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Direct access and patient/client self-referral to physiotherapy: a review of contemporary practice within the European Union

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Abstract

Background Direct access refers to service users being able to refer themselves to physiotherapy without a third-party referral. It represents a model of practice supported globally by the profession, growing research evidence and health policy in some health systems. To the authors' knowledge, no research has been reported to ascertain the extent to which direct access is available within the physiotherapy profession within the European Union (EU).

Objectives To survey member organisations of the World Confederation for Physical Therapy (WCPT); establish the number of member states within the EU where it is possible for individuals seeking physiotherapy services to self-refer; describe the legislative/regulatory and reimbursement contexts in which physiotherapy services are delivered; examine if physiotherapy practice is different in member states where direct access is permitted compared with member states where direct access is not permitted; and to describe the barriers and facilitators to direct access perceived by member organisations of the WCPT.

Design Cross-sectional, online survey using a purposive sample.

Participants Member organisations of the WCPT in the EU.

Results Direct access is not available in all member states of the EU, despite the majority having legislation to regulate the profession, and entry-level education programmes that produce graduates with the requisite competencies. Key barriers perceived are those that can influence policy development, including the views of the medical profession and politicians. Support of service users and politicians, as well as professional autonomy, are seen as key facilitators.

Conclusion These results represent the first report of a comprehensive mapping of direct access to physiotherapy and contexts within the EU. In over half of member states, service users can self-refer to physiotherapists. These results provide insights to further individuals' understanding about the similarities and differences in working practices and service delivery factors, such as reimbursement across and within EU member states. The synergies between barriers and facilitators indicate the importance of targeted advocacy strategies in the introduction of direct access/self-referral to physiotherapy.

Keywords: Direct access; Patient self-referral; Regulation; Education; Autonomy; Barriers; Health policy

Introduction

The terms 'direct access' and 'service users' self-referral' refer to the circumstances where physiotherapy services are available to service users without the need for a third-party referral [1]. In Europe, this is most commonly seen when a service user self-refers to the physiotherapist as an outpatient or in a primary care setting [2,3]. Allowing service users to attend physiotherapy services without the need for a referral has been driven by a number of factors, for example, as a result of larger numbers of health service users who are more informed as 'consumers', or financial imperatives such as the need for reducing waiting lists to see doctors when the physiotherapist may be the most appropriate member of the healthcare team to initially assess the individual. In a number of countries in Europe, health policies and reimbursement models enable service users to refer directly to the healthcare profession of choice [3–5]. This is also supported worldwide by the physiotherapy profession [1].

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The focus of research, to date, has been on service users' self-referral in primary care settings (e.g. people attending for physiotherapy in the community, and as outpatients referring into secondary care services). Two concerns have been raised about direct access and service users' self-referral [2,6,7]. The first is that it may not be safe and that users of physiotherapy services may be placed at risk without a physician referral. The second is that the introduction of direct access to physiotherapy services would result in significant increases in the number of users of the physiotherapy services. Two large health service studies in Europe (the Netherlands and Scotland) have been reported in the literature [2,3,8–11]. In the Netherlands [3], the study focused on patients who self-referred to community-based physiotherapy, and in Scotland [2,8–11], the study included practices in rural, semi-rural and urban primary care settings. Despite the differences in healthcare systems, the studies found similarities: only a certain proportion of patients chose to self-refer (22–26%), and a greater proportion of those who self-referred completed their treatment and reached their goals compared with those who attended physiotherapy with a referral from their general practitioner (GP). In addition, people with neck and back complaints were more likely to self-refer and were also more likely to have symptoms for a shorter duration than patients who attended following GP referral. The research in Scotland [2,8–11] reported no difference between those who self-referred and those who had a GP referral in terms of gender, age, patient- and physiotherapist-determined outcomes, and number of physiotherapy contacts. The authors noted that the average cost of an episode of care for a self-referral was less than that for a GP referral [8]. In the Netherlands, the research reported that younger and more highly educated patients were more likely to self-refer [3]. The studies demonstrated that the introduction of service users' self-referral did not result in an increase in referral rates compared with historic patterns. Moreover, self-referral was safe and acceptable to service users.

Why is direct access important in the European Union?

Within the 27 European Union (EU) member states, the system for the recognition of professional qualifications is designed to 'make labour markets more flexible, further liberalise the provision of services, encourage more automatic recognition of qualifications and simplify administrative procedures' [13]. Physiotherapists represent the third largest group of migrating professionals within the EU [14]. If there is a substantial difference in the knowledge essential for practising the profession, or in the duration and content of the entry-level education between the member state where the applicant acquired his/her professional qualification and the member state to which he/she applies for recognition, a compensatory measure may be required [13]. This may include the extent to which the applicant's experience has prepared her/him for accepting patients without referral. To the authors' knowledge, no research within the EU, to date, has examined the extent to which service users can self-refer to physiotherapists. Hence the purpose of this study was:

- to establish the number of member states within the EU where direct access is possible;
- to describe the legislative/regulatory and reimbursement contexts in which physiotherapy services are delivered;
- to examine if physiotherapy scope of practice is different in member states where direct access is permitted compared with member states where direct access is not permitted; and
- to describe the barriers and facilitators to direct access as reported by the member organisations (MOs) of the World Confederation for Physical Therapy (WCPT) in the EU.

In mapping issues relating to the availability of direct access as reported by the MOs of WCPT within the member states of the EU, information collected could inform education and health policy developments across the EU to support the migration of physiotherapists and effective service delivery models. Lessons can be learned by sharing experiences of the perceived barriers and facilitators to achieving direct access across the EU.

Methods

Survey instrument

An international summit on advanced scope of physiotherapy practice and direct access was held in 2009, and the first version of the survey was developed based on the output of the summit and questions received by WCPT from MOs. Both open and closed questions were included, and their focus was on gathering information about:

- the context for physiotherapy practice in each member state as reported by the MOs (e.g. how physiotherapy services were funded, regulation/legislation, professional practice, whether service users could self-refer and reimbursement issues);
- the support for direct access from the MOs and others; and
- the barriers and facilitators reported by MOs to achieving direct access.

At a workshop hosted by the European Region of WCPT to exchange information about direct access, all delegates were provided with an advance copy of this first version of the survey prepared by the authors for review and discussion. A dedicated session at the workshop allowed participants to feedback to the authors having reviewed the first version of the survey. The aim of this review of the first version was to ensure clarity of the questions being asked and the terminology being used in developing the second version. Thereafter, an international reference group of 11 key informants reviewed the second version of the survey, and the third and final version incorporated their feedback.

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Table 1
Details of respondents: responding member organisations (MOs) of the World Confederation for Physical Therapy (WCPT).

Participants			Responding MOs		Non-respondents	
Number of MOs in the European Union	Surveys completed	Response rate	Size of MO (reported number of members)	Length of membership of WCPT (years)	Size of MO (reported number of members)	Length of membership of WCPT (years)
			Median (range)[a]	Median (range)[a]	Median (range)[a]	Median (range)[a]
27	23	85%	3160 (100 to 38,375)	39 (12 to 60)	354 (290 to 974)	14 (0 to 23)[b]

[a] Data from 2011 reported member numbers per MO (not the same number as practising physical therapists per country).
[b] One new MO in 2011.

An online survey instrument was set up using SurveyMonkey (Palo Alto, CA, USA, http://www.SurveyMonkey.com). The questionnaire included both open and closed questions. Nineteen short closed questions were included as follows: MOs' details ($n = 3$), funding and reimbursement of physiotherapy services ($n = 2$), legislation/regulation and practice ($n = 4$), direct access ($n = 2$), entry-level education ($n = 2$), the views of MOs on direct access ($n = 1$), the views of MOs on the opinions of other stakeholders ($n = 3$), and barriers and facilitators ($n = 2$). Closed questions varied from binary yes/no answers to multiple-choice answers. They were designed to elicit specific information, and logic was used to ensure that those completing the survey were not asked to complete excessive or inappropriate questions. The results of these questions, with the exception of the views of MOs on the opinions of other stakeholders, are reported in this paper. A further eight open questions were asked that sought information in the form of references or web links to legislation ($n = 1$), policy documents ($n = 1$), evidence in support of the views of MOs on direct access ($n = 1$), evidence in support the views of MOs of the opinions of other stakeholders ($n = 3$), a brief description of direct access ($n = 1$), strategies used for influencing the introduction of direct access ($n = 1$), and resources that MOs might be willing to share with others ($n = 1$). The results of the open questions are reported elsewhere [15].

The questions focused on physiotherapy services generally and did not ask for details about the nature and extent of direct access to specific clinical services or specialities. The survey took 15–20 minutes to complete, and is published elsewhere [15].

Participants

In August 2010, all MOs of WCPT were invited to complete the online survey ($n = 106$). WCPT is the sole international representative organisation for physiotherapy and physical therapy worldwide, and has over 100 MOs. Only one MO can represent a country in WCPT. This paper reports on the results from the 27 EU member states that form part of the European Region of WCPT. An e-mail invitation was sent to the primary contact identified by the MO for correspondence from WCPT. Thereafter, reminders were sent by e-mail to MOs. Data were gathered over a 12-month period.

Analysis

Data were analysed using descriptive statistics, and Chi-squared analysis was used to evaluate associations between the existence of direct access, legislation and the scope of practice.

Results

Response rate

MOs from 23 of the 27 member states of the EU responded; a response rate of 85%. The survey was completed by the following: WCPT primary contact ($n = 10$), a professional or policy adviser in the MO ($n = 4$), a international representative of the MO ($n = 4$), or a member of the Executive Board of the MO (e.g. President or Vice-President) ($n = 5$). The mean size of the MOs was 3160 members (range 100 to 38,375). Membership of WCPT ranged from <1 to 23 years. Table 1 provides more details on the characteristics of the MOs of WCPT in the EU.

Legislation/regulation, scope of practice and direct access/patient self-referral

Twenty-two (96%) MOs reported that there was legislation that regulated the physiotherapy profession. Of these, 77% (17/22) reported that this legislation defined the scope of practice. In one MO, despite the existence of legislation to regulate the physiotherapy profession, no registration board had been established. Direct access was permitted by legislation or, where legislation was not in place, by professional scope of practice in 12/23 (52%) member states. Service users were more commonly able to self-refer to physiotherapy in the private sector (83%, 19/23) compared with the public sector (22%, 4/23).

In response to questions about the nature of physiotherapy practice across the EU, there was diversity in the extent to which physiotherapists were permitted by legislation or professional practice to assess, diagnose and treat (i.e.

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Fig. 1. Difference in the scope of practice of physiotherapy depending on whether or not direct access is available.

interventions, advice and evaluation of outcome, refer on to other specialties/services and/or offer preventive advice). Fig. 1 illustrates the nature of physiotherapy practice as reported by MOs. There is a significant positive association between the presence of direct access and the autonomy to diagnose ($\chi^2 = 107.26$, 1 df, $P < 0.001$) and refer ($\chi^2 = 21.41$, 1 df, $P < 0.001$) where direct access is allowed by legislation and/or professional practice.

Funding and reimbursement for physiotherapy services

Respondents reported various ways in which physiotherapy services are funded or paid for across the EU, as illustrated in Fig. 2. In response to the question about whether service users who have health insurance and who self-refer to physiotherapy are reimbursed, 53% ($n = 10$) of MOs reported that the service user was not reimbursed, 16% ($n = 3$) responded that the service user was refunded 'in part', and 32% ($n = 6$) noted that reimbursement depended on the nature of the insurance policy.

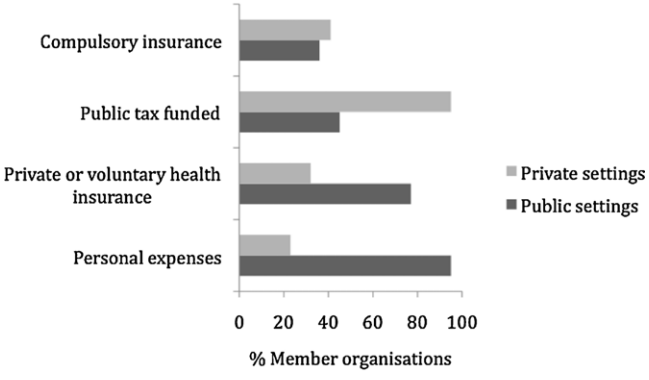

Fig. 2. Sources of funding or payment for physiotherapy services in the European Union as reported by member organisations of the World Confederation for Physical Therapy.

Table 2
Top five most frequently reported barriers to achieving direct access/self-referral to physiotherapy and the strength of the barrier.

	Number (%) of MOs reporting this as a barrier to direct access/patient self-referral	Number (%) of MOs reporting this to be a major barrier[a]
Views of the medical community	16 (70)	12 (75)
Reimbursement models	16 (70)	11 (69)
Economic considerations	13 (57)	7 (54)
Lack of professional autonomy	13 (57)	7 (54)
Lack of support from politicians	13 (57)	7 (54)

MO, member organisation.
[a] Facilitators were ranked from 1 to 5, where the anchors were 'minor' (1) and 'major' (5).

Entry-level education preparation of physiotherapists for direct access and self-referral by service users

Regardless of whether or not direct access is available, the expected competencies of entry-level graduates were reported as being such that the graduates are prepared for direct access in 70% of MOs within the EU. Where this is not possible following entry-level education, physiotherapists may take a Master's degree (29%, 2/7), a period of supervised practice (28%, 2/7) and/or a period of continuing professional development (43%, 3/7) to enable them to become first-contact practitioners.

Views of MOs on direct access/patient self-referral

Seventy-four percent (17/23) of MOs reported that their members were 'completely supportive' of direct access, 13% (3/23) reported 'limited support', and 13% (3/23) indicated that they were 'unsure' of the views of their members.

Perceived barriers and facilitators for direct access and service users' self-referral

The survey investigated both barriers and facilitators to direct access because, for some MOs, the same concept may represent a barrier or a facilitator. MOs were asked to judge the extent to which they perceived barriers and facilitators on a scale from 1 to 5, where the anchors were 'minor' (1) and 'major' (5). These results are reported in Tables 2 and 3.

Discussion

To the authors' knowledge, this is the first study to investigate physiotherapy in the EU and forms part of a larger global survey [15]. The perspectives of the MOs of WCPT in the EU are of interest to a number of different constituencies, ranging from individual practitioners wishing to migrate to professional organisations that may be developing policies, as well as those wishing to influence decision and policy makers. Physiotherapy as a profession is regulated in the majority of

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Table 3
Top five most frequently reported facilitators to achieving direct access/self-referral to physiotherapy and the strength of the facilitator.

	Number (%) of MOs reporting this as a facilitator to direct access/patient self-referral	Number (%) of MOs reporting this to be a major facilitator[a]
Political support for direct access	19 (83)	11 (58)
Service user support	19 (83)	8 (42)
Professional autonomy of physiotherapists	19 (83)	14 (74)
Profession organisation leadership	17 (74)	10 (59)
Waiting lists/service demands	16 (70)	10 (63)

MO, member organisation.
[a] Facilitators were ranked from 1 to 5, where the anchors were 'minor' (1) and 'major' (5).

participating MOs' states consistent with the policy outlined by WCPT [16]. The presence of such regulatory legislation represents a clear indication that public safety and protection is a priority within member states of the EU and will, in future, support initiatives such as the introduction of a professional card to assist in the free migration of health professionals within the EU [17]. Direct access can occur safely within a robust regulatory environment that is in the best interests of both the patients and the profession.

Differences were found between member states within the EU with respect to the ability of service users to self-refer to physiotherapy; this is possible in 52% of member states. Moreover, differences in the nature of practice were reported, with a significant association between increased autonomy in decision making (i.e. diagnosis and referral) and the presence of direct access. Increased autonomy within physiotherapy has developed over the past three decades, driven by the recognition that physiotherapists are appropriately educated, and have adequate codes of conduct and structures in place to ensure that, as first-contact practitioners, their service users were provided with the highest quality and most effective evidence-based interventions [18–21]. Sandstrom [22] suggested that professional autonomy can be both technical (control related to one's work) and socio-economic (economic resources), and this is a useful distinction to explore the results of some of the questions in this survey. Notably, physiotherapists with direct access have more technical autonomy than those without; however, even in the presence of such autonomy, there are limitations to the extent to which service users can self-refer, with the majority only able to refer to services in private practice (83%) compared with publicly-funded services (22%), suggesting a limit in socio-economic autonomy. In private practice, reimbursement to service users is dependent on the type of insurance policy. The reimbursement restriction is also reported by MOs as being a barrier to achieving direct access by over two-thirds of respondents. It is believed that this may be indicative of the challenge to autonomy presented by the 'rationalisation and bureaucracies' as discussed by Sandstrom [22].

Although graduates of entry-level programmes are reported to be educationally prepared for direct access and this is supported by the profession in Europe [1], the results of this survey show that unless the key players and influencers in the development of public policy are in agreement, they are perceived to be significant barriers. In other words, the views of politicians, policy makers and the dominance of the medical profession are reported as being both barriers and facilitators to achieving direct access/self-referral. The power of the medical profession is documented throughout the history of the profession as being a facilitator or a barrier depending on the timing of developments [20,23]. Recognising that a barrier can become a facilitator depending on the 'window of opportunity' [24,25] is of use to professional organisations, who can use the experiences of other professional bodies as well as research findings in their portfolio of material for advocacy initiatives supporting the introduction of direct access/self referral. Of note in the present results is the view of respondents that the public level of support for direct access/self-referral is consistent with the findings of Webster *et al.* [9].

Since the late 1980s, there have been active initiatives to understand the commonalities across physiotherapy entry-level education within Europe [26,27]. More recently, a number of studies [28,29] and reports [30] have attempted to establish a pan-European view of physiotherapy educational programmes and attitudes of students towards professional practice contexts. Whilst these provide insights, none have considered issues from a representative sample across the EU member states. As well as focusing on content and curricula, understanding the similarities and differences in professional autonomy and practice across the EU can inform opportunities for movement of students [28] and the professional community. Data such as those reported in this study support the Migration Policy of the European Region of WCPT: 'it is the priority of the ER-WCPT to facilitate free migration and the right of establishment of physiotherapists within the whole European Region' [31]. It is noted that in the member states of the respondents, the majority of graduates of entry-level programmes are reported to be educationally prepared to act as first-contact practitioners, but that this can only be operationalised in half of the member states. This may be informative for employers in receiving member states, as well as regulators, when attempting to establish the parity of professional qualifications during the process of migration.

These results should be viewed in the context of a number of limitations. Every effort was made to create a common understanding of the questions being asked in the survey, but it is recognised that the language of the survey, English, is not the first language for the majority of those completing the survey. The official language of WCPT is English, and due to limitations in resources, it was not possible to translate the survey into the official languages of 25 other member states. Nevertheless, it is believed that these results, in combination with the clinical research from the UK and the Netherlands [3,8–11], provide an interesting portfolio of information to

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develop further pan-EU research questions, case studies of successful advocacy and lobbying strategies, as well as background material for negotiations with insurance companies about reimbursement models, particularly those that operate across a number of EU member states.

It is recognised that the evidence for the benefits of direct access comes from observational designs [3,8–11] and has not really addressed clinical outcomes, and that further research studies such as randomised controlled trials are desirable. In addition, there may be some responder bias given that four member MOs did not respond to the survey, and the dataset will have to be revised as new member states accede to the EU.

Conclusion

This mapping exercise of the EU identifies the current professional, regulatory and health service contexts in which direct access and service users' self-referral is available across member states. It suggests that greater technical autonomy resides in member states where service users can self-refer to physiotherapists. It reveals that, notwithstanding evidence to support the clinical and cost-effectiveness of direct access, barriers such as the influence of key decision makers and the medical community can still be perceived as preventing its introduction. Notably, these barriers may also be key facilitators, and further analysis of the influential imperatives for that shift to occur need to be undertaken in order to enable professional organisations to be well positioned to roll-out advocacy strategies.

Ethical approval

WCPT does not have an ethical review committee, but the Executive Committee gave its approval of the study, recognising that the study was developed in line with the Declaration of Helsinki and other international guidelines such as the 1991 International Guidelines for Ethical Review of Epidemiological Studies. The anonymity of respondents was assured.

Conflicts of interest

The authors do not believe there are any conflicts of interest, although they are both part of the WCPT Secretariat and Executive Committee. The views expressed are those of the authors and may not represent the views of WCPT.

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