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La profession des masseurs-kinésithérapeutes

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Sommaire

En guise d'introduction

On dénombre 71 791 masseurs-kinésithérapeutes au 31 décembre 2020 en France. Au cours de l'année, 3 574 d'entre eux se sont installés tandis qu'on en recense un sur dix ayant 60 ans ou plus. En moyenne les femmes sont sous-représentées (48%) mais la tendance s'inverse en fonction des tranches d'âge : sur-représentation des hommes à partir de 40 ans et sur-représentation des femmes de moins de 40 ans. Les masseurs-kinésithérapeutes exercent en grande majorité en libéral exclusif (97%) tandis que presque aucun n'exerce en libéral et salarié. Au niveau géographique, la densité de masseurs-kinésithérapeutes pour 100 000 habitants est plus importante en régions Guadeloupe, Réunion ainsi qu'en Corse. A l'inverse, la densité est plus faible dans les régions Normandie, Guyane et Mayotte[1]. A la différence des médecins généralistes, l'accessibilité aux masseurs-kinésithérapeutes est bien meilleure en France. Cette meilleure accessibilité s'explique par la dynamique de la démographie des masseurs-kinésithérapeutes : en effet, entre 1999 et 2017, le nombre d'étudiants autorisés à entrer en première année de formation de masseur-kinésithérapeute a quasiment doublé, passant de 1 412 à 2 756 et les effectifs ont augmenté de 4 % par an. Néanmoins même si les inégalités de répartition diminuent sur la période, elles demeurent. La variabilité d'accessibilité des masseurs-kinésithérapeutes s'expliquent par le type de commune et se rapproche de celle des médecins généralistes. L'accessibilité la plus forte concerne les grands pôles, hors unité urbaine de Paris. Celle des couronnes urbaines des grands pôles et des petits et moyens pôles se situe aux alentours de la moyenne nationale. L'accessibilité diminue ensuite dans les couronnes rurales des grands pôles et les couronnes des moyens et petits pôles. Les communes isolées, hors de l'influence des pôles, présentent l'accessibilité la plus faible[2].

L'objectif ce cette bibliographie est de dresser un portrait de la profession des masseurs-kinésithérapeutes en France et dans les pays de l'OCDE. Après un aperçu sur la sociologie de la profession, les aspects principalement documentés sont les suivants :

- Disparités de répartition territoriale des kinésithérapeutes et mesures de corrections pour l'installation et le maintien dans les territoires ;
- Modalités d'exercices des kinésithérapeutes en groupe pluriprofessionnel ;
- Efficience de l'accès direct pour les kinésithérapeutes.

Les recherches bibliographiques ont été réalisées sur les bases et portails suivants : Pubmed, Web of science, Google scholar, Cairn, Science direct, base de l'Irdes, HAL sur la période 2010-2022/05. Cette bibliographie ne prétend pas à l'exhaustivité.

➢ *Voir aussi sur le site de l'Irdes : les professions paramédicales : sociologie et délégation de soins : Bibliographie thématique. 2020/12.*

Sociologie de la profession et délégation de soins

ÉTUDES FRANÇAISES

(2010). Annexe II. Étude prospective du métier de masseur-kinésithérapeute. Observatoire national des emplois et des métiers de la fonction publique hospitalière. Rennes, Presses de l'EHESP**:** 89-123. https://www.cairn.info/observatoire-national-des-emplois--9782810900268-page-89.htm

> Créé par le décret du 28 décembre 2001, l'Observatoire national des emplois et des métiers de la fonction publique hospitalière présente son second rapport d'activité couvrant les trois années

[1] Cnam (2022). Zoom sur les professions de santé libérale : les masseurs-kinésithérapeutes.
[2] Legendre, B., Aberki, C., Chaput, H., et al. (2019). "Infirmiers, masseurs-kinésithérapeutes et sages-femmes : l'accessibilité s'améliore malgré des inégalités." Etudes Et Resultats(1100): 6.

d'exercice 2005-2008. Les missions réglementaires de l'Observatoire sont distinctes de celle du Conseil supérieur de la fonction publique hospitalière mais complémentaires dans le champ des ressources humaines. De nombreux partenaires ont été associés pour bâtir les outils et les réflexions nécessaires à l'optimisation de la gestion des ressources humaines dans les établissements de la fonction publique hospitalière. L'accent a été particulièrement porté sur la démarche métier et sur l'évolution vers une « fonction publique de métiers », car il convenait de contribuer à la mise en place d'un dispositif nouveau afin de mener une véritable démarche de gestion prévisionnelle, ainsi que sur un travail en commun, sur les emplois et sur certaines professions, avec d'autres observatoires. Le travail ainsi réalisé, en étroite relation avec le bureau de la formation et de l'exercice des professions paramédicales et des personnels hospitaliers (P1), en place jusqu'en 2008, ainsi que la Mission d'études, impact et prospective (MEIP) de la Direction de l'hospitalisation et de l'organisation des soins (DHOS), qui assure le secrétariat de l'Observatoire, répond à une préoccupation forte des professionnels de santé de maintenir une approche qualitative des métiers et de renforcer ce travail en identifiant, sur le terrain, les changements opérés depuis 2004. Ce second rapport d'activité démontre en particulier que l'observation des métiers peut être un vecteur significatif pour adapter les programmes de formation initiale et continue, et que l'ONEM peut constituer un outil pour développer l'attractivité des métiers hospitaliers. Dans un contexte riche de réformes en profondeur du système de santé, guidé par la recherche de l'efficience, l'évolution de ses ressources humaines, de ses métiers s'avère nécessaire pour faire face au vieillissement de la population et aux besoins des patients sur le territoire. À ce titre, la réflexion à venir de l'ONEM devra intégrer la dimension de la coopération entre professionnels de santé, qui permettra notamment de renforcer leur rôle et leurs compétences.

Balas, S. (2011). "Kinésithérapeute, un métier de référence." Nouvelle revue de psychosociologie **12**(2): 223-238.
https://www.cairn.info/revue-nouvelle-revue-de-psychosociologie-2011-2-page-223.htm

Les dispositifs d'analyse de pratiques, à visée prescriptive et évaluative se multiplient actuellement, tout particulièrement dans les métiers de la santé. Ces processus consistent à participer, dans le monde professionnel, à la définition et la promotion de « bonnes pratiques », à travers la rédaction de guides et de référentiels. Cet article, en s'appuyant sur une intervention réalisée avec la méthode des entretiens en auto-confrontation croisés auprès de masseurs-kinésithérapeutes, montre que l'analyse d'activités de travail, à certaines conditions méthodologiques, peut être l'occasion, pour des collectifs de professionnels, de repenser leur travail et sa description. Les référentiels, outils devenus classiques en formation professionnelle comme en management, peuvent devenir un instrument de cette reconception de leur travail par les professionnels. Pour cela, ces référentiels doivent abandonner la description de ce qui se fait ou de ce qui doit se faire, pour intégrer les irrésolus du travail, les dilemmes historiques de métier. Enfin, cet article présente, à titre d'exemple, un extrait d'entretien entre deux professionnels, où un de ces dilemmes se réalise dans l'activité langagière.

Bouchayer, F. (2010). Un regard transversal sur la fonction soignante de proximité : médecins généralistes, infirmières et kinésithérapeutes libéraux. Singuliers généralistes. Rennes, Presses de l'EHESP**:** 169-188.
https://www.cairn.info/singuliers-generalistes--9782810900213-page-169.htm

Chacun de nous connaît un médecin généraliste, en qui il peut trouver un interlocuteur privilégié pour ses soucis de santé. En tant que groupe professionnel pourtant, les généralistes ont longtemps été peu considérés dans notre système de soins et restent méconnus : que sait-on des façons d'être généraliste ? de l'évolution de la profession ? Souvent passionnés par leur métier vécu comme un engagement personnel, les médecins généralistes sont-ils satisfaits de leurs conditions de travail et de leur place dans la société ? À partir d'enquêtes récentes, des sociologues expliquent ce que sont et font les généralistes dans leur cabinet, ils analysent les « flous du métier » et la place du généraliste dans un système de santé en transformation. Écrits dans un style accessible, ces travaux éclairent les dynamiques et les réformes d'une médecine générale aujourd'hui placée au cœur de l'actualité.

Delauney, E. (2010). "Kinés et médecins généralistes : peut mieux faire ? une enquête qualitative en Pays-de-la-Loire." Medecine : Revue De L'Unaformec **6**(6): 277-281.
https://www.jle.com/fr/revues/med/e-docs/kines_et_medecins_generalistes_peut_mieux_faire_une_enquete_qualitative_en_pays_de_la_loire_285192/article.phtml

Le débat à propos d'équipes interprofessionnelles et de prises en charge multidisciplinaires est d'actualité. Hypothèse : Médecins et kinésithérapeutes communiquent peu et l'évolution réglementaire qui a eu lieu depuis 2000, peu respectée, n'a pas changé la situation. Méthode : Enquête qualitative par focus group auprès de 10 kinésithérapeutes libéraux. Résultats : Les relations kinés-généralistes sont généralement qualifiées de « bonnes », avec des variantes selon les personnes et les conditions locales, les côtés les plus négatifs concernant le manque de temps et de formation des médecins. Discussion : Les mêmes problèmes existent entre infirmières et médecins. La situation pourrait s'améliorer avec un effort de communication de la part des médecins, une meilleure formation des médecins sur la kinésithérapie, des formations communes, une amélioration de l'image de la kinésithérapie, la création de maisons de santé et peut-être le développement de relations conviviales extraprofessionnelles. Conclusion : les pathologies prises en charge par les kinésithérapeutes sont fréquemment rencontrées en médecine générale. Une médecine réellement collaborative ne sera possible que si chaque acteur y prête attention.

Matharan, J., Micheau, J. et Rigal, E. (2009). Le métier de masseur-kinésithérapeute. Paris Ondps**:** 137.
https://solidarites-sante.gouv.fr/IMG/p/ONDPS_etude_masseur-kinesitherapeute.pdf

Medina, P., Fontaine Gavino, K., Hamant, C., et al. (2015). "Étude sur les perspectives d'évolution de la démographie des masseurs-kinésithérapeutes et de leurs conditions d'exercice en Rhône-Alpes."
http://www.ors-rhone-alpes.org/pdf/Kines_RA.pdf

L'objectif principal de cette étude est d'anticiper les évolutions possibles de la démographie de la profession ainsi que celles des besoins des patients, afin d'aider au mieux les masseurs-kinésithérapeutes (en exercice ou encore étudiants) à exercer leur profession dans de bonnes conditions dans dix ans, en promouvant alors des stratégies, des politiques adaptées à ces évolutions. Pour cela, tous les éléments d'information pertinents pour anticiper au mieux ces différentes évolutions ont été mis à jour. Il a fallu construire des projections pour "visualiser" les évolutions possibles, en prenant en compte les caractéristiques des professionnels exerçant actuellement dans la région, les tendances et évolutions récentes en matière de modalités d'exercice, afin d'apprécier les besoins dans leur diversité et tenter des projections à l'horizon 2025 pour envisager quelle pourrait être la situation démographique et quelles seront les conditions d'exercice de la profession à cette période. Il s'agit concrètement de poser des éléments de réflexion pour savoir si le nombre de masseurs-kinésithérapeutes dans dix ans sera adapté ou non aux besoins des patients et à la demande des prescripteurs, et quels seront les impacts d'une éventuelle inadéquation entre l'offre de soins et les besoins des patients, à la fois pour les patients et pour les masseurs-kinésithérapeutes eux-mêmes, en termes de conditions d'exercice.

Monnet, S. (2014). Évolution des compétences des masseurs-kinésithérapeutes et besoins de santé : quelle place pour des aides-kinés ? Rennes : Ehesp

Nous avons tenté dans ce travail d'analyser l'évolution récente de la profession de Masseur-Kinésithérapeute (MK). Notre constat global est une forte complexification du métier, avec un changement de paradigme, le MK passant progressivement de sa posture historique de technicien à celle, plus valorisante, de praticien. Dans ce cadre, on s'interroge ici sur la pertinence de la création éventuelle d'un nouveau corps de métier associé d'aides-kinés, ou mieux techniciens de physiothérapie, qui réaliseraient des actes délégués par les MK, soulageant ainsi les pénuries de MK dans les établissements de santé. Une enquête de terrain auprès de professionnels montre des avis très divergents sur les points évoqués ci-dessus. Le défi majeur actuel parait être surtout de progresser encore dans le décloisonnement des diverses professions paramédicales, et de réussir

pleinement la réingénierie en cours de la formation. La piste d'un corps collaboratif reste intéressante, mais ne peut aboutir que dans une étape ultérieure. (R.A.).

Remondière, R. (2014). "L'information du patient en kinésithérapie : une obligation aux multiples facettes." Les Tribunes de la santé **42**(1): 57-63.
https://www.cairn.info/revue-les-tribunes-de-la-sante1-2014-1-page-57.htm

Cet article présente les différentes situations d'information que le kinésithérapeute doit respecter. Distinctes de celles du médecin, leur spécificité réside dans la diversité et la difficulté, selon l'implication du malade et les objectifs négociés avec l'élaboration d'un plan de traitement et d'un délai de récupération. Malgré une législation protectrice pour le malade, ses exigences augmentent, obligeant le professionnel à une plus grande conformité et à de plus grandes précautions auxquelles il n'est pas suffisamment préparé.

Remondiere, R. et Durafourg, M. P. (2018). "Regards sur la kinésithérapie en 2018." Sante Publique **40**(6): 869-876.

À partir d'un état des lieux, les auteurs retracent les étapes de l'évolution de la kinésithérapie au cours des vingt dernières années. Le point fort de cette profession silencieuse est d'avoir achevé, en 2015, sa réforme dans le cadre des accords européens du processus de Bologne. Les mutations, les acquis en lien avec les progrès biologiques, médicaux et issus de la recherche clinique en font un ensemble qui ouvre encore largement ses champs de pratiques, suffisamment pour être attractif auprès des futurs étudiants, mais insuffisamment pour susciter un exercice à l'hôpital. Les contraintes macro- et micro-économiques ont engendré des répercussions importantes et les kinésithérapeutes ont su s'adapter à la nouvelle prise en soins des patients sans altérer la reconnaissance dont ils sont l'objet de leur part. La nouvelle définition de la profession, accompagnée de nouveautés techniques de formation devrait réaffirmer leurs compétences qui n'ont, à ce jour, que peu de traduction au quotidien. La réforme des études doit être comprise comme le point de départ d'une profession en mutation, dont les champs de pratique qui se sont élargis depuis 2016 n'ont pas encore séduits la majorité des professionnels.

Rochut, J. (2014). "Métiers de la rééducation : des professionnels toujours plus nombreux." Etudes Et Resultats (Drees)(895): 6.
https://drees.solidarites-sante.gouv.fr/publications/etudes-et-resultats/metiers-de-la-reeducation-des-professionnels-toujours-plus#:~:text=Ces%20professions%2C%20en%20majorit%C3%A9%20jeunes,%2Dpodologues%2C%20orthophonistes%20et%20orthoptistes.

[BDSP. Notice produite par MIN-SANTE R0xFEtqq. Diffusion soumise à autorisation]. Le champ de la rééducation couvre sept métiers très différents : masseur-kinésithérapeute, pédicure-podologue, ergothérapeute, psychomotricien, orthophoniste, orthoptiste et diététicien. En 2013, les professionnels de la rééducation en activité, âgés de moins de 65 ans sont près de 140 000 en France. Leur nombre est en forte augmentation depuis la fin des années 1990, porté par l'accroissement continu des inscrits en formation sur le territoire et par une hausse des praticiens diplômés à l'étranger venus s'installer en France. Ces professions, en majorité jeunes et féminisées, présentent des modes d'exercice variés. La pratique libérale est très majoritaire pour les masseurs-kinésithérapeutes, pédicures-podologues, orthophonistes et orthoptistes. Les professionnels de la rééducation restent inégalement répartis sur le territoire : les départements côtiers ou du sud de la Loire sont les plus favorisés ainsi que, dans une moindre mesure, ceux de l'Île-de-France.

ÉTUDES ETRANGERES

Downie, F., McRitchie, C., Monteith, W., et al. (2019). "Physiotherapist as an alternative to a GP for musculoskeletal conditions: a 2-year service evaluation of UK primary care data." Br J Gen Pract **69**(682): e314-e320.

BACKGROUND: Physiotherapists are currently working in primary care as first contact practitioners (FCP), assessing and managing patients with musculoskeletal conditions instead of GPs. There are no published data on these types of services. AIM: To evaluate a new service presenting the first 2 years of data. DESIGN AND SETTING: Analysis of 2 years' data of patient outcomes and a patient experience questionnaire from two GP practices in Forth Valley NHS, UK. The service was launched in November 2015 in response to GP shortages. METHOD: Data were collected from every patient contact in the first 2 years. This included outcomes of appointments, GP support, capacity of the service, referral rates to physiotherapy and orthopaedics, numbers of steroid injections, and outcomes from orthopaedic referrals. A patient experience questionnaire was also conducted. RESULTS: A total of 8417 patient contacts were made, with the majority managed within primary care (n = 7348; 87.3%) and 60.4% (n = 5083) requiring self-management alone. Referrals to orthopaedics were substantially reduced in both practices. Practice A from 1.1 to 0.7 per 1000 patients; practice B from 2.4 to 0.8 per 1000 patients. Of referrals to orthopaedics, 86% were considered 'appropriate'. Extended scope physiotherapists (ESPs) asked for a GP review in 1% of patients. CONCLUSION: The results suggest that patients with musculoskeletal conditions may be assessed and managed independently and effectively by physiotherapists instead of GPs. This has the potential to significantly reduce workload for GPs as the service requires minimal GP support. The majority of patients were managed within primary care, with low referral rates and highly appropriate referrals to orthopaedics. Patients reported positive views regarding the service.

Duner, A. (2013). "Care planning and decision-making in teams in Swedish elderly care: a study of interprofessional collaboration and professional boundaries." J Interprof Care **27**(3): 246-253.

In front-line practice, joint working between different professionals in health/social care and rehabilitation is regarded as a means to reach a comprehensive assessment of the needs of the older care recipients, leading to decisions on appropriate care and services. The aim of this study was to examine professional collaboration and professional boundaries in interprofessional care planning teams. Two different care planning teams were studied, one performing care planning in the homes of older individuals and the other performing care planning for older people in hospital wards. The empirical data consisted of audio-recorded care planning meetings and interviews with the professionals in the teams. The integration between the professionals involved was most noticeable in the investigation and assessment phase, while it was lower in the planning phase and almost non-existent in decision-making. The home care planning team tended to work in a more integrated manner than the discharge planning team. The importance of clarifying the roles of all professions concerned with needs assessment and care planning for older people became evident in this study.

Gardner, T., Refshauge, K., Smith, L., et al. (2017). "Physiotherapists' beliefs and attitudes influence clinical practice in chronic low back pain: a systematic review of quantitative and qualitative studies." J Physiother **63**(3): 132-143.

QUESTION: What influence do physiotherapists' beliefs and attitudes about chronic low back pain have on their clinical management of people with chronic low back pain? DESIGN: Systematic review with data from quantitative and qualitative studies. Quantitative and qualitative studies were included if they investigated an association between physiotherapists' attitudes and beliefs about chronic low back pain and their clinical management of people with chronic low back pain. RESULTS: Five quantitative and five qualitative studies were included. Quantitative studies used measures of treatment orientation and fear avoidance to indicate physiotherapists' beliefs and attitudes about chronic low back pain. Quantitative studies showed that a higher biomedical orientation score (indicating a belief that pain and disability result from a specific structural impairment, and treatment is selected to address that impairment) was associated with: advice to delay return to work, advice to delay return to activity, and a belief that return to work or activity is a threat to the patient. Physiotherapists' fear avoidance scores were positively correlated with: increased certification of sick leave, advice to avoid return to work, and advice to avoid return to normal activity. Qualitative studies revealed two main themes attributed to beliefs and attitudes of physiotherapists who have a

relationship to their management of chronic low back pain: treatment orientation and patient factors. CONCLUSION: Both quantitative and qualitative studies showed a relationship between treatment orientation and clinical practice. The inclusion of qualitative studies captured the influence of patient factors in clinical practice in chronic low back pain. There is a need to recognise that both beliefs and attitudes regarding treatment orientation of physiotherapists, and therapist-patient factors need to be considered when introducing new clinical practice models, so that the adoption of new clinical practice is maximised. [Gardner T, Refshauge K, Smith L, McAuley J, Hubscher M, Goodall S (2017) Physiotherapists' beliefs and attitudes influence clinical practice in chronic low back pain: a systematic review of quantitative and qualitative studies. Journal of Physiotherapy 63: 132-143].

Hayward, C. et Willcock, S. (2015). "General practitioner and physiotherapist communication: how to improve this vital interaction." Prim Health Care Res Dev **16**(3): 304-308.

BACKGROUND: Appropriate communication between general practitioners (GPs) and physiotherapists is vital for providing optimal care. Differing opinions exist as to key inclusion in this communication. This study aims to identify the key components that both GPs and physiotherapists would include in inter-professional communication. METHODS: Qualitative study design, using 14 in-depth, semi-structured telephone interviews. RESULTS: Physiotherapists identified relevant past medical history, psycho-social history, yellow flags, anticipated time frame for follow-up and objective measures of current function as the more useful inclusions in written communication. GPs identified the inclusion of a working diagnosis, treatment summary and likely long-term outcomes as the key components to effective communication. DISCUSSION: Effective interprofessional communication requires the provision of information that is both succinct and relevant. While there are individual preferences, this study suggests that certain key characteristics exist, and the inclusion of these in interprofessional communication may lead to improved communication and patient outcomes.

Johansson, G., Eklund, K. et Gosman-Hedstrom, G. (2010). "Multidisciplinary team, working with elderly persons living in the community: a systematic literature review." Scand J Occup Ther **17**(2): 101-116.

As the number of elderly persons with complex health needs is increasing, teams for their care have been recommended as a means of meeting these needs, particularly in the case of elderly persons with multi-diseases. Occupational therapists, in their role as team members, exert significant influence in guiding team recommendations. However, it has been emphasized that there is a lack of sound research to show the impact of teamwork from the perspective of elderly persons. The aim of this paper was to explore literature concerning multidisciplinary teams that work with elderly persons living in the community. The research method was a systematic literature review and a total of 37 articles was analysed. The result describes team organisation, team intervention and outcome, and factors that influence teamwork. Working in a team is multifaceted and complex. It is important to enhance awareness about factors that influence teamwork. The team process itself is also of great importance. Clinical implications for developing effective and efficient teamwork are also presented and discussed.

Jones, A. et Jones, D. (2011). "Improving teamwork, trust and safety: an ethnographic study of an interprofessional initiative." J Interprof Care **25**(3): 175-181.

This study explored the perceptions of staff in an interprofessional team based on a medical rehabilitation ward for older people, following the introduction of a service improvement programme designed to promote better teamworking. The study aimed to address a lack of in-depth qualitative research that could explain the day-to-day realities of interprofessional teamworking in healthcare. All members of the team participated, (e.g. nurses, doctors, physiotherapists, social worker, occupational therapists), and findings suggest that interprofessional teamworking improved over the 12-month period. Four themes emerged from the data offering insights into the development and effects of better interprofessional teamworking: the emergence of collegial trust within the team, the importance of team meetings and participative safety, the role of shared objectives in conflict management and the value of autonomy within the team. Reductions in staff sickness/absence levels

and catastrophic/major patient safety incidents were also detected following the introduction of the service improvement programme.

Marks, D., Comans, T., Bisset, L., et al. (2017). "Substitution of doctors with physiotherapists in the management of common musculoskeletal disorders: a systematic review." Physiotherapy **103**(4): 341-351.

BACKGROUND: There is large variation in models-of-care involving the professional substitution of doctors with physiotherapists. OBJECTIVE: To establish the impact upon patients and health services, of substituting doctors with physiotherapists in the management of common musculoskeletal disorders. DATA SOURCES: Medline, CINAHL and ABI Complete databases, and hand-searching of related studies. STUDY SELECTION: Randomised and non-randomised clinical trials, inter-rater reliability and comparative studies comparing the outcomes of usual care from doctors, with outcomes when the doctor was substituted with a physiotherapist. STUDY APPRAISAL AND SYNTHESIS METHODS: Two reviewers evaluated all studies using the Downs and Black Instrument. Meta-analysis was not possible due to study heterogeneity. A descriptive review was undertaken. RESULTS: 14 studies of moderate to low quality met the inclusion criteria. Professional substitution with a physiotherapist causes no significant change to health outcomes and inconsistent variation in the use of healthcare resources. There is insufficient health economic data to determine overall efficiency. In the selected presentations studied, physiotherapists made similar diagnostic and management decisions to orthopaedic surgeons and patients are as, or more satisfied with a physiotherapist. LIMITATIONS: Further high quality health and economic research is needed, in less selective patient populations, to determine the optimal role for physiotherapists. CONCLUSION AND IMPLICATIONS OF KEY FINDINGS: Physiotherapists provide a professional alternative to doctors for musculoskeletal disorders but the health economic implications of this model are presently unclear. Systematic Review Registration Number PROSPERO (Registration number CRD42015027671).

Perreault, K., Dionne, C. E., Rossignol, M., et al. (2014). "Interprofessional practices of physiotherapists working with adults with low back pain in Quebec's private sector: results of a qualitative study." BMC Musculoskelet Disord **15**: 160.

BACKGROUND: Collaboration and interprofessional practices are highly valued in health systems, because they are thought to improve outcomes of care for persons with complex health problems, such as low back pain. Physiotherapists, like all health providers, are encouraged to take part in interprofessional practices. However, little is known about these practices, especially for private sector physiotherapists. This study aimed to: 1) explore how physiotherapists working in the private sector with adults with low back pain describe their interprofessional practices, 2) identify factors that influence their interprofessional practices, and 3) identify their perceived effects. METHODS: Participants were 13 physiotherapists, 10 women/3 men, having between 3 and 21 years of professional experience. For this descriptive qualitative study, we used face-to-face semi-structured interviews and conducted content analysis encompassing data coding and thematic regrouping. RESULTS: Physiotherapists described interprofessional practices heterogeneously, including numerous processes such as sharing information and referring. Factors that influenced physiotherapists' interprofessional practices were related to patients, providers, organizations, and wider systems (e.g. professional system). Physiotherapists mostly viewed positive effects of interprofessional practices, including elements such as gaining new knowledge as a provider and being valued in one's own role, as well as improvements in overall treatment and outcome. CONCLUSIONS: This qualitative study offers new insights into the interprofessional practices of physiotherapists working with adults with low back pain, as perceived by the physiotherapists' themselves. Based on the results, the development of strategies aiming to increase interprofessionalism in the management of low back pain would most likely require taking into consideration factors associated with patients, providers, the organizations within which they work, and the wider systems.

Sangaleti, C., Schveitzer, M. C., Peduzzi, M., et al. (2017). "Experiences and shared meaning of teamwork and interprofessional collaboration among health care professionals in primary health care settings: a systematic review." JBI Database System Rev Implement Rep **15**(11): 2723-2788.

BACKGROUND: During the last decade, teamwork has been addressed under the rationale of interprofessional practice or collaboration, highlighted by the attributes of this practice such as: interdependence of professional actions, focus on user needs, negotiation between professionals, shared decision making, mutual respect and trust among professionals, and acknowledgment of the role and work of the different professional groups. Teamwork and interprofessional collaboration have been pointed out as astrategy for effective organization of health care services as the complexity of healthcare requires integration of knowledge and practices from differente professional groups. This integration has a qualitative dimension that can be identified through the experiences of health professionals and to the meaning they give to teamwork. OBJECTIVE: The objective of this systematic review was to synthesize the best available evidence on the experiences of health professionals regarding teamwork and interprofessional collaboration in primary health care settings. INCLUSION CRITERIA TYPES OF PARTICIPANTS: The populations included were all officially regulated health professionals that work in primary health settings: dentistry, medicine, midwifery, nursing, nutrition, occupational therapy, pharmacy, physical education, physiotherapy, psychology, social work and speech therapy. In addition to these professionals, community health workers, nursing assistants, licensed practical nurses and other allied health workers were also included. PHENOMENA OF INTEREST: The phenomena of interest were experiences of health professionals regarding teamwork and interprofessional collaboration in primary health care settings. CONTEXT: The context was primary health care settings that included health care centers, health maintenance organizations, integrative medicine practices, integrative health care, family practices, primary care organizations and family medical clinics. National health surgery as a setting was excluded. TYPES OF STUDIES: The qualitative component of the review considered studies that focused on qualitative data including designs such as phenomenology, grounded theory, ethnography, action research and feminist research. SEARCH STRATEGY: A three-step search strategy was utilized. Ten databases were searched for papers published from 1980 to June 2015. Studies published in English, Portuguese and Spanish were considered. METHODOLOGICAL QUALITY: Methodological quality was assessed using the Qualitative Assessment and Review Instrument developed by the Joanna Briggs Institute. All included studies received a score of at least 70% the questions in the instrument, 11 studies did not address the influence of the researcher on the research or vice-versa, and six studies did not present a statement locating the researcher culturally or theoretically. DATA EXTRACTION: Qualitative findings were extracted using the Joanna Briggs Institute Qualitative Assessment and Review Instrument. DATA SYNTHESIS: Qualitative research findings were pooled using a pragmatic meta-aggregative approach and the Joanna Briggs Institute Qualitative Assessment and Review Instrument software. RESULTS: This review included 21 research studies, representing various countries and healthcare settings. There were 223 findings, which were aggregated into 15 categories, and three synthesized findings: CONCLUSIONS: This review shows that health professionals experience teamwork and interprofessional collaboration as a process in primary health care settings; its conditions, consequences (benefits and barriers), and finally shows its determinants. Health providers face enormous ideological, organizational, structural and relational challenges while promoting teamwork and interprofessional collaboration in primary health care settings. This review has identified possible actions that could improve implementation of teamwork and interprofessional collaboration in primary health care.

Saxon, R. L., Gray, M. A. et Oprescu, F. I. (2014). "Extended roles for allied health professionals: an updated systematic review of the evidence." Journal of multidisciplinary healthcare **7**: 479-488.
https://www.ncbi.nlm.nih.gov/pubmed/25342909
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206389/

BACKGROUND: Internationally, health care services are under increasing pressure to provide high quality, accessible, timely interventions to an ever increasing aging population, with finite resources. Extended scope roles for allied health professionals is one strategy that could be undertaken by health care services to meet this demand. This review builds upon an earlier paper published in 2006 on the evidence relating to the impact extended scope roles have on health care services. METHODS: A systematic review of the literature focused on extended scope roles in three allied health professional

groups, ie, physiotherapy, occupational therapy, and speech pathology, was conducted. The search strategy mirrored an earlier systematic review methodology and was designed to include articles from 2005 onwards. All peer-reviewed published papers with evidence relating to effects on patients, other professionals, or the health service were included. All papers were critically appraised prior to data extraction. RESULTS: A total of 1,000 articles were identified by the search strategy; 254 articles were screened for relevance and 21 progressed to data extraction for inclusion in the systematic review. CONCLUSION: Literature supporting extended scope roles exists; however, despite the earlier review calling for more robust evaluations regarding the impact on patient outcomes, cost-effectiveness, training requirements, niche identification, or sustainability, there appears to be limited research reported on the topic in the last 7 years. The evidence available suggests that extended scope practice allied health practitioners could be a cost-effective and consumer-accepted investment that health services can make to improve patient outcomes.

Steihaug, S., Paulsen, B. et Melby, L. (2017). "Norwegian general practitioners' collaboration with municipal care providers - a qualitative study of structural conditions." Scand J Prim Health Care **35**(4): 344-351.

PURPOSE: The purpose of this study was to explore the structural mechanisms that facilitate or counteract collaboration between general practitioners (GPs) and other providers of municipal healthcare. Good collaboration between these actors is crucial for high-quality care, especially for persons in need of coordinated services. MATERIAL AND METHODS: The study is based on semistructured interviews with 12 healthcare providers in four Norwegian municipalities: four GPs, six nurses and two physiotherapists. RESULTS: GPs are key collaborating partners in the healthcare system. Their ability to collaborate is affected by a number of structural conditions. Mostly, this leads to GPs being too little involved in potential collaborative efforts: (i) individual GPs prioritize with whom they want to collaborate among many possible collaborative partners, (ii) inter-municipal constraints hamper GPs in contacting collaboration partners and (iii) GPs fall outside the hospital-municipality collaboration. CONCLUSIONS: We argue a common leadership for primary care services is needed. Furthermore, inter-professional work must be a central focus in the planning of primary care services. However, a dedicated staff, sufficient resources, adequate time and proper meeting places are needed to accomplish good collaboration.

Van Loon, K. et Parent, F. (2013). Chapitre 1. Développer une ingénierie de la professionnalisation et des compétences dans les organisations de santé : l'exemple d'un référentiel de compétences en kinésithérapie. Penser la formation des professionnels de la santé. Louvain-la-Neuve, De Boeck Supérieur**:** 179-204. https://www.cairn.info/penser-la-formation-des-professionnels-de-la-sante--9782804182496-page-179.htm

Cet ouvrage rassemble un corpus de savoirs spécialisés particulièrement original et, à ce jour, inédit en langue française. Ces savoirs ont été exploités et médiatisés dans le cadre d'activités d'enseignement mises en oeuvre avec le concours d'une équipe pluridisciplinaire d'enseignants issus de plusieurs milieux académiques francophones. En cohérence avec les conceptions philosophiques selon lesquelles les finalités de l'éducation et de la médecine ne sont, respectivement, ni la connaissance ni la santé mais bien, pour l'une et pour l'autre, « la personne »,la perspective intégrative développée dans cet ouvrage postule qu'il existe une authentique convergence, voire un réel isomorphisme, entre l'approche éducationnelle centrée sur l'apprenant et l'approche en santé centrée sur le patient et les communautés. Elle avance même que l'une est une condition nécessaire de l'autre. Dès lors, il est primordial que, dans le cadre des formations professionnalisantes en santé, soient réunies, explicitées et mises en oeuvre les conditions d'une forte cohérence entre les finalités éducationnelles et les finalités en santé. En raison de son positionnement épistémologique spécifique et compte tenu de sa nature authentiquement pluri- voire interdisciplinaire, cet ouvrage devrait intéresser tous les acteurs concernés par la problématique de la formation des professionnels de santé (directeurs de programmes, gestionnaires, enseignants, formateurs, maîtres de stage, mais aussi chercheurs), autant dans les contextes du Nord que du Sud, en formation initiale ou en formation continue.

Démographie médicale : disparités territoriales et choix d'installation

ÉTUDES FRANÇAISES

Barlet, M. et Collin, C. (2010). "Localisation des professionnels de santé libéraux." Serie Statistiques - Document De Travail - Drees(149): 27-56, tabl., cartes.
https://sante.gouv.fr/IMG/pdf/dossier_localisation_pro_sante_cns2009.pdf

> La présente étude s'intéresse à la localisation des professionnels de santé libéraux de premier recours (médecins généralistes, pharmacies, infirmiers, masseurs-kinésithérapeutes, chirurgiens-dentistes) ainsi qu'à certains des médecins spécialistes en accès direct (en pédiatrie, en ophtalmologie, en gynécologie) en France métropolitaine en 2008. À l'échelle des bassins de vie, les médecins et les pharmacies sont mieux distribués sur le territoire que la plupart des services et équipements sanitaires ou non sanitaires. Les médecins généralistes libéraux et les pharmacies sont situés là où se trouve la population. Ainsi, même s'il peut exister localement des problèmes d'accès géographique à ces professionnels, ce résultat suggère que ce phénomène est globalement limité. Les autres professionnels de premier recours sont un peu moins bien répartis que les médecins généralistes libéraux. Enfin, les médecins spécialistes présentent l'adéquation avec la population la plus faible des professions étudiées. L'étude distingue pour les médecins généralistes les médecins de moins de 40 ans. Ces derniers ne sont pas aussi bien répartis sur le territoire que leurs confrères au regard de la répartition de la population. L'étude des situations de colocalisation (présence simultanée dans une même zone géographique) montre que les autres professionnels de santé et, en particulier les médecins spécialistes, tout en étant moins bien répartis sur le territoire que leurs confrères généralistes, sont plus fréquemment présents parmi les équipements ou services à proximité des médecins généralistes libéraux que sur l'ensemble du territoire. Les médecins généralistes de moins de 40 ans sont, quant à eux, plutôt installés à proximité d'un de leurs jeunes confrères.

Charpy, C. R. (2018). Les masseurs-kinésithérapeutes libéraux : démographie, activité et recours aux soins. Paris Ministère chargé de la santé**:** 120-124, tab., graph., fig.

> Au 1er janvier 2017, près de 88 000 masseurs kinésithérapeutes étaient recensés au répertoire partagé des professionnels de santé (RPPS) en France, dont 65 900 libéraux présents et actifs. Les remboursements de leurs honoraires par l'assurance maladie ont atteint 4,0 Md€ en 2017, soit 4,6% de l'ensemble des dépenses de soins de ville. Ces remboursements sont particulièrement dynamiques, en progression de 4,2 % par an en moyenne sur les cinq dernières années, contre 2,3% pour l'ensemble des dépenses de soins de ville dans le champ de l'Ondam. Ce dynamisme est principalement porté par la hausse du nombre de praticiens (+3,3 % par an entre 2010 et 2017), en lien avec la hausse du nombre de patients traités qui s'explique notamment par le vieillissement de la population. Leurs honoraires évoluent à un rythme proche de l'inflation (+1,1 % par an entre 2010 et 2015), soutenus par des mesures de revalorisation tarifaire intervenues en 2012 puis en 2017.

Cnam (2022). Zoom sur les professions de santé libérales. Paris Cnam.
https://assurance-maladie.ameli.fr/etudes-et-donnees/par-theme/professionnels-de-sante-liberaux/zoom-professions-de-sante-liberales

> Fiches synthétiques analysant la démographie, la patientèle, l'activité, les prescriptions et les honoraires des différentes catégories de professionnels de santé libéraux : médecins (généralistes, MEP et spécialistes), chirurgiens-dentistes, sages-femmes, auxiliaires médicaux.

Collin, C., Evain, F., Mikol, F., et al. (2012). "Un accès géographique aux soins comparable entre les personnes âgées et les autres adultes." Serie Statistiques - Document De Travail - Drees(172): 57-76, tabl., cartes., graph.
https://drees.solidarites-sante.gouv.fr/sites/default/files/2020-10/er816.pdf

> Les personnes âgées sont en moyenne en plus mauvaise santé et de mobilité plus réduite que le reste de la population. Il apparaît dès lors important de savoir si leurs conditions d'accès aux soins sont identiques à celles des autres adultes. Cette étude cherche à éclairer cette question en comparant l'accès aux soins

des personnes âgées de 70 ans ou plus à l'accès aux soins des plus jeunes (19-69 ans inclus) pour les professionnels de premier recours les plus souvent consultés (médecins généralistes, infirmiers et masseurs kinésithérapeutes) et l'hôpital. Elle s'appuie sur les outils d'analyse de l'accès géographique aux soins développés récemment par la Drees et l'Insee. Ces outils, qui peuvent être mobilisés par les Agences régionales de santé (ARS), permettent d'évaluer les conditions territoriales d'accès aux soins : de calculer, par commune, territoire de santé, département, région, les temps d'accès aux différents professionnels de santé, ou encore d'en évaluer l'accessibilité par une comparaison de l'offre et de la demande « potentielle » de soins (voir annexe). Ils permettent aussi d'estimer l'impact que peut avoir une restructuration hospitalière ou encore une modification de l'implantation territoriale des professionnels de santé en termes de temps d'accès et d'accessibilité.

Croquennec, Y. (2020). Métiers de la rééducation de niveau bac+3 ou plus : davantage de diplômés et une bonne insertion professionnelle. Paris Drees**:** 7 , Tab., graph.
https://drees.solidarites-sante.gouv.fr/sites/default/files/2020-10/ER1159.pdf

En 2019, 121 000 professionnels de la rééducation de niveau bac+3 ou plus (masseur-kinésithérapeute, pédicure-podologue, ergothérapeute et orthoptiste) exercent en France en 2019, quand ils n'étaient que 68 000 en 2000. Ces hausses d'effectifs sont portées par une forte augmentation du nombre annuel des diplômés, passé de 2 500 en 2007 à 4 400 en 2017, soit une croissance moyenne de près de 6 % par an entre ces deux périodes. Les diplômés sont issus de catégories sociales plus favorisées que la moyenne ; deux sur trois sont des femmes. Malgré la hausse du nombre des nouveaux diplômés, leur insertion dans le marché du travail est très rapide : 93 % des diplômés en 2013 ont trouvé leur premier emploi en moins de trois mois. Le mode d'exercice diffère selon la profession exercée, cela dès le premier emploi : 78 % des masseurs-kinésithérapeutes et 85 % des pédicures-podologues diplômés en 2013 se sont installés en libéral dès l'obtention de leur diplôme. Pour leur part, 62 % des ergothérapeutes et 41 % des orthoptistes ont commencé leur carrière par un emploi temporaire (CDD ou intérim), tremplin vers une activité pérenne. Fin 2018, près de 2 600 demandeurs d'emploi de catégories A, B et C sont inscrits à Pôle emploi à la recherche d'un métier de la rééducation de niveau bac+3 ou plus. La part des demandeurs d'emploi (2,1 %) au sein des professions concernées demeure à un très faible niveau, malgré la forte augmentation des professionnels en activité.

Drees (2022). Accessibilité aux soins de premier recours : dégradation de la situation pour les médecins généralistes, amélioration pour les sages-femmes, les infirmières et les masseurs-kinésithérapeutes., Paris : Drees
https://data.drees.solidarites-sante.gouv.fr/explore/dataset/530_l-accessibilite-potentielle-localisee-apl/information/

La Direction de la recherche des études de l'évaluation et des statistiques (DREES) met à disposition les données actualisées de l'indicateur d'accessibilité potentielle localisée (APL) en 2021 pour les médecins généralistes, les infirmières, les masseurs-kinésithérapeutes et les sages-femmes.

Evrard, C. (2018). Le Schéma de démographie médicale : les masseurs-kinésithérapeutes en région Auvergne-Rhône-Alpes, URPS CD - Auvergne-Rhône-Alpes**:** 138 p.
https://hal.archives-ouvertes.fr/hal-03078332

Legendre, B. (2021). "Les trois quarts des personnes les plus éloignées des professionnels de premier recours vivent dans des territoires ruraux." Etudes Et Resultats (Drees)(1206): 6 , graph., tab. Carte.
https://drees.solidarites-sante.gouv.fr/publications/etudes-et-resultats/les-trois-quarts-des-personnes-les-plus-eloignees-des

Entre 2016 et 2019, l'accessibilité géographique aux infirmiers, masseurs-kinésithérapeutes et sages-femmes s'améliore (respectivement +9 %, +9 % et +16 %), alors que celle des médecins se dégrade (-6 %). Toutefois, la répartition des médecins généralistes sur le territoire est plus homogène que celle des trois autres professions. Les inégalités régionales d'accessibilité sont particulièrement importantes en ce qui concerne les infirmiers. Elles existent également pour les masseurs-kinésithérapeutes et les médecins généralistes, mais elles se conjuguent à une concentration forte autour des pôles urbains. Les sages-femmes sont, quant à elles, réparties de manière très hétérogène sur le territoire. La répartition régionale

des jeunes professionnels est globalement proche de celle des professionnels plus âgés. Environ 3 % de la population, soit 1,7 million de personnes, font partie des moins bien lotis en termes d'accessibilité à la fois aux médecins généralistes, aux infirmiers et aux masseurs kinésithérapeutes. Les trois quarts de ces personnes vivent dans des territoires ruraux.

Legendre, B., Aberki, C., Chaput, H., et al. (2019). "Infirmiers, masseurs-kinésithérapeutes et sages-femmes : l'accessibilité s'améliore malgré des inégalités." Etudes Et Resultats(1100): 6.
https://drees.solidarites-sante.gouv.fr/sites/default/files/er_1100.pdf

L'accessibilité géographique aux infirmiers, masseurs-kinésithérapeutes et sages-femmes s'améliore entre 2016 et 2017 (respectivement +2,3 %, +2,8 % et +5,4 %), soutenue par une croissance des effectifs de ces professionnels, notamment de ceux exerçant à titre libéral. Pour ces trois professions, les inégalités de répartition géographique diminuent, entre les communes les moins dotées et les mieux dotées, en particulier pour les sages-femmes. Toutefois, des inégalités territoriales subsistent. Les infirmiers sont plus inégalement répartis selon les régions et les masseurs-kinésithérapeutes selon le type de commune. La répartition des sages-femmes ne répond à aucune de ces deux logiques. Pour les trois professions, l'accessibilité est globalement meilleure dans les grands pôles urbains et le long du littoral. Si 7 habitants sur 10 bénéficient d'un bon accès à un professionnel de premier recours (que ce soit un médecin généraliste, un infirmier ou un masseur-kinésithérapeute), 4,5 % de la population française rencontre simultanément des difficultés d'accès à ces trois professions. Le cumul des difficultés d'accès aux sages-femmes et aux maternités est moins répandu, puisque cela ne concerne que 1,5 % de la population.

Medevielle, P. (2020). La mobilité des professionnels de santé au sein de l'Union européenne. Paris Sénat ; Paris Assemblée Nationale**:** 40.
http://www.senat.fr/rap/r19-563/r19-5631.pdf

Dans ce rapport, on entendra par professionnels de santé les médecins généralistes, les médecins spécialistes, les praticiens de l'art dentaire, les infirmiers, les pharmaciens, les sages-femmes, les aides-soignants et les masseurs-kinésithérapeutes. Ces professions sont des professions réglementées au sens de la directive 2005/36/CE, modifiée par la directive 2013/55/UE, relative à la reconnaissance des qualifications professionnelles, c'est-à-dire des activités professionnelles dont l'exercice est subordonné, en vertu de dispositions législatives, réglementaires ou administratives nationales, à la possession de qualifications professionnelles déterminées. Pour favoriser la mobilité, malgré ces dispositions nationales, le législateur européen a tenté d'harmoniser les conditions de qualifications nécessaires à l'exercice de ces professions réglementées au sein des États membres. C'est dans le secteur de la santé que l'harmonisation a été la plus rapide. Dès lors, la mobilité des professionnels de santé est devenue une réalité avec des conséquences diverses sur l'offre de soins dans les États membres de l'Union européenne. Elle s'accompagne d'inquiétudes au regard des conditions de mise en oeuvre des principes de reconnaissance mutuelle des qualifications et de la remise en cause des conditions particulières d'exercice au sein de chaque État membre. Après avoir présenté le cadre réglementaire en vigueur pour la reconnaissance des qualifications professionnelles, le présent rapport examinera les difficultés liées à la mise en oeuvre de cette réglementation, ainsi que les craintes qu'elle suscite parmi les professionnels de santé.

Millien, C. (2018). "D'ici à 2040, les effectifs de masseurs kinésithérapeutes augmenteraient de 57 % soit bien plus que les besoins de soins." Etudes & Résultats (Drees)(1075): 6p.
https://drees.solidarites-sante.gouv.fr/sites/default/files/er1075.pdf

Dans l'hypothèse où les comportements seraient constants et les politiques en vigueur maintenues, le nombre de masseurs-kinésithérapeutes devrait augmenter de 57 % entre 2016 et 2040 pour s'élever à 133 000 en 2040. Cette hausse, nettement supérieure à celle de la population française, entraînerait une forte augmentation de la densité, de 44 %. L'offre de soins progresserait même plus vite que les besoins : la densité standardisée par la consommation de soins de la population augmenterait de 20 %. Quel que soit le scénario envisagé, la démographie de la profession resterait très dynamIque.

Remondière, R. et Durafourg, M.-P. (2018). "Regards sur la kinésithérapie en 2018." Sante Publique **30**(6): 869-876. https://www.cairn.info/revue-sante-publique-2018-6-page-869.htm

> À partir d'un état des lieux, les auteurs retracent les étapes de l'évolution de la kinésithérapie au cours des vingt dernières années. Le point fort de cette profession silencieuse est d'avoir achevé, en 2015, sa réforme dans le cadre des accords européens du processus de Bologne.Les mutations, les acquis en lien avec les progrès biologiques, médicaux et issus de la recherche clinique en font un ensemble qui ouvre encore largement ses champs de pratiques, suffisamment pour être attractif auprès des futurs étudiants, mais insuffisamment pour susciter un exercice à l'hôpital.Les contraintes macro- et micro-économiques ont engendré des répercussions importantes et les kinésithérapeutes ont su s'adapter à la nouvelle prise en soins des patients sans altérer la reconnaissance dont ils sont l'objet de leur part. La nouvelle définition de la profession, accompagnée de nouveautés techniques de formation devrait réaffirmer leurs compétences qui n'ont, à ce jour, que peu de traduction au quotidien.La réforme des études doit être comprise comme le point de départ d'une profession en mutation, dont les champs de pratique qui se sont élargis depuis 2016 n'ont pas encore séduits la majorité des professionnels.

Rochut, J. (2014). "Métiers de la rééducation : des professionnels toujours plus nombreux." Etudes Et Resultats (Drees)(895): 6.

> [BDSP. Notice produite par MIN-SANTE R0xFEtqq. Diffusion soumise à autorisation]. Le champ de la rééducation couvre sept métiers très différents : masseur-kinésithérapeute, pédicure-podologue, ergothérapeute, psychomotricien, orthophoniste, orthoptiste et diététicien. En 2013, les professionnels de la rééducation en activité, âgés de moins de 65 ans sont près de 140 000 en France. Leur nombre est en forte augmentation depuis la fin des années 1990, porté par l'accroissement continu des inscrits en formation sur le territoire et par une hausse des praticiens diplômés à l'étranger venus s'installer en France. Ces professions, en majorité jeunes et féminisées, présentent des modes d'exercice variés. La pratique libérale est très majoritaire pour les masseurs-kinésithérapeutes, pédicures-podologues, orthophonistes et orthoptistes. Les professionnels de la rééducation restent inégalement répartis sur le territoire : les départements côtiers ou du sud de la Loire sont les plus favorisés ainsi que, dans une moindre mesure, ceux de l'Île-de-France.

ÉTUDES ETRANGERES

(2007). "Improving the recruitment and return of nurses and allied health professionals: a quantitative study." Health Services Management Research **20**(1): 22-36. https://journals.sagepub.com/doi/abs/10.1258/095148407779614972

> The United Kingdom National Health Service (NHS) is continuing to experience recruitment and retention problems of nursing and allied health profession staff. Consequently, the need to study and understand the key factors that encourage or dissuade people to work for the NHS remains a major research and policy issue. This study provides well-focused, independent research to explore how the NHS can be made more attractive for potential new recruits and possible returners. The views of potential recruits and returners interested in working for the NHS as either a qualified nurse, physiotherapist or radiographer were explored through a postal questionnaire survey which achieved a response rate of 23%. Analysis of the results indicate that the strongest predictor of intention to work for the NHS in one of the three professions was the attitude held by respondents. These attitudes in turn were most influenced by the extent to which people perceived that NHS work as a qualified nurse, physiotherapist or radiographer offered positive features, i.e. rewarding career, teamwork and a chance to help people and to get to know them. The views of family and friends regarding working for the NHS were also important as was the belief in one's ability to secure an NHS job.

Adams, R., Jones, A., Lefmann, S., et al. (2015). "Decision Making About Rural Physiotherapy Service Provision Varies With Sector, Size and Rurality." Internet Journal of Allied Health Sciences and Practice **13**(2). <Go to ISI>://WOS:000210244100003

Introduction: Decisions about physiotherapy service provision occur within the context of organisations, locations, and settings. The uniqueness of rural communities means it is important to consider contextual factors when making decisions about rural health services. As literature describing decision making about rural physiotherapy services is limited, this study sought perspectives on service level decision making (SLDM) from a range of stakeholders. The research approach needed to support consideration of both location and the broader health system. Method: A sequential mixed methods approach within a systems theory-case study heuristic provided the framework to explore rural physiotherapy SLDM. The investigation site, a large area of one Australian state, contained a mix of regional, rural, and remote communities. Perspectives on SLDM were obtained through surveys of physiotherapists, colleagues, and managers, with follow up interviews of a purposeful sample of participants. Results: Responses from physiotherapists, colleagues, manager surveys (n= 34), and in-depth interviews (n= 19) revealed commonalities and differences between sites and sectors. Available skill and expertise were common considerations across sites. Decisions about prioritisation of services occurred in both public and private settings; however, organisational priorities were a greater influence in the public sector and financial viability in the private sector. Service size influenced the perceived degree of autonomy of physiotherapists in SLDM, with physiotherapists in smaller sites having more independence. Directions from health facility management and the increasing need to prioritise services were reflected in physiotherapy responses from larger facilities. National health reforms and state level priorities were noted as influencing factors, as were connection to community, rurality, and the distance from decision makers. Conclusion: This study provides insight into decisions informing rural physiotherapy service provision. Understanding context and diversity is important to understanding local health service decisions. System level influences from macro and meso level decision makers provide the framework within which micro level physiotherapy SLDM occurs. Service sector, size and rurality then further qualify local service options and influence SLDM. Decisions about service provision need to take into consideration the current availability of services, the context of each location and skill mix required.

Adams, R., Jones, A., Lefmann, S., et al. (2015). "Rationing is a reality in rural physiotherapy: a qualitative exploration of service level decision-making." BMC Health Serv Res **15**: 121.

BACKGROUND: Deciding what health services are provided is a key consideration in delivering appropriate and accessible health care for rural and remote populations. Despite residents of rural communities experiencing poorer health outcomes and exhibiting higher health need, workforce shortages and maldistribution mean that rural communities do not have access to the range of services available in metropolitan centres. Where demand exceeds available resources, decisions about resource allocation are required. METHODS: A qualitative approach enabled the researchers to explore participant perspectives about decisions informing rural physiotherapy service provision. Stakeholder perspectives were obtained through surveys and in-depth interviews. A system theory-case study heuristic provided a framework for exploration across sites within the investigation area: a large area of one Australian state with a mix of rural, regional and remote communities. RESULTS: Thirty-nine surveys were received from participants in eleven communities. Nineteen in-depth interviews were conducted with physiotherapist and key decision-makers. Increasing demand, organisational priorities, fiscal austerity measures and workforce challenges were identified as factors influencing both decision-making and service provision. Rationing of physiotherapy services was common to all sites of this study. Rationing of services, more commonly expressed as service prioritisation, was more evident in responses of public sector physiotherapy participants compared to private physiotherapists. However, private physiotherapists in rural areas reported capacity limits, including expertise, space and affordability that constrained service provision. CONCLUSIONS: The imbalance between increasing service demands and limited physiotherapy capacity meant making choices was inevitable. Decreased community access to local physiotherapy services and increased workforce stress, a key determinant of retention, are two results of such choices or decisions. Decreased access was particularly evident for adults and children requiring neurological rehabilitation and for people requiring post-acute physiotherapy. It should not be presumed that rural private physiotherapy providers will cover service gaps that may emerge from changes to public sector service

provision. Clinician preference combines with capacity limits and the imperative of financial viability to negate such assumptions. This study provides insight into rural physiotherapy service provision not usually evident and can be used to inform health service planning and decision-making and education of current and future rural physiotherapists.

Adams, R., Jones, A., Lefmann, S., et al. (2016). "Service Level Decision-making in Rural Physiotherapy: Development of Conceptual Models." Physiother Res Int **21**(2): 116-126.

BACKGROUND: Understanding decision-making about health service provision is increasingly important in an environment of increasing demand and constrained resources. Multiple factors are likely to influence decisions about which services will be provided, yet workforce is the most noted factor in the rural physiotherapy literature. This paper draws together results obtained from exploration of service level decision-making (SLDM) to propose 'conceptual' models of rural physiotherapy SLDM. METHOD: A prioritized qualitative approach enabled exploration of participant perspectives about rural physiotherapy decision-making. Stakeholder perspectives were obtained through surveys and in-depth interviews. Interviews were transcribed verbatim and reviewed by participants. Participant confidentiality was maintained by coding both participants and sites. A system theory-case study heuristic provided a framework for exploration across sites within the investigation area: a large area of one Australian state with a mix of regional, rural and remote communities. RESULTS: Thirty-nine surveys were received from participants in 11 communities. Nineteen in-depth interviews were conducted with physiotherapists and key decision-makers. Results reveal the complexity of factors influencing rural physiotherapy service provision and the value of a systems approach when exploring decision-making about rural physiotherapy service provision. Six key features were identified that formed the rural physiotherapy SLDM system: capacity and capability; contextual influences; layered decision-making; access issues; value and beliefs; and tensions and conflict. CONCLUSIONS: Rural physiotherapy SLDM is not a one-dimensional process but results from the complex interaction of clusters of systems issues. Decision-making about physiotherapy service provision is influenced by both internal and external factors. Similarities in influencing factors and the iterative nature of decision-making emerged, which enabled linking physiotherapy SLDM with clinical decision-making and placing both within the broader healthcare context. The conceptual models provide a way of thinking about decisions informing rural physiotherapy service provision.

Adams, R., Jones, A., Lefmann, S., et al. (2016). "Towards understanding the availability of physiotherapy services in rural Australia." Rural Remote Health **16**(2): 3686.

INTRODUCTION: A recent exploration of factors affecting rural physiotherapy service provision revealed considerable variation in services available between communities of the study. Multiple factors combined to influence local service provision, including macro level policy and funding decisions, service priorities and fiscal constraints of regional health services and capacity and capabilities at the physiotherapy service level. The aim of this article is to describe the variation in local service provision, the factors influencing service provision and the impact on availability of physiotherapy services. METHODS: A priority-sequence mixed methods design structured the collection and integration of qualitative and quantitative data. The investigation area, a large part of one Australian state, was selected for the number of physiotherapy services and feasibility of conducting site visits. Stratified purposive sampling permitted exploration of rural physiotherapy with subgroups of interest, including physiotherapists, their colleagues, managers, and other key decision makers. Participant recruitment commenced with public sector physiotherapists and progressed to include private practitioners, team colleagues and managers. Surveys were mailed to key physiotherapy contacts in each public sector service in the area for distribution to physiotherapists, their colleagues and managers within their facility. Private physiotherapist principals working in the same communities were invited by the researcher to complete the physiotherapy survey. The survey collected demographic data, rural experience, work setting and number of colleagues, services provided, perspectives on factors influencing service provision and decisions about service provision. Semi-structured interviews were conducted with consenting physiotherapists and other key decision

makers identified by local physiotherapists. Quantitative survey data were recorded in spreadsheets and analysed using descriptive statistics. Interviews were recorded and transcribed verbatim, with transcripts provided to participants for review. Open-ended survey questions and interview transcripts were analysed thematically. RESULTS: Surveys were received from 11/25 (44%) of facilities in the investigation area, with a response rate of 29.4% (16/54) from public sector physiotherapists. A further 18 surveys were received: five from principals of private physiotherapy practices and 13 from colleagues and managers. Nineteen interviews were conducted: with 14 physiotherapists (nine public, five private), four other decision makers and one colleague. Three decision makers declined an interview. The variation in physiotherapy service availability between the 11 communities of this study prompted the researchers to consider how such variation could be reflected. The influential factors that emerged from participant comments included rurality and population, size and funding model of public hospitals, the number of public sector physiotherapists and private practices, and the availability of specialised paediatric and rehabilitation services. The factors described by participants were used to develop a conceptual framework or index of rural physiotherapy availability. CONCLUSIONS: It is important to make explicit the link between workforce maldistribution, the resultant rural workforce shortages and the implications for local service availability. This study sought to do so by investigating physiotherapy service provision within the rural communities of the investigation area. In doing so, varying levels of availability emerged within local communities. A conceptual framework combining key influencing factors is offered as a way to reflect the availability of physiotherapy services.

Adams, R., Sheppard, L., Jones, A., et al. (2014). "What factors influence physiotherapy service provision in rural communities? A pilot study." Aust J Rural Health **22**(3): 133-138.

OBJECTIVE: To obtain stakeholder perspectives on factors influencing rural physiotherapy service provision and insights into decision making about service provision. DESIGN: Purposive sampling, open-ended survey questions and semi-structured interviews were used in this exploratory, qualitative study. SETTING: A rural centre and its regional referral centre formed the pilot sites. PARTICIPANTS: Nine participant perspectives were obtained on rural physiotherapy services. MAIN OUTCOME MEASURES: Stakeholder perspectives on factors influencing rural physiotherapy service provision and service level decision making. RESULTS: Workforce capacity and capability, decision maker's knowledge of the role and scope of physiotherapy, consideration of physiotherapy within resource allocation decisions and proof of practice emerged as key issues. The latter three were particularly reflected in public sector participant comments. Business models and market size were identified factors in influencing private practice. CONCLUSION: Influencing factors described by participants both align and extend our understanding of issues described in the rural physiotherapy literature. Participant insights add depth and meaning to quantitative data by revealing impacts on local service provision. Available funding and facility priorities were key determinants of public sector physiotherapy service provision, with market size and business model appearing more influential in private practice. The level of self direction or choice about which services to provide, emerged as a point of difference between public and private providers. Decisions by public sector physiotherapists about service provision appear constrained by existing capacity and workload. Further research into service level decision making might provide valuable insights into rural health service delivery.

Arkwright, L., Edgar, S. et Debenham, J. (2018). "Exploring the job satisfaction and career progression of musculoskeletal physiotherapists working in private practice in Western Australia." Musculoskelet Sci Pract **35**: 67-72.

BACKGROUND: Despite increasing workforce numbers, new graduate physiotherapists are reporting short career intentions due to low job satisfaction. Job satisfaction improves retention among allied health professionals, however we have limited understanding of its influence specific to physiotherapists. OBJECTIVES: The aim of this study was to explore factors contributing to the job satisfaction of musculoskeletal physiotherapists working in private practice across different career stages (new graduates, graduates, postgraduates, and owners) in Western Australia. DESIGN: Mixed-methods design with an anonymous self-administered survey capturing job satisfaction and

employment characteristics of Western Australian physiotherapists working in private practice. Factors including peer support and mentoring, career progression and professional development were explored. METHOD: Physiotherapists were recruited through snowball sampling, with 60 practices approached to participate. Survey results were analysed using linear regression models and basic thematic analysis. RESULTS: Two-hundred and five surveys were completed by physiotherapists across 52 practices. The mean job satisfaction score was 41.9 out of 50, and increased job satisfaction was associated with practice ownership, salary satisfaction, established career pathways, and access to mentoring and professional development. CONCLUSIONS: Practice owners were significantly more satisfied with their job compared to new graduate, graduate and postgraduate physiotherapists. Findings illustrated the changing needs for support across different career stages, the importance of accessible senior clinicians, and the limited recognition for the efforts made by physiotherapists to pursue ongoing education.

Barker, R., Chamberlain-Salaun, J., Harrison, H., et al. (2021). "Evaluation of the Allied Health Rural Generalist Program 2017-2019." Aust J Rural Health **29**(2): 158-171.

OBJECTIVE: To evaluate the development and implementation of the Allied Health Rural Generalist Program, a two-level online post-graduate education program, which includes Level 1, an entry-level non-award pathway program, and Level 2, a Graduate Diploma in Rural Generalist Practice. DESIGN: A convergent mixed methodology evaluation in two overlapping stages: a process evaluation on quality and reach, together with a mixed method case study evaluation on benefits, of the program. SETTING: Rural and remote Australia across ten sites and seven allied health professions: dietetics; occupational therapy; pharmacy; physiotherapy; podiatry; radiography; speech pathology. PARTICIPANTS: Process evaluation included 91 participants enrolled in all or part of the Rural Generalist Program. Case study evaluation included 50 managers, supervisors and Rural Generalist Program participants from the ten study sites. INTERVENTIONS: The Allied Health Rural Generalist Program. MAIN OUTCOME MEASURES: Process evaluation data were derived from enrolment data and education evaluation online surveys. Case study data were gathered via online surveys and semi-structured interviews. Quantitative and qualitative data were collected concurrently, analysed separately and then integrated to identify consistency, expansion or discordance across the data. RESULTS: The Rural Generalist Program was viewed as an effective education program that provided benefits for Rural Generalist Program participants, employing organisations and consumers. Key improvements recommended included increasing profession-specific and context-specific content, ensuring Rural Generalist Program alignment with clinical and project requirements, strengthening support mechanisms within employing organisations and ensuring benefits can be sustained in the long term. CONCLUSION: The Rural Generalist Program offers a promising strategy for building a fit-for-purpose rural and remote allied health workforce.

Bastiaens, F., Barten, D. J. et Veenhof, C. (2021). "Identifying goals, roles and tasks of extended scope physiotherapy in Dutch primary care- an exploratory, qualitative multi-step study." BMC Health Serv Res **21**(1): 19.

BACKGROUND: Rising healthcare costs, an increasing general practitioner shortage and an aging population have made healthcare organization transformation a priority. To meet these challenges, traditional roles of non-medical members have been reconsidered. Within the domain of physiotherapy, there has been significant interest in Extended Scope Physiotherapy (ESP). Although studies have focused on the perceptions of different stakeholders in relation to ESP, there is a large variety in the interpretation of ESP. AIM: To identify a paradigm of ESP incorporating goals, roles and tasks, to provide a consistent approach for the implementation of ESP in primary care. METHODS: An exploratory, qualitative multi-step design was used containing a scoping review, focus groups and semi-structured interviews. The study population consisted of patients, physiotherapists, general practitioners and indirect stakeholders such as lecturers, health insurers and policymakers related to primary care physiotherapy. The main topics discussed in the focus groups and semi-structured interviews were the goals, skills and roles affiliated with ESP. The 'framework' method, developed by Ritchie & Spencer, was used as analytical approach to refine the framework. RESULTS: Two focus

groups and twelve semi-structured interviews were conducted to explore stakeholder perspectives on ESP in Dutch primary care. A total of 11 physiotherapists, six general practitioners, five patients and four indirect stakeholders participated in the study. There was a lot of support for 'decreasing healthcare costs', 'tackling increased health demand' and 'improving healthcare effectiveness' as main goals of ESP. The most agreement was reached on 'triaging', 'referring to specialists' and 'ordering diagnostic imaging' as tasks fitting for ESP. Most stakeholders also supported 'working in a multidisciplinary team', 'working as a consultant' and 'an ESP role separated from a physiotherapist role' as roles of ESP. CONCLUSIONS: Based on the scoping review, focus groups and interviews with direct and indirect stakeholders, it appears that there is sufficient support for ESP in the Netherlands. This study provides a clear presentation of how ESP can be conceptualized in primary care. A pilot focused on determining the feasibility of ESP in Dutch primary care will be the next step.

Bath, B., Gabrush, J., Fritzler, R., et al. (2015). "Mapping the Physiotherapy Profession in Saskatchewan: Examining Rural versus Urban Practice Patterns." Physiotherapy Canada **67**(3): 221-231.
<Go to ISI>://WOS:000358311100002

Purpose: People living in rural and remote regions need support to overcome difficulties in accessing health care. The objectives of the study were (1) to compare demographic characteristics, professional engagement indicators, and clinical characteristics between physiotherapists practising in rural settings and those practising in urban settings and (2) to map the distribution of physiotherapists in Saskatchewan. Method: This cross-sectional study used de-identified data collected from the 2013 Saskatchewan College of Physical Therapists membership renewal (n = 643), linked with the Saskatchewan Physiotherapy Association's (SPA) 2012 membership list and a list of physiotherapists who had served as clinical instructors. Employment location (rural vs. urban) was determined by postal code. Results: Only 11.2% of Saskatchewan physiotherapists listed a rural primary employment location, and a higher density of physiotherapists per 10,000 people work in health regions with large urban centres. Compared with urban physiotherapists, rural physiotherapists are more likely to provide direct patient care, to provide care to people of all ages, and to have a mixed client level, and they are less likely to be SPA members. Conclusions: Rural and urban physiotherapists in Saskatchewan have different practice and professional characteristics. This information may have implications for health human resource recruitment and retention policies as well as advocacy for equitable access to physiotherapy care in rural and remote regions.

Berg-Poppe, P. J., Karges-Brown, J. R., Ladwig, A., et al. (2021). "Values that influence employment acceptance among physical therapists practicing in primary care shortage and non-urban designation areas." Rural Remote Health **21**(3): 6614.

INTRODUCTION: Physical therapists (PTs) in all United States, DC, and the US Virgin Islands have first-contact direct access privileges to examine and treat patients. Evidence supports the value of PT services in reducing annual healthcare costs, decreasing the need for prescription pain medication, and decreasing the need for outpatient physician care. PTs can play an essential role in managing patient health needs in primary care health professional shortage areas (pcHPSAs), especially in rural areas, which are disproportionately affected by shortage-related health disparities. The current study examined values that differentiated PTs who accept and maintain employment in pcHPSAs and non-urban areas, as a means of advising health agencies within these designation areas. METHODS: A survey invitation was emailed to PTs in six states. The Determinants of Employment Acceptance Survey was used to survey the importance of six factors (attachment to place, community assets, practice environment, professional advancement, relationships, and remuneration) when considering employment. RESULTS: Respondents included 373 PTs (36% pcHPSA; 33% non-urban). Professional advancement was significantly more important to PTs intending to continue their employment in a pcHPSA. Community assets were more important to PTs in non-urban areas who planned to leave their employment within 5 years. The most valued factors for PTs, regardless of practice location, were practice environment and attachment to place. CONCLUSION: Employers in rural areas or pcHPSAs who are interested in recruiting and retaining PTs should consider the importance of

professional advancement, practice environment, and workplace relationships, and should use strategic measures to fortify these assets within the workplace.

Brennen, R., Sherburn, M. et Rosamilia, A. (2019). "Development, implementation and evaluation of an advanced practice in continence and women's health physiotherapy model of care." Aust N Z J Obstet Gynaecol **59**(3): 450-456.

BACKGROUND: With public health facing workforce shortages, increasing costs and increasing demands, innovative patient pathways are vital to meet patient needs. Advanced practice physiotherapy roles are well established in emergency departments and musculoskeletal/orthopaedic services and have begun to emerge in other clinical areas. AIMS: In 2014, the Royal Women's Hospital, Monash Health and Barwon Health received a Victorian Department of Health and Human Services (DHHS) Workforce Innovation grant to develop and implement an advanced practice in continence and women's health physiotherapy assessment model of care. MATERIAL AND METHODS: A new model of care was developed with an advanced practice physiotherapy-led assessment clinic integrated into the triage and assessment process of gynaecology, urogynaecology and urology clinics in major public health centres. A clinical competency and credentialing pathway and toolkit were developed to support training and development of advanced practice skills for senior physiotherapists in this clinical area. The initial assessment of the new model of care was undertaken by DHHS and Price-Waterhouse Coopers, including access to care, cost of assessment and safety. RESULTS: An advanced practice continence and women's health physiotherapy assessment clinic was implemented safely and contributed to improved access to care as assessed by reduced waiting lists and waiting times for assessment, with high levels of patient satisfaction and no adverse events. CONCLUSION: Advanced practice continence and women's health physiotherapy clinics can contribute to streamlined, cost-efficient triage and assessment processes for patients with urological or gynaecological issues attending tertiary medical clinics.

Campbell, N., Eley, D. S. et McAllister, L. (2016). "How Do Allied Health Professionals Construe the Role of the Remote Workforce? New Insight into Their Recruitment and Retention." PLoS One **11**(12): e0167256.

PURPOSE: Allied health workforce recruitment and retention in remote areas is a global problem. Using case studies from the Australian allied health workforce, this paper adds new information by combining personality trait information with a detailed understanding of how the cases construe the demands of remote work, which may be useful in addressing this problem. METHODS: Four cases (two urban, two remote) are presented from a mixed methods study (n = 562), which used (1) the Temperament and Character Inventory to investigate personality traits of allied health professionals; and (2) repertory grid interviews to reveal quantitatively and qualitatively how the cases construed their Ideal work role compared with their Current and a Remote role. Cases also self-assessed their fit ('suited' or 'not suited') with remote. FINDINGS: Differences in the way cases construed their fit with remote work was related to prior experience. However all were satisfied with their work, perceiving their Current role as similar to their Ideal. All saw remote work as requiring generalist expertise and a reliance on relationships. Personality traits, especially Novelty Seeking and Harm Avoidance, fit with how allied health professionals perceived their role. CONCLUSIONS: The combination of two distinct lines of investigation, illustrates what more can be revealed about allied health professional's career choices by taking into account the fit or lack of fit between their personality tendencies, their construing of remote work and their life circumstances. Understanding the combined influence of perceptions and traits on an individual toward or away from remote work may enhance recruitment and retention internationally.

Campbell, N., Farthing, A., Lenthall, S., et al. (2021). "Workplace locations of allied health and nursing graduates who undertook a placement in the Northern Territory of Australia from 2016 to 2019: An observational cohort study." Aust J Rural Health **29**(6): 947-957.

OBJECTIVE: The aim of the study is to determine the current work locations of allied health professionals and nurses who undertook a student placement in the Northern Territory of Australia

from 2016-2019. DESIGN: An observational cohort study was conducted in October 2020, with students emailed a link to an on-line survey, plus two reminders. SETTING: Primary health care in the Northern Territory of Australia. PARTICIPANTS: All allied health and nursing students who undertook a student learning placement in the Northern Territory from 2016-2019 (n = 1936). MAIN OUTCOME MEASURES: Practicing nurses and allied health professionals were asked about their work history and locations (coded using the Modified Monash Model of remoteness and population size). RESULTS: The response rate was 14.2% (275/1936 students). Most respondents reported that their placement positively influenced them to consider working: in a rural or remote location (76%), in the Northern Territory (81%), and with marginalised or under-served populations (74%). Of the respondents, 224 had graduated and 203 were currently working in their health profession. A total of 31.4% of respondents reported that they had worked in a remote or rural location after graduation. CONCLUSIONS: The student placement had a positive effect on the likelihood of students working in a rural or remote location. A focus on recruiting students with a remote upbringing/background and offering longer placements would likely be successful in helping build the health professional workforce in remote locations.

Campbell, N., McAllister, L. et Eley, D. (2012). "The influence of motivation in recruitment and retention of rural and remote allied health professionals: a literature review." Rural Remote Health **12**: 1900.

INTRODUCTION: Recruitment and retention of allied health professionals (AHPs) to remote and rural Australia is challenging and correlates with poorer health status of remote and rural residents. While much has been written about the recruitment and retention problem, this study took a new approach by reviewing the literature describing the motivation of AHPs to work in remote and rural areas and then analyzing the findings from the perspective of motivation theory using Herzberg's extrinsic and intrinsic classification. Intrinsic motivation incentives are known to contribute to job satisfaction and come from within the individual, for example the pleasure derived from autonomy or challenge at work. In contrast, extrinsic motivation incentives are provided by the job and include such factors as salary and professional development provisions. Extrinsic incentives are important because they prevent job dissatisfaction. Job satisfaction has been shown to be linked with increased retention. METHOD: Thirty-five articles, including 26 from Australia, met the inclusion criteria. The key findings related to motivation from each article are outlined and the results classified into the extrinsic-intrinsic framework. The incentives are then further analyzed as having a positive or a negative influence. RESULTS: In total, 38 different incentives were described a total of 246 times. Of the total, almost half (n=115) comprised extrinsic incentives with a negative influence, with poor access to professional development, professional isolation and insufficient supervision the most frequently reported. Rural lifestyle and diverse caseloads were the most frequently mentioned positive extrinsic incentives, while autonomy and community connectedness were the most cited positive intrinsic incentives. Negative intrinsic incentives were mentioned least frequently (n=18); however, of these, feeling overwhelmed and that your work was not valued by the community were the most commonly reported. CONCLUSIONS: The results demonstrate the significant burden of extrinsic incentives with a negative influence that are perceived by AHPs in remote and rural areas. The high turnover rate of AHPs in remote and rural areas is likely to be, in part, due to the job dissatisfaction from these disincentives. More positive intrinsic incentives were reported than negative. This suggests the potential for intrinsic incentives, known to contribute to job satisfaction, to be mediating the extrinsic disincentives. The policy implications of this work include the importance of addressing extrinsic disincentives. Simultaneously, the existing intrinsic incentives need to be nurtured and developed. Organizations that implement strategies to enhance both extrinsic and intrinsic motivation incentives are more likely to successfully address their AHP workforce shortage.

Chisholm, M., Russell, D. et Humphreys, J. (2011). "Measuring rural allied health workforce turnover and retention: what are the patterns, determinants and costs?" Aust J Rural Health **19**(2): 81-88.

OBJECTIVES: To measure variations in patterns of turnover and retention, determinants of turnover, and costs of recruitment of allied health professionals in rural areas. DESIGN: Data were collected on health service characteristics, recruitment costs and de-identified individual-level employment entry

and exit data for dietitians, occupational therapists, physiotherapists, podiatrists, psychologists, social workers and speech pathologists employed between 1 January 2004 and 31 December 2009. SETTING: Health services providing allied health services within Western Victoria were stratified by geographical location and town size. Eighteen health services were sampled, 11 participated. MAIN OUTCOME MEASURES: Annual turnover rates, stability rates, median length of stay in current position, survival probabilities, turnover hazards and median costs of recruitment were calculated. RESULTS: Analysis of commencement and exit data from 901 allied health professionals indicated that differences in crude workforce patterns according to geographical location emerge 12 to 24 months after commencement of employment, although the results were not statistically significant. Proportional hazards modelling indicated profession and employee age and grade upon commencement were significant determinants of turnover risk. Costs of replacing allied health workers are high. CONCLUSIONS: An opportunity for implementing comprehensive retention strategies exists in the first year of employment in rural and remote settings. Benchmarks to guide workforce retention strategies should take account of differences in patterns of allied health turnover and retention according to geographical location. Monitoring allied health workforce turnover and retention through analysis of routinely collected data to calculate selected indicators provides a stronger evidence base to underpin workforce planning by health services and regional authorities.

Cornwall, M. W., Keehn, M. T. et Lane, M. (2016). "Characteristics of US-Licensed Foreign-Educated Physical Therapists." Phys Ther **96**(3): 293-304.

BACKGROUND: Foreign-educated physical therapists are often viewed as one possible solution to the current shortage of physical therapists, yet there is very little research regarding these individuals. OBJECTIVE: The purpose of this study was to describe those physical therapists who are licensed in the United States but who were educated in another country. This description includes their country of education, their employment patterns, and the reasons they decided to emigrate and work as a physical therapist in the United States. DESIGN: A cross-sectional survey was conducted. METHODS: An electronic survey was sent to all physical therapists currently licensed in the United States who had been educated in another country. Those who had been licensed within the last 5 years are reported. RESULTS: The results of the survey indicated that the typical foreign-educated physical therapist is female, aged 32.2 years, and was born and trained in either the Philippines or India. A majority of foreign-educated physical therapists obtained their first license in New York, Michigan, Illinois, Texas, or Florida. The most common reasons cited as to why a particular jurisdiction was chosen for initial employment were "recruiter recommendation," "family, spouse, partner, or friends," "ease of the licensure process," and "ability to secure a visa sponsor." A majority of foreign-educated physical therapists in this study initially worked in a skilled nursing facility, a long-term care or extended care facility, or a home health setting. LIMITATIONS: Only those foreign-educated physical therapists licensed within the last 5 years are reported. CONCLUSIONS: This study is the first to report on foreign-educated physical therapists in the United States. The findings of this study will provide important and useful information to others dealing with physical therapy professional and workforce issues.

Cosgrave, C. (2020). "Context Matters: Findings from a Qualitative Study Exploring Service and Place Factors Influencing the Recruitment and Retention of Allied Health Professionals in Rural Australian Public Health Services." Int J Environ Res Public Health **17**(16).

Chronic health workforce shortages significantly contribute to unmet health care needs in rural and remote communities. Of particular and growing concern are shortages of allied health professionals (AHPs). This study explored the contextual factors impacting the recruitment and retention of AHPs in rural Australia. A qualitative approach using a constructivist-interpretivist methodology was taken. Semi-structured interviews (n = 74) with executive staff, allied health (AH) managers and newly recruited AHPs working in two rural public health services in Victoria, Australia were conducted. Data was coded and categorised inductively and analysed thematically. The findings suggest that to support a stable and sustainable AH workforce, rural public sector health services need to be more efficient, strategic and visionary. This means ensuring that policies and procedures are equitable and accessible, processes are effective, and action is taken to develop local programs, opportunities and supports that

allow AH staff to thrive and grow in place at all grade levels and life stages. This study reinforces the need for a whole-of-community approach to effectively support individual AH workers and their family members in adjusting to a new place and developing a sense of belonging in place. The recommendations arising from this study are likely to have utility for other high-income countries, particularly in guiding AH recruitment and retention strategies in rural public sector health services. Recommendations relating to community/place will likely benefit broader rural health workforce initiatives.

Cott, C. A., Mandoda, S. et Landry, M. D. (2011). "Models of Integrating Physical Therapists into Family Health Teams in Ontario, Canada: Challenges and Opportunities." Physiotherapy Canada **63**(3): 265-275. <Go to ISI>://WOS:000296677700002

Purpose: To explore the potential for different models of incorporating physical therapy (PT) services within the emerging network of family health teams (FHTs) in Ontario and to identify challenges and opportunities of each model. Methods: A two-phase mixed-methods qualitative descriptive approach was used. First, FHTs were mapped in relation to existing community-based PT practices. Second, semi-structured key-informant interviews were conducted with representatives from urban and rural FHTs and from a variety of community-based PT practices. Interviews were digitally recorded, transcribed verbatim, and analyzed using a categorizing/editing approach. Results: Most participants agreed that the ideal model involves embedding physical therapists directly into FHTs; in some situations, however, partnering with an existing external PT provider may be more feasible and sustainable. Access and funding remain the key issues, regardless of the model adopted. Conclusion: Although there are differences across the urban/rural divide, there exist opportunities to enhance and optimize existing delivery models so as to improve client access and address emerging demand for community-based PT services.

Cottrell, M., Judd, P., Comans, T., et al. (2021). "Comparing fly-in fly-out and telehealth models for delivering advanced-practice physiotherapy services in regional Queensland: An audit of outcomes and costs." J Telemed Telecare **27**(1): 32-38.

INTRODUCTION: Recruitment of advanced-practice physiotherapists to regional and rural healthcare facilities in Queensland, Australia remains a challenge. To overcome this barrier, two different service delivery models (Fly-In, Fly-Out (FIFO), Telehealth) were trialled by one regional facility. This study aims to describe the economic- and service-related outcomes of these two methods of service delivery. METHODS: A retrospective audit was conducted where two nine-week time periods were selected for each service delivery model. Outcomes of interests include patient demographics and case-mix, service utilisation, clinical actions, adverse events and costs. Net financial position for both models was calculated based upon costs incurred and revenue generated by service activity. RESULTS: A total of 33 appointment slots were recorded for each service delivery model. Patient case-mix was variable, where the Telehealth model predominately involved patients with musculoskeletal spinal conditions managed from a neurosurgical waiting list. Appointment slot utilisation and pattern of referral for further investigations were similar between models. No safety incidents occurred in either service delivery model. An estimated cost-savings of 13% for the Telehealth model could be achieved when compared to the FIFO model. DISCUSSION: Telehealth is a safe, efficient and viable option when compared to a traditional in-person outreach service, while providing cost-savings. Telehealth should be seen as a service delivery medium in which sustainable recruitment of advanced-practice physiotherapists to regional and rural healthcare facilities can be achieved.

Couch, A., Menz, H. B., Coker, F., et al. (2021). "Factors that influence workplace location choices in the different allied health professions: A systematic review." Australian Journal of Rural Health **29**(6): 823-834. https://onlinelibrary.wiley.com/doi/abs/10.1111/ajr.12768

Abstract Introduction The maldistribution of health care workers between metropolitan, rural or remote areas is globally recognised. Allied health professional's workplace location choice is a complex interplay between professional and non-professional elements. Policy-makers should understand

factors that influence workplace location choices when designing structures to attract allied health professionals to rural practice. Objective To determine factors influencing recruitment and retention of allied health professionals in metropolitan, rural and remote locations. Design Systematic review. Findings Twenty-two studies met inclusion criteria. Extracted data were synthesised into subthemes: (a) opportunities for career development, (b) clinical load, (c) organisational and workplace structure, (d) previous location exposure and (e) personal factors. Of these 22 studies, 12 reported organisational/workplace structure and personal factors positively impacting recruitment and 11 studies discussed organisational and workplace structure also negatively impacting on retention. Career opportunities positively impacted on recruitment, while lack of opportunity negatively affected retention. Previous location exposure positively impacted recruitment however had limited impact on retention. Similarly, a diverse clinical load was reported as being attractive during recruitment, but unmanageable caseloads affected retention. Discussion This review identifies the need for effective and sustainable solutions for the issues with recruitment and retention of allied health professionals. While the different allied health professions share similar recruitment and retention challenges, further research is needed to isolate factors impacting each discipline. Conclusions Retention and recruitment of different allied health professions is multifactorial. Organisational and workplace structure and opportunities for career development emerged as having impact on the recruitment of allied health professionals.

Durey, A., Haigh, M. et Katzenellenbogen, J. M. (2015). "What role can the rural pipeline play in the recruitment and retention of rural allied health professionals?" Rural Remote Health **15**(3): 3438.

CONTEXT: People living in rural areas have poorer health than their urban counterparts with higher morbidity and mortality rates and lower life expectancy. Challenges attracting health professionals to work in rural locations in Australia and elsewhere have been well- documented. In response, the idea of a rural pipeline emerged in the medical literature as a career pathway for doctors, conceptualised as a career continuum starting at school and ending in a committed, appropriately trained and supported rural doctor. This article draws on the literature to consider how the concept of a rural pipeline can be used to enhance recruitment and retention of allied health professionals (AHPs) in Australia. The complexity of the issue is taken into account, acknowledging the diverse professional, organisational and social needs within and between AHPs and their different career pathways. With this in mind, the rural pipeline is adapted and extended to focus on AHPs who enter at any stage of their career to work in rural areas. ISSUES: Barriers to recruitment and retention require multifaceted strategies to encourage and support AHPs at various stages along the pipeline to enter, and remain in, rural practice. Findings from the literature identify discrete themes within and between AHPs about factors influencing their rural recruitment and retention choices and include career stage at entry to rural practice, age, gender, social context, professional support, organisational environment and public-private practice mix in service delivery. These findings underscored the development of an extended rural pipeline adapted to specifically target AHPs. This flexible framework of entry to rural practice can be applied at any stage of their career and includes suggestions of strategies to support retention. LESSONS LEARNED: Evidence from studies of rural AHPs suggests a flexible approach to recruitment and retention is needed that takes into account the complexity of the issue. The extended rural pipeline adapted to AHPs avoids a one-size-fits-all approach. Instead, it offers a more nuanced approach that addresses the diversity within and between professions and reflects the different stages at which AHPs enter rural practice that can inform recruitment and retention strategies that better meet their needs.

Eighan, J., Walsh, B., Smith, S., et al. (2019). "A profile of physiotherapy supply in Ireland." Ir J Med Sci **188**(1): 19-27.

BACKGROUND: The lack of information on public and private physiotherapy supply in Ireland makes current and future resource allocation decisions difficult. AIM: This paper estimates the supply of physiotherapists in Ireland and profiles physiotherapists across acute and non-acute sectors, and across public and private practice. It examines geographic variation in physiotherapist supply, examining the implications of controlling for healthcare need. METHODS: Physiotherapist headcounts

are estimated using Health Service Personnel Census (HSPC) and Irish Society of Chartered Physiotherapists (ISCP) Register data. Headcounts are converted to whole-time equivalents (WTEs) using the HSPC and a survey of ISCP members to account for full- and part-time working practices. Non-acute supply per 10,000 population in each county is estimated to examine geographic inequalities and the raw population is adjusted in turn for a range of need indicators. RESULTS: An estimated 3172 physiotherapists were practising in Ireland in 2015; 6.8 physiotherapists per 10,000, providing an estimated 2620 WTEs. Females accounted for 74% of supply. Supply was greater in the non-acute sector; 1774 WTEs versus 846 WTEs in the acute sector. Physiotherapists in the acute sector were located mainly in publicly financed institutions (89%) with an even public/private split observed in the non-acute sector. Non-acute physiotherapist supply is unequally distributed across Ireland (Gini coefficient = 0.12; 95% CI 0.08-0.15), and inequalities remain after controlling for variations in healthcare needs across counties. CONCLUSION: The supply of physiotherapists in Ireland is 30% lower than the EU-28 average. Substantial inequality in the distribution of physiotherapists across counties is observed.

Esu, E. B., Chibuzor, M., Aquaisua, E., et al. (2021). "Interventions for improving attraction and retention of health workers in rural and underserved areas: a systematic review of systematic reviews." Journal of Public Health **43**(Supplement_1): i54-i66.
https://doi.org/10.1093/pubmed/fdaa235

Global health workforce shortages exist with disparities in the skill mix and distribution of health workers. Rural and underserved populations are often disadvantaged in terms of access to health care.This systematic review summarized all systematic reviews that assessed interventions for improving attraction and retention of health workers in rural and underserved areas. We systematically searched selected electronic databases up to 31 March 2020. The authors independently screened the reviews, extracted data and assessed the certainty of evidence using GRADE. Review quality was assessed using the ROBIS tool.There was a paucity of evidence for the effectiveness of the various interventions. Regulatory measures were able to attract health workers to rural and underserved areas, particularly when obligations were attached to incentives. However, health workers were likely to relocate from these areas once their obligations were completed. Recruiting rural students and rural placements improved attraction and retention although most studies were without control groups, which made conclusions on effectiveness difficult.Cost-effective utilization of limited resources and the adoption and implementation of evidence-based health workforce policies and interventions that are tailored to meet national health system contexts and needs are essential.

Farquhar, E., Moran, A. et Schmidt, D. (2020). "Mechanisms to achieve a successful rural physiotherapy public-private partnership: a qualitative study." Rural Remote Health **20**(3): 5668.

INTRODUCTION: Longstanding gaps in physiotherapy service delivery exist in rural areas across Australia. In response to this, a large public rural health organisation contracted a private physiotherapy business to implement a public-private partnership (PPP) to supply physiotherapy to hospital inpatients, aged care facility residents and outpatients in four outer regional Australian towns. Treatment rooms were provided by the health organisation for the private physiotherapists to see clients. This study explored how stakeholders defined the success of a PPP model of service delivery in a rural setting and examined if the model was successful according to stakeholder definitions. Barriers and enablers (mechanisms) were identified and linked to stakeholder-defined success measures. METHODS: A qualitative study was conducted using a constructive inquiry design. Participants were purposively recruited, via email invitation and telephone follow-up. Participants comprised managers and clinicians from the rural public health organisation and the private physiotherapy business involved in setting up, working within or alongside the partnership. Semi-structured interviews were undertaken with all participants. Data were transcribed verbatim and analysed using framework analysis. Program logic was used to synthesise all information. RESULTS: Individual interviews were conducted with five staff from each partnering organisation, including managers and clinicians (total n=10). Two main themes and three subthemes were identified. All participants described the model as

being successful. Elements of success included improved access to local services, and satisfied stakeholders. There were three mechanisms identified to successfully implement the service delivery model. The first mechanism was the provision of human and several other resources, which included the workforce model and the use of several resources for the partnership. The second mechanism was stakeholder engagement, which included having motivated stakeholders and consistent stakeholders. The third mechanism was streamlined processes, which included the content of the contract and referral schedule, streamlined administration processes for contracting and accounting, having processes for managing private therapists in a public setting as well as processes for communication. CONCLUSION: This study demonstrates that an innovative physiotherapy PPP model of service delivery can be a successful way to improve access to physiotherapy services in rural areas. Success of service models varies depending on the viewpoint of the stakeholder and achieving success for all stakeholders is contingent on mechanisms such as those identified in this study. PPPs have potential to address service gaps in hospitals, residential aged care and primary care in rural areas.

Gallego, G., Chedid, R., Dew, A., et al. (2016). "Private Practice Disability Therapy Workforce in Rural New South Wales, Australia." J Allied Health **45**(3): 225-229.

Despite an increasing demand for therapy services, there is a shortage of therapists in rural areas. We describe the existing private therapy workforce in rural western New South Wales (NSW), Australia. A cross-sectional design study, using an online survey, was conducted with occupational and physiotherapists, speech pathologists, and psychologists working in private practice in western NSW. Forty-one private therapists completed the survey. The average years of qualification was 19; 51% worked part-time. Two-thirds (68%) indicated they had adequate access to professional development opportunities. Sixty-four percent reported intending to stay in their job for 12 months. Most (95%) reported high levels of job satisfaction. Respondents had worked in western NSW for a median of 17 yrs. Sixty-eight percent described opportunities for social interaction as very good. Sixty-six percent grew up in rural areas. All respondents agreed that they loved the rural lifestyle. The results portray an experienced, stable, flexible, and highly satisfied professional group. With the current changes in policies within the disability sector, it is important to maximise these features of private therapy in order to contribute to the rural workforce and increase access to the range of supports available for people with disability.

Gallego, G., Dew, A., Lincoln, M., et al. (2015). "Should I stay or should I go? Exploring the job preferences of allied health professionals working with people with disability in rural Australia." Hum Resour Health **13**. <Go to ISI>://WOS:000357073700001

Introduction: The uneven distribution of allied health professionals (AHPs) in rural and remote Australia and other countries is well documented. In Australia, like elsewhere, service delivery to rural and remote communities is complicated because relatively small numbers of clients are dispersed over large geographic areas. This uneven distribution of AHPs impacts significantly on the provision of services particularly in areas of special need such as mental health, aged care and disability services. Objective: This study aimed to determine the relative importance that AHPs (physiotherapists, occupational therapists, speech pathologists and psychologists - "therapists") living in a rural area of Australia and working with people with disability, place on different job characteristics and how these may affect their retention. Methods: A cross-sectional survey was conducted using an online questionnaire distributed to AHPs working with people with disability in a rural area of Australia over a 3-month period. Information was sought about various aspects of the AHPs' current job, and their workforce preferences were explored using a best-worst scaling discrete choice experiment (BWSDCE). Conditional logistic and latent class regression models were used to determine AHPs' relative preferences for six different job attributes. Results: One hundred ninety-nine AHPs completed the survey; response rate was 51 %. Of those, 165 completed the BWSDCE task. For this group of AHPs, "high autonomy of practice" is the most valued attribute level, followed by "travel BWSDCE arrangements: one or less nights away per month", "travel arrangements: two or three nights away per month" and "adequate access to professional development". On the other hand, the least valued attribute levels were "travel arrangements: four or more nights per month", "limited autonomy of

practice" and "minimal access to professional development". Except for "some job flexibility", all other attributes had a statistical influence on AHPs' job preference. Preferences differed according to age, marital status and having dependent children. Conclusions: This study allowed the identification of factors that contribute to AHPs' employment decisions about staying and working in a rural area. This information can improve job designs in rural areas to increase retention.

Halls, S., Thomas, R., Stott, H., et al. (2020). "Provision of first contact physiotherapy in primary care across the UK: a survey of the service." Physiotherapy **108**: 2-9.

BACKGROUND: First Contact Physiotherapy (FCP) is an emerging model of care whereby a specialist physiotherapist located within general practice undertakes the first patient assessment, diagnosis and management without a prior GP consultation. Despite institutional and professional body support for this model and NHS commitment to its implementation, data regarding current FCP provision are limited. OBJECTIVES: To identify current FCP service provision across the UK, including models of provision and key professional capabilities. DESIGN: Cross-sectional online survey, targeting physiotherapists and service managers involved in FCP. METHODS: Recruitment involved non-probability sampling targeting those involved in FCP service provision through emails to members of known clinical networks, snowballing and social media. The survey gathered data about respondents, FCP services and the role and scope of physiotherapists providing FCP. RESULTS: The authors received 102 responses; 32 from service managers and 70 working in FCP practice from England (n=60), Scotland (n=22), Wales (n=14), and Northern Ireland (n=2). Most practitioners were NHS band 7 or 8a (91%, n=63), with additional skills (e.g. requesting investigations, prescribing). 17% (12/70) worked 37.5hours/week; 37% (26/70) ≤10hours; most (71%, 50/70) used 20-minute appointments (range 10-30minutes); varying arrangements were reported for administration and follow-up. Services covered populations of 1200 to 600,000 (75% <100,000); access mostly involved combinations of self-booking and reception triage. Commissioning and funding arrangements varied widely; NHS sources provided 90% of services. CONCLUSIONS: This survey provides new evidence regarding variation in FCP practice across the UK, indicating that evidence-informed, context specific guidance on optimal models of provision is required.

Keane, S., Lincoln, M. et Smith, T. (2012). "Retention of allied health professionals in rural New South Wales: a thematic analysis of focus group discussions." BMC Health Serv Res **12**: 175.

BACKGROUND: Uneven distribution of the medical workforce is globally recognised, with widespread rural health workforce shortages. There has been substantial research on factors affecting recruitment and retention of rural doctors, but little has been done to establish the motives and conditions that encourage allied health professionals to practice rurally. This study aims to identify aspects of recruitment and retention of rural allied health professionals using qualitative methodology. METHODS: Six focus groups were conducted across rural NSW and analysed thematically using a grounded theory approach. The thirty allied health professionals participating in the focus groups were purposively sampled to represent a range of geographic locations, allied health professions, gender, age, and public or private work sectors. RESULTS: Five major themes emerged: personal factors; workload and type of work; continuing professional development (CPD); the impact of management; and career progression. 'Pull factors' favouring rural practice included: attraction to rural lifestyle; married or having family in the area; low cost of living; rural origin; personal engagement in the community; advanced work roles; a broad variety of challenging clinical work; and making a difference. 'Push factors' discouraging rural practice included: lack of employment opportunities for spouses; perceived inadequate quality of secondary schools; age related issues (retirement, desire for younger peer social interaction, and intention to travel); limited opportunity for career advancement; unmanageable workloads; and inadequate access to CPD. Having competent clinical managers mitigated the general frustration with health service management related to inappropriate service models and insufficient or inequitably distributed resources. Failure to fill vacant positions was of particular concern and frustration with the lack of CPD access was strongly represented by informants. CONCLUSIONS: While personal factors affecting recruitment and retention of allied health study participants were similar to doctors, differences also existed. Allied health

professionals were attracted by advanced work roles in a context of generalist practice. Access to CPD and inequitable resource distribution were strong 'push' factors in this group. Health policy based on the assumption of transferability between professions may be misguided.

Kelly, A., Bulley, C., Byrne, I., et al. (2022). "A qualitative exploration of factors that influence physiotherapy students’ preferences of location and type of post-graduation employment in Scotland." Physiotherapy **114**: e208-e209.
https://doi.org/10.1016/j.physio.2021.12.192

Kingston, G. A., Williams, G., Judd, J., et al. (2015). "Hand therapy services for rural and remote residents: Results of a survey of Australian occupational therapists and physiotherapists." Aust J Rural Health **23**(2): 112-121.

OBJECTIVE: The aim of this study was to explore how interventions were provided to meet the needs of rural/remote residents who have had a traumatic hand injury, including the coordination of services between rural/remote and metro/regional therapists. Barriers to providing services, use of technology and professional support provided to therapists in rural/remote areas were also explored. DESIGN: Cross-sectional survey. SETTING: Metropolitan/regional and rural/remote public health facilities in Australia. PARTICIPANTS: Occupational therapists and physiotherapists who provide hand therapy to rural/remote patients. MAIN OUTCOME MEASURE: Quantitative and qualitative questionnaire responses analysed with descriptive statistics and inductive analysis. RESULTS: There were 64 respondents out of a possible 185. Over half of rural/remote respondents provided initial splinting and exercise prescriptions, and over 85% reported that they continued with exercise protocols. Videoconferencing technology for patient intervention and clinical review was used by 39.1% respondents. Barriers to providing services in rural/remote locations included transport, travelling time, limited staff, and lack of expert knowledge in hand injuries or rural/remote health care. Four major themes emerged from the open-ended questions: working relationships, patient-centred care, staff development and education, and rural and remote practice. CONCLUSION: The use of technology across Australia to support rural/remote patient intervention requires attention to achieve equity and ease of use. Flexible and realistic goals and interventions should be considered when working with rural/remote patients. A shared care approach between metropolitan/regional and rural/remote therapists can improve understanding of rural/remote issues and provide support to therapists. Further research is recommended to determine the suitability of this approach when providing hand therapy to rural/remote residents.

Koebisch, S. H., Rix, J. et Holmes, M. M. (2020). "Recruitment and retention of healthcare professionals in rural Canada: A systematic review." Can J Rural Med **25**(2): 67-78.

INTRODUCTION: This review explores a pertinent issue for healthcare professionals and recruiters alike: which factors are most important in the recruitment and retention of these professionals in rural practice in Canada. Existing research concentrates on specific factors or focused populations. This review was created to explore multiple factors and a wider population of healthcare professionals, including chiropractors, osteopaths, dentists and physiotherapists. METHODS: A literature search was carried out on four databases. Data from included studies were extracted, and thematic analysis was conducted on relevant findings. The quality of individual studies was assessed, and then themes were evaluated for overall confidence based on four components, using the Confidence in the Evidence for Reviews of Qualitative Research. RESULTS: One quantitative and four qualitative articles were identified, all of which targeted physicians. Five themes - Personal/family matters, Community factors, Professional practice factors, Professional education factors and Economic factors - were generated in two domains, recruitment and retention. Forty major codes were generated through axial coding of open codes. Codes included attraction to rural lifestyle, recreational activities, Scope of practice, rural training and incentives. Scope of practice was deemed very important as a factor of recruitment, as was attraction to rural lifestyle. Incentives were found to be of little importance in influencing the recruitment of healthcare professionals, and even less important for retention. CONCLUSION: Wide scope of practice and attraction to the rural lifestyle were considered the most important for

recruitment and to a lesser extent, retention, among the five papers studied. A lack of research was determined in the realm of factors influencing the recruitment and retention in healthcare professionals other than medical doctors in Canada. Therefore, it is recommended that further such studies investigate specific healthcare professionals.

Kroezen, M., Dussault, G., Craveiro, I., et al. (2015). "Recruitment and retention of health professionals across Europe: A literature review and multiple case study research." Health Policy **119**(12): 1517-1528. https://www.sciencedirect.com/science/article/pii/S0168851015001906

Many European countries are faced with health workforce shortages and the need to develop effective recruitment and retention (R&R) strategies. Yet comparative studies on R&R in Europe are scarce. This paper provides an overview of the measures in place to improve the R&R of health professionals across Europe and offers further insight into the evidence base for R&R; the interaction between policy and organisational levels in driving R&R outcomes; the facilitators and barriers throughout these process; and good practices in the R&R of health professionals across Europe. The study adopted a multi-method approach combining an extensive literature review and multiple-case study research. 64 publications were included in the review and 34 R&R interventions from 20 European countries were included in the multiple-case study. We found a consistent lack of evidence about the effectiveness of R&R interventions. Most interventions are not explicitly part of a coherent package of measures but they tend to involve multiple actors from policy and organisational levels, sometimes in complex configurations. A list of good practices for R&R interventions was identified, including context-sensitivity when implementing and transferring interventions to different organisations and countries. While single R&R interventions on their own have little impact, bundles of interventions are more effective. Interventions backed by political and executive commitment benefit from a strong support base and involvement of relevant stakeholders.

Landry, M. D., Hack, L. M., Coulson, E., et al. (2016). "Workforce Projections 2010-2020: Annual Supply and Demand Forecasting Models for Physical Therapists Across the United States." Phys Ther **96**(1): 71-80.

BACKGROUND: Health human resources continue to emerge as a critical health policy issue across the United States. OBJECTIVE: The purpose of this study was to develop a strategy for modeling future workforce projections to serve as a basis for analyzing annual supply of and demand for physical therapists across the United States into 2020. DESIGN: A traditional stock-and-flow methodology or model was developed and populated with publicly available data to produce estimates of supply and demand for physical therapists by 2020. METHODS: Supply was determined by adding the estimated number of physical therapists and the approximation of new graduates to the number of physical therapists who immigrated, minus US graduates who never passed the licensure examination, and an estimated attrition rate in any given year. Demand was determined by using projected US population with health care insurance multiplied by a demand ratio in any given year. The difference between projected supply and demand represented a shortage or surplus of physical therapists. RESULTS: Three separate projection models were developed based on best available data in the years 2011, 2012, and 2013, respectively. Based on these projections, demand for physical therapists in the United States outstrips supply under most assumptions. LIMITATIONS: Workforce projection methodology research is based on assumptions using imperfect data; therefore, the results must be interpreted in terms of overall trends rather than as precise actuarial data-generated absolute numbers from specified forecasting. CONCLUSIONS: Outcomes of this projection study provide a foundation for discussion and debate regarding the most effective and efficient ways to influence supply-side variables so as to position physical therapists to meet current and future population demand. Attrition rates or permanent exits out of the profession can have important supply-side effects and appear to have an effect on predicting future shortage or surplus of physical therapists.

Landry, M. D., Hastie, R., Onate, K., et al. (2012). "Attractiveness of employment sectors for physical therapists in Ontario, Canada (1999-2007): implication for the long term care sector." BMC Health Serv Res **12**. <Go to ISI>://WOS:000311894600001

Background: Recruiting and retaining health professions remains a high priority for health system planners. Different employment sectors may vary in their appeal to providers. We used the concepts of inflow and stickiness to assess the relative attractiveness of sectors for physical therapists (PTs) in Ontario, Canada. Inflow was defined as the percentage of PTs working in a sector who were not there the previous year. Stickiness was defined as the transition probability that a physical therapist will remain in a given employment sector year-to-year. Methods: A longitudinal dataset of registered PTs in Ontario (1999-2007) was created, and primary employment sector was categorized as 'hospital', 'community', 'long term care' (LTC) or 'other.' Inflow and stickiness values were then calculated for each sector, and trends were analyzed. Results: There were 5003 PTs in 1999, which grew to 6064 by 2007, representing a 21.2% absolute growth. Inflow grew across all sectors, but the LTC sector had the highest inflow of 32.0%. PTs practicing in hospitals had the highest stickiness, with 87.4% of those who worked in this sector remaining year-to-year. The community and other employment sectors had stickiness values of 78.2% and 86.8% respectively, while the LTC sector had the lowest stickiness of 73.4%. Conclusion: Among all employment sectors, LTC had highest inflow but lowest stickiness. Given expected increases in demand for services, understanding provider transitional probabilities and employment preferences may provide a useful policy and planning tool in developing a sustainable health human resource base across all employment sectors.

Martin, R., Mandrusiak, A., Lu, A., et al. (2020). "New-graduate physiotherapists' perceptions of their preparedness for rural practice." Aust J Rural Health **28**(5): 443-452.

OBJECTIVE: Providing health care in a rural or remote setting requires physiotherapists to adapt to a number of unique challenges. New-graduates working in rural or remote settings must respond to these challenges in addition to those of being a novice practitioner. This study investigated the perceived preparedness of new-graduate physiotherapists for work in rural or remote settings. DESIGN: A qualitative general inductive approach. SETTING: Rural and remote Queensland. PARTICIPANTS: New-graduate physiotherapists working in rural or remote locations were contacted via a snowballing recruitment strategy. MAIN OUTCOME MEASURE: Semi-structured interviews. RESULTS: Four key themes emerged from the data: (a) adjusting to rural life, (b) embracing opportunities, (c) stepping up to the plate and (d) preparing through authentic experiences. CONCLUSION: New-graduate physiotherapists perceived rural and remote practice to be a challenging but valuable opportunity with many social and professional rewards. The complex clinical demands and unique cultural factors inherent in rural and remote locations were experienced as additional obstacles to the transition from student to clinician. New-graduate physiotherapists were satisfied that their entry-level training provided the necessary skills required to practise rurally and remotely; however, they expressed 'shock' at the rapid adaptations needed to provide effective service in these settings. New-graduates are confident that exposure to authentic rural and remote clinical practice during their training was integral to their preparedness.

Mbemba, G. I. C., Gagnon, M.-P. et Hamelin-Brabant, L. (2016). "Factors Influencing Recruitment and Retention of Healthcare Workers in Rural and Remote Areas in Developed and Developing Countries: An Overview." Journal of public health in Africa **7**(2): 565-565.
https://pubmed.ncbi.nlm.nih.gov/28299160
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5345405/

Shortage of healthcare workers in rural and remote areas remains a growing concern both in developed and developing countries. This review aims to synthesize the significant factors impacting healthcare professionals' recruitment and retention in rural and remote areas, and to identify those relevant for developing countries. This paper included the following steps: exploring scientific literature through predetermined criteria and extracting relevant information by two independents reviewers. The AMSTAR tool was used to assess the methodological quality. Of the 224 screened publications, 15 reviews were included. Four reviews focused on recruitment factors, and another four reviews focused on retention factors. The remaining focused both on recruitment and retention factors. The most important factors influencing recruitment were rural background and rural origin, followed by career development. Opportunities for professional advancement, professional support

networks and financial incentives were factors impacting retention. While the main factors influencing recruitment and retention have been largely explored in the literature, the evidence on strategies to reduce the shortage of healthcare workers in rural area, particularly in developing countries, is low. Further research in this field is needed.

McCallum, C. A. (2010). "Access to physical therapy services among medically underserved adults: a mixed-method study." Phys Ther **90**(5): 735-747.

BACKGROUND AND OBJECTIVES: This mixed-method case study examined access issues related to physical therapy services among medically underserved adults within an Ohio community. DESIGN: Three community health care clinics served as the units of analysis. METHODS: Eleven health care providers and 110 patients participated in the study, and documents from local, state, and national resources were reviewed. RESULTS: Results revealed that structural, utilization of care, and outcome barriers existed. A lack of accessible physical therapy providers for medically underserved adults and a lack of standardized screening or assessment processes to identify physical mobility problems among people with chronic health conditions were found. Inadequate knowledge about the full scope of physical therapist practice existed, which may impede access to those individuals most in need of services. CONCLUSIONS: Opportunities are present for physical therapist involvement in screening, wellness and prevention, consultation, education, and program development among medically underserved adults. However, challenges exist due to a lack of human and financial resources and the current structure of our health care system, which focuses on acute and chronic care rather than prevention.

McFadden, B., McGrath, K. J., Lowe, T., et al. (2016). "Examining the Supply of and Demand for Physiotherapy in Saskatchewan: The Relationship between Where Physiotherapists Work and Population Health Need." Physiotherapy Canada **68**(4): 335-345.
<Go to ISI>://WOS:000386905700004

Purpose: This research examined the association between the distribution of physiotherapists in Saskatchewan relative to population health characteristics and self-reported physiotherapy use. Methods: Using a cross-sectional design, de-identified data were collected from the 2013 Saskatchewan College of Physical Therapy membership renewals (n = 643), and Saskatchewan population health characteristics data were obtained from the 2009-2012 Canadian Community Health Surveys (CCHSs). Age-and sex-adjusted proportions of selected population health characteristics were calculated and stratified by health region and rural-urban location; both were determined, for physiotherapists and CCHS participants, using postal codes. The association between physiotherapy distribution and physiotherapy use was calculated, and geospatial mapping techniques were used to display physiotherapist distribution across the province relative to population health characteristics. Results: Across health regions, a positive correlation ($r = 0.655$, $p < 0.029$) was found between physiotherapist distribution and self-reported physiotherapy use. Mapping population health characteristics according to physiotherapist distribution demonstrated an imbalance between supply and distribution of physiotherapists and population health needs and demands. Conclusion: There is a discrepancy in Saskatchewan among the distribution of physiotherapists, self-reported physiotherapy use, and population health characteristics, especially in rural settings. These findings provide insight into which areas are in need of increased physiotherapy services.

McGill, T. (2013). "Effectiveness of Physical Therapists Serving as Primary Care Musculoskeletal Providers as Compared to Family Practice Providers in a Deployed Combat Location: A Retrospective Medical Chart Review." Military Medicine **178**(10): 1115-1120.
<Go to ISI>://WOS:000340805600012

Objectives: A medical records review to compare efficiency and effectiveness of a physical therapist (PT) functioning as a musculoskeletal primary care provider (PCP) compared to family practice (FP) physicians functioning as musculoskeletal PCP. Hypothesis: (1) Use of medication/imaging studies will be significantly less with a PT as PCP compared to FP as PCP. (2) Return-to-duty (RTD) rate will show

significant increases when patients with musculoskeletal conditions are seen by PT as compared to FP. Methods: One PT practicing in a deployed combat location collected data on patients that presented directly to the PT clinic or FP clinic for care of musculoskeletal complaints. Treatment patterns of two Air Force physicians were accessed regarding patients with musculoskeletal conditions. Fifty-four patients were randomly selected for the PT group and 95 patients for FP group. AHLTA was searched for cases reported from June 2009 to January 2010. Data regarding age, gender, medication, imaging use, and return to duty (RTD) rate were collected. Results: Of the study population, 126 (84%) were males, 23 (16%) were females (age range: 19-54, mean 29). RTD rate was 50% greater for PT. Rate of medication and imaging use for PT was 24% and 11%, whereas FP was 90% and 82%, respectively ($p < 0.01$). Conclusion: Using PT as the musculoskeletal PCP was shown to be an effective and efficient practice model to assess and treat patients with musculoskeletal complaints.

McMaster, E., Reid, T., Farquhar, E., et al. (2021). "Responding to rural allied health workforce challenges in the public health system: Evaluation of the Allied Health Rural Generalist Pathway pilot in western New South Wales." Aust J Rural Health **29**(5): 701-720.

OBJECTIVE: The Allied Health Rural Generalist Pathway pilot aimed to improve consistent access to physiotherapy services in rural communities using the "grow own" workforce strategy and existing resources. DESIGN: A summative evaluation of the quality improvement project used to implement the Allied Health Rural Generalist Pathway was completed. A mixed method design was used and included focus groups and a framework analysis. PARTICIPANTS: The temporary redesign of specific workforce resources created "development" positions. A shared same-discipline supervisor resource supported five early-career physiotherapists, the participants. SETTING: The project was undertaken in rural New South Wales in the public health system. MAIN OUTCOME MEASURES: The main outcome measures included a number of chronically vacant physiotherapy positions and stakeholder satisfaction. RESULTS: Targeted vacancies were filled, services sustained with minimal service gaps and mean retention rate of 2.9 years. A statistically significant increase in service activity to patients in rural locations occurred as a result of the intervention (R-squared 29%, $P < .05$). Four out of five early career physiotherapists fulfilled terms of their contract and secured senior positions within the region. Whilst participants developed professionally, they did not complete the tertiary education component. CONCLUSIONS: The Allied Health Rural Generalist multi-factorial approach supported recruitment, retention and capacity building within the targeted discipline of the allied health workforce. Patient need was met. The rural pipeline capacity was developed. The pathway was complementary of existing NSW Health systems. Systemic change is needed to overcome inefficiencies experienced during implementation and to ensure sustainability. Further research to develop discipline-specific clinical training guidance through the stages of a rural allied health professionals' career may be helpful.

Mifflin, T. M. et Bzdell, M. (2010). "Development of a physiotherapy prioritization tool in the Baffin Region of Nunavut: a remote, under-serviced area in the Canadian Arctic." Rural Remote Health **10**(2).
<Go to ISI>://WOS:000286342500039

Context: This article describes the development and evaluation of a tool to prioritize physiotherapy referrals in a remote, under-serviced region in Canada's eastern Arctic. The Baffin Region of Nunavut is home to approximately 16 000 people dispersed across 12 communities accessible only by air. Physiotherapists are based out of the capital city, but provide services to clients throughout the region. Physiotherapists in the Baffin Region are generalists, treating clients from across the lifespan and from all practice areas. The region is under-serviced with regard to physiotherapy, and long waitlists for service are maintained. No previous physiotherapy prioritization tool existed to manage the diverse caseload. Issue: Physiotherapists were dissatisfied with perceived inequities in service delivery among the different communities in the region, and between client types. In response, a tool was created to prioritize physiotherapy referrals based on urgency and need, regardless of client location. The prioritization tool was developed by combining the authors' knowledge of the distinct and unique characteristics of the Baffin Region with background research. Three methods were used to collect background information: (1) a literature search; (2) a review of prioritization policies from

other regions; and (3) interviews with physiotherapists working in similar remote areas in Canada. From the background research, common characteristics in prioritizing physiotherapy referrals as 'high priority' emerged. These were combined with the identified characteristics of the Baffin Region to create a tool that could prioritize physiotherapy referrals from multiple client types. The prioritization tool was then implemented and evaluated over a four-month period. Lessons Learned: Following the implementation of the prioritization tool, a greater percentage of scheduled physiotherapy appointments were devoted to high priority groups, and there was a greater amount of service delivered to clients from the remote communities. Physiotherapists subjectively reported improved job satisfaction knowing that clients over the entire region were being assessed in order of priority, and decreased job stress as a result of reduced therapist time spent triaging referrals. Unanticipated outcomes from using the prioritization tool included subjectively reported improved communication with other health professionals, and changes in physiotherapy service delivery methods in the Baffin Region. Using the prioritization tool prompted increased client travel to the capital city for urgent physiotherapy appointments, increased use of videoconferencing for follow-up physiotherapy appointments, and increased use of a consultative model to deliver physiotherapy services. The tool could be adapted for use by other rural or remote physiotherapists working with multiple client populations in under-serviced areas. The Baffin Region Physiotherapy Prioritization Tool provides an objective method for making triage decisions, and has improved the equity with which physiotherapy services are delivered across the region.

Morell, A. L., Kiem, S., Millsteed, M. A., et al. (2014). "Attraction, recruitment and distribution of health professionals in rural and remote Australia: early results of the Rural Health Professionals Program." Hum Resour Health **12**: 15.

BACKGROUND: Australians living in rural and remote communities experience relatively poor health status in comparison to the wider Australian population (Med J Aust 185:37-38, 2006). This can be attributed in part to issues of access to health services arising from difficulties in recruiting and retaining health professionals in these areas. The Rural Health Professionals Program is an initiative designed to increase the number of allied health and nursing professionals in rural and remote Australia by providing case managed recruitment and retention support services. This paper reports on early analysis of available programme data to build knowledge of factors related to the recruitment and distribution of health professionals in rural and remote Australia. METHODS: Administrative programme data were collected monthly from 349 health professionals over the first 13 months of programme operation. These data were collated and quantitative analysis was conducted using SPSS software. RESULTS: Sixty-nine percent of recruits were women, and recruits had a mean age of 32.85 (SD = 10.92). Sixty percent of recruits were domestically trained, and the top two professions recruited were nurses (29%) and physiotherapists (21%). Eighty-seven percent were recruited to regional areas, with the remaining 13% recruited to remote areas. Among reasons for interest in the programme, financial support factors were most commonly cited by recruits (51%). Recruitment to a remote location was associated with being domestically trained, having previously lived in a rural or remote location, being a nurse (as opposed to an allied health professional) and older age. DISCUSSION: The findings provide early support for a case managed recruitment programme to improve distribution of health professionals, and some directions for future marketing and promotion of the programme. It is recommended that an outcome evaluation be conducted to determine the impact of the programme on recruitment and distribution outcomes. CONCLUSION: The findings herein begin to address gaps in the literature relating to the effectiveness of interventions to improve the distribution of health professionals. While this provides some preliminary indication that case managed recruitment and retention programmes have capacity to improve distribution, further research and evaluation is required to confirm the impact of the programme on retention.

Mulcahy, A. J., Jones, S., Strauss, G., et al. (2010). "The impact of recent physiotherapy graduates in the workforce: a study of Curtin University entry-level physiotherapists 2000-2004." Aust Health Rev **34**(2): 252-259.

Physiotherapy is the largest healthcare contributor after nursing and medicine and it is important to understand its employment characteristics. This study aimed to explore workforce trends for recent physiotherapy graduates, including satisfaction and motivating factors, and future career intentions. A self-administered questionnaire was provided to contactable entry-level physiotherapy graduates (2000-2004) from Curtin University. Of 256 respondents (62.9%), 76.5% were employed full-time. A total of 45% of physiotherapists worked in the public health system; 79.3% worked in cities; 92.2% were clinicians. Top salaries were earned by those completing more continuing professional development hours, working privately, in rural locations and males. A total of 65% (n = 118) of respondents believed they would leave physiotherapy within 10 years. The best aspects of working in physiotherapy were 'helping people', 'flexibility' and 'working in a healthcare team'. Major areas for improvement were 'remuneration', 'skill recognition' and 'marketing'. This study suggests serious implications for the future of the health; planning to avert shortages is essential.

O'Sullivan, B. G. et Worley, P. (2020). "Setting priorities for rural allied health in Australia: a scoping review." Rural Remote Health **20**(2): 5719.

INTRODUCTION: The allied health workforce is one of the largest workforces in the health industry. It has a critical role in cost-effective, preventative health care, but it is poorly accessible in rural areas worldwide. This review aimed to inform policy and research priorities for increasing access to rural allied health services in Australia by describing the extent, range and nature of evidence about this workforce. METHODS: A scoping review of published, peer-reviewed rural allied health literature from Australia, Canada, the USA, New Zealand and Japan was obtained from six databases (February 1999 - February 2019). RESULTS: Of 7305 no-duplicate articles, 120 published studies were included: 19 literature reviews, and 101 empirical studies from Australia (n=90), Canada (n=8), USA (n=2) and New Zealand (n=1). Main themes were workforce and scope (n=9), rural pathways (n=44), recruitment and retention (n=31), and models of service (n=36). Of the empirical studies, 83% per cent were cross-sectional; 64% involved surveys; only 7% were at a national scale. Rural providers were shown to have a breadth of practice, servicing large catchments with high patient loads, requiring rural-specific skills. Most rural practitioners had rural backgrounds, but rural youth faced barriers to accessing allied health courses. Rural training opportunities have increased in Australia but predominantly as short-term placements. Rural placements were associated with increased likelihood of rural work by graduates compared with discipline averages, and high quality placement experiences were linked with return. Recruitment and retention factors may vary by discipline, sector and life stage but important factors were satisfying jobs, workplace supervision, higher employment grade, sustainable workload, professional development and rural career options. Patient-centred planning and regional coordination of public and private providers with clear eligibility and referral to pathways facilitated patient care. Outreach and telehealth models may improve service distribution although require strong local coordination and training for distal staff. CONCLUSION: Evidence suggests that more accessible rural allied health services in Australia should address three key policy areas. First, improving rural jobs with access to senior workplace supervision and career options will help to improve networks of critical mass. Second, training skilled and qualified workers through more continuous, high quality rural pathways is needed to deliver a complementary workforce for the community. Third, distribution depends on networked service models at the regional level, with viable remuneration, outreach and telehealth for practice in smaller communities. More national-scale, longitudinal, outcomes-focused studies are needed using controlled designs.

O'Toole, K. et Schoo, A. M. (2010). "Retention policies for allied health professionals in rural areas: a survey of private practitioners." Rural Remote Health **10**(2): 1331.

INTRODUCTION: Retention of rehabilitation therapists (RTs) in rural areas is a growing problem in rural Australia. Current literature demonstrates that private allied health professionals in general remain longer in rural areas than those working in the public sector. However, government focus to enhance retention has been on those employed in the public sector, offering private practitioners little incentive to stay rural. There has been an absence of policy commitment to attracting private professionals to rural areas or offering rural practitioners options for mixing private and public service.

This study aimed to explore the thoughts and perceptions of private RTs in rural areas concerning their incorporation into broader rural health policies and concomitant programs. METHODS: An online survey was sent to a purposively chosen sample of RTs in rural Victoria. Participants were selected from publicly available internet listings and were contacted via email. Possible participants were limited to those who had an email address and to those on three available professional lists (physiotherapy, occupational therapy and speech pathology). The survey consisted of 29 questions: eight related to the perceived place that practitioners in rural areas occupy; eight related to their professional practice; seven related to retention policies; two related to education and training; and four were demographic questions. RESULTS: A total of 72 RTs completed the survey and were included in the analysis (40% response rate). The overwhelming majority of respondents were in favour of having partnerships between private and public practice in rural and regional areas and of governments developing programs to facilitate such partnerships. In total, 26% of respondents currently worked in some form of partnership with public agencies. There was also a reasonable response to the use of government incentives to retain and attract private practitioners to rural and regional areas. CONCLUSIONS: The results of this research indicate that many private RTs in Victoria perceived their greater involvement in the delivery of public health in rural areas in a positive manner.

Park, J. R., Coombs, C., Wilkinson, A. J., et al. (2003). "Attractiveness of Physiotherapy in the National Health Service as a Career Choice: Qualitative study." Physiotherapy **89**(10): 575-583.
https://www.sciencedirect.com/science/article/pii/S0031940605600569

Background and Purpose The National Health Service is currently experiencing a shortfall of staff in the allied health professions and in particular, physiotherapy. This research project aimed to identify the key factors that determine the attractiveness of physiotherapy as a career choice and the National Health Service as an employer to potential recruits and returners. Methods Interviews were conducted with school pupils, mature students on Access courses, physiotherapy students, physiotherapy assistants, agency physiotherapists and independent sector physiotherapists. Findings Ninety-two individuals participated in the qualitative stage of the study. Physiotherapy as a career choice was seen as attractive because of caring for patients, job availability, variety in work content and high levels of teamwork. However, these positive features were offset by high levels of stress and workload, staff shortages and poor equipment. Conclusions In order to improve the attractiveness of a physiotherapy career greater publicity about consultant therapist positions, improved staffing levels, better working environments and increased work flexibility are required. It should be noted that the relatively small number of participants reduces the generalisability of the results of this study.

Pittman, P., Frogner, B., Bass, E., et al. (2014). "International recruitment of allied health professionals to the United States: piecing together the picture with imperfect data." J Allied Health **43**(2): 79-87.

BACKGROUND: Research on the international recruitment of health professionals to the U.S. has focused almost exclusively on physicians and nurses; we are aware of no research on the migration of allied health professionals. OBJECTIVE: We examined the strengths and weaknesses of various public and private data sources on foreign-educated allied health professions in the U.S. and patched together a picture of these migrants. We focus on pharmacists, physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), and medical and clinical laboratory technicians (lab techs). FINDINGS: Based on the American Community Survey, we found that 12% of PTs, 12% of lab techs, 8% of pharmacists, 4% of OTs, and 3% of SLPs are foreign-born and entered the U.S. at age 21 or older. Among foreign-born PTs, about half remain as non-citizens, suggesting the highest proportion of recent arrivals among the five professions. CONCLUSIONS: As Congress debates comprehensive immigration reform, one of the much need changes to the system is better immigration data, disaggregated by occupation.

Pretorius, A., Karunaratne, N. et Fehring, S. (2016). "Australian physiotherapy workforce at a glance: a narrative review." Aust Health Rev **40**(4): 438-442.

Background The ability of the physiotherapy workforce to meet the growing demand in the Australian community is uncertain, despite increasing tertiary students and numbers of registered physiotherapists annually. Objectives The present narrative literature review investigates what is known about the Australian physiotherapy workforce, what factors contribute to attrition from the profession and what strategies could be implemented to improve retention of skilled physiotherapists. Methods A literature search of five databases identified 24 articles that informed the content of the present review. The articles were reviewed and content summarised according to focus areas and results discussed in the current Australian healthcare context. Results Although many factors of attrition are inevitable, the present review identified some potentially modifiable factors of attrition. Strategies to improve retention of skilled physiotherapists were broadly grouped into improving professional support in the workforce and assisting the re-entry process for physiotherapists seeking to return to the workforce. Conclusion Increasing retention of qualified and skilled physiotherapists nationally will help build workforce capacity, meeting the needs of the growing, changing and aging community. What is known about the topic? The demand for physiotherapists is growing significantly in Australia and the ability of the workforce to meet growing demands is uncertain. What does this paper add? Many physiotherapists in Australia leave the workforce and the profession early in their careers. Addressing modifiable factors of attrition could help improve the retention of practitioners and skills in the profession, building workforce capacity. What are the implications for practitioners? Professional support for current physiotherapists is crucial. Re-entry physiotherapists should be supported with flexible return-to-work programs, refresher training and mentorship.

Roots, R. K., Brown, H., Bainbridge, L., et al. (2014). "Rural rehabilitation practice: perspectives of occupational therapists and physical therapists in British Columbia, Canada." Rural Remote Health **14**: 2506.

BACKGROUND: Providing rehabilitation services to address the health needs of rural residents requires overcoming the challenges of geography, limited referral options and a shortage of occupational therapists (OTs) and physical therapists (PTs). However, little is known about how rehabilitation professionals in rural areas enact their practice to meet and overcome these challenges. To address this gap and contribute to enhancing health for rural residents, this study was designed to explore rural rehabilitation practice from the perspectives of OTs and PTs in rural British Columbia (BC). METHODS: A purposive sample of OTs and PTs in rural communities (population <15 000) in northern BC was recruited for this qualitative study. Potential participants received an invitation mailed to workplaces and were selected to ensure a variety of work experiences, roles and practice settings. In semi-structured interviews, participants were asked to describe the skills and knowledge they perceived as unique to rural practice and strategies they used to overcome challenges. Guided by interpretive description, transcripts were analysed inductively using broad-level coding, and findings were collapsed into interpretive categories. Interpretations and implications for education, practice and policy were reviewed with participants to ensure relevance to rural practice. RESULTS: From interviews with 6 OTs and 13 PTs, serving a total of 15 rural communities, rehabilitation practice and participants' definition of health were understood to be substantially shaped by rurality or the contextual features of geography, determinants of health and access to services. Participants considered general practice 'a specialty' requiring advanced skills in assessment. They described 'stretching their role' and 'participating in, and partnerships with, community' as ways to overcome resource shortages. Reflective practice, networking and collaboration were deemed essential to maintaining competence. Rural clinical placements, mentoring and improving access to continuing professional development were regarded as central to the recruitment and retention required to sustain optimal levels of service to residents. CONCLUSION: The research findings illustrate the unique influence that the rural context has on the practice of OTs and PTs in BC. They underscore the importance of facilitating learning about rural health within professional training programs and of providing accessible professional development resources to address health human resource shortages and meet the rehabilitation needs of rural residents.

Roots, R. K. et Li, L. C. (2013). "Recruitment and retention of occupational therapists and physiotherapists in rural regions: a meta-synthesis." BMC Health Serv Res **13**.
<Go to ISI>://WOS:000317461600001

Background: Significant efforts have been made to address the shortage of health professionals in rural communities. In the face of increasing demand for rehabilitation services, strategies for recruiting and retaining occupational therapists (OTs) and physiotherapists (PTs) have yielded limited success. This study aims to broaden the understanding of factors associated with recruitment and retention of OTs and PTs in rural regions, through a synthesis of evidence from qualitative studies found in the literature. Methods: A systematic search of three databases was conducted for studies published between 1980 - 2009 specific to the recruitment and retention of OTs and PTs to rural areas. Studies deemed eligible were appraised using the McMaster Critical Review Form. Employing an iterative process, we conducted a thematic analysis of studies and developed second order interpretations to gain new insight into factors that influence rural recruitment and retention. Results: Of the 615 articles retrieved, 12 qualitative studies met the eligibility criteria. Our synthesis revealed that therapists' decision to locate, stay or leave rural communities was influenced to a greater degree by the availability of and access to practice supports, opportunities for professional growth and understanding the context of rural practice, than by location. The second-order analysis revealed the benefits of a strength-based inquiry in determining recruitment and retention factors. The themes that emerged were 1) support from the organization influences retention, 2) with support, challenges can become rewards and assets, and 3) an understanding of the challenges associated with rural practice prior to arrival influences retention. Conclusions: This meta-synthesis illustrates how universally important practice supports are in the recruitment and retention of rehabilitation professionals in rural practice. While not unique to rural practice, the findings of this synthesis provide employers and health service planners with information necessary to make evidence-informed decisions regarding recruitment and retention to improve availability of health services for rural residents.

Schmidt, D. et Dmytryk, N. (2014). "Exploring a public-private partnership new-graduate physiotherapy recruitment program: a qualitative study." Australian Journal of Rural Health **22**(6): 334-339. <Go to ISI>://WOS:000346239400010

ObjectiveDifficulty in attracting allied health staff to rural areas is well known. In 2012, a small rural health facility and local private practice created an informal public-private partnership to recruit two new-graduate physiotherapists. Graduates were employed part-time in both the public and private sectors. DesignThis qualitative case study employed an appreciative enquiry framework to explore this partnership model. Three focus groups were held, and a combination of content and thematic analysis was used to derive and organise themes arising from the data. SettingA regional public health service and private physiotherapy practice in the Bega Valley region of south-eastern New South Wales, Australia. ParticipantsNew-graduate and second-year physiotherapists (n=5), private sector managers (n=3), and public sector managers (n=4). Main outcome measuresPerceived benefits of the partnership model and improvements that could be made to further develop the model. ResultsOrganisational benefits of a shared public-private role included the ability to attract high-quality applicants to difficult-to-fill positions, reduced the risk of new-graduate attrition due to social isolation, enhanced networking between sectors, and enhanced staff skill development through a broad range of clinical and non-clinical experiences. The model relied on management flexibility and has potential to expand to other areas and professions. Dedicated funding support, targeted recruitment strategies and increased planning to ease the transition into the workplace would further enhance the model. ConclusionsAn informal public-private partnership to overcome established workforce shortages has proven successful to the benefit of the new graduates and both the public and private sectors.

Schoo, A. M., Stagnitti, K. E., Mercer, C., et al. (2005). A conceptual model for recruitment and retention: Allied health workforce enhancement in Western Victoria, Australia." Rural Remote Health. https://search.informit.org/doi/10.3316/informit.611403704521769

Attracting and retaining allied health professionals in rural areas is a recognised problem in both Australia and overseas. Predicted increases in health needs will require strategic actions to enhance

the rural workforce and its ability to deliver the required services. A range of factors in different domains has been associated with recruitment and retention in the allied health workforce. For example, factors can be related to the nature of the work, the personal needs, or the way an organisation is led. Some factors cannot be changed (eg geographical location of extended family) whereas others can be influenced (eg education, support, management styles). Recruitment and retention of allied health professionals is a challenging problem that deserves attention in all domains and preparedness to actively change established work practices, both individually as well as collectively, in order to cater for current and predicted health needs. Changes to enhance workforce outcomes can be implemented and evaluated using a cyclic model. The Allied Health Workforce Enhancement Project of the Greater Green Triangle University Department of Rural Health (GGT UDRH) is working towards increasing the number of allied health professionals in the south west of Victoria. Based on themes identified in the literature, an interactive model is being developed that addresses recruitment and retention factors in three domains: (1) personal or individual; (2) organisation; and (3) community.

Shah, T., Bath, B., Hayes, A., et al. (2019). "Comparative Analysis of Geographic Accessibility of Dentists, Physiotherapists and Family Physicians in an Urban Centre: A Case Study of Saskatoon, Canada." J Can Dent Assoc **85**: j2.

BACKGROUND: The spatial arrangement of primary health care (PHC) services is influenced by many factors and varies across provider types. In Canada, unlike physician services, certain PHC services (i.e., dentistry, physiotherapy) are not fully funded under the health care system. As a result, one might expect the arrangement of these services to differ by neighbourhood, even in dense metropolitan areas. OBJECTIVE: This study examines the intra-urban variability of geographic access to dental (DS) and physiotherapy (PT) services in relation to family physician (FP) services in an urban area and identifies underserviced neighbourhoods. METHODS: Practice location information was gathered from publicly available and routinely updated provincial sources (physician, physiotherapy and dentistry regulatory colleges). A neighbourhood accessibility score for all 3 PHC services was calculated using a GIS-based, 3-step floating catchment area method. A set of parameters, such as catchment type (road network buffer), size (3 km radius) and census centroids (dissemination areas), was used. RESULTS: The overall access scores for FP, PT and DS services (based on the 281 FPs, 226 PTs, and 152 DSs) were 1.45 (SD 0.94), 1.18 (SD 0.81) and 0.79 (SD 0.53) providers/1000 population, respectively. Spatial comparison of the accessibility scores indicated a greater proportion of the Saskatoon population has lower access scores (< 0.5/1000 population) for both physiotherapy (n = 79 450) and dental (n = 101 270) services compared with family physician services (n = 64 420). Exploration of the relation between PHC service arrangement and key sociodemographic variables (e.g. low income, education levels) showed that a considerable proportion of those in each sociodemographic group has poor PT and DS access. CONCLUSION: This research has identified accessibility gaps and serves to inform the development of health policies focused on equitable distribution and funding of PHC services based on population health needs.

Shah, T. I., Milosavljevic, S. et Bath, B. (2017). "Measuring geographical accessibility to rural and remote health care services: Challenges and considerations." Spat Spatiotemporal Epidemiol **21**: 87-96.

This research is focused on methodological challenges and considerations associated with the estimation of the geographical aspects of access to healthcare with a focus on rural and remote areas. With the assumption that GIS-based accessibility measures for rural healthcare services will vary across geographic units of analysis and estimation techniques, which could influence the interpretation of spatial access to rural healthcare services. Estimations of geographical accessibility depend on variations of the following three parameters: 1) quality of input data; 2) accessibility method; and 3) geographical area. This research investigated the spatial distributions of physiotherapists (PTs) in comparison to family physicians (FPs) across Saskatchewan, Canada. The three-steps floating catchment areas (3SFCA) method was applied to calculate the accessibility scores for both PT and FP services at two different geographical units. A comparison of accessibility scores to simple healthcare provider-to-population ratios was also calculated. The results vary considerably

depending on the accessibility methods used and the choice of geographical area unit for measuring geographical accessibility for both FP and PT services. These findings raise intriguing questions regarding the nature and extent of technical issues and methodological considerations that can affect GIS-based measures in health services research and planning. This study demonstrates how the selection of geographical areal units and different methods for measuring geographical accessibility could affect the distribution of healthcare resources in rural areas. These methodological issues have implications for determining where there is reduced access that will ultimately impact health human resource priorities and policies.

Shah, T. I., Milosavljevic, S., Proctor, P. L., et al. (2018). "Variation in the Geographic Distribution of Physiotherapy Student Clinical Placements in Rural Saskatchewan." Physiotherapy Canada **70**(3): 274-279. <Go to ISI>://WOS:000442898300013

Purpose: Rural and remote Saskatchewan has a shortage of physiotherapists. Positive student experiences in rural and remote communities may influence whether graduates choose to work in these settings. The intention of the first full-time, 4-week clinical placement (CP) in the Master of Physical Therapy programme at the University of Saskatchewan is to provide clinical experiences in rural settings outside Saskatoon and Regina. This study examines the geographic distribution of and yearly variation in these CPs to determine whether this stated intent is being realized. Method: We analyzed the locations of physiotherapy student CPs from 2008 to 2016 using geospatial mapping. Results: Spatial patterning using mapping identified variability in the number of rural placements in geographical regions in Saskatchewan over a 9-year period. An average of 75% of CP experiences occurred in rural locations outside the two major cities in Saskatchewan between 2008 and 2016 (ranging from 58% in 2015 to 84% in 2009). Conclusions; The goal of providing all University of Saskatchewan physiotherapy students with a rural experience for their first CP is not being met. Securing more CPs in rural settings may have a positive impact on recruitment of physiotherapists to these communities.

Slagle, D. R., Byington, R. L. et Verhovsek, E. L. (2012). "Rural versus urban: Tennessee health administrators' strategies on recruitment and retention for allied health professionals." J Health Care Finance **38**(4): 91-104.

Due to an increase in the need for allied health professionals, there is a growing interest to assess the allied health workforce and its employment needs. This is especially true in medically underserved rural areas where there is a critical shortage of allied health professionals. A survey was sent to allied health administrators across a variety of allied health disciplines working in Tennessee hospitals in order to gauge opinions on retention and recruitment strategies. Overall successful strategies for recruitment and retention of allied health professionals were reported as well as differences between urban and rural areas, differences of perceptions of strategy effectiveness among allied health disciplines, and key strategies for rural allied health recruitment. Little is known about organizational policies impacting recruitment and retention practices of allied health professionals in Tennessee hospitals. Understanding of this problem is vital to the prevention of a critical shortage of allied health professionals. Therefore, this study sought to compare rural and urban hospital in Tennessee with respect to recruitment and retention needs.

Solomon, P., Salvatori, P. et Berry, S. (2001). "Perceptions of Important Retention and Recruitment Factors by Therapists in Northwestern Ontario." The Journal of Rural Health **17**(3): 278-285. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1748-0361.2001.tb00965.x

ABSTRACT: Recruitment and retention of health professionals in rural and remote communities are well-knoivn challenges. Although the literature states that lifestyle factors and being from a rural background influence recruitment and retention, much of the research is dated and of limited relevance to rehabilitation professionals. This study reports on a survey of physical therapists (PTs) and occupational therapists (OTs) in northwestern Ontario. Seventy-four percent of the OTs and PTs from this geographically isolated region of Canada responded to a mail survey examining factors that influenced their job recruitment and retention decisions. Availability of leisure and recreation

activities, proximity of family of origin, need for OTs and PTs and influence of spouse or partner frequently contributed to recruitment decisions and were also important in retention decisions. Although professional autonomy was an important source of job satisfaction for the respondents, almost one-third reported a feeling of professional isolation. Professional development initiatives appeared to influence job satisfaction but were unlikely to influence working life decisions. TIk findings suggest that recruitment and retention strategies should be multifaceted to reflect tlie complexity of therapists' decision-making.

Spooner, S., Gibson, J., Checkland, K., et al. (2020). "Regional variation in practitioner employment in general practices in England: a comparative analysis." Br J Gen Pract **70**(692): e164-e171.

BACKGROUND: In recent years, UK health policy makers have responded to a GP shortage by introducing measures to support increased healthcare delivery by practitioners from a wider range of backgrounds. AIM: To ascertain the composition of the primary care workforce in England at a time when policy changes affecting deployment of different practitioner types are being introduced. DESIGN AND SETTING: This study was a comparative analysis of workforce data reported to NHS Digital by GP practices in England. METHOD: Statistics are reported using practice-level data from the NHS Digital June 2019 data extract. Because of the role played by Health Education England (HEE) in training and increasing the skills of a healthcare workforce that meets the needs of each region, the analysis compares average workforce composition across the 13 HEE regions in England RESULTS: The workforce participation in terms of full-time equivalent of each staff group across HEE regions demonstrates regional variation. Differences persist when expressed as mean full-time equivalent per thousand patients. Despite policy changes, most workers are employed in long-established primary care roles, with only a small proportion of newer types of practitioner, such as pharmacists, paramedics, physiotherapists, and physician associates. CONCLUSION: This study provides analysis of a more detailed and complete primary care workforce dataset than has previously been available in England. In describing the workforce composition at this time, the study provides a foundation for future comparative analyses of changing practitioner deployment before the introduction of primary care networks, and for evaluating outcomes and costs that may be associated with these changes.

Steenhuis, S., Groeneweg, N., Koolman, X., et al. (2017). "Good, better, best? A comprehensive comparison of healthcare providers' performance: An application to physiotherapy practices in primary care." Health Policy **121**(12): 1225-1232.

Most payment methods in healthcare stimulate volume-driven care, rather than value-driven care. Value-based payment methods such as Pay-For-Performance have the potential to reduce costs and improve quality of care. Ideally, outcome indicators are used in the assessment of providers' performance. The aim of this paper is to describe the feasibility of assessing and comparing the performances of providers using a comprehensive set of quality and cost data. We had access to unique and extensive datasets containing individual data on PROMs, PREMs and costs of physiotherapy practices in Dutch primary care. We merged these datasets at the patient-level and compared the performances of these practices using case-mix corrected linear regression models. Several significant differences in performance were detected between practices. These results can be used by both physiotherapists, to improve treatment given, and insurers to support their purchasing decisions. The study demonstrates that it is feasible to compare the performance of providers using PROMs and PREMs. However, it would take an extra effort to increase usefulness and it remains unclear under which conditions this effort is cost-effective. Healthcare providers need to be aware of the added value of registering outcomes to improve their quality. Insurers need to facilitate this by designing value-based contracts with the right incentives. Only then can payment methods contribute to value-based healthcare and increase value for patients.

Struber, J. (2004). "Recruiting and Retaining Allied Health Professionals in Rural Australia: Why is it so Difficult?" Internet Journal of Allied Health Science and Practice **2**.

Rural communities in Australia have particular health needs, and the recruitment and retention of Allied Health Professionals (AHPs) is a significant concern. Despite the increasing number of AHPs being trained, vacancy and attrition rates in rural areas continue to rise. Professional and social isolation combined with rapidly changing health service delivery structures are identified as major deterrents to long-term rural practice. While strategies are now being implemented, endeavours to resolve the issues lag well behind initiates offered to Medical and Nursing staff. Given the wealth of political, professional and health related issues underlying the recruitment and retention of AHPs to rural areas, total resolution of this issue may not be possible. A unified approach by AHPs combined with concerted effort and collaboration on the part of all the stakeholders may, however, allow management at a level required to sustain a viable rural AHP workforce. INTRODUCTION Recruitment and retention of Allied Health Professionals is a long-standing issue in rural Australia. Despite increasing attention over the past decade little progress has been made in addressing the problem. The 30% of Australians living in rural areas have unique health concerns that relate directly to their living conditions, social isolation, cultural diversity and distance from health services. 1,2 Their health status is measurably poorer than that of their urban counterparts and declines along a continuum as one moves away from the capital cities. 3-7 Dispelling the illusion of a 'healthy country lifestyle', major risk factors contributing to poor health in rural areas include: physical inactivity, overweight and obesity, smoking, risk taking behaviours and harmful alcohol consumption. These are further compounded by low socioeconomic and educational status, fewer employment opportunities and poorer access to health services. 6,8-10

Williams, E. N. et McMeeken, J. M. (2014). "Building capacity in the rural physiotherapy workforce: a paediatric training partnership." Rural Remote Health **14**: 2475.

CONTEXT: Building capacity in the rural physiotherapy workforce: a paediatric training partnership' provided 6 months postgraduate paediatric clinical and academic training for two physiotherapists in rural Australia. It is described as a model for improving services and workforce retention. The need for 'an appropriate, skilled and well-supported health workforce' is the third goal in Australia's National Strategic Framework for Rural and Remote Health 2011. The World Health Organization recently published its first global policy for improving the retention of rural and remote health workers. Education is its first recommendation and aims to 'design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention …'. Additionally, '… to be successful, continuing education needs to be linked to career paths, as well as with other education interventions'. ISSUES: The problem is a lack of paediatric physiotherapy expertise in rural areas due to an absence of postgraduate clinical training opportunities in the rural workforce. The result is fragmented local services for families who are forced to travel to metropolitan services, costly in terms of both time and money. The aims were to improve local paediatric physiotherapy clinical services, provide physiotherapists additional access to professional development and subsequently provide a career path to retain these health professionals. Evaluation of the project used purpose-built questionnaires as there are no specific indicators to monitor the performance of systems and services that are available to children and families in Australia. LESSONS LEARNED: The paediatric physiotherapy training program was enabled through initial funding for a 12-month pilot project. Further government funding built on that success for this reported 6-month project. Funding to employ the postgraduate physiotherapists was essential to the success of the clinical training program, and lack of future funding is a barrier to its sustainability. The program included the consolidation of the initial management and education committees and the expert reference group. Weekly tutorials, case studies and presentations formed an important part of clinical rotation between hospital outpatients, specialist school and the disability sector. This increased the provision of skilled paediatric physiotherapy services close to home in a timely fashion not previously available. Concurrently, the training increased the clinicians' paediatric knowledge and confidence, promoting workforce retention by providing a career pathway. The senior clinicians who provided clinical supervision reported that it enabled succession planning through introduction of appropriately skilled younger peers to their clinical practice. Project recommendations are that funding and stakeholder partnerships are necessary to enable health professionals to undertake postgraduate clinical training in paediatrics in

rural areas. The partnership should include education providers (university), rural health service providers (hospital) and community or disability services (government and non-government) with financial recognition of expertise in the rural workforce for clinical supervision. The training experience was reported as a very positive experience from trainees, families, clinical supervisors, managers, academics and paediatricians. Lack of continued funding to educate skilled postgraduate paediatric physiotherapy clinicians means that rural children with physical disabilities will continue to be disadvantaged.

Winn, C. S., Chisholm, B. A. et Hummelbrunner, J. A. (2014). "Factors affecting recruitment and retention of rehabilitation professionals in Northern Ontario, Canada: a cross-sectional study." Rural Remote Health **14**: 2619.

INTRODUCTION: Historically, Northern Ontario, Canada, has been an underserviced area for health care, including the rehabilitation professions of occupational therapy, physiotherapy, speech-language pathology and audiology. The Rehabilitation Studies and Northern Studies Stream programs were created in the 1990s to improve the recruitment and retention of rehabilitation professionals to Northern Ontario. However, no recent research has been conducted examining the factors that lead to rehabilitation professionals relocating to and remaining in the region. METHODS: A cross-sectional survey of rehabilitation professionals living and working in Northern Ontario was administered in 2009. Information collected included demographics and a rating of the personal and professional factors that had an impact on an individual's decision to continue living and working in Northern Ontario. RESULTS: A total of 345 individuals completed the survey (response rate 57%). Multiple personal and professional factors were closely linked to recruitment and retention with differences noted between those individuals originally from Northern Ontario and those who were not. Rural or remote education experiences and rural/remote origin were identified as important recruitment factors while job satisfaction and lifestyle options were important factors for retention of rehabilitation professionals to rural and remote areas of practice. CONCLUSIONS: This study has provided updated information specific to the recruitment and retention of rehabilitation professionals in Northern Ontario, Canada. These findings support previous work examining health professions worldwide and have clear implications for educational programs, funding agencies, and health human resource planning in underserviced areas.

Winn, C. S., Chisholm, B. A., Hummelbrunner, J. A., et al. (2015). "Impact of the Northern Studies Stream and Rehabilitation Studies programs on recruitment and retention to rural and remote practice: 2002-2010." Rural Remote Health **15**(2): 3126.

INTRODUCTION: A shortage of rehabilitation practitioners in rural and/or remote (rural/remote) practice areas has a negative impact on healthcare delivery. In Northern Ontario, Canada, a shortage of rehabilitation professionals (audiology, occupational therapy, physiotherapy, speech-language pathology) has been well documented. In response to this shortage, the Northern Studies Stream (NSS) and Rehabilitation Studies (RS) programs were developed with the mandate to increase the recruitment and retention of rehabilitation professionals to Northern Ontario. However, the number of NSS or RS program graduates who choose to live and work in Northern Ontario or other rural/remote areas, and the extent to which participation in these programs or other factors contributed to their decision, is largely unknown. METHODS: Between 2002 and 2010, a total of 641 individuals participated in the NSS and RS programs and were therefore eligible to participate in the study. Current contact information was obtained for 536 of these individuals (83.6%) who were eligible to participate in the study. An internet-hosted survey was administered in June of 2011. The survey consisted of 48 questions focusing on personal and professional demographics, postgraduate practice and experience, educational preparation, and factors affecting recruitment and retention decisions. RESULTS: A total of 280 respondents completed the survey (response rate 52%). Of these, 95 (33.9%) reported having chosen rural or remote practice following graduation. Multiple factors predictive of recruitment and retention to rural/remote practice were identified. Of particular note was that individuals raised in a rural or remote community were 3.3 times more likely to work in a rural or remote community after graduation. Recruitment was strongly associated with length of time

immersed in rural/remote education settings and to participation in the NSS academic semester. Job satisfaction, professional networking opportunities, and rural lifestyle options were identified as important factors for retention in rural/remote practice areas. CONCLUSIONS: The NSS and RS programs have experienced encouraging recruitment outcomes in the past 10 years. Recruitment and retention of rehabilitation therapists to rural/remote locations appears to be positively and significantly affected by the origins of the health professional. The completion of both academic and clinical education in a rural/remote setting and longer duration of rural/remote education were positively associated with an increased likelihood of choosing to practice in a rural/remote area following entry to practice. These findings have potential implications for admission criteria to rehabilitation education programs with a rural curriculum focus as well as implications for postgraduate mentorship programs and employers in rural/remote areas.

Yisma, E., Gillam, M., Versace, V. L., et al. (2021). "Geographical distribution of 3 allied health professions in South Australia: A summary of access and disadvantage." Aust J Rural Health **29**(5): 721-728.

OBJECTIVE: To describe the distribution of 3 allied health professionals-occupational therapists, physiotherapists and podiatrists-in South Australia stratified by the Modified Monash Model and the Index of Relative Socio-Economic Disadvantage. DESIGN: A descriptive data linkage cross-sectional study. SETTING: The state of South Australia, Australia. PARTICIPANTS AND MAIN OUTCOME MEASURES: Distribution of the 3 registered allied health professional groups stratified by Modified Monash Model and Index of Relative Socio-Economic Disadvantage. RESULTS: The largest proportion of the 3 allied health professional groups (occupational therapists, physiotherapists and podiatrists) were found in areas classified as Modified Monash 1 and Modified Monash 2 (86.5%). The lowest proportion of allied health professionals were found in Modified Monash 7. The largest number of allied health professionals per 10 000 population was found in areas classified as Modified Monash 1 and Modified Monash 2. The lowest number of allied health professionals per 10 000 population was found in Modified Monash 7 areas. The largest number of allied health professionals per 10 000 population was found in areas with Index of Relative Socio-Economic Disadvantage quintile 2, while the lowest number of allied health professionals per 10 000 population was found in areas with Index of Relative Socio-Economic Disadvantage quintile 1. CONCLUSIONS: The distribution of allied health professionals according to geographical remoteness, socio-economic disadvantage and per 10 000 population varies widely in South Australia. The number of allied health professionals per 10 000 population was lowest in rural and remote/very remote areas, explaining the typically poor access to allied health services for communities in these areas. The number of allied health professionals per 10 000 population according to Index of Relative Socio-Economic Disadvantage was variable within the context of both urban and rural areas.

Young, S. G., Gruca, T. S. et Nelson, G. C. (2020). "Impact of nonphysician providers on spatial accessibility to primary care in Iowa." Health Serv Res **55**(3): 476-485.

OBJECTIVE: To assess the impact of nonphysician providers on measures of spatial access to primary care in Iowa, a state where physician assistants and advanced practice registered nurses are considered primary care providers. DATA SOURCES: 2017 Iowa Health Professions Inventory (Carver College of Medicine), and minor civil division (MCD) level population data for Iowa from the American Community Survey. STUDY DESIGN: We used a constrained optimization model to probabilistically allocate patient populations to nearby (within a 30-minute drive) primary care providers. We compared the results (across 10 000 scenarios) using only primary care physicians with those including nonphysician providers (NPPs). We analyze results by rurality and compare findings with current health professional shortage areas. DATA COLLECTION/EXTRACTION METHODS: Physicians and NPPs practicing in primary care in 2017 were extracted from the Iowa Health Professions Inventory. PRINCIPAL FINDINGS: Considering only primary care physicians, the average unallocated population for primary care was 222 109 (7 percent of Iowa's population). Most of the unallocated population (86 percent) was in rural areas with low population density (< 50/square mile). The addition of NPPs to the primary care workforce reduced unallocated population by 65 percent to 78 252 (2.5 percent of Iowa's population). Despite the majority of NPPs being located in urban areas, most of the improvement in

spatial accessibility (78 percent) is associated with sparsely populated rural areas. CONCLUSIONS: The inclusion of nonphysician providers greatly reduces but does not eliminate all a

Modes d'exercice : pratique en groupe pluriprofessionnel

ÉTUDES FRANÇAISES

Anap (2021). "Centres de santé pluriprofessionnels : Leviers et bonnes pratiques organisationnelles en faveur de l'équilibre économique". Paris : Anap
https://ressources.anap.fr/parcours/publication/2800

> À la demande du ministère des Solidarités et de la Santé (Direction générale de l'offre de soins), en concertation avec les représentants des centres de santé (organismes gestionnaires et professionnels de santé), des ARS et de la CNAM, l'ANAP a identifié les leviers et les bonnes pratiques organisationnelles favorisant l'équilibre économique des centres de santé pluriprofessionnels. Les caractéristiques du territoire et des personnes prises en charge, les dynamiques de quartier, l'offre disponible vont modeler les projets de santé des centres de santé pluriprofessionnels. Au-delà de la définition légale, nous avons identifié 8 missions qui pourront être portées au sein du projet de santé : favoriser l'accessibilité, développer les prises en charge pluriprofessionnelles au sein du centre de santé, assurer la prise en charge en lien avec un système qualité, prendre en charge des personnes en situation de précarité, développer des solutions de 2nd recours et de plateaux techniques, favoriser la fidélité d'une patientèle médecin traitant et participer aux actions d'enseignements, de recherche et d'innovation. La question de la réponse organisationnelle à chacune de ces missions est d'autant plus cruciale pour les gestionnaires des centres de santé pluriprofessionnels que leur financement n'est pas toujours assuré par les dispositifs de droit commun et que la nature des réponses dépend, notamment, du territoire. Selon les territoires, aux difficultés des personnes (évolution des maladies chroniques, comportements à risque, précarité…) s'ajoute une mise en œuvre organisationnelle complexe (difficulté de recrutement, problème d'attractivité territoriale…). Dans ce contexte, la forte précarité des personnes accueillies peut nécessiter une réponse spécifique (accès aux droits, aide à la modification d'habitude de santé, prévention…), requérant tout à la fois des compétences peu disponibles dans le territoire et la recherche de financements complémentaires permettant de l'exercer en interne. Aussi, pour le gestionnaire, les collectivités territoriales, la CPAM, l'ARS, des choix devront être faits pour organiser la réponse à chaque mission tout en favorisant l'équilibre économique du centre. Cette publication propose aux gestionnaires des centres de santé ainsi qu'à leurs directeurs, aux ARS et aux CPAM des pistes d'amélioration (identifiées dans les monographies et utiles pour tous les centres de santé : éléments organisationnels qui ont une incidence sur l'équilibre économique), des exemples d'organisation pour chacune des missions et des outils de gestion de ressources humaines ou de pilotage.

Beaucourt, C., et al. (2014). "La coordination au sein des maisons de santé : d'une mise en cohérence à l'animation d'interactions." Gestion et management public **2/4**(2): 61-79.
https://www.cairn.info/revue-gestion-et-management-public-2014-2-page-61.htm

> Cette contribution se propose d'analyser le processus de coordination au sein des maisons de santé pluri professionnelles. Notre recherche s'inscrit dans le prolongement des travaux sur la coordination "en pratique" qui soulignent notamment l'importance du débat contradictoire dans les processus de coordination, pour faire face à des situations complexes et inattendues. Cependant, à partir de deux études de cas (la maison Valbona et la maison Vermers), notre analyse questionne la finalité de ces interactions ou discussions : Plus qu'un dispositif de « recherche de cohérence », la coordination est un processus foisonnant d'interactions sans cesse développées et permettant de cristalliser les énergies autour de débats et d'enjeux différenciés.

Dellandréa, A. (2013). "Study of relations between general practitioners and physiotherapists : quantitative survey of lorraine professionals
Etude des relations nterprofessionnelles entre médecins généralistes et masseurs-kinésithérapeutes. Enquête quantitative auprès de professionnels lorrains", Université de Lorraine **:** non renseigné.
https://hal.univ-lorraine.fr/hal-01732013

Le médecin généraliste est au cœur du parcours de soins du patient. Les relations interprofessionnelles sont donc primordiales pour assurer leur prise en charge et leur suivi. La politique de santé actuelle, au travers des lois HPST et Fourcade, encourage le travail en réseaux de santé (formels ou non) et soutient la création des maisons de santé. Pour étudier comment le médecin généraliste communique avec les autres professionnels de santé, nous nous sommes intéressés à sa relation avec les masseurs-kinésithérapeutes sous la forme d'une enquête épidémiologique quantitative à visée descriptive et comparative, réalisée auprès de médecins généralistes et de masseurs-kinésithérapeutes lorrains. La profession de masseur-kinésithérapeute s'est en effet beaucoup développée ces dernières années et, suite aux changements législatifs de 2000, le masseur-kinésithérapeute est devenu responsable du caractère quantitatif et qualitatif des séances. Le médecin généraliste manque apparemment de connaissances dans cette discipline et il semble peu communiquer avec le masseur-kinésithérapeute. Nos résultats montrent que cette relation est plutôt vécue de manière satisfaisante mais qu'elle présente certains paradoxes. Le médecin généraliste prescrit quotidiennement de la masso-kinésithérapie sans connaître réellement le travail du masseur-kinésithérapeute (son bilan diagnostic kinésithérapique, ses techniques, son champ de compétences) ; les masseurs-kinésithérapeutes souhaiteraient une valorisation de leur travail grâce à des études cliniques et des recommandations, et une relation plus collaborative que hiérarchique ; ils insistent aussi sur le fait d'établir des prescriptions avec des diagnostics plus précis et de ne plus y faire apparaître le nombre de séances. Certaines propositions comme la réalisation de formations communes, l'organisation de réunions pluridisciplinaires, l'instauration d'un stage pour les médecins généralistes en cabinet libéral de masso-kinésithérapie, ou encore le développement d'une messagerie électronique sécurisée entre médicaux et paramédicaux, ont été accueillies très favorablement. Concernant le travail en maison de santé, la collaboration et la communication y semblent favorisées. La fréquence des contacts y est augmentée mais peu de réunions formelles pluridisciplinaires y sont organisées. Le lieu faciliterait donc déjà les contacts non formels et permettrait une meilleure connaissance des uns et des autres entraînant plus d'échanges. Cependant, d'autres études seront nécessaires pour voir si cet idéal de travail en maison de santé confirme toutes les attentes

Delauney, E. (2010). "Kinés et médecins généralistes : peut mieux faire ? une enquête qualitative en Pays-de-la-Loire." Médecine : Revue De L'Unaformec **6**(6): 277-281.

Le débat à propos d'équipes interprofessionnelles et de prises en charge multidisciplinaires est d'actualité. Hypothèse : Médecins et kinésithérapeutes communiquent peu et l'évolution réglementaire qui a eu lieu depuis 2000, peu respectée, n'a pas changé la situation. Méthode : Enquête qualitative par focus group auprès de 10 kinésithérapeutes libéraux. Résultats : Les relations kinés-généralistes sont généralement qualifiées de « bonnes », avec des variantes selon les personnes et les conditions locales, les côtés les plus négatifs concernant le manque de temps et de formation des médecins. Discussion : Les mêmes problèmes existent entre infirmières et médecins. La situation pourrait s'améliorer avec un effort de communication de la part des médecins, une meilleure formation des médecins sur la kinésithérapie, des formations communes, une amélioration de l'image de la kinésithérapie, la création de maisons de santé et peut-être le développement de relations conviviales extraprofessionnelles. Conclusion : les pathologies prises en charge par les kinésithérapeutes sont fréquemment rencontrées en médecine générale. Une médecine réellement collaborative ne sera possible que si chaque acteur y prête attention.

Demont, A., et al. (2020). "Impact des modèles de soins intégrant l'accès direct à la kinésithérapie dans un contexte de soins primaires ou d'urgence pour les patients présentant une affection musculosquelettique : revue de la littérature." Revue d'Épidémiologie et de Santé Publique **68**(5): 306-313. https://www.sciencedirect.com/science/article/pii/S0398762020304156

Position du problème Les affections musculosquelettiques sont confrontées à une augmentation de leur prévalence, principalement en raison de la sédentarité. Des données probantes fortes soutiennent le recours précoce à un traitement de première ligne incluant la kinésithérapie. De nouveaux modèles innovants en soins primaires et aux urgences ont été développés et utilisent les

compétences du masseur-kinésithérapeute pour la prise en charge précoce et de première ligne des patients souffrant d'affections musculosquelettiques. L'objectif de cette revue était d'identifier et de décrire les études évaluant les modèles de soins intégrant l'accès direct à la kinésithérapie en soins primaires et aux urgences pour les patients présentant une affection musculosquelettique et proposer des perspectives sur l'application de ces deux modèles en France. Méthodes Une revue de la littérature a été réalisée à partir de l'inclusion d'études provenant de quatre bases de données scientifiques, PubMed, CINAHL, Embase et PEDro. Les articles recherchés devaient traiter de l'efficacité clinique ou de l'efficience de ces modèles de soins dans un contexte de soins primaires ou d'urgence. Une méthode narrative de revue de la littérature a été utilisée. La synthèse porte sur l'analyse qualitative des études incluses. Résultats Au total, 39 études ont été incluses dans cette revue : 19 sur l'évaluation de l'accès direct à la kinésithérapie en soins primaires et 20 sur l'évaluation de l'accès direct aux urgences. Celles-ci rapportaient que les différents modèles de soins intégrant l'accès direct en soins primaires ou aux urgences fournissaient de meilleurs résultats en termes de qualité et d'accès aux soins tout en maintenant une sécurité similaire. La méthodologie des études incluses a cependant été estimée comme de qualité hétérogène. Conclusion Les études portant sur ces nouveaux modèles de soins intégrant l'accès direct à la kinésithérapie en soins primaires et aux urgences permettent de retenir deux enseignements : ils n'ont pas vocation à remplacer le médecin et encouragent la collaboration entre professionnels de la santé afin d'améliorer l'accès pour les patients à des soins efficients. Il convient de s'intéresser désormais aux facteurs de dissémination permettant d'assurer l'efficience de ces modèles innovants dans d'autres pays, comme la France.

Douguet, F. et Vilbrod, A. (2019). "L'exercice du métier de sage-femme libérale dans une organisation pluridisciplinaire : quels effets sur les coopérations interprofessionnelles ?" La Revue Sage-Femme **18**(2): 68-73. https://www.sciencedirect.com/science/article/pii/S1637408819300070

Les professionnels de santé indépendants sont incités à se regrouper et à coopérer au sein d'organisations pluridisciplinaires pour faciliter l'accès aux soins et améliorer leur qualité. Cet article étudie les pratiques de collaboration des sages-femmes avec les autres professionnels rassemblés dans ces structures. La méthodologie employée repose sur l'analyse de contenu d'un corpus de 21 entretiens semi-directifs réalisés avec des sages-femmes libérales exerçant dans des maisons de santé ou pôles de santé pluridisciplinaires à l'échelle d'une région française (la Bretagne). Les résultats rendent compte de l'existence de 4 configurations de relations interprofessionnelles et soulignent la relative faiblesse des pratiques de coopération des sages-femmes avec les autres acteurs de santé dans ces contextes. Les sages-femmes libérales tendent à conserver un mode d'exercice monoprofessionnel et éprouvent des difficultés à trouver leur place dans ces structures.

Fournier, C. (2019). "Travailler en équipe en s'ajustant aux politiques : un double défi dans la durée pour les professionnels des maisons de santé pluriprofessionnelles." Journal de gestion et d'économie de la santé **1**(1): 72-91.
https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2019-1-page-72.htm

Instrument récent de politique publique, une maison de santé pluriprofessionnelle repose avant tout sur la création d'une équipe dont les membres, appartenant à différentes professions libérales, développent des pratiques collectives. Si chaque équipe s'inscrit dans une histoire, indissociable des trajectoires de ses membres et des opportunités liées à l'environnement local, ses pratiques et leur évolution dépendent également étroitement des politiques publiques qui les soutiennent, dans un contexte d'injonction croissante à l'organisation pluriprofessionnelle des soins de premier recours. L'enquête renouvelée à quatre ans d'intervalle dans quatre maisons de santé aux caractéristiques variées permet de saisir des manières contrastées de construire des actions pluriprofessionnelles et de travailler ensemble, dans des configurations et des environnements changeants, au fil de l'évolution des politiques publiques. Elle montre tout d'abord des tensions entre les dynamiques de chaque profession et une dynamique pluriprofessionnelle émergente. Ces dynamiques se voient elles-mêmes bousculées de différentes manières par la logique gestionnaire, associée à l'action publique et à ses instruments, qui s'est renforcée entre les deux moments de l'enquête. Cela permet d'étudier ce qui fait la force et la fragilité des équipes prises dans des dynamiques et des logiques qui se conjuguent ou

s'opposent, transformant les rôles, les identités et les frontières professionnelles au fil de la structuration d'une offre de soins primaires renouvelée.

Guy, C., et al. (2018). "Du patient à l'actient, de la prise en charge thérapeutique individuelle à l'approche préventive pluridisciplinaire. Comment allier pluridisciplinarité et prévention en milieu libérale." Kinésithérapie, la Revue **18**(194): 38.
https://www.sciencedirect.com/science/article/pii/S1779012317306538

Comment intégrer la pluridisciplinarité dans un centre libéral ? Quelle place pour la prévention ? Après une re-contextualisation du modèle de santé actuel, nous définirons la « santé 5P » puis aborderons les différents outils (numériques et juridiques) pouvant intégrer la pluridisciplinarité en milieu libéral. Enfin nous évoquerons la place de l'individu et du masseur-kinésithérapeute dans ce nouveau contexte.

Marchand, O., et al. (2015). "Développement et fonctionnement des maisons de santé pluriprofessionnelles dans la région Rhône-Alpes." Santé Publique **27**(4): 539-546.
https://www.cairn.info/revue-sante-publique-2015-4-page-539.htm

Objectif : La nécessité d'améliorer la coopération interprofessionnelle conduit à inciter au regroupement des professionnels de santé de premier recours au sein de structures pluriprofessionnelles telles que les maisons de santé. L'objectif de cette étude était d'établir un état des lieux de l'implantation des maisons de santé pluriprofessionnelles (MSP) dans la région Rhône-Alpes et d'examiner leur organisation et leur fonctionnement. Méthodes : Enquête transversale par questionnaire autoadministré, auprès des responsables des MSP de la région Rhône-Alpes. Résultats : L'étude a porté sur 35 MSP réparties dans les huit départements de la région. La plupart d'entre elles (86 %) avaient été mises en fonctionnement à partir de 2009. Le nombre de professionnels par structure variait de 6 à 30 avec une médiane à 12. Les métiers les plus représentés étaient les infirmiers (125), les médecins généralistes (105) et les kinésithérapeutes (59). La coopération interprofessionnelle reposait sur des réunions de concertation pluridisciplinaires dans 68 % des MSP et sur un dossier informatique partagé dans 74 % des MSP. La majorité des MSP (54 %) étaient implantées dans des zones où l'offre de soins était déficitaire. La plupart (86 %) étaient accessibles aux personnes à mobilité réduite, 49 % avaient une amplitude d'ouverture supérieure à 60 heures par semaine, et 54 % déclaraient pratiquer fréquemment le tiers-payant. Conclusion : La dynamique d'implantation des MSP semblait traduire une attirance des professionnels de santé vers les modes d'exercice collectifs. Cette évolution est cohérente avec les orientations de la stratégie nationale de santé.

Mousquès, J. (2011). "Le regroupement des professionnels de santé de premiers recours : quelles perspectives économiques en termes de performance ?" Revue française des affaires sociales(2): 253-275.
https://www.cairn.info/revue-francaise-des-affaires-sociales-2011-2-page-253.htm

Résumé Le regroupement des médecins spécialisés en médecine générale avec d'autres professionnels exerçant dans les soins de premiers recours, notamment paramédicaux et de secrétariat, connaît un intérêt croissant de la part des professionnels de santé et des pouvoirs publics, bien qu'il soit plus récent pour ces derniers. Il n'en reste pas moins que le regroupement en ambulatoire en France, autour du généraliste, est moins développé, de moins grande taille et moins pluriprofessionnel que dans d'autres pays. Un état des lieux économique, théorique et empirique sur le lien entre regroupement et performance permet de tirer des enseignements tant sur les politiques qui accompagnent en France le développement du regroupement que sur les perspectives de recherche autour de l'exercice en groupe.

Moyal, A. (2020). "L'exercice pluriprofessionnel en MSP : une division du travail sous contrôle médical." Revue française des affaires sociales(1): 103-123.
https://www.cairn.info/revue-francaise-des-affaires-sociales-2020-1-page-103.htm

Cet article se propose d'étudier la forme que prend la coordination entre professionnels de santé qui exercent en maisons de santé pluriprofessionnelles (MSP). À travers une étude qualitative dans cinq MSP signataires de l'ACI, nous montrons que les nouvelles procédures de coordination qui formalisent la division du travail en MSP, ainsi que les pratiques informelles de coordination entre professionnels, reconfigurent les territoires professionnels. Les professionnels non médecins voient notamment leurs périmètres d'activité s'étendre, sous l'effet de délégations de tâches des médecins généralistes, qui peuvent être volontaires ou contraintes par le contexte organisationnel. Nous soutenons que ces délégations soient volontaires ou contraintes par le contexte organisationnel, elles demeurent sous le contrôle des médecins généralistes, qui s'affirment ce faisant comme les orchestrateurs des prises en charge pluriprofessionnelles en soins primaires.

Sebai, J. et Yatim, F. (2017). "Les maisons de santé pluriprofessionnelles en France : une dynamique réelle mais un modèle organisationnel à construire." Revue française d'administration publique **164**(4): 887-902.
https://www.cairn.info/revue-francaise-d-administration-publique-2017-4-page-887.htm

Résumé En France, les Maisons de santé pluriprofessionnelles (MSP) sont présentées comme une réponse efficace aux nouveaux besoins en matière de santé. Le but de cet article est de proposer des éléments d'analyse pour un premier bilan de l'ensemble des structures de ce type en France, et plus particulièrement sur le plan organisationnel. Nous nous appuyons sur les données de l'enquête nationale réalisée en 2014 par la Direction générale de l'offre de soins. Nous montrons ainsi qu'il existe une réelle dynamique d'implantation des Maisons de santé pluriprofessionnelles sans que cette dynamique ne s'accompagne des évolutions organisationnelles attendues.

ÉTUDES ETRANGERES

Cioffi, J., et al. (2010). "Multidisciplinary teams caring for clients with chronic conditions: experiences of community nurses and allied health professionals." Contemp Nurse **36**(1-2): 61-70.

In Western societies the community prevalence of chronic conditions is increasing rapidly. Evidence has shown the benefits of care given to these clients by multidisciplinary teams. However, the experience of diverse health professionals working in these teams is not well understood. This study presents the experiences of members in multidisciplinary teams caring for clients with chronic conditions in the community. A qualitative descriptive study was used with a purposive sample of 34 multidisciplinary team members who participated in focus groups that were audio-taped, transcribed and analysed. Team members' experiences of working in multidisciplinary teams are described within three categories: shared purpose, working in the team, and tensions within the team. The findings provide direction for addressing team effectiveness, including issues of team leadership and evaluation of team performance.

Cott, C. A., et al. (2011). "Models of integrating physical therapists into family health teams in Ontario, Canada: challenges and opportunities." Physiother Can **63**(3): 265-275.
https://pubmed.ncbi.nlm.nih.gov/22654231
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3157985/

PURPOSE: To explore the potential for different models of incorporating physical therapy (PT) services within the emerging network of family health teams (FHTs) in Ontario and to identify challenges and opportunities of each model. METHODS: A two-phase mixed-methods qualitative descriptive approach was used. First, FHTs were mapped in relation to existing community-based PT practices. Second, semi-structured key-informant interviews were conducted with representatives from urban and rural FHTs and from a variety of community-based PT practices. Interviews were digitally recorded, transcribed verbatim, and analyzed using a categorizing/editing approach. RESULTS: Most participants agreed that the ideal model involves embedding physical therapists directly into FHTs; in some situations, however, partnering with an existing external PT provider may be more feasible and sustainable. Access and funding remain the key issues, regardless of the model adopted. CONCLUSION:

Although there are differences across the urban/rural divide, there exist opportunities to enhance and optimize existing delivery models so as to improve client access and address emerging demand for community-based PT services.

Doolittle, B. R., et al. (2015). "Implementing the patient-centered medical home in residency education." Educ Health (Abingdon) **28**(1): 74-78.

BACKGROUND: In recent years, physician groups, government agencies and third party payers in the United States of America have promoted a Patient-centered Medical Home (PCMH) model that fosters a team-based approach to primary care. Advocates highlight the model's collaborative approach where physicians, mid-level providers, nurses and other health care personnel coordinate their efforts with an aim for high-quality, efficient care. Early studies show improvement in quality measures, reduction in emergency room visits and cost savings. However, implementing the PCMH presents particular challenges to physician training programs, including institutional commitment, infrastructure expenditures and faculty training. DISCUSSION: Teaching programs must consider how the objectives of the PCMH model align with recent innovations in resident evaluation now required by the Accreditation Council of Graduate Medical Education (ACGME) in the US. This article addresses these challenges, assesses the preliminary success of a pilot project, and proposes a viable, realistic model for implementation at other institutions.

Downie, F., et al. (2019). "Physiotherapist as an alternative to a GP for musculoskeletal conditions: a 2-year service evaluation of UK primary care data." Br J Gen Pract **69**(682): e314-e320.

BACKGROUND: Physiotherapists are currently working in primary care as first contact practitioners (FCP), assessing and managing patients with musculoskeletal conditions instead of GPs. There are no published data on these types of services. AIM: To evaluate a new service presenting the first 2 years of data. DESIGN AND SETTING: Analysis of 2 years' data of patient outcomes and a patient experience questionnaire from two GP practices in Forth Valley NHS, UK. The service was launched in November 2015 in response to GP shortages. METHOD: Data were collected from every patient contact in the first 2 years. This included outcomes of appointments, GP support, capacity of the service, referral rates to physiotherapy and orthopaedics, numbers of steroid injections, and outcomes from orthopaedic referrals. A patient experience questionnaire was also conducted. RESULTS: A total of 8417 patient contacts were made, with the majority managed within primary care (n = 7348; 87.3%) and 60.4% (n = 5083) requiring self-management alone. Referrals to orthopaedics were substantially reduced in both practices. Practice A from 1.1 to 0.7 per 1000 patients; practice B from 2.4 to 0.8 per 1000 patients. Of referrals to orthopaedics, 86% were considered 'appropriate'. Extended scope physiotherapists (ESPs) asked for a GP review in 1% of patients. CONCLUSION: The results suggest that patients with musculoskeletal conditions may be assessed and managed independently and effectively by physiotherapists instead of GPs. This has the potential to significantly reduce workload for GPs as the service requires minimal GP support. The majority of patients were managed within primary care, with low referral rates and highly appropriate referrals to orthopaedics. Patients reported positive views regarding the service.

Dufour, S. P., et al. (2014). "Integrating physiotherapists within primary health care teams: perspectives of family physicians and nurse practitioners." J Interprof Care **28**(5): 460-465.

The international literature suggests a number of benefits related to integrating physiotherapists into primary health care (PHC) teams. Considering the mandate of PHC teams in Canada, emphasizing healthy living and chronic disease management, a broad range of providers, inclusive of physiotherapists is required. However, physiotherapists are only sparsely integrated into these teams. This study explores the perspectives of "core" PHC team members, family physicians and nurse practitioners, regarding the integration of physiotherapists within Ontario (Canada) PHC teams. Twenty individual semi-structured in-depth interviews were conducted, transcribed verbatim, and then analyzed following an iterative process drawing from an interpretive phenomenological approach. Five key themes emerged which highlighted "how physiotherapists could and do contribute

as team members within PHC teams particularly related to musculoskeletal health and chronic disease management". The perceived value of physiotherapists within Ontario, Canada PHC teams was a unanimous sentiment particularly in terms of musculoskeletal health, chronic disease management and maximizing health human resources efficiency to ensure the right care, is delivered by the right practitioner, at the right time.

Dufour, S. P., et al. (2014). "Understanding physiotherapists' roles in ontario primary health care teams." Physiother Can **66**(3): 234-242.

PURPOSE: To understand physiotherapists' roles and how they are enacted within Ontario primary health care (PHC) teams. METHODS: Following a pragmatic grounded theory approach, 12 physiotherapists practising within Ontario PHC teams participated in 18 semi-structured in-depth in-person interviews. All interviews were audiotaped and transcribed verbatim, then entered into NVIVO-8. Coding followed three progressive analytic stages and was iterative in nature, guided by grounded theory. An explanatory scheme was developed. RESULTS: Physiotherapists negotiate their place within the PHC teams through five interrelated roles: (1) manager; (2) evaluator; (3) collaborator; (4) educator; and (5) advocate. These five roles are influenced by three contextual layers: (1) inter-professional team; (2) community and population served; and (3) organizational structure and funding. Canada's PHC mandate (access, teams, information, and healthy living) frame the contexts that influence role enactment. CONCLUSIONS: To fulfill the PHC mandate, physiotherapists carry out multiple roles that are based on a broad holistic perspective of health, within the context of a collaborative inter-professional team and the community, through an evidenced-informed approach to care. There appear to be multiple ways of successfully integrating physiotherapists within PHC teams, provided that role enactment is context sensitive and congruent with the mandate of PHC.

Duner, A. (2013). "Care planning and decision-making in teams in Swedish elderly care: a study of interprofessional collaboration and professional boundaries." J Interprof Care **27**(3): 246-253.

In front-line practice, joint working between different professionals in health/social care and rehabilitation is regarded as a means to reach a comprehensive assessment of the needs of the older care recipients, leading to decisions on appropriate care and services. The aim of this study was to examine professional collaboration and professional boundaries in interprofessional care planning teams. Two different care planning teams were studied, one performing care planning in the homes of older individuals and the other performing care planning for older people in hospital wards. The empirical data consisted of audio-recorded care planning meetings and interviews with the professionals in the teams. The integration between the professionals involved was most noticeable in the investigation and assessment phase, while it was lower in the planning phase and almost non-existent in decision-making. The home care planning team tended to work in a more integrated manner than the discharge planning team. The importance of clarifying the roles of all professions concerned with needs assessment and care planning for older people became evident in this study.

Edwards, S. T., et al. (2015). "Who is responsible for what tasks within primary care: Perceived task allocation among primary care providers and interdisciplinary team members." Healthc (Amst) **3**(3): 142-149.

BACKGROUND: Unclear roles in interdisciplinary primary care teams can impede optimal team-based care. We assessed perceived task allocation among primary care providers (PCPs) and staff during implementation of a new patient-centered care model in Veterans Affairs (VA) primary care practices. METHODS: We performed a cross-sectional survey of PCPs and primary care staff (registered nurses (RNs), licensed practical/vocational nurses (LPNs), and medical assistants/clerks (MAs)) in 23 primary care practices within one VA region. We asked subjects whether PCPs performed each of 14 common primary care tasks alone, or relied upon staff for help. Tasks included gathering preventive service history, disease screening, evaluating patients and making treatment decisions, intervening on lifestyle factors, educating patients about self-care activities and medications, refilling prescriptions, receiving and resolving patient messages, completing forms, tracking diagnostic data, referral tracking, and arranging home health care. We then performed multivariable regression to determine predictors of

perceived PCP reliance on staff for each task. RESULTS: 162 PCPs and 257 staff members responded, a 60% response rate. For 12/14 tasks, fewer than 50% of PCPs reported relying on staff for help. For all 14 tasks, over 85% of RNs reported they were relied upon. For 12/14 tasks, over 50% of LPNs reported they were relied on, while for 5/14 tasks a majority of MAs reported being relied upon. Nurse practitioners and physician assistants (NP/PAs) reported relying on staff less than physicians. CONCLUSIONS: Early in the implementation of a team-based primary care model, most PCPs perceived they were solely responsible for most clinical tasks. RNs, and LPNs felt they were relied upon for most of the same tasks, while medical assistants/clerks reported being relied on for fewer tasks. Better understanding of optimal inter-professional team task allocation in primary care is needed.

Gum, L. F., et al. (2020). "Exploring interprofessional education and collaborative practice in Australian rural health services." J Interprof Care **34**(2): 173-183.

This article explores how work-based interprofessional education (IPE) influences collaborative practice in rural health services in Australia. Using a qualitative case study design, three rural hospitals were the focal point of the project. Marginal participant observations (98 hours) and semistructured interviews (n = 59) were undertaken. Participants were medical practitioners, nursing and midwifery professionals, physiotherapists, paramedics, social workers and administrative staff, who provided services in relation to each hospital. Data in the form of audio recordings and field notes, including researcher reflections were recorded over a three-year period. Whilst this study comprised of three phases, this article explores the extent to which collaborative practice was present or not before and after IPE. An inductive content analysis resulted in the following themes: Conceptualizing Collaborative Practice, Profession-Driven Education, and Professional Structures and Socialization. Community of practice theory is used to explore the barriers created through profession-based communities of practice.

Herrero Babiloni, A., et al. (2020). "Interprofessional Collaboration in Dentistry: Role of physiotherapists to improve care and outcomes for chronic pain conditions and sleep disorders." J Oral Pathol Med **49**(6): 529-537.

Physiotherapists can manage chronic pain patients by using technical interventions such as mobility, strengthening, manual therapy, or flexibility in a specific and functional manner, being a key component of a multidisciplinary team. Dentists are involved in the management of different chronic pain conditions such as temporomandibular disorders and sleep disorders such as obstructive sleep apnea. However, they are frequently unaware of the benefits of collaborating with physical therapists. In this review, the collaboration of physical therapists and dentists will be explored when managing orofacial pain, headaches, and sleep disorders. The physical therapist is important in the management of these disorders and also in the screening of risk factors.

Josi, R. et De Pietro, C. (2019). "Skill mix in Swiss primary care group practices - a nationwide online survey." BMC Fam Pract **20**(1): 39.
https://bmcprimcare.biomedcentral.com/track/pdf/10.1186/s12875-019-0926-7.pdf

BACKGROUND: Increasing chronic conditions and multimorbidity is placing growing service pressures on health care, especially primary care services. This comes at a time when GP workforce shortages are starting to be felt across Switzerland, placing a threat on the sustainability of good access to primary care. By establishing multiprofessional teams in primary care, service capacity is increased and the pressures on the GP workforce can be alleviated. The roles of non-medical health professions in primary care are not established so far in Switzerland and the personnel composition of primary care group practices is not known. Therefore this study aims to provide insights into the current composition, educational background and autonomy of the these new professional roles in primary care. METHODS: For this descriptive exploratory study a web-based online survey methodology was used. Group practices were defined as being a medical practice with any specialisation where at least three physicians work together in a team. Based on this restriction 240 eligible group practices were identified in Switzerland. The following four tertiary-level health professions were included in the study: nurses, physiotherapists, occupational therapists and dietitians. Additionally medical practice

assistants with couselling competencies were included. RESULTS: A total of 102 practices answered the questionnaire which is equivalent to an answer rate of 43%. The sample included data from 17 cantons. 46.1% of the practices employed non-physician health professionals. Among the tertiary-level health professions, physiotherapists were the most frequent profession with a total of 78 physiotherapists over all group practices, followed by nurses (43), dietitians (34) and occupational therapists (3). In practices which employ those professionals their average number per practice was 3.4. 25.5% of the practices had health professionals employed with advanced roles and competencies. CONCLUSION: The results from this study demonstrate that while nearly 50% of groups practices have established non-physician professionals, only 25% of practices integrate these professionals with advanced roles. Compared with other countries, there would appear to be significant scope to extent and broaden the uptake of non-physician professionals in primary care in Switzerland. Clear policy direction along with supporting regulation and financing arrangements are required.

Kowalska-Bobko, I., et al. (2020). "[Skill mix in medical and about medical professions]." Med Pr **71**(3): 337-352.

An important problem faced by many healthcare systems is the shortage of medical staff, and in particular doctors and nurses. Their number, competences and qualifications determine the level of availability and quality of medical services. Unfortunately, the demand for medical services is increasing, along with the progressive aging of the population, as well as the increase in the incidence of chronic diseases and frequent reforms of health systems. Employee costs related to healthcare are the most burdensome for the system; therefore, based on the available resources, it is necessary to create effective teams of sector employees. This results in rationalizing employment, or providing new medical and about medical competencies to new groups of professionals, which gives rise to the skill mix phenomenon. A well-prepared and implemented skill mix contributes to improving the quality of patient care, increased patient satisfaction and better clinical outcomes. In the process of mixing of competences, the roles that have been exercised so far are being changed. While some professionals are expanding their existing roles, other employees are required to accept some aspects of the previous roles. In Poland, in order to counteract such negative trends (the shortage of doctors), changes have been introduced to increase access to medical services (e.g., nurses and midwives being vested with the right to issue prescriptions and medical ordinances, paramedics - with the right to perform medical emergency services and provide healthcare services, and physiotherapists - with the right to conduct independent physiotherapeutic visits). A new profession of a medical coordinator has also been introduced. Med Pr. 2020;71(3):337-52.

Kuo, Y. F., et al. (2019). "Use of Medicare Data to Identify Team-based Primary Care: Is it Possible?" Med Care **57**(11): 905-912.

BACKGROUND: It is unclear whether Medicare data can be used to identify type and degree of collaboration between primary care providers (PCPs) [medical doctors (MDs), nurse practitioners, and physician assistants] in a team care model. METHODS: We surveyed 63 primary care practices in Texas and linked the survey results to 2015 100% Medicare data. We identified PCP dyads of 2 providers in Medicare data and compared the results to those from our survey. Sensitivity, specificity, and positive predictive value (PPV) of dyads in Medicare data at different threshold numbers of shared patients were reported. We also identified PCPs who work in the same practice by Social Network Analysis (SNA) of Medicare data and compared the results to the surveys. RESULTS: With a cutoff of sharing at least 30 patients, the sensitivity of identifying dyads was 27.8%, specificity was 91.7%, and PPV 72.2%. The PPV was higher for MD-nurse practitioner/physician assistant pairs (84.4%) than for MD-MD pairs (61.5%). At the same cutoff, 90% of PCPs identified in a practice from the survey were also identified by SNA in the corresponding practice. In 5 of 8 surveyed practices with at least 3 PCPs, about ≤20% PCPs identified in the practices by SNA of Medicare data were not identified in the survey. CONCLUSIONS: Medicare data can be used to identify shared care with low sensitivity and high PPV. Community discovery from Medicare data provided good agreement in identifying members of practices. Adapting network analyses in different contexts needs more validation studies.

Long, J. (2019). "European region of the WCPT statement on physiotherapy in primary care." Prim Health Care Res Dev **20**: e147. core/content/view/146429752089B6D10A9FFD7A0D6DA1B2/S1463423619000811a.pdf/div-class-title-european-region-of-the-wcpt-statement-on-physiotherapy-in-primary-care-div.pdf

> This statement has been produced by the European Region of the World Confederation for Physiotherapy (ER-WCPT) to promote the role of the physiotherapy profession within primary care, to describe the health and economic benefits to health systems and populations of having a skilled, appropriately resourced and utilised physiotherapy workforce in primary care services, and to illustrate how different models of physiotherapy service delivery are contributing to these health and cost benefits.

McKay, S. E., et al. (2021). "Impact of interprofessional embedding of physical therapy in a primary care training clinic." J Interprof Care **35**(4): 532-537.

> Musculoskeletal pain is a prominent complaint in primary care resulting in increased referrals to physical therapy (PT); however, the referral system often results in delays and discontinuation of care. Several models have been developed to improve the referral process including integrating PT into primary care clinics. The Veterans Health Administration (VHA) Center of Excellence in Primary Care Education (CoEPCE), which educates post-graduate trainees in interprofessional teams, began (in 2015) embedding physical therapists into primary care clinics enabling patients to see a physical therapist during their primary care visit. To evaluate the efficacy of this model we tracked the numbers of PT referrals, the number of completed referrals, and the length of time between referral and completion. PT referral parameters from PT-integrated trainees in the CoEPCE were compared to two traditional primary care training clinics at the same VHA site (Firm A and Firm B). Results indicate that the CoEPCE placed and completed more PT referrals and did so with a shorter turnaround time than was seen in the other two clinics. Further analysis suggests that the decreased turnaround time can be attributed to the integration of PTs into the primary care clinic. The results support extending the use of interprofessional clinics that integrate PT into primary care settings.

Moczygemba, L. R., et al. (2013). "An interprofessional practice capability framework focusing on safe, high-quality, client-centred health service." J Interprof Care **42**(2): e45-49.

> This paper describes an interprofessional capability framework which builds on the existing interprofessional competency and capability frameworks from the United Kingdom, Canada, and the United States of America. Existing published frameworks generally make reference to being client-centred and to the safety and quality of care, and locate interprofessional collaborative practice as the central theme or objective. In contrast, this framework interlinks all three elements: client-centred services, safety and quality of services, and interprofessional collaborative practice. The framework is clear and succinct with an accompanying visual representation that highlights all key features. The framework has informed curriculum which incorporates a common first-year, case-based educational workshops and practice placements within a large complex health sciences faculty of approximately 10,000 students from 22 disciplines. The articulation of these key elements of health practice has facilitated students, academic staff, and community health professionals to develop a shared understanding of interprofessional education and practice. The design, implementation, and evaluation of learning outcomes, learning experiences, and assessments have been transformed with the introduction of this framework, which is highly applicable to other contexts.

Mulholland, P., et al. (2020). "A grounded theory of interprofessional learning and paramedic care." J Interprof Care **34**(1): 66-75.

> Interprofessional learning (IPL) is a dynamic process. It incorporates adult learning principles and requires active participation. Contemporary paramedic care typically involves collaboration with other health-care professionals. However, little is known about how paramedics work and construct meaning within this interprofessional milieu. Rural areas, where professional collaboration is well

illustrated, provide an opportune setting from which to conduct the examination of IPL and paramedic care. Twenty-six participants took part in this investigation. Participants were paramedics and other professionals involved in collaboration in rural locations across the state of Tasmania, Australia. Rural Tasmania provided a diverse range of paramedic practice for investigation, including traditional (pre-hospital) care, extended care, volunteer services, and hospital-based practices. A grounded theory approach was adopted, and semi-structured interviews used to collect critical incidents in which participants described effective and less effective episodes of collaboration. Memos were kept during the research process. Analysis of data followed a process of initial and then focused coding from which the main concepts could be determined. From 75 episodes of collaboration, three main concepts emerged to create a theory of IPL and paramedic care. Relationships included reciprocity and respect, as well as professional acknowledgment. Cooperation recognized professionals as interdependent practitioners adopting open communication. Operational barriers identified contextual features under which professionals work, with constituent categories of protecting turf, and workplace culture. The findings provide new insight into IPL and paramedic care. Hierarchy, professional dominance, and gender disparity emerged as barriers to IPL. Knowledge and skills were shared between professions and this influenced how individuals interacted within interprofessional teams. A successful collaboration produced a clinical environment where patient care was informed by contributions from all team members.

Pellekooren, S., et al. (2022). "The introduction of advanced practice physiotherapy within Dutch primary care is a quest for possibilities, added value, and mutual trust: a qualitative study amongst advanced practice physiotherapists and general practitioners." BMC Health Serv Res **22**(1): 529. https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-022-07906-6.pdf

BACKGROUND: Despite the increased deployment and added value of Advanced Practitioner Physiotherapy (APP) in musculoskeletal care internationally, APP is not yet widely accepted within Dutch primary care. This may be due to specific constraints in the implementation of APP within the Dutch healthcare system. This study aimed to explore the experiences and perceptions of Advanced Practitioner Physiotherapists (APPs) and General Practitioners (GPs) with respect to implementing APP within Dutch primary care. METHODS: This explorative and interpretive qualitative study included 12 APPs and 3 GPs who were in various stages of implementing an APP care model. Semi-structured interviews were conducted between January and March 2021. The topic list was based on existing literature, the personal input of researchers, and the Constellation Approach framework. Data were analysed using a thematic inductive approach. RESULTS: Four main themes emerged from the data; 1) Both GPs' trust in APP and a clear added value of APP are critical for starting implementation, 2) APPs need continuous support from GPs, 3) APPs believe that their position needs strengthening, and 4) Implementation of the APP model creates tension over ownership. These four themes highlight the perceived difficulties in gaining trust, lack of clarity over the added value of APP, ambiguity over APPs' professional profile and positioning, a need on behalf of GPs to maintain authority, lack of reimbursement structure, and the struggle APPs face to strike a balance with current care. CONCLUSION: This study demonstrates that implementing an APP model of care is challenging, in part, because the deployment of APP does not sufficiently align with the core values of GPs, while GPs appear reluctant to hand over control of elements of patient care to APPs. APPs do not appear to have ownership over the implementation, given their strong dependence on the practice, values and needs of GPs. TRIAL REGISTRATION: Ethical approval was obtained from the Medical Ethics Committee of VU University Medical Centre in Amsterdam; reference number 2020.17 . All participants were asked to provide written informed consent prior to participating in the study.

Peterson, G., et al. (2021). "Extended roles in primary care when physiotherapist-initiated referral to X-ray can save time and reduce costs." Int J Qual Health Care **33**(3).

OBJECTIVE: The objective of this study was to evaluate an extended role for the physiotherapist in primary care in referring patients to plain X-ray. METHODS: This prospective cohort study was set in a single region in Sweden. It included 20 physiotherapists who were educated in a 1-day training in performing referral to X-ray, along with 107 patients with musculoskeletal disorders who were

referred to X-ray. We evaluated referral quality and patient and physiotherapist satisfaction and calculated healthcare and patient costs. RESULTS: All referrals fulfilled the basic requirements of quality, and 78% were classified as good, fulfilling all criteria. Both patients and physiotherapists were satisfied with the extended role for the physiotherapist that decreased the waiting time to diagnosis and to adequate treatment. Costs were reduced for patients (by €53/patient) and healthcare (by €6286.2/107 patients). The cost to visit a physician was twice that of a physiotherapist visit. CONCLUSIONS: An extended role for physiotherapists in primary care in referring patients to X-ray was effective and safe for patients and reduced costs for patients and for healthcare. Physiotherapists in primary care were able to refer patients to X-ray after a 1 day of training, and the extended role freed up 45 min of physician time for each patient with a musculoskeletal disorder in need of an X-ray.

Schofield, B. et Voss, S. (2020). "Exploring how paramedics are deployed in general practice and the perceived benefits and drawbacks: a mixed-methods scoping study." **4**(2).
https://bjgpopen.org/content/bjgpoa/4/2/bjgpopen20X101037.full.pdf

BACKGROUND: General practice in the UK faces continuing challenges to balance a workforce shortage against rising demand. The NHS England GP Forward View proposes development of the multidisciplinary, integrated primary care workforce to support frontline service delivery, including the employment of paramedics. However, very little is known about the safety, clinical effectiveness, or cost-effectiveness of paramedics working in general practice. Research is needed to understand the potential benefits and drawbacks of this model of workforce organisation. AIM: To understand how paramedics are deployed in general practice, and to investigate the theories and drivers that underpin this service development. DESIGN & SETTING: A mixed-methods study using a literature review, national survey, and qualitative interviews. METHOD: A three-phase study was undertaken that consisted of: a literature review and survey; meetings with key informants (KIs); and direct enquiry with relevant staff stakeholders (SHs). RESULTS: There is very little evidence on the safety and cost-effectiveness of paramedics working in general practice and significant variation in the ways that paramedics are deployed, particularly in terms of the patients seen and conditions treated. Nonetheless, there is a largely positive view of this development and a perceived reduction in GP workload. However, some concerns centre on the time needed from GPs to train and supervise paramedic staff. CONCLUSION: The contribution of paramedics in general practice has not been fully evaluated. There is a need for research that takes account of the substantial variation between service models to fully understand the benefits and consequences for patients, the workforce, and the NHS.

Seaton, J. et Jones, A. (2021). "Allied health professionals' perceptions of interprofessional collaboration in primary health care: an integrative review." **35**(2): 217-228.

This integrative review synthesizes research studies in order to explore the perceptions of allied health professionals regarding interprofessional collaboration in primary health care. A comprehensive literature search was conducted using three electronic databases and a manual search of the Journal of Interprofessional Care. The Crowe Critical Appraisal Tool was used to assess the quality of included papers. Study findings were extracted, critically examined and grouped into themes. Twelve studies conducted in six different countries met the inclusion criteria. Thematic analysis revealed five themes: (1) shared philosophy; (2) communication and clinical interaction; (3) physical environment; (4) power and hierarchy; and (5) financial considerations. This review has identified diverse key elements related to interprofessional collaboration in primary health care, as perceived by allied health professionals. Opportunity for frequent, informal communication appeared essential for interprofessional collaboration to occur. Allied health professionals working in close proximity to health practitioners from other professions had more regular interprofessional interactions than those who were geographically separated. Co-location of multiple primary health care services within the same physical space may offer increased opportunities for interprofessional collaboration. Future research should avoid reporting on allied health professionals in primary health care collectively, and isolate data to the individual professions. Direct observational methods are warranted to investigate whether allied health professionals' perceptions of interprofessional collaboration align with their actual clinical interactions in primary health care settings.

Sheaff, R., et al. (2015). Health Services and Delivery Research. Integration and continuity of primary care: polyclinics and alternatives – a patient-centred analysis of how organisation constrains care co-ordination. Southampton (UK) more likely to be favoured by an integrated organisation than by a system of care networks. There are at least four different variants of ownership/management of integrated primary care providers that are practicable in a NHS-like setting., NIHR Journals Library
https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr03350/

BACKGROUND: An ageing population, the increasing specialisation of clinical services and diverse health-care provider ownership make the co-ordination and continuity of complex care increasingly problematic. The way in which the provision of complex health care is co-ordinated produces – or fails to produce – six forms of continuity of care (cross-sectional, longitudinal, flexible, access, informational and relational). Care co-ordination is accomplished by a combination of activities by patients themselves; provider organisations; care networks co-ordinating the separate provider organisations; and overall health-system governance. This research examines how far organisational integration might promote care co-ordination at the clinical level. OBJECTIVES: To examine (1) what differences the organisational integration of primary care makes, compared with network governance, to horizontal and vertical co-ordination of care; (2) what difference provider ownership (corporate, partnership, public) makes; (3) how much scope either structure allows for managerial discretion and 'performance'; (4) differences between networked and hierarchical governance regarding the continuity and integration of primary care; and (5) the implications of the above for managerial practice in primary care. METHODS: Multiple-methods design combining (1) the assembly of an analytic framework by non-systematic review; (2) a framework analysis of patients' experiences of the continuities of care; (3) a systematic comparison of organisational case studies made in the same study sites; (4) a cross-country comparison of care co-ordination mechanisms found in our NHS study sites with those in publicly owned and managed Swedish polyclinics; and (5) the analysis and synthesis of data using an 'inside-out' analytic strategy. Study sites included professional partnership, corporate and publicly owned and managed primary care providers, and different configurations of organisational integration or separation of community health services, mental health services, social services and acute inpatient care. RESULTS: Starting from data about patients' experiences of the co-ordination or under-co-ordination of care, we identified five care co-ordination mechanisms present in both the integrated organisations and the care networks; four main obstacles to care co-ordination within the integrated organisations, of which two were also present in the care networks; seven main obstacles to care co-ordination that were specific to the care networks; and nine care co-ordination mechanisms present in the integrated organisations. Taking everything into consideration, integrated organisations appeared more favourable to producing continuities of care than did care networks. Network structures demonstrated more flexibility in adding services for small care groups temporarily, but the expansion of integrated organisations had advantages when adding new services on a longer term and a larger scale. Ownership differences affected the range of services to which patients had direct access; primary care doctors' managerial responsibilities (relevant to care co-ordination because of their impact on general practitioner workload); and the scope for doctors to develop special interests. We found little difference between integrated organisations and care networks in terms of managerial discretion and performance. CONCLUSIONS: On balance, an integrated organisation seems more likely to favour the development of care co-ordination and, therefore, continuities of care than a system of care networks. At least four different variants of ownership and management of organisationally integrated primary care providers are practicable in NHS-like settings. Future research is therefore required, above all to evaluate comparatively the different techniques for coordinating patient discharge across the triple interface between hospitals, general practices and community health services; and to discover what effects increasing the scale and scope of general practice activities will have on continuity of care. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Sheridan, B., et al. (2018). "Team-based primary care: The medical assistant perspective." Health Care Manage Rev **43**(2): 115-125.

BACKGROUND: Team-based care has the potential to improve primary care quality and efficiency. In this model, medical assistants (MAs) take a more central role in patient care and population health management. MAs' traditionally low status may give them a unique view on changing organizational dynamics and teamwork. However, little empirical work exists on how team-based organizational designs affect the experiences of low-status health care workers like MAs. PURPOSES: The aim of this study was to describe how team-based primary care affects the experiences of MAs. A secondary aim was to explore variation in these experiences. METHODOLOGY/APPROACH: In late 2014, the authors interviewed 30 MAs from nine primary care practices transitioning to team-based care. Interviews addressed job responsibilities, teamwork, implementation, job satisfaction, and learning. Data were analyzed using a thematic networks approach. Interviews also included closed-ended questions about workload and job satisfaction. RESULTS: Most MAs reported both a higher workload (73%) and a greater job satisfaction (86%) under team-based primary care. Interview data surfaced four mechanisms for these results, which suggested more fulfilling work and greater respect for the MA role: (a) relationships with colleagues, (b) involvement with patients, (c) sense of control, and (d) sense of efficacy. Facilitators and barriers to these positive changes also emerged. CONCLUSION: Team-based care can provide low-status health care workers with more fulfilling work and strengthen relationships across status lines. The extent of this positive impact may depend on supporting factors at the organization, team, and individual worker levels. PRACTICE IMPLICATIONS: To maximize the benefits of team-based care, primary care leaders should recognize the larger role that MAs play under this model and support them as increasingly valuable team members. Contingent on organizational conditions, practices may find MAs who are willing to manage the increased workload that often accompanies team-based care.

Supper, I., et al. (2015). "Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors." J Public Health (Oxf) **37**(4): 716-727.

BACKGROUND: The epidemiological transition calls for redefining the roles of the various professionals involved in primary health care towards greater collaboration. We aimed to identify facilitators of, and barriers to, interprofessional collaboration in primary health care as perceived by the actors involved, other than nurses. METHODS: Systematic review using synthetic thematic analysis of qualitative research. Articles were retrieved from Medline, Web of science, Psychinfo and The Cochrane library up to July 2013. Quality and relevance of the studies were assessed according to the Dixon-Woods criteria. The following stakeholders were targeted: general practitioners, pharmacists, mental health workers, midwives, physiotherapists, social workers and receptionists. RESULTS: Forty-four articles were included. The principal facilitator of interprofessional collaboration in primary care was the different actors' common interest in collaboration, perceiving opportunities to improve quality of care and to develop new professional fields. The main barriers were the challenges of definition and awareness of one another's roles and competences, shared information, confidentiality and responsibility, team building and interprofessional training, long-term funding and joint monitoring. CONCLUSIONS: Interprofessional organization and training based on appropriate models should support collaboration development. The active participation of the patient is required to go beyond professional boundaries and hierarchies. Multidisciplinary research projects are recommended.

Taylor, S. M., et al. (2022). "Bridging Allied Health Professional Roles to Improve Patient Outcomes in Rural and Remote Australia: A Descriptive Qualitative Study." J Multidiscip Healthc **15**: 541-551.

PURPOSE: Australia's rural and remote populations experience inequality of access to healthcare, with demand exceeding capacity for delivery of health services, often due to a maldistribution of the health workforce. A strategy which may overcome barriers to accessing adequate healthcare includes implementation of interdisciplinary collaborative teams, identified as a successful method of healthcare delivery. This study thus aimed to explore interdisciplinary allied health collaborative practice in a rural community. METHODS: Role theory, as a philosophical perspective, was used to explore role perceptions and the potential for interdisciplinary collaboration between pharmacists and allied health professionals including dieticians/public health nutritionists, speech pathologists, occupational therapists, and physiotherapists, by conducting 29 interviews in a rural community. All

interviews were transcribed verbatim, coded, and categorised into emerging themes. RESULTS: Five constructs of role theory were used to describe the data: role identity, role overload, role sufficiency, role conflict, and role ambiguity. Participants identified as rural generalists and health promoters, who work within innovative and adaptive healthcare settings. Role overload was reported as considerable due to high demand for services and a lack of resources in rural and remote regions, resulting in poor role sufficiency. Overall, there was a low level of role conflict, and participants were highly in favor of interprofessional collaboration; however, uncertainty of the pharmacist's role (role ambiguity) was a major barrier identified. Health professionals with more years in practice provided few examples of how they would utilise a pharmacist in their practice, although these gave valuable insight into the potential integration of a pharmacist into an interdisciplinary health team, with allied health professionals. CONCLUSION: This study has applied role theory providing a greater understanding of the enablers and barriers of pharmacists working within interdisciplinary allied health teams and highlighting opportunities to bridge interprofessional roles to improve patient outcomes, especially in rural and remote communities.

Thurman, W. A. (2021). "A scoping review of community paramedicine: evidence and implications for interprofessional practice." J Interprof Care **35**(2): 229-239.

Community paramedicine (CP) is an evolving method of providing community-based health care in which paramedics function outside of their traditional emergency response roles in order to improve access to primary and preventive health care and to basic social services. Early evidence indicates that CP programs have contributed to reducing health care utilization and improving patient outcomes leading some to call for a transformation of EMS into value-based mobile healthcare fully integrated within an interprofessional care team. The purpose of this scoping review was to understand the evidence base of CP in order to inform the further evolution of this model of care. Following the PRISMA extension for Scoping Reviews, 1,163 titles were screened by our research team. Eligibility criteria were publication in English after January 1, 2000; description of a CP program located in a Western nation; and inclusion of a discussion of outcomes. Twenty-nine publications met the criteria for inclusion. The literature was varied in terms of study design, program purpose, and target audience. The lack of rigorous, longitudinal studies with control groups makes rendering conclusions as to the value and effectiveness of CP programs difficult. Further, the extent to which community paramedics operate within interprofessional teams remains unclear. However, some programs demonstrated improvement in both health services and patient outcomes. As stakeholders continue to explore the potential of CP, results of this review highlight the importance of further investigation of outcomes, the professional identity of the community paramedic, and the role of the community paramedic on interprofessional teams.

Vader, K., et al. (2022). "Physiotherapy Practice in Primary Health Care: A Survey of Physiotherapists in Team-Based Primary Care Organizations in Ontario." Physiother Can **74**(1): 86-94.

Purpose: This study describes (1) the current state of physiotherapy practice in team-based primary care organizations in Ontario, (2) the perceived barriers to and facilitators of providing physiotherapy services, and (3) recommendations for improving how these services are provided. Method: This was a cross-sectional, web-based survey. We analyzed the responses using descriptive statistics and summative content analysis. Results: A total of 66 responses were received, and 61 were included in the final analysis. The respondents reported that most of their practice was directed toward musculoskeletal care, followed by multi-system, neurological, and cardiorespiratory conditions, and that most of their direct patient care was focused on in-person, one-to-one assessment or follow-up. Frequently identified barriers to providing physiotherapy services included a lack of space, resources, time, and equipment. The most common facilitators were support from management, recognition and support from other health care providers about the value and role of physiotherapists, and appropriate referrals from other health care providers. The most common recommendation was to increase the physiotherapist-to-patient ratio at primary care sites. Conclusions: Physiotherapists provide care to diverse populations in team-based primary care, which is influenced by specific

barriers and facilitators. Our results highlight opportunities for physiotherapists in this context, such as increasing the provision of first-contact care and group-based interventions.

Wieser, H., et al. (2019). "Perceptions of collaborative relationships between seven different health care professions in Northern Italy." **33**(2): 133-142.

This article presents quantitative findings from a mixed method study that aimed to explore the status quo of interprofessional collaboration (IPC) in a Health Trust, located in a trilingual region in Northern Italy. The survey targeted seven health professions (physicians, nurses, dieticians, occupational therapists, physiotherapists, speech therapists, and psychologists). The survey was distributed online to more than 5,000 health professionals and completed by 2,238. This paper presents results on the frequency of collaboration as well as data from a multiple-group measurement scale for assessing IPC. Descriptive statistics were calculated for continuous variables while categorical data were analysed as counts and percentages. Pearson's Chi-square test and Fisher's exact test were calculated while Mann Whitney and Kruskal Wallis tests were applied to analyse statistical differences in IPC between groups according to sociodemographic variables. In general, our survey data showed that participants, perceived IPC in a positive way, even if the analysis indicated heterogeneity in the level of collaboration expressed. We also found that not all professions had an opportunity to collaborate with others. In addition, we found evidence to suggest that the way health care is organised impacted on perceptions of collaboration between the health professionals in this study. This study provides an initial insight into the perceived levels of IPC within a North Italian context. As such, it offers an account of the strengths and weaknesses of IPC from seven different professional groups based in this region of Europe.

Wood, A. J., et al. (2020). "Strengthening teamwork capability in allied health: implementation of a team development program in a metropolitan health service." J Interprof Care **44**(3): 443-450. https://www.publish.csiro.au/ah/AH19055

Objective Collaborative practice is critical to optimising patient outcomes in contemporary healthcare settings. Evidence suggests interprofessional learning is an effective way to develop teamwork capabilities, yet these skills are traditionally developed in professional silos, or not at all. This study evaluated the implementation of a team development program, the Team Management Systems (TMS) program, for allied health staff within a large metropolitan health service. Methods A mixed-methods audit-quality improvement study was conducted, using Kirkpatrick's four-level evaluation model to structure evaluation of the program. Semistructured questionnaire and workforce survey data were retrieved immediately, 6 months and 1-2 years after training and applied to each level of the model (Reaction, Learning, Behaviour, Results). Results In all, 886 staff participated in the TMS program from 2014 to 2018. High satisfaction with the program was observed. Knowledge of what constitutes effective teamwork improved significantly (P=0.008) in TMS participants compared with a matched untrained cohort. Participants reported positive behaviour change and continued engagement with TMS principles 6 months after training. Perceived impact of the program on patient and/or organisational outcomes was evident, although less compelling than the changes to knowledge and behaviour. Conclusions The TMS program yielded positive effects on staff satisfaction, knowledge, team dynamics and team behaviours. These findings demonstrate the significant value of such initiatives to enhance the capability and effectiveness of interdisciplinary healthcare teams. What is known about the topic? Complex conditions, increasing comorbidities, specialisation and scarcity of resources mean healthcare workers need to work effectively in teams to achieve quality, safe, person centred patient care. There is some evidence of the effect of teamwork initiatives on knowledge or behaviour in specific clinical specialities, single services or single professions, but limited research is available regarding the effects of teamwork programs across multiple professions, including allied health professions, and on patient and organisational outcomes. What does this paper add? This paper describes the effect of a large-scale teamwork program implemented across multiple professions, including enablers and barriers. It presents outcomes at all four levels of Kirkpatrick's evaluation model, including the less studied behaviour and results levels. What are the implications for practitioners? This paper supports health service leaders to consider developing and implementing

interprofessional teamwork programs to foster essential teamwork capabilities. Learning together about teamwork, across professional silos, will lead to collaborative, patient-centred care, which leads to safe, quality patient outcomes.

Accès direct à la profession : un modèle d'efficience

ÉTUDES FRANÇAISES

(2020). "Accès direct à la masso-kinésithérapie en France : exploration de l'avis des masseurs-kinésithérapeutes." Kinésithérapie, la Revue **20**(218): 39.
https://www.sciencedirect.com/science/article/pii/S1779012319304085

Bastide, N. et Nouvel, L. (2022). "L'accès direct aux soins de masso-kinésithérapie. Partie 2 : vers un nécessaire changement de paradigme de la prescription médicale." Kinésithérapie, la Revue **22**(244): 33-39.
https://www.sciencedirect.com/science/article/pii/S1779012321003326

La création de la Communauté professionnelle territoriale de santé du Confluent a permis d'expérimenter un élargissement de l'accès direct au kinésithérapeute de manière structurée. Les données récoltées ont mis en lumière que, comme dans de nombreux pays étrangers qui le pratiquent depuis longtemps, cet accès direct est un modèle vertueux, sûr, efficace, rentable et qui peut contribuer à améliorer l'accès aux soins primaires. Le faible nombre d'adressages a amené à vérifier l'hypothèse selon laquelle les médecins prescripteurs méconnaîtraient les compétences réelles et actualisées des kinésithérapeutes. Le traitement statistique des données récoltées au travers d'un questionnaire adressé à un échantillon de prescripteurs du territoire de la Communauté professionnelle territoriale de santé du Confluent a vérifié l'hypothèse et mis en avant que la quasi-totalité des répondants est favorable à l'accès direct au kinésithérapeute, mais également demandeuse de formations communes et d'échanges médico-kinésithérapiques. Niveau de preuve 5.

Bruant-Buisson, A., et al. (2022). "Expérimentation de l'accès direct aux actes de masso-kinésithérapie". Paris : Igas
https://www.igas.gouv.fr/spip.php?article853

Suite à une saisine ministérielle ainsi qu'à la décision du Parlement de lancer une expérimentation dans 6 départements de l'accès direct aux masseurs-kinésithérapeutes, dans le cadre du projet de loi de financement de la sécurité sociale (PLFSS) 2022, l'IGAS présente dans ce rapport ses préconisations pour la mise en œuvre de cette expérimentation. Ce rapport analyse le contexte et les positions des acteurs concernés (médecins, kinésithérapeutes…) en vue des futures concertations. Il présente les expériences d'accès direct à l'étranger s'appuyant sur une bibliographie des évaluations disponibles et un état des lieux des diverses conditions d'accès et de prise en charge des soins par l'assurance santé publique. Enfin, il formule des propositions sur le périmètre, les pré-requis et le dispositif d'évaluation de l'expérimentation, afin de faciliter le travail d'écriture du décret par les administrations centrales et le travail d'analyse des autorités scientifiques (Haute Autorité de santé et Académie nationale de médecine).

Hery-Goisnard, M., et al. (2019). "Accès direct au masseur-kinésithérapeute : l'avis des usagers du système de santé français. Étude exploratoire." Kinésithérapie, la Revue **19**(216): 33-38.
https://www.sciencedirect.com/science/article/pii/S1779012319303183

Introduction En 2019, l'accès direct au kinésithérapeute/physiothérapeute est possible dans plus d'une quarantaine de pays. Les études comparant ce modèle innovant de soin et le modèle usuel, nécessitant de consulter au préalable un médecin généraliste, sont nombreuses et tendent à démontrer des bénéfices en matière de coûts de santé ainsi qu'une augmentation de la satisfaction du patient. En France, les instances représentatives de la profession de Masseur-Kinésithérapeute (MK) souhaitent la mise en place d'un accès direct au MK. Cette étude a pour objectif d'évaluer la

perception des usagers du système de santé français sur l'instauration potentielle d'un accès direct au MK. Méthode Il s'agit d'une étude qualitative transversale utilisant un questionnaire d'enquête auto-administré diffusé sur internet pendant un mois. Pour les analyses statistiques, nous avons utilisé des tests de Fisher et de Khi2. Le risque α est fixé à 5 %. Résultats Un total de 1122 réponses ont été retenues après vérification des critères d'inclusion. Au total, 90,2 % des répondants se déclarent favorables à l'instauration de l'accès direct au MK. Un total de 92 % déclarent qu'ils utiliseraient l'accès direct s'il était disponible en cas de nécessité. Une majeure partie des répondants pense que les MK sont compétents en diagnostic d'exclusion et différentiel dans le champ musculo-squelettique, ainsi que dans l'élaboration d'un traitement sans prescription médicale. Seulement, 26,2 % des répondants sont prêts à consulter un MK en accès direct sans remboursement. Discussion Les répondants font confiance aux MK pour les compétences nécessaires à l'accès direct, souhaitent pouvoir les consulter en première intention, et aimeraient bénéficier d'une prise en charge financière pour ce type de consultation. Une enquête avec plus de participants et un meilleur échantillonnage est nécessaire afin de pouvoir extrapoler ces résultats à tous les usagers du système de santé français. Conclusion Ce questionnaire montre que les usagers du système de santé français interrogés souhaitent un accès direct au MK. Deux éléments en rapport avec ce mode de consultation les questionnent : la prise en charge financière de ce mode de consultation et l'acquisition de compétences diagnostiques suffisantes et nécessaires par la formation des MK. Niveau de preuve Non adapté.

Kubicki, A. (2017). "Enjeux et perspectives de l'accès direct en Masso-Kinésithérapie." Kinésithérapie, la Revue **17**(185): 1-2.
https://www.sciencedirect.com/science/article/pii/S1779012317302218

Lemersre, P. (2019). "Les facteurs susceptibles d'influencer la mise en place de l'accès direct en masso-kinésithérapie en France. Étude exploratoire." Kinésithérapie, la Revue 19(216): 18-23.
https://www.sciencedirect.com/science/article/pii/S1779012319303171

Introduction L'accès aux soins en France constitue un défi majeur parmi les enjeux que le système de santé français doit relever. Depuis quarante ans, se développent des modèles d'accès direct à la physiothérapie dans le monde qui semblent être bénéfiques et apporter des solutions aux enjeux de santé de publique dans les pays dans lesquels ils sont implantés. Méthodologie L'objectif de cette étude qualitative est de mettre en évidence les facteurs susceptibles d'influencer la mise en place de l'accès direct pour les masseurs-kinésithérapeutes au sein du parcours de soin du patient en France. Cinq entretiens semi-directifs ont été réalisés avec des masseurs-kinésithérapeutes considérés comme experts sur ce sujet. Résultats Les entretiens ont mis en évidence 13 facteurs susceptibles d'influencer la mise en place de l'accès direct en masso-kinésithérapie. Discussion Les problématiques d'accès aux soins, le cheminement de la formation vers l'université et la recherche, et les récentes évolutions de la profession peuvent influencer favorablement une évolution de la masso-kinésithérapie vers l'accès direct. Toutefois, il demeure de nombreux freins comme le manque de volonté politique des pouvoirs publics et l'absence de données scientifiques française sur ce sujet. Conclusion Ces données mènent à s'interroger sur la mise en place d'un modèle de parcours de soin intégrant l'accès direct pour des patients présentant une affection en France. Il serait pertinent d'approfondir la véracité de ces facteurs par une ou plusieurs études qualitatives complémentaires. Niveau de preuve Non adapté

Mangot, A. (2019). "L'accès direct en France : avis des masseurs-kinésithérapeutes libéraux concernant un besoin de formation quant à sa mise en place. Étude exploratoire." Kinésithérapie, la Revue **19**(216): 13-17.
https://www.sciencedirect.com/science/article/pii/S1779012319303146

Introduction L'accès direct aux soins de kinésithérapie est effectif dans certains pays, comme l'Australie, le Québec, les Pays-Bas et le Luxembourg ; mais pas en France. Afin de comprendre les différences entre ces pays et la France, nous les avons comparés en termes de réglementation de la profession, de compétences du physiothérapeute, de la formation initiale, puis de la prise en charge des soins pour le patient. Les comparaisons effectuées ont comme base les recommandations de la WCPT. La différence principale retrouvée suite à ces comparaisons fut la formation initiale des kinésithérapeutes français avant la dernière réforme de 2015. Le but de cette étude exploratoire fut

de recenser les avis des masseur-kinésithérapeutes libéraux concernant une éventuelle formation afin d'agir en première intention. Méthode Cette étude fut réalisée via un questionnaire destiné aux masseurs-kinésithérapeutes libéraux français afin de savoir s'ils ressentent un besoin de formation quant à la mise en place de l'accès direct. La question des compétences nécessaires et de la rémunération des séances sans ordonnance par l'assurance maladie fut aussi posée. Résultats Le questionnaire a recueilli 119 réponses. Un total de 94,1 % (112/119) kinésithérapeutes libéraux sont prêts à se former. Les compétences proposées ont obtenu : 89,3 % (100/112) pour le « bilan et l'évaluation clinique », 76,8 (86/112) pour « l'éducation thérapeutique du patient », 75,9 % (85/112) pour la « prévention et santé publique », 75,9 % (85/112) pour « la recherche en masso-kinésithérapie », 99,1 % (111/112) pour « l'expertise en masso-kinésithérapie ». Une solution proposée serait une rémunération plus élevée des bilans réalisés en première intention par l'assurance maladie. Ce bilan justifierait les séances qui seraient prises en charge de la même façon que les séances actuelles. Conclusion Les masseurs-kinésithérapeutes libéraux concernés par le questionnaire ont exprimé un besoin de se former afin d'intégrer l'accès direct dans leur pratique.

Nicolas, B. et Nouvel, L. (2022). "Accès direct à la masso-kinésithérapie Partie 1 : un projet-pilote au sein d'un bassin de vie francilien." Kinésithérapie, la Revue **22**(243): 29-40.
https://www.sciencedirect.com/science/article/pii/S1779012321001972

Les textes récents relatifs à la création d'entités telles que les Communautés professionnelles territoriales de santé et la possibilité de se rendre directement chez son kinésithérapeute dans deux cas bien circonscrits, ont permis de tester un élargissement des possibilités de recours à l'accès direct au kinésithérapeute. Ce projet-pilote visait à vérifier si un accès direct au kinésithérapeute constituait un axe de progrès du système de santé français. Le partenariat entre deux cabinets libéraux a permis de définir strictement les cas de recours possibles, tout en garantissant au patient la liberté de choix du thérapeute, mais aussi et surtout sa sécurité au travers du protocole adopté pour cette étude. Les données récoltées ont mis en lumière que, comme dans de nombreux pays étrangers qui le pratiquent depuis longtemps, cet accès direct est un modèle vertueux, sûr, efficace, rentable et qui peut contribuer à améliorer l'accès aux soins et traitements primaires. Le succès mitigé en nombre d'adressages questionne sur le paradigme de la prescription.

Panchout, É. (2018). "L'accès direct en masso-kinésithérapie : une mise en évidence." Kinésithérapie, la Revue **18**(194): 19.
https://www.sciencedirect.com/science/article/pii/S177901231730596X

La masso-kinésithérapie est en pleine mutation en France avec des avancées significatives depuis 2015. En cas d'urgence, le masseur-kinésithérapeute est habilité à accomplir les premiers actes de soins nécessaires. (article L4321-1 du code de la Santé Publique modifié le 16 Janvier 2016). L'accès direct en physiothérapie en France oppose des opinions et des croyances guidées par les émotions, rendant parfois difficile le débat. De la même façon qu'il convient de se servir de l'evidence based practice pour justifier les techniques de soin, l'ambition de cette communication est d'appliquer cette même rigueur intellectuelle pour discuter de l'intérêt d'un accès direct pour les masseurs kinésithérapeutes français. Quelles évidences font de l'accès direct en kinésithérapie une évidence ? Tout d'abord, les articles interrogeant les expériences d'accès direct à l'étranger montrent un intérêt sur plusieurs facteurs notamment en termes de coût pour la société. D'autre part, la législation sur la prescription médicale en masso-kinésithérapie, et le processus de raisonnement clinique, conduisent le physiothérapeute à user de sa compétence de triage pour assurer la sécurité et l'efficacité du soin. À partir de ces notions, il semble intéressant d'observer la compétence de triage qui reste le point clé de l'accès direct. Le référentiel de formation du septembre 2015 contient l'enseignement des notions telles que le diagnostic différentiel, les red flags ou encore le processus de raisonnement clinique permettant de consolider cette compétence chez les étudiants. Les choix pédagogiques des instituts de formation sont donc déterminants pour la sécurité des patients mais aussi pour l'obtention d'un accès direct. Pour conclure, les connaissances requises pour l'obtention de l'accès direct sont indispensables pour les physiothérapeutes formés et en formation. Cet accès aurait une influence sur la fluidification du système de santé en soulageant nos partenaires praticiens médicaux.

Remondière, R. et Durafourg, M. P. (2014). "[Direct access to physiotherapy: the case of France]." Santé Publique **26**(5): 669-677.

> The first direct access initiatives were conducted in 1976 and many English-speaking countries have followed this movement, which is designed to obviate a visit to the doctor for certain procedures, apart from diagnosis. Cooperative actions in this field are exceptional in France. Direct access must be distinguished from advanced practices in hospital in the fields of orthopaedics, musculoskeletal disorders, preoperative assessment and total hip and knee replacement. In hospital, men between the ages of 40 and 59 years have access to this type of consultation, with an excellent correlation between 86% and 100% compared to the physician's practice, opening the way to direct access. The apparently successful trajectory in Quebec and the opinion of the Swiss subjects interviewed reveal a very different trajectory. France occupies a special place in this field, as, although cooperative actions with physicians are encouraged, they are exceptional, despite a favourable territorial coverage. Strong points and weak points are considered, but it appears that this process is hampered by numerous obstacles and challenges. Chronic diseases are perfectly suitable for these exchanges of practices, as many other professionals are already active in this field. Delegations of responsibility and transfers of practices indicate a growing professional autonomy in the form of partial direct access.

Vallet, É. (2019). "Accès direct à la masso-kinésithérapie en France : évaluation des compétences de raisonnement clinique et de collaboration interprofessionnelle des MK. Étude exploratoire." Kinésithérapie, la Revue **19**(216): 24-27.
https://www.sciencedirect.com/science/article/pii/S1779012319303134

> Introduction L'accès direct représente pour beaucoup, comme nous le montre les modèles étrangers, l'avenir de la profession de Masseur-Kinésithérapeute (MK). Cela-dit, des obstacles s'opposent à la mise en place de ce genre de système. L'un d'eux est la question de la compétence des professionnels pour garantir la sécurité et l'efficience des soins. Les compétences de raisonnement clinique (RC) et de collaboration interprofessionnelle (CI), notamment, semblent, selon les experts et la littérature, indispensables pour un accès direct sécurisé et efficient. Il convient alors de se demander si les professionnels sur le terrain possèdent ces compétences – ce qui constitue notre problématique : les masseurs-kinésithérapeutes possèdent-ils les compétences de raisonnement clinique et de collaboration interprofessionnelle pour un accès direct sécurisé et efficient ? Méthode Une méthode qualitative a été basée sur 9 entretiens effectués avec des MK français exerçant dans différents champs cliniques. Grâce à une analyse thématique basée sur l'autoévaluation de leurs capacités de raisonnement clinique et collaboration interprofessionnelle, nous avons questionné en profondeur la pratique de ces 9 professionnels. Résultats/Discussion Les MK semblent très confiants quant à leurs capacités de raisonnement clinique, et moins quant à leur investissement en collaboration interprofessionnelle, bien qu'ils en identifient l'indispensabilité pour l'accès direct. Malgré ces lacunes en CI, leurs compétences en RC, et le fait qu'ils semblent disposer d'une bonne capacité de remise en question, ces professionnels sauraient s'adapter demain pour un accès direct sécurisé et efficient.

ÉTUDES ETRANGERES

Bishop, A., et al. (2021). "Providing patients with direct access to musculoskeletal physiotherapy: the impact on general practice musculoskeletal workload and resource use. The STEMS-2 study." Physiotherapy **111**: 48-56.

> OBJECTIVES: This study examined the real-world impact of patient direct access to NHS physiotherapy (self-referral) on (a) general practice consultations for musculoskeletal (MSK) conditions and (b) specified clinical management for patients with MSK conditions. DESIGN AND SETTING: Natural experiment in four general practices and the associated physiotherapy service. METHODS: Anonymised routinely collected data were obtained. MSK coded GP consultations, recorded fit notes, MSK-related prescription medication, X-rays and MRI requests, and referrals to secondary care for patients consulting with MSK conditions were identified and trends described across a 6-year period

(June 2011 to June 2017). Joinpoint regression analysis was used to identify any significant changes in GP MSK consultation trends before and after the introduction of self-referral to physiotherapy. Physiotherapy service data examined access methods used by patients (GP referred, GP recommended self-referral, true self-referral) and the number of physiotherapy sessions. RESULTS: Direct access resulted in inconsistent impact on general practices. In one arm of the experiment a significant increase in GP consultations was observed and in one arm was stable. Exploratory examination of clinical management showed only requests for X-rays (arm 1) and possibly requests for MRI (arm 2) changed over time. Physiotherapy service referrals showed a low uptake of true self-referral (10% and 6%) in each arm respectively. CONCLUSION: This is the first study to examine the real-world impact of patient direct access to physiotherapy at general practice level. We found no consistent impact of patient direct access on GP MSK workload. Impact on some clinical management was observed but not consistently in the direction suggested by previous studies.

Bury, T. J. et Stokes, E. K. (2013). "A global view of direct access and patient self-referral to physical therapy: implications for the profession." Phys Ther **93**(4): 449-459.

BACKGROUND: International policy advocates for direct access, but the extent to which it exists worldwide was unknown. OBJECTIVE: The purpose of this study was to map the presence of direct access to physical therapy services in the member organizations of the World Confederation for Physical Therapy (WCPT) in the context of physical therapist practice and health systems. DESIGN: A 2-stage, mixed-method, descriptive study was conducted. METHODS: A purposive sample of member organizations of WCPT in Europe was used to refine the survey instrument, followed by an online survey sent to all WCPT member organizations. Data were analyzed using descriptive statistics, and content analysis was used to analyze open-ended responses to identify themes. RESULTS: A response rate of 68% (72/106) was achieved. Direct access to physical therapy was reported by 58% of the respondents, with greater prevalence in private settings. Organizations reported that professional (entry-level) education equipped physical therapists for direct access in 69% of the countries. National physical therapy associations (89%) and the public (84%) were thought to be in support of direct access, with less support perceived from policy makers (35%) and physicians (16%). Physical therapists' ability to assess, diagnose, and refer patients on to specialists was more prevalent in the presence of direct access. LIMITATIONS: The findings may not be representative of the Asia Western Pacific (AWP) region, where there was a lower response rate. CONCLUSIONS: Professional legislation, the medical profession, politicians, and policy makers are perceived to act as both barriers to and facilitators of direct access. Evidence for clinical effectiveness and cost-effectiveness and examples of good practice are seen as vital resources that could be shared internationally, and professional leadership has an important role to play in facilitating change and advocacy.

Demont, A., et al. (2021). "The impact of direct access physiotherapy compared to primary care physician led usual care for patients with musculoskeletal disorders: a systematic review of the literature." Disabil Rehabil **43**(12): 1637-1648.
https://www.physiotherapyjournal.com/article/S0031-9406(20)30388-6/pdf

PURPOSE: To update and appraise the available evidence with respect to the impact of direct access physiotherapy compared to primary care physician-led usual medical care for patients with musculoskeletal disorders in terms of efficacy, health care utilization and processes, health care costs, patient satisfaction, and compliance. MATERIALS AND METHODS: Systematic searches were conducted in five bibliographic databases up to June 2019. Studies presenting quantitative data of any research related to direct access physiotherapy for patients with musculoskeletal disorders were included. Two independent raters reviewed the studies, conducted the methodological quality assessment and a data extraction regarding patient outcomes, adverse events, health care utilization and processes, patient satisfaction, and health care costs. RESULTS: Eighteen studies of weak to moderate quality were included. Five studies found no significant differences in pain reduction between usual primary care physician-led medical care and direct access physiotherapy. Four studies reported better clinical outcomes in patients with direct access in terms of function and quality of life. In terms of health care costs, four studies demonstrated that costs were lower with direct access and one study reported

similar costs between both types of care. CONCLUSION: Emerging evidence of weak to moderate quality suggest that direct access physiotherapy could provide better outcomes in terms of disability, quality of life, and healthcare costs compared to primary physician-led medical care for patients with musculoskeletal disorders but not for pain outcomes. These conclusions could be modified when higher quality trials are published. CLINICAL RELEVANCE: Direct access physiotherapy for patients with musculoskeletal disorders appears as a promising model to improve efficiency of care and reduce health care costs, but more methodologically sound studies are required to formally conclude. TRIAL REGISTRATION PROSPERO: #CRD42018095604IMPLICATIONS FOR REHABILITATIONEmerging evidence of weak to moderate quality indicates that direct access physiotherapy could provide better outcomes in terms of disability, quality of life and healthcare costs compared to primary physician led usual medical care for musculoskeletal disorders patients.Direct access physiotherapy may lead to increased access to care and a more efficient use of health care resources.Direct access physiotherapy does not appear to improve pain outcomes compared to primary care physician-led usual medical care.

Denninger, T. R., et al. (2018). "The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry." J Orthop Sports Phys Ther **48**(2): 63-71. https://www.physiotherapyjournal.com/article/S0031-9406(13)00023-0/fulltext

Study Design Retrospective study. Background Alternative models of care that allow patients to choose direct access to physical therapy have shown promise in terms of cost reduction for neck and back pain. However, real-world exploration within the US health care system is notably limited. Objectives To compare total claims paid and patient outcomes for patients with neck and back pain who received physical therapy intervention via direct access versus medical referral. Methods Data were accessed for patients seeking care for neck or back pain (n = 603) between 2012 and 2014, who chose to begin care either through traditional medical referral or direct access to a physical therapy-led spine management program. All patients received a standardized, pragmatic physical therapy approach, with patient-reported measures of pain and disability assessed before and after treatment. Patient demographics and outcomes data were obtained from the medical center patient registry and combined with total claims paid calculated for the year after the index claim. Linear mixed-effects modeling was used to analyze group differences in pain and disability, visits/time, and annualized costs. Results Patients who chose to enter care via the direct-access physical therapy-led spine management program displayed significantly lower total costs (mean difference, $1543; 95% confidence interval: $51, $3028; P = .04) than those who chose traditional medical referral. Patients in both groups showed clinically important improvements in pain and disability, which were similar between groups (P>.05). Conclusion The initial patient choice to begin care with a physical therapist for back or neck pain resulted in lower cost of care over the next year, while resulting in similar improvements in patient outcomes at discharge from physical therapy. These findings add to the emerging literature suggesting that patients' choice to access physical therapy through direct access may be associated with lower health care expenditures for patients with neck and back pain. Level of Evidence Economic and decision analyses, level 4. J Orthop Sports Phys Ther 2018;48(2):63-71. Epub 26 Oct 2017. doi:10.2519/jospt.2018.7423.

Garrity, B. M., et al. (2020). "Unrestricted Direct Access to Physical Therapist Services Is Associated With Lower Health Care Utilization and Costs in Patients With New-Onset Low Back Pain." Phys Ther **100**(1): 107-115.

BACKGROUND: Low back pain (LBP) is one of the most prevalent conditions for which patients seek physical therapy in the United States. The American Physical Therapy Association categorizes direct access to physical therapist services into 3 levels: limited, provisional, and unrestricted. OBJECTIVE: The objective of this study was to evaluate the association of level of access to physical therapist services with LBP-related health care utilization and costs. DESIGN: This was a retrospective cohort study of patients with new-onset LBP between 2008 and 2013; data were from OptumLabs Data Warehouse. METHODS: We identified 59,670 individuals who were 18 years old or older, who had new-onset LBP, and who had commercial or Medicare Advantage insurance through a private health plan. We examined 2 samples. The first was health care utilization among individuals who saw a physical therapist first in states with either unrestricted access or provisional access. The second was

LBP-related costs among individuals who saw either a physical therapist or a primary care physician first. RESULTS: Individuals who saw a physical therapist first in states with provisional access had significantly higher measures of health care utilization within 30 days, including plain imaging and frequency of physician visits, than individuals who saw a physical therapist first in states with unrestricted access. Compared with individuals who saw a primary care physician first, pooled across provisional-access and unrestricted-access states, those who saw a physical therapist first in provisional-access states had 25% higher relative costs at 30 days and 32% higher relative costs at 90 days, whereas those who saw a physical therapist first in unrestricted-access states had 13% lower costs at 30 days and 32% lower costs at 90 days. LIMITATIONS: This was a claims-based study with limited information on patient characteristics, including severity and duration of pain. CONCLUSIONS: Short-term LBP-related health care utilization and costs were lower for individuals in unrestricted-access states than in provisional-access states.

Goodwin, R. W. et Hendrick, P. A. (2016). "Physiotherapy as a first point of contact in general practice: a solution to a growing problem?" Prim Health Care Res Dev **17**(5): 489-502.

Aim To evaluate the clinical effectiveness, patient satisfaction and economic efficacy of a physiotherapy service providing musculoskeletal care, as an alternative to GP care. BACKGROUND: There is a growing demand on general practice resources. A novel '1st Line Physiotherapy Service' was evaluated in two GP practices (inner city practice, university practice). Physiotherapy, as a first point of contact, was provided as an alternative to GP care for patients with musculoskeletal complaints. Participants A convenience cohort sample of over 500 patients with a musculoskeletal complaint was assessed within the physiotherapy service. For the economic evaluation a cohort of 100 GP patients was retrospectively reviewed. METHOD: Clinical outcome measures were collected at assessment, one and six months following assessment. Patient satisfaction was collected at assessment. An economic evaluation was undertaken on the physiotherapy cohort of patients and compared to a retrospective cohort of patients (n=100) seen by a GP. This evaluation considered only the health care perspective (primary and secondary care). Societal issues such as absence from employment were not considered. RESULTS: There were no adverse events associated with the physiotherapy service. Patients reported high levels of satisfaction with the physiotherapy service. Patients managed within the 1st Line Physiotherapy Service demonstrated clinical improvements (EQ-5D-5L, Global Rating of Change) at the six-month point. There was a statistically significant difference in favour of the physiotherapy groups using a non-parametric bootstrap test; inner city practice, mean difference in costs=£538.01 (P =0.006; 95% CI; £865.678, £226.98), university practice mean difference in costs=£295.83 (P=0.044; 95% CI; £585.16, £83.69). CONCLUSION: The limitations of this pragmatic service evaluation are acknowledged. Nevertheless, the physiotherapy service appears to provide a safe and efficacious service. The service is well received by patients. There appear to be potential financial implications to the health economy. Physiotherapists, as a first point of contact for patients with musculoskeletal-related complaints, could contribute to the current challenges faced in primary care.

Green, C. E., et al. (2019). "Explanatory multivariate modeling for disability, pain, and claims in patients with spine pain via a physical therapy direct access model of care." J Back Musculoskelet Rehabil **32**(5): 769-777.

BACKGROUND: Direct access physical therapy (DAPT) may result in improved patient outcomes and reduced healthcare costs. Prognostic factors associated with spine-related outcomes and insurance claims with DAPT are needed. OBJECTIVE: To identify factors that predict variations in outcomes for spine pain and insurance claims using DAPT. METHODS: Individuals (N = 250) with spine pain were analyzed. Outcomes were classified into High, Low, or Did Not Meet minimal clinically important difference (MCID) scores. Claims were categorized into low, medium, or high tertiles. Prognostic variables were identified from patient information. RESULTS: Females were more likely to meet High MCID (odds ratio [OR] 2.84 (95% CI = 1.32, 6.11) and Low MCID (OR 2.86, 95% CI = 1.34, 6.10). Higher initial ODI/NDI scores were associated with High MCID (OR 1.04, 95% CI = 1.07, 1.22) and Low MCID (OR 0.91, 95% CI = 0.77, 1.07). Odds of a high claim were lowered by the absence of imaging (OR 0.04, 95% CI = 0.02, 0.09) and an active versus passive treatment (OR 0.38, 95% CI = 0.18, 0.80). CONCLUSION: Females and higher initial disability predicted favorable outcomes. The novel

introduction of claims into the prognostic modeling supports that active interventions and avoiding imaging may reduce claims.

Hackett, G. I., et al. (1987). "Evaluation of the efficacy and acceptability to patients of a physiotherapist working in a health centre." Br Med J (Clin Res Ed) **294**(6563): 24-26.
https://www.bmj.com/content/bmj/294/6563/24.full.pdf

The records of the first 805 patients who had been referred by general practitioners at this health centre to the attached physiotherapist were examined in November 1985, three years after the physiotherapy department was opened. Seventy per cent (549) of the patients had been treated within one week, treatment having started on the same day for 8.5% (67) of the patients. This compares with a mean of six weeks for direct access to a district general hospital that is eight miles away and between six and 13 months for the three nearest orthopaedic consultants who are 13 miles away. The most common conditions treated were knee injuries (16.5%), followed by cervical (15.5%) and shoulder (13.8%) injuries. Surprisingly, only 9% were back injuries. The non-attendance rate was 2.2% and only 7% of patients failed to complete treatment. Nearly all the patients were able to attend the clinic, only 4% requiring home treatment. By March 1986, 90 treatments a week were being carried out at a cost of 6.11 pounds per patient. Compared with official hospital figures, this represents a savings of 21,500 pounds a year for a practice of 12,000 patients.

Hon, S., et al. (2021). "Cost-Effectiveness and Outcomes of Direct Access to Physical Therapy for Musculoskeletal Disorders Compared to Physician-First Access in the United States: Systematic Review and Meta-Analysis." Phys Ther **101**(1).

OBJECTIVE: Direct access to physical therapy provides an alternative to physician-first systems for patients who need physical therapy for musculoskeletal disorders (MSDs). Direct access across multiple countries and the United States (US) military services has produced improved functional outcomes and/or cost-effectiveness at clinical and health care system levels; however, data remain scarce from civilian health care systems within the United States. The purpose of this study was to compare evidence regarding costs and clinical outcomes between direct access and physician-first systems in US civilian health services. METHODS: A database search of PubMed, CINAHL, Cochrane Reviews, and PEDro was conducted through May 2019. Studies were selected if they specified civilian US, physical therapy for MSDs, direct access or physician-first, and extractable outcomes for cost, function, or number of physical therapy visits. Studies were excluded if interventions utilized early or delayed physical therapy access compared with physician-first. Five retrospective studies met the criteria. Means and standard deviations for functional outcomes, cost, and number of visits were extracted, converted to effect sizes (d) and 95% CI, and combined into grand effect sizes using fixed-effect or random-effects models depending on significance of the Q heterogeneity statistic. RESULTS: Direct access to physical therapy showed reduced physical therapy costs (d = -0.23; 95% CI = -0.35 to -0.11), total health care costs (d = -0.19; 95% CI = -0.32 to -0.07), and number of physical therapy visits (d = -0.17; 95% CI = -0.29 to -0.05) compared to physician-first systems. Disability decreased in both direct access (d = -1.78; 95% CI = -2.28 to -1.29) and physician-first (d = -0.89; 95% CI = -0.92 to -0.85) groups; functional outcome improved significantly more with direct access (z score = 0.89; 95% CI = 0.40 to 1.39). CONCLUSIONS: Direct access to physical therapy is more cost-effective, resulting in fewer visits than physician-first access in the United States, with greater functional improvement. IMPACT: These findings within civilian US health care services support a cost-effective health care access alternative for spine-related MSDs and can inform health care policy makers.

Igwesi-Chidobe, C. N., et al. (2021). "Implementing patient direct access to musculoskeletal physiotherapy in primary care: views of patients, general practitioners, physiotherapists and clinical commissioners in England." Physiotherapy **111**: 31-39.
https://www.physiotherapyjournal.com/article/S0031-9406(20)30388-6/pdf

PURPOSE: Musculoskeletal problems are the leading cause of chronic disability. Most patients in the UK seek initial care from general practitioners (GPs), who are struggling to meet demand. Patient

direct access to National Health Service physiotherapy is one possible solution. The purpose of this study was to understand the experiences of patients, GPs, physiotherapists and clinical commissioners on direct access in a region in England with it commissioned. METHODS: The study was informed by Normalisation Process Theory (NTP). Data collection was via semi-structured individual face-to-face and telephone interviews with 22 patients and 20 health care professionals (HCPs). Data were analysed thematically using NPT. RESULTS: Three themes emerged: understanding physiotherapy and the direct access pathway; negotiating the pathway; making the pathway viable. HCPs saw direct access as acceptable. Whilst patients found the concept of direct access, those with complex conditions continued to see their GP as first point of contact. Some GPs and patients reported a lack of clarity around the pathway, reflected in ambiguous paperwork and inconsistent promotion. Operational challenges emerged in cross-disciplinary communication and between HCPs and patients, and lack of adequate resources. CONCLUSION: Direct access to NHS musculoskeletal physiotherapy is acceptable to patients and HCPs. There is need to ensure: effective communication between HCPs and with patients, clarity on the scope of physiotherapy and the direct access pathway, and sufficient resources to meet demand. Patient direct access can free GPs to focus on those patients with more complex health conditions who are most in need of their care.

Mallett, R., et al. (2014). "Is physiotherapy self-referral with telephone triage viable, cost-effective and beneficial to musculoskeletal outpatients in a primary care setting?" Musculoskeletal Care **12**(4): 251-260.

OBJECTIVE: The aim of the present study was to establish if physiotherapy self-referral (SR) is viable, cost effective and beneficial to musculoskeletal outpatients in a primary care setting. SETTING: In an urban National Health Service (NHS) primary care physiotherapy service, waiting times, attendance rates and treatment ratios (thus, episode-of-care costs) were deemed unsustainable. The introduction of 'Any Qualified Provider' is imminent and will drive NHS physiotherapy services to compete directly with private counterparts. Current literature, healthcare policy and the Chartered Society of Physiotherapy strongly advocate SR to promote value for money and improve the patient experience. DESIGN: A repeated measure prospective cohort study introduced an SR pathway parallel to existing general practice (GP) referrals and compared costs, attendance and data relating to the patient experience across groups. RESULTS: SR referral groups were found to have a higher proportion of female patients presenting with acute conditions. Cost minimization analysis indicated an average 32.3% reduction in episode-of-care cost with an SR-initiated intervention. An estimated cost minimization of between £84,387.80 and £124,472.06 was calculated if SR were to be expanded service-wide. SR referral reduced waiting times and improved patient satisfaction relating to waiting times and communication compared with traditional pathways. CONCLUSIONS: The results of the present study showed that the introduction of the described SR pathway was feasible, cost-effective and offered comparable care. Certain aspects of the SR patient experience compared more favourably than those studied in traditional GP referral routes. They also added to an existing body of evidence supporting SR with a variety of administrative processes in various socioeconomic settings.

Maselli, F. et Piano, L. (2022). "Direct Access to Physical Therapy: Should Italy Move Forward?" **19**(1). https://mdpi-res.com/d_attachment/ijerph/ijerph-19-00555/article_deploy/ijerph-19-00555.pdf?version=1641308340

Direct access to physical therapy (DAPT) is the patient's ability to self-refer to a physical therapist, without previous consultation from any other professional. This model of care has been implemented in many healthcare systems since it has demonstrated better outcomes than traditional models of care. The model of DAPT mainly focuses on the management of musculoskeletal disorders, with a huge epidemiological burden and worldwide healthcare systems workload. Among the healthcare professionals, physical therapists are one of the most accessed for managing pain and disability related to musculoskeletal disorders. Additionally, the most updated guidelines recommend DAPT as a first-line treatment because of its cost-effectiveness, safety, and patients' satisfaction compared to other interventions. DAPT was also adopted to efficiently face the diffuse crisis of the declining number of general practitioners, reducing their caseload by directly managing patients' musculoskeletal disorders traditionally seen by general practitioners. World Physiotherapy organization also advocates DAPT as a

new approach, with physical therapy in a primary care pathway to better control healthcare expenses. Thus, it is unclear why the Italian institutions have decided to recognize new professions instead of focusing on the growth of physical therapy, a long-established and autonomous health profession. Furthermore, it is unclear why DAPT is still not fully recognized, considering the historical context and its evidence. The future is now: although still preliminary, the evidence supporting DAPT is promising. Hard skills, academic paths, scientific evidence, and the legislature argue that this paradigm shift should occur in Italy.

Maselli, F. et Piano, L. (2022). "Reply to Moretti et al. Would Moving Forward Mean Going Back? Comment on "Maselli et al. Direct Access to Physical Therapy: Should Italy Move Forward? Int. J. Environ. Res. Public Health 2022, 19, 555"." 19(8).

Moffatt, F., et al. (2018). "Physiotherapy-as-first-point-of-contact-service for patients with musculoskeletal complaints: understanding the challenges of implementation." Prim Health Care Res Dev **19**(2): 121-130. https://www.cambridge.org/core/services/aop-cambridge-core/content/view/B1F605DBA35FFD1201C132804747A816/S1463423617000615a.pdf/div-class-title-physiotherapy-as-first-point-of-contact-service-for-patients-with-musculoskeletal-complaints-understanding-the-challenges-of-implementation-div.pdf

BACKGROUND: Primary care faces unprecedented challenges. A move towards a more comprehensive, multi-disciplinary service delivery model has been proposed as a means with which to secure more sustainable services for the future. One seemingly promising response has been the implementation of physiotherapy self-referral schemes, however there is a significant gap in the literature regarding implementation. Aim This evaluation aimed to explore how the professionals and practice staff involved in the delivery of an in-practice physiotherapy self-referral scheme understood the service, with a focus on perceptions of value, barriers and impact. Design and setting A qualitative evaluation was conducted across two UK city centre practices that had elected to participate in a pilot self-referral scheme offering 'physiotherapy-as-a-first-point-of-contact' for patients presenting with a musculoskeletal complaint. METHODS: Individual and focus group interviews were conducted amongst participating physiotherapists, administration/reception staff, general practitioners (GPs) and one practice nurse (in their capacity as practice partner). Interview data were collected from a total of 14 individuals. Data were analysed using thematic analysis. RESULTS: Three key themes were highlighted by this evaluation. First, the imperative of effecting a cultural change - including management of patient expectation with particular reference to the belief that GPs represented the 'legitimate choice', re-visioning contemporary primary care as a genuine team approach, and the physiotherapists' reconceptualisation of their role and practices. Second, the impact of the service on working practice across all stakeholders - specifically re-distribution of work to 'unburden' the GP, and the critical role of administration staff. Finally, beliefs regarding the nature and benefits of physiotherapeutic musculoskeletal expertise - fears regarding physiotherapists' ability to work autonomously or identify 'red flags' were unfounded. CONCLUSION: This qualitative evaluation draws on the themes to propose five key lessons which may be significant in predicting the success of implementing physiotherapy self-referral schemes.

Moretti, A., et al. (2022). "Would Moving Forward Mean Going Back? Comment on Maselli et al. Direct Access to Physical Therapy: Should Italy Move Forward? Int. J. Environ. Res. Public Health 2022, 19, 555." Int J Environ Res Public Health **19**(8).

Ojha, H. A., et al. (2014). "Direct access compared with referred physical therapy episodes of care: a systematic review." Phys Ther **94**(1): 14-30.

BACKGROUND: Evidence suggests that physical therapy through direct access may help decrease costs and improve patient outcomes compared with physical therapy by physician referral. PURPOSE: The purpose of this study was to conduct a systematic review of the literature on patients with musculoskeletal injuries and compare health care costs and patient outcomes in episodes of physical therapy by direct access compared with referred physical therapy. DATA SOURCES: Ovid MEDLINE,

CINAHL (EBSCO), Web of Science, and PEDro were searched using terms related to physical therapy and direct access. Included articles were hand searched for additional references. STUDY SELECTION: Included studies compared data from physical therapy by direct access with physical therapy by physician referral, studying cost, outcomes, or harm. The studies were appraised using the Centre for Evidence-Based Medicine (CEBM) levels of evidence criteria and assigned a methodological score. DATA EXTRACTION: Of the 1,501 articles that were screened, 8 articles at levels 3 to 4 on the CEBM scale were included. There were statistically significant and clinically meaningful findings across studies that satisfaction and outcomes were superior, and numbers of physical therapy visits, imaging ordered, medications prescribed, and additional non-physical therapy appointments were less in cohorts receiving physical therapy by direct access compared with referred episodes of care. There was no evidence for harm. DATA SYNTHESIS: There is evidence across level 3 and 4 studies (grade B to C CEBM level of recommendation) that physical therapy by direct access compared with referred episodes of care is associated with improved patient outcomes and decreased costs. LIMITATIONS: Primary limitations were lack of group randomization, potential for selection bias, and limited generalizability. CONCLUSIONS: Physical therapy by way of direct access may contain health care costs and promote high-quality health care. Third-party payers should consider paying for physical therapy by direct access to decrease health care costs and incentivize optimal patient outcomes.

Piscitelli, D., et al. (2018). "Direct access in physical therapy: a systematic review." Clin Ter **169**(5): e249-e260.

BACKGROUND: Grooving evidence suggests that patients could have Direct Access (DA) to physiotherapy. It represents a new model of care, which might lead to improve patients' health status and decrease cost services for healthcare compared with a secondary care referral pathway. The aim of this study is to explore the evidence regarding feasibility, effectiveness, costs, safety and patient satisfaction through DA compared to other organizational models. METHODS: A systematic review was carried out through MEDLINE, CINAHL, and EMBASE databases from their inceptions until March 2018 using keywords related with DA. All articles in English, Italian or Polish comparing the modality of DA with any other organizational modality were included. Two reviewers independently selected eligible studies, extracted the data, and assessed methodological quality using the Newcastle-Ottawa Scale for cohort studies. RESULTS: 1593 articles were initially identified, and thirteen studies met the inclusion criteria. The mean NOS score for study quality was 6.4 ± 1.4 out of a possible total score of nine points. Patients impairments and health care status, were similar through all studies. DA showed less number of physiotherapy treatments, visits to physician, imaging performed and required fewer non-steroidal anti-inflammatory drugs and secondary care. Patients were more satisfied with the service in comparison to the group referred by the physician. and costs per subject were lower. DA patients were younger, with a higher level of education; mostly, they presented a less severe clinical condition and a more acute pathologies related to the spine. No harms were reported. Only one study assessed the clinical safety of the DA. CONCLUSION: The findings suggest that DA to physiotherapy is feasible considering the clinical and economic point of view. However, more research is still needed due to the low evidence of the reviewed studies and to explore the clinical safety of DA.

Scheele, J., et al. (2014). "Direct access to physical therapy for patients with low back pain in the Netherlands: prevalence and predictors." Phys Ther **94**(3): 363-370.

BACKGROUND: In the Netherlands, direct access to physical therapy was introduced in 2006. Although many patients with back pain visit physical therapists through direct access, the frequency and characteristics of episodes of care are unknown. OBJECTIVE: The purposes of this study were: (1) to investigate the prevalence of direct access to physical therapy for patients with low back pain in the Netherlands from 2006 to 2009, (2) to examine associations between mode of access (direct versus referral) and patient characteristics, and (3) to describe the severity of the back complaints at the beginning and end of treatment for direct access and referral-based physical therapy. DESIGN: A cross-sectional study was conducted using registration data of physical therapists obtained from a longitudinal study. METHOD: Data were used from the National Information Service for Allied Health Care, a registration network of Dutch physical therapists. Mode of access (direct or referral) was registered for each episode of physical therapy care due to back pain from 2006 to 2009. Logistic

regression analysis was used to explore associations between mode of access and patient/clinical characteristics. RESULTS: The percentage of episodes of care for which patients with back pain directly accessed a physical therapist increased from 28.9% in 2006 to 52.1% in 2009. Characteristics associated with direct access were: middle or higher education level (odds ratio [OR]=1.3 and 2.0, respectively), previous physical therapy care (OR=1.7), recurrent back pain (OR=1.7), duration of back pain <7 days (OR=4.2), and age >55 years (OR=0.6). LIMITATIONS: The study could not compare outcomes of physical therapy care by mode of access because this information was not registered from the beginning of data collection and, therefore, was missing for too many cases. CONCLUSIONS: Direct access was used for an increasing percentage of episodes of physical therapy care in the years 2006 to 2009. Patient/clinical characteristics associated with the mode of access were education level, recurrent back pain, previous physical therapy sessions, and age.

Swinkels, I. C., et al. (2014). "An overview of 5 years of patient self-referral for physical therapy in the Netherlands." Phys Ther **94**(12): 1785-1795.

BACKGROUND: Self-referral for physical therapy was introduced in 2006 in the Netherlands. Internationally, debate on self-referral is still ongoing. OBJECTIVE: The aim of this study was to evaluate the effects of self-referral for physical therapy in the Netherlands, focusing on volume of general practice and physical therapy care (incidence rates and utilization of services). DESIGN: The study was based on monitoring data from existing data sources. METHODS: Longitudinal electronic medical record data from general practitioners (GPs) and physical therapists participating in the NIVEL Primary Care Database were used, as well as public data from Statistics Netherlands. Descriptive statistics and Poisson multilevel regression analyses were used for analyzing the data. RESULTS: Incidence rates of back (including low back), shoulder, and neck pain in general practice declined slightly from 2004 to 2009. No linear trends were found for number of contacts in GP care for back (including low back) and neck pain. The number of patients visiting physical therapists and the proportion of self-referrers are growing. Self-referrers receive treatment less often after initial intake than referred patients, and the mean number of visits is lower. LIMITATIONS: This study was based on data of various patient populations from existing data sources. CONCLUSIONS: The current study indicates that self-referral in the Netherlands has fulfilled most expectations held prior to its introduction, although no changes to the workload of GP care have been found. Use of physical therapy grew, but due to population aging and increasing prevalence of chronic diseases, it remains unclear whether self-referral affects health care utilization. Therefore, cost-benefit analyses are recommended.

Yang, M., et al. (2021). "Economic evaluation of patient direct access to NHS physiotherapy services." Physiotherapy **111**: 40-47.
https://www.physiotherapyjournal.com/article/S0031-9406(20)30429-6/fulltext

OBJECTIVES: Our aim was to undertake an economic evaluation of patient direct access to physiotherapy in the UK NHS by comparing the number of patients treated, waiting time, cost and health gain from a direct access pathway versus traditional GP-referral to NHS physiotherapy. DESIGN: The authors used a discrete event simulation (DES) model to represent a hypothetical GP practice of 10,000 patients. Costs were measured from the perspective of the NHS and society. Outcomes were predicted waiting times, the total number of patients with musculoskeletal conditions who received physiotherapy and quality adjusted life years (QALYs) gained, each estimated over a one year period. Model inputs were based on a pilot cluster randomised controlled trial (RCT) conducted in four general practices in Cheshire, UK, and other sources from the literature. RESULTS: Direct access could increase the number of patients receiving at least one physiotherapy appointment by 63%, but without investment in extra physiotherapist capacity would increase waiting time dramatically. The increase in activity is associated with a cost of £4999 per QALY gained. CONCLUSIONS: Direct access to physiotherapy services would be cost-effective and benefit patients given current cost per QALY thresholds used in England. This is because physiotherapy itself is cost-effective, rather than through savings in GP time. Direct access without an increase in supply of physiotherapists would increase

waiting times and would be unlikely to be cost saving for the NHS owing to the likely increase in the use of physiotherapy services.

Pour aller plus loin

Ameli – Démographie des professions de santé
https://assurance-maladie.ameli.fr/etudes-et-donnees/par-theme/professionnels-et-etablissements-de-sante/demographie-professionnels-sante-liberaux

Conseil de l'Ordre des masseurs-kinésithérapeutes
https://www.ordremk.fr/

Data.drees – Accessibilité aux professions de santé
https://data.drees.solidarites-sante.gouv.fr/explore/dataset/530_l-accessibilite-potentielle-localisee-apl/information/

Fédération française des masseurs-kinésithérapeutes (FFMK)
https://www.ffmkr.org/

Syndicat national des masseurs-kinésithérapeutes (SNMK)
https://www.snmkr.fr/

PEDro (Physiothérapy evidence database)
https://pedro.org.au/french/about/who-we-are/