pattern that delays necessary specialist treatment and creates unnecessary work.

The APA recently commissioned an economic evaluation by Griffith University's Centre for Applied Health Economics and the Deeble Institute to determine the cost of this process of circular referral. The report found that, if patients who were directly referred to a range of specialist medical practitioners by all physiotherapists could receive Medicare rebates, there would be substantial savings:

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

The APA believes that physiotherapy referral to medical specialists is safe and appropriate and makes for best use of physiotherapy skills.

Diagnostic imaging

Direct referral for diagnostic imaging was, effectively, outside the scope of the Griffith University / Deeble Institute study.

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.

The argument used to justify this lower rebate is that if patients of physiotherapists were able to access imaging without consulting a GP, it would have an adverse impact on the consumer, as physiotherapists would be indiscriminate in their use of diagnostic imaging and expose patients to high radiation. However, the 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.[3]

The APA recommends that MBS rules that result in lower rebates for services provided by the same provider be removed as they encourage inefficiency (through the incentive for a physiotherapist to refer the patient to a GP who then makes a referral for imaging), encourage complexity in the patient journey, and are inequitable for patients.

Personal attendance as a prerequisite for a professional attendance

In some circumstances (e.g. Item 2100), the MBS recognises that telehealth is a suitable modality for clinical care.

However, at present,

> "The personal attendance of the medical practitioner upon the patient is necessary, before a "consultation" may be regarded as a professional attendance. … " (Note A1 of the MBS)

Personal attendance can provide a barrier to ongoing care. This includes circumstances where the patient is in a rural or regional location and the expert treating practitioner in an urban location.

The APA recommends that the requirement for personal attendance of the practitioner be reviewed, with a view to broadening the attendance to include circumstances of synchronous audio-visual communication (telehealth) after a personal attendance for initial assessment and where the treating practitioner is satisfied that it is safe and clinically appropriate to provide a 'live' video consultation. This change reflects the rapidly changing digital landscape, especially for Australians (both patients and health professionals) in rural and regional locations.

4. Are there alternative solutions to deliver the original intent?

A fee-for-service model is suitable for episodic care and for targeted screening continues to be appropriate for Australians who present with straightforward, episodic health issues.

The APA recognises that innovative funding models for community-dwelling Australians who have complex and chronic health conditions is outside the scope of the Taskforce's remit.

The APA supports the work of the Primary Health Care Advisory Group, as it addresses these issues. The innovative models could include:

- packages of service for people with more complex conditions
- capitated payments for particular conditions, and
- more flexible access, possibly based on a fee for service, for people with lesser healthcare needs.

Funding models should support GPs to provide the best level of care possible and the same should be true for the funding of physiotherapy services. Access to physiotherapy services should be based on patient choice and physiotherapy assessment, not only on GP assessment.

Additionally, the APA recommends that the Commonwealth government undertake a review of the Aged Care Funding Instrument (ACFI), which underpins the provision of a range of health-related services in residential aged care.

5. In amending any existing rule/s, are there any potential adverse impacts on consumers, providers or government?

The APA has considered the likelihood of adverse impacts (e.g. reductions in patient safety and increases in unnecessary costs) of amending rules. The APA's recommendations maintain safety and reduce unnecessary costs.

6. Should the role of the MBS be simply that of an administrative tool, or should it be used actively to guide quality medical practice?

The APA recommends that judicious use of requirements in MBS item codes and descriptors be used to guide quality health practice overall and not only medical practice.

For example, the MBS could include preclusions, where clinically appropriate, on claiming for some surgery items until such time as the patient has attempted conservative physiotherapy for their condition.

In a recent public hearing on chronic disease prevention and management in primary health care, the Standing Committee on Health was provided the example that at least 10 per cent of joint replacements are avoidable. In this example, it was estimated that a reduction in government expenditure of around $200 million per annum could be made by providing a multidisciplinary program for people with hip and knee osteoarthritis. This sort of program can be delivered for around $750 per person, compared to a joint replacement, which costs $25,000.[4]

Additionally, the inclusion of new items in the MBS and the alteration of descriptors or removal of items can play a role in guiding quality health care.

Being primary contact professionals with excellent communication skills, physiotherapists can focus on early intervention to flag preliminary signs of chronicity and to prevent acute and sub-acute conditions from developing into chronic pain.[5] In line with international evidence of cost-effectiveness, the APA submits that the MBS should fund physiotherapy consultations for musculoskeletal issues, knee osteoarthritis, lower-back pain, and female stress urinary incontinence, as there is a strong evidence base to support physiotherapy treatment to prevent surgery in future ***(Please refer to Appendix)***.

Finally, the structure of rebates can assist to guide quality health care. The structure of rebates for existing attendance items can act as a disincentive to spend sufficient time with a range of populations who have greater health needs (e.g. people with a disability, people with mental health issues not seeking a consultation with respect to their health concerns, and people whose preferred language differs from that of their health practitioner). The APA recommends that consideration be given to the adverse impact of rebate structures on these important consultations, with a view to establishing a scheme that promotes quality for less advantaged populations.

7. What can be done to reduce unexpected variation in the MBS items claimed for similar services?

The APA considers it important for a distinction to be made between unexpected variation that results in claims levels that are low compared with health need, and those which are unexpectedly high in a way that cannot be justified by health need.

Where unexpected variation arises for low access compared with health need, consideration needs to be given to measures that will facilitate improved access.

The APA supports clinician-led reviews of pooled claims data to assess variations in MBS items claimed for similar services, absent of variations accounted for by comparative health need. This review process can predict common servicing patterns for particular conditions or injuries and bring up anomalies in claims data, which can be used to inform strategies to reduce unwarranted variation. If anomalies are identified in service profiles of particular health practitioners, the APA advocates for transparency as an important principle of the review. Health practitioners should have visibility of their service data to better understand identified variations and to inform future practice going forward.

It may be important for the drivers of the variation to be addressed outside the mechanisms of the MBS if they relate to factors such as workforce (mal)distribution, for example.

8. How can the impact of the MBS Review be measured?

The APA supports that there should be no savings target and that the review should focus more on how to get more value out of healthcare spend, to support best clinical practice.

The APA acknowledges that the impact of the MBS Review may be difficult to measure.

The APA has reservations about using reductions in MBS-related expenditure as a stand-alone measure. This is because the economic benefits of the MBS Review may be found outside the MBS. For example, as a result of MBS reforms, more may be spent on physiotherapy but if this occurs in the way recommended by the APA, the costs will be more than offset by a reduction in the number of surgical events. The impact of this will not be seen in the MBS.

The impact of the Review might be measured by reference to the following:

- cost-savings to the health system – a health care system that encourages high-value choices and minimises unnecessary expenditure
- more effective use of health services within the system - conservative management saves money to the hospital sector, reduces waiting lists for surgery.
- decreased patient out-of-pocket expenses at a population level – as a result of direct access to the right health professional, instead of multiple occasions of service.

9. What implementation issues should be considered when amending or removing MBS items?

As the MBS is, principally, a mechanism for subsidising consumers when they pay for health services, the APA believes that it is critical to ensure that accessible consumer information is provided at the point of implementation of any changes.

As clinicians and their teams will also be directly impacted by any changes to claiming rules, it is also essential that information be provided to clinicians and their teams. Evaluation of impact should also be considered prior to implementation so that any data required is incorporated into routine data collection.

To ensure that the MBS is properly managed into the future, clinical input and feedback will be necessary to flag any concerns to current items and keep pace with innovation to ensure the MBS schedule is relevant for current practice.

10. What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

The APA suggests that three activities will make it easier for clinicians and consumers to understand the MBS and apply the rules and regulations correctly.

Firstly, consistency between the rules within the MBS and rules in other major health insurance schemes (e.g. motor vehicle accident and workers' compensation schemes) will assist.

Secondly ongoing education is necessary, especially for new graduates. Education should support health professionals to use their clinical judgment to assess the number and type of interventions required to provide person-centred team care.

Thirdly, social and/or mass media campaigns targeted at particular items or populations (e.g. access to health assessment items by people with intellectual disability) will assist.

11. Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as a priority?

GP Management Plans are currently low-value because they are overly complex and appear to inconsistently fill their intended role – as part of a process, not a process in themselves. The APA recommends that Treatment Plans:

- should be simplified, and
- written by the most appropriate care provider (which does not necessarily need to be a GP).

Case Study

Recently my youngest son, Justin, was referred to an occupational therapist and it was suggested that a CDM plan would be helpful. My wife took him to a GP who did not know about, or was not interested in setting up the plan. She tried a second GP who told my wife that their clinic did not know how to fill out a Treatment Plan, but made an appointment for my wife and son to see a practice nurse the following day.

My wife (who is a speech pathologist working with children with a range of disabilities in a primary care setting) had to talk the nurse through completion of the form. It is frustrating that the process took three Medicare funded visits, hours of my wife's time, and Justin got no clinical benefit from his three visits to the medical practices.

The APA submits that an effective primary healthcare system should fund the most appropriate care provider to complete the CDM Treatment Plan, assess the child's clinical needs and start treatment immediately.

12. Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

The APA submits that a greater focus should be placed on Aboriginal and Torres Strait Islander health services (item number 81335), as this MBS item is high-value for a key demographic group but is chronically under-utilised.

Aboriginal and Torres Strait Islander peoples have a far greater risk of disease – specifically diseases of the nervous, digestive, musculoskeletal, respiratory, and genitourinary systems[6] - and injury, and their life expectancy is far lower than that of other Australians.[7] In 2014, Indigenous peoples had a high prevalence of circulatory problems (26%), as well as endocrine, metabolic and nutritional disorders including diabetes (9%) and respiratory diseases (8%).[8] There is a significant body of evidence relating to the effectiveness and cost-efficiency of physiotherapy in the management of chronic conditions such as these.[9]

Despite the potential for physiotherapy to improve health outcomes for Indigenous Australians, there are major gaps in access to physiotherapy services through the MBS.

This MBS item number is chronically underused and one major reason for this is that GPs are not clear on the requirements of entry to this program, hence this program has had extremely poor uptake. Another problem with the Indigenous health service program is that 'Indigenous status' is not always identified in health practices, so many Aboriginal and Torres Strait Islander peoples may not be identified as eligible for the Medicare rebates under this program. Furthermore, there is a lack of GP services in rural and remote areas of Australia, where Aboriginal and Torres Strait Islander peoples primarily reside.

Health assessment items also have the potential to represent high-value patient care. This occurs when the items are used consistently over time as part of a process (rather than as a process in themselves). The assessment process can identify important opportunities for physiotherapy care. As these items are targeted at groups which are likely to benefit more from this comprehensive assessment it is important that barriers to use in groups such as people with intellectual disability and recent humanitarian entrants are overcome.

13. Are there rules which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care?

The rules which apply to the item number 10960 *Chronic Disease Management* need to be amended. The program lacks flexibility because:

- Only a GP practice can write a plan, despite the suitability of other primary contact health practitioners to do so. For example, a physiotherapist for an older person who has had falls due to osteoarthritis, or a paediatrician for a child with cerebral palsy.
- Care plans are difficult to change once they have been written, despite the propensity for patients to improve or decline depending on their circumstances.
- The CDM program allows for just five allied health services per year, more than a patient who is motivated to self-manage their condition might need, but far less than a truly complex patient requires.
- The CDM program provides for only one consultation model – prolonged consultations or consultations in the home are outside scope
- GPs are compensated well for their role in managing care and completing Medicare paperwork, but physiotherapists and other allied health professionals are not acknowledged or paid for writing mandatory reports or coordinating care.
- Communication lines are vital for connection of care, and two-way communications are not a feature of the CDM program.
- Physiotherapists are limited to individual 1:1 treatment sessions (No group item numbers are available for physiotherapy unlike the schedules for other schemes such as workers' compensation and motor vehicle accident schemes).

14. Do you have any comments on the proposed MBS Review process?

The APA supports a transparent process that incorporates clinical input from a range of health disciplines through the clinical committees being formed as a part of the Review. Clinical committees should comprise medical and allied health practitioners to review the available evidence base, to analyse clinical case studies and to provide recommendations on eliminating wasteful expenditures in the MBS to maximise the affordability and quality of care.

The APA has prioritised the involvement of physiotherapists to the following Clinical Committees:

- Allied health (includes currently funded chronic disease management services)
- Diagnostic imaging (includes nuclear medicine and bone densitometry)
- Gynaecology
- Indigenous health
- Neurology (includes neurosurgery and interventional neuro-radiology)
- Orthopaedics
- Pain management
- Rules and Regulations Committee
- Spinal surgery
- Thoracic medicine (includes sleep medicine and thoracic surgery)

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Appendix

Allied health management for health conditions to avoid surgery

With the establishment of the Medical Services Advisory Committee (MSAC) in 1998, Australia became the first country in the world to adopt a national evidence-based approach to the public funding of health services. To support this international best-practice model, the APA submits that the MBS should fund physiotherapy consultations for musculoskeletal issues, knee osteoarthritis, lower-back pain, and female stress urinary incontinence, as there is a strong evidence base to support physiotherapy treatment to prevent surgery in future.

- **Knee osteoarthritis** - physiotherapy has been recommended in a number of international guidelines, including the guidelines of the American College of Rheumatology (2000), for the management of knee osteoarthritis[10]. Clinical guidelines also recommend the use of a *transcutaneous electrical nerve stimulator* (TENS) machine for relieving pain. Evidence also supports that knee taping appears to be beneficial when applied by a trained physiotherapist, and has been proven effective in immediate and short-term reduction of knee pain in OA patients[11].
- **Lower back pain** – A combination of physiotherapy interventions, including manual therapy, specific exercise training, and education focusing on the neurophysiology of pain has shown to be effective in producing functional and symptomatic improvement in patients with chronic low back pain[12]. Intensive rehabilitation programs led by physiotherapists have shown to be as effective as spinal surgery in improving outcomes for patients with chronic low back pain (LBP) and are associated with lower costs. Exercise therapy has also shown to be effective for patients with sub-acute (6–12 weeks) and chronic (> 12 weeks) low back pain[13]. There is also evidence to support specifically water-based exercise therapy, which has been shown to be effective in treatment of rheumatic conditions and chronic low back pain, as it improves function, self-efficacy, joint mobility, strength and balance[14].
- **Female stress urinary incontinence -** Physiotherapy treatments for FSUI can include instructing patients in pelvic floor exercises to strengthen muscles, electrical stimulation, real time ultrasound and biofeedback (teaching patients to control involuntary body processes to improve health). A 2005 study published in the Australia and New Zealand Journal of Obstetrics and Gynaecology, found that 82 per cent of women were cured of FSUI after one episode of physiotherapy care[15]. A further outcome of the study, which has been published in the Australia and New Zealand Journal of Public Health[16], found that physiotherapy management of FSUI cost on average $302.40 while surgical management costs between $4668 and $6124. Additionally, surgical management would require greater workforce contribution by specialist surgeons, anaesthetists and additional nursing and health support staff.

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