

MAKING SENSE OF THE NUMBERS

Analysis of the Physiotherapy Workforce

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Making sense of the numbers

This report was prepared for Physiotherapy New Zealand (PNZ), which seeks greater understanding of key workforce issues in physiotherapy. PNZ is the national membership organisation for physiotherapists, with a membership of over 4,000 people across New Zealand. Physiotherapists use evidence-based practice to assess, diagnose and manage patients, using their specific skills, expertise and knowledge of human function and malfunction to ensure patients receive the right treatment and exercise prescription in a timely manner.

We consider that many of the workforce issues identified through this research could be addressed through the activities of PNZ's Advocacy Strategy. This is particularly relevant with the priorities related to funders such as ACC, DHBs and MOH, as improving the funding models will also deal with many remuneration concerns. In addition to maintaining relationships with ACC and DHBs as primary funders and employers of physiotherapists, there is a need to advocate on behalf of physiotherapists on the impact of the current funding levels on workforce sustainability and health outcomes.

It is also our view that physiotherapy has a workforce retention issue rather than a new graduate supply issue. The enrolment levels with current training providers supplemented by immigration could maintain a diverse and stable physiotherapy pipeline if retention levels were improved by increasing the long-term attractiveness of the profession. To support retention, we recommend developing a career pathway that encompasses a competency framework, enabling identification where the practitioner is on the continuum of performance and experience, and providing guidance for development of specific areas of expertise. However, we recognise that physiotherapy as a profession is governed by legislation with Physiotherapy Board of New Zealand (PBNZ) as the regulatory body tasked with scopes of practice. Therefore, our recommendation is that PNZ represents member interests and works in conjunction with PBNZ in career pathway development.

Raising the public profile of physiotherapy is a space PNZ could be more active in, including promoting physiotherapists' abilities to diagnose and clinically reason, and the different areas of speciality they are involved in. This may also support the position of physiotherapy in primary health, especially in working in collaboration with other agencies and consumer groups to promote the inclusion of physiotherapy into primary care. There was considerable appetite expressed to be working more in this area.

The research was undertaken in two steps, using quantitative data analysis and qualitative research methodologies. Stakeholder engagement helped us to identify current and potential future workforce issues, as well as potential opportunities available to the profession. Qualitative research consisted of:

- Three focus groups in Christchurch, Auckland and Wellington in mid-November with 22 participants
- A feedback activity using themes and post-it notes at the Leadership Day on 23 November with 39 participants
- Nine semi-structured interviews with key stakeholders, including training providers
- Email feedback from 23 PNZ members who were unable to attend any of the focus groups.

Some workforce data, including from the 2015 and 2018 PNZ Remuneration Surveys, supports the qualitative data where relevant. We also provide a high level cohesive view derived from existing workforce data. We use data provided by the PBNZ from their 2018 Workforce Survey and from physiotherapy training providers to provide a picture of the current workforce.

Feedback was provided by physiotherapists from a range of geographical locations, employment types and special interest groups. Responses were grouped and analysed by emerging themes, including remuneration, recruitment, location issues, career pathway, and retention and attrition.

Contents

1	Introduction	1
1.1	Background	1
1.2	Engagement process and report outline	1
1.3	Limitations.....	2
2	Employment issues.....	3
2.1	Remuneration	3
2.2	Recruitment concerns	11
2.3	Conditions of employment.....	13
2.4	Issues around location.....	14
3	Funding models	16
3.1	Feedback	16
3.2	ACC	16
3.3	Public health funding.....	17
4	The physiotherapist’s journey	19
4.1	Training providers.....	19
4.2	PBNZ registration	21
4.3	Career pathway.....	22
4.4	Retention and attrition.....	23
5	Emerging issues	26
5.1	Change – clients and ways of working.....	26
5.2	Improving diversity in the pipeline	27
6	Workforce data.....	30
6.1	Employment.....	30
6.2	Qualifications	32
7	Recommendations	33
7.1	Implement Stakeholder Relationship Plan	33
7.2	Maintain relationships with ACC as primary funder of physiotherapy.....	33
7.3	Improve the position of physiotherapy in primary health	34
7.4	Address physiotherapy workforce issues	34
7.5	Promote needs of physiotherapists inside DHBs	35

Figures

Figure 1: Overall change in average income, hourly rate and weekly hours, 2015 and 2018	3
Figure 2: Change in average income, hourly rate and weekly hours by average weekly hours, 2015 and 2018	4
Figure 3: Change in average income, hourly rate and weekly hours by gender, 2015 and 2018.....	4
Figure 4: Change in average income, hourly rate and weekly hours by main employer type, 2015 and 2018	5
Figure 5: Change in average income, hourly rate and weekly hours by qualification, 2015 and 2018	6
Figure 6: Change in average income, hourly rate and weekly hours by broad region, 2015 and 2018	7
Figure 7: Change in average income, hourly rate and weekly hours by years of experience, 2015 and 2018	8
Figure 8: Physiotherapy occupation standard Work Visa principal applicants by year of application decision ...	12
Figure 9: Overall enrolments in physiotherapy qualifications	19
Figure 10: Enrolments in Bachelor-level physiotherapy qualifications	19
Figure 11: Length of time (in years) registered with PBNZ at 31 May 2018	24
Figure 12: Years of physiotherapy practice within New Zealand at 31 May 2018	25
Figure 13: Reasons for not holding an Annual Practicing Certificate (at 31 May 2018).....	25
Figure 14: Ethnicity of physiotherapists registered with PBNZ at 31 May 2018.....	27
Figure 15: Gender of physiotherapists registered with PBNZ at 31 May 2018.....	29
Figure 16: Gender of students enrolled in physiotherapy degrees at 2017	29
Figure 17: Employment type of physiotherapists registered with PBNZ at 31 May 2018	30
Figure 18: Average weekly hours worked (from PBNZ at 31 May 2018)	31
Figure 19: Age of physiotherapists registered with PBNZ at 31 May 2018.....	31
Figure 20: Highest qualification of physiotherapists registered with PBNZ at 31 May 2018.....	32
Figure 21: Qualifications by decade first registered (from PBNZ at 31 May 2018)	32

1 Introduction

This report was prepared for Physiotherapy New Zealand (PNZ), which seeks greater understanding of key workforce issues in physiotherapy. The research was undertaken in two steps, using quantitative data analysis and qualitative research methodologies.

1.1 Background

1.1.1 Physiotherapy New Zealand

Physiotherapy New Zealand (PNZ) is the national membership organisation for physiotherapists, with a membership of over 4,000 people across New Zealand. Physiotherapists use evidence-based practice to assess, diagnose and manage patients, using their specific skills, expertise and knowledge of human function and malfunction to ensure patients receive the right treatment and exercise prescription in a timely manner.

As at March 2018, there were 5,133 physiotherapists registered with annual practicing certificates (APC) from PBNZ.¹ They work in multiple settings with 25 percent of physiotherapists working for District Health Boards (DHBs) and 58 percent working as primary care providers in private practices located in urban and rural settings. Eighty one percent of physiotherapists work in urban areas, with a discrepancy in the ratio of physiotherapists (via workplace postcode) to population for rural areas.²

In developing PNZ's Advocacy Strategy and key issues for 2018-2020, the PNZ Executive considered workforce issues were a membership priority, with determining the scope and extent the first step in gaining understanding of workforce issues.

1.1.2 Government policy and strategy

The health system is under increasing pressure driven by increased demand for health services. The government has signalled that the sustainability of the health system requires a greater focus towards primary and community-based care, whilst maintaining current tertiary care services. However, the change in government in 2017 has seen shifting policies and priorities, and it is currently unclear how these will impact the physiotherapy profession.

Health Workforce New Zealand (HWNZ), supported by the Workforce Strategy Group (WSG), is developing a New Zealand Health Workforce Strategy and Action Plan (also called Workforce Strategy for the Health Sector), informed and supported by DHBs and the wider sector. A lack of a comprehensive health workforce strategy is a risk as the reality of workforce development, particularly around recruitment, retention and career pathways, may not be aligned with government priorities.

The Allied Health Taskforce (AHT) was due to add physiotherapists to a workforce modelling tool in 2017, enabling dynamic workforce forecasting by using data such as entry age distributions, age-specific exit rates and working patterns over a lifetime. There does not appear to have been any progress on this since mid-2017.

1.2 Engagement process and report outline

Stakeholder engagement helped us to identify current and potential future workforce issues, as well as potential opportunities available to the profession. Qualitative research consisted of:

¹ Physiotherapy Board of New Zealand Annual Report 2017/18

² 2018 Physiotherapy Board of New Zealand Workforce Survey

- Three focus groups in Christchurch, Auckland and Wellington in mid-November with 22 participants
- A feedback activity using themes and post-it notes at the Leadership Day on 23 November with 39 participants
- Nine semi-structured interviews with key stakeholders, including training providers
- Email feedback from 23 PNZ members who were unable to attend any of the focus groups.

Five people were involved in more than one activity. Feedback was provided by physiotherapists from a range of geographical locations, employment types and special interest groups. Responses were grouped and analysed by emerging themes, including remuneration, recruitment, location issues, career pathway, and retention and attrition.

In reality, all feedback is connected, for example ACC funding models impact on remuneration rates in private practices, which then influence conditions of employment and potential for burnout, and whether someone stays or leaves a position or the profession. In practicality, this makes for a difficult report to read with little room to provide strategic feedback and recommendation. So for ease of reading, we have grouped analysis and commentary by themes with some supporting statistical information where available or relevant.

Sections 2 to 5 of the report present themes gleaned from the above engagement process. In particular, section 2 discusses employment issues including remuneration, recruitment, conditions, and location of work. The impact of the funding model is discussed in section 3, while section 4 explores the career path journey travelled by physiotherapists. Section 5 covers emerging issues included changing work patterns and increasing diversity. Some workforce data, including from the 2015 and 2018 PNZ Remuneration Surveys, supports the qualitative data where relevant.

In Section 6, we provide a high level cohesive view derived from existing workforce data. We use data provided by the Physiotherapy Board of New Zealand (PBNZ) from their 2018 Workforce Survey and from physiotherapy training providers to provide a picture of the current workforce.

Section 7 presents recommendations Physiotherapy New Zealand could adopt to meet their Advocacy Strategy objectives.

1.3 Limitations

We had a tight scope and limited time frame for this research. Most feedback came from “senior” practitioners with extensive experience and post-graduate qualifications, and we did not have a large enough cohort of new graduates to feel this was a representative sample. While we had good gender diversity across stakeholders, there was very little ethnic and age diversity from feedback participants. In all cases, we feel this will skew feedback to particular viewpoints.

There were many anecdotal stories about why people left the profession, but it was not possible to investigate these further.

As an internal workforce review, we did not engage with any current or potential funders.

A note regarding language; we have used the terms “specific areas of expertise” and “clinical expertise” for practitioners that may have been described in feedback as “specialists” to avoid confusion with the Specialist scope of practice, which is defined in legislation.

2 Employment issues

Issues that could broadly be considered employment issues were the workforce issues of greatest concern for physiotherapists. This section addresses the most widely raised.

2.1 Remuneration

It is difficult to unpack issues around remuneration with associated workforce issues, such as recruitment, retention, attrition, location, conditions of employment, and especially, funding models. For the purposes of this report, this sub-section will address remuneration from the perspective of an income that befits the considerable education and skills of physiotherapists, the high levels of unpaid work in private practice, and the limits with salary scales in DHBs.

2.1.1 PNZ Remuneration Survey data

We undertook data cleaning (removing data that was obviously inaccurate or incomplete) and analysis of the PNZ Remuneration Surveys from 2015 and 2018, in order to understand recent remuneration trends. While average annual income has increased between 2015 and 2018, the hourly rate has not increased at the same percentage rate due to the slight increase in hours (Figure 1).

Figure 1: Overall change in average income, hourly rate and weekly hours, 2015 and 2018

	2015	2018	Percentage change
Average Income (\$)	62,242	65,875	5.8%
Average hourly rate (\$)	36.0	37.8	4.8%
Average weekly hours	33.2	33.6	1.0%
Survey respondent population	1,042	1,172	

In identifying where the greatest changes have occurred between 2015 and 2018 (see Figure 2), we found those working under 20 hours per week had experienced significant drops in annual income and hourly rates with very small increases in hours worked. This is concerning when bearing in mind the large numbers of women working part-time in the profession, and in considering feedback on recruitment, CPD and retention in later sections. Conversely, those working 21-30 hours per week experienced considerable increases in annual income and hourly rates, and those working 41 or more hours a week had significant increases in these areas. Average weekly hours has had minimal changes across the groupings.

Figure 2: Change in average income, hourly rate and weekly hours by average weekly hours, 2015 and 2018

	2015	2018	Percentage change
1 to 20 hours			
Average Income (\$)	33,900	30,957	-8.7%
Average hourly rate (\$)	44.4	39.9	-10.2%
Average weekly hours	14.7	14.9	1.7%
21 to 30 hours			
Average Income (\$)	44,495	53,513	20.3%
Average hourly rate (\$)	33.8	40.3	19.4%
Average weekly hours	25.3	25.5	0.7%
31 to 40 hours			
Average Income (\$)	73,682	73,395	-0.4%
Average hourly rate (\$)	38.8	38.5	-0.7%
Average weekly hours	36.5	36.7	0.3%
Greater than 40 hours			
Average Income (\$)	79,053	87,264	10.4%
Average hourly rate (\$)	32.4	35.3	8.9%
Average weekly hours	46.9	47.6	1.3%

Figure 3 shows that women are earning less than men on an hourly basis, and are working less hours. Income and hourly rates for women had smaller increases than those for men. Women were working slightly more hours, while weekly hours for men are comparatively stable. There is a gap of \$1.10 between the hourly rates for men and women, with men being paid a higher average hourly rate.

Figure 3: Change in average income, hourly rate and weekly hours by gender, 2015 and 2018

	2015	2018	Percentage change
Female			
Average Income (\$)	57,579	60,649	5.3%
Average hourly rate (\$)	36.1	37.4	3.8%
Average weekly hours	30.7	31.1	1.5%
Male			
Average Income (\$)	76,785	82,138	7.0%
Average hourly rate (\$)	35.9	38.5	7.3%
Average weekly hours	41.2	41.1	-0.3%

Private practice contractors have had the greatest increase in average income and hourly rates, with private practice employees also seeing monetary increases with reasonably similar average weekly hours from 2015 to 2018 (Figure 4). However, DHB employees have seen a decrease in average income and hourly rate over the same period.

Figure 4: Change in average income, hourly rate and weekly hours by main employer type, 2015 and 2018

	2015	2018	Percentage change
Business Owner			
Average Income (\$)	77,400	82,484	6.6%
Average hourly rate (\$)	40.2	41.7	3.8%
Average weekly hours	37.0	38.0	2.6%
District Health Board			
Average Income (\$)	59,736	58,237	-2.5%
Average hourly rate (\$)	34.7	34.0	-2.2%
Average weekly hours	33.1	32.9	-0.4%
Private Practice Contractor			
Average Income (\$)	50,489	58,662	16.2%
Average hourly rate (\$)	33.9	39.6	16.7%
Average weekly hours	28.6	28.5	-0.4%
Private Practice Employee			
Average Income (\$)	55,953	61,346	9.6%
Average hourly rate (\$)	31.7	34.4	8.7%
Average weekly hours	34.0	34.3	0.9%

Figure 5: Change in average income, hourly rate and weekly hours by qualification, 2015 and 2018

	2015	2018	Percentage change
Diploma in Physiotherapy			
Average Income (\$)	59,009	64,906	10.0%
Average hourly rate (\$)	40.2	42.2	4.9%
Average weekly hours	28.2	29.6	4.9%
Bachelor			
Average Income (\$)	52,861	61,833	17.0%
Average hourly rate (\$)	29.9	34.5	15.2%
Average weekly hours	34.0	34.5	1.5%
Postgraduate certificate			
Average Income (\$)	63,190	64,966	2.8%
Average hourly rate (\$)	38.3	39.1	2.2%
Average weekly hours	31.8	32.0	0.6%
Postgraduate diploma			
Average Income (\$)	67,908	70,763	4.2%
Average hourly rate (\$)	37.4	39.5	5.7%
Average weekly hours	34.9	34.4	-1.4%
Masters			
Average Income (\$)	73,899	69,092	-6.5%
Average hourly rate (\$)	41.9	39.0	-7.0%
Average weekly hours	33.9	34.1	0.5%

Figure 5 shows a drop in average annual income and hourly rates for those with Masters degrees and they now earn less on average than those with Postgraduate diplomas. Physiotherapists with Bachelor degrees have seen the greatest increase in average annual income and hourly rates, with significant increases in both compared to the small increase in weekly hours. Those with a Diploma in Physiotherapy have seen an increase across all measures, with the highest average hourly rate. This makes sense when considering the level of experience of physiotherapists with this qualification.

Figure 6: Change in average income, hourly rate and weekly hours by broad region, 2015 and 2018

	2015	2018	Percentage change
Auckland			
Average Income (\$)	62,409	63,592	1.9%
Average hourly rate (\$)	35.6	35.7	0.1%
Average weekly hours	33.7	34.3	1.8%
Wellington			
Average Income (\$)	73,777	69,617	-5.6%
Average hourly rate (\$)	39.9	39.9	-0.2%
Average weekly hours	35.5	33.6	-5.5%
Christchurch			
Average Income (\$)	62,800	65,815	4.8%
Average hourly rate (\$)	37.9	40.3	6.5%
Average weekly hours	31.9	31.4	-1.6%
Rest of South Island			
Average Income (\$)	56,101	63,757	13.6%
Average hourly rate (\$)	33.3	37.0	11.1%
Average weekly hours	32.4	33.1	2.3%
Rest of North Island			
Average Income (\$)	58,641	67,039	14.3%
Average hourly rate (\$)	34.5	37.7	9.4%
Average weekly hours	32.7	34.2	4.5%

Wellington-based physiotherapists have seen a decrease in income from 2015-18 due primarily to a reduction in average weekly hours, as the hourly rate has remained static (Figure 6). Non-metropolitan areas have seen the greatest increases in hourly rates and average annual income, with physiotherapists in Auckland now earning less on average than those in urban and rural settings. Given feedback about the cost of living in Auckland (see sub-section 2.4), this is a concern. Anecdotes about higher wages in Auckland do not appear to be supported by data, and this is an area that would be worth exploring in future research. Christchurch physiotherapists have the highest average hourly rates and lowest average weekly hours, indicating a high level of part-time private practice contractors or employees.

Figure 7: Change in average income, hourly rate and weekly hours by years of experience, 2015 and 2018

	2015	2018	Percentage change
Less than 2 years			
Average Income (\$)	49,681	46,025	-7.4%
Average hourly rate (\$)	24.9	21.7	-13.0%
Average weekly hours	38.3	40.8	6.5%
2-5 years			
Average Income (\$)	54,129	56,496	4.4%
Average hourly rate (\$)	26.9	28.0	4.0%
Average weekly hours	38.7	38.8	0.4%
6-10 years			
Average Income (\$)	55,796	73,512	31.8%
Average hourly rate (\$)	31.2	40.2	29.0%
Average weekly hours	34.4	35.2	2.2%
11-20 years			
Average Income (\$)	64,023	62,959	-1.7%
Average hourly rate (\$)	39.7	39.2	-1.1%
Average weekly hours	31.0	30.8	-0.6%
21+ years			
Average Income (\$)	66,924	71,332	6.6%
Average hourly rate (\$)	39.8	42.3	6.2%
Average weekly hours	32.3	32.4	0.4%

Figure 7 highlights a drop in average income and hourly rate for new graduates, who are now working more hours for less income. This is likely a factor in new graduate retention, as \$21.70 is only fractionally above the 2018 Living Wage rate of \$20.55³ and is unlikely to be a motivating factor after a four-year degree. Those with 6-10 years of experience have seen sizeable income and hourly rate increases, understandable given the feedback about the dearth of physiotherapists at mid-tier level and indicates a competitive employment market. Curiously though, this effect drops off after 11 years of experience, with the most experienced physiotherapists now earning less on average than those with less experience.

Feedback

Among the 19 focus group participants who identified remuneration as an issue, 95 percent said it was an industry wide concern, with 5 percent considering it contextual, ie their own workplace setting. At the Leadership Day activity, the relationship between funding models and remuneration was evident with 2/3 of post-it notes on the “remuneration” theme explicitly referring to Accident Compensation Corporation (ACC). DHB or Ministry of Health (MOH) funding.

³ https://www.livingwage.org.nz/information_sheets Retrieved 3 December 2018

By far, the most common feedback across all stakeholder engagement was fair remuneration for the level of skill and training required compared to other professions, both within health and with unrelated professions. One email respondent noted, “My husband has a three year degree and I have four year degree and a postgraduate diploma - because of the industries we are in, my husband earns over twice what I do”. Another said, “Our industry lacks appropriate financial reward for years of study, experience and continuing professional development demands”.

Focus group participants talked of paying themselves less (as private practice owners) or of earning the same as new graduates despite 20 years of experience. The majority of focus group participants and interviewees had postgraduate qualifications, and expressed minimal financial benefit for the expected postgraduate study and specialisation. This links in with the lack of a career pathway with feedback that additional study is also not reflected in job titles. This feedback is also supported by Remuneration Survey data which shows minimal financial incentive for Masters-level study.

There were several anecdotes of undergraduates and new graduates discussing their study loan debt, or moving to Australia for better remuneration and packages. However, this does not appear to be a new trend as many focus group participants and interviewees worked overseas after graduation, particularly in the UK and Australia, and returned to New Zealand after 2-5 years. More relevant, the PBNZ Graduate Surveys from 2014-6 indicate very low single digit rates of new graduate employment and registration in Australia, suggesting this is not as large an area of concern as the anecdotes may suggest.⁴ There were as many comments about the number of overseas trained physiotherapists working in New Zealand and how essential they are to maintaining staffing levels, so there would appear to be an equilibrium in these migration flows.

Most experienced physiotherapists referred to the drop in the average hourly rate in the past few years over all sectors, and in some cases said they had less buying power with their incomes than 20-30 years ago. There were questions about whether the largely female workforce is a causative factor in the low remuneration, and whether this was a pay equity issue. These comments are valid given the Remuneration Survey data which showed a pay gap between men and women in the sector, and the decrease in remuneration for those with Masters degrees.

While there are a wider range of physiotherapy settings than working within private practice and DHBs, including rest homes and disability support services, feedback was predominantly provided by people working within those settings. Interestingly, both groups felt the other was more fairly remunerated. Specific feedback from those groups follows.

2.1.2 Working in private practices

There appears to be a wide range of remuneration strategies in private practice (aside from ownership), including self-employed, employed, and contractor. On the whole, stakeholders expressed dissatisfaction with private practice remuneration. Feedback included:

- Contractors and self-employed:
 - No room to bargain for higher wages as remuneration is tied to patient numbers
 - No base salary with an inability to predict earnings
 - No standard hourly rate with wide variation across practices even within the same location
 - No payment for missed appointments or time required to be at the clinic if there’s a large gap between appointments

⁴ <https://www.physioboard.org.nz/resources/reports/graduate-survey> Retrieved 27 November 2018

- Contracting more physiotherapists than necessary and creating competitive, not collegial, environment
- Only paid for billable hours (client contact time), with no compensation or reimbursement for time spent on:
 - Clinical notes, letters to other practitioners and GPs, discharge summaries, and ACC Case Manager communications
 - Communications and non-treatment contact with clients, including exercise programmes
 - Covering receptionist absences, preparing and presenting in-house education sessions, attending compulsory staff meetings (that meet practice audit guidelines but are “a waste of time”)
 - Continuing Professional Development (CPD) – neither time taken off nor direct CPD expenditure – but it is often expected or required
- Employees:
 - Lack of reimbursement or acknowledgement for teaching and mentoring new graduates who are not clinic-ready and require lots of assistance
 - Low salary ceilings for mid-tier top of scope or
 - Expectation to be a “workhorse” and get through as many clients per day as possible with some noting they don’t have regular break times, breaching both their employment contracts and employment legislation.

It is clear the funding model has encouraged a contract based system that has directly contributed to the increase in hours worked, and the decrease in hourly rates.

2.1.3 Working within DHBs

Feedback on remuneration within DHB settings related more to the limitations and challenges of the Career and Salary Progression (CASP) framework. A focus group participant who had undertaken the CASP process twice said that it had taken close to a year each time and it was as onerous as doing postgraduate study. One person said that within DHBs there was a poor understanding and utilisation of the CASP process by DHB management where goals are set way too big. There was a general consensus that CASP was a “heck of a lot of work for very little financial gain”, with one DHB Team Leader commenting that it was unfair that pay increases were retrospective, with staff putting up to a year of effort to attain goals in their own time with no reward or acknowledgement until the end of the process.

There was mixed feedback on comparing pay rates with nurses and allied health professionals within DHB settings. While some felt the level of training and autonomy required of physiotherapists meant they should be considered on their own merits, others specifically mentioned being remunerated at the same level as nurses and receiving the same percentage pay increases.

There was also commentary around the salary scale and steps within DHBs, with feedback from those at smaller DHBs that they didn’t do the type of work that warranted top of scale so there was no room for them to move. One interviewee told us of a “senior” physiotherapist at an urban DHB. This DHB has a policy of 0.8 FTE for senior roles, which creates a dilemma whereby they have to choose between moving up in the workforce and earning a pro-rated non-fulltime salary. Another DHB Team Leader talked about therapists working at end-of-scope alongside allied health providers but with no adequate reimbursement for doing so. Another said postgraduate qualifications in clinical roles are not recognised by DHBs in terms of remuneration.

2.2 Recruitment concerns

In the discussion group activity, most recruitment concerns were related to physiotherapists migrating to Australia (addressed in section 2.1) or the lack of a career pathway (addressed in section 4.3), with a smaller number referring to the difficulty in recruiting experienced practitioners and the number of people perceived to be leaving the profession. This was a recurring theme through the focus groups and interviews, with over a third of participants identifying critical recruitment issues with experienced practitioners within their working environment.

Although there are strong relationships between retention of experienced physiotherapists within the profession, career pathway and conditions of employment, feedback on attrition/churn (people leaving the profession) will be addressed in sub-section 4.4. In addition, feedback that specifically addresses rural recruitment will be taken account of in sub-section 2.4. This sub-section will focus specifically on general recruitment challenges, including recruiting for experienced roles.

Feedback

Central Region's Technical Advisory Services Limited (TAS) 2017 report on the DHB physiotherapy workforce stated, "DHBs report that the supply of graduates is sufficient (and increasing) but significant issues are occurring around the recruitment of experienced physiotherapists".⁵ Feedback across all feedback modes supported this finding, with some DHBs and private practices describing long-term vacancies for experienced or roles for specific areas of expertise, with one provincial DHB reporting seven vacancies.

Specific DHB roles referred to included community, mental health, paediatric, women's health, pelvic health, and cardiorespiratory. Paediatric and women's health were particularly highlighted as areas of concerns. One DHB Team Leaders said widespread morale issues across the sector were not helped by DHB levers in recruitment processes (approval of positions and purposefully delaying recruitment). DHB staff talked about the significant flow-on effect to the rest of the workforce and to patients – the term "stretch and cover" was mentioned frequently. They also said vacancies intended to be for experienced practitioners (with 4-5 years of experience) were sometimes filled by physiotherapists with insufficient skills or experience in those roles, which was a risk for patients and the DHBs, and contributed to burn out and early exit of the profession. One provincial DHB said they were trying to recruit for a maternity role, but that it was nearly impossible to recruit for short- or fixed-term outside of metropolitan areas especially for senior or roles for specific areas of expertise.

Private practices reported recruiting constantly through Seek and targeted Facebook advertisements, and two larger group practices had perpetual advertisements in UK professional publications seeking Long Term Skill Shortage Visa applicants. Several private practice owners said the biggest issue they had was staffing and locum work was a particular concern. Most private practices had multiple part-time physiotherapists, but were still short staffed and not filling FTEs. This relates to concerns around remuneration as maintaining CPD and registration on top of family expenses (which for many includes childcare) on a part-time wage is unsustainable.

DHBs reported new graduate roles were relatively easy to recruit for, especially in metropolitan and urban areas, with more difficulty rurally. Several said new graduates came on two year rotational vacancies regularly. Private practices also reported success with recruiting new graduates, with several having formal graduate programmes that included mentoring and additional training.

Related feedback described a lack of collegiality among private practices, with several reports of active "poaching" of experienced staff, especially with experience in pain management and vocational rehabilitation.

⁵ *Strategic Workforce Services – Physiotherapy Workforce Assessment April 2017*. Central Region's Technical Advisory Services Limited (TAS)

Some clinics were attempting to address this with clauses in contracts about where contractors could work, but contractors felt these were undermining their ability to effectively support themselves.

2.2.1 Immigration New Zealand visas

Physiotherapists are listed on the Skilled Migrant Category (SMC) and Long Term Skill Shortage List by Immigration New Zealand (INZ).⁶ Physiotherapy is at ANZSCO level 1 (code 252511). If granted, the initial visa term is two years. Registration with PBNZ is a necessary condition of a visa being granted:

- NZ registration as a physiotherapist in the general scope of practice or the Specialist scope of practice with the Physiotherapy Board of New Zealand (Qualifications in this area of absolute skill shortage are: a bachelor's degree at NZQF Level 7, or higher qualification, which includes the requirements of a major in Physiotherapy – see Note 5)
- Note 5: Where New Zealand registration is specified as a requirement and states “a qualification(s) in this area of absolute skill shortage is/are”, a person only needs to hold the particular New Zealand registration and to have undertaken any necessary work experience in order to meet the requirements of the List. In these cases, qualifications are listed only for the purposes of people applying for work visas under WF4.1.

July 2017 to June 2018 saw a record number of Work Visa’s applied for under the ANZCO standard, after a decline in applications from 2011-14. Eleven percent of applications in the 2017/18 period were declined.

Figure 8: Physiotherapy occupation standard Work Visa principal applicants by year of application decision

	Approved	Declined	Total
2008/09	155	1	156
2009/10	152	0	152
2010/11	109	0	109
2011/12	85	0	85
2012/13	61	3	64
2013/14	89	1	90
2014/15	112	3	115
2015/16	114	4	118
2016/17	126	2	128
2017/18	156	14	170
2018/19 (incomplete)	27	1	28
Totals	1186	29	1215

Source: Immigration New Zealand, Data for period: Date of decision between 1 July 2008 and 30 September 2018

Changes to immigration policy

In November, Immigration NZ announced changes to the remuneration thresholds under the SMC with instructions taking effect from 26 November 2018. For affected employers, these changes may result in:

⁶ <http://skillshortages.immigration.govt.nz/physiotherapist/> Retrieved 19 November 2018

- More frequent labour market tests
- Requests for salary increases, and
- Requests for confirmation of salary to support a SMC visa application.

Applicants under the SMC must be paid at a rate that meets the threshold for their relevant skill level. From 26 November 2018, the threshold for gaining points for skilled employment will increase from \$24.29 to \$25 per hour (\$52,000 per year based on a 40 hour week) for roles that have an ANZSCO skill level of 1, 2 or 3. This is expected to have negligible impact on the recruitment of physiotherapists under the SMC as the average salary is higher than the minimum.

Feedback

Only four people in focus groups or interviews, all private practice owners, discussed recruiting from overseas. One owner said overseas recruitment was necessary due to the difficulty of recruiting for rural positions and commented that it was quite a large cost to the practice. One clinic with ongoing advertisements in the United Kingdom (UK) (with several UK trained staff as a result) said the visa process was painless.

Two other owners indicated that the entire visa process was onerous as applicants needed to be registered with PBNZ before the visa was granted and this could take up to three months. A comment was made that, “PBNZ seem to want to go through every detail of academic record of applicants who have same qualifications as others who already have their APC - this can take months and the visa only takes weeks”. Three people in the Leadership Day activity indicated the DHB they worked for had overseas trained staff, with one person stating their DHB wouldn't be able to offer physiotherapy without them.

PBNZ indicated that the average time for registration assessment (completion and decision), including overseas applicants, is 11.5 days. However, eighty six percent of applications are incomplete with a range of issues that needed to be followed up on, including feedback from education institutions that may no longer be operating, or incomplete work history or referee details. Police checks may expire and need to be reapplied for while seeking these additional details.

Given the small and variable feedback and the high rate of visa application rejection in 2017/18, overseas applicants may need increased support when completing both PBNZ and visa applications to allow for a smoother and shorter recruitment process.

2.3 Conditions of employment

Feedback

Conditions of employment was identified as a personal issue by over a third of focus group and Leadership Day activity participants, and in the majority of email feedback. The term “burnout” was mentioned in over half of all feedback, with fatigue, a lack of feeling valued, increasing workloads and expectations, and feelings of isolation also described by physiotherapists across private practice, NGOs, DHBs and academia.

One person said there was no budget allocation for leave and cover of services at her DHB, and another said staff burnout increased over winter when bed occupancy was high and staff got sick. DHB staff also indicated that workloads increased with student placements and new graduate rotations, and there was no allowance for the increased pressure on service delivery due to mentoring and supervision. Levers, such as annual leave or wellness leave instead of getting burnt out, were mentioned, but there was a consistent concern that when staff take any leave, their colleagues pick up work or patients miss out. They also described burnout at both clinical and leadership level, and many said the chronic understaffing was a contributing factor (see sub-section 2.2).

A senior physiotherapist at a private practice stated, “Physios do a lot of things for intrinsic rewards because our extrinsic rewards aren’t that great” but that came at a cost. Another said she felt like a charity not a professional and was finding it increasingly difficult to manage her own wellbeing. The number of hours people are working with clients, and the number of hours they are also spending on their business, administration, and ongoing education tasks, were of concern for all self-employed and contract physiotherapists. These issues directly relate to the concerns around remuneration and non-billable hours (see sub-section 2.1), and we consider this practice to be a causal factor for burnout.

Academic physiotherapists also described feeling stretched with one saying that an increase in student numbers increased their teaching workload as staff numbers hadn’t increased. They were also still expected to be delivering their previous levels of research. Another person working in an academic environment said they had to maintain their clinical workload on top of increasing administration and teaching, and they weren’t earning much more than a colleague with less than five years’ experience.

In reference to supervision, several people said physiotherapists across the spectrum should have mandatory and funded professional and clinical supervision due to the nature of the work. However, some expressed concerns about their reputation with fears around confidentiality and professionalism.

2.4 Issues around location

All email feedback from physiotherapists from rural areas or small towns communicated that they felt their issues were different from metropolitan issues, and their perspective was often excluded. Some Leadership Day activity participants also indicated specific concerns. Consequently, we have carved this feedback into separate sub-section as these issues in a rural context may require different solutions.

Feedback

Eighty one percent of physiotherapists work in metropolitan and main urban centres, and there is a big discrepancy in the ratio of physiotherapists to population in rural areas. Email feedback from rural physiotherapists described significant shortages and difficulties in attracting applicants for advertised positions that have worsened the past few years.

One private practice owner in Canterbury said, “When recently advertising in our (rural) and (metropolitan) clinics, we had 7 applicants for our (metropolitan) clinic and none for our (rural) clinic”. Another clinic in Otago offered considerable incentives for successful candidates including relocation allowances, retainers and sign on and travel bonuses, but found new graduates don't want to work rurally unless they've grown up in an area or have a partner there, and more experienced physiotherapists are often established in their area and aren't looking to move.

A physiotherapist in Southland said the DHB had only been fully staffed twice in the past 13 years; once for 6 months and once for 12 months, and there was a two year period with no applicants for advertised positions. There are 12-18 month waits for outpatient and specific clinical expertise physiotherapy services as a result. A West Coast physiotherapist expressed concern about paediatric physiotherapy shortages across the country, and the impact of this on patients.

Rural practitioners spoke of having to be generalists due to the difficulty in recruiting those with specific areas of expertise. They felt higher levels of competency were expected as a result. They also indicated a lack of peer support due to often being isolated.

In email feedback, rural practice owners said they struggled to recruit due to new graduates desire to find employment in metropolitan areas. A private practice in Southland advertised a partnership two years ago with no applications. In verbal conversations, possible applicants stated the thought of moving to Southland was “off-

putting". Another rural practice in the area offered substantially more than the average Auckland new graduate would receive plus considerable incentives, however the two applicants they initially spoke to signed contracts with metropolitan employers and they were not able to fill this vacancy. One rural DHB offers higher salaries than metropolitan DHBs for new graduates, but is also still struggling to fill vacancies.

At the other end of the spectrum, Auckland physiotherapists referred to the high cost of living as a barrier to staying in the profession, and described a "cut-throat" private practice landscape. In Christchurch, the ongoing impact of the earthquakes on population health and wellbeing was mentioned, with no access to additional funding, support or supervision for dealing with patients with chronic psychosocial comorbidities.

3 Funding models

Funding models, especially health funding managed by ACC and MOH, directly contribute to some of the workforce issues of most concern, particularly remuneration, retention and working conditions.

3.1 Feedback

Among the 21 focus groups participants who identified funding models as an issue, 95 percent said funding was an industry wide concern, with 5 percent considering them contextual, ie their own workplace setting. Funding was also widely referred to by interview and Leadership Day activity participants, and in email feedback.

Some felt the practice of physiotherapy had become shaped by institutional and financial drivers from funders, including ACC, MOH, and DHB, and education and research providers, as well as larger groups or networks of private practices. Many expressed concern that smaller practices were unsustainable in the current environment. Business owners often said they were overworked, stressed and undervalued. Others looked to dentistry, pharmacy and audiology with similar consolidated group models, and said efficiencies from economies of scale was the only way private practice could work under ACC levels of funding.

For many, the funding landscape determined what clients and conditions could be treated, with narrowly focused treatments in short time periods across all sectors, and limited funding for chronic conditions despite considerable evidence of physiotherapy's efficacy. Osteoarthritis was mentioned several times as an example, with feedback of research showing physiotherapy driven drug-free treatment plans with advice, education and self-management having better outcomes than medication, but there was no funding for this. However, there was also feedback that there was too much focus on chronic conditions and not enough on non-communicable diseases, such as obesity and diabetes.

There was a call for more lobbying or advocacy by PNZ and PBNZ directly with ACC, MOH, Primary Health Organisations (PHOs) and insurance companies, to increase current funding rates, widen the scope of treatments that could be provided, and seek funding from new sources. Insurance was mentioned by a few people with comments that private health insurance often doesn't include physiotherapy but it will include acupuncture or massage. Others felt PNZ and PBNZ weren't unions, therefore had limited power to be lobbying in this space. Many shared it was up to the profession itself to be more collegial and band together. One email respondent stated, "This is something we, the NZ physiotherapy profession, needs to sort for ourselves...hopefully the profession has developed the maturity required to do the necessary soul searching and do the necessary work...to survive". Another said it concerned them that there was a lot of angst and division in the profession and "we do not always present as a united front".

3.2 ACC

The different contractual models with ACC were contentious within one focus group and with some interview participants and email feedback expressing polarised views. Evaluating the pros and cons of the current ACC contractual models in any depth is outside the scope of this research, but it is clear that the two approaches generate a lot of feeling and disagreement within the physiotherapy community.

Some comments on the overall ACC funding strategy include:

- Reimbursement doesn't reflect actual time spent with and on patient - the time required to fully assess (including physical and psychosocial issues), clinically reason, communicate with patient, problem-solve, work on activity management and self-management, and develop an effective rehabilitation regime along with motivational education, is not accounted for

- No incentive for quality treatment or outcomes (“number of treatments/patients more highly valued than quality of care”)
- No variability in funding for location with metropolitan clinics under pressure due to higher costs
- No differentiation in reimbursement for qualification and expertise
- Limitations on what can be treated:
 - Default to injury treatment rather than rehabilitation or exercise as medicine (“we often treat the worried well”, “we treat injuries that would probably have gotten better by themselves anyway”)
 - Limitations for treatment injury and sexual assault claims
 - No recognition of the value of physiotherapy input after injury or PTSD to manage stress and anxiety
 - No funding for prevention or wellness
 - An overreliance on imaging findings over clinical examinations, with cover declined when degeneration (a normal aging process) is found on imaging
 - ACC funded group classes only available to post-surgical patients
 - No funding available for green prescriptions by physiotherapists
- No way to fund treatments for patients who need care but can’t afford the co-payments
- Creates division and competition between private practices, and encourages fraudulent behaviour like over-invoicing or overworking/patient churn
- No incentive for multi-disciplinary care models.

There was an overwhelming sentiment that ACC has been able to dictate the nature of private practice physiotherapy, rather than being informed by best practice treatment and prevention, and the model was system-based rather than patient-centered.

3.3 Public health funding

Public health funding discussed here refers to funding from Vote Health, including DHBs and MOH service contracts with rest home, palliative care services, and other providers. We had limited feedback from physiotherapists working in public health outside of DHBs so have consolidated feedback here to maintain confidentiality.

Comments regarding DHB funding frequently referred to significant waitlists to access public health treatments, due to chronic understaffing or a scarcity of experienced staff in the sector. There was also considerable concern that underfunding was generating a public safety issue by creating sub-optimal safe physiotherapy practice as the norm. DHB patients were perceived to receive a raw deal due to lack of funding and lack of choice, contributing to population health inequities as those who can afford to access treatment faster, go private and self-fund.

There was a concern that the MOH infrastructure and funding model will not cope with population health needs, especially around the clinicity of living older. Physiotherapists in rest homes spoke of the lack of funding from DHBs once an older patient moved to a rest home level of care, and the pressure this placed on rest home physiotherapists. Email feedback spoke of the need for new models of funding and healthcare that are sustainable for an aging population with complex health needs.

MOH drivers were questioned with some stating that funding practices and models of care often don't fund, recognise or utilise allied health well. This was reflected in the lack of recognition of the importance of physiotherapy in primary health despite being evidence proven, and in the perceived lack of funding in public health for prevention and chronic disease management.

4 The physiotherapist's journey

Within this section, we explore the physiotherapy career landscape, including tertiary education, registration and CPD, career path, and retention and attrition.

4.1 Training providers

We spoke to representatives of Auckland University of Technology (AUT), University of Otago (Otago), and Wintec. Representatives spoke of the changing needs of undergraduates, with higher levels of stress and mental health concerns due to greater expectations in the university system. They also reflected on gaps in communication skills, with speculation that this was due to increasing time on devices both in academic and personal settings. There was a feeling that the curriculum was missing an emphasis on improving interpersonal communication skills and health promotion, as well as some focus on management skills.

There has been growth in postgraduate enrolment overall, with focus shifting from manipulative therapy to rehabilitation, and significantly smaller wait lists for manipulative therapy papers as a result. This is believed to be driven by the marketplace and funding models.

4.1.1 Training provider enrolments

There has been an overall decrease in physiotherapy qualifications, predominantly driven by decreases in enrolments at Otago, which dropped 8 percent from 2008-17, with an 11 percent reduction in undergraduate enrolments. AUT has seen a significant increase in that same period, largely in undergraduate enrolments with 12 percent growth from 2008-17. Honours enrolment has been consistent since being introduced in 2012, with up to seven enrolments each year. Supply of graduate physiotherapists appears to be stable.

Figure 9: Overall enrolments in physiotherapy qualifications

	2008	2015	2016	2017	Change 2008 to 2017
University of Otago	464	464	482	429	-8%
Auckland University of Technology	611	776	763	621	2%
Total students	1,075	1,240	1,245	1,050	-2%

Figure 10: Enrolments in Bachelor-level physiotherapy qualifications

	2008	2015	2016	2017	Change 2008 to 2017
University of Otago	415	395	415	370	-11%
Auckland University of Technology	530	580	595	595	12%
Total students	945	975	1,010	965	2%

Waikato Institute of Technology (Wintec)

From 2019, there will be three undergraduate physiotherapy education providers, taking New Zealand from one school per 2.45 million people to one school per 1.63 million people, in line with OECD countries such as Australia, Canada and Ireland. After extensive research, stakeholder consultation, and a comprehensive accreditation and approval process with PBNZ and NZQA, the Waikato Institute of Technology (Wintec) will offer a Bachelor of Physiotherapy to an initial intake of approximately 25 students.

The number of Māori and Pasifika in physiotherapy is low compared to general population representation, and Wintec has been working with a wide range of stakeholders to encourage Māori and Pasifika secondary school students into tertiary health education, including physiotherapy, through initiatives such as Kia Ora Hauora, Puna Waiora and WhyOra. By offering local opportunities for local students, Wintec is aiming for 50 percent Māori and/or Pasifika representation in the first year.

The curriculum has a focus on developing culturally responsive practitioners through the inclusion of Te Tiriti o Waitangi, Te Reo Māori and Tikanga Māori teaching and learning opportunities in all years of the programme and students will benefit from wānanga and noho at Wintec's on-campus Te Kōpū Mānia marae. Ongoing cultural exposure and interprofessional education including the importance of psychosocial considerations and a focus on community health and health equity are also prioritised.

Clinical placements will occur across the Midlands region and Hawkes Bay, with DHBs and private practices similar to the current training providers, and with observations beginning in the first year of study. If students are from an area, they're more likely to be placed there in order to support the workforce pipeline, but may need to go further afield at times to gain a more rounded range of clinical experiences. In order to support quality clinical health placements, Wintec has established a number of dedicated education units in partnership with providers such as the Waikato DHB, and considers these important investments to support the physiotherapy workforce in mentoring students.

4.1.2 Placements

Feedback

There were varying perspectives on the placement experience across the training providers and from the physiotherapy community, including a very small cohort of new graduates. Staffing levels in DHBs and private practices directly impact the ability of the providers to obtain and maintain ongoing placement opportunities for students, creating some tension with placement availability. In some cases, chronic understaffing and under-resourcing had a direct impact on the placement experience, as heavy workloads take priority over supervising students.

In DHBs, taking students can add to a practitioners' stress, and there were anecdotes of new graduates supervising undergraduates because there are no experienced clinicians. In private practice, students require experienced supervision but it is not financially viable to have a lot of hands on contact due to the funding model not allowing for the increased time taken. Consistent feedback was that students are frequently being provided observation or administration experiences or more than practical hands-on experiences. There was consensus that new graduates have a good standard of skills and competences, but that not all students have enough variety in their placements and the type of work they undertake their clinical placement in may not sync well with the type of work they end up doing. This may impact their level of job satisfaction in the crucial early years after graduation.

4.2 PBNZ registration

4.2.1 Feedback

“The registration costs and professional costs for physiotherapy keep going up, while the remuneration would appear to have gone backwards”.

Feedback around registration was that it was largely a personal issue and dependent on circumstances. The majority of negative feedback was around the cost of maintaining registration, with physiotherapists with overseas qualifications and those working part-time feeling the burden the greatest.

One overseas physiotherapist with a PhD is working as an aide due to the challenge and cost, and another said the overseas registration instructions weren't clear enough and they'd received information on criteria after submitting their application. A DHB Team Leader said they were having to look overseas to fill experienced and roles with specific areas of expertise, and found the PBNZ process overly complicated due to difficulties supplying the historical information required. An applicant for a DHB role with a specific area of expertise that had been vacant for over a year was “struggling to get registered” despite 25 years of UK experience.

For part-timers, many felt penalised by taking parental leave and challenged with returning to work, both with the costs of maintaining registration, with continuing CPD while not working, and with the “Return to Practice” application process. Given the demographic of current physiotherapy workforce, this is a consideration regarding encouraging retention of experienced practitioners with the profession.

4.2.2 Continuing Professional Development

The PBNZ website states the following regarding Continuing Professional Development (CPD):

- The current recertification audit programme requirements are:
 - Minimum 100 formally recorded CPD hours per three year cycle
 - Minimum of 20 formally recorded CPD hours in any one year
 - At least one CPD activity in each learning category over the three year cycle
 - Anyone who gets an APC partway through the audit cycle will have proportionally less hours of CPD to show if they are selected for audit
 - Use the Board's log book for documenting your CPD
 - Reflective practice demonstrated by reflective statements
 - Retain supporting personalised evidence – 5 pieces from a cross-section of the professional development logged in the four learning categories
 - One Professional Peer Review per three year cycle.

Feedback

While those who discussed issues around CPD felt development activities were necessary, the majority indicated the time and financial commitment required to maintain registration was a struggle. CPD opportunities often require two or three nights' accommodation, course fees, travel and time off work (often taken as leave) and family commitments. This is a barrier for some as they live too far from where the CPD is held, and it is a barrier for others who are part-time or working as contractors as they are not paid for their time while at CPD trainings and have to pay for the CPD themselves. This also creates a financial disincentive, and decreases their effective

hourly rate further. To increase accessibility, people requested more flexible ways of accessing CPD, such as the facility to attend workshops through virtual/online platforms.

Three DHB physiotherapists (from different regions) indicated that they needed to apply for professional development funding in a competitive process where only one physiotherapist attended trainings and subsequently fed back to the rest of their team. There was a desire expressed for individualised funding to support more effective learning and clinical practice.

4.2.3 Specialist Scope of Practice

An amendment to the Health Practitioners Competence Assurance Act 2003 (HPCA) specifying a new scope of practice, that of Physiotherapy Specialist, took effect from 1 January 2013.⁷ The Physiotherapy Specialist scope of practice and registration recognises physiotherapists who are practising at an advanced level, and are expected to demonstrate advanced clinical skills and knowledge, and contribute to the profession through leadership and research. Applying for registration as a Physiotherapy Specialist is a three-part process entailing a portfolio assessment, a practical clinical assessment and a panel review. As at 16 November 2018, there were eight Physiotherapy Specialists registered with PBNZ.

Feedback

There was some confusion in focus groups and interviews as to the purpose and value of the Physiotherapy Specialist scope. One private practice employee said it was meant to be a step towards improved reimbursement from payers, but criteria was not representative of specific areas of expertise and excellent clinical physiotherapists were not able to be Specialists due to the narrow criteria. Another private practice owner said that it was for academic practitioners and did not provide any clarity on seniority or experience. Most other participants said there was no incentive to undertake a lengthy and expensive assessment and registration process as funding models did not allow for reimbursing Specialists at a higher rate anyway.

Leadership Day activity participants also indicated concern or misunderstanding about the Specialist scope. Some said the scope was linked only to postgraduate study so did not seem aware of the clinical practice requirement, while a few felt that a “lifetime of experience in a specialised treatment area” did not enable them to apply for Specialist registration. There was a call to have a stepping stone between general and Specialist registration, ie Advanced Practitioner, which may recognise experience and career progress.

Neither of the training providers had noticed an increase in postgraduate enrolments subsequent to the HPCA amendment, and one provider said postgraduate study was driven more by the market seeking a specific clinical skillset. No private practice owners indicated they had hired someone with this registration, however given the small pool of Specialists, this is not statistically significant.

PBNZ agreed there was a misperception that Physiotherapy Specialist registration was for academics, but only one of the eight currently registered was employed by an academic institution and they also had a full clinical workload. Rather, it is intended as a clinical scope of practice for practitioners at the top of their game with a minimum of six years FTE clinical practice in the last 10 years, with four of those years in their nominated speciality, with the purpose of assuring the public that registered Physiotherapy Specialists have been through a suitable robust process.

4.3 Career pathway

Lack of a universal career path was identified as a concern by all focus group participants and received substantial feedback in the Leadership Day activity. Some private practice owners described formal graduate programmes,

⁷ <https://gazette.govt.nz/notice/id/2012-gs6993> Retrieved 20 November 2018

but there didn't appear to be a structure after that. Within DHBs, there was mention of two year rotational programmes, otherwise it appeared physiotherapists would stay in a rotation until a vacancy came up. Concerns were expressed about the consistency of new graduate programmes, ie how competencies are tested, quality of mentoring and support for mentors.

There is a huge question about what happens after these two year programmes across all sectors, with feedback including:

- “You have to make it up yourself”
- A perception that undergraduate students are unaware of the depth of physiotherapy and are focused on musculoskeletal physiotherapy, so they are not encouraged to consider different specialities earlier in their study
- No clear way to move to different scopes, a concern given the shortages in some specialities such as paediatrics and mental health, with
- Gaps between new graduates and experienced physiotherapists, what happens in the 2-6 year “intermediate” period
- Getting “stuck” in a framework defined by the employer with little succession planning in place in practices or DHBs (although larger DHBs were said to have more of a framework or pathway)
- Lack of clarity of what is considered a “senior” physiotherapist
- Lack of alternatives to career advancement outside of management or business ownership.

A clear career path helps with “stickiness” in a profession, and supports re-entry back into the occupation as it is clearer what their entry point is. We will discuss this point in our recommendations in section 7.

4.4 Retention and attrition

Physiotherapists staying in (retention) or leaving the profession (attrition) were identified as concerns by the majority of people who fed back. Based on this feedback, there appears to be two primary exit points; within the first two years, and at 4-6 years. The limited scope of the study and the nature of self-selecting for stakeholder engagement means that we were not able to investigate why people leave the profession and we had limited feedback from new graduates.

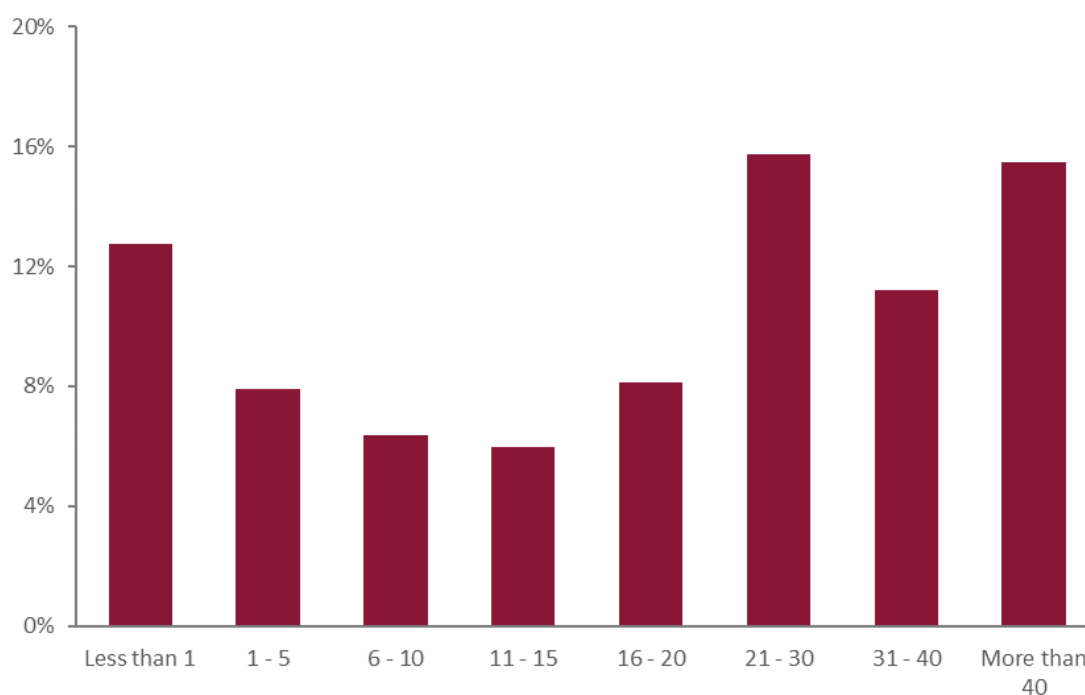
The growth in the aged care section was discussed in relation to retention and attrition with new graduates, with many describing how new graduates get disgruntled when working with older people or those with strokes for example, when they've come in to physiotherapy expecting to work with high performing athletes. Anecdotally, we heard stories of recent graduates completely changing careers in first 2-3 and sometimes retraining in different fields. Several senior physiotherapists highlighted that physiotherapy attracts bright and capable people who have the ability to make different choices, and there was a feeling that there is a growing generational gap with the younger workforce having different drivers around personal growth and different work ethics and motivations that are not recognised in the current employment landscape.

None of the new graduates we spoke to felt optimistic about the profession, with one stating, “There are few positive aspects of working as a physio in private practice as a relatively new grad and now part-timer”. Another new grad described feeling bitter and “like I've been sold a lemon”, as the reality of physiotherapist work was not what she'd expected. Most new graduates said they weren't prepared for the heavy workloads or the psychosocial aspect of face-to-face client interaction, although some experienced physiotherapists said this was impossible to teach academically.

We were told that the average career length clinically is <7yrs with people moving into management or going on parental leave and either not returning or returning in different role. This has led to a shortage of “mid-tier” experience reflected in the competitive job market and workforce shortages of experienced physiotherapists at this level across sectors. We had feedback that there is little incentive for experienced physiotherapists, especially those with Masters degrees, to return to part-time work given the time and financial costs of registration, CPD, and childcare. Given the high numbers of women in the physiotherapy workforce, flexible and supportive working environments with appropriate remuneration are imperative to retaining experienced physiotherapists in the profession.

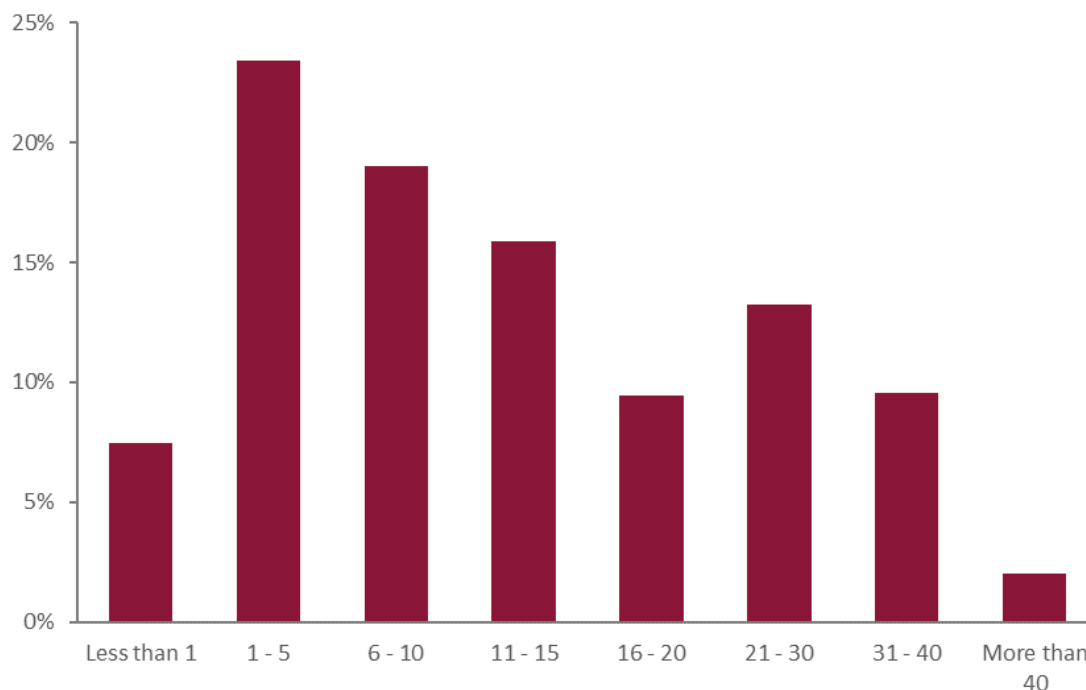
Figure 11 shows the length of time of PBNZ registration with 60 percent being registered for 11 or more years, 23 percent less than 5 years, and 17 percent for 6-10 years.

Figure 11: Length of time (in years) registered with PBNZ at 31 May 2018



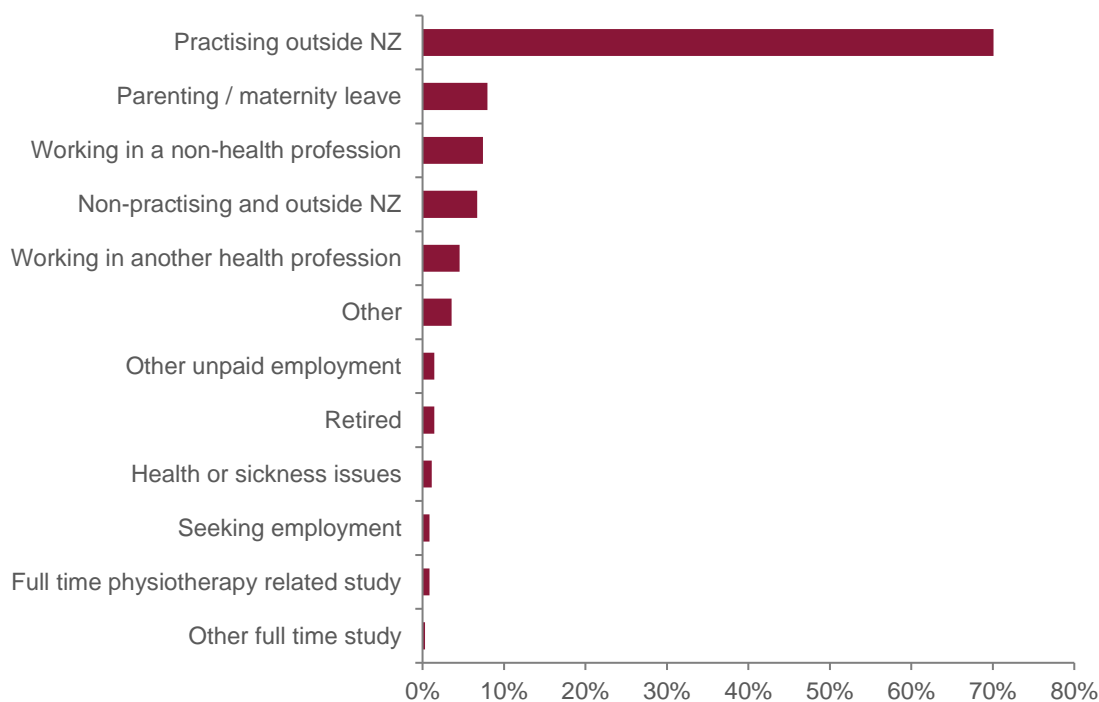
Fifty percent of those registered with PBNZ had 11 or more years of physiotherapy experience in New Zealand with 30 percent having less than 5 years, and 19 percent having 6-10 years (Figure 12). Figure 11 also includes those registered with PBNZ who have not practiced in New Zealand, so it is difficult to align the two sets of data exactly. However, there is enough correspondence between the two datasets to broadly support the anecdotal feedback of a mid-tier (6-10 years experience and registration) shortage.

Figure 12: Years of physiotherapy practice within New Zealand at 31 May 2018



The Workforce Survey also asked the 702 respondents who were not holding an APC their reasons for not doing so (Figure 13). The vast majority (70 percent) were practicing overseas with 12 percent working in non-health or another health profession, and 8 percent being on leave related to parenting.

Figure 13: Reasons for not holding an Annual Practicing Certificate (at 31 May 2018)



5 Emerging issues

5.1 Change – clients and ways of working

There was a range of feedback about change and disruption with comments like, “We have to get our head around there being other ways to do things”. Within this section, we share feedback on how client expectations and needs are changing around health in general and what positive disruptors exist creating opportunities for physiotherapy.

5.1.1 Clients

In section 3 we shared feedback on how funding models limit or constrain who and what can be treated. In this sub-section, we include observations on changing consumer expectations and opportunities from this. Responses included:

- Clients come after consulting “Dr Google”, they already think they know what their diagnosis is and have expectations around what treatment they’ll receive
- Clients are often busy and don’t want to travel distances between different types of health practitioner or to search out who they should see, they want one-stop shops (multidisciplinary centres)
- Seeing changes in health expectations as people age – they want to be physically fit and active so there are huge opportunities to improve health issues
- Opportunities to diversify offerings outside of current funding models, such as
 - Corporate programmes and workplace education – some practices are using funding from these types of programmes to support clinic operations
 - Community exercise classes – physiotherapy-based exercises have more evidence and safety than community yoga or Pilates classes
 - Health coaching – focusing on wellbeing and quality of life.

5.1.2 Ways of working

Alongside the opportunities around working with clients, there are opportunities in how services can be provided. The two most commonly mentioned positive disruptors were technology and collaboration.

Telehealth, in particular, was mentioned as a positive disruptor. For example clients could be given online exercises and have weekly Skype sessions, with a face-to-face session every 4-6 weeks for physical assessment. This was considered more palatable for rural clients and using technology platforms to change the way physiotherapy is delivered may also make better use of senior staff and address mid-tier shortage issues.

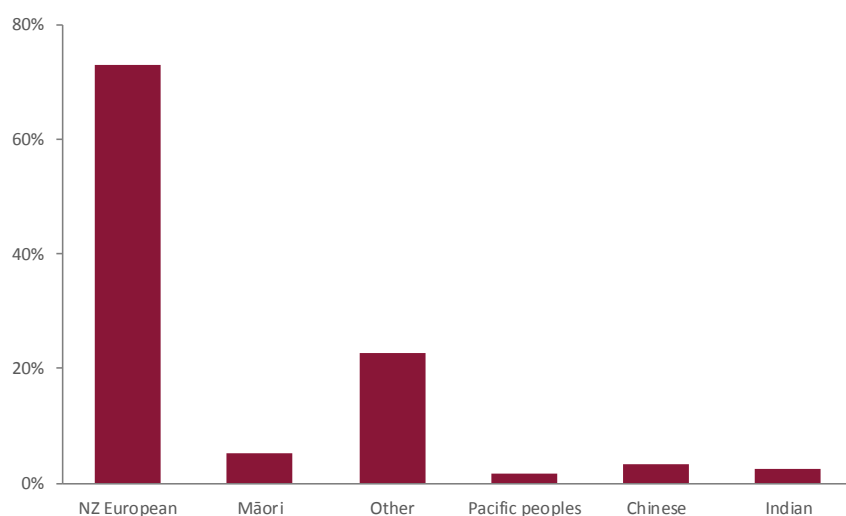
Collaboration between physiotherapists and across allied health was also brought up. Feedback included collective databases that scale client severity, IT shared records and care plans, and collaborative practice with other physios and across other disciplines. There was a call for true multidisciplinary teams focused on patient/client-centered service delivery and outcomes across primary and tertiary care, and across public and private sectors. We received some feedback that there was potential to develop allied health with the new disability funding model.

5.2 Improving diversity in the pipeline

5.2.1 Ethnic diversity

Ethnic representation of registered physiotherapists is 4.9 percent Māori, 1.5 percent Pasifika and 5.2 percent Asian (see Figure 14), compared to 2013 Census results of 16 percent Māori, 8 percent Pasifika and 12 percent Asian.⁸ These figures are all expected to increase over the next 20 years.⁹ Overseas research has shown that inequities in health are connected to ethnic and racial diversity among healthcare professionals, with increased diversity linked to improved healthcare access and health outcomes, more patient-centred care, and enhanced patient-clinician communication, and ethnic bias can affect decision-making in healthcare professionals.^{10 11}

Figure 14: Ethnicity of physiotherapists registered with PBNZ at 31 May 2018



New Zealand research on Māori participation in the physiotherapy workforce noted Māori underrepresentation in the physiotherapy workforce was of particular concern given that Māori have disproportionately high health need, and have expressed preferences for Māori practitioners.¹² Research on cultural competency indicated that enhanced cultural competence would enable physiotherapists to better contribute to addressing longstanding inequalities in health, ethnicity as a determinant of health, and differential access to physiotherapy care.¹³

Feedback

Diversity was the least identified issue among the focus groups with 14 of the 22 participants considering it an issue overall, and nine of those seeing it as a workplace concern rather than an industry one. Most of the feedback on increasing diversity in the Leadership Day activity focused on increasing participation of rural

⁸ www.stats.govt.nz/information-releases/national-ethnic-population-projections-2013base2038-update Retrieved 28 November 2018

⁹ Ethnic population estimates overlap because people can and do identify with multiple ethnicities. As a result, the ethnic shares sum to more than 100 percent.

¹⁰ <http://www.aapcho.org/wp/wp-content/uploads/2012/11/NeedForDiversityHealthCareWorkforce.pdf> Retrieved 21 November 2018

¹¹ https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_23_Apr_2016.pdf Retrieved 21 November 2018

¹² Wikaire, Erena & Ratima, Mihi. (2011). *Māori participation in the physiotherapy workforce*. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 9(2). 473-495.

¹³ Ratima, Mihi & Waetford, Cathrine & Wikaire, Erena. (2006). *Cultural competence for physiotherapists: Reducing inequalities in health between Māori and non-Māori*. New Zealand Journal of Physiotherapy. 34.

students in placements, with only 1/18 post-it notes explicitly mentioning ethnicity/culture and none mentioning gender.

However, we consider the minimal ethnic diversity in the focus groups and at the Leadership Day activity to have skewed the feedback. Among Māori, Asian and Pasifika physiotherapists who we spoke to outside of these forums, there was consistent feedback of institutional racism, unconscious ethnic bias, and loneliness, and of feeling they needed to “shut down culture to survive in those roles”. In general, they felt workplace culture was a very real, and frequently negative, influence in retaining these physiotherapists.

One new Pasifika graduate was constantly asked if she received preferential entry to her University and would hear fellow students talk about how Māori and Pasifika wouldn't have “gotten in” otherwise. Another recent Māori graduate said the cultural support promised by her DHB was on paper only and she had no one to turn to when she experienced racism from patients or colleagues.

This issue is not confined to physiotherapists and is a broader issue in the health workforce. But the stakeholders we spoke to said this was not an excuse, and they called on the profession to make itself more amenable to a wider range of ethnicities. They also suggested increasing cultural competency education in undergraduate degrees and CPD, and integrating cultural competency, in particular understanding of tikanga (Māori protocol), in workplaces so Māori and Pasifika feel more accepted and are more likely to stay in the profession. In addition, Māori and Pasifika clients will feel more understood and welcomed. As one practitioner said, “Cultural competence is a life long journey and is based on listening, respect, and preparedness to be innovative.”

5.2.2 Gender diversity

Physiotherapy is heavily dominated by women, with 76 percent of physiotherapists registered with being women (see Figure 15). New Zealand is not alone in this position. In the UK, 76 percent of Chartered Society of Physiotherapy members are women¹⁴, and in Australia, 67 percent of physiotherapists registered with the Physiotherapy Board of Australia at 30 September 2018 were women.¹⁵

While increasing numbers of women are training in the health workforce across specialities, not just allied health or physiotherapy, of concern is the disparity between the gender balance of registered physiotherapists and the gender balance of enrolled students (see Figure 16). This figure is reflective of enrolment data from 2008-17. On analysis, the highest percentage of men registered with PBNZ is in the 20-34 year age range (27 percent) with the percentage lowering through the age groups to 18.9 percent of 55-64 year olds.

¹⁴ www.csp.org.uk/news/2018-03-08-profession-marks-phenomenal-women-physiotherapy-international-womens-day
Retrieved 28 November 2018

¹⁵ www.physiotherapyboard.gov.au/about/statistics.aspx Retrieved 28 November 2018

Figure 15: Gender of physiotherapists registered with PBNZ at 31 May 2018

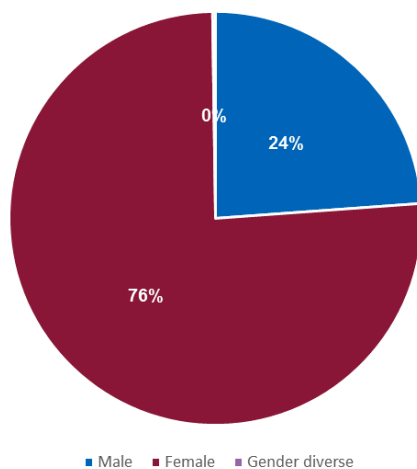
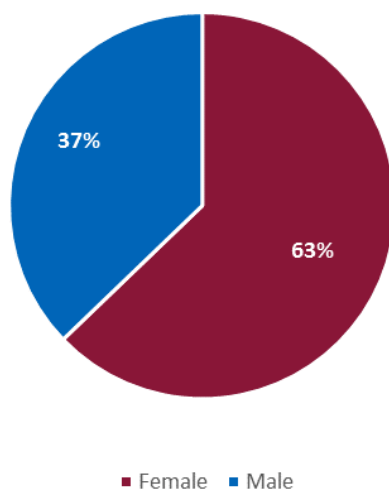


Figure 16: Gender of students enrolled in physiotherapy degrees at 2017



Feedback

One third of focus group participants were men, and one quarter of stakeholder interviews were with men, giving a reasonably representative sample. In our stakeholder engagement, men reported feeling the pressure of social expectations to be the breadwinner. Remuneration was identified as a significant feature in more men leaving physiotherapy, and it was argued this is a reason that men leave the profession due to not earning enough to support their families, and women stay on because they are in a position of not being the sole income earner in their family unit. We heard several anecdotes of young male graduates feeling disillusioned and re-training within the first two years, and of more experienced male physiotherapists becoming real estate agents or selling orthopaedic and orthotic devices in order to “support their families”. No feedback on increasing diversity in the Leadership Day activity referred to increasing men in the profession.

6 Workforce data

The following figures include information sourced from the 2018 PBNZ Workforce Survey of registered physiotherapists. They paint a picture of a workforce predominantly employed in private practice or hospital or health services (80 percent) Figure 17, with 46 percent working more than 40 hours per week (Figure 18). Although some feedback was that physiotherapy is an aging workforce, Figure 19 shows that statistically, two thirds are under 44 years of age (65 percent). Nearly half have Bachelor's degrees as their highest qualification (47 percent), with only fractionally less having postgraduate qualifications (43 percent) (Figure 20). Figure 21 shows a decline in the rate of postgraduate qualifications at initial registration since the 1990s. This may be the influence of government policy regarding student loans, or it may be market-driven, but it is difficult to make a conclusion without further research.

6.1 Employment

Figure 17: Employment type of physiotherapists registered with PBNZ at 31 May 2018

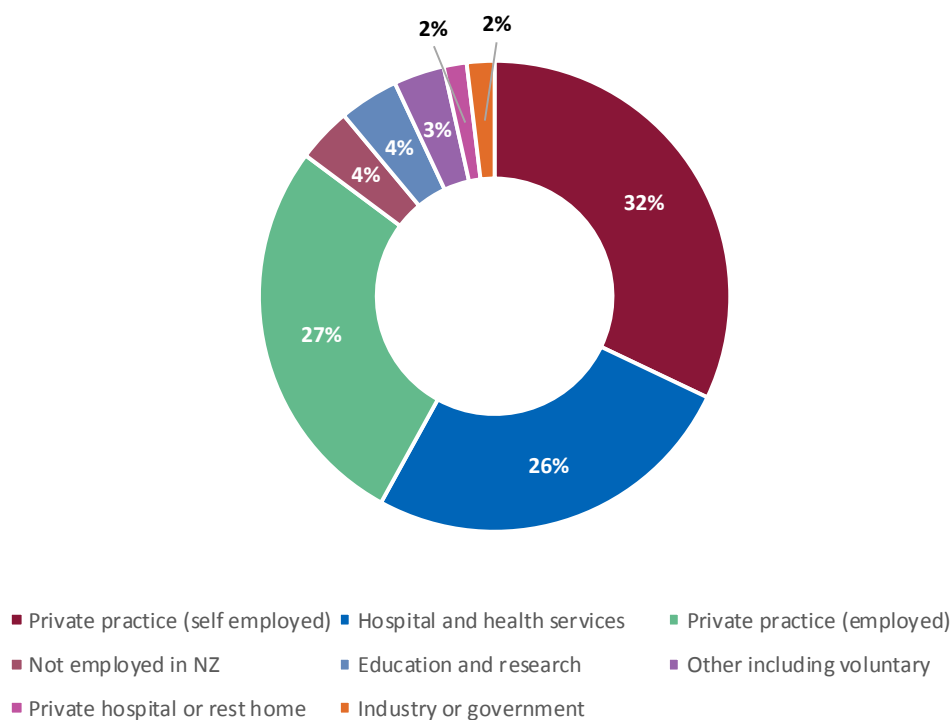


Figure 18: Average weekly hours worked (from PBNZ at 31 May 2018)

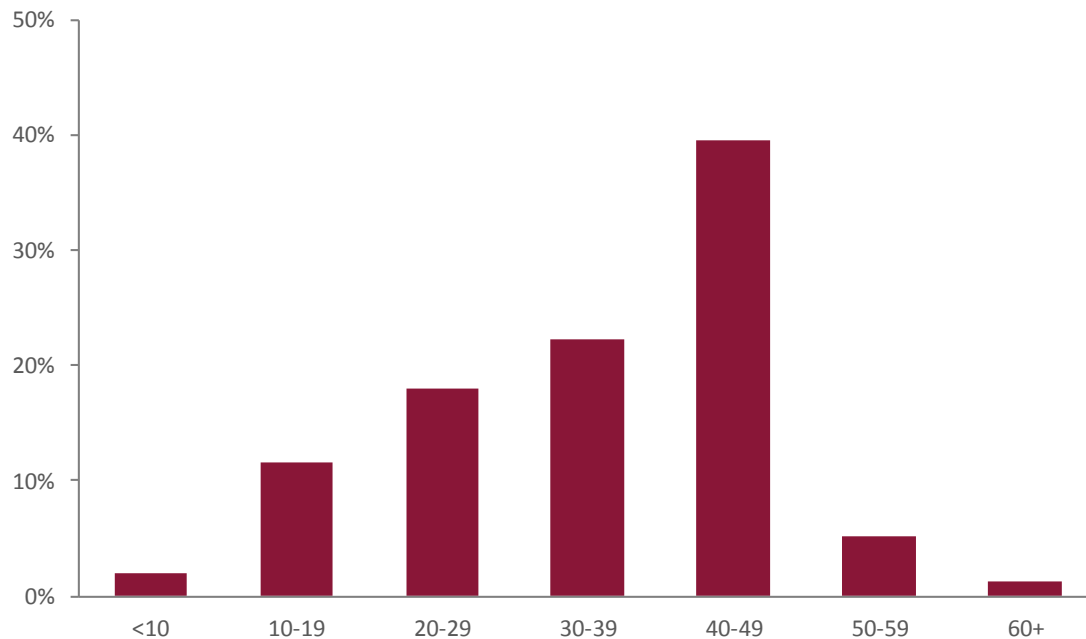
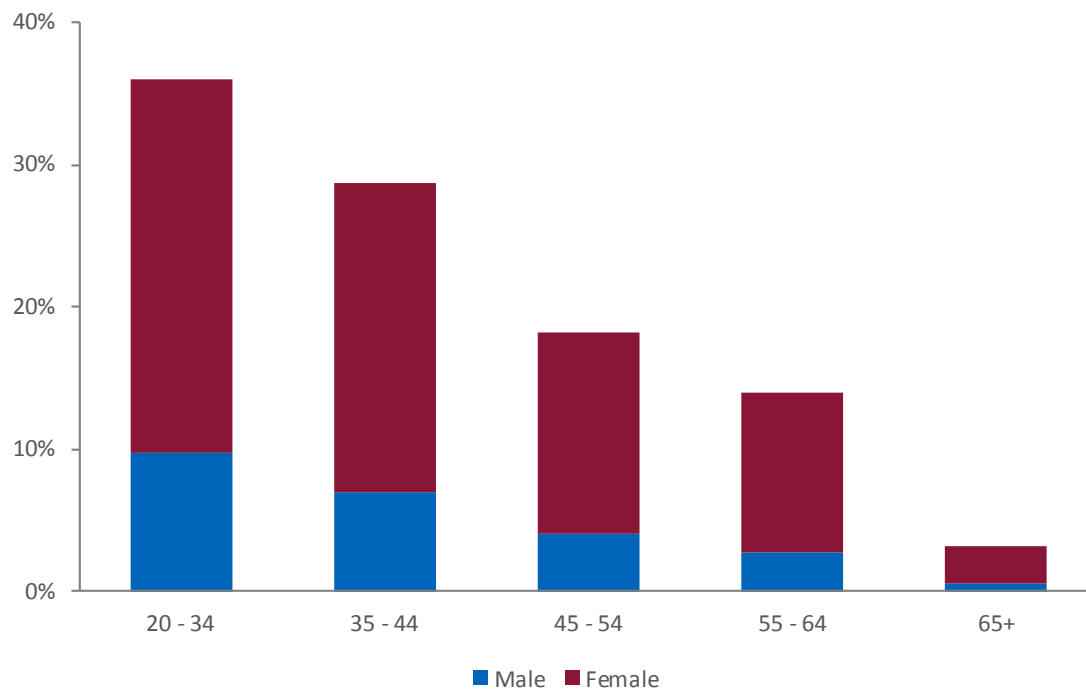


Figure 19: Age of physiotherapists registered with PBNZ at 31 May 2018



6.2 Qualifications

Figure 20: Highest qualification of physiotherapists registered with PBNZ at 31 May 2018

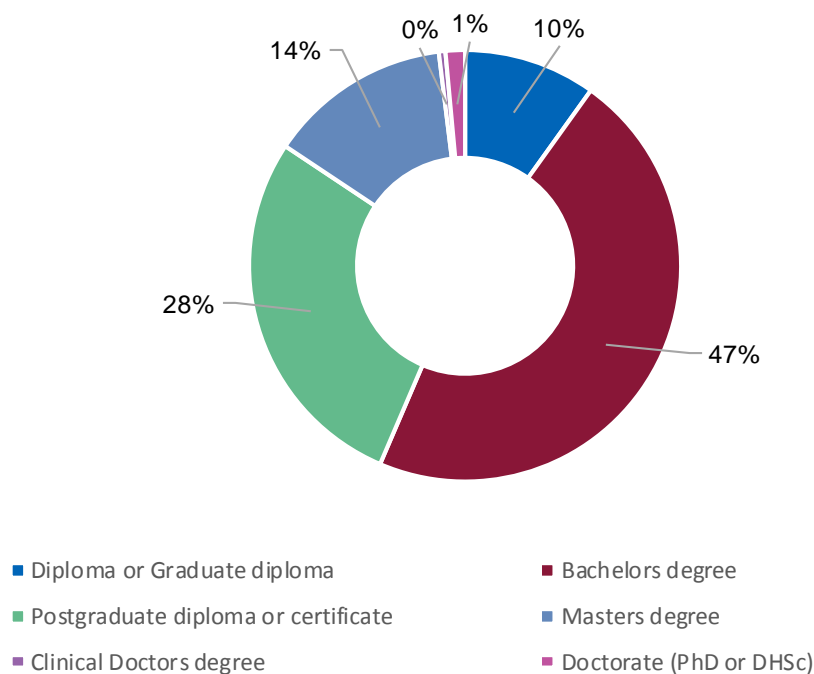
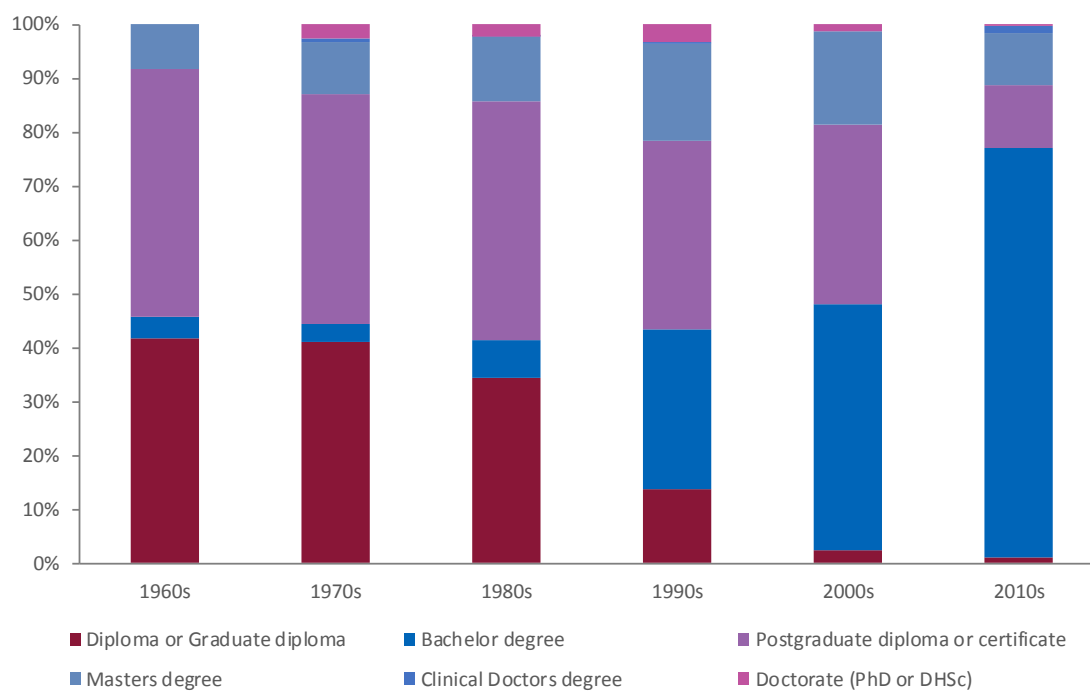


Figure 21: Qualifications by decade first registered (from PBNZ at 31 May 2018)



7 Recommendations

We consider that many of the workforce issues identified through this research could be addressed through the activities of key priorities in PNZ's Advocacy Strategy for 2018-20. Our recommendations will therefore be described under each of the priority headings.

7.1 Implement Stakeholder Relationship Plan

To position PNZ as the leading voice for physiotherapy and promoting physiotherapy as an evidence based option to meet identified needs whilst positioning PNZ members as leaders of excellence within the profession.

Changing demographics and population health needs may require a clearer positioning of what physiotherapy is and the breadth of conditions with considerable evidence of physiotherapy's efficacy in treating. Raising the profile of physiotherapy through effective external stakeholder mapping and relationship building is a space PNZ could increase activity in, including promoting physiotherapists' abilities to diagnose and clinically reason, and communicating the different areas of clinical expertise they are involved in.

There was a call for more lobbying or advocacy by PNZ with stakeholders to increase current funding rates, widen the scope of treatments that could be provided, and seek funding from new sources. Insurance was mentioned in feedback with comments that private health insurance often doesn't include physiotherapy but will include acupuncture or massage. Southern Cross, Sovereign and nib are among the large private health insurance providers that include physiotherapy in health plans, so these comments do not appear to be accurate. However, maintaining effective relationships with health insurance providers to ensure physiotherapy is maintained as an option with appropriate reimbursement for a wide range of treatments is an essential advocacy activity for PNZ.

We understand that a stakeholder management plan is being developed to address advocacy with key influencers, and consider this to be an effective activity to meet this recommendation. This type of advocacy is more effective when stakeholders' levels of influence and interest have been clearly identified.

7.2 Maintain relationships with ACC as primary funder of physiotherapy

This includes advocating for improvements to the ACC physiotherapy contract through the Expert Reference Group.

ACC funding models were explicitly connected to remuneration concerns, and the ACC funding landscape is complex with several avenues to access funding. The majority of physiotherapists in private practice received funding through either Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2018 (the Regulations) or Physiotherapy Services Contracts (the Contracts), with other funding available, for example through Vocational Rehabilitation Services and Pain Management Contracts.

PNZ has limited influence on the Regulations rates, as these rates cover all of health and is a legislated funding mechanism covering consultations, specified treatments and imaging provided to ACC claimants by a wide range of healthcare providers. Advocacy in this area is a long-game, and PNZ needs to ensure their voice is heard when the government seeks consultation.

We understand the Expert Reference Group has recently negotiated an increase in rates paid by the Contracts, and we recommend evaluating the impact of this increase in any future Remuneration Surveys. In addition to maintaining a relationship with ACC as a primary funders of physiotherapists in private practice, there is a need to advocate on behalf of physiotherapists on the impact of the current funding levels on workforce sustainability and health outcomes. There was a lack of consensus from PNZ members about what PNZ's role is with funders such as ACC, and improving membership communication on funder engagement activity is recommended.

7.3 Improve the position of physiotherapy in primary health

This includes working with PBNZ to promote the *Physiotherapy and the New Zealand Health Strategy*.

There was considerable feedback that funding practices and models of care often don't fund, recognise or utilise allied health well. This was reflected in the lack of recognition of the importance of physiotherapy in primary health despite being evidence proven, and in the perceived lack of funding in public health for prevention and chronic disease management. Physiotherapists in private practice are currently underutilised in this area, and there was considerable appetite to be working more in this space to improve health outcomes for New Zealanders.

Raising the profile of physiotherapy and the evidence base for range of treatments physiotherapists can treat (as per section 7.1) may support the priority on the position of physiotherapy in primary health, especially when working in collaboration with other agencies and consumer groups to promote the inclusion of physiotherapy into primary care. In particular, lobbying MOH through submissions (where applicable) and regular meetings with key figures, including the Minister of Health, in order to influence MOH funding and treatment strategies, are recommended activities for PNZ to engage in.

7.4 Address physiotherapy workforce issues

Define the workforce issues and identify range of policy options.

The bulk of this report is focused on defining the workforce issues within the physiotherapy profession.

7.4.1 Retention

It is our view that physiotherapy has a workforce retention issue rather than a new graduate supply issue. The enrolment levels with current training providers supplemented by immigration could maintain a diverse and stable physiotherapy pipeline if retention levels were improved. Addressing retention is two-fold.

Firstly, it is essential to address how physiotherapy can be more supportive of those who take time out for overseas experience or parenting thereby increasing the long-term attractiveness of the profession. Secondly, improved understanding is needed of the expectation gap of new graduates in order to better understand how to address this issue. We support PNZ's plan to measure physiotherapy retention, with baseline measures and metrics to track improvement.

To support retention, we also recommend developing a career pathway that encompasses a competency framework, enabling identification where the practitioner is on the continuum of performance and experience, and providing guidance for development of specific areas of expertise (outside of the PBNZ Specialist scope). The Australian Physiotherapy Association (APA) and Canadian Physiotherapy Association have developed career pathways, with the APA pathway being the most relevant to the New Zealand context.^{16 17} However, we recognise that physiotherapy as a profession is governed by the HPCA with PBNZ as the regulatory body assigned to undertake relevant career pathway development. Therefore, our recommendation is moderated to ensure PNZ represents member interests during this process and works in conjunction with PBNZ in career pathway development.

¹⁶ https://australian.physio/sites/default/files/professional-development/download/career-pathway/WhitePaper_APACareerPathway.pdf Retrieved 3 December 2018

¹⁷ https://australian.physio/sites/default/files/professional-development/download/career-pathway/Competence_Framework_V6.0.pdf Retrieved 3 December 2018

7.4.2 Attrition

Physiotherapists staying in (retention) or leaving the profession (attrition) were identified as concerns by the majority of people who fed back. Based on this feedback, there appears to be two primary exit points; within the first two years, and at 4-6 years. The limited scope of the study and the nature of self-selecting for stakeholder engagement means that we were not able to investigate why people leave the profession.

We recommend discussing with PBNZ the implementation of a process such as an exit interview or survey, to understand the reasons for leaving, whether attrition is statistically different between genders, and what the different causalities may be. There was strong feedback that for a predominantly female profession, the cost and commitment of staying competent may be too inflexible while having families.

7.4.3 Remuneration

Non-metropolitan areas have seen the greatest increases in hourly rates and average annual income, with physiotherapists in Auckland now earning less on average than those in urban and rural settings. Given feedback about the cost of living in Auckland (see sub-section 2.4), this is a concern. Anecdotes about higher wages in Auckland do not appear to be supported by data, and this is an area that would be worth exploring in future research.

7.4.4 Graduate expectations

There was feedback on the changing needs of undergraduates, with higher levels of stress and mental health concerns due to greater expectations in the university system. There was consensus that new graduates have a good standard of skills and competences, but that not all students have enough variety in their placements and the type of work they undertake their clinical placement in may not sync well with the type of work they end up doing. This may impact their level of job satisfaction in the crucial early years after graduation.

However, we had limited feedback from new graduates themselves and it is therefore difficult to make specific recommendations on what actions PNZ could take to improve the new graduate experience. Consequently, we advise undertaking specific research with new graduates within their first years of practice to better understand their overall expectations and experiences through their training and first years of employment. This research could be administered as a survey to PNZ members who are in the “Student” and “First and second year graduate” category. To ensure a breadth of perspectives, including gender and ethnicity, screening type questions are recommended. The results of this research could then be used to inform discussions with training providers and employers.

7.4.5 CPD

To increase CPD accessibility, people requested more flexible ways of accessing, such as the facility to attend workshops through virtual/online platforms. We understand there are considerable education resources on the member section of PNZ, and recommend continuing to communicate this to members.

7.5 Promote needs of physiotherapists inside DHBs

Raise awareness of issues and develop options.

Our research supports findings from the 2017 TAS report on the DHB physiotherapy workforce, in particular the sufficient supply of graduates and the issues occurring in recruitment of experienced physiotherapists. DHB levers in recruitment processes (approval of positions and purposefully delaying recruitment) was said to be contributing to widespread morale issues across the sector and the significant flow-on effect of chronic understaffing to the rest of the workforce and to patients – the term “stretch and cover” was mentioned

frequently. Some DHB staff described long-term vacancies for experienced or roles for specific areas of expertise, with one provincial DHB Team Leader reporting seven vacancies. Vacancies intended to be for experienced practitioners (with 4-5 years of experience) were sometimes filled by physiotherapists with insufficient skills or experience in those roles, which was a risk for patients and the DHBs, and contributed to burn out and early exit of the profession. Workforce conditions for physiotherapists within DHBs is an area of concern that we suggest PNZ advocate strongly on.

In addition, DHB employees have seen a decrease in average income and hourly rate from 2015 to 2018 (Figure 4). However, we understand a Public Service Association (PSA) Allied, Public Health and Technical Multi-Employer Collective Agreement has been recently ratified with a pay rise and an increase salary steps within DHBs. We recommend evaluating the impact of this increase in any future Remuneration Surveys.