COMMENTS ON THE

NATIONAL HEALTH INSURANCE WHITE PAPER

BY

THE SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY (SASP®)

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1. EXECUTIVE SUMMARY

South African Society of Physiotherapy

1.1. The SASP® was founded in 1924 and represents the majority of physiotherapists, physiotherapy students and physiotherapy assistants or technicians in South Africa. The members work in both the public and private sectors - in hospitals, medical clinics, community health centers, schools, sports institutes, industrial-related positions, private practices and academic institutions.

1.2. The core functions and roles of the SASP® include being concerned with the continued development of the physiotherapy profession, meeting the needs of the public and furthermore maintaining the high quality standard of physiotherapy services in SA through continuing education.

1.3. The SASP® has a national footprint of members who could be contracted under National Health Insurance (NHI) to render services to NHI beneficiaries, which would also address the shortage of physiotherapists currently experienced in the public sector.

1.4. The SASP® strongly supports integration of private sector physiotherapists into the NHI, either as individuals or in group practices.

Essential role of physiotherapy services

1.5. Physiotherapists are recognised as First Line Practitioners (FLPs) by the Health Professions Council of SA (HPCSA), which means that they can diagnose, treat and refer patients. Physiotherapy is a multi-faceted discipline and physiotherapists are trained and skilled in the provision of preventative, promotive, curative and rehabilitative services.

1.6. Furthermore, the scope of practice of physiotherapists is very wide and covers a large number of conditions in all patient age groups.

1.7. Physiotherapy is also relevant to all levels of care from community home-based care to highly skilled and specialised central hospital and rehabilitation centres level.

1.8. Physiotherapists can therefore contribute significantly to the health and well-being of the population and as such render invaluable health services under NHI.

1.9. An appeal is made that the national and all provincial health departments should recognise the FLP status of physiotherapists to enable them to meaningfully contribute to the health system in the interest of good patient care.

Recommendations

1.10. Physiotherapy must be included in the NHI in service packages on all levels of care for all age groups namely, Integrated School Health programmes, District Clinical Specialists teams, Primary Healthcare (PHC), all hospital and Specialist Rehabilitation Units.

1.11. Physiotherapists should be identified on the staff establishment organograms of services from the community/PHC to central hospital care, with a phased-in approach to achieve the ideal numbers required for optimal service rendering.

1.12. It is recommended that physiotherapy services should be involved in Operation Phakisa to provide assistance in respect of rehabilitation services. The "Ideal Clinic" comprehensive package must include physiotherapy and/or occupational therapy, speech therapy and audiology services, essential medicines and essential assistive devices or consumables.

1.13. It is recommended that the Office of Health Standard Compliance (OHSC) should develop tools to assess PHC and community services and services provided in rehabilitation departments of hospitals.

1.14. The SASP® has been implementing an accreditation programme for private physiotherapy practices since 2009, and it is recommended that accredited practices be recognised as an “ideal clinic” within the NHI.

1.15. The SASP® strongly recommended that professional associations, representing the different professions, must be involved in preparing protocols and guidelines within the NHI and be involved in the determination of the package of services relating to their profession.

1.16. It is strongly recommended that access to care with specific reference to assistive devices in the lesser resourced (rural) areas be improved and be on the same level of access and availability as in urban areas.

1.17. The SASP® strongly recommend that the work stream chairs must consult with the therapy groups who were involved in the Ministerial Task Team on Disability and Rehabilitation.

Gaps identified

1.18. The White Paper unfortunately provides no detail as to how remuneration for service providers would be calculated. It merely states that capitation would be the preferred method.

1.19. "Out of pocket" payments within the public sector needs investigation.

1.20. It is a concern that, if Compensation Fund and Road Accident Fund are not effective in managing claims and pay-outs to date, the incorporation of these funds into the NHI fund would not be effective or efficient.

1.21. Mental health services are only mentioned in the White Paper as primary mental healthcare or as specialist hospital care. It is important to note that a gap exists in the area of specialist level community mental health services, which needs to be addressed.

2. PREAMBLE

2.1. As a stakeholder with an interest in the healthcare sector in South Africa, the South African Society of Physiotherapy (SASP®) is grateful for the opportunity to comment on the White Paper on NHI.

2.2. We are in support of endeavors to ensure the development of a sustainable, accessible and cost-effective healthcare sector that provides services of good quality. This is essential to broaden access of healthcare services in terms of the Constitutional mandate.

2.3. Our aim is to make constructive comments and recommendations in an attempt to assist the National Department of Health (NDoH) to gain a comprehensive understanding of all relevant issues related to physiotherapy and how the profession can contribute to the success of the NHI. Our comments will therefore focus on those features of the White Paper that pertain specifically to physiotherapists or physiotherapy services.

3. SA SOCIETY OF PHYSIOTHERAPY

3.1. The SASP® recognises the importance of high quality standards as well as the affordability and accessibility of patient care, quality management and the need to develop outcome measures for physiotherapy interventions to ensure the most efficient and cost-effective management of the specific condition encountered.

3.2. The main role and core functions of the SASP® are:

3.2.1. Research and development relevant to the physiotherapy profession, which includes the burden of disease, health system needs and other relevant matters;

3.2.2. Addressing the educational requirements of physiotherapists;

3.2.3. Maintaining standards in physiotherapy practice in SA through various mechanisms such as continuing education;

3.2.4. Establishing and maintaining quality standards through the development of clinical protocols and accreditation of physiotherapists in private practice; and

3.2.5. Guiding the professional conduct of members through various educational tools and a peer review process.

3.3. The SASP® is a founder member of the World Confederation for Physical Therapy (WCPT),[1] which was established in 1951. There are currently 111 countries that belong to the WCPT, representing over 350 000 physiotherapists from around the world. The SASP's involvement with the WCPT allows for international benchmarking opportunities, participation in research, clinical guideline development, education and health issue discussions. The SASP® therefore stays abreast of international trends and scientific developments in physiotherapy. This knowledge is imparted to its members.

3.4. The current membership of the SASP® comprises 4 012 physiotherapists working in both the public and private sectors.

4. PHYSIOTHERAPY: ROLE, FUNCTIONS AND SCOPE

4.1. It should be noted that physiotherapists fall under the jurisdiction of the HPCSA and *not* the Allied Health Professions Council of SA (AHPCSA). Physiotherapists must register at the HPCSA in terms of the Health Professions Act, 1974 (Act 56 of 1974) before they are allowed to practise physiotherapy in South Africa (SA).

4.2. Physiotherapy is concerned with:

4.2.1. Assessing, treating and preventing human and animal movement disorders;

[1] www.wcpt.org

4.2.2. Restoring normal function or minimising dysfunction and pain in adults and children with physical impairment to enable them to achieve the highest possible level of independence in their lives;

4.2.3. Preventing recurring injuries and disability in the workplace, at home, or during recreational activities; and

4.2.4. Health promotion in the community for all age groups.

4.3. Physiotherapists use amongst others, the following techniques and modalities in the treatment of patients:

4.3.1. Skilled evaluation techniques;

4.3.2. Hands-on therapy such as mobilisation, manipulation, massage and acupressure;

4.3.3. Individually designed exercise programmes;

4.3.4. Relaxation techniques;

4.3.5. Sophisticated equipment;

4.3.6. Hydro or aquatic therapy;

4.3.7. Specialised electrotherapy equipment, heat, ice and traction to relieve pain and assist healing and recovery;

4.3.8. Suitable walking aids, splints and appliances;

4.3.9. Patient education and health promotion.

4.4. Physiotherapists may have different titles in different countries, for example physical therapists. They are all part of the same profession. The WCPT's description of physical therapy/physiotherapy is as follows:

4.4.1. Physical therapists provide services that develop, maintain and restore people's maximum movement and functional ability. They can help people at any stage of life, when movement and function are threatened by ageing, injury, diseases, disorders, conditions or environmental factors.

4.4.2. Physical therapists help people maximise their quality of life, looking at physical, psychological, emotional and social wellbeing. They work in the health spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation.

4.4.3. Physical therapists are qualified and professionally required to

- Undertake a comprehensive examination/assessment of the patient/client or needs of a client group;
- Evaluate the findings from the examinations/assessments;
- Make clinical judgments regarding patients/clients;
- Make a diagnosis and formulate a prognosis and plan;
- Provide consultation within their expertise;
- Determine when patients/clients need to be referred to another healthcare professional;
- Implement a physical therapist intervention/treatment programme;
- Determine the outcomes of any intervention/treatment; and
- Make recommendations for self-management.

4.5. First Line Practitioner Status

4.5.1. Physiotherapists are the only therapeutic ancillary/allied healthcare practitioners in SA who have been recognised as "first line practitioners" (FLP) by the HPCSA[2], since 1985. "FLP" status means that physiotherapists may assess, diagnose and treat patients within their scope of practice and competency levels without referral from other healthcare practitioners in the out-patient setting. In addition, this status also allows physiotherapists to refer patients to other healthcare practitioners and medical specialists, including for diagnostic investigations such as x-rays[3].

4.5.2. In a research study conducted by Neeta Khandoo[4], reference is made to three studies conducted by Holdsworth and Webster in 2004, 2006 and 2007 in which the self-referral to physiotherapy services in the National Health Services (NHS) in the United Kingdom (UK) was examined. It was stated amongst others that:

"The benefits of self-referral are said to be 'increased flexibility, reduced waiting times and improved communication, encouraging leadership, innovation and creativity in primary care' as well as time-saving for GP's. …This reduced workload for GP's had the added projected benefit of cost savings for the NHS and patient, thereby adding value to the NHS and the patient."

4.5.3. The FLP status of physiotherapists has been poorly embraced by the public health system. Accepting this status of physiotherapists on all levels of care, will assure that physiotherapists are used to their full potential, especially on a PHC level, decreasing the workload of doctors and nurses in understaffed departments and clinics.

4.5.4. The key at PHC level is to improve access to care for patients with disabilities as most of them have to hire a car, at huge cost to the family, to access a clinic. Upon arrival at the

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[2] Letter from the Professional Board for Physiotherapy, Podiatry and Biokinetics to the SASP® dated 26 November 2008; SASP®.
[3] Guiding Principle document: First Line Practitioner Status of Physiotherapists.
[4] "*Views and management plans of private physiotherapists on a proposed National Health Insurance (NHI) system, South Africa".* December 2012.

clinic, they have to see a doctor/nurse first and can generally only see a physiotherapist on another day or alternatively they have to wait for long periods of time, all of which act as a deterrent for patients in need to access the right service at the right time.

4.6. Scope of Physiotherapy

4.6.1. Physiotherapists are concerned with preventative care and wellness, which includes curative and rehabilitative care, to improve the health of the population and decrease the burden of disease.

4.6.2. The scope of physiotherapy practice covers the rendering of comprehensive services for a broad range of conditions, including conditions from the acute phase or onset of the disease to final stage rehabilitation, to patients of all ages.

4.6.3. The scope of practice of physiotherapy as defined by the HPCSA[5] is attached hereto as **Annexure A**. It provides for physiotherapy involvement amongst others in the following fields:

- Musculoskeletal health, including orthopaedic conditions: The conditions include joint, soft tissue and peripheral neural dysfunctions, fractures, dislocations, joint deformities, amputations and diseases/infections of bone, which requires manual and soft tissue therapy, exercise prescription and movement rehabilitation.
- Neurological conditions: These conditions require intensive care physiotherapy and rehabilitation.
- Respiratory and cardio-vascular conditions: These conditions require intensive care physiotherapy, inhalation therapy, exercise prescription and rehabilitation.
- Women's health, including obstetrics and gynaecological conditions: These conditions include amongst others pelvic infections and other gynaecological

[5] Regulations defining the Scope of the Profession of Physiotherapy. Government Notice R. 2301. 3 December 1976. Refer also to Scope of Practice: Physiotherapists and Physiotherapy Assistants as published by the Professional Board for Physiotherapy, Podiatry and Biokinetics. 8 December 2001.

conditions and require amongst other ante- and post-natal instruction. The role of physiotherapy in women's health is further explained in **Annexure B** attached hereto.

- Intensive Care: Physiotherapists work in intensive care units (ICUs) as part of a multi-disciplinary team.
- Pre-surgical habilitation and post-surgical rehabilitation related to neurosurgery, thoracic surgery, abdominal surgery, spinal surgery, orthopaedic surgery, urological surgery and gynaecological surgery: This requires physiotherapy treatment, exercise prescription, rehabilitation of movement and optimising the patient for work and sport-related activities, including adaptation to permanent disabilities.
- Sports medicine: This involves prophylaxis and treatment of all injuries and rehabilitation of disabilities related directly to sport.
- Paediatrics: This requires physiotherapy involvement in all related fields, from developmental abnormalities to postural deformities in infants and children.
- Geriatrics: This involves the care of the aged, rehabilitation and recreational activities.
- Pain: A bio-psychosocial approach to address pain, from the acute to the chronic phases, including prevention of chronic pain.
- Medical fields: This requires physiotherapy involvement amongst others in rheumatology, dermatology, cancer, burns and the resultant long-standing effects and possible deformities of patients, and HIV/AIDS.

4.6.4. Rehabilitation is a key function of physiotherapy. The World Health Organisation (WHO)[6] describes the goal of rehabilitation as follows:

"The ultimate goal is to enable individuals to live in the least restrictive, least costly environment at their highest possible level of independence with the best possible quality of life".

4.6.5. The NDoH's National Rehabilitation Policy (2002) describes rehabilitation as a goal-orientated process, which is:

[6] International Classification of Functioning, Disability and Health (ICF). WHO 2001.

"Aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustments or readjustments."

4.6.6. The approach of the SASP® to rehabilitation is however, broader than that of the NDoH, by encompassing the biomedical as well as bio-psychosocial approach and thus acknowledging the need for intersectoral collaboration. It supports the consideration of Community Based Rehabilitation (CBR) guidelines and a different approach to PHC services in the training of physiotherapy students at undergraduate level.

4.6.7. The role of physiotherapy in rehabilitation is described as follows by the SASP®[7]:

"Whilst physiotherapists need to work broadly within all of the arenas noted above: physical, psychosocial, vocational, emotional, occupation and lifestyle, they have an essential role within rehabilitation – that being the management of the physical factors critical to an individual's overall rehabilitation.

At a very basic level, this would involve the management of range of motion of muscles, joints and neural tissue, muscle strength and endurance, quality of movement, pain and functional activities such as walking.

Implicit within the achievement of these goals, is the support given by the physiotherapists for the emotional, psychological and social issues confronting the individual; an understanding of the occupation and lifestyle of the individual so that treatment goals are both functional and relevant to the person; and knowledge of pathology and prognostic indicators with regard to each individual so that overall physiotherapy management is directed towards realistic and achievable outcomes."

4.6.8. Physiotherapists are often required to render emergency services, e.g. when a patient

[7] "The Role of Physiotherapy in Rehabilitation". Guiding Principles. SASP®. November 2013.

aspirates or experiences difficulty in breathing or to provide critical care in ICU and high-care wards. These events could occur at any time and therefore require the availability of physiotherapists 7 days a week and 24 hours a day.

4.6.9. Physiotherapists also play an important advocacy role regarding the inclusion of patients with disabilities in all aspects of society, health system design and service delivery, which is currently very poor. In this regard physiotherapists work within community structures to address attitudinal and physical barriers that patients with disability face on a daily basis.

4.7. Core Functions of Physiotherapy

4.7.1. Physiotherapists play an essential role in the health sector in SA. The core functions of physiotherapists[8] include the following:

- Care and rehabilitation of illness, injury and impairment or disability from the acute and sub-acute settings up to the final stage of rehabilitation;
- Restoration of functional ability; and
- Health promotion (lifestyle promotion, promotion of inclusion in society and access to services for patients with disabilities) and disease prevention (prevention of disability and further disability).

4.8. Settings for Service Delivery

4.8.1. Physiotherapy services are provided amongst others in the following settings:

- Community based rehabilitation: Communities, clinics and at home;
- Community Health Centres (CHCs);
- Day hospitals;
- Rehabilitation centres;
- Schools and special schools,

[8] HPCSA: Professional Board for Physiotherapy, Podiatry and Biokinetics. "*Definition of Core Functions of Physiotherapy, Podiatry and Biokinetics".* PPB 10. 23 November 2007.

- Industries and other organisations;
- District, secondary, tertiary and central hospitals in both the private and public sectors; and
- Private practices.

5. THE ROLE OF PHYSIOTHERAPY WITHIN NHI

5.1. The Basis of Physiotherapy Services in SA

5.1.1. The SASP® supports evidence-based physiotherapy practice. Therefore ongoing research to development of evidence-based practice is essential to ensure the ongoing provision of quality physiotherapy care to the population of SA.

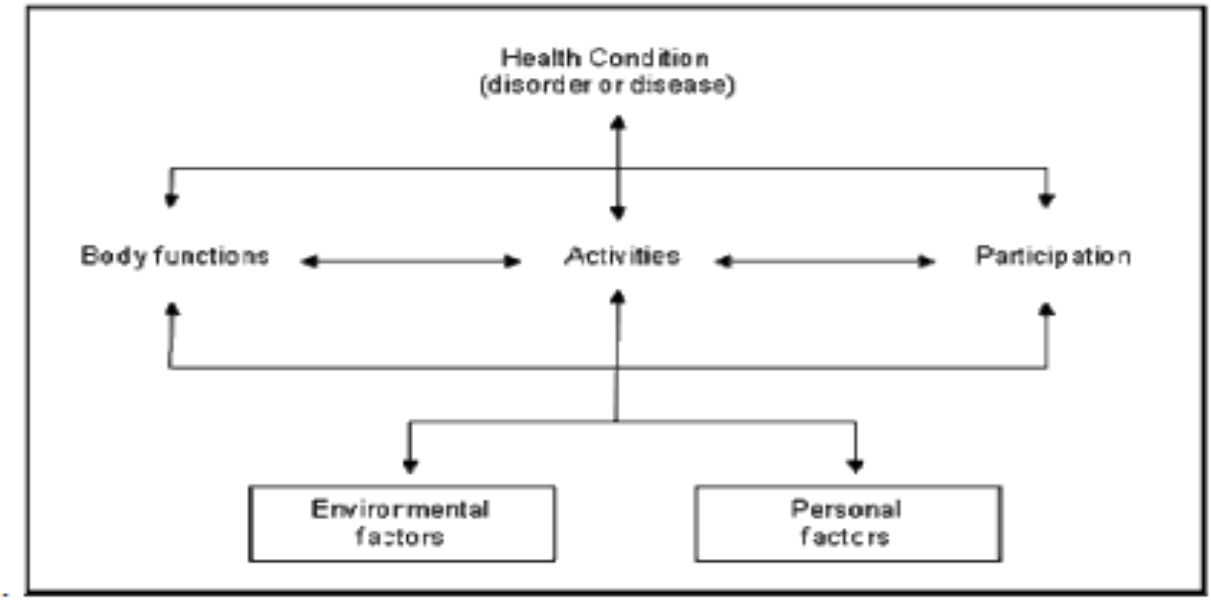
5.1.2. The SASP® has adopted the following standards and frameworks to underpin the provision of physiotherapy services:

- The Standards of Practice of Physiotherapy (SOPP) in SA, which is attached hereto as **Annexure C**, is the SASP®'s statement of performance and standards that it expects physiotherapists and physiotherapy assistants/technicians to aspire to, in order to provide high quality and professional physiotherapy services to society. This provides the foundation for the assessment of physiotherapy practice and represents the physiotherapy profession's commitment to society to promote optimal health and function in individuals and populations by pursuing excellence in practice. This statement includes detail in respect of administration and practice management, communication, community responsibility, cultural competence, documentation, education, ethical behaviour, informed consent, legalities, patient/client management, personal/professional development, quality assurance, research and support personnel. The SOPP ensures credibility, uniformity and consistency of physiotherapy training and practice at all levels.

- The philosophy of the International Classification of Functioning, Disability and Health

(ICF)[9] framework. This framework, which provides a standard language with a conceptual basis for the definition and measurement of health and disability. The ICF integrates the major models of disability and recognises the role of personal and environmental (contextual) factors in the creation of disability, including the relevance of associated health conditions and their effects. This demonstrates that physiotherapy services are moving away from a purely medical model to a bio-psychosocial model. Refer to Figure 1 below.

Figure 1: ICF Model



5.1.3. The rehabilitation process as it pertains to physiotherapy is described in terms of levels[10]. The levels are as follows:

- Early stage rehabilitation (outcome levels 0 and 1);
- Mid stage rehabilitation (outcome levels 2, 3 and 4); and
- Final/Late stage rehabilitation (outcome level 5).

5.1.4. Each level equates to recovery outcomes that should be achieved in relation to the medical condition and pathologies present during that phase of treatment or management. It

[9] http://www.who.int/classifications/icf/en/
[10] Landrum PK, Schmidt ND & McLean A. Outcome-oriented Rehabilitation. Principles, Strategies and Tools for Effective Program Management. First edition. Maryland: Aspen Publishers, 1995.

should be noted that any phase of recovery may be affected by a relapse or return of a pathology requiring the patient then to be treated by the most appropriate professional(s) at that phase of recovery.

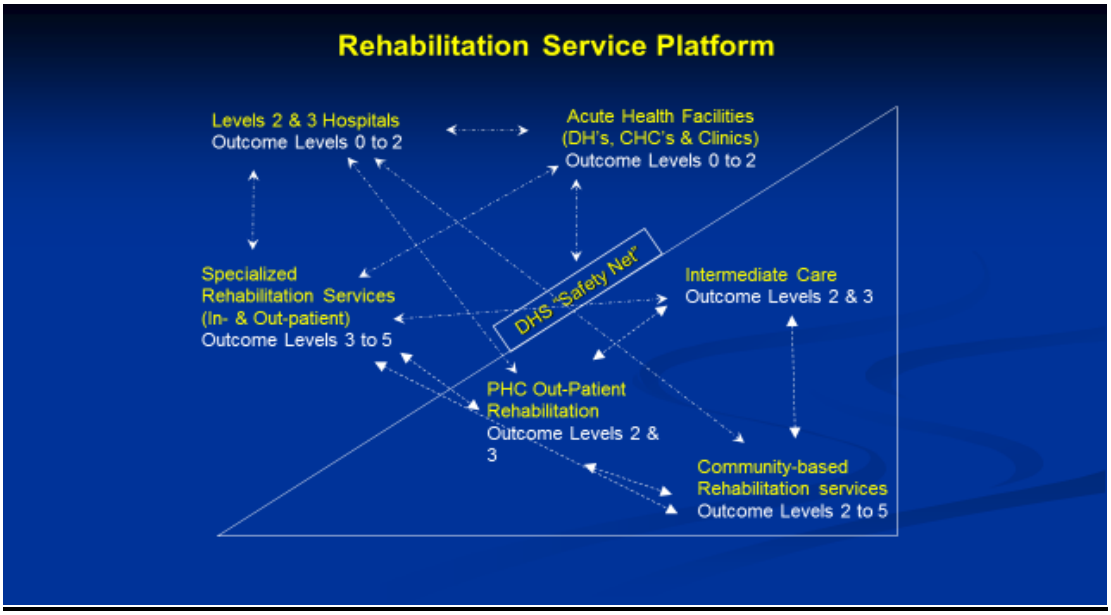
5.1.5. The outcome levels for rehabilitation 0 – 5 are as defined in table 1 below.

Table 1: Outcome Levels

Outcome level	Definition
0	Physiological Instability
1	Physiological (Medical) Stability
2	Basic Rehabilitation Outcome (Physiological Maintenance)
3	Intermediate Rehabilitation Outcome (Home and/or Residential Re-Integration)
4	Advanced Rehabilitation Outcome (Community Re-Integration)
5	Productive activity

Based on the outcome levels mentioned above, a flow diagram was implemented very successfully in the Western Cape Province and is strongly recommended for all physiotherapy and other rehabilitation services in SA. Refer to Figure 2 below.

Figure 2: Flow Diagram Western Cape



Source: Jenny Hendry (2010)

5.2. The Role of Physiotherapy in PHC

5.2.1. In keeping with Batho Pele, offering physiotherapy at PHC level and within the NHI framework, will allow the population to have greater access to physiotherapy and rehabilitation services in order to prevent complications and be referred to the appropriate levels of care without delay. Unfortunately, there is often a misconception with the general population, and even healthcare workers, as to the role of disability and rehabilitation services, disability rights, specific barriers faced and specific needs of people with disabilities, which must be addressed though awareness and education programmes[11].

5.2.2. The significance of physiotherapy, as FLPs in PHC of the National Health Services (NHS) in the UK, has been described in various studies. The research report, *"Views and management plans of private physiotherapists on a proposed National Health Insurance (NHI) system, South Africa"*, referred to the findings in these studies as follows:

[11] Mlenzana et al, 2013

"Weatherley and Hourigan (1998) had a different focus where physiotherapists would triage patients with lower back pain and refer when appropriate to an orthopaedic surgeon. The aim of the triage was to reduce the load of the orthopaedic surgeons.

Childs et al. (2007) stated that physiotherapists are said to possess better knowledge of musculoskeletal conditions than medical students, interns, residents and specialists, with the exception of orthopaedic surgeons.

Daker-White et al. (1998) conducted a randomised controlled study and found that in addition to cost savings (by less referral to radiology or orthopaedic surgery) it was found that the initial assessment and management of new orthopaedic referrals by specialist physiotherapists were comparable to that of junior orthopaedic surgeons.

The common theme emerging from the Clemence and Seamark (2003) and Weatherley and Hourigan (1998) studies is that there is insufficient multidisciplinary collaboration amongst health professionals, which the NHI aims to remedy."

5.2.3. The SASP® would like to implore the NDoH to consider these studies and include physiotherapy services at all levels of care, but particularly on PHC level, to ensure the successful rehabilitation of the population within NHI.

5.3. The Role of Physiotherapy in the Community

5.3.1. Physiotherapy service delivery in the community includes the following:

- Promotion of physical health, independence and wellness;
- Raising awareness of disability and rehabilitation services amongst community members as well as governmental, municipal, tribal and non-governmental sectors and about challenges faced by people with disabilities in their communities. The specific needs of this population should be emphasized.
- Provision of preventative, promotive and rehabilitative services within the community (including receiving referrals);

- Strengthening the referral and case management interface between the community and clinics (and other centres such as orphanages, stimulation centres, care villages, etc.);
- Facilitating engagement of community members and structures with the health, education and social services that they require;
- Provision of training, supervision and support to mid-level workers, including community health workers and community caregivers;
- Provision of consultative services and support to the non-profit and non-governmental organisations such as the Disabled Persons' Organisation (DPO) within the community;
- Provision of intermediate care, i.e. linking health and social care;
- Working in and with multi-interdisciplinary teams by being a member of the district health team;
- Facilitation of community development projects and programmes;
- Conducting screening services;
- Provision of occupational health-related services e.g. ergonomic and risk assessments;
- Conducting research, in order to provide needs driven community services;
- Provision of school health based physiotherapy services;
- Training personnel for provision of basic physiotherapy and rehabilitation services; and
- Rehabilitation of chronic disease profiles (HIV/AIDS; hypertension and diabetes, heart conditions) to assist with a decrease in the quadruple burden of disease.

5.3.2. Physiotherapists who function on the community level often need to provide highly skilled services due to the nature of conditions and the resource challenges faced.

5.4. Recommendations

5.4.1. The SASP® would like to propose a package of physiotherapy services to be included under NHI. It is noteworthy that the suggested package mentioned in **Annexure D,** covers physiotherapy services currently provided in private and public sector.

5.4.2. The SASP® recommends the following with respect to service delivery under NHI:

5.4.2.1. **Primary Health Care (Paragraphs 6.1 of the White Paper)**

(a) The needs of people with disabilities and rehabilitation must be integrated into all PHC programmes and systems. Disability and rehabilitation services cannot operate as stand-alone services. It is recommended that a section on disability and rehabilitation services be included in the community health worker training syllabus to enable them to identify and refer patients with disabilities in the community.

(b) The identification of a disability must form part of the criteria of a vulnerable household and be included in the standard data collection at household level.

(c) A mid-level rehabilitation worker and/or a therapist must form part of the Ward-based Outreach Teams (WBOT) not only to ensure early identification of disabilities and referral of the patients, but also to provide ongoing education and training in respect of disabilities and appropriate rehabilitation.

(d) It would be challenging to adhere to the requirement of the Ideal Clinic model[12] of "staying open until the last patient is seen" as this could effectively result in a 24 hour service in over-populated areas, which is not achievable from a human resource point of view. It is suggested that organisational skills pertaining to appointments and communication with patients should amongst others be improved to make the "Ideal Clinic" model a success. It is agreed that all scheduled appointments and emergencies must be attended to every day.

(e) It is recommended to consider including a community disability worker as part of the Municipal Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) with well-demarcated functions, including appropriate referrals to the PHC rehabilitation team.

[12] https://www.idealclinic.org.za/

(f) The proposed package for PHC services should be flexible and tailored to the particular needs of the province and area of implementation. Priority setting and planning processes at sub-district and district levels should highlight local priorities and a package of services should then be developed that is based on the particular needs in that area.

(g) A broader public health approach, such as education and awareness campaigns, which emphasises prevention, is critical.

(h) Prioritising specific conditions does not imply that treatment of minor ailments and other conditions are not important. These services are important and must remain in the package.

(i) The PHC system can only achieve the desired outcomes if it is supported by other levels of the health system in a coordinated and integrated manner. The delivery of good quality essential care relies amongst others on an effective referral system starting at community level.

(j) The delivery of a comprehensive PHC package of services requires adequate resources, such as funding; adequate, committed and motivated staff; appropriate infrastructure and clinical support services in order to deliver high quality and efficient services.

5.4.2.2. **Integrated School Health Programme (ISHP) (Paragraph 6.1.2 of the White Paper)**

(a) Rehabilitation personnel e.g. physiotherapists, occupational therapists and orthotists should play a role in the screening of children as part of an ISHP. These personnel should also be included in health promotion and preventive and curative services as part of the ISHP.

(b) The reason for the inclusion of physiotherapists in the ISHP is their insight and assessment skills, which are valuable in the assessment of developmental delay conditions in children.

(c) According to the White Paper, 201 770 learners have already been identified by the ISHP as experiencing physical barriers to learning (hearing, speech, eyesight and oral health). It is the view of the SASP that numerous physical limitations and the suffering of children could have been prevented if the children's needs were identified timeously. This would have happened if physiotherapists were part of the school health teams. Physiotherapists should therefore not only be consulted when there is a curative need, but must play a pivotal role in the prevention of certain conditions and disabilities.

(d) It is highly recommended that the Department of Basic Education's (DBE's) Special Needs Education Unit forms part of the school health teams. This will assist in highlighting the need for rehabilitation services at school level. The services and assistive devices required should be the responsibility of the DBE and not the NDoH. It should, however, be noted that the DBE has an acute shortage of therapists preventing the provision of an adequate service to all schools. This needs to be addressed.

(e) It is strongly recommended that:

- The DBE must employ at least one therapist per category of professionals, i.e. physiotherapists, occupational therapists, speech therapists, audiologists and orthotists and prosthetists, for each special and full service school; and
- More physiotherapy or occupational therapy technicians must be trained to address the shortage of qualified therapists.

5.4.2.3. **District Clinical Specialist Teams (DCSTs) (Paragraph 6.1.2 of the White Paper)**

(a) Ideally, there must at least be a provincial or regional physiotherapy consultant for these teams or at least a rehabilitation practitioner, with a background in public health, must be part of the DCSTs.

5.4.2.4. **District Hospital level (Paragraph 6.3.1. of the White Paper)**

(a) It is recommended that the following physiotherapy services must be included in the package of services to be rendered at district hospital level:

- Raising awareness of disability and rehabilitation services amongst community members, non-governmental sectors, healthcare professionals and workers;
- Strengthening of the referral and monitoring and evaluation (M&E) systems to improve early identification and referral to rehabilitation services in order to prevent and minimize disability. It needs to be emphasized that physiotherapists are able to provide comprehensive services at all levels. This includes preventative, promotive, rehabilitative and curative services, which is not dependent on the place of treatment, but rather the condition of the patient at the point of intervention. It is therefore recommended that, the effectiveness of the referral interface in case management and continuity of post-hospital care, especially in deep rural areas, must be thoroughly explored;
- Providing intensive rehabilitation for patients post-surgery, post-stroke, during and upon resolution of acute conditions affecting their mobility and functional independence as well as pre- and post-labour (for mother and child);
- Providing training, supervision and support to physiotherapy technicians and physiotherapy assistants as well as providing ongoing training to nurses, allied health practitioners, medical officers and other appropriate persons on the role and scope of physiotherapy and the referral system;
- Monitoring and evaluating services rendered in order to implement continuous quality improvement programmes;

- Providing strategic leadership and governance in respect of the physiotherapy services;
- Rendering services at clinic and home levels, managing the interfaces, meeting with community care givers and PHC nurses on a monthly basis for purposes of care coordination and continuation; and
- Doing pre-discharge home assessments for those with significant disabilities and managing patients prior to and after discharge.

5.4.2.5. **Regional, Tertiary and Central Hospitals (Paragraphs 195, 196 and 197 of the White Paper)**

(a) Physiotherapy supports all clinical regional and tertiary medical services including the specialized units.

(b) On regional, tertiary and central hospital levels the ICF framework for physiotherapy would include impairment, body structures, activity limitation and improving of function with cognizance of reintegration and active participation into the community and society. The outcome level of rehabilitation would be between 0-3.

(c) It is recommended that physiotherapy services from regional, tertiary and central hospitals should include the following:

- Preventative, promotive, palliative,[13] curative and rehabilitative services. The focus should be more on in-patient rather than out-patient care. Out-patient services would focus on specialized care and advanced interventions;
- After hours' services, services on week-ends and 24-hour on call services;
- Treatment interventions in ICU, specialized wards, clinics and out-patients;
- Education, home programmes and advice to all relevant stakeholders;

[13] http://www.physio-pedia.com :/Promoting_the_role_of_Physiotherapy_in_Palliative_care:_Information_for_allied_health_professionals#cite_note-Emma_6-6

- Relevant referrals to level 2 (Regional), district hospitals, CHCs, clinics and community centres according to accessibility;
- Assistance with and participation in data gathering, surveys, clinical audits and formal research that will help improve the evidence-based services delivered to patients.

(d) It should be noted that physiotherapy plays a vital role in critical care to maintain and improve patients' respiratory function. The tertiary level physiotherapy department has the infrastructure, knowledge and the clinical skills to rehabilitate patients that are unable to be seen at CHC's due to infrastructural constraints and the complex nature of the conditions that often require a broader multi-disciplinary team approach that is only available at the tertiary level.

(e) Physiotherapists must form an integral part of the multi-disciplinary teams across the various clinical areas in the hospital.

5.5. <u>Special Rehabilitation Units (Paragraph 6.3. of the White paper)</u>

5.5.1. Rehabilitation hospitals were created to meet the need for a facility that was less costly than general hospitals, but which provided comprehensive rehabilitation services by amongst others nurses, physiotherapists, psychologists, speech therapists, occupational therapists and dieticians.

5.5.2. Physiotherapy services in Special Rehabilitation Units must concentrate on activity limitation and improving function with cognizance of reintegration into the community and society as per the ICF model. The patients at these Units would be at outcome level 2-4 of rehabilitation, which includes curative care. Except for the normal physiotherapy modalities such as aquatic therapy, electrotherapy, pain management, physiotherapy services should also include services such as the assessment of conditions, outcomes-based goal planning using various outcome measures (e.g. ICF; stages of rehabilitation); neuro rehabilitation; the prescription and issuing of, and the training and education on, assistive devices; gait re-education; wheelchair/buggy seating; family/caregiver education and training and incontinence services.

6. ENHANCING HUMAN RESOURCES FOR HEALTH

6.1. It is acknowledged that the shortage of healthcare professionals is a world-wide phenomenon and not unique to SA. This shortage also affects physiotherapy services as stated below.

6.2. The SASP® agrees with the statement in paragraph *225: "The health workforce is the key pillar of the health system and the planning, development, provisioning, distribution and management of human resources will be further improved to meet the needs of the population."* This could be done without the NHI healthcare reform, but is endorsed as part of the NHI vision. Funding will be required to fill the many vacant and frozen posts in the public sector.

6.3. It needs to be emphasised that physiotherapy services could play an essential role in the healthcare of South Africans. Therefore, the SASP requests that physiotherapists should be identified on the staff establishment organograms of services from the community/PHC to central hospital care, with a phased-in approach to achieve to the ideal numbers required for optimal service rendering. The NDoH is currently in the process of determining the ideal number of physiotherapists per population[14].

6.4. Rehabilitation and disability service providers are listed as a scarce skill[15] with medium to high impact on the healthcare system. In order to provide equitable, affordable and appropriate healthcare for people with disabilities, as well as to address the vital prevention and promotion component, rehabilitation services need to be provided at PHC and community level. This will demand significantly more staff and posts than are currently available. The retention of community service staff upon completion of their community service and ensuring that available staff are motivated, skilled and experienced, would assist in addressing this need.

[14] Workload Indicators for Staffing Needs (WISN) project.
[15] Department of Health MTEF Human Resource Plan 2015-2018

6.5. Key cadres required to address specific needs of people with disabilities currently do not exist within the public health system and are unlikely to be found within the private health system. These cadres, such as orientation and mobility trainers, CBR workers and peer supporters are a rare occurrence and are more likely to be found at NGO level. Urgent attention towards establishing these cadres within the public health system at all levels (but particularly in rural areas where NGO reach is minimal), in support of NHI, is paramount.

6.6. It is recommended that a full cadre of permanent rehabilitation therapists should be secured at each institution in addition to a more equitable distribution of community service therapists as a matter of urgency.

6.7. Over several years, physiotherapy and other rehabilitation personnel in several provinces[16,17] attempted to determine staffing norms based on data analysis available within the rehabilitation fields. It is strongly recommended that these efforts should be taken into consideration when considering physiotherapy staffing for the different levels.

6.8. When physiotherapist numbers in SA are compared with those of other countries, the shortage of physiotherapists in SA is evident. Refer to Table 2 below[18].

TABLE 2: POPULATION VS PHYSIOTHERAPISTS

Country	Population	Number of P/T's	People per P/T
Brazil	200,000,000	220,000	910
South Africa	54,960 000	6,927	7,934
Thailand	68,114,077	8,000	8,514
Turkey	79,456,663	8,004	9,927
Canada	35,236,000	21,137	1,667
Sweden	9,595,000	11,800	813
Finland	5,436,000	8,500	640

[16] KZN staffing norms and standards- Physiotherapy, 27 March 2015
[17] Free State Physiotherapy staffing norms, 2006
[18] http://en.wikipedia.org/wiki/Category:Lists_of_countries_by_continent,_by_population and member organisations of WCPT.

Norway	5,096,300	14,700	347
UK	64,097,000	40,000	1,602

6.9. With reference to Table 2, SA is best compared with Turkey, Thailand and Brazil - middle-income countries with a similar disease burden as well as large disparities between social groups and large and expensive private sectors.[19]

6.10. When physiotherapist numbers in SA are compared with those of countries where universal coverage had been implemented, mentioned in the table above, the following is evident:

6.10.1. The high income countries' ratio of physiotherapists per population varies from 1 667 in Canada to a well-resourced 314 in Norway;

6.10.2. The middle to low income countries', i.e. Thailand and Turkey, ratio of physiotherapists per population compares well with SA:

- Thailand: 1:8 514;
- Turkey: 1:9 927; and
- SA: 1:7 934.

6.10.3. Compared with the number of people per physiotherapist in Brazil (1:910), SA is lagging behind.

6.11. The paucity of physiotherapy services in SA cannot easily be addressed with the current training numbers at university level. On average only 40% of students starting their first year of study will complete their studies in the 4th year. Refer to Table 3 below.

[19] Lloyd, B., Sanders, D. & Lehman, U. (2010): Human resource requirements for National Health Insurance. *South African Health Review*, (2010) 17, 171–178).

Table 3: Physiotherapy Student numbers for 2015

University	1st	2nd	3rd	4th	Total
Cape Town	122	60	55	42	**279**
Free State	41	41	40	38	**160**
KZN	56	57	58	38	**209**
Pretoria	60	55	56	50	**221**
Sefako Makgatho Health Sciences	55	44	55	44	**198**
Stellenbosch	67	66	48	63	**244**
Western Cape	63	63	55	49	**230**
Witwatersrand	64	62	57	51	**234**
TOTALS	**528**	**448**	**424**	**375**	**1775**

6.12. Once these students have completed their studies, they must perform one year of community service, which is fully supported by the SASP® as a method of providing services to communities closer to home. Unfortunately community service placements have not achieved the initial goals and many problems have arisen, which include that

6.12.1. Placements occur regardless of the presence of supervisory staff, which is both illegal and unsustainable; and

6.12.2. Placements do not always occur in the areas where services are needed, i.e. rural or under-served areas. In the Free State[20] for example all 18 community service physiotherapists work in urban areas and none in rural areas.

[20] Persal Staff Establishment Report of Free State HR Department of 1 April 2016.

6.13. In addition, community service physiotherapists are not retained upon completion of their community service. This is essential in an attempt to address the shortage of physiotherapists and to ensure the continuity and sustainability of rehabilitation services, especially in the rural areas.

6.14. Currently in South Africa, most physiotherapists work in the private sector addressing the physiotherapy needs of 16% of the population compared to approximately 2000 physiotherapists (including physiotherapy assistants, technicians and community service practitioners) employed in the public sector serving the balance of the population. Information on the number of vacant posts in the public sector is not available.

7. IMPACT OF PHYSIOTHERAPY ON QUALITY OF LIFE

7.1 Burden of Disease

7.1.1. Physical therapy and rehabilitation are the “quality of life interventions” between life and death. None of the non-communicable diseases (NCD) or maternal and child conditions as well as injury and trauma can be prevented or treated without the support of physiotherapy. Refer to the scope of practice for physiotherapy discussed above as well as **Annexure A**.

7.1.2. When considering the common risk factors for NCDs, physiotherapists are well-qualified to advise on exercise and wellness, which would prevent most of these diseases. In addition to the need for services mentioned, there would definitely be a need to increase the physical rehabilitation services as well.

7.1.3. Violence and injury also contribute significantly to the burden of disease. However, many people do not die, but are disabled (permanently or temporarily) and require rehabilitation.

7.1.4. Furthermore, with increased life expectancy and decreased neonatal mortality, an increase in disability arises. The current rehabilitation services cannot cope with the

demand within the public health system, largely due to poor structuring of health systems, a poor integration of rehabilitation and disability services into current health programmes and a perpetual human resource shortage.

7.2. Quality of Healthcare Services

7.2.1. In addition to significant increases in utilisation due to the high burden of disease and increased patient loads, quality problems in the areas of staff attitude especially towards patients with disabilities, patient waiting times, cleanliness, stock-outs of drugs and assistive devices, the lack of specialised allied health professionals (i.e. physiotherapists, occupational therapists, speech therapists, audiologists, orthotists and prosthetists) particularly on a PHC level and difficulties in providing sufficient outreach services by allied health professionals have further compromised the quality of care.

7.2.2. The SASP fully supports quality service delivery of physiotherapy services on all levels of care. Unfortunately, physiotherapists were only consulted on the development of the national core standards at a late stage by the OHSC. The proposed evaluation criteria appear to be arbitrary and not appropriate.

7.2.3. Quality physiotherapy services and appropriate rehabilitation at the right time for the right condition save money, as:

- Length of stay in hospital will be shorter;
- Medicolegal claims will reduce;
- In respect of spinal cord injuries and poly-trauma patients, the potential for entitlements to disability grants and the resultant burden on the state will reduce.

8. FEEDBACK FROM THE PILOT SITES

8.1. The following statement appears in paragraph 157 of the White Paper: "The Green Paper on NHI identified activities to be undertaken in selected districts. These activities were

implemented in the NHI Pilot districts. Lessons that have been learnt from the pilots and will be used to further strengthen service delivery".

8.2. It would be appreciated if information could be provided as to what specific activities have been implemented in respect of service delivery at the pilot sites to enable us to understand the focus of the lessons learnt.

8.3. All the feedback received from physiotherapists, other professionals and managers working at some of the pilot sites has unfortunately not been positive and encouraging. Some of the comments made are referenced below:

8.3.1. No additional funding was made available to provide the necessary support;

8.3.2. Staffing levels have not improved as we are still waiting for the Workload Indicators for Staffing Needs (WISN) implementation. A concern was raised that the WISN concept relied heavily on previous data from the Health Information System. Data used must show a true reflection of the services rendered. As previously mentioned, rehabilitation is not high on the priority list in the public service, which has resulted in limited data being collated and analysed. It is therefore questionable of how the WISN process would be able to establish the ideal workforce load necessary for physiotherapy services to function optimally;

8.3.3. Not enough consumables were purchased;

8.3.4. Hardly any changes were made with regards to upgrading facilities suitable for rehabilitation services;

8.3.5. None of the above expectations have materialized to date, which poses the question of how the government would be able to cope with more than 3 000 facilities if the few in the pilot sites could not be managed optimally;

8.3.6. Whilst we applaud the move towards the realization of the Ideal Clinic model, rehabilitation service delivery at ideal clinics still require testing with reference to cost-efficiency,

logistics and outcomes / effectiveness. An option would be to deploy a generic mid-level rehabilitation worker at each clinic to provide the screening, basic intervention and support services required on a daily basis across PHC programmes with the full rehabilitation team visiting on a weekly basis depending on the need;

8.3.7. The "Ideal Clinic" comprehensive package must include physiotherapy and/or occupational therapy, speech and audiology services, essential medicines and essential assistive devices or consumables;

8.3.8. The rehabilitation team should also be responsible for community outreach in the clinics' catchment areas and participate within the WBOTs. The number of clinics allocated to each rehabilitation team would depend on clinic utilisation as well as epidemiology and need at community level within the catchment population. Low utilisation of clinics may not necessarily indicate a lack of need, and may point to other factors such as accessibility, appropriateness and acceptability of clinic services; and

8.3.9. In Gauteng the mandate of recruiting private practitioners, "*to beef up the staffing"*, has been given to the Foundation for Professional Development (FPD) and thus far seems to be working well.

9. ACCREDITATION OF SERVICE PROVIDERS

9.1. The SASP® supports the establishment of the OHSC for quality purposes and for performing the accreditation of service providers under NHI. Although the OHSC has only been recently established, it is already clear that the office is active and productive.

9.2. It would, however, be necessary for the legislation[21] supporting the activities of the OHSC to be finalised as soon as possible to ensure that the OHSC can effectively discharge its mandate and impose the necessary sanctions. Government for example fails to provide

[21] Procedural Regulations (draft regulations) pertaining to the functioning of the Office of Health Standards Compliance and its Board. R 110. Government Gazette 38486 of 18 February 2015.

the necessary facilities and equipment in certain areas resulting in non-compliance with the OHSC standards, e.g. no oxygen in the department for resuscitation, physiotherapists do not have a workplace and had to work in one corner of a theatre. In some instances there are also no provincial policies to guide the services.

9.3. It is recommended that the OHSC should develop tools to assess:

9.3.1. PHC and community services. Their standards should be specific to the services provided and not form part of the district hospital standards; and

9.3.2. Services provided in the rehabilitation departments of hospitals.

9.4. It is requested and recommended that physiotherapy services should be involved in Operation Phakisa to provide assistance in respect of rehabilitation services, i.e. to determine the minimum standards of facilities, the size of the treatment space and safe storage for rehabilitation outreach services as well as ensuring vehicles for the rehabilitation staff to be able to reach the clinics.

9.5. It should be noted that the SASP® has been implementing an accreditation programme for private physiotherapy practices since 2009, and is recommended that each accredited practice be recognised as an "ideal clinic" within the NHI. The accreditation process consists of 5 standards and 3 phases. The standards relate to:

- Management;
- Policies and Standard Operational Procedures;
- Human Resources;
- Facilities and Equipment; and
- Quality Management.

9.6. The phases are:

- Phase 1: Enrolment of Practice Management Accreditation;

- Phase 2: Electronic Evaluation; and
- Phase 3: Onsite visit and final accreditation,

9.7. The SASP is currently engaging with the OHSC to ensure accreditation of physiotherapists under NHI.

10. GAPS IN THE NHI WHITE PAPER

10.1. Financial Arrangements

10.1.1. The White Paper unfortunately provides no detail as to how remuneration for service providers would be calculated. It merely states that capitation would be the preferred method.

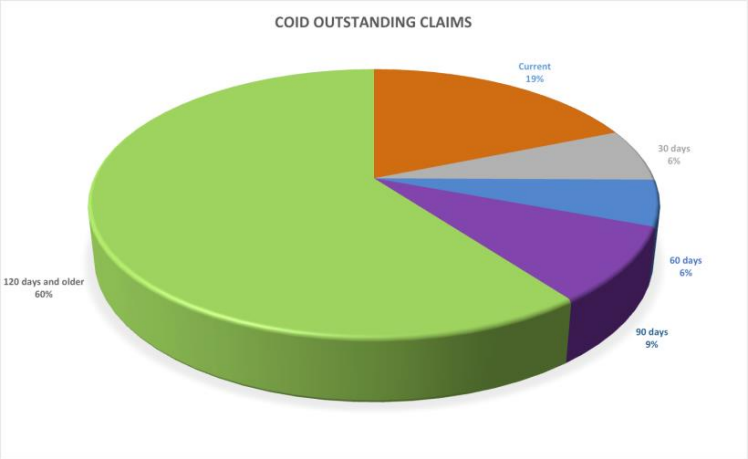
10.1.2. It is also stated that "out-of-pocket" payments in the private sector amount to R22 980 000. It is submitted that this statement is incorrect. Both in the public and private sector patients incur out-of-pocket expenses to access healthcare services. For example transport is often a major expense especially for patients with disabilities when they travel with assistive devices, wheelchairs and/or a companion. These types of out-of-pocket expenses result in financial hardship and should therefore be considered and included for the public sector.

10.2. The Compensation Fund and Road Accident Fund

10.2.1. The SASP is concerned about the possible inclusion of the Compensation Fund (CF) and Road Accident Fund (RAF) into the NHI Fund. Both these Funds are currently ineffective and owe the healthcare professions millions of Rands,

10.2.2. One of the biggest physiotherapy practices in Cape Town, only dealing with "injury on duty" patients shared their data with us. The outstanding amount owed to the practice is R7.5 million of which 60% (R4.5 million) has been outstanding in excess of 120 days. See figure 3 below of a pie chart on outstanding amounts owed by the CF.

Figure 3: Outstanding claims of a Cape Town-based Physiotherapy Practice



10.2.3. The Umehluko system implemented by the CF in August 2014 is still incurring problems resulting in major backlogs in payments to practitioners. In a recent case in the Supreme Court of Appeal, it transpired that the CF owed a number of doctors R458 million.[22]

10.2.4. It is a concern that if CF and RAF are not effective in managing claims and pay-outs to date, the incorporation of these funds into the NHI fund would not be effective or efficient.

10.2.5. The proposed inclusion of the Unemployment Insurance Fund (UIF) is also not understood as it has no direct relevance to the health system.

10.3. Treatment guidelines

10.3.1. The performance of healthcare providers will heavily depend on the protocols, treatment guidelines and the package of services to be offered.

[22] *Compensation Solutions (Pty) Ltd v The Compensation Commissioner (072/2015) [2016] ZASCA 59 (13 April 2016)*

10.3.2. The SASP® strongly recommends that professional associations, representing the different professions, must be involved in preparing these protocols and guidelines and be involved in the determination of the package of services. Most of the professional associations have already prepared various treatment protocols and guidelines, which are evidence-based, which is in the best interests of patients.

10.3.3. From a physiotherapy point of view, it is for example essential that sufficient rehabilitation is provided to ensure timely access to care and appropriate referrals. The current deficiencies in the system, the need to provide appropriately for rehabilitation services and the important role that physiotherapists can play in this regard have been highlighted above and are not repeated again.

10.3.4. The SASP therefore requests to be involved in the various Advisory Committees dealing with these matters.

10.4. Provision of Assisted Devices

10.4.1. It is critical to the success of rehabilitation and good patient outcomes that patients have access to appropriate assistive devices (such as walking aids).

10.4.2. It is strongly recommended that access to care with specific reference to assistive devices in the lesser resourced (rural) areas should be improved and be on the same level of access and availability as in urban areas.

10.4.3. Practitioners should also have access to ongoing training in the assessment, prescription, fitting and training of use, of these devices.

10.4.4. Maintenance and repair services need to be accessible and affordable in order to prolong the life of the device, reduce cost and improve utilization by the end user.

10.5. Mental Health

10.5.1. Mental health services are only mentioned in the White Paper as primary mental healthcare or as specialist hospital care. It is important to note that a gap exists in the area of specialist level community mental health services, which needs to be addressed. These services are very well described by the Mental Healthcare Act, 2002 (Act 17 of 2002).

10.5.2. The SASP supports the concept of Community Mental Health Teams to be established, as part of the deinstitutionalization process, where people with severe and complex mental illness require care within their communities. For this process to be successful, adequate human resources, multi-disciplinary teams and supporting infrastructure need to be provided at community level.

10.5.3. Physiotherapists play an important role in the multi-disciplinary teams, especially as mentally ill patients often present with back pain and/or neck pain. These patients become a health risk because of their sedentary behaviour caused by the mental illness. There is therefore an overlap between mental illness and musculoskeletal disorders, which has a significant impact on the burden of disease. The role of physiotherapy in psychiatry, mental health (and chronic pain) is explained in the SASP's clinical guideline document attached hereto as **Annexure E**.

11. LIST OF ABBREVIATIONS

AHPCSA	Allied Health Professions Council of SA
CF	Compensation Fund
DBE	Department of Basic Education
DoH	Department of Health
DPO	Disabled Persons' Organisation
FLP	First Line Practitioner
HPCSA	Health Professions Council of SA
ICF	International Classification of Functioning, Disability and Health
ICU	Intensive Care Unit
ISHP	Integrated School health Program
NCD	Non-Communicable Disease
NDoH	National Department of Health
NHI	National Health Insurance
NHS	National Health Services
OHSC	Office of Health Standards Compliance
PHC	Primary Health Care
P/T	Physiotherapist
RAF	Road Accident Fund
SA	South Africa
SASP	South African Society of Physiotherapy
SOPP	The Standards of Practice of Physiotherapy in South Africa
UIF	Unemployment Insurance Fund
UK	United Kingdom
WBOT	Ward-based Outreach Team
WBPHCOT	Ward-based Primary Health Care Outreach Team
WCPT	World Confederation for Physical Therapy
WHO	World Health Organisation
WISN	Workload Indicators for Staffing Needs

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13. ANNEXURES

Annexure A – Scope of practice for physiotherapy

Annexure B – The role of physiotherapy in Women's Health

Annexure C – The Standards of Practice of Physiotherapy in South Africa

Annexure D – Physiotherapy service delivery package

Annexure E - The role of physiotherapy in mental health