Direct Access and Physiotherapy Service Implementation in South Africa

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‘To present evidence for the effectiveness of direct access and service implementation with an emphasis on how services are implemented’

- Very little evidence for effectiveness from South African studies but
- Remarkable concord in our experiences & research conclusions reported from other countries!
- Not direct access any other African country
Summary of presentation

- Current population and PT statistics
- Implications of FLPS we realise
- Advantages of FLPS we market
- Challenges of FLPS we have to negotiate
- Conclusions on Sustainability and Credibility of Direct Access/FLPS
Physiotherapy services in South Africa - 2009

- SA population: about 50 million
- 5683 PTs registered at HPCSA = 1 PT for 9 million
- 3687 SASP members = 1 PT for 14 million
Physiotherapy services in South Africa - 2009

- SASP represent 64.8% of all registered PTs
- Private sector members: 2237 (60.7%)
  - Owners: 1414 & employed: 823
- Total working in public sector: 891 (24.2%)
  - Public sector members: 499 [570 employed in public sector]
  - New graduate members: 378 Community service physiotherapists [Compulsory to be licensed to practice]
  - Assistant members: 14 [294 employed]
Physiotherapy services in South Africa - 2009

- 2237 (60.7%) SASP member PTs serve 16% = 7 million people with private health insurance
- 891 (24.2%) SASP member PTs serve 84% = 43 million, in public health care facilities
- SA Government recently proposed a National Health Insurance Plan incorporating ALL health services
‘First Line Practitioners Status’ in South Africa - History

- The South African Society of Physiotherapy was born in 1924 = 85 years old!

- Physiotherapists were officially recognised as First Line Practitioners in 1985 = by the South African Medical and Dental Council.
‘First Line Practitioners Status’ in South Africa - History

- 13th General Meeting of WCPT, June 1995: Declarations of Principle of Autonomy and of Principal of Private Practice:

  - Individual Physical Therapists have the freedom to exercise professional judgment within the limits of the therapist’s prevailing knowledge and competence.

  - Their professional decisions cannot be controlled or compromised by employers, persons from other professions or others.
‘First Line Practitioners Status’ in South Africa - History

In 1997 legal status was re-confirmed for SA Physiotherapists when the Physiotherapy Board of the HPCSA, further verified the first line practitioner status of physiotherapists upon request from the SASP.

- These rules and ruling again provided support for
  - direct access of physiotherapists by patients
  - clinical autonomy of physiotherapists to diagnose and treat patients within their scope of practice.
- Legally and ethically acceptable for a patient to approach a physiotherapist for treatment without intervention of another health care practitioner.
‘First Line Practitioners Status’ in South Africa - History

- SASP Position Paper was tabled in 1998:
  
  THE FIRST LINE PRACTITIONER STATUS OF SA PHYSIOTHERAPISTS

- A First line status practitioner is a person who
  - can make an independent diagnosis
  - can treat such a condition, provided it falls within his / her scope of practice
  - Can refer on if the condition falls outside their scope of practice or if other investigations seem necessary

→ is autonomous in professional decision-making
‘First Line Practitioners Status’ in South Africa - History


- All physiotherapists registered with the Health Professions Council of South Africa are considered first line practitioners, working in open and equal partnership with medical and other health care practitioners, in the care of their patients.

- The following was highlighted in the position paper:
  - Principle of private practice
  - Implications of FLPS

Principle of Private Practice.

- No impediment to physiotherapists in a service delivery system designated as private practice = individual therapists contract to deliver services to the public in accord with Government health care policies or market forces.
- Methods of payment determined by Government health care policies or market forces [Health Insurance Schemes and SASP being involved in negotiations on behalf of members]
- Physiotherapists not to be employed by anybody but another PT, the state & universities – not by medical practitioners, medical insurance groups or other service providers

‘Physician-owned physical therapy services stop competition for the private practitioner, and POPTS stop consumer choice. Sandstrom’, 2007
‘First Line Practitioners Status’ in South Africa: SASP Position Paper 2008 [Revised]

IMPLICATIONS

1. ‘Independent judgment’
   - Professional discretion to make a diagnosis and present alternative solutions
   - Physiotherapists practice and work in association with the patients’ medical team and may refer patients for X-rays, to a specialist, write and issue sick notes & administer prescribed medicine.
   - Physiotherapists evaluate and treat or refer patients in their own right, within their scope of practice
   - FLPS physiotherapists carry a great deal of responsibility, i.e. physiotherapist’s control and are responsible for their own practice.

IMPLICATIONS

2. Autonomous practice: Autonomy of action is based on
   1. Professional standards
   2. Social organisation
   3. Advanced knowledge and skill

Sandstrom 2007: ‘Autonomy is a negotiated, social contract between a profession and policy elites based on the public trust in a profession to act in the best interests of the society. A core purpose of professional autonomy is to preserve the individual autonomy of people’.

IMPLICATIONS

2.1 Autonomy of action is based on professional standards:

- Practitioner’s own predisposition
- Attitudes of colleagues (peer review)

General criteria:

- Commitment to public good
- A distinctive attitude to professional work
- Judged by the standards of the profession
- Good working relationships between related and/or allied professionals
- A specific code of conduct.
- Fiduciary (trust/confidential/reliance) matters
- Honest and disinterested following of vocation
IMPLICATIONS

2.2 Autonomy of action requires social organisation:

- A body that protects the public from professional misconduct and malpractice; guides entry into, and qualifications of the profession = HPCSA
- A body that protects the professional by acting as the authoritative voice in technical matters, protection for its members, guarding their interests (politically, socially, and legally) = SASP
- Responsibility of the profession of self-regulation [peer review system]
IMPLICATIONS

2.3. Autonomy needs **Advanced Expertise**

- Based upon a substantial body of advanced theoretical knowledge and skill built from intake to continuing professional development
- Professional and legal obligation to update this knowledge and to keep abreast of new developments
- Knowledge-base should be substantiated by research.
Advantages of FLPS in South Africa:
Advantages of FLPS in South Africa:

1. Primary Health Care

- Private practitioners naturally act in the field of Primary Health Care
  - Patients often ONLY see a physiotherapist for problem, eg
  - Also a strong referral base, eg

- Public Health practitioners work both in Primary, Secondary and Tertiary Healthcare settings with direct access, as well as referral from specialist clinics to OPDs
Advantages of FLPS in South Africa: 2. Therapeutic effectiveness

- Appropriate diagnosis, timing and care for the condition at first contact [prevention?]
  - Early appropriate intervention acute injuries
  - Immediate follow-up with rehabilitation
  - Bio-psychosocial approach; pain physiology
  - Lessen chronicity & disability

- SA Low back pain study: Pilot of 50 patients: Louw et al, 2009;
- Jette et al, 2006; Aiken & Mccoll, 2008:
- Nova Scotia Physiotherapy Advisory Group
Advantages of FLPS in South Africa: 3. Cost effectiveness

- Cost-effectiveness
  - In private health care
  - In public health care
- Patient satisfaction

SA Low back pain study: Louw et al 2009. Average of ZAR827.90 [US$100] for treatment series of 4-8 treatments to clear acute LBP [Trial study 50 subjects].
Advantages of FLPS in South Africa:

4. Professional power

- Strongest Ancillary Health Group registered with our Health Professional Council
- Direct agreements with Road Accident Fund
- Direct discussions with the "The Compensation for Occupational Injuries and Disease Commission"
- Direct discussion with medical insurers about physiotherapy benefits
- Direct approaches by medical insurers for a plan to decrease hospital and surgery costs in LBP by a PT rehabilitation protocol
- Direct involvement in talks to government regarding the proposed National Health Insurance Plan
Challenges to Direct Access/FLPS
Challenges to FLPS in South Africa: Financial

- Some Medical Insurers still demand referral from medical practitioners
- Some Medical Insurers prescribe treatment protocols
- Some medical specialists have prescribed protocols and ‘holistic ‘plans forced on patients
- ‘Group’ employment puts pressure on private practitioners
Challenges to FLPS in South Africa: Diagnostic

- Diagnostic issues: Terms, words
  - Medical professionals diagnose with medical terms
  - Physiotherapists clinically hypothesize movement dysfunctions and resultant disability
  - Patients/Medical Insurers confused

- Coffin-Zadai, 2006
- Dutch Study 2006:
Challenges to FLPS in South Africa:
Levels of qualification

- ‘Just qualifieds’ vs. Clinical experience and expertise
- Generalists vs. Specialists – Currently no specialisation process for PTs in SA. SASP started with APDL membership of Special Interest Groups
- Preferred Provider Status not based on qualification and accreditation, but on negotiated tariffs
Challenges to FLPS in South Africa: Evidence-based practice

- Medical specialists have prescribed protocols
- In-hospital PT often no evidence for need but prescribed by surgeons
- Guidelines often exclude PT
Challenges to FLPS in South Africa: Insularity

Sandstrom 2007: Insularity = the inward focus of a profession that blinds itself to broad and significant social concerns in favor of its own narrow agendas. The profession should be able to do rational re-organization when societal priorities change.

• Profession needs to be sensitive for current social needs,
  • HIV Aids
• Professional needs to be sensitive to and pro-actively involved in multi-professional management of conditions, e.g.
  • Pain conditions; LBP
  • Respiratory conditions
  • Chronic diseases
  • Post-surgical in-hospital PT treatment
Conclusion

For sustainability and credibility of Direct Access, the Physiotherapy profession needs to constantly develop and groom certain concepts of autonomous practice.
For sustainability and credibility

1. Not to be an isolated profession
Successful autonomous practice requires:

1. To be part of MAINSTREAM Healthcare Service
   - **Dedication to Public Health**, embracing and contributing to the advancement of accepted public health initiatives, in cooperation with others involved in public health.
   - **Clear identity and purpose** to fill a need in the society, providing society with services that people actually want and need.
   - **Communication to policy makers** - ability of PTs to address, in a cost-effective manner, the impairments and functional limitations of people who are experiencing disability [Struber 2004]
For sustainability and credibility

2. Fidelity to the Social Contract
Successful autonomous practice requires

2. Fidelity to the Social Contract

- A profession’s members “profess” to have knowledge that the laity do not comprehend.
- Based on this asymmetry of knowledge, society has granted to the professions a certain degree of autonomous control over themselves.
- Lay persons put their faith in the professional.
- This social contract demands that each profession, and each professional, place the wellbeing of society and the patient/client ahead of the profession and professional.

Murphy et al 2008
For sustainability and credibility

3. Keeping up to date with political, social and health changes
Successful autonomous practice requires: ‘Keeping up’

The profession to be seen as valuing ‘prevention’ and ‘health promotion’

- *Health in addition to ill health.*
- *Not only diseases but also lifestyle conditions, Epidemiological evidence and health care trends.*
- *Minimize the harm of the illness care system*
- *Actively promote health and wellbeing, and prevention, while promoting quality of life rather than merely survival* [Dean 2009]
For sustainability and credibility

4. Assurance of adequate training
Successful autonomous practice requires: Assurance of adequate training

- Adequate training for diagnosis and differentiation
  - Professional entry education is a major determinant of the shape of direct access service
  - ‘If we wish to be regarded as proactive, professional world citizens, and with the capacity to determine our own future, then we must ensure our future graduates receive relevant education to facilitate achievement of this new direction’  [Higgs et al 1999]
For sustainability and credibility

5. A solid scientific base
Successful autonomous practice requires: A Solid Scientific Base

- Clinical Guidelines with an evidence-base, including multiprofessional management
- Reliable Patient-related outcome measures
- Evidence-based position papers on issues like
  - Cervical manipulation
  - Ethical issues [Informed consent; Professional conduct]
  - Access to & Affordability of Physiotherapy services
  - Inter-professional teamwork
For sustainability and credibility

6. Acceptance of responsibilities & address of challenges of autonomous practice
Finally we need to accept the responsibilities and address challenges of autonomous practice

1. How does EBP effects professional autonomy?
2. How does EBP effect client autonomy?
3. How does ‘red tape from the top’ effect professional autonomy?
4. How is teamwork possible between autonomous practitioners?
5. How should we advocate professional autonomy in all fields of direct access practice?
I Thank you............

Soccer World Cup South Africa 2010!!