



AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

Prepared by the

Australian Physiotherapy Association

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Authorised by

APA President, Katie Mickel

Australian Physiotherapy Association
3/201 Fitzroy Street
St Kilda Vic 3182
Tel: (03) 9534 9400
Fax: (03) 9534 9199
Email: national.office@physiotherapy.asn.au

www.physiotherapy.asn.au

INTRODUCTION

This submission argues for the creation of two new Medicare Benefits Schedule (MBS) item numbers, and for the extension of payment arrangements under the Enhanced Primary Care (EPC) program. The recommendations relate to incontinence and knee joint osteoarthritis, which are two common, distressing, readily diagnosed conditions for which there are a range of evidence-based physiotherapy interventions. Physiotherapy management of these conditions is more cost effective than conventional medical or surgical intervention.

The EPC program must be extended to include payment for physiotherapists to facilitate the multidisciplinary management of patients with chronic illness, the aged and the terminally ill.

This submission is made on behalf of members of the Australian Physiotherapy Association (APA). The APA has well over 9,000 members, who constitute the vast majority of the physiotherapy workforce in Australia. APA members work in every sector of the physiotherapy profession and are located in capital cities, metropolitan areas, rural and remote areas and in Indigenous communities. Members, particularly those in rural and remote areas, are ideally placed to assist over-worked general practitioners by relieving some elements of their primary care caseload.

The APA believes that these proposals encourage more efficient and effective usage of health resources and that there would be broad support for them among the medical community¹ and consumers.

¹ The National Rural Health Alliance recently called for an increased role for other health professionals in the Medicare system, specifically referring to, among other health professionals, physiotherapists. *Budget Media Release*, 13 May 2003.

CONTENTS

Introduction	2
Recommendations	4
Incontinence	5
Prevalence.....	6
Benefits of physiotherapy	6
Female urinary incontinence.....	7
Male urinary incontinence	8
Faecal incontinence.....	8
Knee osteoarthritis	10
Payments for Enhanced Primary Care.....	13
Back and neck pain.....	15
Neck pain.....	15
Back injury in the workplace	16
Conclusion	17
Definitions	18

RECOMMENDATIONS

The federal government should:

in the short term:

- Introduce an MBS item number for physiotherapy management of all forms of incontinence;
- Introduce an MBS item number for physiotherapy management of knee joint osteoarthritis; and
- Work with the APA to introduce appropriate remuneration services for physiotherapists involved in the Enhanced Primary Care Program.

in the medium term:

- Work with the APA to develop new MBS item numbers for the management of back and neck pain.

INCONTINENCE

Urinary and faecal incontinence are common, debilitating and distressing conditions that afflict many Australians. There are a variety of nonsurgical interventions to manage incontinence and physiotherapists are experts in the practice many of these interventions in the primary care context.

Evidence of the efficacy of physiotherapy for incontinence management is irrefutable. A précis of the evidence is presented below. A combination of physiotherapy treatment options can avoid the need for the patient to have surgery. The patient will probably need a maintenance program,² but this is safer for the patient and substantially cheaper than surgical intervention.

The Medicare system should allow a rebate for patients directly attending physiotherapy clinics or via GP referral. Expanding the Medicare system in this way increases consumer choice and encourages good outcomes, without surgical or pharmacological intervention.

Incontinence costs the community money – medical and surgical management are expensive. Physiotherapy can replace medical and surgical management in many cases, particularly when the incontinence is mobility related. It is also worth noting that lack of capacity to manage incontinence is a frequent cause for people to be admitted to a residential aged care facility. During the 2001-02 financial year the Commonwealth spent \$40 707 million on residential aged care. Assisting older people to stay at home costs less and promotes independence. An MBS item for the physiotherapy management of incontinence will save money.

There are a range of existing options that could be utilised in the promotion of physiotherapists' management of incontinence. For instance patient materials on the National Continence Management homepage already recommend physiotherapy for male³ and female⁴ incontinence so it would be a simple matter to add a reference to the availability of a Medicare rebate.

General practitioners could be advised of the option of referral for physiotherapy via the Australian Divisions of General Practice and organisations such as the National Prescribing Service.⁵

² Bourcier AP, Juras JC. Nonsurgical therapy for stress incontinence. *Urologic Clinics of North America* 1995 22(3):613.

³ See: <http://www.continence.health.gov.au/info/pmen.htm>

⁴ See: <http://www.continence.health.gov.au/info/pwomen.htm>

⁵ See: <http://www.nps.org.au/main.html>

Prevalence

The prevalence of urinary incontinence in Australian women is surprisingly high: being 12.8 per cent of women aged 18-23 years; 36.1 per cent 45-50 years; and 35 per cent of women 70-75 years.⁶ Estimates reported in international studies vary from 9.8 to 69 per cent, with a median prevalence of 27.7 per cent.

Female urinary incontinence costs the community money. In 1998 the estimated cost of urinary incontinence among community-dwelling women was \$710.44 million.⁷ Of this sum, \$338.47 was directly spent on treatment.⁸ The APA contends that increased accessibility of physiotherapy services will encourage early intervention and reduce the burden of cost on the community.

Estimates of the prevalence of male incontinence vary from 3.6 to 47 per cent.⁹ The prevalence is much higher in men who have had a radical prostatectomy, with estimates varying from eight per cent to 87 per cent at six months and 44.5 per cent at 12 months postoperatively.¹⁰ This prevalence is much higher than the general community. Although the prevalence of urinary incontinence is lower in men than women, it does tend to have a greater impact on the quality of life of men.

In the general Australian population, the prevalence of solid and liquid faecal incontinence is two per cent and nine percent respectively,¹¹ while the prevalence of faecal incontinence post-partum is 9.6 per cent.¹²

Benefits of physiotherapy

Physiotherapists provide a range of highly effective treatments for both urinary and faecal incontinence. The diagnosis of faecal incontinence is a relatively simple matter and well within the skills of most physiotherapists. Physiotherapists can perform a differential diagnosis for urinary incontinence, but

⁶ Chiarelli P, Brown W, McElduff P. Leaking urine: Prevalence and associated factors in Australian women. *Neurology and Urodynamics* 1999 18:567.

⁷ Doran CM, Chiarelli P, Cockburn J. Economic costs of urinary incontinence in community-dwelling Australian women. *Medical Journal of Australia* 2001 174:456.

⁸ Ibid.

⁹ Personal communication with Dr Pauline Chiarelli, Senior Lecturer, School of Health Sciences, University of Newcastle.

¹⁰ Van Kampen M, Weerd, Van Poppel H, De Ridder D, Feys H, Baert L. Effect of pelvic-floor re-education on duration and degree of incontinence after radical prostatectomy: a randomised, controlled trial. *The Lancet* 2000 355(9198):98.

¹¹ Kalantar JS, Howell S, Talley NJ. Prevalence of faecal incontinence and associated risk factors; an underdiagnosed problem in the Australian community. *Medical Journal of Australia* 2002 176(2):47.

¹² MacArthur C, Glazener CM, Wilson PD, Herbison GP, Gee H, Lang GD, Lancashire R. Obstetric practice and faecal incontinence three months after delivery. *British Journal of Obstetrics and Gynaecology* 2001 108(7):678.

urodynamic analysis is generally required to confirm a definitive diagnosis (ie whether the problem is urge or genuine stress incontinence).

The range of available interventions include: teaching pelvic floor exercises; electrical stimulation; real time ultrasound; biofeedback and education on bladder habits. When the cause of incontinence is related to mobility, physiotherapists provide a range of solutions to assist the patient in getting to the bathroom more quickly. These solutions are part of core physiotherapy.

Overall, physiotherapy offers effective primary care for sufferers of incontinence, and does so without pharmaceuticals or invasive interventions. Treatment could be provided on the basis of GP referral or by direct attendance at physiotherapy. The evidence supporting physiotherapy interventions for incontinence is strong.

Female urinary incontinence

A major review of international research, conducted in 2003, found that pelvic floor muscle training is effective in managing stress or mixed incontinence in adult women.¹³ This review is of high evidentiary value and provides strong support for the prescription of pelvic floor training where indicated.

Physiotherapists are experts in the provision of this training, and in educating patients about other management strategies to implement before the training takes effect.

While pelvic floor muscle training is considered more effective than electrical stimulation¹⁴ in the management of female urinary incontinence, the treatment is effective for some patients.

The role of physiotherapy in postpartum continence management has been examined in Australia. Examining only women who had forceps or ventouse (vacuum extraction) delivery, which are associated with a slightly higher prevalence of incontinence, researchers found that the prevalence of incontinence in the group who received physiotherapy was lower at three months, and that the prevalence of severe incontinence was significantly lower in this group at follow up, compared with a control group who received no physiotherapy.¹⁵

¹³ Hay-Smith EJC, Bø K, Berghmans LCM, Hendriks HJM, de Bie RA, van Waalwijk van Doorn ESC. Pelvic floor muscle training for urinary incontinence in women. *Cochrane Library* 2003 Issue 2. Oxford: Update Software.

¹⁴ Bo K, Talseth T, Holme I. Single blind, randomised controlled trial of pelvic floor exercises, electrical stimulation, vaginal cones, and no treatment in management of genuine stress incontinence in women. *British Medical Journal* 1999 318:487.

¹⁵ Chiarelli P, Cockburn J. Promoting urinary continence in women after delivery: randomised controlled trial. *British Medical Journal* 2002 324:1241.

Male urinary incontinence

Pelvic floor training or exercise is effective for men as well as women. There are fewer studies on incontinence in men, presumably because its prevalence is so much lower in men. Most studies tend to focus on interventions post prostatectomy. Pelvic floor retraining has been found to be significantly more effective than placebo treatment, both in decreasing the severity and duration of post-surgical incontinence.¹⁶ These findings led researchers to conclude:

*Since there are no side-effects or risks from therapy we advise that physiotherapy should be offered to all patients with incontinence from day 1 after catheter removal. Treatment is most effective during the first 4 months after surgical intervention.*¹⁷

Another study examined interventions for post micturition dribble. Australian researchers found that pelvic floor training was significantly more effective than counselling or urethral milking.¹⁸

Faecal incontinence

A systematic review of the evidence indicates that biofeedback in combination with exercise will assist the majority of patients with faecal incontinence.¹⁹

A South Australian prospective trial concluded that pelvic floor retraining 'is a physical therapy that should be considered as the initial treatment in patients with faecal incontinence'.²⁰ This study provided strong evidence that physiotherapy is an important primary care modality in the management of faecal incontinence. The APA argues that the treatment should therefore be directly accessible to patients, with an applicable Medicare payment.

Faecal incontinence can follow labour, particularly in the case of a third degree tear of the perineum. A multidisciplinary team of researchers examined the use of two forms of biofeedback training as a treatment for incontinence resulting from obstetric trauma. Both augmented and sensory biofeedback significantly improved the incontinence, with the former being the superior method.²¹

¹⁶ Van Kampen, above 10.

¹⁷ Ibid.

¹⁸ Paterson J, Pinnock C, Marshall VR. Pelvic floor exercises as a treatment for post micturition dribble. *British Journal of Urology*. 1997 79: 892.

¹⁹ Norton C, Kamms MA. Anal sphincter biofeedback and pelvic floor exercises for faecal incontinence in adults – a systematic review. *Alimentary Pharmacology and Therapeutics* 2001 15(8):1147.

²⁰ Reiger NA, Wattchow DA, Sarre RA, Cooper SJ, Rich CA, Saccone GT, Schloithe AC, Toouli J, McCall JL. Prospective trial of pelvic floor retraining in patients with fecal incontinence. *Diseases of the Colon and Rectum* 1997 40(7):821.

²¹ Fynes MM, Marshall K, Cassidy M, Behan M, Walsh D, O'Connell PR, O'Herlihy C. A prospective, randomised study comparing the effect of augmented biofeedback with sensory

Direct access to publicly subsidised physiotherapy would assist men and women in the management of faecal incontinence. The evidence indicates that treatments are effective, which is suggestive that reliance on surgical intervention can be reduced. It is a condition that causes great distress to people and the APA argues that there would be a public benefit in increasing patient access to these primary health care services.

biofeedback ae on faecal incontinence after obstetric trauma. *Diseases of the Colon and Rectum* 1999 42(6):753.

KNEE OSTEOARTHRITIS

Osteoarthritis is the fourth most common condition leading to loss of years due to disability.²² It is the tenth most important disease detracting from the quality of life of Australians.²³ With an ageing population the incidence is sure to increase: people aged over 65 are expected to comprise 20 per cent of the population by 2040.²⁴ In Australia it is predicted that there will be a 24 per cent increase in disablement due to rheumatic disease (of which osteoarthritis is a form) by 2020.²⁵

The best available estimate of the prevalence of knee osteoarthritis is that one third of people aged over 60 years show evidence of this condition.²⁶ So based on the figures above, by 2040 a sixth of the population may have knee osteoarthritis.

Physiotherapist prescribed exercise is more cost effective than drug treatment. Pendleton *et al* rated the effectiveness of treatments for knee joint osteoarthritis as reported in a range of studies. Researchers combined the ratings from various trials to gain an effectiveness score (the higher the score the better the treatment). Non-steroidal anti inflammatory drugs (expensive drugs commonly prescribed to treat arthritis) scored only 0.49 while exercise scored 0.78.²⁷

In September 2001 the APA produced a Knee Joint Osteoarthritis Position Statement. The statement contains evidence-based recommendations regarding the management of knee joint osteoarthritis. It represents a best practice guide based on current research. A copy of the statement is available on request from the APA National Office.

²² Mathers C, Vos T, Stevenson C, Begg SE. The Australian Burden of Disease Study: measuring the loss of health from diseases, injuries and risk factors. *Medical Journal Australia* 2000 172:592.

²³ Ibid.

²⁴ Hamerman D. Clinical implications of osteoarthritis and ageing. *Annals of Rheumatic Disease* 1995 54(2):82-5.

²⁵ Badley EM, Crotty M. Quantitative estimates of the impact of the aging population on the need for rheumatological services: an international comparison. *Arthritis and Rheumatism* 1992 35:S177.

²⁶ Felson DT, Naimark A, Anderson J, Kazis L, Castelli, Meenan RF. The prevalence of knee osteoarthritis in the elderly. The Framingham osteoarthritis study. *Arthritis and Rheumatism* 1987 30(8):914-8.

²⁷ Pendleton A, Arden N, Dougados M, Doherty M, Bannwarth B, Bijlsma JW, Cluzeau F, Cooper C, Dieppe PA, Gunther KP, Hauselmann HJ, Herrero-Beaumont G, Kaklamanis PM, Leeb B, Lequesne M, Lohmander S, Mazieres B, Mola EM, Pavelka K, Serni U, Swoboda B, Verbruggen AA, Weseloh G, Zimmermann-Gorska I. EULAR recommendations for the management of knee osteoarthritis: report of a task force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCISIT). *Annals of Rheumatic Disease* 2000 59(12):936-44.

Recent physiotherapy research demonstrates the value of knee taping.²⁸ It is a cheap, simple therapy that acts as an adjunct to other therapies and reduces pain.²⁹ Many physiotherapy strategies, such as taping and exercise, can become self-management strategies with appropriate instruction from physiotherapists. Such instruction, when properly delivered, allows the patient to take control of their condition and this makes physiotherapy management even more cost-effective. Self-management is always the goal for the management of any condition and it is highly recommended for any chronic conditions. Physiotherapy for knee joint osteoarthritis is ideal as publicly funded primary care because its simple interventions (compared with medical and surgical management) are cheap and effective.

Another physiotherapy modality was recently shown to be effective in increasing mobility. Pulsed magnetic field therapy was shown to reduce impairment in normal daily activities and improve overall knee function.³⁰ Mobility is a very important factor in determining whether the elderly can stay at home rather than be forced to enter aged care facilities so treatments increasing mobility are vital to the maintenance of independence.

Therapies are also highly effective in combination. Manual physiotherapy combined with supervised exercise reduces pain and can delay or obviate the need for surgery for knee osteoarthritis.³¹ Subjects in a controlled trial achieved both clinically and statistically significant improvement in both mobility (as measured by a standard test) and walking distance over a set interval.³²

The Arthritis Foundation of Australia states that physiotherapy and exercise:

*Can be used to strengthen muscles, maintain joint mobility and position, improve heart and lung fitness, reduce stress, control weight, improve sleep and contribute to overall wellness and coping strategies..*³³

Australia's pre-eminent arthritis organisation acknowledges the value of physiotherapy in the management of arthritis. Although the statement refers to all arthritis, it still applies to knee joint osteoarthritis. The Foundation's statement

²⁸ Hinman RS, Bennell KL, Crossley KM, McConnell J. Immediate effects of adhesive tape on pain and disability in individuals with knee osteoarthritis. *Rheumatology (Oxford)* 2003 Mar 31 (epub ahead of print).

²⁹ Ibid.

³⁰ Nicolakis P, Kollmitzer J, Crevenna R, Bittner C, Erdogmus CB, Nicolakis J. Pulse magnetic therapy for knee osteoarthritis – a double-blind sham controlled trial. *Wien Klin Wochenschr.* 2002 30;114(15-16):678-84.

³¹ Deyle GD, Henderson NE, Matekel RL, Ryder MG, Garber MB, Allison SC. Effectiveness of manual physical therapy and exercise in osteoarthritis of the knee. A randomized, controlled trial. *Annals of Internal Medicine* 2000 1;132(3):173-81.

³² Ibid.

³³ Access Economics Pty Ltd. Prevalence, cost and disease burden of arthritis in Australia. *The Arthritis Foundation of Australia* March 2001.

demonstrates that physiotherapy is accepted as a core primary care modality in the management of knee joint osteoarthritis.

The APA contends that the importance of physiotherapy should be recognised by the creation of an appropriate MBS item number for physiotherapy consultations for knee joint osteoarthritis. Further, there is clear evidence that physiotherapy interventions are highly effective, and substantial evidence that they reduce the need for more costly interventions such as surgery.³⁴

³⁴ Bennell K, Crossley K. Knee Joint Osteoarthritis Position Statement. *Australian Physiotherapy Association* September 2001.

PAYMENTS FOR ENHANCED PRIMARY CARE

The Enhanced Primary Care (EPC) Medicare Items provide funding for medical practitioners' participation in case conferencing and the development of multidisciplinary care plans. The items largely apply to residents of residential aged care facilities, the terminally ill or patients with a long-term illness.

According to the Department of Health and Ageing, the items

Provide a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services.³⁵

From this it is clear that the multidisciplinary approach is highly valued, but the program does not equally value the contributions of all team members.

Teams must consist of the patient's GP and at least two other team members.³⁶ The other practitioners have to agree to the plan,³⁷ and the medical practitioner cannot bill for the plan until the other practitioners have been consulted.³⁸

The anomaly is that there is only provision for the medical practitioner to be paid – there is no facility for the payment of other team members, regardless of the level of their involvement. Understandably, physiotherapists are reluctant to give up their time for free, particularly when they are aware that the medical practitioner is paid for what is often an equal contribution.

For the aims of the EPC items to be met there must be payment for the participation of other practitioners, including physiotherapists. There is a shortage of physiotherapists, particularly in gerontology. Many are overworked and unable to contribute unpaid labour and many object to having their skills and knowledge taken for granted.

Members report that at present EPC is seriously underutilised in residential aged care facilities. As many residents have multiple, chronic conditions, care under EPC would be the ideal way to manage residents' care. Payments for other health professionals, and allowing them to prepare, review and contribute to care plans, will encourage the utilisation of EPC, resulting in better health outcomes for residents.

³⁵ www.health.gov.au/epc.

³⁶ MBS section A.21.7 states that two other practitioners must contribute to the plans and provides an indicative list of persons who may be involved. Physiotherapists are included in this list.

³⁷ MBS section A.21.8

³⁸ MBS section A.21.25

If the Government is committed to encouraging a multidisciplinary approach to health care then it must be prepared to recompense all members of the multidisciplinary team. One of three approaches could be taken: nominated practitioners could be given provider numbers that allow access to the existing MBS items; new item numbers could be created and all physiotherapists could be provided with provider numbers; or practitioners could invoice based on fee for service guidelines.

The APA prefers the second approach as this would be consistent with the recommendation to create two new physiotherapy MBS items.

BACK AND NECK PAIN

Physiotherapists are experts in managing back and neck pain – this musculoskeletal work constitutes a core component of physiotherapy practice. A range of physiotherapy interventions are highly effective in treating neck and back pain of various aetiology. A raft of evidence supports the efficacy of most of the interventions, and a few examples are given below.

Hospitals are increasingly relying on physiotherapy services to reduce the necessity for surgical intervention and to assist in post-operative recovery. For instance, the Austin Hospital in Victoria has used the skills of physiotherapists to triage patients with low back pain in orthopaedic outpatient clinics. They have succeeded in reducing the waiting time to see an orthopaedic surgeon and, through early physiotherapy intervention, decreased the number of hospital admissions and attendances at emergency. Public hospital patients have long benefited from back and neck care, and hospitals have found these treatments to be cost effective. The APA contends that funding physiotherapy treatment of neck and back pain in the private sector will also be cost effective.

The APA is confident that the inclusion of physiotherapy for knee osteoarthritis and incontinence management on the MBS will prove cost effective and popular with the public. Once these items have been established the APA recommends that consideration be given to extending MBS coverage to physiotherapy management of neck and back pain. Two brief examples are presented below demonstrating the type of management that is envisaged.

Neck pain

Numerous studies attest to the effectiveness of physiotherapy for neck pain. A recent study goes further and demonstrates its cost effectiveness versus GP intervention.³⁹

The results showed that ‘manual therapy’ (an intervention used by physiotherapists in Australia) led to faster recovery at 26 weeks and that it was significantly cheaper overall than GP intervention. In fact, GP intervention was up to three times more expensive than ‘manual therapy’.⁴⁰

³⁹ Ingeborg B C Korthals-de Bos, Jan L Hoving, Maurits W van Tulder, Maureen P M H Rutten-van Mülken, Herman J Adèr, Henrica C W de Vet, Bart W Koes, Hindrik Vondeling, Lex M Bouter
Cost effectiveness of physiotherapy, manual therapy, and general practitioner care for neck pain: economic evaluation alongside a randomised controlled trial. *British Medical Journal* 2003
326:911.

⁴⁰ Ibid.

Back injury in the workplace

All of Australia's workers' compensation authorities retain physiotherapists to provide services to back injured workers. Treatment results in reduced pain for the worker and a more rapid return to work.

New South Wales WorkCover has produced a comprehensive literature review examining work hardening/work conditioning programs. It clearly demonstrates the value of these programs for injuries that do not require surgical intervention and are unrelated to other serious pathologies, and shows the importance of physiotherapists in these programs.⁴¹ The Victorian WorkCover Authority is now piloting an early intervention program based on available research evidence. The results are yet to be reported but APA members state that patient outcomes are improved and that the level of intervention required is reduced.

A recent review provides high-level evidence that physiotherapy gets injured workers back to work faster. Workers with back pain participating in properly designed work conditioning programs involving a physiotherapist have an average of 45 days less sick leave than those without an appropriate conditioning program.⁴²

Compensable bodies are increasingly encouraging and relying on physiotherapy services because they know that intervention costs are reduced and that workers are able to return to work faster. Many people in the general community experience the same type of back injuries out of work (gardening injuries are a perfect example) and seek treatment for these via GPs and public hospitals. The APA believes that better outcomes at lower cost could be achieved by allowing such patients direct access to subsidised physiotherapy.

⁴¹ Nicholas MK . Work Hardening/ Conditioning, Functional Restoration and Pain Management Programs For Injured Workers With No 'Red Flag' Conditions. *NSW WorkCover* June 2002, http://www.workcover.nsw.gov.au/html/pdf/work_conditioning_report.pdf.

⁴² Schonstein, E; Kenny, DT; Keating, J; Koes, BW. Work conditioning, work hardening and functional restoration for workers with back and neck pain. *The Cochrane Database of Systematic Reviews*, The Cochrane Library, Copyright 2003, The Cochrane Collaboration.

CONCLUSION

At present there are no Medicare rebates available for physiotherapy services. Physiotherapy is a core component of primary health care in Australia and should be recognised under the national public health insurance scheme.

The APA believes that physiotherapy management of incontinence and knee joint osteoarthritis should be allocated MBS items. In both cases diagnosis is discrete and relatively simple, economies will be gained by applying physiotherapy interventions rather than pharmaceutical or invasive interventions, the physiotherapy interventions required could easily be defined into MBS discrete item numbers, health consumers will be afforded greater choice and pressure will be taken off overworked GPs allowing them to apply skills appropriate to other areas of practice.

The APA presents a reasoned case based on research evidence of the value and cost effectiveness of physiotherapy for incontinence and knee joint osteoarthritis. Further evidence will be provided on request.

There is sound evidence supporting the management of back and neck pain by physiotherapists. In the medium term the APA wishes to work with the government to develop MBS items for the management of back and neck pain.

The APA supports the EPC program and calls on the government to ensure its success by instituting arrangements to ensure that physiotherapists are appropriately remunerated for their contribution to case conferences and multidisciplinary care plans.

DEFINITIONS

Perineum	Space between the anus and vagina or penis .
Stress incontinence	Involuntary release of urine resulting from a stress to the abdomen like sneezing or coughing.
Urge incontinence	A sudden urge to urinate followed by loss of bladder control
Urodynamic analysis	Analysis of bladder function employed to determine the type of incontinence