

Victorian Allied Health Workforce Research Program

Physiotherapy Workforce Report

July 2016

Physiotherapy Workforce Report

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Abbreviations and acronyms

ACFI	Aged Care Funding Instrument
AH	Allied health
AHA	Allied health assistant
AHOMT	Allied Health Organisation Mapping Tool
AHPRA	Australian Health Practitioner Regulation Agency
AHWQ	Allied Health Workforce Questionnaire
AIHW	Australian Institute of Health and Welfare
APA	Australian Physiotherapy Association
CPD	Continuing professional development
ED	Emergency department
EFT	Equivalent full time
FTE	Full time equivalent
MSK	Musculoskeletal
NDIS	National Disability Insurance Scheme
NFP	Not for profit
OR	Odds ratio
PBA	Physiotherapy Board of Australia

Executive summary

Overview

This report provides an overview of the physiotherapy workforce in Victoria in 2015 - 2016. It is based on survey responses from 1,037 individual physiotherapists (approximately 15% of the physiotherapy workforce identified by the Australian Institute of Health and Welfare (AIHW) or 15% physiotherapists registered with the Physiotherapy Board of Australia), three focus groups involving 17 participants, and surveys from 73 organisations providing services across 299 different locations or sites.

Female and older employees were over-represented in the survey sample compared to 2016 registration and 2015 workforce data. It is also likely that public sector practitioners are over-represented, however accurate comparisons of employment sector are not available. Where appropriate, issues of representativeness have been addressed through detailed subgroup analyses.

Key findings

Physiotherapists	Survey	AIHW, 2015 ^a	PBA, 2015 ^b
Victorian population	1,037	6,835	7,026
Female	81%	67%	68%
Aboriginal and / or Torres Strait Islander	<1%	0.2%	
Australian trained	90%	85%	
Age 30 years and under	29%	Not able to calculate	
55 years and older	14%	11%	
Median age (years)	37	34	
Median income / annum	\$60,000- to \$69,000		
Public sector			
Private sector	16%	55%	
Not for profit sector	6%		
Principal area of practice	Musculoskeletal (MSK) – 62%	MSK – 47%	
Clinical stream	Rehabilitation – 43%		
Reporting advanced scope of practice role	14%		
Work with allied health assistants	62%		
Reported use of telehealth	7%		
First qualification to practise	Bachelor degree – 74% Honours degree - 7%		
Hold PhD	3%		
Intention to stay in profession for more than 5 years	73%	17%	
Work for two or more employers	27%		
Of those with supervisor, physiotherapist as supervisor	74%		
% of workforce primary role in non-metro	23%		

^a Source: Australian Institute of Health and Welfare (AIHW) 2016;

^b Source: Physiotherapy Board of Australia (PBA), 2016

The picture of workforce supply and demand for physiotherapy was mixed. As with other allied health (AH) professions, there has been a rapid growth in new graduates entering the physiotherapy profession, (AIHW, 2016) and increasing competition for jobs, particularly in the public sector. Despite this, there is anecdotal evidence of substantial unmet demand for physiotherapy services in the community.

Some advertised physiotherapy positions receive more than 50 applications. Yet around 50% of organisations said that they experience shortages of physiotherapists across lower and higher grades and vacant senior positions can take more than six months to fill. Indicators of workforce shortages include lack of services, service rationing, long waiting lists, increased delegation to AHAs and physiotherapists appointed at grades higher than their levels of skill or qualification.

To ensure effective patient outcomes, AH services require, at a minimum, sufficient staff to meet patient demand and provide backfill for absent staff. Further, having adequate staffing capacity to meet demand, provide backfill and enable CPD, project and research capacity, further enables services to plan, innovate, and create longer term solutions to better meet community health need, provide patient centred care and improve outcomes and health service efficiencies.

Physiotherapists identified a number of advanced scope of practice roles which were being performed by 14% of the workforce. Further advanced scope opportunities were available in referrals, diagnosis and treatment. Supportive funding models and more flexible ways of working (by all professions) will be required to fully realise the potential opportunities presented by advanced scope roles.

The self-reported attrition rate from the physiotherapy workforce is 2% in the next 12 months increasing to 27% in five years. Approximately 15% of physiotherapists propose to change their job within 12 months. The majority of participants said that they were moving to take up better job opportunities, better pay or better working conditions.

Recruitment and retention of physiotherapists was more challenging in regional, rural and some outer metropolitan areas than in inner-metropolitan regions. Rural and regional employers face challenges including competition for staff with metropolitan employers, perceived lack of career development and continuing professional development (CPD) opportunities, as well as the more generalist nature of the work. Regional university training courses were seen to increase rural physiotherapy capacity and keep clinicians in regional/rural areas.

Some organisations fund physiotherapy positions on short term, temporary or part-time contracts which are less attractive from a recruitment perspective.

AHAs are recognised as a way to increase physiotherapy service capacity and were utilised by 72% of the public sector and 9% of self-employed physiotherapists responding to the survey.

There is some evidence of innovation in the use of telehealth in the delivery of physiotherapy services. A small number of respondents (3%) were using telehealth in direct service delivery to support patient handovers, to undertake remote consulting in speciality areas, and to support clinical research. This may be an area of potential growth and opportunity for the profession.

Leadership from senior roles is necessary both to build advocacy on behalf of patients and the profession and to provide governance structures for more junior staff, regardless of their employment location. There are relatively few senior physiotherapy positions. Yet some organisations expressed challenges recruiting to senior physiotherapy roles, suggesting a lack of succession planning within the profession.

Workforce capacity development and career advancement of the physiotherapy workforce requires access to CPD, particularly in rural areas. Other enablers include support from management, time, funding and availability of appropriate CPD. Failure to provide these enablers limits clinicians' ability to access further training which would provide career opportunities and advance the profession in its ability to meet community health need.

The physiotherapy workforce is highly qualified: around half of all physiotherapists have or were studying for post-graduate qualifications and 25% bring skills from a previous career. These additional qualifications present potential untapped opportunities to enhance workforce capacity.

Physiotherapists working in private practice highlighted specific difficulties around recruitment, particularly in rural areas, and the challenges paying staff at a level equivalent to public sector pay, while covering the costs and burden of running a small business.

Physiotherapists have a high level of career satisfaction. While most are satisfied with the type of work they perform and the clients they work with, they would like to see improvements in their pay, professional development and career advancement opportunities. Physiotherapists are motivated by achieving a positive work/life balance, the type of work they do and clients they work with, and by having access to professional development opportunities.

There was a suggestion that the physiotherapy profession should aim to attract students on the basis of their interpersonal skills and a desire to work with people, rather than academic ability. More appropriate marketing to prospective students may influence their ultimate career satisfaction and retention.

There were no systemic skills gaps identified within physiotherapy, however several organisations identified specific skills that would be of benefit locally, including a mixture of clinical skills, knowledge of the health system, and supervision skills. Improved access to CPD may be a way to resolve several local skills gaps.

New roles are emerging for physiotherapists to work alongside other health professionals in specialised areas such as oncology, diabetes care and back pain as well as interdisciplinary roles. Work needs to be done to further define these roles and build the necessary skills in the workforce to take them on.

Conclusions

Key areas of consideration for the physiotherapy workforce going forward include:

- Developing metrics of community need/demand for physiotherapy services.
- Increasing evidence and knowledge base of the professions models of care to improve referrals and business cases for optimal staffing levels to improve patient outcomes.
- Undertake modelling around AH, nursing and medical staffing numbers and mix that ensure optimal service capacity and health outcomes.
- Improving health service workforce and succession planning to best meet community health need.
- Improving clinical governance and support, particularly for private practitioners and those working for a large number of different employers.
- Ensuring adequate supply and skills for growing areas of need, including acute and sub-acute areas, aged care, disability, complex patients and interdisciplinary roles.
- Addressing attrition by providing support, flexibility and a career opportunities.
- Developing business case's for areas in which physiotherapy can add value to the patient pathway including referral, diagnostic and treatment pathways, which are currently restricted by professional boundaries, funding models or organisational norms.
- Exploring workforce capacity opportunities such as skills that current physiotherapists bring from previous careers, current and potential interdisciplinary and advanced scope roles.

Introduction

The Victorian Allied Health Workforce Research Program (the Program) aims to contribute to the evidence base about 27 selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the AH workforce as well as guide any improvements to the associated education and training system.

This report presents the data arising from a survey and focus groups of the physiotherapy workforce in Victoria.

Please note: terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

Background

Who are physiotherapists?

The Australian Physiotherapy Association (APA) describes physiotherapy as a healthcare profession that assesses, diagnoses, treats, and works to prevent disease and disability through physical means.

Physiotherapists are experts in movement and function who work in partnership with their patients, assisting them to overcome movement disorders, which may have been present from birth, acquired through accident or injury, or are the result of ageing or life-changing events (APA 2015a).

Physiotherapists use a range of treatments including mobilisation and manipulation of joints, massage, therapeutic exercise, electrotherapy and hydrotherapy to reduce pain and restore function (APA 2015a).

Physiotherapists work in a wide range of contexts including hospitals, community health centres, centres for people with physical disabilities, mental health services, rehabilitation centres, sports clinics and fitness centres, private practices, government departments and universities.

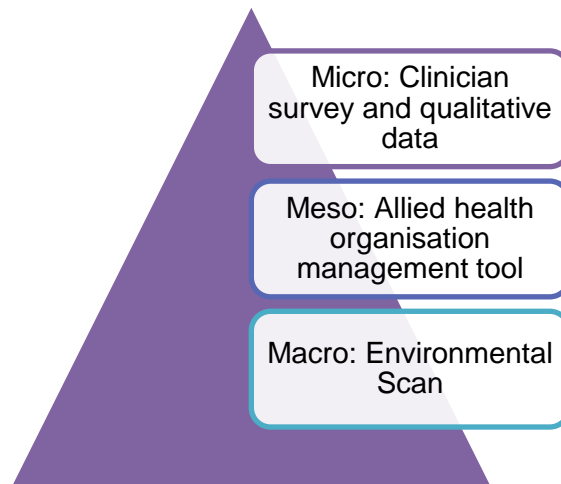
Physiotherapy is a registrable profession under the *National Registration and Accreditation Scheme* through the *Australian Health Practitioners Regulation Agency* (AHPRA). To practice in Australia, physiotherapists must be registered with the *Physiotherapy Board of Australia* (PBA).

Qualification as a physiotherapist requires completion of an approved entry-level program at either the bachelor, masters or doctoral level (Australian Physiotherapy Council 2015).

Method

A three tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

Figure 1: Three tiered research approach



Macro

Environmental scan

The environmental scan examined 27 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations regarding workforce trends and issues alongside the analysis of a range of existing data sources. A 'snapshot' was generated for each profession which included key workforce statistics, workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the physiotherapy environmental scan have been incorporated into this report.

Meso

Subsequent to the environmental scan, four professions (speech pathology, physiotherapy, allied health assistance and sonography) were analysed in-depth at organisational and individual level using the approaches described below. The rationale for initially focussing on these professions was that they were all high priority professions for Department of Health and Human Services and existing data sources provided different levels of coverage for each profession. Therefore, the in-depth analysis for each of the four professions required different research methodologies and consultation strategies to achieve the project aims.

Allied Health Organisation Mapping Tool

At a meso level, we developed an Allied Health Organisation Mapping Tool (AHOMT) which provides information on a profession's size, location, skill set, recruitment and retention issues, and organisational contexts. The AHOMT was developed using a Qualtrics online survey tool and distributed electronically. It was completed at the regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

The AHOMT was adapted from a previously developed tool called the Service Proforma, which was designed to be completed by a multidisciplinary team leader to provide team or service level information

about the staffing size, organisation and configuration. The Service Proforma tool was substantially modified for this project to be completed at an organisational level for specific disciplines. Despite substantial initial piloting, the first iteration of the AHOMT presented some challenges for complex organisations with multiple sites. In particular, organisations providing services across geographic locations felt that the nuances of specific sites were not being addressed (for example, outer Melbourne has different recruitment issues to inner metropolitan Melbourne).

To address this issue, a modified version of the AHOMT (AHOMT2) was developed that could be completed at a team level, and a new tool, the Allied Health Human Resource Tool was developed to capture the whole of organisation workforce data (workforce numbers and location).

Allied Health Human Resource Tool

As outlined above, the Allied Health Human Resource Tool was introduced after the first round of data collection to address a perceived gap in the data, i.e. the geographic location, numbers and grades of workers, particularly for large, complex organisations. This tool was also developed online using Qualtrics and distributed electronically.

Micro

Allied Health Workforce Questionnaire

Individual clinician data were captured through the Allied Health Workforce Questionnaire (AHWQ). The AHWQ captured information about education and training, nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ were invited to provide their contact details for future follow-up.

Focus groups

Survey respondents who agreed to be followed-up were invited by email to participate in one of four focus groups, stratified by grade (or equivalent pay level), rurality and public/private sector. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using GoToMeeting and took around 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

Research governance

The research was overseen by an overarching research advisory group comprising experts from across disciplines and fields. In addition, each of the four professions had a discipline specific reference group comprising members of the profession representing specific sectors or subgroups (such as new graduates; public, private and NFP sectors; and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

Distribution approaches

Surveys were initially distributed through the reference groups, professional associations and DHHS contact lists. In addition, a communications database was developed comprising employers, professional networks and associations, and individual professionals and relevant contacts for each profession. This database evolved during the project, and continues to evolve.

The AHWQ and AHOMT surveys were circulated from October until 31 December 2015. The Allied Health Human Resource Tool and modified AHOMT were circulated during February and March 2016.

Other methods of distribution and marketing included Department of Health and Human Services newsletters and road shows, a stand at the National Allied Health Conference, and regional conference presentations.

Analyses

The Qualtrics survey tool generates descriptive results for all questions in Microsoft Word and Microsoft Excel formats. In addition, all survey data were exported directly into IBM SPSS V21 where they were analysed descriptively, and where appropriate, correlations and ANOVA analyses were performed.

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of each profession.
- It was difficult to engage with the large number of small private physiotherapy practices. As a result, it is not possible to determine the representativeness of the data for this group.
- Distribution of revised AHOMT (AHOMT 2) may have confused some respondents and created some challenges for data analysis.
- The focus group participants were invited from the AHWQ respondents who agreed to be followed-up. This may have resulted in selection bias. However, more than half of all survey respondents agreed to further follow-up.

Results

The source of data in the tables and figures going forward is AHWQ or AHOMT survey response data unless otherwise specified.

Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

Table 1: Respondent numbers by data collection approach

AHWQ (individuals)	HR survey (organisations)	AHOMT1 (organisations)	AHOMT2 (organisations)	Focus groups
1,037	14 (57 sites/locations)	47 (185 sites)	26 (114 sites)	8 (Grade 4 and above) 7 (Grade 3) 2 (Grade 1 and 2)

Allied Health Workforce Questionnaire

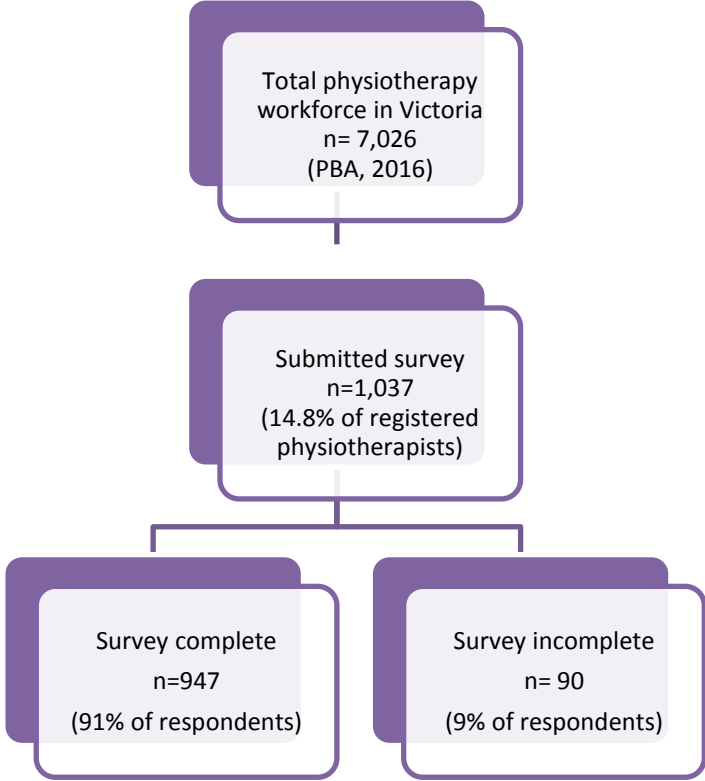
The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 1,037 physiotherapists completed at least one question on the survey and submitted their survey¹: This represents 15% of the registered physiotherapists in Victoria in March 2016 (Physiotherapy Board of Australia, 2016). The range of responses to an individual question was from 138 to 2,305². Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not (Figure 2).

¹ A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

² Some questions allowed for multiple responses

Figure 2: Survey responses



Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at a political, professional and organisational level (Figure 3).

Figure 3: Workforce capacity framework



Key findings

- There is evidence of unmet demand for physiotherapy services in the community. However, this cannot be quantified due to a lack of systematic approaches to measure AH service need and appears to vary by region.
- While there is growth in newly graduated physiotherapists suggesting that supply is adequate, their dispersion is patchy and some services have unfilled positions whereas others receive in excess of 50 applications for new graduate positions. Supply and demand of physiotherapy services appear to be misaligned and there are problems with distribution.
- There was strong evidence from this study that physiotherapists who have grown up in country areas are more likely to return to these areas.
- Public sector physiotherapy services have insufficient resources to provide services across the range of required contexts which increases the pressure on existing staff (resulting in workplace risks and absenteeism), reduces the quality and access to care for clients, and reduces the resilience of services to grow and respond to changing contexts and evidence.
- Appears to be a need for business support for practitioners running private practices.
- 14% of respondents reported that their work involved advanced scope of practice. There was a desire by many participants to be able to expand their scope, with opportunities to explore in diagnostic and prescribing services, as well as non-clinical opportunities in policy, evaluation and service reform
- Physiotherapists have a high level of engagement with allied health assistants (AHA) and sometimes AHAs are employed in the absence of physiotherapists. There was some role boundary concern, but this could be used as opportunity for career progression opportunity for AHAs and physiotherapists and capacity and capability potential. There is opportunity for other professions to learn from physiotherapy in how AHAs can help increase AH capacity.
- Telehealth was used by 7% of respondents for direct service delivery, training and clinical supervision.
- Retention in physiotherapy is an issue and is attributed to limited career pathways (particularly in rural areas) and unrealistic expectations of graduates. Remuneration is also a factor, particularly in private practice.

Workforce distribution

Demographics

Based on the most recently available workforce (2015) and registration data (March 2016), there were 6,009 physiotherapists employed in Victoria (AIHW, 2016)³ and 6,829 physiotherapists registered with the PBA as practising in Victoria (PBA, 2016). The PBA total registrant data (practising (6,829) and non-practising (197)) for Victoria comprises 68% female and 38.5% aged 30 years and under (PBA, 2016), while the Australian Institute of Health and Welfare (AIHW) data has 67% female, 52% aged 34 years and under, and 11% 55 years and older (AIHW, 2016).

The AHWQ respondents were predominantly female (81%) with an average age of 39 years (range 23 - 72, median 37 years). A small per cent of respondents (14%) were aged 55 and older while 29% of respondents were 30 and younger. Table 2 compares the survey respondents to AIHW workforce data. The survey respondents were also older and had a higher proportion of females than reported in the registration data (PBA, 2016). The majority of AHWQ respondents (78%) were from the public sector; this differs significantly from the 45% publically employed as reported in the AIHW workforce data (AIHW, 2016).

The majority of survey respondents (96%) were employed in the physiotherapy workforce at the time of completing the survey. Seven respondents were actively seeking physiotherapy work.

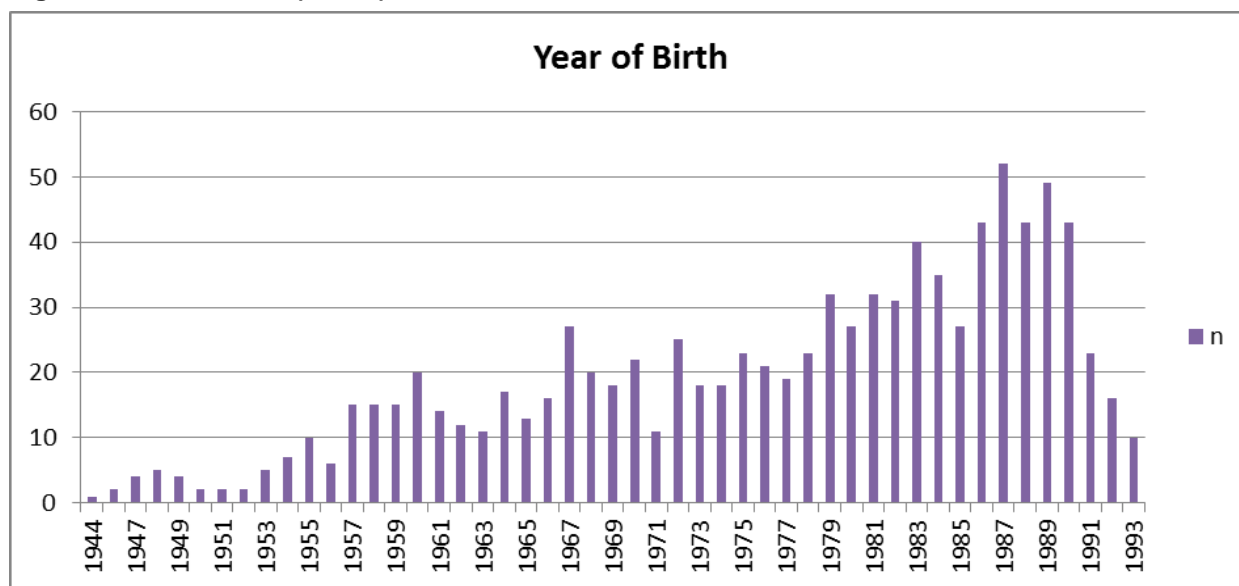
Table 2: Demographics (n=955) compared with AIHW 2015 data

Demographics	AHWQ		AIHW 2015 ^a
	n	%	%
Female	770	81	67
Aboriginal and/or Torres Strait Islander	2	<1	0.2
Australian citizen / permanent resident	945	99	96
Age 55 years and over	129	14	11
Age 30 years and under	279	29	Not able to calculate as age range different
Median age (years)	35	-	-
Private sector	150	16% + 6% NFP	55

^a Source: Australian Institute of Health and Welfare (AIHW) 2016

³ The AIHW national workforce dataset is constructed from the annual *Workforce Survey* undertaken as part of the registration renewal process undertaken by AHPRA on behalf of the PBA. While the survey is attached to the required registration renewal documentation, completion is voluntary. Only registrants who are renewing their registration can complete it. This survey focuses on whether a registrant is actually employed or looking for work, and the type of work they are undertaking. The physiotherapy version consists of 20 questions, some of which are conditional on the response to previous questions. Registrants can complete all, some or none of the questions; as a result the number of responses to each question will vary. AIHW data in this report is from the 2015 workforce survey, unless otherwise stated.

Figure 4: Year of birth (n=946)



Geography

The majority of the survey respondents (75%) worked in metropolitan Melbourne. Just over half (55%) of respondents reported that they work only in a single local government area (Table 3).

Table 3: Geographic distribution (n=1,396) compared to AIHW 2015 respondents

Victorian region	Barwon south West	Gippsland	Grampians	Hume	Loddon Mallee	Northern and Western metro	Eastern Metro	Southern Metro	Other state	Overseas	Total
Primary location (AHWQ)	86	27	53	69	85	445	277	338	14	2	1,396
Primary location (AHWQ) %	6	2	4	5	6	32	20	24	1	0.1	100
Primary location (AIHW) %	7	3	3	3	4	30	20	30	NA	NA	100

Almost three quarters of the survey respondents (73%) were city-based with 22% of these migrating from regional areas. Of the 201 respondents who were working in regional areas, 62% had grown up in a regional area. There was strong evidence from this study that physiotherapists who have grown up in country areas are more likely to return to these areas. The study findings also showed a strong correlation between physiotherapists who came from regional areas undertaking their training in regional areas. This was supported by data from the management level survey (AHOMT) and the focus group respondents who indicated that regionally-based physiotherapy training builds regional capacity and workforce self-sufficiency in physiotherapy services.

Sector

Just less than three quarters of the AHWQ respondents (72%) were employed in the Victorian public health sector (Figure 5). It is important to note that this is a significantly different finding than the AIHW workforce data where only 45% of physiotherapists worked in the public sector. From the survey, physiotherapists who were working in the private and public health sectors were the youngest groups of practitioners with a mean age of 39 years. Self-employed practitioners were older (mean = 47 years) and had been qualified for longer (mean of 25 years) (Figure 6).

Figure 5: Employment sector of current main employer

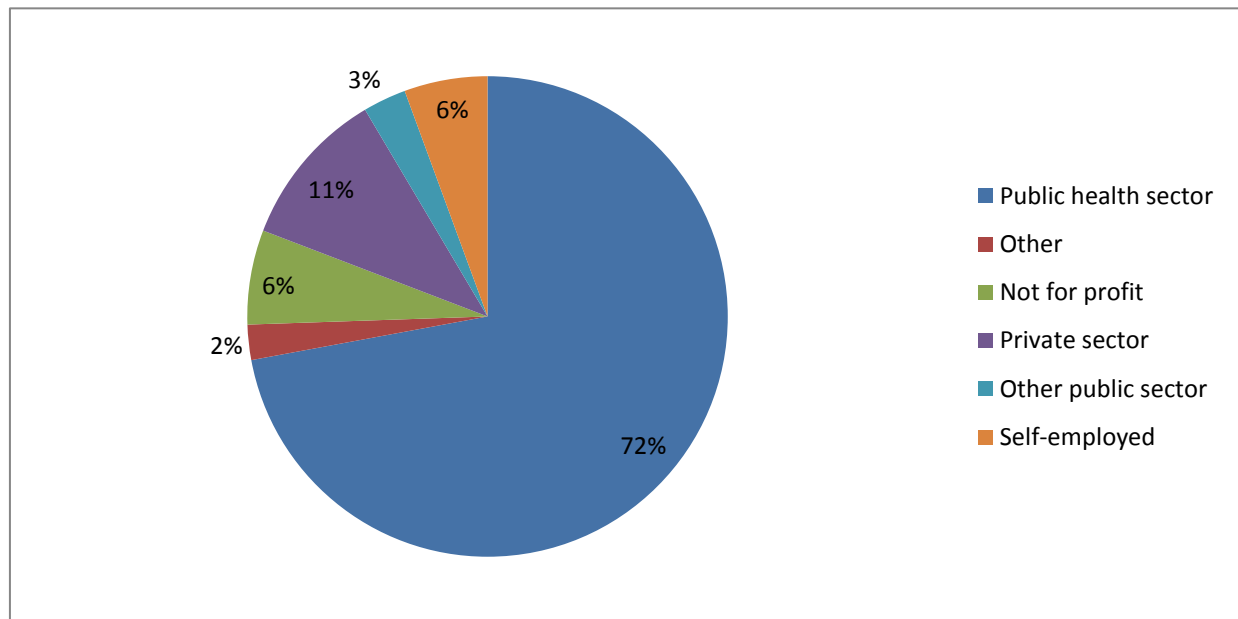
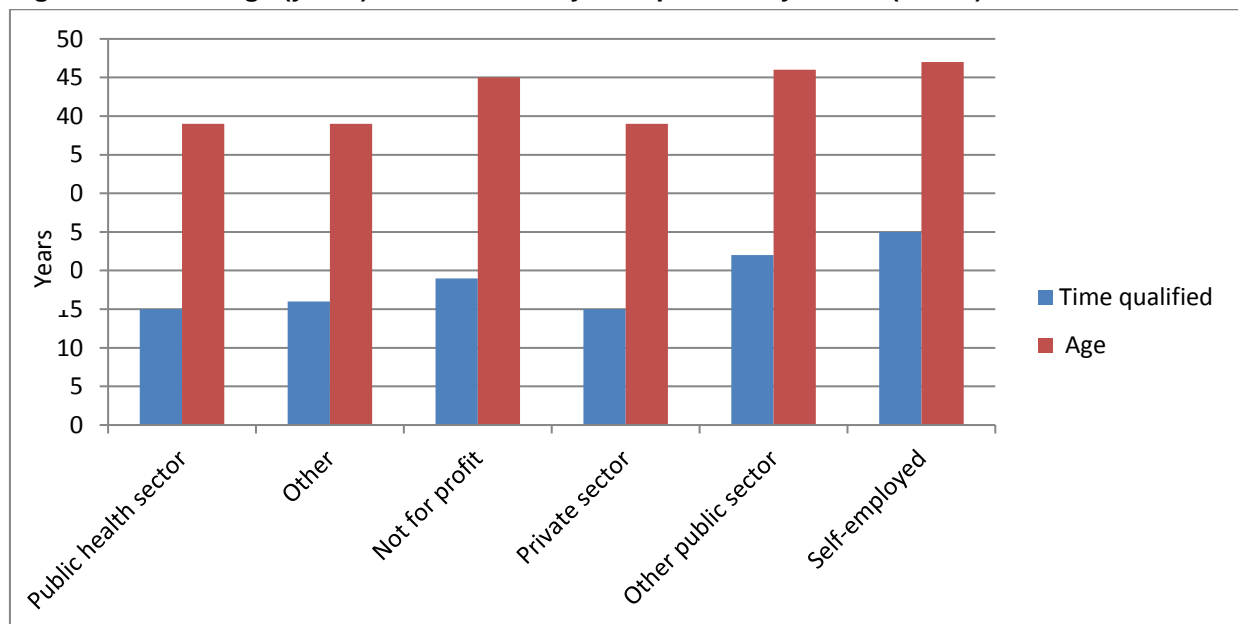


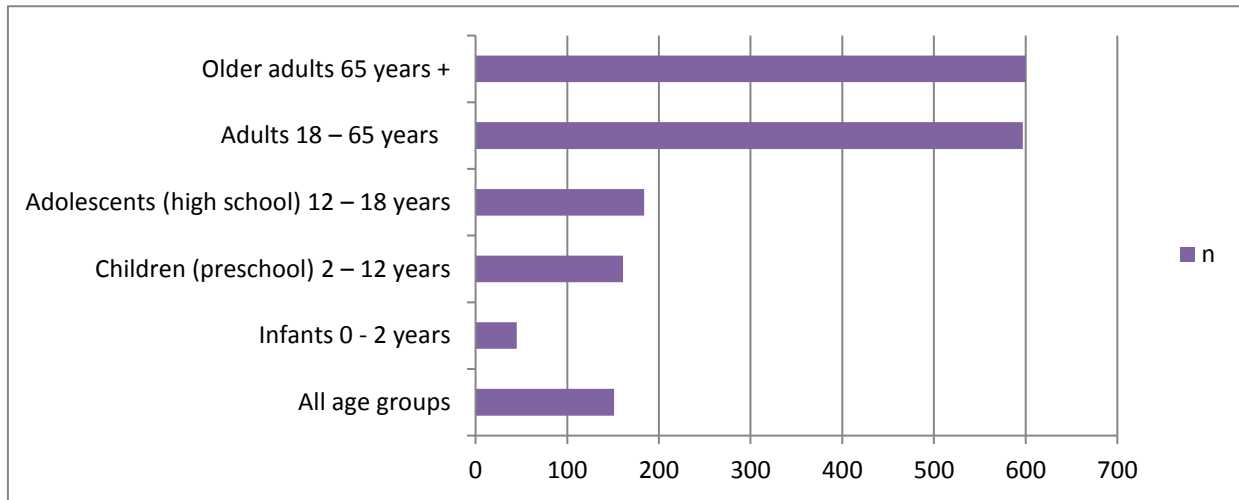
Figure 6: Median age (years) and number of years qualified by sector (n=928)



Clients

The majority of respondents (69%) reported that they were most likely to work with older adults and adults aged 18-65 years, 19% worked with children, and 5% with infants (Figure 7).

Figure 7: Clients by age (n=1,738) ^a

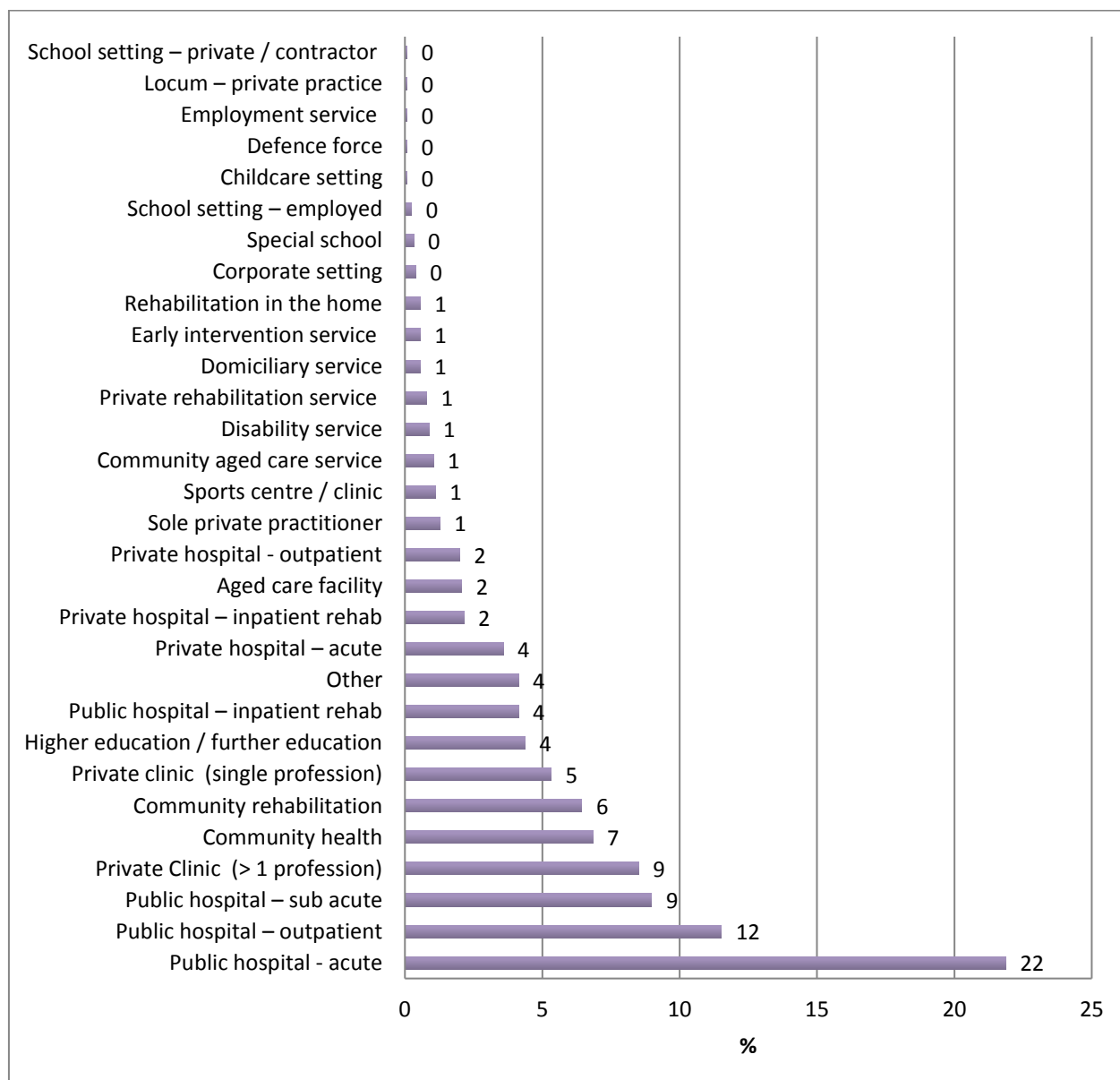


^a Respondents could select more than one response.

Settings

In describing their service delivery settings and area of practice, the survey respondents were asked to select all areas that were applicable to their main job. The most commonly reported primary setting for delivery of clinical services in this survey was acute public hospital (22%), followed by public hospital outpatients (12%), public hospital sub-acute (9%) and private clinic with multiple practitioners (8.5%) (Figure 8).

Figure 8: Setting for service delivery for all employers (n = 1258)^a



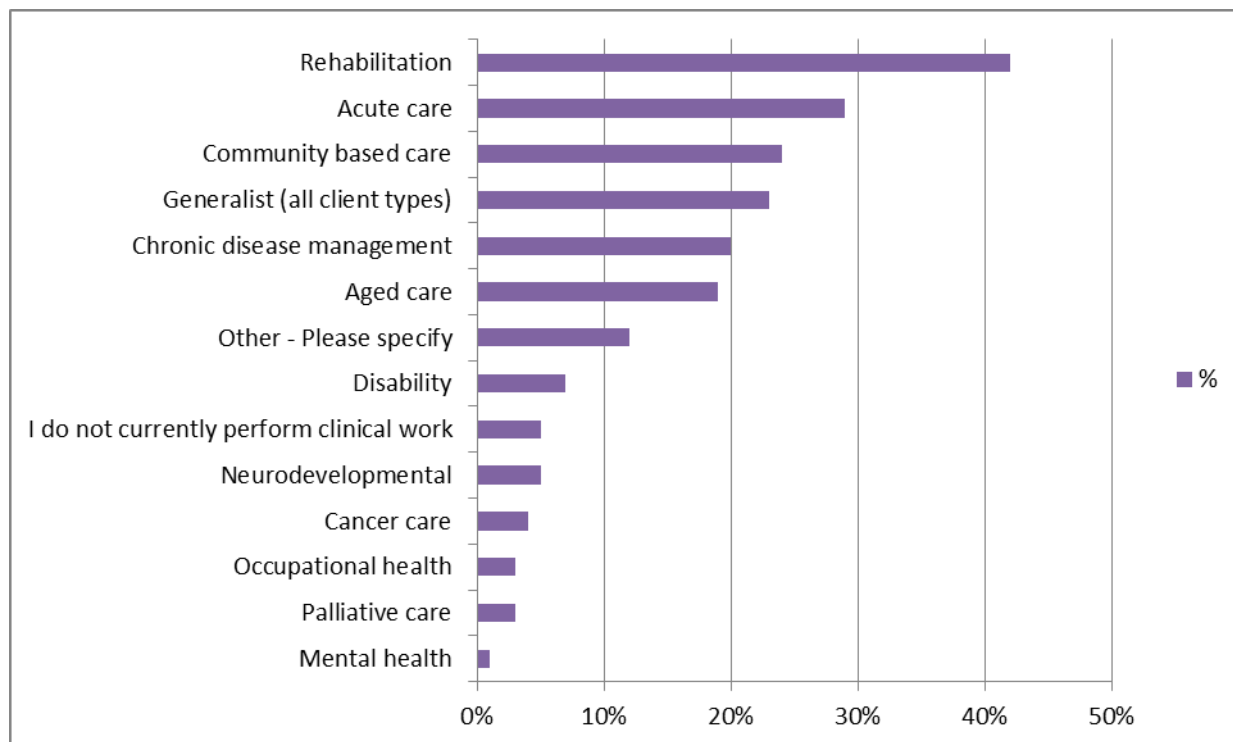
^a Respondents could select more than one response.

Area of practice

The majority of respondents reported their area of practice as working in rehabilitation (42%), this was followed by acute care (29%) and community based care (24%). Interestingly, nearly one quarter (23%) reported their practice as 'generalist' or all client types (Figure 9).

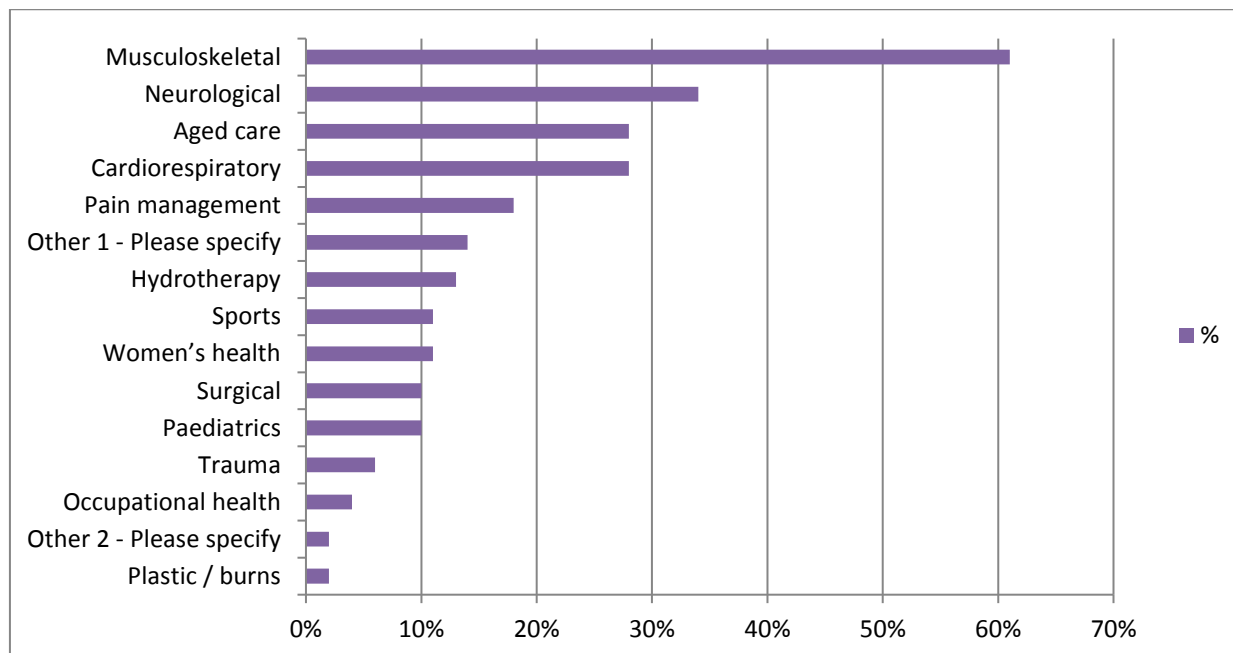
The most commonly reported clinical areas of practice of physiotherapists were musculoskeletal (n=557), neurological (n=309), aged care (n=262), and cardiorespiratory (n=253). Less common areas of practice were plastics/burns (n=21), occupational health (n=33) and paediatrics (n=99) (Figure 10, and Appendix Table 6 and Table 7).

Figure 9: All areas of practice (n=1,828) ^a



^a Respondents could select more than one response to signify 'all other areas of practice'

Figure 10: Clinical area of practice of main role (n=2,305) ^a



^a Respondents could select more than one response to signify 'all other areas of practice'

Demand

The data around demand for physiotherapists is patchy. Several services and individual practitioners identified workforce shortages and unmet need for services in their communities; however, it was difficult to obtain an overall and clear picture of the nature and extent of those shortages.

This reinforces the findings from the macro level physiotherapy environmental scan which identified a lack of systems to measure and report on community need for physiotherapy services. In turn, this compromises the capacity to establish the business case necessary to gain management support for establishing adequately resourced physiotherapy services.

The qualitative feedback provided by practitioners in the AHWQ specifically identified the need to increase physiotherapy service access in the following ways:

- more timely access to care
- more appropriate care, targeted to specific conditions and evidence based
- improved funding and reimbursement for services
- more flexible models of care to enhance client centred care approaches.

“Access to treatment in a timely manner. Our referral rate is constantly increasing (has for decades) and hours in Continence and Women’s Health have decreased within our health network, through lack of staff support and replacement of staff who have left.”

“Better opportunities for patients with chronic conditions to access physiotherapy-led management programs. This involves improved rebates and recognition from funders (e.g. government including public health funding & Medicare/EPC [enhanced primary care]; private health insurers etc.).”

“Better support services, including funding to support the needs of people living in the community with newly acquired, non-compensable, disabilities.”

“Flexibility in the way we can work, e.g. hours and sites. An example is to be able to manage a client in their own environment and or during hours that may not be fixed.”

The focus groups identified high and increasing unmet demand for physiotherapists in acute areas, particularly emergency departments (ED).

“In the acute or sub-acute area the number of patients coming through the door is increasing, the number of patients presenting to ED is growing, and we’re having to spread and stretch because there is no more money.”

Supply

There are a number of factors that interact with and influence the supply of physiotherapists. These include the size of the physiotherapy workforce, the number of graduating physiotherapists, the profession’s age and gender profile, employment grades, remoteness, remuneration and local approaches to recruitment.

Student completions

In recent years, many new physiotherapy training programmes have opened across Australia. As a result, student numbers have increased dramatically. This is making it difficult to secure adequate clinical training places to provide students with a quality education that ensures they graduate with appropriate skill and experience (APA, 2015b; HWA, 2014). Prior to 2012, the number of physiotherapy graduates in Victoria averaged around 250 per year; however since the numbers have increased significantly with the

new programs starting to graduate students. In 2012 there were 643 new registrants in Victoria, 679 in 2013, and 739 in 2014 (AIHW, 2015).

Workforce supply

Evidence of workforce shortages in physiotherapy is patchy and varies widely by region and grade. Of 30 organisations that responded directly to a question about workforce shortages, 14 said that they experience physiotherapy shortages. There was evidence of physiotherapy shortages in grade 1 and 2, as well as senior clinical physiotherapy positions, with some significant delays (more than six months) in filling higher grade positions (Table 4 and 5).

The only region that specifically identified challenges in recruiting physiotherapists was Southern Metro (Melbourne) (grade 1 and 2 positions). Four (out of 19) organisations stated that they employ physiotherapists at a level lower than their qualifications, skill or experience; this suggested that appropriate, higher grade positions are not being funded or made available to qualified staff.

"We have a physio who is 10 years qualified but as a small business that is building clientele we can only afford to employ him at pay point 2 from the HPSS award plus commission."

There was some evidence of delays to fill vacancies with lag times of more than 20 weeks not uncommon. There were reports of funded positions remaining unfilled for six months or longer in grade 2 (n=4 organisations) or senior clinical physiotherapy roles (n=2 organisations).

Table 4: Workforce shortages (n=30 organisations)

	Total EFT currently employed	Total headcount	Unfilled EFT in this role	Shortages in this role (EFT not funded but required to meet demand)	EFT currently unfilled for ≥ 6 months
Grade 1	152.4	141	5	8.5	0
Grade 2	247.1	342	5.4	7.5	2.7
Senior Clinical Physio	102.4	104	2	6.9	2
Deputy Chief	5.2	5	0	0	0
Chief Physio	14	12	0.6	0.4	0
Grade 4	6.8	4	0	2	0
ESP SP	2	4	0	0	0

(EFT – Equivalent fulltime)

Unfilled positions

Table 7: Reasons for unfilled positions

No unfilled positions	Lack of applicants	Lack of suitably qualified applicants	Funding unavailable from service	Total responses
33	13	7	2	55

Respondents could select more than one response

While the AHOMT highlighted a lack of applicants for unfilled positions, focus groups discussions indicated that public sector workforce shortages were due to funding cuts and productivity pressures that impact negatively on workforce morale. Lack of sustainability of funding for new positions was cited as a particular issue.

“There is a lack of funding for sufficient public positions. All hospitals are in the same boat – we’re going through a big crisis of having to save more money in public health”.

“In public health the need for the increased productivity makes everyone’s workload more stressful and heavy at times. It’s challenging trying to balance budgets, throughput and productivity as hospitals become more and more required to do this, while maintaining quality of care for patient.”

“There’s a huge inequity across the health services in terms of staffing levels and access to services. For example in our ED there is no allocated physio EFT [equivalent full time], but we are expected to provide some service to it“

Respondents noted a number of indicators of physiotherapy workforce shortages including:

- unavailability of services for specific client groups
- inability to provide services (in particular where particular skills are lacking e.g. cardiorespiratory, aged care)
- service rationing
- long waiting periods for assessment and/or treatment
- greater delegation of work to assistants
- staff employed at a level above their skill or qualification.

Related impacts of these factors included:

- longer distances travelled by patients to access services rather than being able to access services locally
- increased length of (inpatient) stay / longer waiting lists
- inability to meet budgets or targets, resulting in subsequent service cuts
- workload pressures, stress and burnout
- inability to take annual leave
- loss of business
- increased acute inpatient hospital costs
- reduced reputation of the service and profession
- increased physiotherapist attrition rates
- increased sick leave
- increased overtime costs

- inability to see higher risk clients
- inability to grow and respond to changing contexts

“When staff are on annual leave we have to reduce our service to a nearby smaller town. Without extra staff we are unable to increase our service to a nearby smaller town.”

“If it was better funded, we could see them there (in ED) and then the patient could go home.”

Focus group respondents said that physiotherapists are open to doing things more efficiently but the main barrier to innovation is money and finding the time to introduce innovations given the clinical service demand.

Of particular concern was the impact of workforce shortages of staff health, sick leave and the inability to cover staff absences.

“Unable to find locum support for physiotherapist’s long service leave and annual leave - other than two weeks NAHRLS cover.”

“Increased sick leave due to no cover position, no increase in EFT over the last eight years despite additional services requiring EFT on the acute wards.”

“Not currently but one of our physiotherapists has just resigned after 12 months and it will be challenging to recruit to this post.”

“Increased pressure on staff. Impetus to modify service delivery model, increasing utilisation of AHAs.”

Workforce shortages also limit the ability of the services to plan and improve service provision. Instead, there was a sense of day-to-day survival. Ironically, the inability to meet service demand relayed into an inability to achieve targets, and created subsequent risks for further service cuts.

“While department numbers have increased over time so has the clinical demand. There is no relief for staff days off / annual leave / study leave etc. putting constant added demands on staff who are always stretched. In spite of having a grade 4 / team leading position, the clinical demands leave very little time to adequately do tasks to progress the service provision. Each day you are just trying to get through the day the best you can. The physical, emotional, and cognitive demands in this environment wear you down.”

“Longer waiting time for patients not meeting targets = recall of budget.”

Recruitment

Table 5: Time to fill vacancies

No vacancies	0 - 5 weeks	6 - 10 weeks	11 - 20 weeks	> 20 weeks	Total responses
26	15	14	13	10	78
33%	19%	18%	17%	13%	100%

Despite the delays filling vacancies reported by some services, the number of responses to advertisements by those services that did advertise positions reinforces the mixed picture of workforce distribution across the profession. For instance, three organisations received no applications for new

graduate roles, while three organisations received over 20 applications. Lack of applicants was identified as the main reason for organisations to have unfilled positions (Table 6 and 7).

“Depending on the position and the timing there may be no applications for physiotherapy positions and will often have to re-advertise and network / alter time fraction to ensure part of position filled”

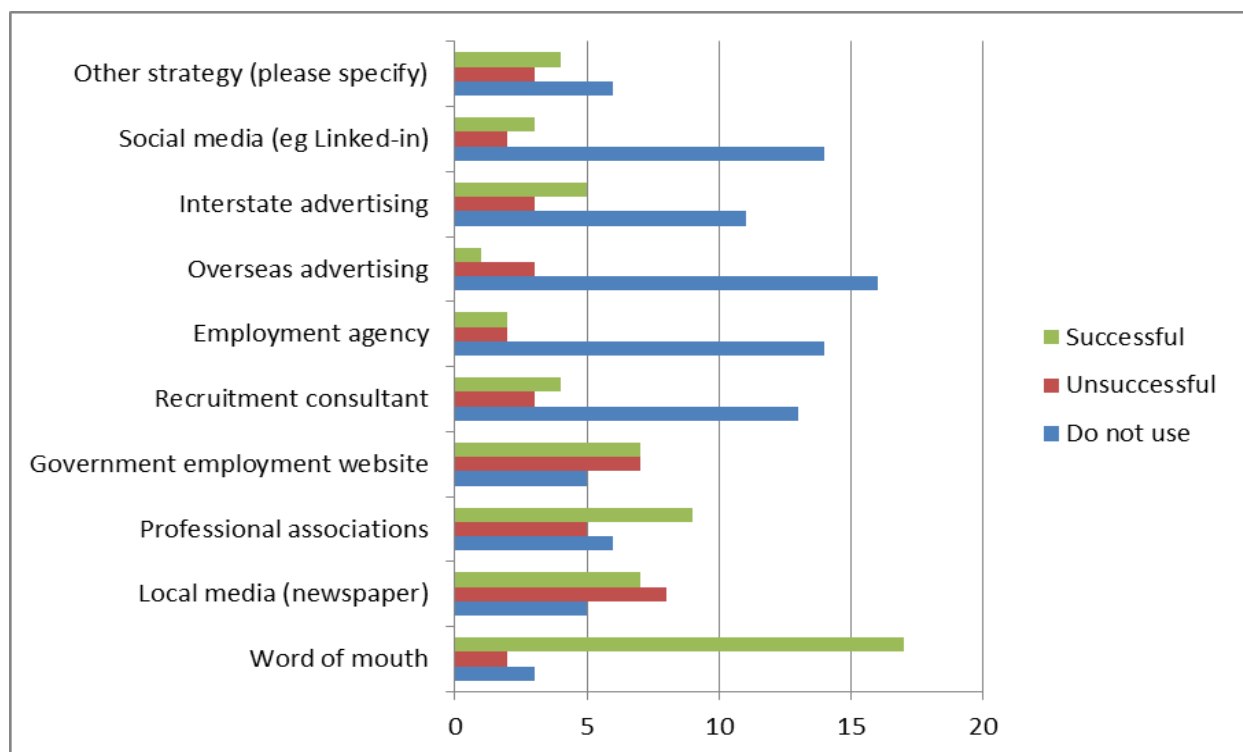
Table 6: Number of applications received for positions advertised in past year by grade*

Grade	None advertised	0	1-5	6-10	11-20	21-50	>50	Total responses
Grade 1*	4	3	6	1	4	1	2	21
Grade 2*	8	0	7	2	1	0	1	19
Grade 3* or above	12	1	2	1	1	0	0	17

*or equivalent

Only 16 organisations responded to the question about recruitment strategies. Recruitment strategies used by these organisations, and their success, are identified in Figure 11.

Figure 11: Relative success of strategies used to recruit (n=16)



Barriers to recruitment identified by employers included:

- rural or regional location
- difficulty finding appropriately skilled or experienced physiotherapists
- lack of specialist roles offered
- lack of applicants in general
- recruiting to short term or part-time positions not attractive to applicants (especially if in rural or regional area)
- lack of funding or insufficient funding to support necessary positions
- timing (difficulty recruiting new graduates mid-year)

- staff leaving to go travelling
- less popular areas of work (e.g. community health, aged care)
- changes to the models of care which impact on ways of working

“Rural area - lack of qualified people living in the area. Need to attract practitioner with established generalist skills who is happy to work as a sole practitioner- no peer support on site. Position is part time so is not an attractive proposition to make a shift to the area.”

“Lack of applicants (due to workforce shortage). Once recruited retention rates are good.”

“They won’t move from metro areas to come rural. We found it dissatisfying to take graduates from metro because they would leave.”

“Current award/agreement not competitive with other states or private providers. Workforce data appears to demonstrate that experienced physiotherapists are moving out of the profession and public sector.”

“Reduction in the length of stay in acute hospitals and reduced workforce has resulted in difficulties in retaining physiotherapists - the constant patient ‘churn’ requires a different way of working and a model that is not often attractive to new staff. The focus on discharge rather than therapy is impacting on staff satisfaction.”

“We have a high physiotherapy demand though a fractional FTE [full time equivalent] of 0.64 due to insufficient community health funding.”

There were several suggestions that AHAs could and would be used as substitutes for qualified physiotherapists if physiotherapists could not be recruited.

“Distribution of allied health, particularly AHAs has in the past been dependent upon availability of allied health clinicians. At times we may have employed more AHA working under an AH clinician if we could not recruit to the AH clinician position (particularly in physiotherapy).”

Practitioners working on the outskirts of larger centres reported that competition from more centralised providers could be challenging.

“We are located 40kms from two main regional health services. At times there is a lot of competition for recruitment of physiotherapists in the region.”

Focus group participants perceived that people were leaving the physiotherapy profession because universities were not targeting the right students. In particular they highlighted a focus on recruiting students with strong academic skills rather than necessarily the interpersonal attributes required for the profession.

“I personally think we are doing the profession a disservice by taking a very academic cohort every year. My experience with the very academic students is they have huge knowledge in the theory, but they lack the personal skills and I personally don’t think they can be trained in what is the basis of physio. The smart people don’t get the mental stimulation. The bulk of our profession needs to be people people. We’re setting our profession up for failure.”

“When you get to the top, if you’re not a doctor there is a limitation as to how much you can progress.”

Private practitioners identified specific challenges to recruitment, including their ability to appropriately reimburse physiotherapists or offer a full-time workload. They say that the pay in private practice has not kept up with the cost of living.

“Size of business and client throughput dictates the number, remuneration and type of positions we can offer.”

“It is very expensive to run a clinic and most income generated from our employees simply funds the overheads for the clinic rather than generating more income for employees to access.”

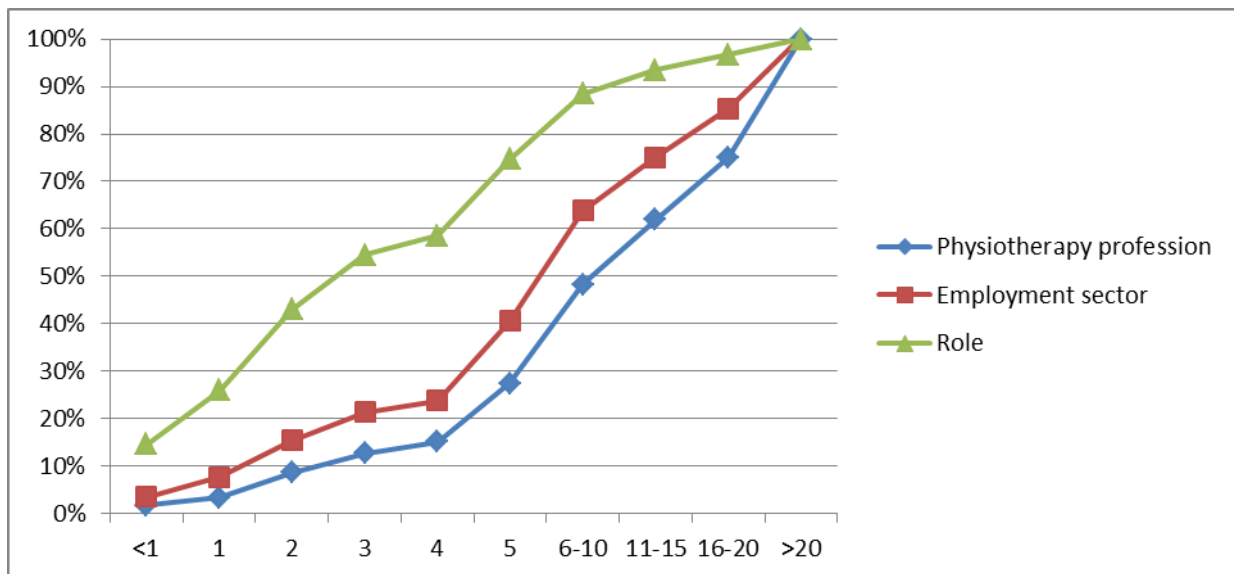
“The time involved in running a private clinic is considerable especially when employing and investing in new graduates. The costs and time implications of running and managing a small practice are considerable and most of the administration and management time spent by my business partner and I is unpaid and is certainly not reflected in the profit margin and income we generate for ourselves from the clinic. These factors mean we have very little ability to attract and retain good practitioners past a certain point unless we can generate more business ... It's exhausting!”

“I have taken a second job, working every Saturday because my wage has not kept up with the cost of living. It has become much harder to make ends meet. When I first started working 15 years ago, I would never have thought I'd need to work in two jobs to make ends meet“

Retention

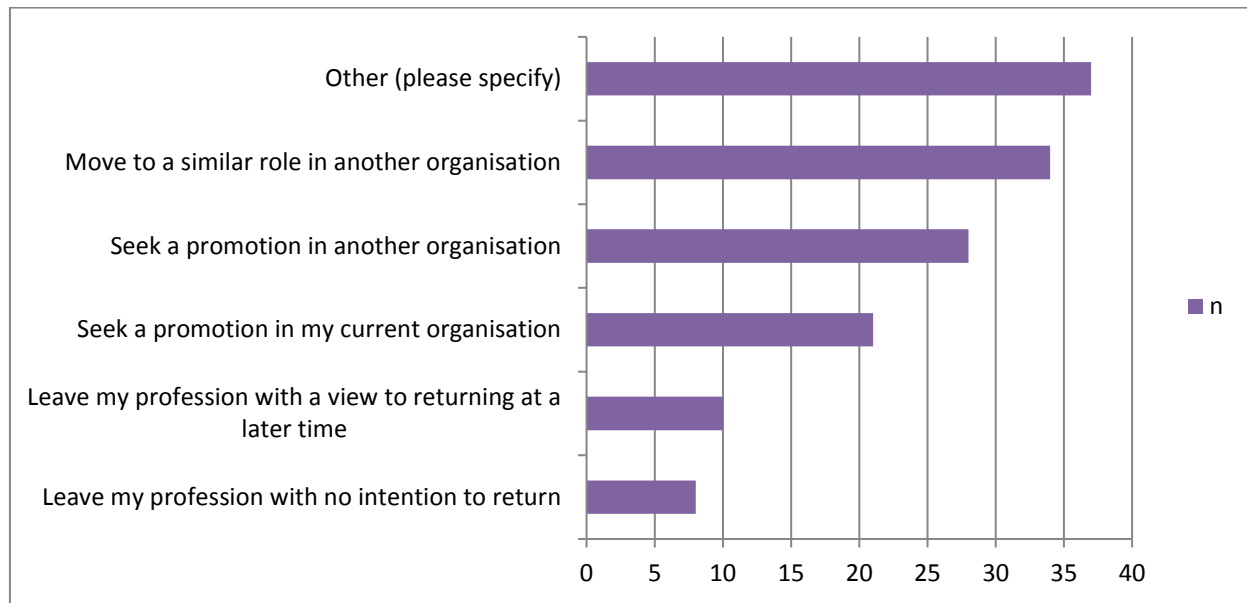
Intention to leave the physiotherapy profession is relatively high, with 27% of the profession intending to leave within the next five years (2% within one year, 2% in one to two years, and 5% in three years). The intended rate of attrition from the physiotherapy workforce is higher than other AH professions (e.g. nearly double speech pathology and 40% higher than sonography) (Figure 12). The average age of those intending to leave within the next 12 months is 41 years, so this is unlikely to be a retirement decision.

Figure 12: Cumulative intention to change current job situation by years (n=924)



Nearly three quarters of respondents (74%) intended to change their role within the next five years; 15% of these within the next 12 months, and 25% within two years. The main reasons for changing roles within the next 12 months included access to better job opportunities, pay; and working conditions (Figure 13).

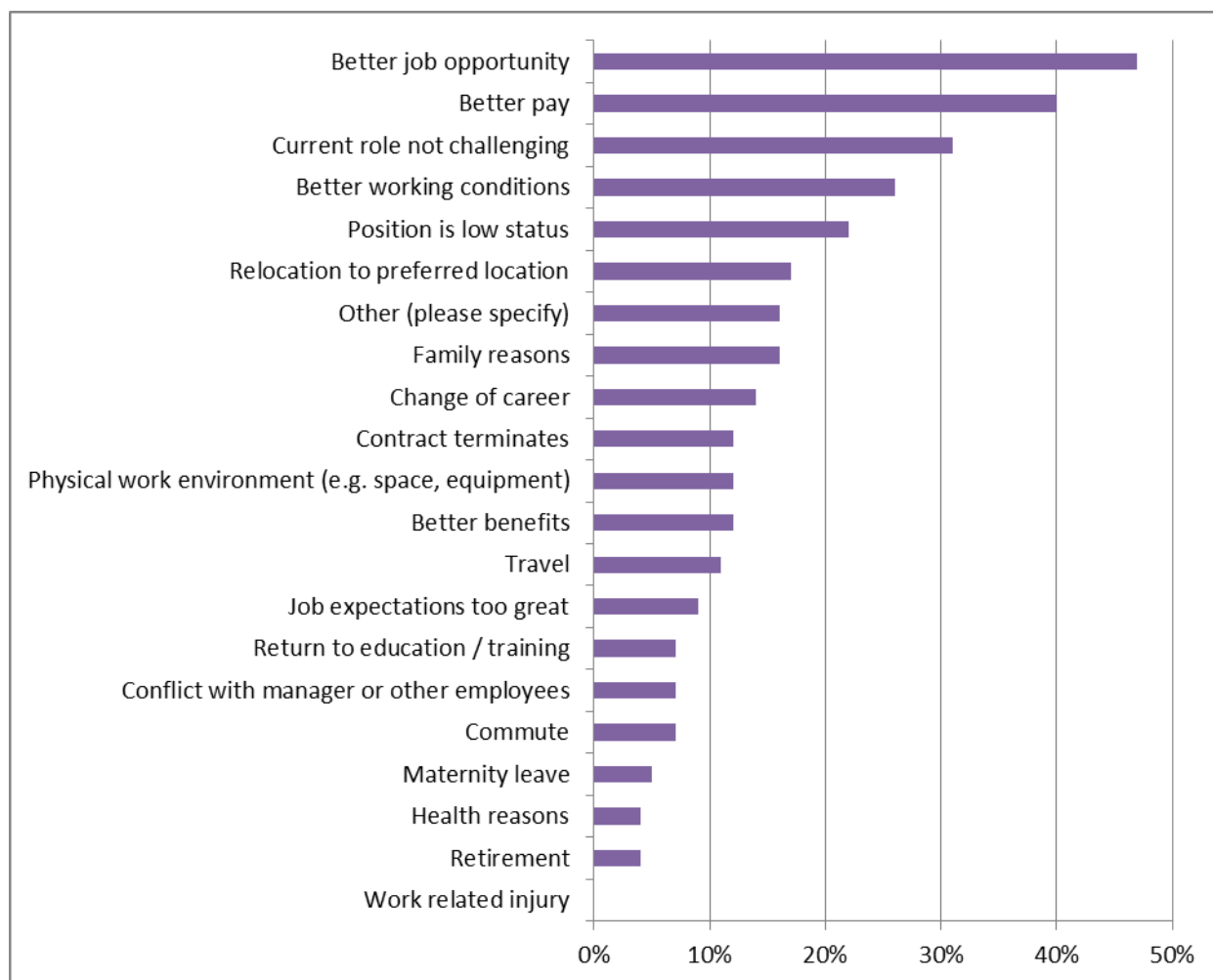
Figure 13: Career directions of those who intend to leave in the next 12 months (n= 138)



Reasons given for leaving included retirement, studying medicine, moving into academia or studying, and health reasons (Figure 14).

“Limited vision and flexibility within AH; lack of vision and leadership from senior AH management/executive; lack of respect for AH within public health; lack of evidence for AH interventions in public health; lack of interest in generating evidence to support AH roles in public health from clinicians and managers/leaders; resistance to conduct clinical research from clinicians, managers and leaders.”

Figure 14: Reasons for changing role within the next 12 months (n=138)



Several issues were identified as contributing to physiotherapy retention challenges including:

- new graduates moving into new roles or leaving the profession after a short time in new graduate position
- poor career development or advancement opportunities
- small services unable to offer workforce variety or specialisation
- regional areas unable to retain new graduates or loss to metropolitan areas
- lack of business and high cost of overheads leave insufficient capacity to offer greater advancement financially (private practice)
- high workload pressures
- unrealistic expectations of new graduates entering physiotherapy
- high cost of access to continuing professional development (CPD) in rural or regional areas
- organisational culture (resistance to change and staff stasis).

“The biggest problem is retention of junior physiotherapy staff and I feel this is a reflection on the university course content and perception of the physiotherapy role not always aligning with the reality of the working environment and scope of practice.”

“Many younger physios are looking to develop skills in specialist fields and we cannot offer this experience. The cultural challenges of living and working in a remote rural location are a barrier to many physios who have lived and trained in metro areas. Distance to access professional development is a detractor. (The emergence of Webinars as a training method has been valuable).”

“We have a quite stable but older in age workforce, which we have not had any staff movement for a while. That will cause some resistance to change in some improvement processes. I would love to see some younger generation to come to the service, but the younger one tends to go to work in hospital or private practice. They are hard to keep as well.”

Career development opportunities not meeting expectations is also seen to impact on retention.

“There is the assumption of automatic carer progression. They think that they’re automatically ready for a grade 2 job after two years as a grade 1. They’re disappointed that it is not the linear progression that they expected, so they leave and pursue other options.”

Specific challenges identified by rural and regional services included lack of access to staff; an (perceived or actual) inability to provide adequate variety in workforce roles, career pathways, support and specialisation; high staff turnover; a need for good generalist skills in the rural workforce; and loss to private practice.

“Regional issues and perception that smaller regional hospitals / health services don't provide these health professionals with the experiences they require clinically.”

“Having people move into the community is something which is beyond our control in the short term, but it is a reason why we support high school work experience to encourage local students into allied health professions. Retention can be challenging as clinicians are not able to access broader areas of clinical practice in a regional area. Also we can lose clinicians to work in private practice.”

“Yes - very difficult to attract to rural area and then to keep once they have completed two to three years as they want to go private, specialise, bigger organisation, and move to bigger city.”

“As a small rural health service we only have one EFT physiotherapist which can cause clinicians to feel isolated. LCH [local health area] has an aged care facility and the physiotherapist is expected to have a role within aged care, we have received feedback that this aspect of the role is unattractive.”

There was evidence from the qualitative data that rural training of physiotherapists increases access to practitioners. This approach was also supported in focus groups.

“We don't struggle with recruitment in Wodonga due to the high numbers of physiotherapy graduates each year from CSU [Charles Sturt University].”

“I would love to see scholarships for local students to go to uni and come back to the region. The money comes from home, so people feel a responsibility to come back home, and stay regional. The solution has to be a local solution.”

Organisation of the workforce

Pay and award

It should be noted that the respondents to this survey were predominantly from the public sector and slightly younger than the AIHW workforce survey respondents. As a result the following findings may not be representative of the Victorian physiotherapy population.

The most common level of employment (39%) was a grade 2 or equivalent (approx. \$71,000 to \$80,000 per annum). Very few respondents (17%) were employed above the level of a senior clinical physiotherapist (Figure 15). The median salary was between \$60,000 and \$69,000 per annum. The majority (59%) of respondents reported annual earnings of between \$40,000 and \$90,000 (Figure 16). Two per cent (2%) reported annual earnings of more than \$150,000. As Figure 17 illustrates, the public, NFP and private sectors employ the majority of their staff with pay scales of below \$100,000. In contrast, self-employed respondents were spread more widely over the pay grades, but this group are likely to have the greatest proportion of high income earners.

Figure 15: Employment level, pay grade or equivalent (n=916)

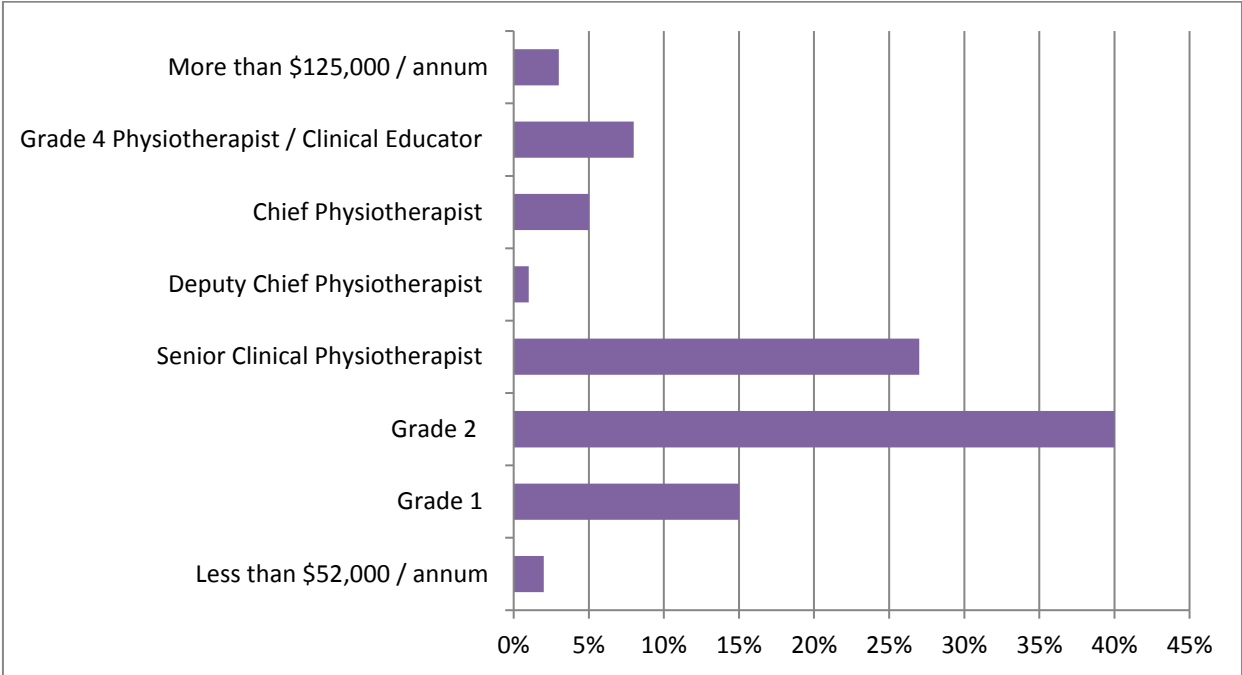


Figure 16: Total annual income last year, before tax (n=916)

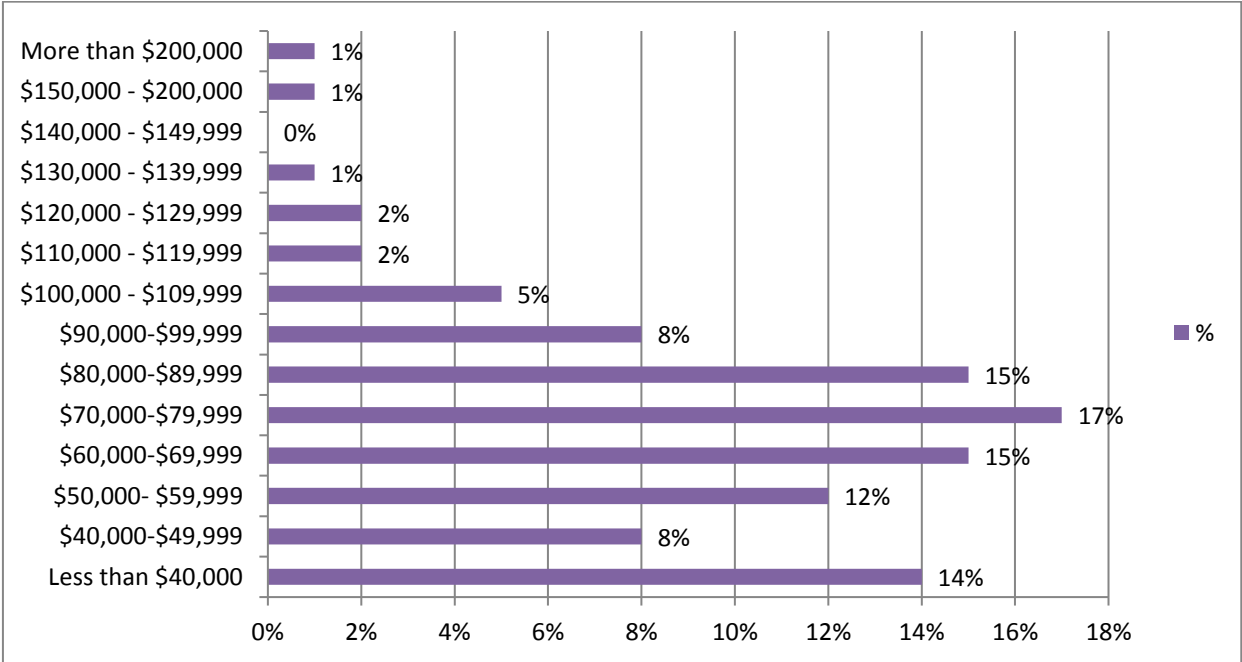
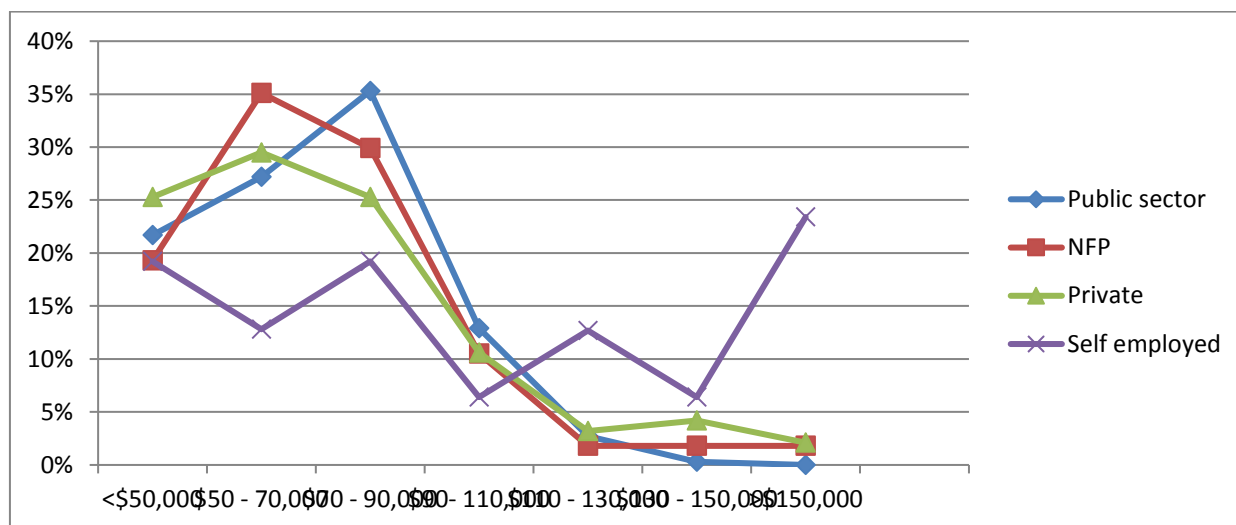


Figure 17: Pay range by sector

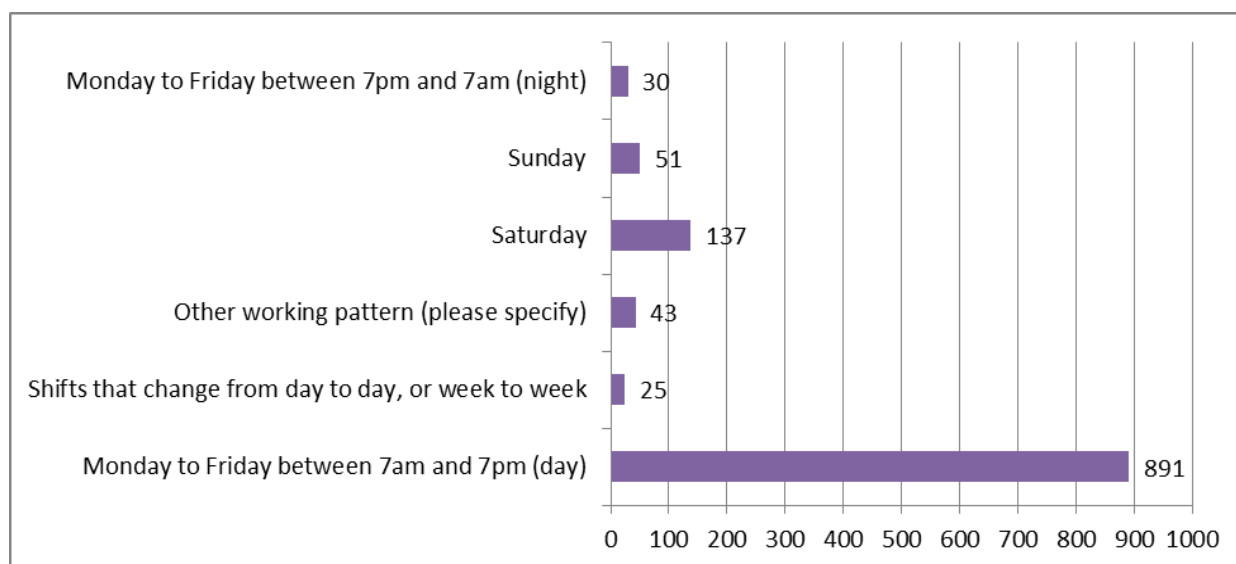


Excluded from this analysis were other public sector employees and others (n=45).

Hours of work

Most physiotherapists who responded to the AHWQ reported performing their duties between 7am and 7pm Monday to Friday (n=891) (Figure 18, and Appendix Table 5). A small per cent worked on Saturdays (n=137) or Monday to Friday between 7pm and 7am (night) (n=30). This question allowed for more than one answer per respondent. The majority of respondents (n=450) worked more than 32 hours for a single employer (Appendix Table 2).

Figure 18: Working pattern during normal work week (n=1,177) ^a



^a Respondents could select more than one response.

A typical working week for respondents involved an average of 26 hours performing clinical work, eight and a half hours of management and administration, and five hours of teaching, education, research or project work (Appendix Table 3).

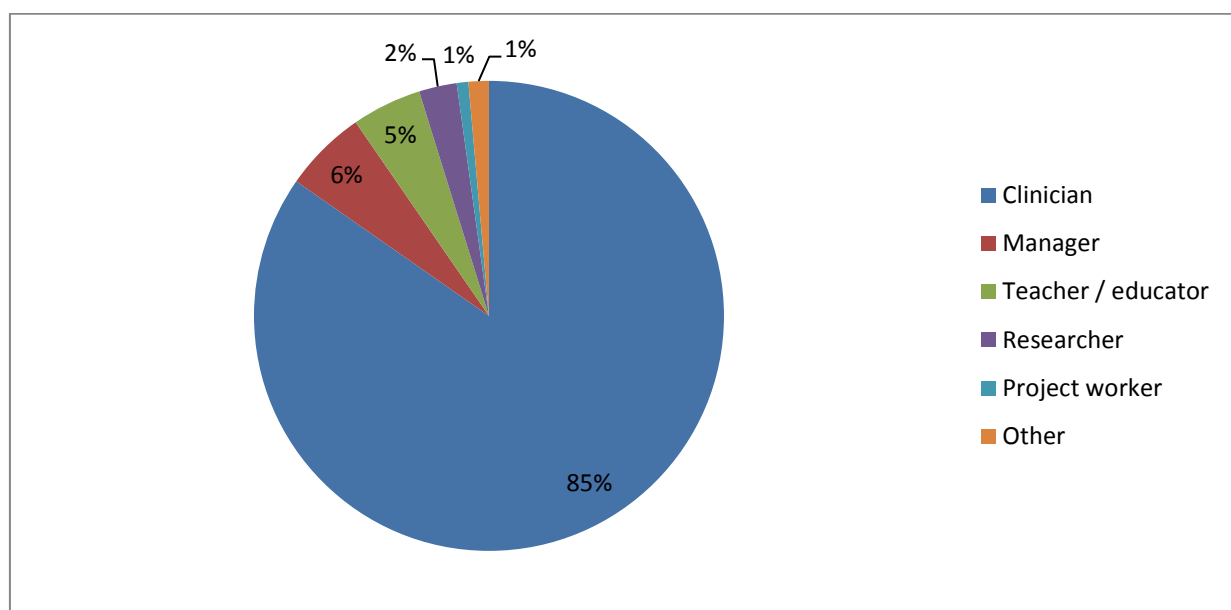
Number of employers

Most physiotherapists (73%) worked for a single employer on a permanent basis (Appendix Table 1). However, a significant minority (27%) worked for between two and four employers. These workers were more likely to work more flexible hours and be self-employed or work on a contract or casual basis (Appendix Table 4).

Roles

The majority of respondents' primary roles were predominantly clinical (85%), only a small per cent reported management (6%), teaching (5%) or research (2.5%) as their primary roles (Figure 19). This is comparable to the AIHW data where only 1.4% reported teacher/educator, 2% researcher and 5% administrator as their primary role.

Figure 19: Primary role across all current employers (n=1258)



Scope of practice

Advanced practice

The following definition of advanced scope of practice was used and respondents were asked to describe their advanced scope of practice role.

Work that is currently within the scope of practice for your profession, but that through custom and practice has been performed by other professions. The advanced role requires additional training, competency development as well as significant clinical experience. Examples include non-medical prescribing (e.g. pharmacy, podiatry), physiotherapy led post-operative review clinics; physiotherapy and occupational therapy led spasticity and intervention clinics.

Fourteen per cent (14%, n=130) of respondents reported that their work involved advanced scope of practice. The most common advanced practice roles reported included orthopaedics (e.g. surgical and MSK screening / assessment / surgical follow up / emergency department), complex case reviews, transdisciplinary practice, bronchoscopy and spasticity management.

There was a desire by many participants to be able to expand their scope, as well as several suggestions as to areas in which this could be achieved. These included identifying the unique aspects of physiotherapy, access to diagnostic and prescribing services, as well as non-clinical advancement opportunities:

“Ability to advance a career in policy, evaluation, service reform as a physio and which acknowledges/remunerates this level of expertise.”

“Able to request diagnostic imaging with equal Medicare rebate to doctors.”

“Advanced scope of practice, injecting and prescribing rights. Injecting for Botox”

“Being able to refer for imaging for all areas of the body instead of just the spine.”

“Closer ties with the medical profession and an improved role for physiotherapists as primary care practitioners and leaders of musculoskeletal evidenced based medicine.”

“Introduction of advanced practice roles in community health, e.g. pain management, OAHKS screening.”

Focus group participants reported inconsistencies in their ability to practice to their full scope of practice across different sectors. In private practice, physiotherapists can order X-Rays, MRIs and CTs but in hospitals they are restricted from ordering these tests because of funding models that support doctors ordering these tests. There was concern that junior private staff do not have the skills to order tests.

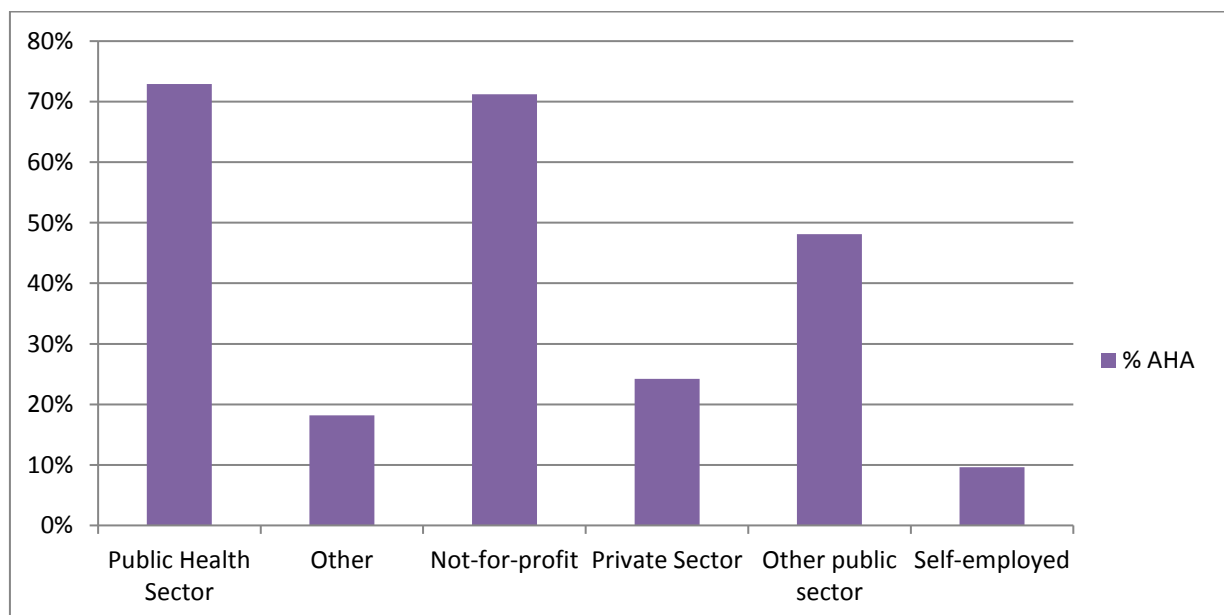
Focus groups participants highlighted that having ‘medical champions’ helped create opportunities for extended practice and innovation.

“There are huge variations in opportunities. It depends on the clinical area, the health service, and the support of the medical team. If you have medical champions, you have opportunities, if you don’t or have saboteurs, you have no chance.”

Allied Health Assistants (AHAs)

Almost two thirds (62%) of physiotherapists in the survey reported they directly supervise and delegate to AHAs. There were large variations by sector with the Victoria public sector, NFP and ‘other’ public sector employees reporting the highest rates of delegation to AHAs. Nearly 10% of self-employed practitioners reported working with AHAs (Figure 20).

Figure 20: Delegation to AHAs by sector (n=931)



Focus group participants were ambivalent about the role of AHAs. On one hand they found them indispensable in assisting physiotherapists get through the volume of patients, but on the other, there was unease about the potential for AHAs to overstep their role, particularly when services are subject to budget pressures.

“It’s that hard thing of how much scope can they do. Obviously they’re much cheaper than physios, but we need to be careful that our colleagues know that we have financial pressures to push to work more with AHAs, but if we don’t make it clear that we are responsible for what they do, and they help us to get through the volume, but it needs to be within the scope they’re hired for. We don’t want to do ourselves out of our professional skill sets and work we’ve trained for.”

“We love our AHAs. They are used on the wards alongside physios to assist transfers, ordering stock and maintaining equipment etc.”

“I work with them a lot. The quality varies hugely and it is hugely dependent on the AHA. If they’re good, they are better than a grade one because they stay around. They have different motivations to a grade 1.”

Telehealth

Telehealth was used for direct service delivery by 3% of respondents and for other purposes by 4% of respondents. Other uses included for training / professional development (receipt of lectures or courses), meetings, to provide clinical supervision of physiotherapy students or staff delivering services via videoconferencing, for research, and to provide telephone consultation or advice.

“We use teleconferencing for ICU [intensive care unit] to review and consult remotely on our tracheostomy patients, they then do one face to face consult per week.”

“Research team communicate by video conferencing. Hoping to set up video conferencing with clients.”

“For professional development and some meetings. No clinical care via telehealth.”

“Handover of patients.”

Workforce movement

To identify movement between sectors and settings, respondents were asked to describe the location, sector, role and duration of their first position (starting position), most recent position, and their three most significant positions in between. The results are presented in per cent as not all respondents had five roles. The numbers of respondents for each role are summarised in Table 7. Figures 22-25 illustrate the broad trends in shifts between locations, sectors and settings.

Table 7: Number of respondents for each position

Position	Numbers of Respondents
Most recent	919
Position 2	757
Position 3	564
Position 4	369
First (starting) position	423

Changes in location

The AHWQ findings demonstrated clear trends in the career paths of physiotherapists with a strong increasing movement towards metropolitan settings (Figure 22). The per cent of respondents who reported that they worked in the metropolitan area of Victoria increased by nearly 20% from the first position to their most recent; however the growth in metropolitan work does not come at the expense of regional and rural roles. Nearly 30% of respondents reported that their most recent role was in a regional or rural setting. At least 20% of physiotherapists included overseas work within their career trajectory.

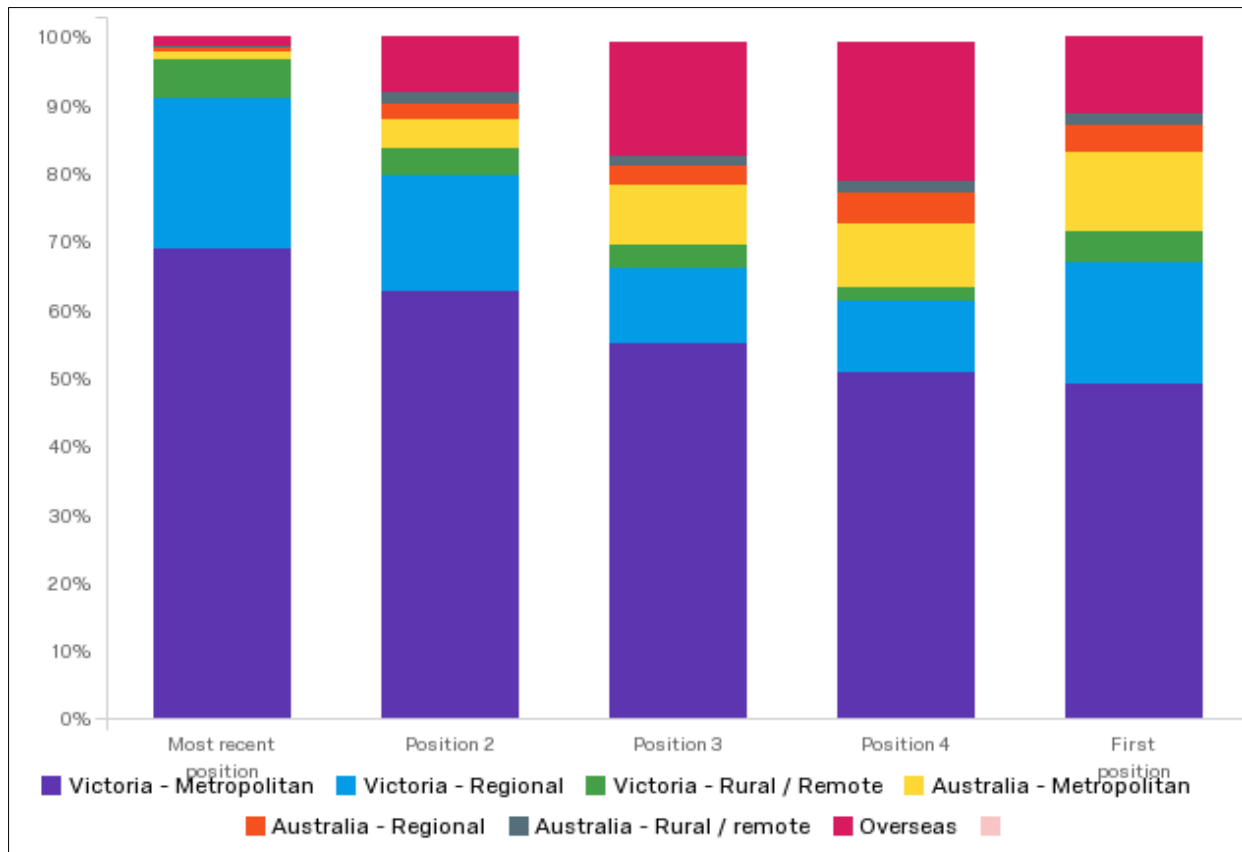
Most (91%, n=711) physiotherapists were qualified in city-based educational institutions. Of these, 27% (n=194) came from regional centers. Of the small proportion educated in regional centers (n=74, 10%), the vast majority (87%, n=64) were originally from regional areas.

The odds ratio (OR=17.1) indicates the odds that physiotherapists educated in the city were raised in the city is 17 times greater than the odds that physiotherapists educated in the country were raised in the city; or alternatively the odds that physiotherapists educated in the country were raised in the country is 17 times greater than the odds that physiotherapists educated in the city were raised in the country (Appendix Table 7).

Almost three quarters (n=545, 73%) of the physiotherapy respondents were city-based; of which, only 22% (n=119) originally came from regional areas. Of the physiotherapy workforce currently in regional areas (n=201), 63% grew up in regional areas. The odds ratio (OR= 6.0) indicates that the odds of physiotherapists currently working in the country having grown up in the country is six times higher than that for physiotherapists currently working in the city having grown up in the country (Appendix Table 8).

More than three-quarters (n=539, 78%) of respondents who studied in the city are currently working in the city, while 28% (n=21) of those who studied in the country are now also working in the city. Of those physiotherapists who currently work in the country (n=206), most were educated in the city (n=152, 74%). The odds ratio (OR = 9.1) indicates that physiotherapists working in the city are nine times more likely than physiotherapists working in the country to have been educated in the city (Appendix Table 9).

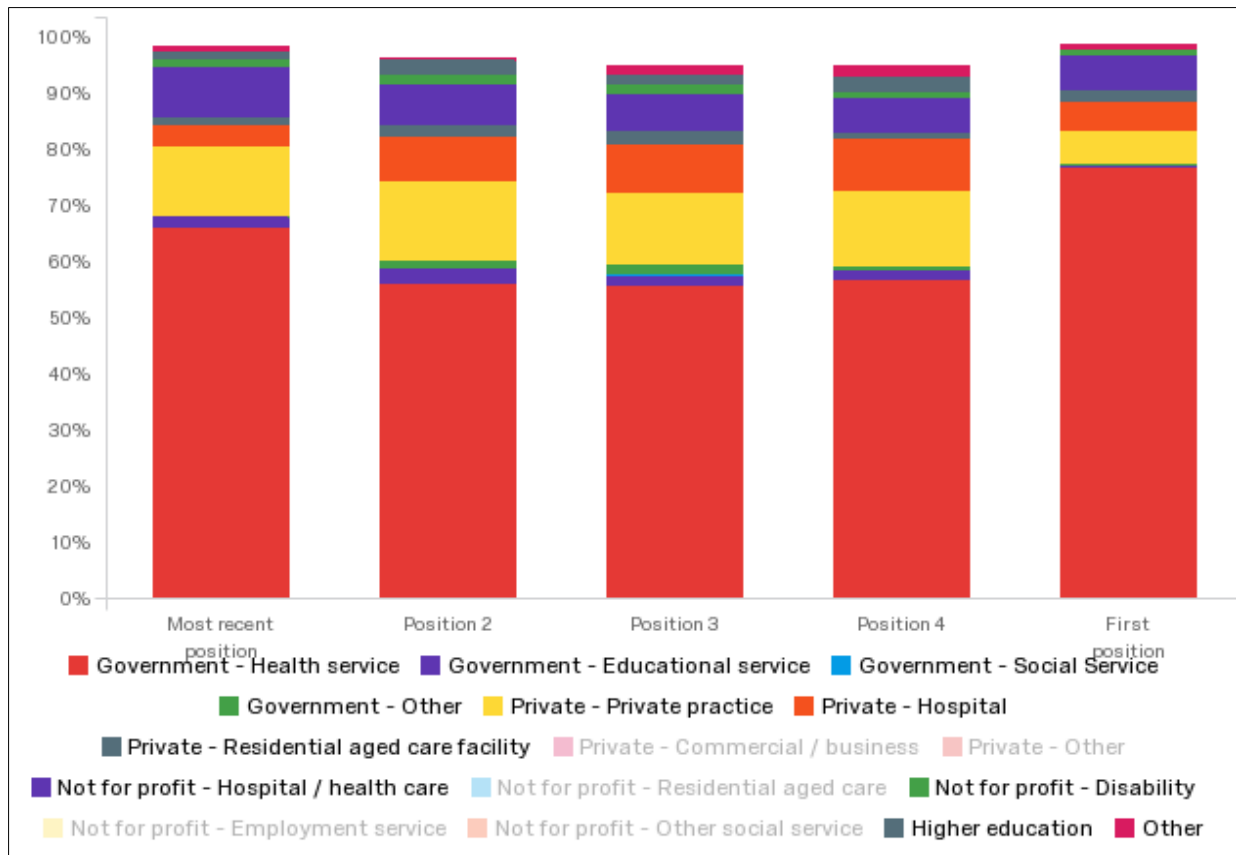
Figure 22: Changes in location across the career path



Changes in sector

From the data provided it appears that physiotherapists’ first jobs were most likely to be in the government sector (77%) (Figure 23). Employment in the public sector drops to around 55% for mid-career roles, then increases again to 66% in the most recent role. Other large employers are private practice, which increases from 6% in the first role to 12% in subsequent roles and remains roughly stable thereafter. Private hospitals account for between 4% and 10% and the NFP sector is also relatively stable, accounting for between 6% and 9% of workplaces.

Figure 23: Changes in sector over the career path ^a

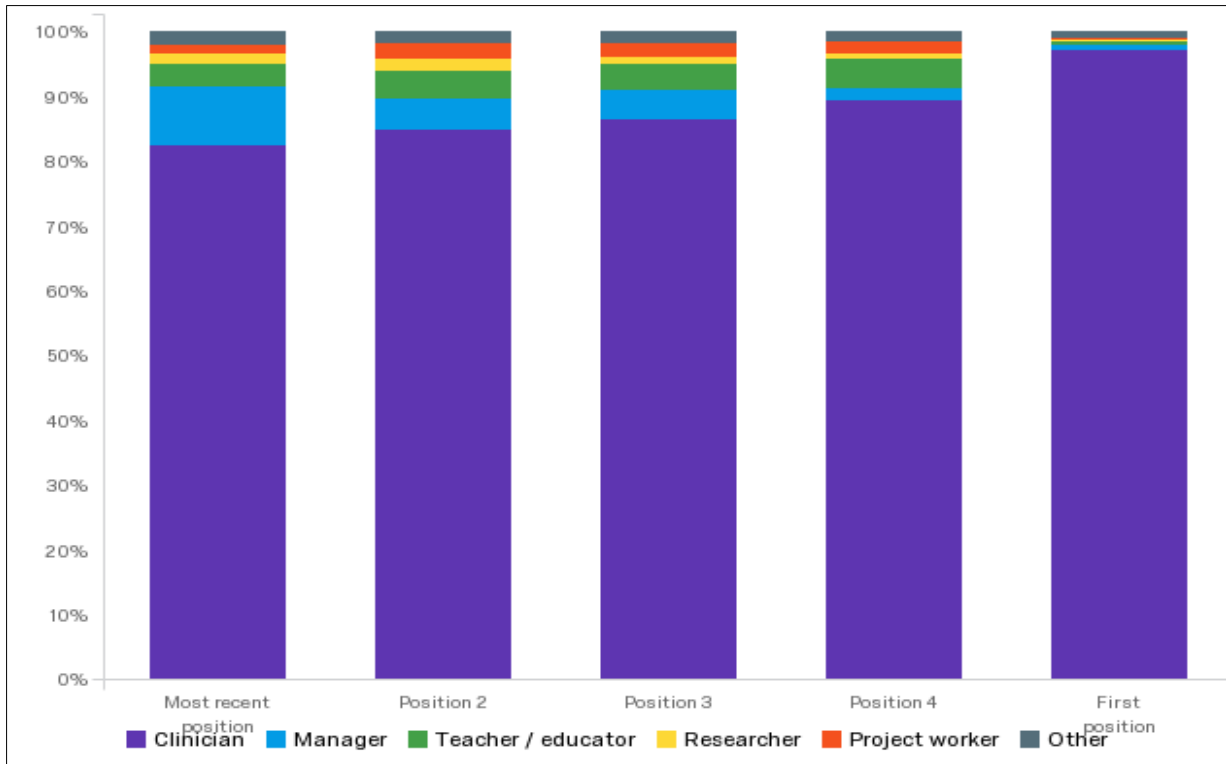


^a Note that some of the potential sectors were suppressed in this output due to small numbers of respondents which is why the bars in Figure 23 do not total 100%.

Changes in role

From the available data there was a slight trend for physiotherapists to progress away from clinical roles into other roles over the course of their career (97% first position compared with 84% most recent position clinical), although the majority remain in clinical work (Figure 24). Correspondingly a small proportion of physiotherapists to move into management roles as their career progresses (1% as first position compared to 9% in their most recent position). Other roles (teachers / educators, research or project workers) appear to remain relatively stable over the career pathway once practitioners have left their starting position.

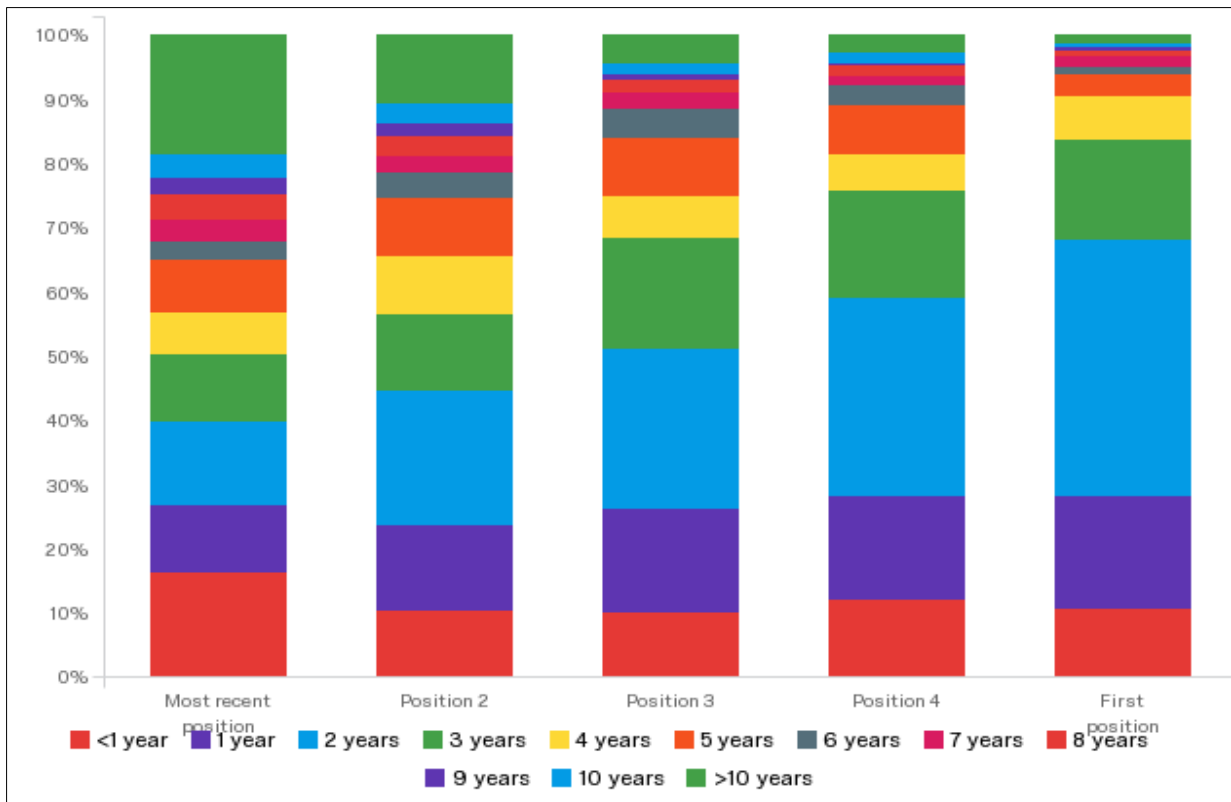
Figure 24: Changes in role over the career path



Years in role

Physiotherapists reported quite a lot of career mobility with the time that they spent in each role becoming slightly more stable over their career trajectory. Eighty per cent (80%) of respondents reported that they stayed for three years or less in their starting position. Sixty per cent (60%) of respondents remained in their starting position for two years or less. In comparison, 22% of respondents reported that they had stayed for 10 years or more in their most recent position.

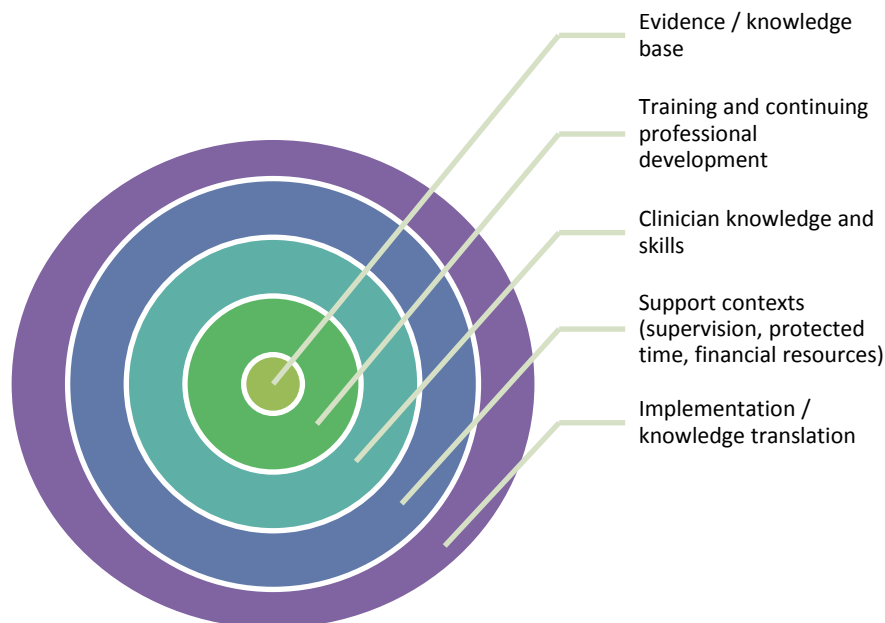
Figure 25: Years in each role over the career path



Capability

Capability refers to the strength of the evidence underpinning relevant physiotherapy activities, access to training and continuing professional development (CPD) to develop the appropriate skills, the standard of skills practitioners have to deliver evidence-based services, the contextual supports available (supervision, mentoring, dedicated time and appropriate funding models), and opportunities for change in practice to occur (i.e. knowledge translation and implementation) (Figure 26).

Figure 26: Workforce capability framework



Key findings

- Physiotherapists have difficulty accessing adequate professional development due to lack of access to training, training not being adequately resourced, particularly when compared to medical staff, and gaps in training provision
- Skill gaps include working with complex patients (new graduates), management and administration skills and specialist skills in aged care and disability to prepare for increased demand in these areas
- There is a need to provide support for physiotherapists to upgrade and continue to maintain their skills
- While the majority of physiotherapists have a clinical supervisor, more mentoring and support may be required. Strong efforts are made with the lower grades but the middle and higher grades and regional practitioners often miss out.
- Physiotherapists expressed that they need to engage with and generate more research to sustain clinical quality and ensure they are employing evidence-based practice.
- Physiotherapists reported a range of prior study experiences and a proportion also hold or are working towards additional post-graduate qualifications including research.

Evidence / knowledge base

The importance of evidence-based practice to enhance the quality of care was identified by a small number of respondents in the qualitative data. Participants expressed a desire to ensure that best practice is implemented and maintained within the multi-disciplinary team, but recognised the barriers to achieving this. In particular, the lack of research to support the evidence base of physiotherapy and lack of equipment to enable best practice provision.

“Lack of evidence for AH interventions; lack of interest in generating evidence to support AH roles in public health from clinicians and managers / leaders; resistance to conduct clinical research from clinicians, managers and leaders.”

“Not having all appropriate equipment for all patients...e.g. getting Bariatric standing / walking again not just hoisted out of bed!”

This was particularly seen as important in sustaining quality clinical care and the reputation of the physiotherapy profession amongst their peers and the community. However, there was recognition that there is a lack of consistent performance and quality management across Victorian health networks to help govern the quality and consistency of care.

“Appropriate and accurate performance enhancement. Inconsistent practices between all Victorian health networks with no body to manage practices that should be shared.”

There was also recognition of the lack of data on the cost effectiveness of physiotherapy treatments.

“Minimal data re: cost effectiveness.”

“Issue with inappropriate servicing that give the profession a bad name amongst peers, third party payers and the community.”

One risk to clinical quality was seen to be a focus on the quantity of new physiotherapy course service providers over quality.

“Maintaining the quality of physiotherapists graduating in a climate where courses are flourishing and quantity is becoming more important than quality.”

Focus group respondents said that part of the problem is that there are not enough research clinicians to help translate research into practice, and that physiotherapists are expected to have these skills, but may not.

“Everyone is expected to be able to read a paper and implement evidence-based practice without a clear understanding of what research is being produced.”

“It is a shame because clinicians are expected to do research in their clinical work, so the research produced is poor quality, or done before so it doesn't change practice.”

Training and continuing professional development

Prior work experiences

The AHWQ explored previous work experience prior to becoming a physiotherapist. Physiotherapists reported a range of prior work experiences.

A quarter (25%) of respondents reported that they had worked in a role or profession other than physiotherapy for an average of three to four years (Appendix Table 10). A wide range of roles were described including waitress and hospitality workers (n=11), project managers and project workers (n=11), and AHA and research assistant roles (n=14). It is likely that previous work experience brings a variety of skills to the practice of physiotherapy; however the impact of previous careers on physiotherapy outcomes has not been explored.

Qualifications

Entry to practise physiotherapy qualifications

Physiotherapists reported a range of prior study experiences, entering the profession through both undergraduate and graduate pathways, and a proportion also hold or are working towards additional post-graduate qualifications. On average, each physiotherapist held 1.7 qualifications.

The main qualification held by respondents was a bachelor degree (n=844); this was also the dominant entry to practise qualification for these physiotherapists (n=768). In addition, 147 participants held an honours degree; this was the qualification for entry to practise for 76 respondents. Seventy five participants held a graduate entry master's degree. Ninety four respondents also hold a certificate or diploma qualification. It is unclear whether these were part of their career pathway into physiotherapy (Table 8).

Post-graduate qualifications

One hundred and seven (107) respondents held, or are studying for a higher degree by research (PhD, research masters); and a further 502 respondents held, or are studying for an additional form of post-graduate qualification (Table 8).

The majority of respondents (71%) attained their main qualification to practise as a physiotherapist in Victoria, or another Australian state (19%), predominantly NSW or Queensland. Ten per cent of respondents were trained overseas (Table 9). This is slightly lower than the AIHW findings which showed that 15% of physiotherapists were overseas trained (including 4.3% New Zealand).

Table 8: Qualifications held or currently studying (n=956)

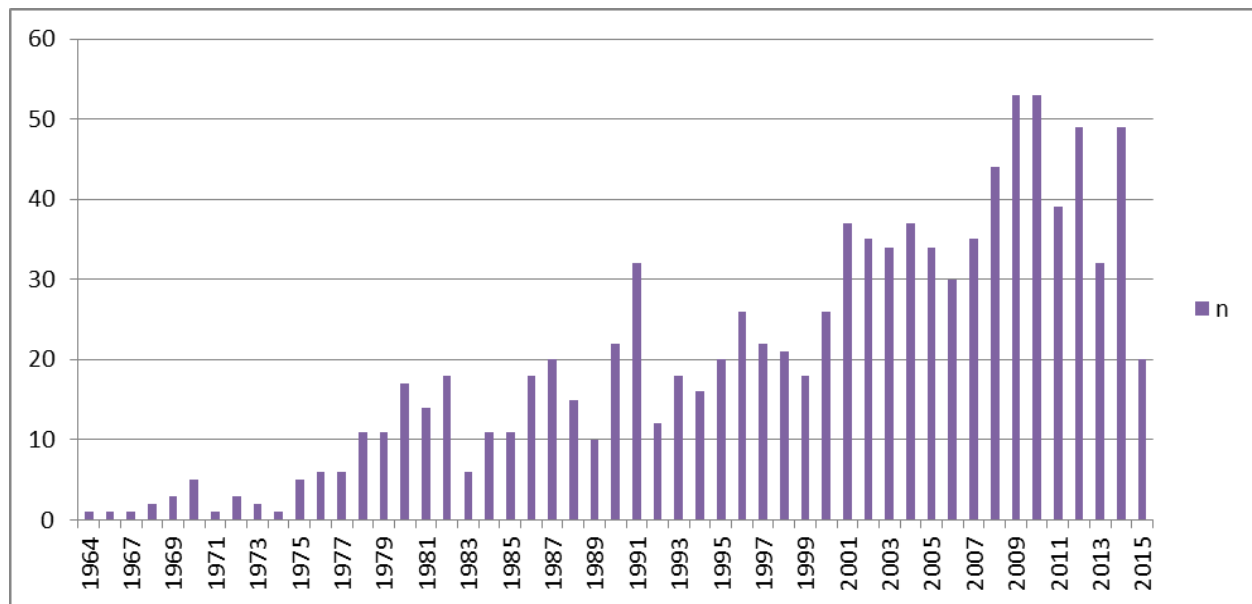
Qualification	Current qualification/s	Qualifications currently studying	Main qualification to practise
Certificate III	18	1	0
Certificate IV	41	3	0
Associate diploma	14	2	3
Advanced diploma	21	4	14
Bachelor degree	844	4	768
Honours degree	147	2	76
Graduate certificate	123	22	0
Graduate diploma	139	8	8
Master's degree - Graduate entry	75	8	60
Master's degree – Clinical	138	24	14
Master's degree - Management (e.g. MBA)	30	18	0
Master's degree - Research	23	22	2
Professional Doctorate	14	1	1
PhD	29	33	0

Table 9: Origin of first qualification (n=1,016)

Origin	n	%
Victoria, Australia	720	71%
Other Australian state or territory	198	19%
- New South Wales	88	
- Australian Capital Territory	1	
- Tasmania	0	
- South Australia	28	
- Western Australia	30	
- Northern Territory	0	
- Queensland	45	
New Zealand	22	2%
United Kingdom	37	4%
Canada	7	1%
South Africa	5	0%
Other overseas country (India, Italy, Hungary, Switzerland, Finland, The Netherlands, Ireland, Northern Ireland, Philippines, Hong Kong)	27	3%

On average, physiotherapists had been qualified for 16 years (range 0 – 52 years) (Figure 27).

Figure 27: Year of qualification (n=1,013)



Continuing professional development

Despite the high levels of uptake of post-graduate qualifications, the participants reported difficulties accessing training that will further their career. Barriers included lack of access to training; training not being inadequately resourced, particularly when compared to medical staff; and gaps in training provision.

Lack of access to further training

Respondents reported:

- Lack of opportunities for post-graduate training in specialist areas.
- Lack of availability and access to training in rural areas
- Lack of appropriate variety (emphasis on sports)

“As a grade 4 physiotherapist there is no pathway - this is the end destination other than a manager role. I've already been on a management pathway and chose to not pursue that. Once you take a grade 4 role you are on the same pay level for the rest of your career. There is nothing more. You just keep doing what you are doing, improving yourself in your job, but there is no recognition or reward for those improvements and developments.”

“Minimal opportunities to be a clinical expert and have adequate remuneration. Changing face of public health reduces the opportunity for clinical physiotherapists to practice in area of expertise without leaving the public service.”

“Opportunities: develop clear career structure and opportunities to be a clinical expert with administrative / management duties across all areas of practice. This is currently available in limited form mostly in specific areas of metropolitan health services.”

Training not adequately resourced

Respondents reported:

- No backfill for staff to undertake training
- Lack of funding for training
- Cost of training without return on investment
- Lack of equivalence with other practitioners (medical and nursing)

“Large cost to undertake further study, but without financial reward in workplace.”

“Professional development financial assistance equivalent to medical practitioners in the public sector.”

Focus group respondents reported that physiotherapists are expected to pay for their own professional development and to undertake a master's degree it costs \$30,000. This deters people from furthering their careers.

Participants in focus groups highlighted a lack of equity in relation to training between AH professionals and nurses and doctors who have professional development included in their awards.

Gaps in training

Senior physiotherapists in focus groups reported that students are not doing as much clinical practice as they used to and therefore lack confidence on the job.

“It's not unusual for graduates to say they have never seen an acute stroke patient before. You wonder how that can possibly be.”

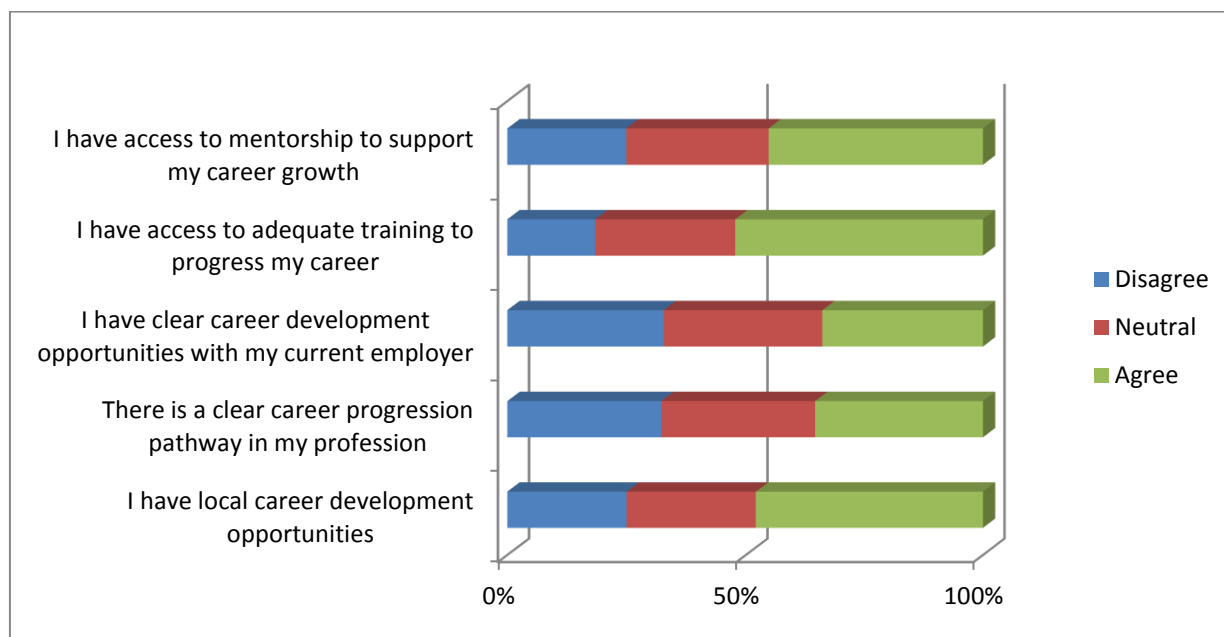
They also identified a gap in provision of training in the management / administration area.

“They've inherited this with the role, but they don't feel that they have a good understanding of it. How do we equip people to do these jobs, what sort of PD do we create for them? We're good at the clinical professional development, but not the admin aspects of the roles as people progress higher.”

Career development opportunities

When surveyed about career progression opportunities and pathways, equal proportions of respondents agreed and disagreed with the statement “I have clear career development opportunities with my current employer / profession”. A greater proportion agreed that there were career development opportunities locally (Figure 28). The majority of respondents reported access to training and mentoring to progress their career.

Figure 28: Career development opportunities (n=880)



Participants were asked an open ended question about barriers and facilitators to career progression as a physiotherapist. Over 500 participants responded to this question. The responses were analysed thematically. Several barriers to career development opportunities were identified by practitioners in rural / regional / remote areas. These included:

- lack of exposure to varied caseload / skills
- lack of supervision
- lack of access (or high cost of) to training in rural / region (even outer metro) areas
- fewer job opportunities in rural / regional areas (diversity and promotion)

“Exposure to higher level practice or advanced techniques in a rural / remote setting. Adopting new ways of service delivery and implementing emerging treatment techniques.”

“I think that working in a big regional centre, while there is always change at the grade 1 level, there is little change at the senior levels, and therefore, if you wish to remain working in the regional centre, you don’t get the opportunity for further career progression.”

Respondents generally reported frustration with the lack of access to senior positions to advance into, and that career advancement tends to be associated with management rather than clinical progression.

“As you become more senior your opportunity to progress is limited by those above you, i.e. for me to progress to a grade 4 role I would need one of the grade 4 physios to resign which given there is nowhere for them to progress clinically creates a stop to career opportunities.”

“Unless you want to go into management you reach your maximum salary at age 30.”

Challenges of juggling work and family life was identified by 30 respondents who suggested that the physiotherapy workplace could be more flexible to support practitioners with young families and that leaving the workplace means that practitioners fall behind. However this view was not shared by all physiotherapists.

“Lack of flexible work options to fit with family. Barriers- having children and not being allowed back to previous work in a part time capacity / Opportunity- to be able to work the hours I want that also allows for parenting.”

“I am travelling towards the end of my career, however I have not found any barriers to progressing in my career other than the time when my children were at school, and the difficulty, attending courses due mainly to time constraints. This has been addressed with the availability of online education. There are great opportunities to progress and to continue with obtaining more knowledge, I am envious.”

“I resigned after my first maternity leave because the hospital required that I return to work full time. There are now requirements for post graduate qualifications which are expensive and hard to obtain - of course an increasing number of people to obtain them now, best done soon after graduating which was not part of the culture when I graduated.”

Focus group participants also reported that support for people raising a family is not always available and may be getting scarcer. Participants from lower grades said that it is not easy to find flexible, part time roles. However established clinicians in the higher grades said they were able to work part time while they were raising their families.

“When I first started, I had 3 young children and was fortunate during the last 13 years I’ve been able to increase and reduce my work to match what was happening in my family life. This was incredibly important for us as a family.”

“I’m not seeing others coming through being benefitted by the same degree of flexibility.”

Lack of management support and inequity in access to career development was highlighted as a barrier by a number of participants in the qualitative feedback in the AHWQ. A key concern was the inequity between AH practitioners, nurses and doctors in ability to access training and career development opportunities. Similarly, the professional dominance of medicine was seen to diminish the input of AH. Managers were also perceived to deprioritise the needs of AH in comparison with other professions.

“Inequitable access to continuing professional development by physiotherapists (and AH in general) in comparison with other professions (nursing and medicine).”

“Other barriers include the lack of respect afforded to AH in general within public health by executives / managers / medical and nursing staff, which influences acceptance of and support for extended or advanced scope.”

Focus groups highlighted that after a certain number of years many physiotherapists are looking for a broader role.

“After about 15 years you wonder whether there is any more than you can do ‘more’ than seeing patients. Can I do more for the community in another way? How do I find the next career path?”

Focus group participants also reported that there are more opportunities at the junior levels and few opportunities at the senior levels. Funding cuts tend to target physios at the higher grades.

“As a senior clinician interested in health services management, there aren’t that many roles for me to choose from. Often the jobs seem to be ‘jobs for the boys’ – not transparently offered / advertised.”

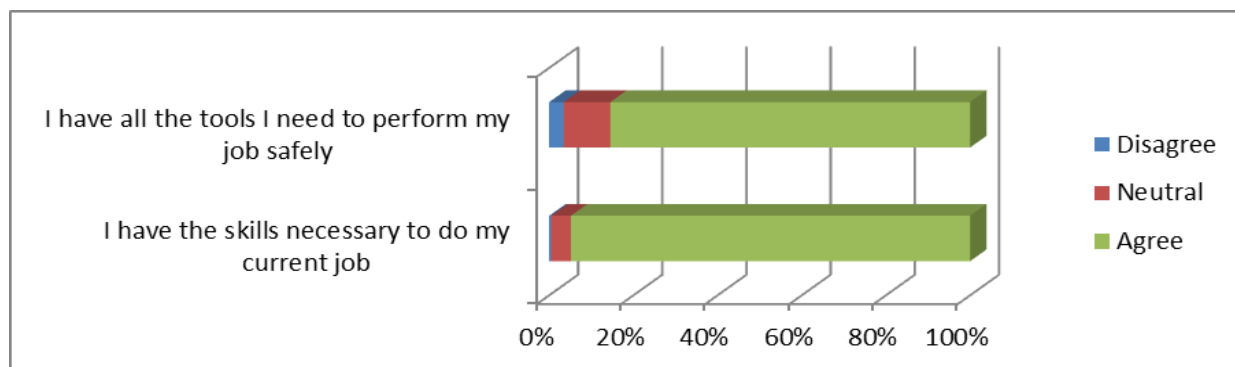
“They target the grade 3s and 4s, so you wonder if you want those roles, because they are seen as the higher risk jobs. Last year they lost their clinical educator. This role is now picked up by other managers.”

“Once you get past grade 2 there are very few opportunities in the Victorian system. Where they do exist they are advertised internally, so external applicants don’t have a look in.”

Clinician knowledge and skills

The vast majority of survey respondents felt that they have the skills to perform their job; only 3.5% felt that they do not have the adequate tools to perform their job safely (Figure 29).

Figure 29: Clinician knowledge and resources (n=874)



Skill gaps

Several employers identified specific skills gaps for the physiotherapy workforce locally; however no single skill was identified as a gap for the workforce as a whole. The skills can broadly be categorised into two areas: generalist and clinical specialist.

The need for ‘rural generalist’ skills was identified. Specifically this involved the need to deal with diverse client groups, clinical issues and professional skills to help the practitioner respond appropriately to diverse issues including resourcefulness, problem solving, clinical reasoning, developing networks, self-confidence and delegation to AHAs, rather than an extensive list of skill competencies for different conditions. An additional skill set was identified for those clinicians moving into management including budgeting, performance management and recruitment.

“Role calls for a generalist - with the ability to draw on external resources when referred clients fall outside of the specific expertise of the practitioner. So we are looking for a set of professional qualities (resourcefulness, problem solving, clinical reasoning, developing networks, self-confidence), rather than an extensive list of skill competencies for different treatable conditions.”

“Gaps are when senior clinicians move to team lead or managers positions (i.e. budget / finance, performance management, recruitment etc.). Skills in communication with patients.”

The clinical specialty areas were more specific to particular clinical contexts.

“Specialty areas: paediatric physio (especially with NDIS [National Disability Insurance Scheme]); grade 3 or 4 with oncology clinical experience as well as other grade 4 attributes; intensive care unit; assessment and management of vestibular disorders is also an area where further development is required; respiratory; equipment prescription; continence; lymph oedema; mental health coaching.”

“Delegation to AHA’s.”

“Research”

“Graduate skills are great.”

The focus groups highlighted concerns that graduates were not being well prepared for complex patients, even though it is a growing area.

“Students find complex patient presentations difficult to handle – they need to develop more evidence and prepare students around this. This is a gap we need to look at.”

Where specific local skills are required, it would be appropriate to address these through the provision of CPD, however the lack of clinician access to CPD presents a barrier to meeting local skill requirements. Examples of specific skill areas identified for development included:

- aged care
- NDIS
- manual handling
- emotional intelligence / team work

“Aged care is the fastest growing area of physiotherapy yet it is still not consistently addressed in the university syllabus. I would like to see structured aged care education on topics such as dementia and integrating complex chronic conditions in the university syllabus.”

“Less emphasis on intellectual ability and more on emotional connection with other team members and clients“

“This is a skill gap (NDIS) – being in the community working with clients with multiple complex care needs and helping them to negotiate the system.”

A small number of respondents expressed concerns about physiotherapists being work ready, and specifically have the skills to work in private practice.

“Compulsory registration year in public or approved private setting to ensure new graduates are appropriately supervised to ensure professional ongoing practice.”

“New graduate readiness for private practice.”

Respondents identified a need for ongoing training to enable existing practitioners to maintain and upgrade their skills, including self-employed practitioners.

“Providing more support for self-employed physiotherapists i.e. professional support/advice i.e. helpline / forum, professional development pathways, research assistance.”

“Clinical training of undergraduate students is getting changed more and more and I am worried about the quality of undergraduate education (as well as the non-uniform course structure across universities).”

Support contexts to enhance capability

Supervision and support

Associated with the need for better career development opportunities and CPD was a recognised need for better supervision and support within the physiotherapy profession.

The majority of physiotherapists (74%) were supervised by another physiotherapist; however 15% of physiotherapists reported working clinically but not having a clinical supervisor (Figure 30). The level of support and supervision was felt to generally be acceptable (Figure 31).

There were sectoral differences in the levels of access to professional support. Groups most likely to report a lack of clinical supervision were self-employed practitioners (43%), other public sector employees (22%), and privately employed practitioners (18%). In the Victorian public and NFP sectors 11% and 12% of respondents reported lack of access to supervision respectively. The grades reporting the least access to supervision were those in the lowest and highest income categories (not aligned to public sector pay grades), reflecting the likelihood of less formal working contexts for these practitioners.

Figure 30: Professional background of clinical supervisor (n=874)

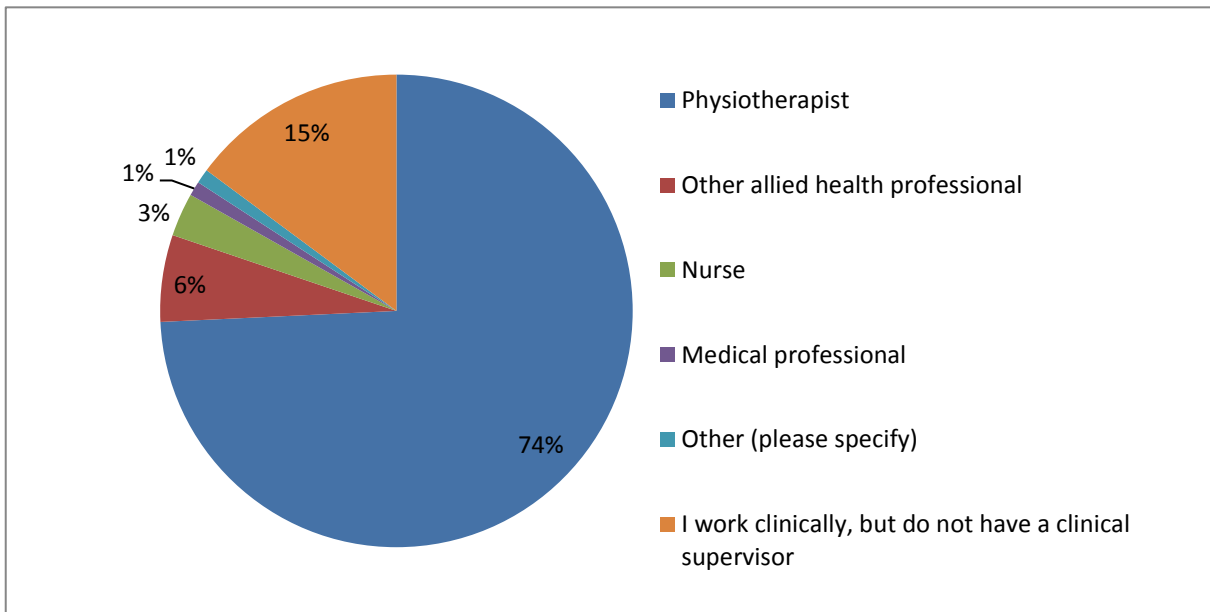
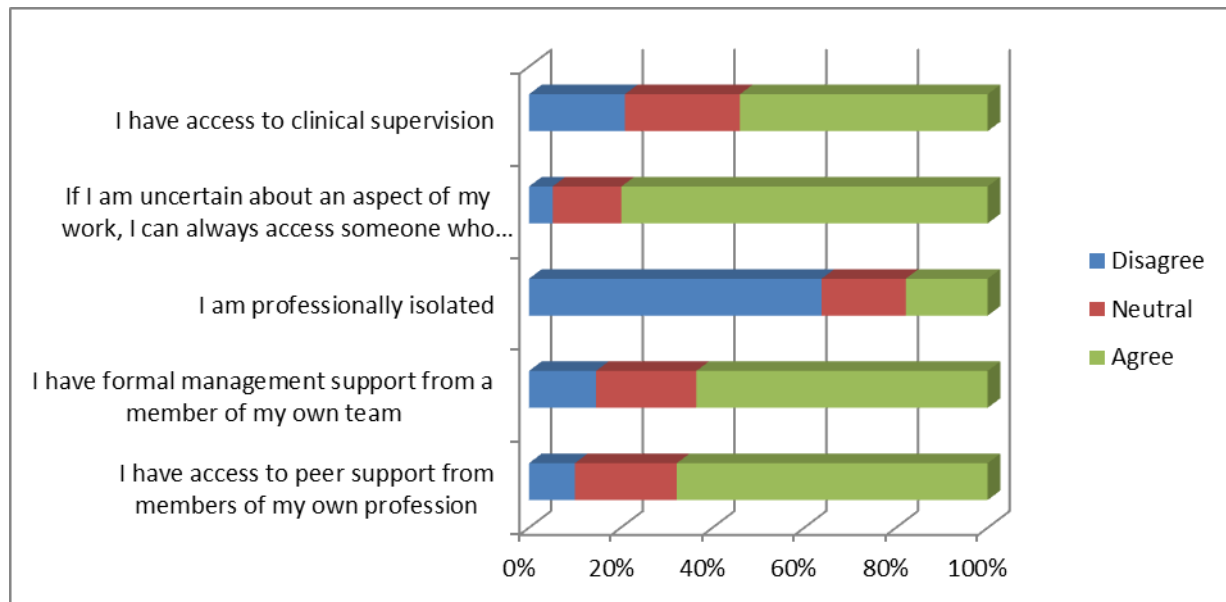


Figure 31: Access to clinical supervision and support (n=833)



The need for improved access to supervision and support was highlighted in the qualitative data, including a lack of access to supervision, the importance of supervision to the quality of patient care, and the need for more clinical support around speciality areas and not just for lower grades.

“There is continual disengagement from senior managers and CEO [Chief Executive Officer] to the front line workforce. Clinical issues are not resolved, efficiency of service is poor and there is a real risk to the quality of the clinical service delivered.”

“I believe that it is vital that multidisciplinary AH teams are managed and supported by skilled AH professionals and that there is training in the public sector to support management training and support to ensure teams are managed and governed effectively and safely.”

“Ensuring professional development, competency, clinical supervision reinforced.”

“Mentoring - particularly for rural practitioners.”

“Support for rural practitioners to see practice elsewhere to reduce the effect of isolation / distance.”

“Mentoring and support, particularly for regionally located grade 2 staff. I found there are supports for grade 1s, but often grade 2s lack that kind of mentoring and support.”

Supervision of students was a particular issue highlighted by focus group participants, due to the large numbers requiring supervision.

“It is a problem as we don’t have enough supervision for students, so we do have to use grade 1s and they’re not trained or experienced, and it’s not in their contract. But we do use more senior grade 1s, and attempt to support them as much as possible – I imagine it could be quite confronting though.”

“We all enjoy student supervision, but it adds a significant amount of pressure... It adds significant load. It sometimes creates a bottleneck in outpatients because the students need to be supervised.”

There was also a view from some focus group participants that the private sector does not provide adequate supervision for new graduates and that new graduate positions need to be created in the public sector to ensure that inexperienced staff do not go directly into an unsupported environment in the private sector.

“It is difficult to teach clinical reasoning, clinical skills alongside the business side of things in a limited time frame for training.”

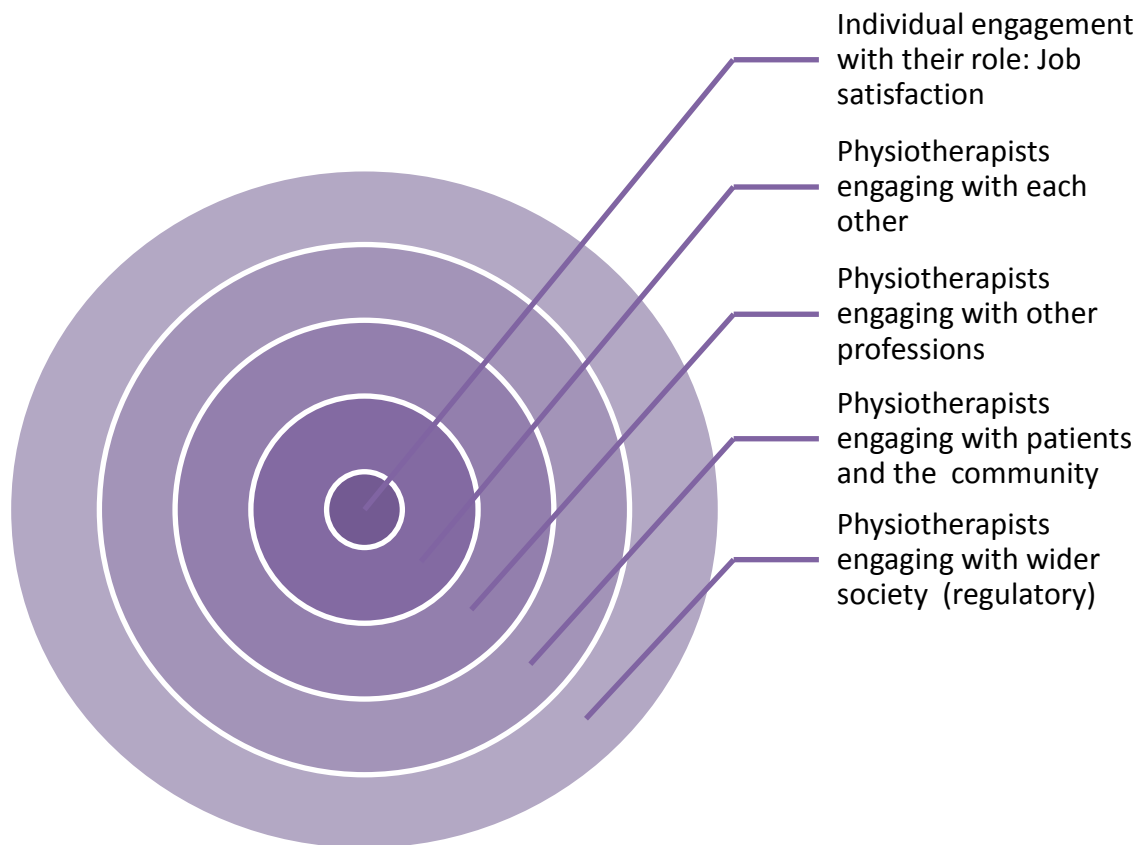
Senior staff also highlighted the lack of access to mentorship; this was supported by the quantitative data.

“Mentoring once in more senior positions not really available. Pressures of working in a very busy public setting mean you have to put all your energy into seeing clients and have little time for projects, research etc. There are good opportunities, though limited, for advanced practice in the public sector, so long as you are able to fund your training yourself.”

Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. Within this course there is engagement with the profession, engagement with other professions, and engagement with patients and the community (Figure 31).

Figure 31: Model of engagement



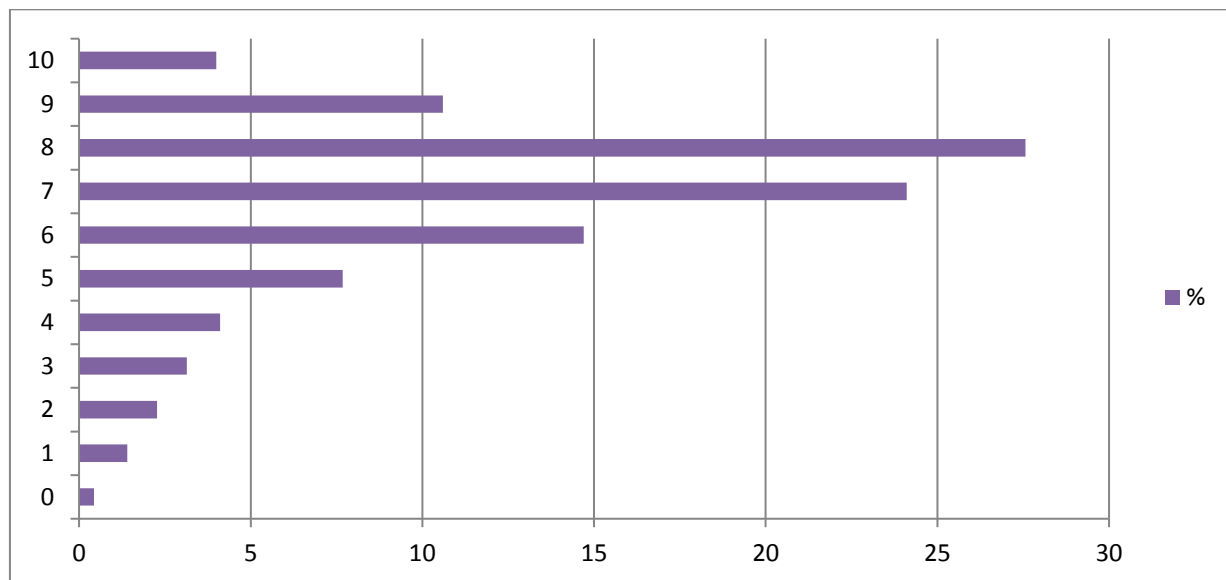
Key findings

- Physiotherapists have a high level of career satisfaction. Nevertheless, there are a number of aspects of their jobs that they are not satisfied with, notably pay (compared with other states) and career advancement opportunities.
- Another key issue underlying satisfaction is burn-out and the challenges in managing large caseloads.
- Despite being a registered profession and having a relatively high profile amongst the AH professions, physiotherapists perceive that their role and expertise is not well understood by society generally or by the medical profession.
- There appeared to be a want for the professional body to engage more with the profession to support factors affecting physiotherapists.
- New roles are emerging for physiotherapists to work alongside other health professionals in specialised areas such as oncology, diabetes care and back pain as well as interdisciplinary roles. Work needs to be done to further define these roles and build the necessary skills in the workforce to take them on.

Individual role engagement

Physiotherapists have high levels of satisfaction with their role, with a mean satisfaction score of 8 on a 10 point scale (Figure 32). However, satisfaction varied by sector and grade. Satisfaction was greatest amongst those who are self-employed or employed in the private sector and lowest in the NFP sector. The least satisfied grades were deputy chief physiotherapists and grade 2 physiotherapists (or equivalent).

Figure 32: Overall satisfaction (n=925)



Qualitative findings from the AHWQ and focus groups suggests that the high levels of satisfaction are largely due to their enjoyment of clinical work and client interaction, contributing to meaningful outcomes for their clients, and working with their team.

“Most satisfying is being able to make a difference and being recognised in the community for doing this.”

“When working in a niche area at a higher level, you’re making a huge difference to a lot of people in the community, particularly those who are vulnerable.”

The most important factors affecting employment choices for physiotherapists were work-life balance, the type of work and clients, professional development opportunities and support, location and career advancement opportunities (Figure 33). However, the levels of satisfaction with these factors suggested that a proportion of staff were dissatisfied with their work-life balance, income and career development opportunities presented by their work (Figure 34).

Two thirds (68%) of respondents were either moderately or very satisfied with their current income, 32% were dissatisfied.

Figure 33: Importance of factors affecting employment choices (n=883)

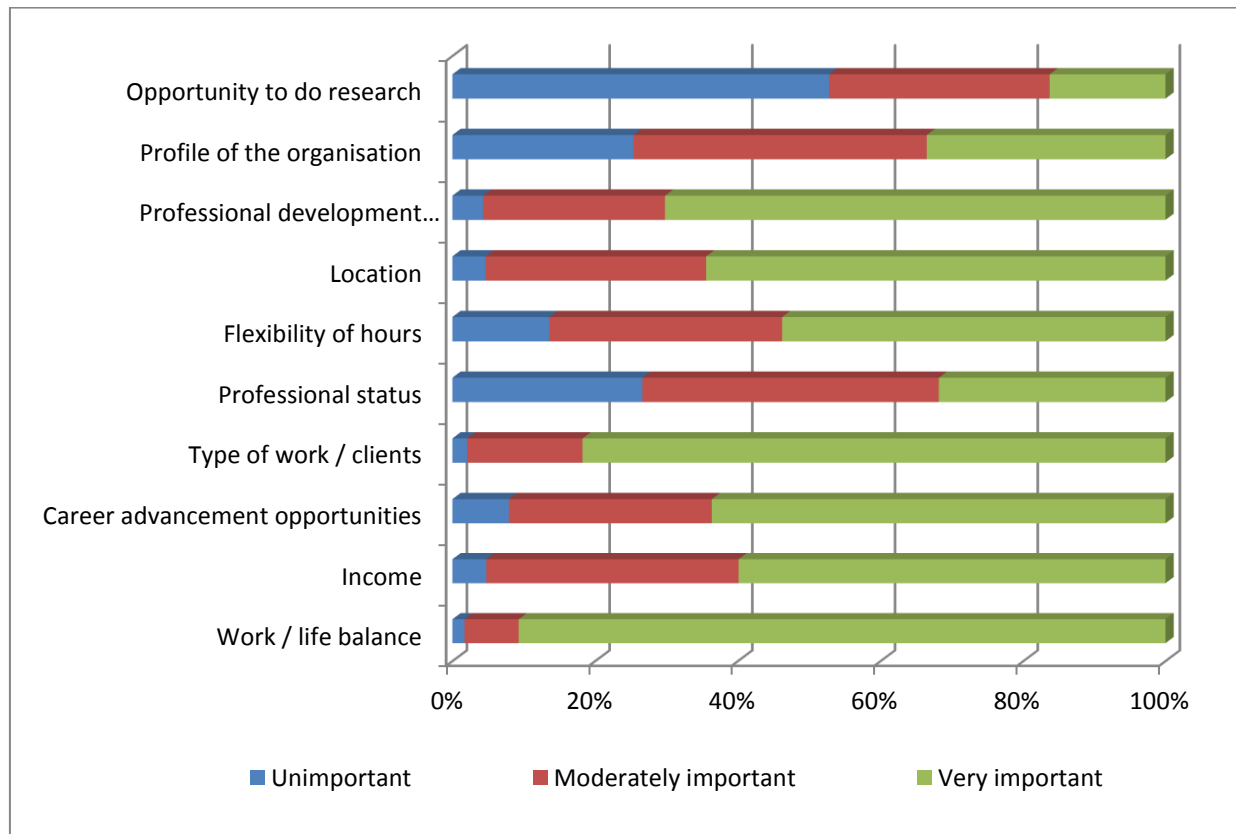
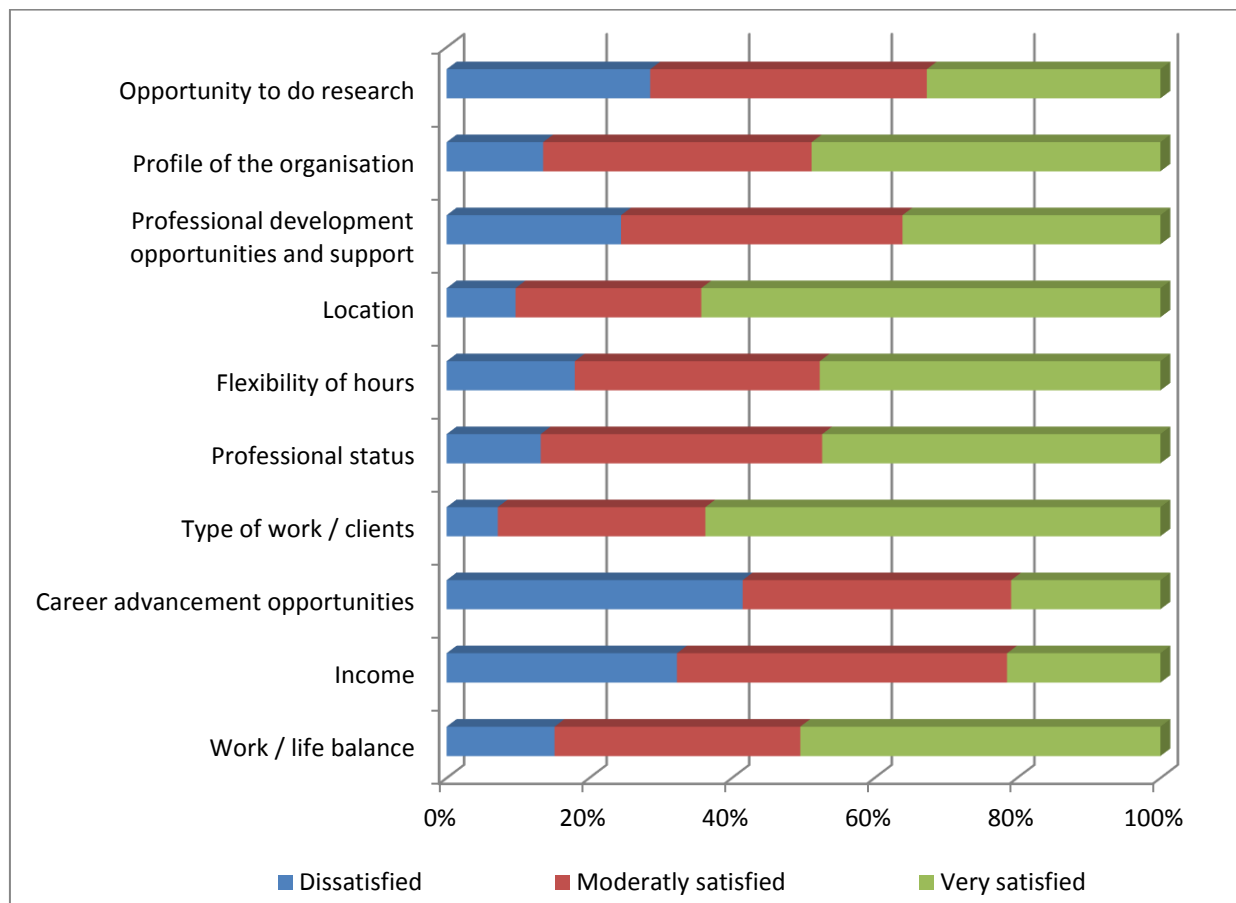


Figure 34: Current satisfaction with factors affecting employment choices (n=879)



Employment sector appears to be more stable, with 21% of respondents saying that they would change sector within the next five years, and only 4% of respondents intending to change within the next 12 months. Reasons given for changing sector include starting private practice, moving to academia, and going overseas.

“Go to private as it pays a lot more. Or go interstate as automatic pay rise of \$10,000.”

“I am actually choosing worse pay, worse conditions but working in developing countries is my passion.”

Employment conditions were highlighted as a key issue underpinning job satisfaction in the qualitative feedback; specifically burnout, and the challenges managing caseloads.

“Caseload management- too many clients, not enough EFTs, therefore no ability to allocate time to prepare for student supervision / teaching, admin, projects or research. Poor understanding from my organisation of the amount of EFT required for my position.”

Respondents expressed a desire for more workforce flexibility:

“Clear and easy pathways back into physiotherapy after a non-practising period.”

“Flexibility with annual leave around school holiday time. Option of unpaid leave if required.”

“Increased stability in the workplace, including environment, expectations / demands, location, to enable longer term projects and research.”

A proportion of physiotherapists (15%) identified poor pay and perceived pay inequality as the most important issue facing their profession.

“We have to rely on salary packaging to earn the equivalent of other professions such as teachers.”

“Staff profile and equity in the public health service - different health services have differing EFT for a similar program or ward set up; different profile and ratio of grade 1, 2, 3, 4; different services for patients i.e. An ED that offers AH services as to those who do not. There needs to be more consistency across the sector that demonstrates equity for patients and for staff.”

“The discrepancy in pay throughout Victoria. Physiotherapists in other states earn considerable amount more than we do. Victoria is the lowest paying state.”

Intra-professional engagement

There was a call for stronger engagement by the professional body in a range of factors effecting physiotherapists.

“For the professional body to be involved in reviewing and revamping the Aged Care Funding Instrument (ACFI) to allow physiotherapists working in residential aged care to use the whole range of their skills and work towards improving function without being professionally undermined by the constraints of ACFI and improve outcomes for older Australians living in residential aged care.”

The cost of membership to the professional association was identified as an issue in focus groups, particularly for part-time employees. They also felt the association could be more involved in promotion and branding of the profession and advocating for public health (not just private).

“If you’re spending \$1000 per year, when you’re not earning a big income, this is a huge cost. If you’re not seeing the profession getting much out of it...”

Inter-professional engagement

While acknowledging that there is better awareness about physiotherapy than many other AH professions, physiotherapists perceived that their roles and understanding of what they do was still not well understood by other practitioners, particularly medical practitioners.

“As a physiotherapist in a rural community I work closely with local medicos. Their knowledge of what physiotherapy involves, and how it can contribute to their patients care, is often very poor. On the other hand once they are aware of what I have to offer they are usually fully supportive of my role and consult in my areas of expertise. The problem is not that they do not like physiotherapists, more that they are not educated about what physiotherapy is.”

“As a GP I would struggle to know the difference between what an osteo, chiro, physio does. I’m not sure we can expect them to know the differences.”

“In New Zealand, half of the course was shared between physio, medicine, pharmacy, radiology, dentistry etc. This helped improve the culture of “were all in it together”. Where knowledge overlapped, we did it together.”

Physiotherapists are increasingly working alongside other health professionals. The role of interdisciplinary practitioner is being introduced in some areas. This has the potential to reduce patient length of stay. There are also new roles for physiotherapy specialists in oncology, diabetes care and back pain.

According to focus group participants the barriers to further development these roles are funding and having qualified staff to take them on. There is also some concern about defining limits of practice in transdisciplinary roles.

“They have had to establish quite strict limits about what occupational therapists can do in our profession. What are we going to do about these in the future? How do we manage this so they work within the scope of what they should do?”

Community and society engagement

Physiotherapists are registered practitioners so did not identify the same issues about professional regulation as other (non-registered professions); however they did identify the need for health reform to increase access, equity and quality of health services. Reforms largely related to improving access through improved funding mechanisms.

“Fair access for patients to receive treatment funded by the Medicare system. Physiotherapy has been shown to be an effective, low cost, low risk intervention with a sound evidence base.”

“Advocacy for broader health reform - the financial inefficiencies in standard practice are going to impede the survival of other niche areas of care such as ours (Hydrotherapy).”

“Department of Health setting KPIs [key performance indicators] for acute public hospitals for outpatient appointment waiting times i.e. length of time from referral to first appointment as this would make the current situation more transparent and re-allocate funding to reducing the years of waiting that some patients have if they are not deemed urgent.”

“Electronic record keeping.”

Professional recognition

Physiotherapists reported that a lack of recognition by other agencies, patients and professions is still a concern for the profession.

"You've got that old thing that you're either a sports or MSK physio, which is what the public perceive, but we provide so much more. The public don't have a good idea of what we provide. It's not well recognised in the community."

"Importance of therapy in the NDIS rollout."

"I am heartily sick of the overemphasis placed on the medical profession in our health funding system, in preference to the cheap and effective physios (and other AH)!!!"

"I am in general community health role here and not recognised for my extra training and work that I do with lymph oedema clients as not a lymph oedema clinic as such so just paid at base level rate for the role I do."

Conclusion

As with other AH professions, there has been a rapid growth in new graduates entering the physiotherapy profession, but they lack adequate support, with many graduates unable to access positions, particularly in the public sector. Yet there is still evidence that community need for physiotherapy is not being met. While physiotherapists are, on the whole, satisfied with the role they play in improving patient outcomes, they have many underlying grievances that affect retention. These include a lack of clinical pathways, inequities with medical professions, poor remuneration and a lack of professional recognition.

Future priorities for the physiotherapy profession should focus on improving clinical governance and support, particularly for private practitioners and those working for a large number of different employers; ensuring adequate supply and skills for growing areas of need, including acute and sub-acute areas, aged care, disability, complex patients and interdisciplinary roles; and addressing attrition by providing mentoring, flexibility and a range of career opportunities.

References

- Australian Institute of Health and Welfare (AIHW) (2015). *Physiotherapy - National Health Workforce data set – Registered physiotherapists: Selected characteristics by workforce status and principal role (Victoria 2011 to 2014)*. Retrieved from: <http://www.aihw.gov.au/workforce/physiotherapy/>
- Australian Institute of Health and Welfare (AIHW) (2016). *Physiotherapy - National Health Workforce data set – Victoria (2015)*
- Australian Physiotherapy Association. (2015a). *What is physiotherapy?* Retrieved from http://www.physiotherapy.asn.au/APAWCM/Physio_and_You/physio/APAWCM/Physio_and_You/physio.aspx?hkey=25ad06f0-e004-47e5-b894-e0ede69e0fff
- Australian Physiotherapy Association. (2015b). *Response to survey for Victorian Allied Health Workforce Research Program*. Southern Cross University. Unpublished data.
- Australian Physiotherapy Council. (2015). *Accreditation of entry-level physiotherapy programs: Guide for education providers*. Retrieved from <http://www.physiocouncil.com.au/accreditation>
- Health Workforce Australia. (2014). *Australia's health workforce series: Physiotherapists in focus*. Retrieved from <https://www.hwa.gov.au/our-work/australia%E2%80%99s-health-workforce-series/selected-occupations-focus>
- Physiotherapy Board of Australia (PBA), 2016 *Registrant Data, March 2016*. Melbourne: Australian Health Practitioner Regulation Agency

Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ physiotherapy survey.

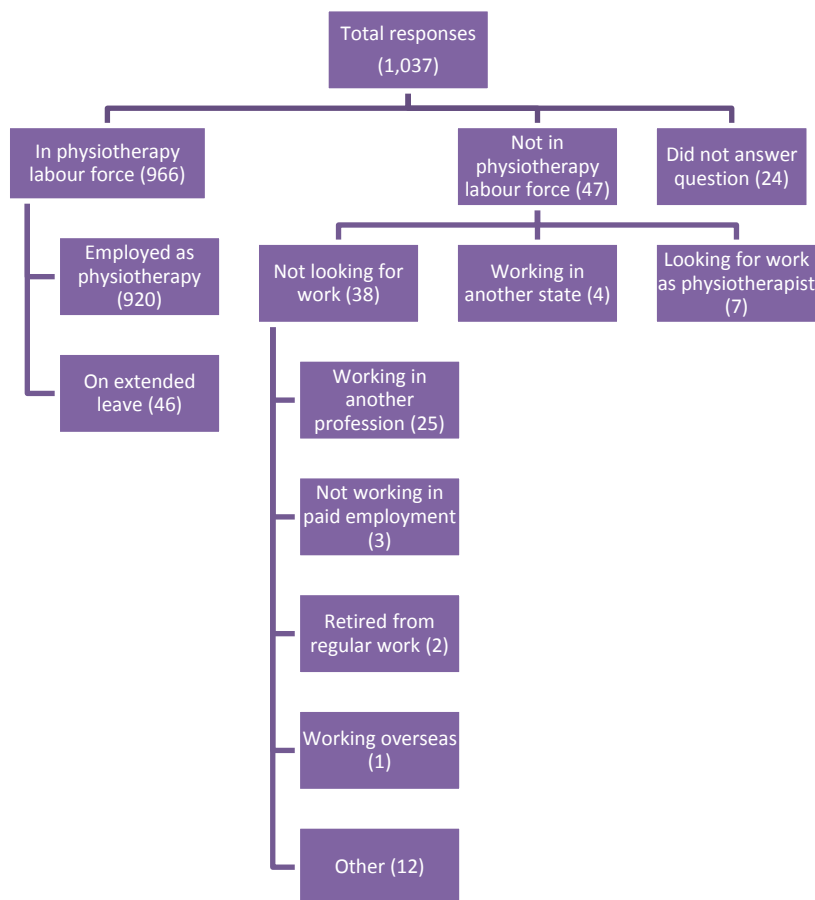
Responses and respondents

The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 1,037 physiotherapists completed at least one question on the survey and submitted their survey. The range of respondents to an individual question was from 138 to 2,305. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

Most respondents (96%) were employed in the physiotherapy workforce at the time of completing the survey. Seven respondents were actively seeking physiotherapy work.

Figure 1: Current employment status⁴



⁴ All data in Figure 1 and Tables 1 – 10 comes from AHWQ survey

Table 1: Number of employers

Number of employers	n	%
0	1	0.1
1	572	72.8
2	164	20.9
3	37	4.7
4	9	1.1
5 or more	3	0.3
Total	786	100

Table 2: Hours worked per week across all employers

Hours	Employer 1	Employer 2	Employer 3	Employer 4	Employer 5
0 – 8	29	142	35	8	0
8 – 16	71	36	6	1	0
16 – 24	124	19	1	0	0
24 – 32	99	4	3	0	0
32 – 40	373	6	1	0	0
>40	77	0	0	0	0

Table 3: Hours worked in each role

Role	Range	Average number of hours	Responses
Clinical	0 -56	25.64	883
Management and administration	0 - 52	8.24	731
Teaching or educating	0 - 45	5.33	480
Research	0 - 46	5.13	201
Project work (not involving direct clinical or research)	0 - 40	3.61	275

Table 4: Nature of employment

	Employer 1	Employer 2	Employer 3	Employer 4
Permanent	621	64	10	1
Temporary	24	9	0	0
Self-employed	35	28	4	1
Contract	67	20	9	2
Voluntary	0	0	0	1
Casual	20	85	22	3
Locum	4	0	0	0
Total Responses	773	207	46	9

Table 5: Working pattern during a normal working week (n=1,177)^a

	n
Monday to Friday between 7am and 7pm (day)	891
Shifts that change from day to day, or week to week	25
Other working pattern (please specify)	43
Saturday	137
Sunday	51
Monday to Friday between 7pm and 7am (night)	30

^a Respondents could select more than one response.

Table 6: Scope of practice

Practice	n	%
Participants reporting their work includes an advanced practice role	130/935	14%
Participants who delegate to AHAs	577/931	62%
Use of telehealth (including video conferencing for supervision)	69/932	7%

Table 7: Relationship between where physiotherapists grew up and where they studied

Childhood location	Study location		Total
	Metro	Regional	
Metro	517	10	527
Regional	194	64	258
Total	711	74	785

Table 8: Relationship between where physiotherapists grew up and current work location

Childhood location	Workplace location		
	City	Country	Total
Metro	426	75	501
Regional	119	126	245
Total	545	201	746

Table 9: Relationship between where physiotherapists studied and current work location

Study location	Workplace location		
	City	Country	Total
Metro	539	152	691
Regional	21	54	75
Total	560	206	766

Table 10: Time worked in 'other' profession

Years	Profession 1	Profession 2	Profession 3	Profession 4	Profession 5	Sum	%
< 1 year	41	13	8	4	0	66	20.9
1 - 2 years	71	17	6	1	3	98	31.0
2 - 3 years	26	3	4	1	1	35	11.1
3 - 4 years	14	7	2	0	0	23	7.3
4 - 5 years	10	3	0	0		13	4.1
5 - 10 years	13	1	1	0		15	4.7
>10 years	15	2	1	0	0	18	5.7
Total Responses	215	65	25	7	4	316	100