POLICY ANALYSIS OF LEGISLATIVE FRAMEWORKS RELATING TO PHYSIOTHERAPY IN BELGIUM AND SOUTH AFRICA

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A dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, in fulfilment of the requirements for the degree of Master of Science in Physiotherapy.

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Johannesburg, 2020.

DECLARATION

I, Tim Németh declare that this Dissertation is my own, unaided work and that assistance was obtained in the form of professional supervision from Professor Hellen Myezwa, Mr Kganetso Sekome and Professor Raf Meesen. It is being submitted for the Degree of Master of Science in Physiotherapy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

(Signature of candidate)

The 7th of May 2020 in Belgium and South Africa.

In memory of my grandparents

János Németh
1926 – 2002

Katica Urban
1928 – 2013

"Azért indulok el mindig egy nagy útra, hogy bennem is elinduljon valami."
(I set off on a long journey so that something will set off in me as well)
Jenő Cholnoky

PRESENTATIONS ARISING FROM THIS DISSERTATION

Németh T, Myezwa H, Sekome K, Meesen R. Policy development (IN-23), 11 May 2019, World Confederation of Physical Therapy Congress, Geneva. Indaba – Zone 2: “Points of view”

ABSTRACT

Introduction

From a physiotherapy service provider point of view, the outlines and the content of the legislative framework in which to operate differ from country to country. The revelation of differences and similarities should contribute to recommendations for improvement in physiotherapy policy for practice, education and future policy changes. A preliminary search on PubMed showed that although studies have been conducted on health policy, no policy was found pertaining to physiotherapy in particular. Conducting research was justified to be able to produce a first analysis on the topic.

Aim

The aim of the study was to analyse the current rehabilitation policies underpinning physiotherapy service delivery in Belgium and South Africa.

Method

This study is a qualitative content analysis with three components: a) literature scoping review, b) analysis of current policies and legislation pertaining to physiotherapy and c) interviews with physiotherapists that are key stakeholders in the policy development process. The data was analysed using the Walt and Gilson (1994) policy analysis triangle framework.

Results

Literature review showed a paucity of available research addressing the topic of this study. The analysis of current policies outlined that in both countries physiotherapy is embedded in a regulated health care system, providing a framework for policy. An important outlined gap is the outdated regulation governing physiotherapy in both countries. The physiotherapy key stakeholders expressed that physiotherapists in Belgium and South Africa have an opportunity to engage in policy development as stakeholders through their professional associations. Strong elements addressed for Belgium were the accessible physiotherapy services and a secured budget for physiotherapy services. South African key stakeholders outlined the importance of

being a self-regulating profession. The lengthy policy development process and the inadequate budget were outlined as important gaps in both systems.

Conclusion

Important gaps such as disempowerment of Belgian physiotherapists and the lack of knowledge on physiotherapy policy development by South African regulators were revealed. These gaps point to the need of well targeted advocacy to showcase the value of physiotherapy to other involved stakeholders. The outlined strength of being a part of a regulated health care system enables physiotherapists to influence policy development. Knowledge on how policy development is organised will allow more physiotherapists to engage and participate in legislative processes.

Ethical consideration

Ethical clearance was granted from the University of the Witwatersrand Human Resources Ethics Committee (Medical) with protocol number M180852 on 17/10/2018.

Key words

Physiotherapy policy, Policy analysis, Belgium, South Africa

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LIST OF ABREVIATIONS

AH - Allied Health

CAO – Collectieve ArbeidsOvereenkomst (Collective Labour Agreement)

CBR - Community Based Rehabilitation

CPD - Continuous Professional Development

DPO - Disabled People Organisation

FOD - Federale Overheidsdienst *(Federal Public Service)*

FRK - Federale Raad voor Kinesitherapie *(Federal Council for Physiotherapy)*

HPCSA - The Health Professions Council of South Africa

NCOP - National Council of Provinces

NEDLAC - National Economic and Development and Labour Council

NGO - None-governmental Organisation

NMS - Neuro Musculo Squélettiques *(Neuromuscular Skeletal)*

PHC AH - Primary Health Care Allied Health

RIZIV - Rijksinstituut voor ziekte – en invaliditeitsverzekering *(NIHDI – National Institute for Health and Disability Insurance)*

SASP - South African Society of Physiotherapy

TMO - Thérapy Manuelle Othopédique *(Orthopedic Manual Therapy)*

TRK - Technische Raad voor Kinesiterapie *(Technical Council for Physiotherapy)*

WCPT - The World Confederation for Physical Therapy

WHO - The World Health Organization

CHAPTER ONE – INTRODUCTION

1.1 Background and need

The first chapter starts with a brief general overview of the global physiotherapy community, the definition of physiotherapy and the concept of health policy. In this global setting, the general legal concepts of physiotherapy in Belgium and in South Africa will be outlined. This outline demonstrates the possibility of comparing both systems. Through this comparison strengths and gaps can be identified. Identification and categorisation of these issues can provide physiotherapists and people advocating for physiotherapy with valuable elements for future negotiations with regulating instances and policy makers. The significance of this study lies in the possible utilisation of gaps identified within the policy framework when South African's and Belgium's guiding policies for physiotherapy are compared from a physiotherapy point of view.

1.2 Introduction

1.2.1 Physiotherapy

Physiotherapy on a global level is represented by The World Confederation for Physical Therapy (WCPT). The WCPT was founded in 1951 by 11 founding member organisations, including the South African Society of Physiotherapy (WCPT, 2019).

WCPT defines physiotherapy in the glossary as follows: "The services for individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan." (WCPT, 2017a). The scope is described comprehensively in the WCPT policy statement: Description of Physical Therapy (WCPT, 2015). In its core aspect, specific service delivery to the community, physiotherapy is the same all over the world.

1.2.2 Health policy

The World Health Organization (WHO) defines health policy as *"the decisions, plans, and actions that are undertaken to achieve specific health care goals within a society"* (WHO, 2019). A policy document is not a law; however, it will often identify new adaptations to laws needed to achieve its goals. The methods and principals

used to accomplish the policy goal are outlined in a policy (Education and Training Unit, n.d.).

In spite of the common understanding of the definition of physiotherapy, the policies governing physiotherapy services to the community throughout the world differ. Constructed legislation is determined by available and sufficient resources, the public opportunities and the validity of the set goals within the political timeframe (Rütten et al., 2003). The next paragraphs will explore and outline the policy frameworks in Belgium and in South Africa more profoundly.

1.3 Policy framework in Belgium

Physiotherapy in Belgium is regulated by the Federale Overheidsdienst Volksgezondheid, Veiligheid van de voedselketen en leefmilieu *(Federal Government Service Public Health, Safety of the foodchain and environment)* (Federale OverheidsDienst Volksgezondheid, 2016). A physiotherapist in Belgium has to follow strict legal outlines under health insurance. The ministries of Social Affairs and Public Health are the regulating bodies who implement laws, royal decrees and ministerial decrees, ordinances, regulations and rules of interpretation (Stappaerts, 2017).

Figure 1.1 outlines the legal procedure under the governing ministry of Social Affairs in Belgium. This procedure is followed for all new policy and to make a change in existing policy in healthcare legislation for physiotherapy. The solid arrow lines indicate connection between committees in the Rijksinstituut voor Ziekte en Invaliditeitsverzekering *(National Institute for Health and Disability Insurance)* (RIZIV) where physiotherapists are involved. The dotted arrow lines indicate interactions between committees or instances where physiotherapists are not involved. Finally, the striped arrow line indicates the federal governments connection with the regional government. Figure 1.1 also includes references towards the possible involvement and level of influence of physiotherapists in the policy development process.

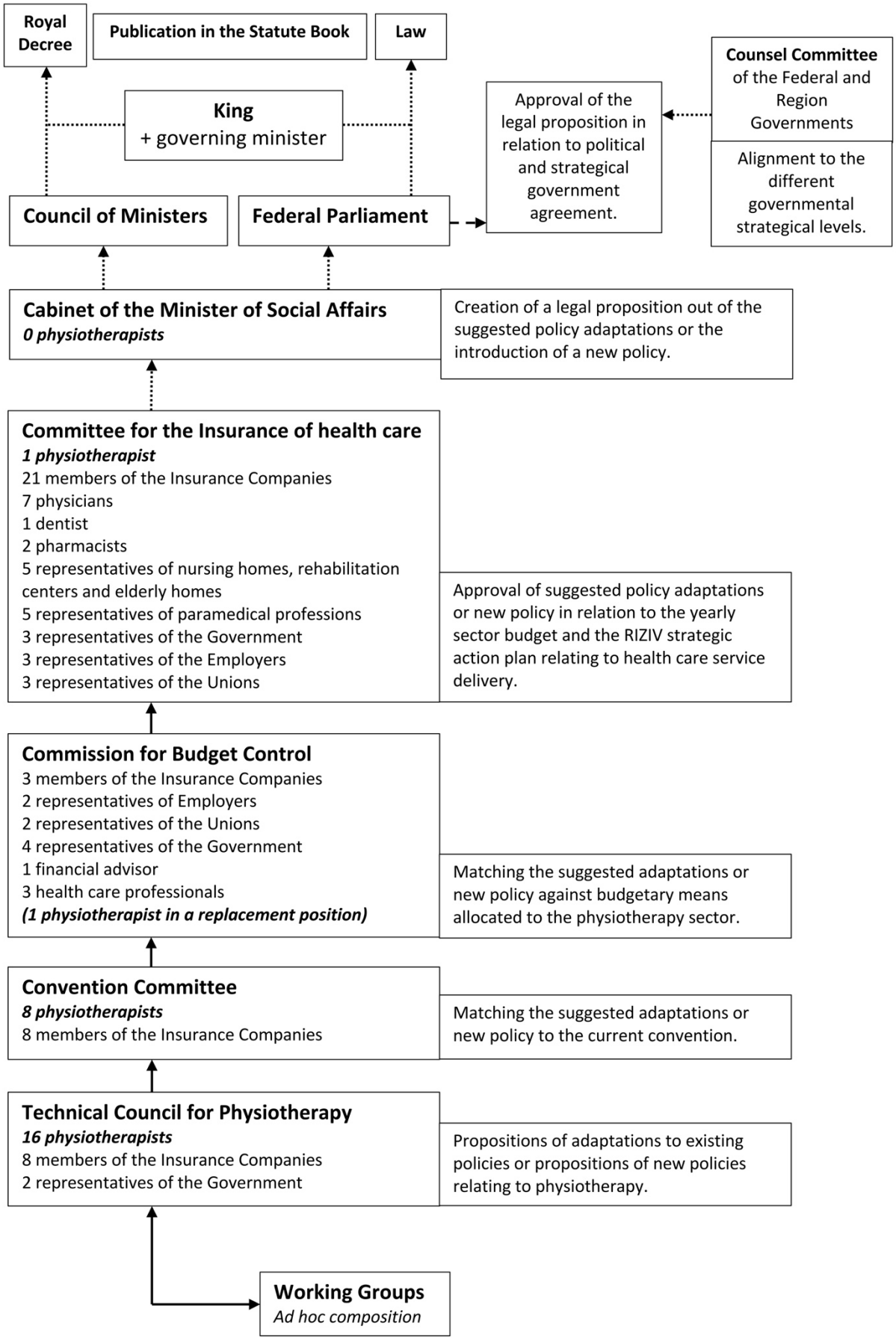

Figure 1.1 Physiotherapy policy development framework in Belgium adopted from RIZIV (2019a) and from Vlaams Parlement (2019).

In the Nomenclature for medical interventions, the annex of the Royal Decree of 14 September 1984, article 7 deals with the nomenclature for physiotherapy. Article 7 is under section 3 of Chapter III, the common medical aid (RIZIV, 2018a). The current nomenclature version active since 1 November 2017 is accessible online. An example of policy changes that may be taken through the process in Figure 1.1 is the autonomy of physiotherapists to decide if a treatment should take place in the physiotherapy practice or in the domicile of the patient. Before this change in 2015, it was the medical doctor prescriber's decision. From the proposal to the legal publication in the Statute Book the procedure took nearly one and a half years (RIZIV, 2018b).

There is a lack of physiotherapists' involvement in the policy development regarding legislation reformation affecting physiotherapy in Belgium. An example is the case when the governing minister drew up a plan to reform the entire healthcare system in Belgium (De Block, 2016). No representative physiotherapists were invited to give their professional input prior to the presentation of the written plan. Bijlsma, Bots, Wolters and Hoekstra (2011) found that involving affected stakeholders in the policy development facilitates the development process. It is therefore questionable why physiotherapists were not involved in the process as it has direct implications on physiotherapy as a service to the community within the national health care system.

Although physiotherapists were not consulted prior to the presentation of the health reform plan, one positive implication can be identified. A hint towards mandatory continuous professional development (CPD) is written down. The reform underscored the need for being a competent professional in a multidisciplinary, patient-centered health care model. This recommendation may influence physiotherapy practice positively as to date physiotherapists in Belgium are not obligated to engage in CPD and lifelong learning (De Block, 2016).

An absolute negative implication of the proposed reform is found in the following statement: "Acts for which the physician was made exclusively competent: conducting non-therapeutic experiments" (De Block, 2016). This adaptation implies there is an exclusive competence of the physician to conduct research with

participants making it illegal for physiotherapists, master students, PhD-students and professors to conduct or supervise research involving participants.

1.4 Policy framework in South Africa

In South Africa, the Health Professions Council of South Africa (HPCSA) serves as the promotor of public health care and safeguards the public and the health care professionals. This is done by guiding and regulating the health professions (HPCSA, 2018a).

The policy process in South Africa shown in Figure 1.2 has a top-down structure. In South Africa the starting point is the relevant minister, initiating the process. Figure 1.2 also shows the possible ways for physiotherapists to influence the policy throughout the process. These possibilities are indicated by the small striped arrows. The solid arrows indicate the pathway of the policy adaptation process. The wide striped arrows indicate the start of the second possibility for physiotherapists to interact with the proposition.

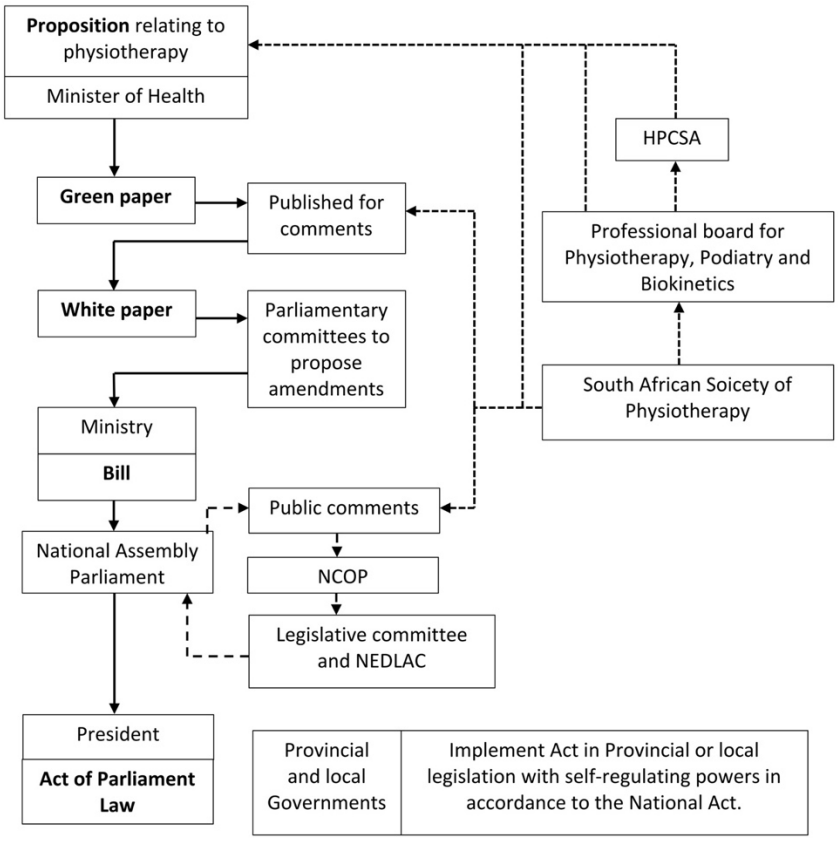

Figure 1.2 Physiotherapy policy development framework in South Africa adopted from Parliament of the Republic of South Africa (2019)

1.5 Problem statement

A preliminary search on PubMed learned that although research is done relating to health policies, it is not done specifically for physiotherapy. We applied a subsequent set of terms. The first search was performed on the words “health policy” in the title or abstract. The search resulted in 19.763 articles. For the second search we combined the words “health policy” and “reform”. The second search showed 1.089 articles. For the last search we combined the words from searches one and two with the words “Belgium” or “South Africa”. The search with Belgium provided five articles and the search with South Africa produced 11 articles. No article addressed policy reform relating to physiotherapy.

For both Belgium and South Africa there were articles on mental health care policy Lund and Flisher (2006) which described a set of norms for mental health services in South Africa. Lorant et al. (2016) analysed the priority target group of mental health services in the reform of psychiatric care in Belgium. We also found articles addressing the general health care systems. Gilson et al. (2012) performed a stakeholder analysis to support moves towards universal health coverage in South Africa. Bantuelle (2013) analysed if the fragmented political system continues to restrict health promotion.

Furthermore, Gilson and Raphaely (2008) conducted a comprehensive study on health policy analysis in low and middle-income countries. The conclusion was that published work is scarce. None of the included papers in their article addressed physiotherapy as a rehabilitation profession.

Belgium and South Africa are both countries where physiotherapy is regulated. The national legislative structure of South Africa is comparable to the national structure in Belgium. In South Africa the provinces have profound self-regulation powers regarding health care policies. Even though South Africa is regarded as a developing country, the policies governing physiotherapy in South Africa are more advanced than the policies structuring physiotherapy in Belgium (HPCSA, 2018a) (RIZIV, 2018a).

Comparing processes between two countries may benefit physiotherapists and improve their influence on systems governing them. The rationale behind comparing the processes between Belgium and South Africa is to identify similarities and gaps that may contribute to a better understanding of how physiotherapy is regulated in both countries. We did not find a study undertaken by physiotherapists to assess how policy influences, enables or prohibits their practice and ability to interact with the patient. Policy governing physiotherapy services towards the community in Belgium and in South Africa is developed mostly without the full involvement of physiotherapists as stakeholders. A study of policy development in two countries with differing levels of involvement could through a descriptive process illuminate possible gaps in the process in involvement and outcomes required by physiotherapists.

1.6 Research question

The question investigated was: What are the strengths and gaps of the policy framework towards enhancement of physiotherapy service delivery in Belgium and in South Africa?

1.7 Aim of the study

The aim of the study was to analyse the current rehabilitation policies underpinning physiotherapy service delivery in Belgium and South Africa.

1.8 Objectives of the study

The objectives of the study were to:

- Describe articles and policy documents relating to physiotherapy in Belgium and in South Africa.
- Identify key role players in the policy process relating to physiotherapy in Belgium and in South Africa.
- Compare the structure, content and the level of inclusion of physiotherapy within the legislative framework between Belgium and South Africa using the Walt and Gilson (1994) Framework.
- Compare the outcomes of policy documents relating to physiotherapy in Belgium and in South Africa with the proposed minimum standards of the WCPT.
- Identify similarities and differences in the policies and the policy frameworks that could highlight strengths or gaps in physiotherapy practice.

1.9 Significance of the study

Walt and Gilson (2014) argued that analysis of policy processes in different settings is difficult due to the inherent complexity. However, they found that a synthesis adds value, cross-country and cross-policy. It is evident that there is a different approach to policy formulation in South Africa and Belgium. The analysis of the policies in both countries revealed the goals and gaps in the policy processes, context, content and among stakeholders. The revelation of differences and similarities will contribute to recommendations for improvement in physiotherapy policy for practice, education and future policy changes in both Belgium and South Africa.

Physiotherapists need to understand the possibilities that exist to change the legislative environment in which they operate. Once there is a clearer understanding of this, more physiotherapists can participate in the legislative processes, advisory boards or think tanks to contribute significantly in the process of policy making and the adaptation of legislation. This can only be done with increased knowledge and understanding of the global, national and the regional manner in which policies are developed.

Thomas (2000) outlined key reasons for writing a dissertation. We can link the significance of the dissertation to three of the key reasons. Firstly, the subject of the dissertation deals with something we do no know already. The preliminary search confirmed the perceived paucity of available literature. Secondly, the researched topic affects a lot of people in a particular unfortunate way. Stakeholders in the area of rehabilitation and physiotherapy in Belgium and South Africa are all affected by policy. The extent of involvement has thus far not been interrogated. In addition, policies that impact and direct physiotherapy and rehabilitation practice have not been assessed in terms of their content and context as no literature could be found to support this. An understanding of policy in terms of stakeholder engagement, the contextual factors and the actual content of the policy will hopefully enable key stakeholders to engage and fully participate in the development and enactment of policy that affects them. Mapping and analysing the strengths and gaps of the policies and policy frameworks and being able to make comparisons could enable positive steps towards physiotherapy policy development.

1.10 Conclusion

The general description of how physiotherapy is defined by the global physiotherapy community and the WHO's definition of a health policy, provided a basis for this research. In this first chapter the difference in physiotherapy policy development between Belgium and South Africa is described. Policy development in Belgium is structured in a bottom-up manner while in South Africa it is constructed in a top-down manner. The Belgian structure allows physiotherapists to exercise some influence in policy development at base level. Following the policy development framework in Belgium, proceeding towards more executive levels of decision-making, Belgian physiotherapists have minimal powers. In South Africa, physiotherapists in general have two possibilities to weigh in on physiotherapy policy development in the top-down structured framework. In the next chapter an outline of the study methodology is provided.

CHAPTER TWO – METHODOLOGY

2.1 Introduction

In this study, we used a policy analysis to examine existing policies in order to establish a framework that would support and improve expected outcomes for physiotherapy services. Walt and Gilson (1994) stated that a comprehensive framework for thinking about health reform is obtained through policy analysis rather than through approaches concentrated on the technical features of the content of policy development or policy adaptations. Therefore this research sought to understand the physiotherapy legislative framework and process through a policy analysis framework.

2.2 Type of study

The study is a qualitative content analysis design using a directed approach (Hsieh & Shannon, 2005). Themes previously identified from the data are the basis for the analysis. Walt and Gilson (1994) described the themes as the factors influencing a policy as the context, content, processes and actors. The outlined procedure qualifies as a deductive approach (Gale, Heath, Cameron, Rashid & Redwood, 2013).

Figure 2.1 has been adapted from Walt and Gilson (1994) initiating the important interaction in policy analysis. The four main influencing concepts, context, actors, process and content, were the themes in the qualitative analysis. The adaptations from the, by Walt and Gilson (1994) suggested simple analytic model are the created subthemes derived from the literature. These sub concepts are added in Figure 2.1. and include under context structural, situational and cultural. Actors include interests and concerns, stakeholders and influence and power. Content includes the objectives, policy design and specific mechanisms while process involves stages, strategies and dealing with actors.

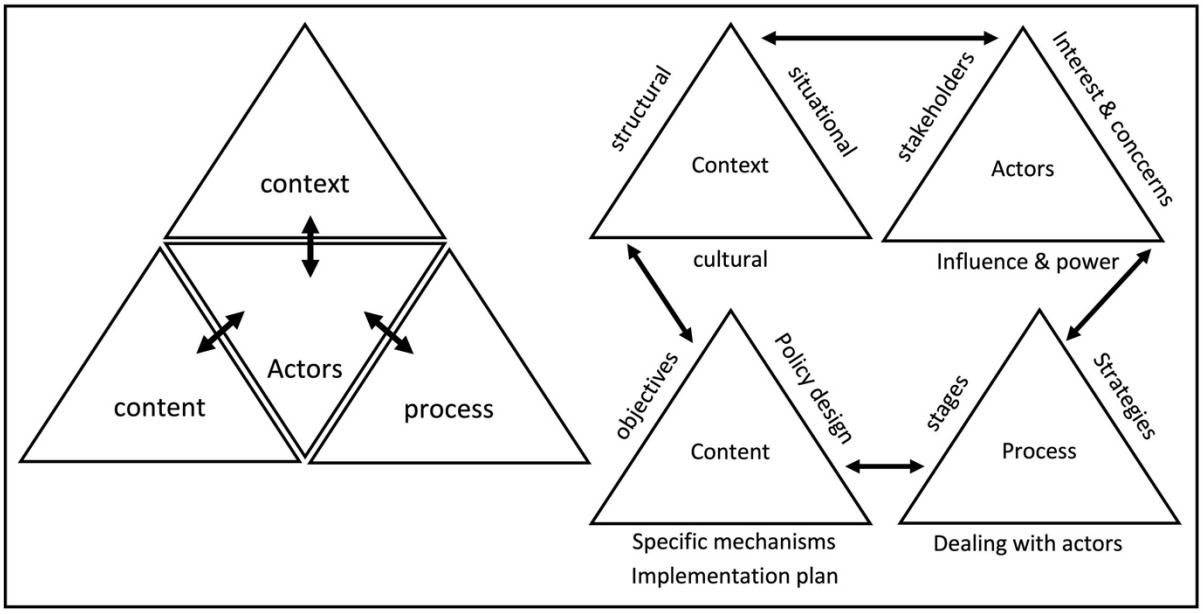

Figure 2.1 Adapted model of health policy analysis (Walt & Gilson, 1994)

For each concept, three or four sub concepts are defined from the literature.

Table 2.1 provides a schematic diagram of the relationship between the themes and subthemes. The third column in Table 2.1 explains the meaning of the adjoint sub concept. The fourth column provides the interpreted meaning to physiotherapy in the context of this study. The examples provided under the contextual interpretation in physiotherapy are not limited and will be expended on based on the results of the study.

Table 2.1 Walt and Gilson themes and categories

Theme	Subtheme	Meaning	Contextual interpretation in physiotherapy
Context	Structural	"How" is the policy structured?	In line with WCPT or HPCSA.
	Situational	"Why" is the policy structured as it is?	To address quality of care, to ensure continuity of effective patient/client services
	Cultural	Societies values incorporated in the policy?	Physiotherapy as a medical profession. Professional ethics.
Actors	Stakeholders	People influenced by / influencing the policy.	Physiotherapists, patients, other health care professionals.
	Interests and concerns	What binds the actors to the policy?	Access to primary health care and direct access to physiotherapy.
	Influence and power	Possibilities and restrictions for actors in the policy?	Consultation and stearing powers of physiotherapists during the processes.
Content	Objectives	Outlines of the aim and goals of the policy.	Structuring private practice, the connection between education and profession.
	Policy design	Details on the set-up of the policy.	Law, policy.
	Specific mechanisms	New features, incorporated elements, developments or adaptations to the existing policy.	Creating central databases.
	Implementation plan	Outlines of the process to incorporate content.	Consultation rounds with stakeholders, step by step gradual implementation.
Process	Stages	The progressing steps in order to implement the policy.	Subsequent steps according to the installed processes outlined in figure 1.1 and figure 1.2, incorporated analysis of existing policies.
	Strategies	Outlines of the strategic plan to meet the objectives with coherent and subsequent actions.	Quality improvement plan, server user satisfaction measurement.
	Dealing with actors	Outlines the reputation and credibility within the context of the policy.	Continuous professional development, professional collaboration.

2.3 Procedure

Details on the methodologies are provided in each chapter. Step one of the research procedure started with a scoping review on existing physiotherapy policy frameworks in Belgium and South Africa. Arksey and O'Malley (2005) described that scoping studies aim to map important concepts from a research area. For this dissertation, we used a scoping review to establish what research existed in the area of rehabilitation and physiotherapy policy. According to Arksey and O'Malley (2005) scoping reviews are conducted to investigate the following:

- To examine the extent, range and nature of research activity.
- To determine the value of undertaking a full systematic review.
- To summarise and disseminate research findings.
- To identify research gaps in the existing literature.

A broad preliminary search outlined a general paucity of research around policy in physiotherapy specifically. No review could be found that gave a comprehensive picture and therefore this study would begin to address the gap.

For step two we used the policy triangle framework developed by Walt and Gilson (1994) to perform an analysis of legislation governing physiotherapy. Validation of the findings and identifying further gaps was searched through the key stakeholder interviews. The procedure went through these different steps to cover the stated research objectives. Table 2.2 outlines the methodological approach to the objectives and places search strategies where applicable.

Table 2.2 Research procedure outline

Specific objective	Methodological approach
Conduct a scoping review on policy documents related to physiotherapy in Belgium and in South Africa.	- Identify available policy documents relating to physiotherapy in Belgium and in South Africa. - Select and review identified policy documents relating to physiotherapy in Belgium and in South Africa using a directed content analysis. - Identify key role players through appearance and references in the selected documents.
Describe selected policy documents.	
Identify key role players in the selected policy documents.	
Compare context, content and level of inclusion of physiotherapy in legislative frameworks against the proposed minimum standards of the WCPT.	
Identify similarities and differences in the policies and the policy frameworks that could be strengths or gaps to physiotherapy practice.	- Conduct key informant semi-structured interviews - Analysis of policy documents via directed content analysis

Mortelmans (2013) states there are four issues of trustworthiness in qualitative research: credibility, transferability, dependability and confirmability.

In this study we applied techniques, described by Lincoln and Guba (1986), to address the components of trustworthiness. Table 2.3 gives an overview of all four trustworthy issues and provides an explanation on how this study carefully took all of them into account.

Table 2.3 Addressing the issues of trustworthiness in this study (Mortelmans, 2013)

Issue	Definition	Compliance in this study
Credibility	Link the research study's findings with reality to ensure the truth of the findings.	- Triangulation. - Member checking.
Transferability	Generalisation to ensure findings are applicable in other contexts.	- Purposive sampling - Search for generic patterns. - Description of collected data
Dependability	Possibility to repeat the study by other researchers with similar findings.	- Possible confirmation of the process and derived data through detailed description of the methodology.
Confirmability	The degree of neutrality in the study's findings based on participants responses and not on any potential bias by the researcher.	- Logging of decisions rationale. - Use of data only obtained from interview transcripts.

Credibility for truth value was assured through triangulation. In this study we looked at data findings from literature, grey literature and interviews as a means of multiple resources. We used member checking for accuracy when interview participants were given the opportunity to verify their answers in the language in which the interviews were conducted. All participants of the interviews confirmed the accurate representation of their input in the transcripts. After translation to English for the interviews conducted in Dutch and French, the participants were given a final opportunity to check and confirm transcripts were an accurate representation. The translations were deemed accurate representations of the conducted interviews by the Dutch and French participants of the interviews.

Transferability for applicability was obtained by means of purposive sampling and the search for generic patterns in a small sample of two countries to ensure a theoretical generalisation. The description of the collected data is basic information usable by other researchers. The researchers identified key role players in the policy process from both countries involved in the study. The selected persons understand the policies and they were elected to represent their respective countries through their

national society. These are the contextual outlines (Lincoln & Guba, 1986) to which findings were derived.

The complete and detailed description of the methodology complies with the possibility of confirmation of the consistency of the process and the derived data addresses the aspect of dependability. The research, under supervision did not deviate from the outlines agreed at the start of the study. The aims and objectives served as strict guidelines to every subsequent aspect of the study.

To address the issue of confirmability of the study to ensure neutrality, the researcher adopted a mentality of reflexibility (Attia & Edge, 2017) throughout the research process. Confirmability was met through the rationale to log every decision to ensure an audit trail. To exclude potential bias from the researcher only data derived from the literature, the policy documents and the interview transcripts were analysed.

2.4 interview Participants

Participants for the interviews for key role players were selected based on the responsibilities they hold in the policy framework process and their roles in the profession from both countries. Presidents of the professional physiotherapy associations from both countries were interviewed either in person or telephonically. In addition, for South Africa, a physiotherapy representative in the Health Professions Council of South Africa's professional board for Physiotherapy, Podiatry and Biokinetics was invited for an interview. A professional consultant from the South African Society of Physiotherapy was also invited to participate in the interview process. For Belgium, the president of the Technical Council for Physiotherapy and the president of the Federal Council for Physiotherapy were invited to participate in the interviews.

2.5 Ethical consideration

Ethical clearance was applied for and granted from the University of the Witwatersrand Human Research Ethics Committee (Medical) on 17/10/2018 with protocol number M180852. The considered date for unconditional approval was 31/08/2018 (Appendix A).

Participants who took part in the interviews were invited in the study on a voluntary basis. Each participant signed an informed consent (Appendix B) agreeing on participating in an individual interview that was recorded. Participants were informed of their right to withdraw from the study at any given time, without consequences. The confidentiality of the participant's records was guaranteed through external, offline storage of the data. All data will be destroyed permanently after two years if the report is published or otherwise after six years if there is no publication.

CHAPTER THREE – SCOPING REVIEW

3.1 Introduction

The legislative structure of South Africa is comparable to the structure in Belgium. South Africa is categorised as a developing country by the United Nations (United Nations, 2019) and yet, policy governing physiotherapy in Belgium is not as advanced (Stappaerts, 2017) (SASP, 2012). In South Africa the provinces have self-regulation powers regarding health care policies (South African Department of Health, 2004). After the sixth state reform, initiated on October 11, 2011 (Vlaamse Overheid, 2018), the changes made in the two Belgian regions, Flanders and Wallonia, resulted in similarities of regulatory powers to those described for the South African provinces. The issues that are similar and are affected by this reformation, related to this study are Gezondheidszorg en welzijn *(Health Care and well-being)*, Arbeidsmarkt *(Employment)*, and Andere *(Others)*. For Employment, the regions are now competent to set rules on outplacement and on economic migration. Within Health Care and well-being autonomous decisions relating to rehabilitation, mental health care and geriatrics are in the sphere of the regions. Under the chapter Others the executive decision making relating to logistics regulation surrounding self-employed professionals is covered (Vlaams Parlement, 2019).

In spite of these changes that align the two regions in Belgium to the South African legislative environment there are evident differences. The legislation structuring physiotherapy policy development in Belgium appears to be challenging to physiotherapists when proposing adaptations to current policies. In the next paragraphs detail is provided to illustrate this challenging situation.

Firstly, the closed – envelope budgetary system (RIZIV, 2014) for each separate health care profession, makes it impossible to introduce adaptations or new features that could have a negative financial impact. The closed – envelope system ensures every Belgian health care sector has its own budget, however this budget contains structural and yearly imposed governmental economisations (Commission for Budget Control, 2019). All policy adaptations need to be within the fixed attributed sector budget. The most recent report of the Commission of Budget Control (2019) dealing with billed physiotherapy services in the year 2018, revealed a maximised utilisation

of available financial resources for physiotherapy services. Therefore, introducing adaptations with financial implications is only considered if matching economisations in the budget are presented alongside.

Secondly, as illustrated in Figure 1.1, physiotherapists have limited to no influence on executive decisionmaking levels in the policy development process. Figure 3.1 provides more detail on the possible level of physiotherapist's influence. This influence is linked to the number of physiotherapists mandated in the different hierarchic National Instititute for Health and Disability Insurance (RIZIV) structures, illustrated in Figure 1.1. This potential influence is placed against the executive powers of the structures.

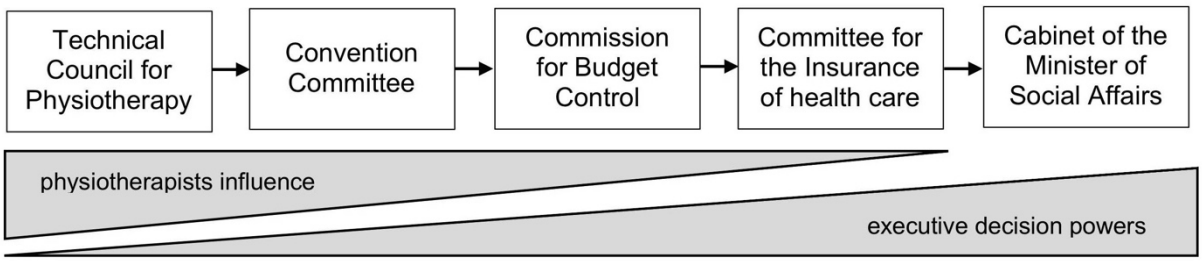

Figure 3.1 Physiotherapist's influence in RIZIV structures adopted from RIZIV (2019a)

It is illustrated that policy governing physiotherapy services towards the community in Belgium and South Africa is often developed and reviewed without the full involvement of physiotherapists as stakeholders. Figures 1.1 and 1.2 illustrate the possible interactions and the levels of engagement physiotherapists possess in the policy development process. Therefore, the research sought to gain an understanding of previous research that could illuminate processes in which physiotherapists had been involved in policy formulation or review, to identify, from literature, the system related elements that were used to evaluate community based rehabilitation (CBR).

3.1.1 Aim of the scoping review

The aim of this review was to identify from the literature policy research and policy related to physiotherapy (in relation to actors, content processes and context) in Belgium and South Africa.

3.1.2 Objectives of the scoping review

- To determine the availability of policy and policy related literature in physiotherapy.
- To determine the quality of literature in policy related literature in physiotherapy.
- To determine the policy related elements in the literature related to physiotherapy in terms of content, context, actors and process.

3.2 Methodology

The scoping review followed a five-step search strategy namely: to identify the research question and relevant studies, to select documents for the study, to chart the data, to collate, summarise and to report the results (The Joanna Briggs Institute, 2015).

3.2.1 Identification of the relevant study question

The research question for this scoping review was derived from the perceived situation of a paucity of existing literature addressing the possible influence of physiotherapists in the policies related to physiotherapy practice in Belgium and in South Africa. Through this scoping review, the question to answer was: “Which published articles addressed physiotherapy policy development in Belgium and in South Africa”.

3.3 Selection of relevant publications

Searches were made for the following databases: PubMed, Web of Science and Scopus. In paragraph 3.3.1 the searche procedure followed is outlined.

3.3.1 Search procedure

The following search terms were employed in different combinations, in three languages:

- ‘South Africa’, ‘Belgium’, ’Physiotherapy’, ‘Physical Therapy’, ‘Physiotherapist’, ‘Physical Therapist’, ‘Health Care’, ‘Policy’, ‘Legislation’, ‘Influence’, ‘Stakeholder’ and ‘Framework’.
- ‘Zuid Afrika’, ‘België’, ‘Kinesitherapie’, ‘Kinesitherapeut’, ‘Gezondheidszorg’, ‘Beleid’, ‘Wetgeving’, ‘Invloed’, ‘Belanghebbende’ and ‘Kader’.
- ‘Afrique du Sud’, ‘Belgique’, ‘Kinésithérapie’, ‘Kinésithérapeute’, ‘Soins de Santé’, ‘Politique’, ‘Législation’, ‘Influence’, ‘Partie Prenante’ and ‘Cadre’.

The combinations used followed the subsequent pattern, based on the Boolean search strategy:

English:

- ‘South Africa’ AND ‘Physiotherapy’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘South Africa’ AND ‘Physiotherapist’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘South Africa’ AND ‘Physical Therapy’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘South Africa’ AND ‘Physical Therapist’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘Belgium’ AND ‘Physiotherapy’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘Belgium’ AND ‘Physiotherapist’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘Belgium’ AND ‘Physical Therapy’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)
- ‘Belgium’ AND ‘Physical Therapist’ AND (‘Health Care’ OR ‘Policy’ OR ‘Legislation’ OR ‘Influence’ OR ‘Stakeholder’ OR ‘Framework’)

Dutch:

- ‘Zuid Afrika’ AND ‘Kinesitherapie’ AND (‘Gezondheidszorg’ OR ‘Beleid’ OR ‘Wetgeving’ OR ‘Invloed’ OR ‘Belanghebbende’ OR ‘Kader’)
- ‘Zuid Afrika’ AND ‘Kinesitherapeut’ AND (‘Gezondheidszorg’ OR ‘Beleid’ OR ‘Wetgeving’ OR ‘Invloed’ OR ‘Belanghebbende’ OR ‘Kader’)
- ‘België’ AND ‘Kinesitherapie’ AND (‘Gezondheidszorg’ OR ‘Beleid’ OR ‘Wetgeving’ OR ‘Invloed’ OR ‘Belanghebbende’ OR ‘Kader’)
- ‘België’ AND ‘Kinesitherapeut’ AND (‘Gezondheidszorg’ OR ‘Beleid’ OR ‘Wetgeving’ OR ‘Invloed’ OR ‘Belanghebbende’ OR ‘Kader’)

French:

- ‘Afrique du Sud’ AND ‘Kinésithérapie’ AND (‘Soins de Santé’ OR ‘Politique’ OR ‘Législation’ OR ‘Influence’ OR ‘Partie Prenante’ OR ‘Cadre’)
- ‘Afrique du Sud’ AND ‘Kinésithérapeute’ AND (‘Soins de Santé’ OR ‘Politique’ OR ‘Législation’ OR ‘Influence’ OR ‘Partie Prenante’ OR ‘Cadre’)
- ‘Belgium’ AND ‘Kinésithérapie’ AND (‘Soins de Santé’ OR ‘Politique’ OR ‘Législation’ OR ‘Influence’ OR ‘Partie Prenante’ OR ‘Cadre’)
- ‘Belgium’ AND ‘Kinésithérapeute’ AND (‘Soins de Santé’ OR ‘Politique’ OR ‘Législation’ OR ‘Influence’ OR ‘Partie Prenante’ OR ‘Cadre’)

3.3.2 Inclusion and exclusion criteria

Inclusion of articles in this scoping review was structured on the articles’ relation to the existing policy framework in Belgium or in South Africa. All articles from 2003 to August 2018, published in English, Dutch or French were considered for inclusion in this scoping review. The year 2003 is the first year after major imposed reformations of physiotherapy service delivery in Belgium due to a substantial structural budget cut by the governing Minister of Social Affairs (RIZIV, 2018a). Table 3.1 outlines the eligibility criteria of the studies.

Table 3.1 Eligibility criteria

	Inclusion criteria	Exclusion
Country	All studies conducted on policies addressing the legal framework in Belgium or the legal framework in South Africa.	Studies addressing policy framework in other countries. Studies not addressing policy research in Belgium or in South Africa.
Subject	All articles, from January 2003 to August 2018 on policies addressing: • Context – What is physiotherapy in Belgium or in South Africa? • Actors – All issues relating to stakeholders in the policy framework. • Content – The framework of the physiotherapy scope of practice in the legislative framework. • Process – The structure of processes installed, providing physiotherapists with possibilities of engagement in the policy framework.	Literature preceding 2003 and all other documents not addressing the physiotherapy framework in Belgium or in South Africa.
Study type	All qualitative, quantitative and mixed methods studies published in peer reviewed literature.	

3.4 Extraction and charting of the data

3.4.1 Data findings

The search on the Web of Science database conducted on 21 October 2018, in English matched 15 reviews with the criteria. The same search conducted in Dutch and French matched zero reviews. None of the reviews addressed physiotherapy policy development. Figure 3.2 gives an overview of the search.

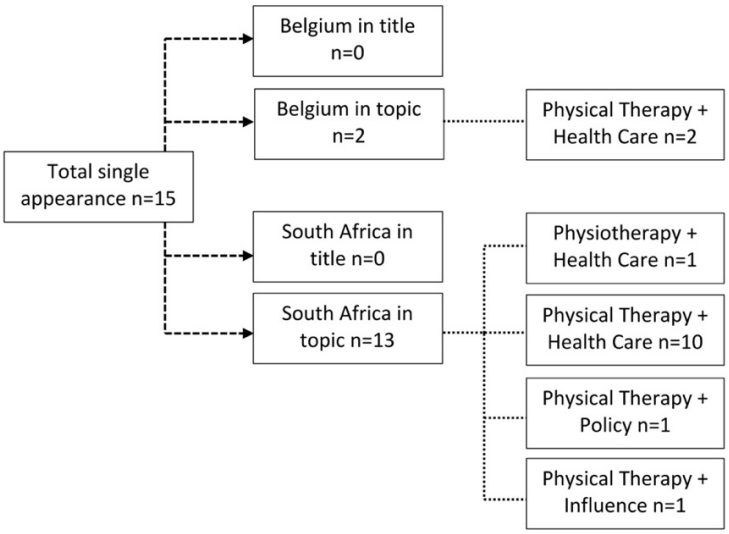

Figure 3.2 Web of Science search outline

The search in the PubMed database conducted on 27 October 2018, in English matched 21 articles with the criteria. The same search conducted in Dutch and in French matched zero articles. Out of the 21 articles, two articles addressed issues related to physiotherapy policies. Figure 3.3 provides an overview of the search.

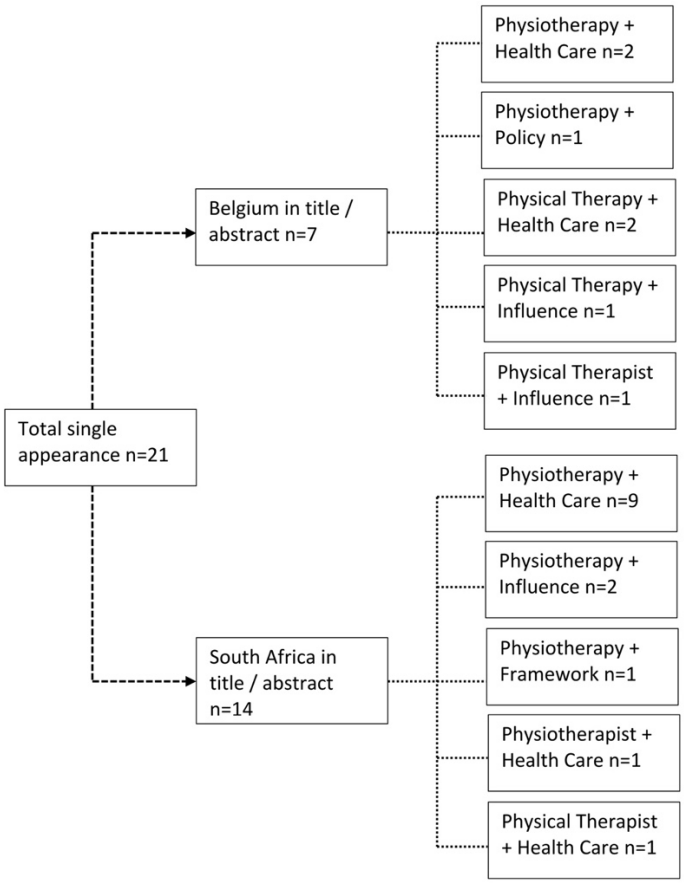

Figure 3.3 PubMed search outline

The search in the Scopus database conducted on 28 October 2018, in English matched 31 articles with the criteria. The same search conducted in Dutch and in French matched zero articles. Out of the 31 articles, one review addressed issues related to physiotherapy policies. Figure 3.4 provides an overview of the search.

For the search in Scopus, some of the search terms in English needed to be adapted. ‘Health Care’ is treated by the search engine of the database as ‘Health’ and ‘Care’. The search term ‘Health Care’ was replaced by ‘Healthcare’. The search with ‘Physical Therapy’ was left out as the search engine of the database treated ‘Physical Therapy’ as ‘Physical’ and ‘Therapy’.

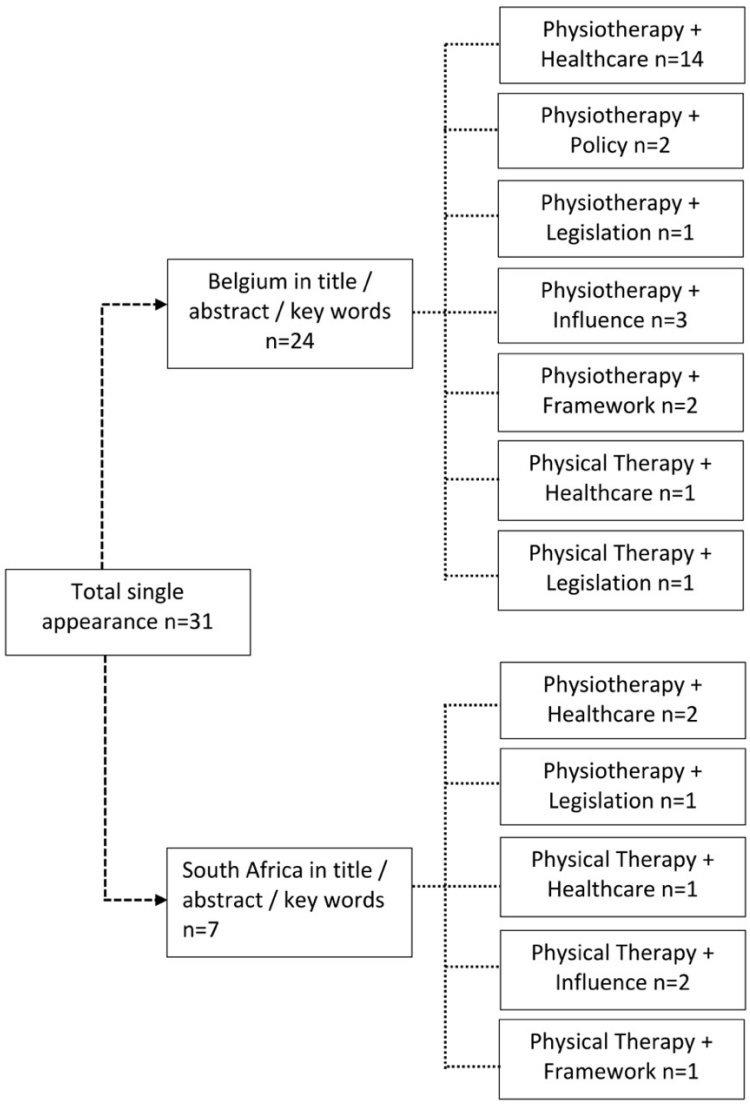

Figure 3.4 Scopus search outline

3.4.2 results

A total of 84 documents were identified from the databases, 17 duplicates were removed. A review of the titles and abstracts included three studies and excluded 81 articles.

References cited in the three selected articles were searched for additional information related to the study. A total of 99 references were identified. 72 references addressed studies within the year range set in the inclusion criteria. One duplicate was removed. Ten referenced documents were not retrievable due to invalid links and three references pointed to documents other than policy articles. The remaining 58 articles were excluded after review of the titles and/or the abstracts for not meeting the inclusion criteria, leaving zero additional articles.

Three articles were thus included in the scoping review. Figure 3.5 outlines the flowchart of the article selection process.

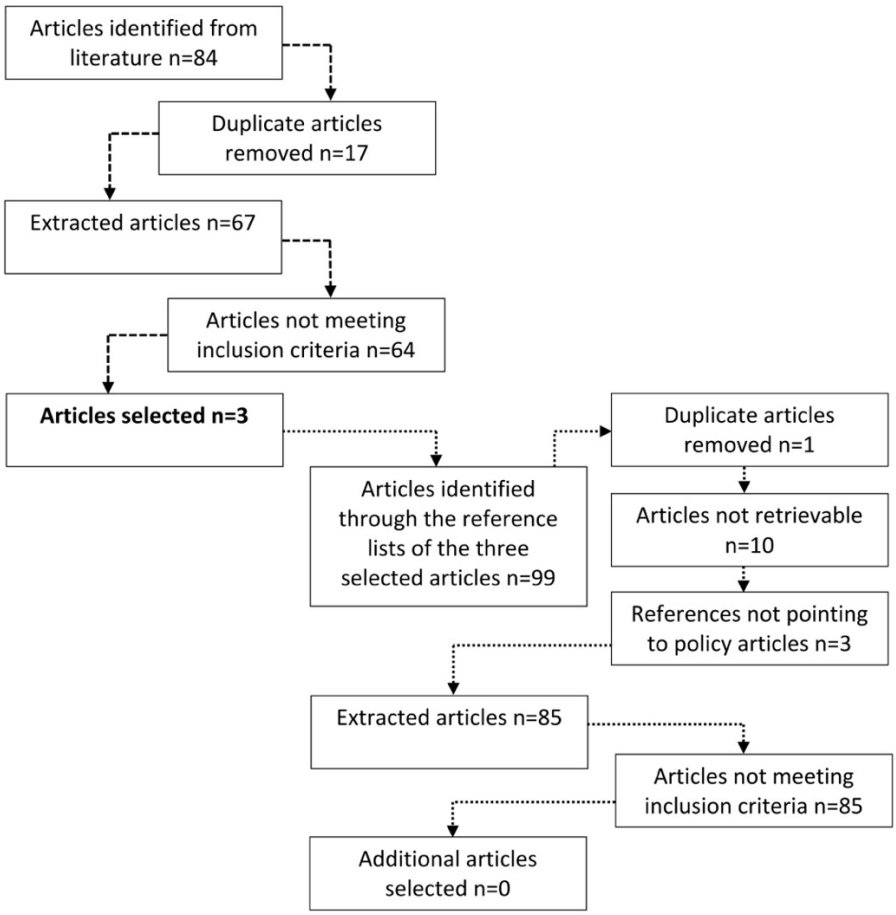

Figure 3.5 Flowchart of the article selection process

3.5 Description of the selected published literature

Table 3.2 charts the specifics of the data extracted from the selected literature including references towards the policy framework components and policy stakeholders.

Table 3.2 Characteristics of the incorporated articles

Title	Obstacles to the implementation of evidence-based physiotherapy in practice: A focus group-based study in Belgium (Flanders).
Author / Year of publication	Hannes, K., Staes, F., Goedhuys, J. and Aertgeerts, B. (2009).
Country	Belgium
Aim of the study	Identify the obstacles amongst Belgian physiotherapists to the implementation of evidence-based practice (EBP) in clinical work.
Objective of the study	Suggest solutions to the found obstacles in the developed problem tree.
Reference to the policy framework	Revealed links between the lack of autonomy of physiotherapists and the dominant position of the physicians having impact on the boundaries of the profession and the weight of physiotherapists in governmental advisory boards.
Reference to stakeholder	Physiotherapists, Physicians, Insurance Company, Government

Title	Mapping South African allied health primary care clinical guideline activity: establishing a stakeholder reference sample.
Author / Year of publication	Dizon, J.M., Grimmer, K., Machingaidze, S., McLaren, P. and Louw, Q. (2016).
Country	South Africa
Aim of the study	Establish a stakeholder reference sample by mapping South African allied primary care clinical guideline activity.
Objective of the study	Identify allied health engagement in primary care clinical practice guidelines.
Reference to the policy framework	The composition of the Provincial boards in South Africa as key role players in the South African physiotherapy policy framework.
Reference to stakeholder	National Government, Provincial Government, Physiotherapists, Private and compensable insurers

Title	La thérapie manuelle orthopédique: definition, caractéristiques et mis au point sur la situation en Belgique.
Author / Year of publication	Demoulin, C. et al. (2017).
Country	Belgium
Aim of the study	Provide a summary of the definition, the characteristics and the current situation in Belgium regarding patient's access and reimbursement.
Objective of the study	To summarise the history of manual therapy, in relation to the Belgian system. To describe and summarise the concepts, the techniques and the possibilities of treatment. To describe the current Belgian situation relating to manual therapy physiotherapy.
Reference to the policy framework	Lack of recognition from the general population and a majority of the medical community of manual therapy, making it very difficult to advance.
Reference to stakeholder	Physiotherapists, Patients, Government, Physicians

For the critique of the articles the Critical Appraisal Skills Programme (CASP) was used. The CASP uses a checklist with ten questions appraising three categories: rigour, credibility and relevance (CASP, 2018).

The questions 1-10 analysed the areas:

1. A clear statement of research aims
2. Appropriate qualitative methodology
3. How research design addresses research aims
4. Recruiting strategy to address the aims of the research
5. Data collection to address research issues
6. Consideration of the relationship between researcher and participants
7. Consideration of ethical issues
8. Sufficiently rigorous data analysis
9. A clear statement of findings
10. Value of the research

Table 3.3 outlines the appraisal of the selected articles to the CASP criteria. One of the three possible responses is indicated for each of the ten questions, providing a total score for each article.

Table 3.3 Outline of the CASP appraisal

Article	Response	1	2	3	4	5	6	7	8	9	10	total
Hannes, K. et al. 2009	Yes	✓	✓	✓		✓				✓	✓	6
	Can't tell				✓		✓	✓	✓			
	No											
Dizon, J.M. et al. 2016	Yes	✓	✓	✓	✓	✓		✓	✓	✓	✓	9
	Can't tell						✓					
	No											
Demoulin et al. 2017	Yes	✓		✓		✓				✓	✓	5
	Can't tell		✓		✓			✓	✓			
	No											

Question 6 was irrelevant for the article of the author Demoulin as it is a qualitative description and the study does not involve participants. Therefore the total score for this article is 5/9 in relation to the other articles scores against a maximum ten.

The three selected articles were all included in the analysis. The inclusion was based on the following criteria:

- Converting the CASP appraisal for each article to a percentage, all three articles arrive at a score above 50%.
- The selected articles are published and peer reviewed.
- The selected articles are cited at least once. (Google Scholar, 2019)

3.6 Analysis of the selected published literature

The quotes derived from the articles are matched to codes linked to the categories in the Walt and Gilson (1994) framework. The analysis is presented per article. Key issues are in italics.

Table 3.4 provides the content analysis for the article 1: Obstacles to the implementation of evidence-based physiotherapy in practice: A focus group-based study in Belgium (Flanders) (Hannes et al., 2009).

Table 3.4 Results of content analysis using Walt and Gilson matrix Hannes et al. (2009)

Theme	Subtheme	Category	Code	Quote
Actors	Influence and power	Professional collaboration	*One-way referral relation*	*The one-way relationship in which the physician decides whether a patient is referred to a physiotherapist ...*
	Interest and concerns	Scope of practice	*Professional autonomy*	*Belgian physiotherapists do not have professional autonomy.*
		Legal requirements	*Physician's obliged prescription*	*A physician is obliged to provide the patients with a prescription*
			Not allowed to deviate from physician's referral	Physiotherapists are bound to physicians' referrals and are officially not allowed to deviate from those
Context	Cultural	Professional collaboration	Advisory physiotherapists	Why the health insurance companies still don't have advisory physiotherapists is beyond me.
		Commercial influence	Believed commercial influence	Some doctors are believed to be influenced by commercial firms who promote certain products with incentives
		Professional collaboration	*Lack of autonomy*	*A lack of autonomy and authority as opposed to the dominant position of physicians*
			Limited negotiation powers	Compared to doctors, they have only limited power in negotiations
		Scope of practice	Comparable physiotherapy care for outpatients	The boundaries of the physiotherapy profession are not well defined. Hospitals, rehabilitation centres, and centres for mental health care provide outpatient physiotherapy care comparable to what is offered by private practitioners.
	Structural	Professional collaboration	Referral with limited number of treatment sessions	physicians tend to refer patients for a limited number of treatments at a time, forcing them to visit their physician for a new prescription repeatedly, which is considered a waste of money
			Little government support	*Government provides little support to grant physiotherapists legal monopoly over their sphere of work.*

The review of article 1 (Hannes et al., 2009) underscores the presence of a lack of autonomy for physiotherapists in Belgium, illustrated with the mandatory prescription. Furthermore, the article highlights that physicians are given a dominant position and physiotherapists have little power in the processes that govern them. Finally, the fact that the government provides little support on protecting the physiotherapy scope of practice is also addressed.

Table 3.5 provides the content analysis for the article 2: Mapping South African allied health primary care clinical guideline activity: establishing a stakeholder reference sample (Dizon et al., 2016).

Table 3.5 Results of content analysis using Walt and Gilson matrix Dizon et al. (2016)

Theme	Subtheme	Category	Code	Quote
Context	Cultural	Health care system	*no uniformity in organisation of support for PHC AH services*	*There were disability/rehabilitation portfolios at national and provincial governments, but no uniformity in provincial government organisation of, or support for, PHC AH services.*
Context	Structural	Health care system	*selection of Provincial governments*	*Provincial governments should be selected to reflect heterogeneity in local economics, population demographics and availability of university AH training programs*

The review of article 2 (Dizon et al., 2016) underscores the lack of uniformity in the organisation of PHC AH services and indicates to the important reflective selection of Provincial governments.

Table 3.6 provides the content analysis for the article 3: La thérapie manuelle orthopédique: definition, caractéristiques et mis au point sur la situation en Belgique (Demoulin et al., 2017). *(Orthopaedic manual therapy: definition, caractheristics and focus on the situation in Belgium.)*

Table 3.6 Results of content analysis using Walt and Gilson matrix Demoulin et al. (2017)

Theme	Subtheme	Category	Code	French code	Quote	French quote
Context	Cultural	Scope of practice	*Lack of recognition for manual therapy*	*Une méconnaissance au sujet de la TMO*	*Despite numerous scientific publications relating to Orthopaedic Manual Therapy and the significant growth of the number of manual therapists ... possessing international recognition, an enormous lack of knowledge from the general public and from the majority of the medical world persists on the topic of Orthopaedic Manual Therapy.*	*Malgré les nombreuses publications scientifiques relatives à la TMO ainsi que la croissance importante du nombre de thérapeutes manuels ... disposant d'une reconnaissance internationale, une méconnaissance majeure de la part de la population générale et de la majorité du monde médical demeure au sujet de la TMO.*
Context	Cultural	Legal requirements	*Mandatory physiotherapy prescription*	*Une prescription médicale demeure nécessaire*	*a medical prescription is still necessary today in Belgium for patients to access Orthopaedic Manual Therapy services.*	*une prescription médicale demeure actuellement nécessaire en Belgique pour pouvoir bénéficier d'une prise en charge en TMO.*

The review of article 3 (Demoulin et al., 2017) underscores the legal necessity of a medical prescription for manual therapy services. The lack of recognition for manual therapy is also highlighted.

3.7 Discussion

The two selected articles addressing Belgian policy, both highlight the lack of professional autonomy for physiotherapists because of the mandatory medical prescription. Professional autonomy is essential for growth and effective delivery of service. Changes have been shown in other professions such as nursing. Salhani and Coulter (2009) found that nurses working in Canadian mental health teams gained more administrative, organisational and content control over their work. Canadian nurses succeeded through both simultaneous and sequential micro-political advocacy. The nurses established political tactics and strategies to (re)organise themselves and other professionals through interprofessional collaboration. Belgian physiotherapists could adapt similar strategies for more professional autonomy advocacy.

Physicians, in their role as prescribers of physiotherapy services have a dominant position. The review on *factors influencing prescribing decisions of physicians* concluded that valid and practice guidelines could promote rational prescribing effectively (Davari, Khorasani & Tigabu, 2018). In relation to the Belgian legal outline, providing guidelines to physicians prescribing physiotherapy, could better direct prescription behavior towards patient benefit and proper use of physiotherapy.

Physicians also play an important role as appointed representatives for the insurance companies in the physiotherapy policy development process. In relation to physicians appointed as representatives for the insurance companies for physiotherapy policy development we can refer to a paper issued by the National Council of State Boards of Nursing (NCSBN) in the United States. NCSBN (2009) found that if one profession estimates that policy change on scope of practice encroaches their own scope of practice, they are more likely to oppose the legislative efforts to change the scope. Therefore the Belgian physiotherapists should strive for positions as representatives of the insurance companies. Turf battles on physiotherapy scope of practice would be countered, preventing costly legislative battles.

The legal protection of the government relating to the physiotherapy scope of practice in Belgium is missing according to one article. The Belgian physiotherapists are battling invasion in their scope of practice. Instead, Belgian physiotherapists should perhaps direct more efforts towards advocacy for a broader scope of practice. The statement is supported by nurses in the United States that have argued that reducing scope of practice restrictions, is in line with more value-based care (Committee for Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report, 2016). Belgian physiotherapists should invest their advocacy time in expansion of the scope of physiotherapy practice, backed up by quality education, rather than only looking at possibilities of preserving the current scope of practice outlines.

The article addressing South African policy, highlights the lack of uniformity in PHC AH services and stresses the importance of properly selected Provincial Governments. The authors of the selected South African article have published another article relating to South African primary health care allied services, after the review of our study was finished. Dizon et al (2018) found that the use of clinical practice guidelines (CPGs) would dismiss frustration, duplication and fragmentation of efforts. South African physiotherapists should investigate the standardised framework provided by the researchers, to weigh in on uniformity issues in primary health care.

The identified key stakeholders in the articles addressing physiotherapy policy are: physiotherapists, physicians, insurance companies and the government. The articles also mentioned other people or instances involved, namely: patients, other health professions, hospitals and rehab centers.

3.8 Conclusion

The literature review provided insight confirming the perceived paucity of studies underpinning the research on possibilities for physiotherapists as stakeholders to influence policy. The paucity of available studies is demonstrated by the fact that only three articles were found eligible to analyse in this scoping review. These three articles were selected out of 84 initial articles and an additional search through the 99

references found in the three selected articles. The fact that none of the selected articles addressed the policy development process, is also eye-opening.

The sample size of the retrieved studies matching the inclusion criteria is very small and therefore generalisation is difficult. For the key stakeholders, however, the selected articles provide an overview on people involved in the processes in South Africa and Belgium.

This review did provide some confirmation on the non-involvement of physiotherapists and their specific knowledge related to physiotherapy policy development in Belgium. The issue of the physiotherapists' possible engagement will be further explored through the analysis of the policies already in effect and through the interviews with key stakeholders.

CHAPTER FOUR – PHYSIOTHERAPY POLICIES ANALYSIS

4.1 Introduction

The aim of this study was to establish the strengths and gaps of the policy framework towards enhancement of physiotherapy service delivery in Belgium and in South Africa. The overall study followed a policy analysis approach using the Walt and Gilson concepts, namely context, actors, process and content, in the qualitative analysis. Prior to analysing the policies, in chapter three a comprehensive scoping literature review was undertaken to establish policy research and policy related to physiotherapy (in relation to actors, content processes and context) in Belgium and South Africa.

The scoping review revealed a paucity of available articles on physiotherapy policy development. Furthermore, the review showed there was little involvement of physiotherapist in policy development processes.

Subsequent to the literature review, analysis of the actual policies was undertaken and the analysis covered three of the study objectives namely:

- Compare the structure, content and the level of inclusion of physiotherapy within the legislative framework between Belgium and South Africa using the Walt and Gilson (1994) framework.
- Compare the outcomes of policy documents relating to physiotherapy in Belgium and in South Africa with the proposed minimum standards of the World Confederation for Physical Therapy (WCPT).
- Identify similarities and differences in the policies and the policy frameworks that could be strengths or gaps to physiotherapy practice.

Policy documents relating to physiotherapy in Belgium are primarily issued by one of the following:

- The ministry of Social Affairs
- The ministry of Public Health
- The Flemish Government
- Axxon, Physical Therapy in Belgium
- The Federal Council for Physiotherapy

Policy documents relating to physiotherapy in South Africa are primarily issued by one of the following:

- The Department of Health
- The Health Professions Council of South Africa's professional board for physiotherapy, podiatry and biokinetics (HPCSA PPB)
- The South African Society for Physiotherapy (SASP)

Both for Belgium and for South Africa policy documents that are laws or acts are issued by the government. In Belgium, the national government is represented through the ministry of Public Health and the ministry of Social Affairs. In South Africa the national government is represented through the Department of Health. All other policy documents can be issued either by the governments, the professional physiotherapy organisation or the designated regulatory and consultative bodies.

4.2 Methodology

4.2.1 Search methodology

The first step was to conduct a broad search for issued policy documents by the relevant authorities governing and/or directing physiotherapy in both countries. Table 4.1 provides an overview of the websites searched.

Table 4.1 Websites of policy issuing organisations

Country	Issuing authority / organisation	Website link
Belgium	Ministry of Social Affairs	https://socialsecurity.belgium.be/nl/publicaties https://www.riziv.fgov.be/nl/Paginas/default.aspx
	Ministry of Public Health	https://www.health.belgium.be/nl/publicaties-en-onderzoek
	Flemisch Parliament	https://vlaamsparlement.be
	Axxon, Physical Therapy in Belgium	https://www.axxon.be/nl/artseninfo/
	Federal Council for Physiotherapy	https://overlegorganen.gezondheid.belgie.be/nl/advies-en-overlegorgaan/raden/federale-raad-voor-de-kinesitherapie
South Africa	Department of Ministry of Health	http://www.health.gov.za/index.php/2014-03-17-09-09-38/policies-and-guidelines
	HPCSA professional board for physiotherapy, podiatry and biokinetics	https://www.hpcsa.co.za/PBPhysiotherapy
	South African Society for Physiotherapy	https://www.saphysio.co.za/documents-folder/documents-open-to-public/

From this search we identified the documents addressing physiotherapy in Belgium and South Africa. From the identified documents we identified policies to benchmark against the proposed minimum standards of the WCPT. This benchmark enabled us to identify strengths and gaps in the current policy framework in Belgium and in South Africa. From the documents identified for the benchmark, we selected four policy documents that were similar in level and type for comparison in order to find similarities and differences.

Figure 4.1 provides the flowchart of the selection procedure.

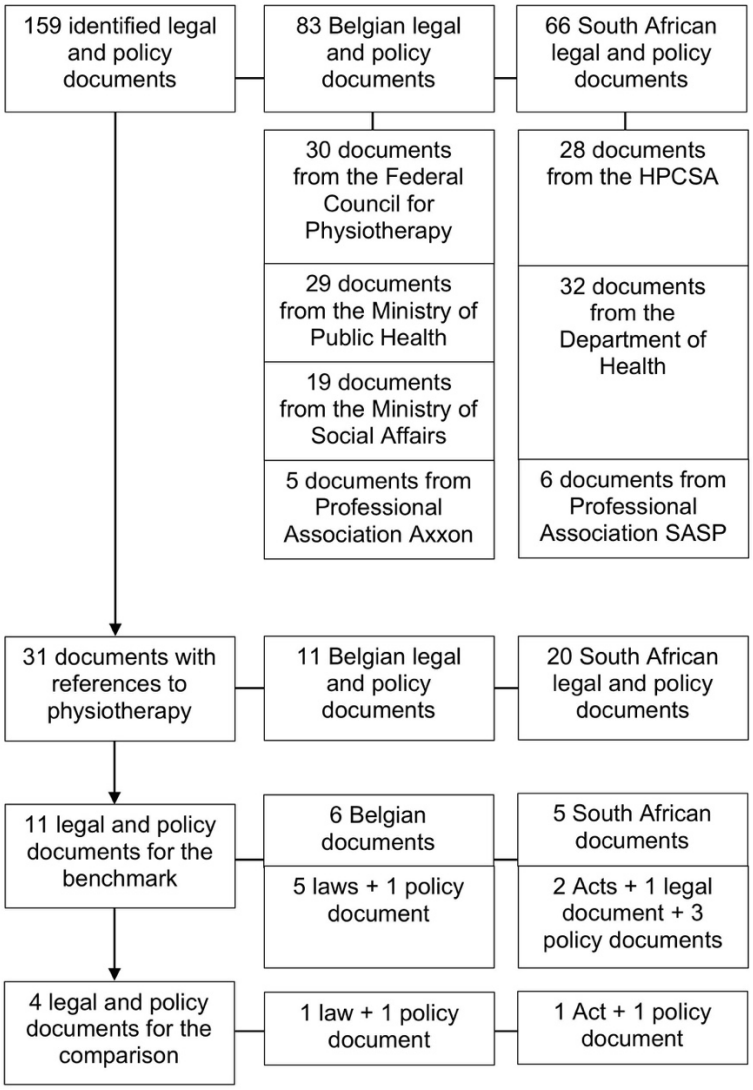

Figure 4.1 Policy document selection flow chart

Searches on the nine websites performed on 24 April 2019, provided a total of 159 policy documents. We identified 83 Belgian policy documents and 66 South African policies. The Federal Council for Physiotherapy published a total of 30 documents.

The ministry of Public Health issued 29 documents, while the ministry of Social Affairs has 19 policy documents available on their website. The Belgian professional physiotherapy association has five policy documents on their website. The South African Department of the Minister of Health published 32 documents. The HPCSA issued 28 policy documents and the South African Society for Physiotherapy has six policy documents available on their website.

All the 159 documents identified from the websites were then searched by title and key words in the text that referred to physiotherapy. This search resulted in eleven Belgian policy documents and 20 South African policy documents relating or referring to physiotherapy. The 31 retrieved documents were all read for the references towards this study. Out of the 31 policy documents, six Belgian and five South African policy documents were selected to be included in the benchmark analysis. Selection of the documents was based on the documents' content relating to the legal framework of physiotherapy relevant to this study.

4.2.2 Coding methodology

For the coding of the policy documents, the software MAXQDA Plus (release 28.2.0) Copyright © 1995-2018, was used. Moghaddam (2006) (Figure 4.2) described the three coding stages we applied in this study. Stage one started with open coding to break down the data in separate units of meaning to this research. Stage two involved axial coding where separate codes were assigned to relevant overarching categories, subthemes and themes. The final stage was the selective coding where concepts were brought together and integrated into categories within the context of this study. Figure 4.2 outlines the coding procedure.

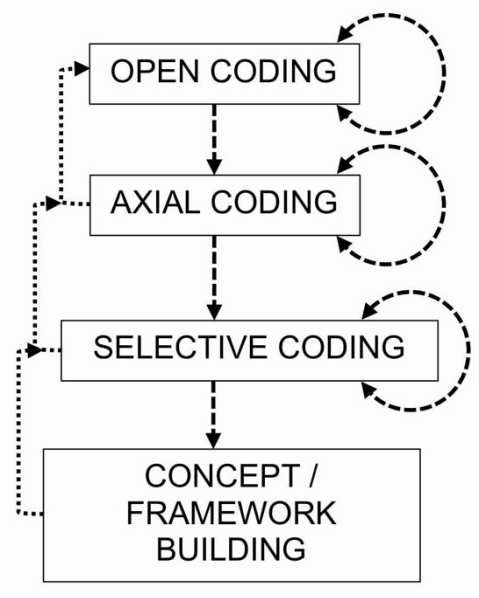

Figure 4.2 Coding procedure (Moghaddam, 2006).

The codes selected were discussed with three supervisors through a constant feedback process. Conflicts in coding were discussed and where necessary codes and categories were adapted to resolve the identified conflicts.

4.3 Description of the selected policy documents

The sections 4.3.1 to 4.3.3 provide a brief overview of the policy documents selected for the analysis. The purpose and the description of the document are included.

4.3.1 Policy documents selected

The documents selected are five laws and six policy documents in total. Three Belgian laws and three Belgian policy documents were included in the selection. For South Africa, two Acts and three policy documents were included. Table 4.2 outlines the selected policy documents per country. The purpose of the selected documents is added to the table.

Table 4.2 Selected policy and legal documents

Belgium	
Title of document	**Purpose of document**
Coordinated law of 10 May 2015	Regulating all aspects relating to the practice of health professions.
The convention M/18	Regulating all aspects of remuneration and specifics of physiotherapy services for 2018 and 2019.
The Decree concerning the reform of higher education in physiotherapy and rehabilitation sciences in the Flemish Community	Regulating adaptations of physiotherapy education duration.
The framework law regarding the use of a professional title for a service providing intellectual profession and the use of a professional title for a craftmanship	Regulating the use of the professional title.
The nomenclature for physiotherapy	Regulating the applicable billing codes for physiotherapy services and general rules of physiotherapy services
The professional competence profile of the physiotherapist anno 2020.	Proposition for a possible scope of practice in 2020 for physiotherapists to provide quality physiotherapy services.
South Africa	
Title of document	**Purpose of document**
Health professions act 56 of 1974	Establishment of the Health Professions Council and professional boards.
HPCSA scope of physiotherapy	Outlining the acts pertaining to physiotherapy.
National Health Act No 61 of 2003	Provision of a framework for a structured, uniform health system.
Standards of practice of physiotherapy 2012	Statement on performance and conditions for physiotherapists to provide quality physiotherapy services.
The first line practitioner status of physiotherapists	Guidance for physiotherapist to the meaning of first line practitioner status in practice.

4.3.2 Description of the Belgian legal and policy documents

- The coordinated law of 10 May 2015.

  This law is the most recent adaptation of the Royal Decree No 78 of 1967, the first law written to encompass health professions regulation (Minister van Volksgezondheid, 1967). The coordinated law regarding the exercise of health care professions regulates all aspects relating to the practice of health care professions (Kanselarij van de eerste minister, 2015).

- The convention M/18.

  The national insurance companies and the professional physiotherapy association, representing all Belgian physiotherapists, signed an agreement called the convention on 21 December 2017. (RIZIV, 2019b) This convention, a legal binding document, is applicable for the years 2018 and 2019. After negotiations in 2018, an amendment was added on 11 December 2018, applicable for the year 2019 (RIZIV, 2019c).
- The Decree concerning the reform of higher education in physiotherapy and rehabilitation sciences in the Flemish Community.

  This Decree regulates and outlines the reform of physiotherapy education (Vlaams parlement, 1998).
- The framework law regarding the use of a professional title for a service providing intellectual profession and the use of a professional title for a craftmanship.

  This framework law organises, all procedures relating to the use of a professional title (Economie, KMO, middenstand en energie, 2006).
- The nomenclature for physiotherapy.

  The nomenclature for physiotherapy stipulates, besides the codes for billing monodisciplinary physiotherapy services, the specific rules imposed on practicing physiotherapists (RIZIV, 2018a).
- The professional competence profile of the physiotherapist anno 2020.

  This policy document with a strong emphasis on advisory aspects, was written and communicated to the minister of Public Health in 2016 (Overlegorganen gezondheid België, 2016). The document outlines the professional competences of the Belgian physiotherapist. The purpose of this policy document is to set the criteria necessary to uphold quality physiotherapy services in the future. In the document parts of the existing framework are reworked to match strived quality criteria.

4.3.3 Description of the South African legal and policy documents

- Health Professions Act 56 of 1974.

  The former title of this Act was: Medical, Dental and Supplementary Health Service Professions Act. The purpose of this Act is to establish the Health Professions Council of South Africa and professional boards. The created institutions are to provide control over the education, training and registration for and the practicing of registered health professions (HPSCA, 2019).
- HPCSA scope of physiotherapy.

  The physiotherapy scope of practice was legally defined in December 1976. In this legal outline, the acts pertaining to the profession of physiotherapy are specified (HPCSA, 2003).
- National Health Act No 61 of 2003.

  This Act was established to provide a framework for a structured uniform health system, taking into account the obligations imposed by the Constitution and other laws with regards to health services (HPCSA, 2014).
- Standards of practice of physiotherapy 2012.

  "The Standards of Physiotherapy Practice are the SASP's statement of performance and conditions that it expects physiotherapists to aspire to in order to provide high quality physiotherapy professional services to society" (SASP, 2012).
- The first line practitioner status of physiotherapists.

  This policy document contains guidance for physiotherapists, registered with the HPCSA, as to the meaning of first line practitioner status in practice as well as in the relevant legal and ethical framework (SASP, 2016).

4.3.4 Legal documents and policy documents for comparison

Comparing the Belgian and the South African policy documents as an important aspect of this study, is only possible if comparable documents are identified.
Out of the eleven selected policy documents, two legal documents and two policy documents were identified and selected for complete analysis. The two legal documents and two policy documents could be compared because they are situated at the same level structurally and in terms of scope and purpose. Each document was read and analysed, using the Walt and Gilson (1994) framework to identify the

context, actors, content and process. Table 4.3 provides an overview of the four documents identified for comparison.

Table 4.3 Legal and policy documents for comparison

Belgium	South Africa
The coordinated law of 10 May 2015	National Health Act No 61 of 2003
The professional competence profile of the physiotherapist anno 2020	Standards of practice of physiotherapy 2012

4.4 Results

The key results of the analysis are presented per policy document in the sections 4.4.1 to 4.4.4. The presented tables only contain the translated English quotes and codes when presenting Belgian policy documents. The key quotes emerging from the analysis are presented in italic font. The full coding documents are included in appendix F.

4.4.1 The coordinated law of 10 May 2015

Table 4.4 presents the key themes, related categories, codes and selected quotes that emerged from the analysis of the coordinated law of 10 May 2015. The reference to identify the quote in the document is provided in the right column.

Table 4.4 Key results - Coordinated Law of 10 May 2015

Theme	Category	Code	Quote	Reference
Context (Cultural)	Legal requirements	*Illegal practice of medicine*	*Is considered illegal practice of medicine, the performance by a person not meeting criteria in section 1 (being a physician) of each act pertaining to assessing, diagnosing or starting a treatment ...*	Chapter 2 – art 3
	Policies and procedures	Physiotherapy prescription	The prescription is a hard copy ...	Chapter 2 – art 43
Context (Structural)	Professional bodies	Federal Council for Physiotherapy	The purpose of the Federal Council for Physiotherapy is to provide advice to the minister of Public Health	Chapter 3 – art 44
Actors (Influence and power)	Legal requirements	*Physiotherapy only on prescription*	*... are only allowed to practice physiotherapy on patients that are referred with a prescription by a person authorised to practice medicine ...*	Chapter 3 – art 43
Actors (Interests and concerns)	Legal structures	Purpose of the Federal Council for Physiotherapy	The Federal Council for Physiotherapy has a duty to the minister ... to advise relating to all issues relating to physiotherapy.	Chapter 3 – art 44
	Physiotherapy profession	*Recognised practice of physiotherapy*	*... no one is allowed to practice physiotherapy without a recognition ...*	Chapter 3 – art 43
		Professional title	No one is allowed to adhere the professional title of physiotherapist without a recognition ...	Chapter 3 – art 43
Content (Objective)	Legal structures	*Installation of the Federal Council for Physiotherapy*	*By the ministry responsible for Public Health, a Federal Council for Physiotherapy is installed.*	Chapter 3 – art 44
	Legal requirements	Registration objectives	The registration purpose ... 1° collect necessary data ... 3° creating a possibility to ameliorate communication between health care professionals.	Chapter 8 - 97

This law refers to the legal outlines of the practice of health care professions in Belgium. The key issues that emerged with regards to physiotherapy are the prohibition to diagnose as a physiotherapist, the mandatory medical prescription and the mandatory registration to practice as a recognised physiotherapist by the ministry of Public Health. Furthermore, the Federal Council for Physiotherapy is established and given purpose as an advisory committee towards the governing minister.

4.4.2 The professional competence profile of the physiotherapist anno 2020

Table 4.5 presents the key themes, the related categories, codes and selected quotes that emerged from the analysis of the *professional competence profile of the physiotherapist anno 2020*. The right column contains the reference to the document of where the quote was retrieved.

Table 4.5 Key results - Professional competence profile of the physiotherapist anno 2020

Theme	Category	Code	Quote	Reference
Context (Cultural)	Legislation	*Illegal practice of medicine*	*Providing information and advice ... or the administration of first aid or necessary care without a prescription is ... considered as illegal practice of professional title.*	page 14 - paragraph 1
	Physiotherapy profession	*Physiotherapy as medical profession*	*Physiotherapy is a medical profession embedded in biomedical sciences ... striving towards functional retainment, functional improvement or functional recovery ...*	page 6 - paragraph 1
	Professional association	*Axxon as representative of the physiotherapists*	*Axxon, Physical Therapy in Belgium, represents physiotherapists in the different government structures, committees and commissions.*	page 33 - paragraph 4
	Scope of practice	Confronted with direct questions to provide care	In the accessible Belgian health care system, physiotherapists are confronted on a daily basis with direct questions for care ...	page 14 - paragraph 1
Context (Situational)	Quality of care	*Quality criteria for the protection of the profession*	*Professional quality has to be protected through fixed criteria such as effective professional practice and lifelong learning in the concerned sub-domain.*	page 15 - paragraph 6
Context (Structural)	Physiotherapy profession	Important role in primary and secondary prevention	The physiotherapist, in his academic formation, has acquired the skills and the attitude ... With this he can fulfil a valuable task in primary and secondary prevention.	page 11 - paragraph 5
Actors (Influence and power)	Scope of practice	*Physiotherapy on medical prescription*	*In the coordinated law of 10 May 2015 ... is enacted that physiotherapy services are executed on a prescription from a physician or a dentist (art 43 §6).*	page 14 - paragraph 1
Actors (Interest and concerns)	Personal professional development	*Improvement of professional competences through lifelong learning*	*The professional competences acquired in the initial physiotherapy education need to be maintained and improved through lifelong learning.*	page 31 - paragraph 4
	Professional collaboration	Referral from a physiotherapist	The physiotherapist needs to be able to refer or to trust task to other health professionals and vice versa when necessary or desired according to the patient.	page 13 - paragraph 2

	Quality assurance	Systematic quality control	... the physiotherapist controls his quality care through specific instruments and techniques for measurement, analysis and amelioration.	page 30 - paragraph 7
		Integrated quality of care	On the level of integral quality of care all quality aspects are integrated, taking into account all relevant stakeholders ...	page 31 - paragraph 1
	Scope of practice	*Competences for a more elaborate role in prevention and health promotion*	*Besides the involvement of physiotherapists in cure and (chronic) care areas, they also possess the competences and skills to fulfil a more pertinent role in prevention and health promotion.*	page 5 - paragraph 2
Process	Professional collaboration	*Collaboration as an important element in efficient health care*	*Collaboration and meeting with other health care workers in local care networks is an important element of efficient health care service.*	page 31 - paragraph 3
Content (objective)	physiotherapy	Physiotherapist's objectives	The physiotherapist aims towards the objectives relating to recovery of impairments ... normalisation or amelioration of movement and function, prevention or reducing limitations and prevention ...	page 10 - paragraph 5
		Active in levels of prevention	*The physiotherapist can be active in various levels of prevention*	page 11 - paragraph 4
	Quality assurance	Quality criteria for involved physiotherapists	Participating physiotherapists strive towards and fulfil predetermined criteria ...	page 32 - paragraph 1
	Scope of practice	Connection between education and profession	The professional competence profile positions physiotherapy in health care and is the key for connection between education and profession.	page 3 - paragraph 2

The professional competence profile of the physiotherapist anno 2020 is a policy document specifically addressing physiotherapy and presents with more codes in relation to the Belgian *coordinated law of 10 May 2015* (Table 4.4).

One of the key elements relating to this study derived from the analysis of the policy document is the mandatory prescription although physiotherapy is classified as a medical profession. Furthermore, quality criteria such as lifelong learning and (inter)professional collaboration are stressed as being important. Prevention is highlighted as an issue part of the scope of physiotherapy practice. Lastly, the professional association is given a place and purpose in the physiotherapy policy framework.

4.4.3 National Health Act No 61 of 2003

Table 4.6 presents the key themes, the relating categories, codes and selected quotes that emerged from the analysis of the *National Health Act No 61 of 2003*. The references of the retrieved quotes are also included to enable verification.

Table 4.6 Key results - National Health Act No 61 of 2003

Theme	Category	Code	Quote	Reference
Context (Cultural)	History	Past injustices, imbalances and inequities	RECOGNISING – the socio-cultural injustices, imbalances and inequities of health services of the past	preamble
	Policies and procedures	*Validation of a certificate of need*	*A certificate of need is valid for a prescribed period, but such period may not exceed 20 years.*	Chapter 6 – 37.
Context (Structural)	Health system	Establishment of a health system	establish a health system based on decentralised management, principles of equity, sound governance, internationally recognised standards of research …	preamble
	Quality assurance	*Compliance with quality requirements and standards*	*All health establishments must comply with the quality requirements and standards prescribed …*	chapter 6 – 47.
Actors (Influence and power)	Policies and procedures	Appointment of a national health officer	The Minister may appoint any person in the employ of the national department as a health officer of the national department	chapter 10 – 80.
Actors (Interests and concerns)	Communication	Informing the user in understandable language	The health care provider must … inform the user … in a language that the user understands …	chapter 2 – 6.
		Ensuring communication between registered professions	The Forum of Statutory Health Professional Council must – ensure communication and liaison … upon matters affecting more than one of the registered professions	chapter 7 – 50.
	Duties of users	Treating health care providers with dignity and respect	A user must – treat health care providers and health care workers with dignity and respect	chapter 2 – 19.
	Ministers duties	*Making of regulation (details are provided)*	*The Minister … may make regulations regarding – anything which may or must be prescribed in terms of this Act … (more detail provided)*	chapter 11 – 90.

	Policies and procedures	Coherent policy development	The Forum of Statutory Health Professional Council must – advise the Minister on the development of coherent policies …	chapter 7 – 50.
		Monitoring and advising on policy implementation	The Forum of Statutory Health Professional Council must – monitor and advise the Minister on the implementation of health policy …	chapter 7 – 50.
	Quality assurance	Advise on quality norms and standards	The Office of Standards Compliance must – advise the Minister on norms and standards for quality in health services	chapter 10 – 78.
Content (Objectives)	Communication	Dissemination of information	The national department and every provincial department, district health council and municipality must ensure that appropriate, adequate and comprehensive information is disseminated …	chapter 2 – 12.
	Legal requirements	*Regulation of a uniform national health*	*The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation*	chapter 1 – 2.
	Policies and procedures (advisory)	Proposed legislation	The National Health Council must advise the Minister on – proposed legislation pertaining to health matters …	chapter 3 – 23.
		National health policy implementation	The National Health Council must advise the Minister on – the implementation of national health policy	chapter 3 – 23.
	Professional collaboration	Prescription of co-ordinated private and public health relationship	The Minister must prescribe mechanisms to enable a coordinated relationship between private and public health establishments in the delivery of health services.	Chapter 6 – 45.

The Act refers to the framework of the structured uniform South African health system. The Act does not address a health profession specifically. However, the key issue that emerged with regards to physiotherapy is the compliance with quality requirements and standards. Another issue that emerged are general standards on policies and procedures applicable to all health services and the regulation of a uniform health system, including physiotherapy.

4.4.4 Standards of practice of physiotherapy 2012

Table 4.7 presents the key themes, the related categories, codes and selected quotes that emerged from the analysis of *the standards of practice of physiotherapy 2012*. In the right column, the references to the retrieved quotes are included.

Table 4.7 Key results - Standards of practice of physiotherapy 2012

Theme	Category	Code	Quote	Reference
Context (Cultural)	Ethics	*Practice according to Code of Ethics*	*The physiotherapist must practice according to a Code of Ethics that is consistent with the WCPT, SASP's and HPCSA Ethical Principles*	page 14 - under 9.1
Context (Situational)	Communication	*Effective and appropriate services facilitated through communication*	*communication … facilitates the provision of effective and appropriate physiotherapy services.*	page 10 - under 4.1
		Communication between colleagues	*The physiotherapist communicates with other physiotherapists to ensure continuity of effective patient/client services*	page 11 - under 4.5
Context (Structural)	Global	WCPT objectives alignment	in line with the objectives of the World Confederation for Physiotherapy (WCPT)1	page 3 - paragraph 1
	Legal requirements	Content of documentation is according to HPCSA regulation	Physiotherapists ensure that the content of documentation is according the HPCSA regulations (Booklet 15) so that the records are accurate, complete and legible, in permanent black ink, corrections to the record are initialed and finalised in a timely manner	page 13 - under 7.2
	Personal professional development	*Professional devlopment and continuing education*	*Ensures professional development and continuing education*	page 6 - under 3.2.3.3
	Policies and procedures	Regular review and revision of policies	The written policies and procedures: Are reviewed regularly and revised as necessary	page 8 - under 3.9.2.1
	Professional collaboration	Appropriate collaboration with professionals	The physiotherapy service collaborates with all professionals as appropriate.	page 6 - under 3.2.1
		Awareness of other professional's qualifications and roles	The physiotherapist shall be aware of the qualifications and roles of other professionals involved in comprehensive patient/client care/management ...	page 6 - under 3.2.2
	Quality assurance	*Quality assurance program (outline provided)*	*A QA programme is a systematic evaluation of physiotherapy service, which facilitates continuous improvement. QA strives to achieve optimum care by means of the most appropriate and effective level of training, education, practice and ethical conduct in physiotherapy*	page 20 - under 14.1

	Scope of practice	Interaction for physiotherapy service provision	The provision of physiotherapy services requires interaction between physiotherapist, patients or clients, families and caregivers	
Actors (interests and concerns)	(support) personnel	Participation in QA program	Staff participates in the quality assurance program	page 9 - under 3.11.4
Actors (Influence and power)	Scope of practice	*Physiotherapy view to diagnose and strategy planning*	*The physiotherapist's distinctive view of the body ... is central to determining a diagnosis and an intervention strategy*	page 3 - paragraph 3
		Initial examination/assessment	*The physiotherapist performs an initial examination/assessment and evaluation to establish a diagnosis and prognosis prior to intervention/treatment.*	page 16 - under 12.1.1
		Provision / direction / supervision of intervention/treatment	The physiotherapist provides, or directs and supervises, the physical therapy intervention/treatment	page 17 - under 12.3.1
Process (Dealing with actors)	Personal professional development	*Lifelong learning commitment*	*The physiotherapist demonstrates commitment to lifelong learning*	page 14 - under 8.3
	Quality assurance	Quality assurance commitment	The physiotherapist shall demonstrate commitment to quality assurance by peer review and self-assessment	page 21 - under 14.3
Process (Strategy)	Quality assurance	*Quality improvement plan*	*The physiotherapy service has a written plan for continuous improvement of quality of care and performance of services*	page 21 - under 14.2
Content (Objectives)	Communication	Communication of policies and procedures	All policies and procedures of the organisation are communicated to staff.	page 11 - under 4.9.2
	Mission statement	Physiotherapy service mission statement, purposes and goals	The physiotherapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the patients/clients served, the physiotherapy personnel affiliated with the service, and the community.	page 7 - under 3.5.1

	Policies and procedures	Reference to health policies relevant to physiotherapy	There is evidence of reference to the national, provincial and district health policy documents relevant to physiotherapy.	page 12 - under 4.11.2
		strategies for prevention (examples given)	There is evidence that: Strategies for the prevention of primary, secondary and tertiary complications, disability or disease exist.	page 19 - under 12.9.2
Objectives (Specific mechanisms)	Personal professional development	*Continuous professional development*	*professional development and continuing education*	page 6 - under 3.2.3.3
		Lifelong learning (outline provided)	*lifelong learning by participating in continuous professional development activities related to their specific field of practice, ethical and medico legal practice and basic life support*	page 14 - under 8.3
	Professional collaboration	Operational policies	Operational policies exist for cross referral to other professionals in the team, discharge, and transfer of patients/clients	page 6 - under 3.2.4.2

The standards of practice of physiotherapy document is specifically aimed at South African physiotherapy services. In terms of context the document clearly states the need for ethical practice and alignment with the WCPT objectives. One of the key issues that emerged from the analysis is the importance of professional communication. Furthermore, quality assurance of physiotherapy services is outlined as an important aspect to follow. Professional development of the practicing South African physiotherapist is included as a key issue. Finally, the scope of practice of the South African physiotherapist is outlined, including diagnosing, strategy planning, assessment, provision and supervision of treatment.

4.5 Comparison

An identification of similarities and differences in the four identified documents that could be strengths or gaps to physiotherapy practice was undertaken. This was then followed by a comparison of the outcomes of the policy documents relating to physiotherapy in Belgium and in South Africa with the proposed minimum standards of the WCPT.

4.5.1 Similarities

- The Belgian *coordinated law of 10 May 2015* and the South African *National Health Act No 61* outline a general health system, including physiotherapy services.
- The Belgian policy document *professional competences of the physiotherapist anno 2020* and the South African policy document *standards of practice of physiotherapy 2012* addressed more issues specifically pertaining to physiotherapy than the Belgian law and the South African Act.
- The *professional competence profile of the physiotherapist anno 2020* and the *standards of practice of physiotherapy 2012* both address the importance of (inter)professional collaboration and a professional development through lifelong learning.

4.5.2 Differences

- The Belgian *coordinated law of 10 May 2015* addresses physiotherapy in two distinct articles while the South African *National Health Act No 61* addresses health care delivery in its whole without specifying a health care profession.
- The Belgian *coordinated law of 10 May 2015* specifies explicitly the legal boundaries towards physiotherapy services. The boundaries include the mandatory prescription and the prohibition to diagnose as a physiotherapist. The South African *National Health Act No 61* does not specify any particular boundaries for physiotherapy services.
- The *professional competence profile of the physiotherapist anno 2020* policy document is drawn up as an advice to the relevant minister. It sets a framework of a desired, achievable scope of physiotherapy practice in the future. *The standards of practice of physiotherapy 2012* outlines the current South African physiotherapy scope of practice framework.

4.6 Benchmarking selected legal and policy documents

In section 4.6 the benchmark of the identified and selected Belgian and South African documents will be outlined. Benchmarking the selected legal and policy documents against the proposed minimum standards of the WCPT allowed us to identify strengths and gaps in the physiotherapy governing documents.

The WCPT produces guidelines and policy documents to support the development of the physiotherapy profession globally. The proposed minimum standards of the WCPT are the standards set in the issued WCPT policy documents. The WCPT policy documents cover a wide range of physiotherapy topics. The WCPT policy documents, available on the WCPT website, are presented and grouped in four themes namely: education, professional issues, professional practice and social issues (WCPT, 2018). Following the description a table is provided to illustrate the selected mirroring policies for comparison.

The policy documents on the WCPT website were under revision in anticipation of the WCPT General Meeting in May 2019 in Geneva at the time of consultation for this study. All WCPT documents for this study were accessed on March 16th, 2019.

The 52 available WCPT documents were all read for relevance to this study. Out of the 52 WCPT documents, 13 documents were selected for the benchmark. The selection contains 12 policy documents and one guideline. The selected documents were included because of their specific purpose and content related to this study: namely education, quality of care, regulation of the profession, standards of the profession, autonomy, description of physiotherapy, human resources, protection of title, direct access and self-referral, (inter)professional collaboration, support personnel, primary health care and private practice.

Education was included as it provides a minimum standard of entry level for the profession. *Autonomy* relates to the responsibilities and organisation of physiotherapy services. Linked to *autonomy* are the aspects of *direct access/self referral* and *private practice*. *Primary health care* is also linked to *autonomy* as the provision of accessible care at community level without interference of other professions. The *description of physical therapy* outlines what physiotherapy should be and how it should be set up. The link with advocacy for individuals (information towards professionals) and professional associations (policy advocacy) is included in the *human resources* WCPT document. The documents on the *protection of title* document and *support personnel* provide information on profession specific regulation. The document on *interprofessional collaboration* was included because of the link with autonomous decision making relating to physiotherapy practice and the keep/refer policy towards equally placed professionals in the care surrounding the patient.

Table 4.8 summarises the documents included in this study, the reason for selection of the document is stated in the fourth column. The documents that were excluded are the policies and guidelines not specifically addressing aspects relating to physiotherapy policy development. Examples are documents addressing specific physiotherapy terminology or documents addressing general health care themes such as torture, disaster management or ethical principles in times of armed conflicts. A comparison with the WCPT standards was undertaken to benchmark the content of each of the documents selected from the Belgian and South African context. Each of the selected topics is compared with the outcomes analysed from Belgium and South Africa.

Table 4.8 Selected WCPT policy documents

Name	Type	Category	Reason for Inclusion
Education	Policy statement	Education	Link with the proposed minimum education level for physiotherapy.
Delivering quality continuing professional development for physical therapists	Guideline	Education	Link with the aspect of CPD in relation to quality of physiotherapy care.
Regulation of the physical therapy profession	Policy statement	Professional issues	Links to various aspects dealing with physiotherapy regulatory issues.
Standards of physical therapist practice	Policy statement	Professional issues	Links with various aspects dealing with physiotherapy care delivery.
Autonomy	Policy statement	Professional issues	Link with the ability to act as a first contact practitioner.
Description of physical therapy	Policy statement	Professional issues	Link with various aspects dealing with the core aspects of physical therapy.
Health human resources	Policy statement	Professional issues	Link with various aspects of strategic planning and communication with governing authorities.
Protection of title	Policy statement	Professional issues	Link with the exclusivity of the name to ensure recognition.
Direct access and patient/client self-referral to physical therapy	Policy statement	Professional issues, professional practice	Link with the ability to deliver physiotherapy without the referral of a medical practitioner.
Relationships with other health professionals	Policy statement	Professional issues, professional practice	Link with the autonomy aspect of physiotherapy care.
Physical therapist support personnel	Policy statement	Professional practice	Link with legislation regarding different levels of practicing physiotherapy.
Primary health care	Policy statement	Professional practice	Link with the ability of being a first contact practitioner.
Private practice	Policy statement	Professional practice	Link with the ability of being an autonomous practitioner.

The benchmarking exercise will be outlined in sections 4.6.1 to 4.6.13. The approach undertaken provides the title of the WCPT document, followed by the key quote or key quotes selected in the WCPT policy document. After the quote(s), a table with the selected key elements outlines the Belgian and South African policy documents addressing the elements of the WCPT policy document where possible. The section in the Belgian or South African policy document, addressing a key element in the WCPT document is also provided alongside. The benchmark per document finishes with a brief summary on key elements achieved or not achieved in the Belgian and South African policy documents.

In order to make the tables concise, the Belgian and South African policy documents are abbreviated as follows:

- The coordinated law of 10 May 2015 regarding the practice of health professions (CLHP)
- The decree concerning the reform of higher education in physiotherapy and rehabilitation sciences in the Flemisch Community (DECREE)
- The convention M/18 (CONV)
- The framework law regarding the use of a professional title for a service providing intellectual profession and the use of a professional title for a craftmanship (FLPT)
- The nomenclature for physiotherapy (NOMEN)
- The professional competence profile of the physiotherapist anno 2020 (PCP)
- Health Professions Act 56 of 1974 (HPA)
- HPCSA scope of physiotherapy (SCOPE)
- National Health Act No 61 of 2003 (NHA)
- Standards of practice of physiotherapy 2012 (SOPP)
- The first line practitioner status of physiotherapists (FLPS)

4.6.1 WCPT policy statement: Education

"*The first professional qualification should be completion of a curriculum that qualifies the physical therapist for practice as an independent autonomous professional. Education for entry level physical therapists should be based on university or university level courses of at least four years*" (WCPT, 2017b). Table 4.9 matches the

key elements from the WCPT policy on education with the Belgian and South African elements, where available.

Table 4.9 Education benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Independent and autonomous	/	/	/	SOPP	11.2	"... registered at the HPCSA as independent practitioner..."
University / University level	DECREE	Article 24	*"Universities apply the education leading to the academic physiotherapy degree ... starting 1999-2000."*	HPA	16	"...no person or educational institution, excluding a university or a technikon, may offer or provide any training ..."
≥ 4 years	DECREE	Article 24	"... with a total education duration of four years ..."	✓		

The study length for physiotherapy entry level qualification is not mentioned in the selected South African policy documents. However, on the website of the University of the Witwatersrand (WITS), one of the eight South African universities offering physiotherapy education (SASP, 2019), data on education length is provided. In South Africa the duration of the physiotherapy entry level education is four years. The degree awarded is Bachelor of Science in Physiotherapy (WITS, 2019).

The analysis relating to the suggested minimum standards in the WCPT policy document on education, revealed Belgian policies fall short on the stipulation on being an independent and autonomous practitioner. In Belgium access to physiotherapy services is always through a referral and with a mandatory medical prescription.

4.6.2 WCPT guideline: Delivering quality continuing professional development for physical therapists

"*Continuing professional development (CPD) describes the systematic, ongoing structured process of learning that underpins professional practice. CPD enables physical therapists who have completed an entry level programme to maintain, develop and enhance their personal and professional skills, knowledge and behaviours, and ongoing competence to practise. This, in turn, advances practice, service delivery and ultimately outcomes for patients/clients. All physical therapists should participate in learning activities that maintain or increase their professional competence"* (WCPT, 2011). Table 4.10 matches the key elements from the WCPT policy on CPD with the Belgian and South African documents.

Table 4.10 CPD benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
CPD	CLHP	Art.94	"... system of peer review ... professional competences ..."	SOPP	13.,14.	"... responsible for personal professional development ..."
	CONV	§3	"... quality criteria ... online platform ..."			"... commitment to quality assurance by peer review ..."

The analysis of the CPD aspect underscored that for Belgium and for South Africa the criteria is met. However, CPD is not mandatory for Belgian physiotherapists. In Belgium the concept of continuous professional development is mentioned in *the coordinated law of 10 May 2015*. In 2008 the government appointed a budget to develop a system of quality enhancing system. In 2011 the system became operational and is updated and refined every year (Pro-Q-Kine, 2019).

In South Africa the HPCSA (2008) has a policy document on continuing professional development guidelines for the health care professionals. This document is endorsed by the South African physiotherapy association. South African physiotherapists are required to obtain a set amount of Continuous Education Units (CEUs) per set timeframe.

4.6.3 WCPT policy statement: Regulation of the physical therapy profession

"Physical therapy is an internationally recognised health profession which should only be practised by qualified physical therapists. Where required by state or national legislation, they are entitled to hold a valid registration/licence to practise physical therapy and/or use the title physical therapist" (WCPT, 2017c). Table 4.7 matches the key elements from the WCPT policy on regulation with the Belgian and South African documents.

Table 4.11 Regulation benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Qualified physical therapists	CLHP	Art.43	"... owner of a recognition from the minster of Public Health."	HPA	61	"... the conditions under which any registered person may practice ..."
Valid registration / licence to practice	CLHP	Art.25	"... are permitted to practice after the visum of their diploma ..."	SOPP	11.	"... registered at the HPCSA ..."
	NOMEN	§20	"... physiotherapists with a recognition ..."	HPA	17	"... apply to the register ..."

The analysis outlined that in Belgium and in South Africa the standards set out by the WCPT regarding the regulation of the physical therapy profession are met. Physiotherapy in both countries can only be practiced by qualified, registered and licensed physiotherapists.

4.6.4 WCPT policy statement: Standards of physical therapist practice (WCPT, 2011b)

There were many statements of relevance that were extracted from this document. The 13 statements in total could be summarised into ten key elements namely:

1. **Responsibility of physiotherapy service.** *"A physical therapist is responsible for the direction of the physical therapy service."* (WCPT, 2011b).
   "The physical therapist communicates and coordinates all aspects of patient/client management including the results of the initial examination/assessment and evaluation, diagnosis, prognosis/plan of care, intervention/treatment, response to interventions/treatment, changes in patient/client status relative to the interventions/treatments, re-examination and discharge/discontinuation of intervention/treatment and other patient/client management activities." (WCPT, 2011b).
   "The physical therapist performs an initial examination/assessment and evaluation to establish a diagnosis and prognosis/plan of care prior to intervention/treatment."
2. **Standards for physiotherapy work setting**. *"The physical setting is designed to provide a safe and accessible environment that facilitates fulfilment of the mission, purposes and goals of the physical therapy service. The equipment is safe and sufficient to achieve the purposes and goals of physical therapy."* (WCPT, 2011b).
3. **Written policies and procedures.** *"The physical therapy service has written policies and procedures that reflect the mission, purposes and goals of the service, and are consistent with the WCPT Member Organisation's standards, policies, positions, guidelines and Code of Ethics."* (WCPT, 2011b).
4. **Referral system.** *"A referral system is in place to ensure that patients/clients can access a physical therapist either by direct access or from an appropriate referral source."* (WCPT, 2011b).
   "Where the examination, diagnostic process, or any change in status reveals findings outside the scope of knowledge, experience, and/or expertise of the physical therapist, the patient/client shall so be informed and referred to the appropriate practitioner/professional." (WCPT, 2011b).
5. **Documentation.** *"The physical therapist clearly documents all aspects of the patient/client management including the results of the initial examination/assessment and evaluation, diagnosis, prognosis/plan of care, intervention/treatment, response to interventions/treatment, changes in patient/client status relative to the interventions/treatment, re-examination and discharge/discontinuation of intervention, and other patient/client management activities."* (WCPT, 2011b).

6. **Information of the patient/client.** *"The physical therapist shall inform the patient/client verbally, and where required, in writing of the nature, expected duration and cost of intervention/treatment prior to the performance of such activities."* (WCPT, 2011b).
7. **Physiotherapy assessment.** *"The physical therapist determines the interventions/treatments and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis/plan, anticipated goals and expected outcomes of the planned interventions/treatments for identified impairments, activity limitations and participation restrictions and/or for prevention, health promotion, fitness, and wellness."* (WCPT, 2011b).
8. **Continuous professional development (CPD).** *"The physical therapist is responsible for individual professional development and must maintain a high level of professional competence by continued participation in varied learning experiences."* (WCPT, 2011b).
9. **Research.** *"The physical therapist shall advance the science of physical therapy by conducting and/or supporting research activities or by assisting those engaged in research."* (WCPT, 2011b).
10. **Support personnel.** *"Support personnel must be clearly identified as 'physical therapist support personnel' so that the patient/client is never in doubt that the employee is not a physical therapist."* (WCPT, 2011b).

Table 4.12 outlines the key elements from the WCPT policy on practice standards. The table matches the elements with the Belgian and South African where available.

Table 4.12 Standards benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Responsibility of physiotherapy service	/	/	/	FLPS	9.2	"... responsibility and accountability for decisions made."
Standards for physiotherapy work setting.	NOMEN	§20	"...a practice with at least: (details provided)..."	SOPP	3.7	"The physical setting is designed to ..."

Written policy / procedures consistent with WCPT policies	/	/	/	SOPP	Pre-amble	"... in line with the objectives of the World Confederation for Physiotherapy ..."
Referral system	CLHP	Art.31/1	"... the obligation to refer a patient..."	SOPP	3.10	"A referral system is in place ..."
				SCOPE	(n)(b)	"... the referring medical practitioner ... in conjunction with other registered ... health services personnel ..."
Documentation	NOMEN	§8	"Realisation of a personal patient file ..."	SOPP	7.	"... clearly documents all aspects of patient/client care/management."
Information of the patient / client	CONV	Art.6. §§1,2	"The physiotherapist informs before the start of a treatment ..."	SOPP	4., 10.	"The physiotherapist provides the patient/client ... with ... information ..." "The physiotherapist shall inform the patient/client ..."
				HPA	53	"... before rendering ant professional services inform the person ..."
				NHA	7.	"... a health service may not be provided without the user's informed consent ..."
				SCOPE	(n)(c)	"... advice to, the patient ..."
Physiotherapy assessment	CLHP	Art.43. §4,2°	"examinating ... to contribute in the physician's diagnosis ..."	SOPP	12.1	"The physiotherapist performs an initial examination/assessment ..."
CPD	CLHP	Art.94	"... determines the rules ... continuing professional development ..."	SOPP	13., 14.	"... responsible for personal professional development ..." "... commitment to quality assurance by peer review ..."
	CONV	§3	"... quality criteria ... online platform ..."			
Research	PCP	4.2	"... tradition of scientific research ..."	SOPP	15.	"The physiotherapist applies research findings .."
				NHA	51.	"... to conduct research in health services ..."
Support personnel	/	/	/	SOPP	16.	"Support personnel must be clearly identified ..."

The analysis underscored that Belgian policies do not meet all criteria relating the proposed standards namely: responsibility of physiotherapy services, written policies/procedures consistent with WCPT policies and support personnel. Belgian physiotherapists are not fully responsible for physiotherapy services as parts of the services are outlined by a prescription by other medical healthcare professionals. Furthermore there are no written policies consistent with the WCPT policies and support personnel is not defined in the Belgian legislative structure governing physiotherapy.

4.6.5 WCPT policy statement: Autonomy

"*Physical therapists operate as independent practitioners, as well as members of health service provider teams, and are subject to the ethical principles of WCPT and the codes of ethics and best practice in the country in which they practise. They are able to act as first contact practitioners, and patients/clients may seek direct services without referral from another health professional. The services provided by physical therapists encompass health promotion, prevention, examination/assessment, evaluation, interventions/treatments and outcomes assessment. The actions of individual physical therapists are their own responsibility, and their professional decisions cannot be controlled or compromised by employers, members of other professions or other individuals"* (WCPT, 2017d). Table 4.13 matches the key elements from the WCPT policy on autonomy with the Belgian and South African where available.

Table 4.13 Autonomy benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Independent practitioner	/	/	/	SOPP	11.2	"... registered at the HPCSA as independent practitioner..."
First contact practitioner	/	/	/	FLPS	9.1	"... patients may access physiotherapist directly without referral ..."
Prevention	NOMEN	§9bis	"... instructions and council for secondary prevention."	SCOPE	(n)(c)	"... prophylactic physiotherapy, prevention ..."

The analysis outlined that Belgian policy do not meet stipulated criteria towards autonomy. Physiotherapy services in Belgium are by law only accessible through a medical prescription, hence Belgian physiotherapists are not able to act as independent or as first contact practitioners. Furthermore, preventive services are limited to secondary prevention as primary prevention is prohibited for physiotherapists in Belgium.

4.6.6 WCPT policy statement: Description of physical therapy

"Physical therapists operate as independent practitioners, as well as members of health service provider teams, and are subject to the ethical principles of WCPT. They are able to act as first contact practitioners, and patients/clients may seek direct services without referral from another health professional" (WCPT, 2015). Table 4.14 matches the key elements from the WCPT policy on the description of physical therapy with the Belgian and South African where applicable.

Table 4.14 Description of physical therapy benchmark

Key element	Belgium		South Africa		
	Policy	Section	Policy	Section	
Independent practitioner	/	/	SOPP	11.2	"... registered at the HPCSA as independent practitioner..."
First contact practitioner	/	/	FLPS	9.1	"... patients may access physiotherapist directly without referral .."

Analysis of the WCPT policy statement on the description of physical therapy outlined two items namely: being and independent practitioner and being a first contact practitioner. These items were also outlined in 4.6.5, illustrating Belgian policy documents not meeting proposed criteria.

4.6.7 WCPT policy statement: Health human Resources

"*WCPT strongly supports the involvement of member organisations in the development of any national health human resource planning, management and development strategies"* (WCPT, 2017e). Table 4.15 matches the key elements from the WCPT policy on health human resources with the Belgian and South African policy documents.

Table 4.15 Health human resources benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Member organisation as key role player in strategy development	CLHP	Art. 44	"The members are appointed ... by representative professional associations ..."	SOPP	9.4	"The professional association ... acts as the authoritative voice ..."

Analysis underscored that both countries meet the criteria where professional organisations are entitled to a role in the legal framework for physiotherapy policy development. For Belgium, the role is described in a law while for South Africa the role of the professional association is outlined in a policy document.

4.6.8 WCPT policy statement: Protection of title

"*WCPT believes it is in the public interest to protect the professional names and titles as part of national legislation/regulation/recognition. This should ensure that qualified physical therapists always have the right to practise as physical therapists"* (WCPT, 2017f). Table 4.16 matches the key elements from the WCPT policy on protection of title with the Belgian and South African documents.

Table 4.16 Protection of title benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Protection of title	FLPT	Art. 5	"No person ... is allowed to use a professional title when not complying to each of the next terms "	HPA	36	"... any person, not registered as a medical practitioner ... shall be guilty of an offence ..."

Analysis underscored Belgian and South African policy documents contain elements to meet proposed minimum standards relating to the protection of the physiotherapy title. There are laws/Acts in place in both countries securing the protection of title.

4.6.9 WCPT policy statement: Direct Access and patient/client self-referral to physical therapy

"The World Confederation for Physical Therapy advocates that direct access to physical therapy and patient/client self-referral will allow service users to meet their physical therapy goals. Physical therapy professional entry-level education prepares physical therapists to be first contact autonomous practitioners, able to examine/assess, evaluate, diagnose, prognose, intervene/treat, determine outcomes and discharge patients/clients without referral from another health professional (e.g. medical practitioner) or other third party. WCPT advocates for service developments and delivery models that allow patients/clients improved access to physical therapy services through the ability to refer themselves directly to a physical therapist" (WCPT, 2017g). Table 4.17 matches the key elements from the WCPT policy on direct access and self-referral with the Belgian and South African documents where applicable.

Table 4.17 direct access and self-referral benchmark

Key element	Belgium		South Africa		
	Policy	Section	Policy	Section	
Direct access	/	/	FLPS	9.1	"... patients may access physiotherapist directly without referral .."
Self-referral	/	/	FLPS	9.1	"... patients may access physiotherapist directly without referral .."
First contact practitioner	/	/	FLPS	9.1	"... patients may access physiotherapist directly without referral .."

Analysis outlined all criteria for direct access and self-referral were met in the South African policy documents. In the Belgian policy documents, none of the proposed minimum criteria are met.

4.6.10 WCPT policy statement: Relationship with other health care professionals

"It is the responsibility of WCPT's member organisations, as well as individual physical therapists, to have strategies in place so that the roles and functions of physical therapists and the efficacy of physical therapy services can be demonstrated and marketed to other health professions" (WCPT, 2017h). Table 4.18 matches the key elements from the WCPT policy on interdisciplinary relations with the Belgian and South African where possible.

Table 4.18 Interdisciplinary relations benchmark

Key element	Belgium		South Africa		
	Policy	Section	Policy	Section	
Strategies to market physiotherapy to other health professions	/	/	SOPP	8.	"... educates and provides consultation ... regarding the purposes and benefits of physical therapy.

Analysis underscored that in the Belgian policies there is mention of the necessity of interdisciplinary relations (included in the *professional competence profile of the physiotherapist anno 2020* document in sections 2.4 and 5.2). However, a strategy to market physiotherapy is not included. South African policy documents meet the proposed minimum criteria relating to interdisciplinary relations.

4.6.11 WCPT policy statement: Support personnel

"*The World Confederation for Physical Therapy advocates that policies for using physical therapist support personnel have to be determined at a national level. Physical therapy is an internationally recognised health profession. It may be practised only by qualified and, where required by state or national legislation, duly licensed/registered physical therapists. WCPT advocates that where physical therapist support personnel are utilised, direction and supervision from a physical therapist are essential in the provision of quality physical therapy services. The degree of direction and supervision necessary for assuring quality physical therapy services is dependent upon many factors, including the education, experiences, and responsibilities of the parties involved, the needs of the patient/client and the*

organisational structure in which the physical therapy services are provided" (WCPT, 2017i). Table 4.19 matches the key elements from the WCPT policy on support personnel with the Belgian and South African where possible.

Table 4.19 Support personnel benchmark

Key element	Belgium		South Africa		
	Policy	Section	Policy	Section	
Support personnel	/	/	SOPP	16.	"Support personnel must be clearly identified ..."

Analysis showed that in Belgian policy documents there is no reference towards physiotherapy support personnel. In Belgium there is no legal outline for support personnel.

4.6.12 WCPT policy statement: Primary health care

"WCPT encourages its member organisations and individual physical therapists to raise awareness of the important role and contribution of physical therapists in primary health care as: direct and indirect providers of services, collaborative members of multi-professional teams, consultants to governments, non-governmental organisations (NGOs) and disabled people's organisations (DPOs), developers, implementers and managers of services, educators of other health personnel and support staff" (WCPT, 2017j). Table 4.20 matches the key elements from the WCPT policy on primary health care with the Belgian and South African where applicable.

Table 4.20 Primary health care benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Primary health care	/	/	/	SOPP	12.	
Direct service providers	/	/	/	SOPP	2.	"These standards apply to all physiotherapists ... in direct or indirect contact with patients/clients ..."
				FLPS	9.1	"... patients may access physiotherapist directly without referral .."
Indirect service providers	CLHP	Art.43§6	"... physiotherapy only with patients with a referral ..."	SOPP	2.	"These standards apply to all physiotherapists ... in direct or indirect contact with patients/clients ..."

The World Health Organization (2004) defines the ability to be accessed directly as one of the criteria for primary health care. Analysis underscored the Belgian legal restrictions towards patients' access to physiotherapy services. Therefore, Belgian physiotherapists are not in primary health care.

4.6.13 WCPT policy statement: Private practice

"*Physical therapists as autonomous practitioners should be allowed to engage in private practice, free of restrictions imposed by other professions on how they should practice"* (WCPT, 2017k). Table 4.21 matches the key elements from the WCPT policy on private practice with the Belgian and South African where possible.

Table 4.21 Private practice benchmark

Key element	Belgium			South Africa		
	Policy	Section		Policy	Section	
Private practice	CONV	In its whole	"This convention describes ... private practice physiotherapists ..."	FLPS	6.2	"Since physiotherapy is an autonomous and independent profession ... designated as private or public practice ..."
	NOMEN	In its whole	"Acts pertaining to the competence of physiotherapists."			
No restrictions imposed by other professions on the practice	/	/	/	FLPS	6.1	"... their professional decisions cannot be controlled ... by ... persons from other professions ..."

Analysis underscored that Belgian law allows physiotherapists to work in private practice. The criteria of being free from restrictions imposed by other professions is not met. South African policy meets all proposed minimum criteria relating to private practice.

The two South African Acts and three South African policy documents revealed that South African policy and legislative framework meets all requirements of the minimum standards proposed by the WCPT. The specific Belgian legislation governing physiotherapy limits the possibility to meet all of the proposed minimum standards of the WCPT.

4.7 Discussion

We analysed four documents for the comparison aspect of this study. The Belgian *coordinated law of 10 May 2015* and the South African *National Health Act No 61* were the two comparable legal documents. The Belgian *competence profile of the physiotherapists anno 2020* and the South African *standards of practice of physiotherapy 2012* were the two comparable policy documents.

The comparative exercise revealed similarities and differences between legal outcomes and policy outcomes in Belgium and South Africa. The Belgian *coordinated*

law of 10 May 2015 outlines a general health framework and includes a specific outlining for each regulated Belgian health care profession, including physiotherapy. This was found to be different from the South African *National Health Act No 61* which outlines the general structured South African health system framework.

Outlining a general health system, as the South African *National Health Act No 61* does, enables overall and generic regulation to be implemented. General regulation can provide for a uniform structured system as is the intention of the South African Department of Health. The South African Act provides for a certain open flexibility. Roosevelt (2018) states that flexibility of a system provides an open range of possibilities. Specifying in detail in the legislation what physiotherapy is, as provided in the Belgian *coordinated law of 10 May 2015*, makes it possible to render profession specific legislation. Rigidity of an outlined system enhances predictability and simplicity (Roosevelt, 2018). However on the other hand, excessive rigidity may potentially stifle growth. In Belgium, the combination of the strict legal outlining of physiotherapy services and the rigid construction of policy development/adaptation processes are in fact important barriers to change.

The *coordinated law of 10 May 2015* has a strong emphasis on the supportive role of the physiotherapist. This supportive role is in relation to the physician's central role in assessing, diagnosing and referring a patient towards physiotherapy services. Different from the outline in the Belgian law, there are no restrictions relating to the practice of physiotherapy in the South African *Health Act No 61*. In the United States research is conducted on the nurse's scope of practice regulation. Under a restrictive scope of practice, it is impossible to function as an independent provider. Furthermore, supervision by physicians limits the possibility of delivering care (Xue, Ye, Brewer & Spetz, 2015). In their study on nurse practitioners, Kleinspell, Hudspeth, Scordo and Magdic (2011) concluded that the scope of practice is a responsibility of the profession. Matthews (2012) outlined that *the code of ethics for nurses* is not negotiable or possibly adapted by others than nurses. Placing the content of the Belgian *coordinated law of 10 May 2015* in a broader health professions international context, it appears a restrictive outlining is not supported in the retrieved literature. Therefore, Belgian physiotherapists should put efforts towards a legal outlining of physiotherapy without imposed restrictions as in South Africa. At

the same time the Belgian physiotherapists should work to establish and provide a well defined updated scope of practice policy governed by the profession itself. Policies for physiotherapists and physiotherapy services in Belgium and South Africa are constructed within the legal outlines of the profession. The Belgian *professional competence profile of the physiotherapist anno 2020* policy document was drawn up and presented by the Federal Council for Physiotherapy in 2016 as advise to the minister. This advice outlines a legal scope of practice for physiotherapists, achievable in the year 2020, taking into account the scientific developments in physiotherapy education and research. The South African policy document *standards of practice of physiotherapy 2012* outlines the legal authorised scope of practice and standards to be adhered to by South African physiotherapist.

The content of the policy documents *professional competence profile of the physiotherapist anno 2020* and *standards of practice of physiotherapy 2012* is similar. Issues as quality assurance, continuous professional development (CPD), (inter)professional collaboration, and the scope of physiotherapy practice are outlined. The key difference to highlight is the fact that the aspired scope of practice for Belgian physiotherapists outlined in the *professional competence profile of the physiotherapist anno 2020*, will not be implemented as advised to the minister in 2016. Being involved in policy advocacy for Belgian physiotherapist, I was unfortunately privileged to be a first hand witness to the status quo of the physiotherapy scope of practice for the past five years. The outlines presented in the *professional competence profile of the physiotherapist anno 2020* were advised to be implemented in the year 2020. On May 26th, 2019, Belgian citizens chose new political representatives. In November 2019, upon finishing this dissertation, there is still no new government formed. The previous legislator cannot implement any further decisions. Taking all this into account, we can state that the implementation of the advices relating to the increase of the scope of practice incorporated in the *professional competences profile of the physiotherapist anno 2020* will be postponed. The Federal Council for Physiotherapy will have to present the policy document to the new appointed minister of Public Health once he/she is in office for reconsideration. In relation to this non-implementation, the content and processes in the provided context with the mentioned actors outlined in the South African policy document *standards of practice of physiotherapy 2012* are already in place for South African physiotherapists.

The cause of the missing implementation of the advice provided in the Belgian policy document *professional competence profile of the physiotherapist anno 2020* is discussed in other research. Greener (2002) argued that because of the self preservation nature of organisations and the protective attitude of involved actors towards existing and often suboptimal policy models, policy change is difficult. Policies and formal institutions are usually designed to sustain, so decision making encourages policy continuity (Pierson, 2000).

The differences and similarities found in the analysed documents present a picture of the health systems of Belgium and South Africa. In the context of these health systems we also benchmarked the content of Belgian and South African legal and policy documents to 13 selected WCPT policy documents. The purpose of this benchmarking was to identify strengths and gaps in the content of Belgian and South African documents.

An important element is the fact that both in Belgium and in South Africa physiotherapy is a regulated profession. In their study on registration factors, Foo, Storr and Maloney (2016) found that physiotherapy regulation is characterised by four elements. These four key elements are: registration, standards of education and accreditation processes and standards of professional ethics and conduct. Belgium and South Africa both meet the requirements stipulated in relation to existing regulation.

The South African policy outline managed to meet all of the proposed minimum standards of the WCPT. The Belgian policy outline presented a picture that fell short of meeting all required minimum standards. The elements where Belgian policy needs to be adapted in order to achieve the WCPT minimum standards are:

- being an independant and autonomous practitioner,
- having full responsibility of physiotherapy services,
- being a first contact practitioner,
- allowed direct access and self-referral from patients,
- allowed to provide primary preventive services.

These elements are related to other points important to change:

- having written policies and procedures consistent with WCPT,
- having strategies to market physiotherapy.

The first five elements in the summary are all related to the aspect of professional autonomy of the Belgian physiotherapist. The *coordinated law of 10 May 2015* places physiotherapy services in a subordinate position towards physicians in the Belgian legal health framework. Linn (2003) argued that accountability is the result of available responsibility. Belgian physicians legally presume responsibilities for initiating and outlining physiotherapy services. Having this stipulated as a legal requirement has the potential to result in Belgian physiotherapists not taking (full) accountability for their actions based on the lack of responsibility.

Relating to the aspect of being a first contact practitioner, Belgian nurses, also regulated in the *coordinated law of 10 May 2015*, have achieved a certain level of autonomy. Through article 46 of the *coordinated law of 10 May 2015*, nurses in Belgium are legally authorised to perform technical acts without the necessity of a prescription. Perhaps, by approaching physiotherapy autonomy in a step wise manner Belgian physiotherapists can introduce aspects of it within the scope of physiotherapy practice without the necessity of a medical prescription.

In the Netherlands, The Royal Dutch Society for physiotherapy *(Het Koninklijk Nederlands Genootschap voor Fysiotherapie)* (KNGF), provides guidelines for its members working with direct access for patients and patients self-referral (KNGF, 2019). Direct access and patient self-referral was legally authorised starting January 1st in 2006. Implementation in legislation was achieved through positive evaluation of direct access concept projects (Nederlandse Organisatie voor Toegepast Natuurwetenschapplijk Onderzoek, 2004). The Dutch insurance companies ordered the study to examine sustainability of a health system with direct access for patients to physiotherapy services. The Dutch policy adaptation was evaluated through the RE-AIM model (Reach, Efficacy, Adoption, Implementation and Maintenance) (Glasgow, McKay, Piette & Reynolds, 2001). The study included aspects relating to the policy analysis framework of Walt and Gilson (1994) that we used in this research study. Aspects such as the stakeholders (insurance companies, prescribers of

physiotherapy, physiotherapist, patients) and context of the change (history, other countries, workload of the physician) were included.

In contrast to the Dutch insurance companies, one of the policy adaptation drivers in the outlined situation in the Netherlands, the Belgian insurance companies are not engaging in policy change relating to more autonomy for physiotherapists. The reason for this lingering stagnation is the evident non participation of physiotherapists at the level of the insurance companies. Furthermore, the secondary representation through physicians speaking on behalf of physiotherapy on the level of the insurance companies and the level of the cabinet of the minister, limits the voice of the physiotherapy profession in policy development. Physiotherapy is an evidence based scientific profession. Physiotherapists are trained as experts in their area of practice and can well represent themselves in discussions relating to scope of practice issues. The Belgian insurance companies should therefore start engaging physiotherapists as representatives instead of physicians. Belgian physiotherapists should direct resources towards positive interaction with the insurance companies to discuss representation.

Belgian physiotherapists need to explore other ways of physiotherapy policy advocacy, perhaps by more prominently including patients or patient organisations as a relevant stakeholder more prominently. One of the benefits of patient participation in health care decision making is a more positive and lasting effect on health (Vahdat, L. Hamzehgardeshi, Hessam & Z. Hamzehgardeshi, 2014). The World Health Organisation (2016) states that patient engagement is critical to the sustainability of health systems. Patients could signify numbers of relevant stakeholders. Shoemaker (2012) identified that the number of individuals and their political influence play a decisive role in policy change. Direct access for physiotherapy services in Michigan, USA was denied during three successive legislative attempts due to the opponent's ability to exert greater political influence. It seems pertinent to involve patients or patients organisations in Belgian physiotherapy policy development to counterweigh the current power of physicians and insurance companies.

Belgian and South African physiotherapists should also emphasise the important role of the professional association in policy development and advocacy. Both in Belgium and in South Africa, the professional associations have a legal place in physiotherapy policy development. However, their specific roles need to be more highlighted. Greenwood, Studdaby and Hinnings (2002) found that professional organisations play a significant role in legitimating change. A professional association enables the formation and reproduction of shared meanings and understandings. The study argued that professional associations are important for three reasons. Firstly, professional organisations are a means of interacting and collectively representating themselves. Secondly, professional associations negotiate for and represent their members collectively. Thirdly, professional associations play an important role in self monitoring of the members of the profession. Furthermore, Matthews (2012) found that professional organisations help facilitate three key issues in advocacy: informing members, dissemination of professional knowledge and providing guidance towards professional development. As professional associations are the organisations most closely engaged with contemporary practices, they are recognised as the experts for making recommendations to update scope of practice (Kleinspell et al., 2011).

Lewinski and Simmons (2018) conducted a pilot study on the knowledge and engagement of nurses in health policy making. The conclusion of the study was that an easily accessible continuing educational program could provide insight on different advocacy approaches to help leverage clinical expertise to influence policy advocacy. South African physiotherapists and Belgian physiotherapists have a continuous professional development (CPD) plan in place. Although CPD is not mandatory for physiotherapy practice in Belgium, more and more physiotherapists are engaged every year (Pro-Q-Kine, 2019). Physiotherapists in Belgium and South Africa should include education on policy advocacy in the CPD program to raise awareness and knowledge amongst physiotherapists. Another important aspect is the fact that CPD is currently not mandatory in Belgium in relation to the mandatory aspect in South Africa. One of the barriers to CPD in physiotherapy found by French and Dowds (2008) is the relevance of the CPD program. In Belgium the legal embedded restriction of physiotherapy autonomy provides for a lack of interest to engage (fully) in lifelong learning. In my opinion, CPD should be made mandatory for Belgian physiotherapists. It is through continuous demonstration of engagement physiotherapists can demonstrate to regulators their professional abilities in services

delivery. Besides the obvious practice benefits, CPD ensures other important elements such as assertiveness, autonomy and better competences (French and Dowds, 2008).

The aspect of having strategies to market physiotherapy closely relate to the process of identifying policy gaps and constructing new policy or policy adaptation. The same goes for the policies to be in line with the policies of the WCPT. Constructing a policy in a context that is already outlined by the WCPT and is in place in various WCPT member organisations will help facilitate the implementation process. Knowledge sharing is important in a globalised community.

4.8 Conclusion

The policy document analysis provided insight on the similarities and on the differences. In general we can conclude that, when comparing the four selected policy documents, the South African *National Health Act No 61* provides for a regulated uniform health system encompassing physiotherapy services. The physiotherapy service outlines are not specified or restricted in the Act. The Belgian *coordinated law of 10 May 2015* regulates, besides the general framework for health professions, in specific and explicit terms outlines the physiotherapy service outlines. The Belgian law, therefore, provides for a more strict outlining of physiotherapy services.

To investigate the strengths and gaps of the legal and the policy documents a benchmark on the content of the documents was conducted. The benchmark revealed that South African legal and policy documents form the basis of a more elaborate framework of scope of practice in comparison to the Belgian legislation and policies governing physiotherapy. Belgian law provides a strict and limiting framework for physiotherapy services in a supportive role towards the physician as a prescriber of physiotherapy while the South African Act encompasses health professions in a uniformly structured health system.

In the next chapter, we sought expert opinions through interviews with selected key stakeholders in the Belgian and South African policy development. The expert opinions were examined to provide further detailed information on Belgian and South

African physiotherapy policy development alongside the findings from the literature review in chapter three and the policy analysis in chapter four.

CHAPTER FIVE – KEY ROLE PLAYERS IN THE POLICY PROCESS.

5.1 Introduction

In this chapter the analysis of the interviews conducted with selected key stakeholders in the physiotherapy policy process is outlined. Prior to these interviews, a policy analysis was conducted to establish differences and similarities that could account for strengths and gaps in the physiotherapy policy framework. The documents included in the policy analysis were: the *coordinated law of 10 May 2015*, the *National Health Act No 61*, the *professional competence profile of the physiotherapist anno 2020* and the *standards of practice of physiotherapy 2012*. The outcomes of the analysis were multiple. Belgian legislation prohibits physiotherapists from making diagnoses. Furthermore, physiotherapists in Belgium need to work on a mandatory prescription. South African legislation provides for a structured uniform health system without specifying professions. The South African legislation outlines requirements and general standards with policies and procedures. The Belgian policy document *professional competence profile of the physiotherapist anno 2020* provides detail on quality assurance, lifelong learning and interprofessional collaboration as important aspects. The South African policy *standards of practice of physiotherapy 2012* outlines quality assurance, (inter)professional communication and the elaborate scope of practice of the South African physiotherapist. The analysis of the selected documents provided a picture on the similarities and the differences of incorporated content.

Belgian and South African selected documents were benchmarked to proposed minimum standards of the World Confederation for Physical Therapy (WCPT). The benchmark provided detail on the strengths and gaps of the content of the benchmarked documents. Analysis underscored that South African selected documents provided an outcome meeting all proposed minimum standards of the WCPT. The Belgian documents fell short of meeting proposed criteria addressing the aspects of autonomy.

In order to validate the results of the policy analysis, stakeholders key to the policy matters concerning physiotherapists were interviewed. The interviews were conducted to explore expert opinions on strengths and gaps of the current policy frameworks in Belgium and in South Africa.

The stakeholders were asked to provide their professional opinion on four key elements. The questions asked during the interview were based on an interview guide (Appendix C). the four key elements that directed the interviews are:

- The structure of physiotherapy policy development.
- The strengths of the described policy framework.
- The gaps in the physiotherapy policy development framework.
- Possible solutions for the highlighted gaps.

5.2 Identification of the stakeholders

Participants were selected through purposive sampling, based on the responsibilities they hold in the policy framework process and their roles in the profession from both countries. The selection of the stakeholders ensured selection of comparable persons in specific positions and level of responsibility within professional organisations.

5.3 Methodology

5.3.1 Invitation of the selected stakeholders

The selected stakeholders all received an e-mail in December 2018 with the request to consider participating in an individual interview. The e-mail briefly outlined the purpose of the interview and how the interview would be structured (appendix E). All South African participants received the e-mail in English. The e-mail was translated into Dutch for the president of the Belgian professional association Axxon and the president of the Federal Council for Physiotherapy (FRK). The president of the Technical Council for Physiotherapy (TRK) received the e-mail translated into French. Translation of the e-mails was possible because the student-researcher speaks both Dutch and French fluently.

All the selected stakeholders responded positively and agreed to participate by signing the informed consent forms (appendix B). Each stakeholder also received a

copy of the interview guide (Appendix C) and an information sheet to provide detail about the study (Appendix D). The participants of the interviews all returned the consent forms in due time.

5.3.2 Interview procedure

All interviews were conducted by the researcher. The interviews were conducted in person with the president of the Federal Council for Physiotherapy and the president of the Belgian professional association. The president of the Technical Council for Physiotherapy, the president of the South African Society for Physiotherapy and the professional liaison officer were interviewed telephonically through the teleconference platform GoToMeeting V9, version 9.6.0 (9.6.0.589) Copyright © 2018 LogMein, Inc.

The interviews were simultaneously audio-recorded with two recording devices. The first recording device was the internal recorder of the computer, Dictaphone version 2.0 Copyright © 2018 Apple Inc. The second recording device was a stand-alone digital recorder: Olympus – digital voice recorder WS-831.

The interview with the president of the professional association Axxon and with the president of the FRK were conducted in Dutch. The interview with the president of the TRK was conducted in French. The interviews with the South African participants were conducted in English. One of the supervisors of this dissertation, Prof. Meesen, was present during all interviews to observe and note the participants non-verbal communication. All interviews took approximately one hour.

Due to challenges in diary clashes and internet connectivity over a number of days, it was not possible to conduct a telephone interview with the chairperson of the professional board of PPB of the HPCSA. The chairperson received an email from the researcher with the interview schedule and responded to the questions in writing. This document was then accepted by supervisors for inclusion in the analysis.

5.3.3 Interview transcription process

All recorded interviews were transcribed verbatim by the student-researcher directly from the audio recorder. The observed non-verbal communication was added. Transcription of the interviews was e-mailed to the participants with the request to verify the content. All participants acknowledged the content was a true representation of the conducted interviews. No changes to content were needed to be made.

After verification of the participants the Dutch and French interviews were translated to English. The translated interviews were again e-mailed to the relevant participants with the request to verify accuracy on content. All participants agreed with the content of the translations. The interview analysis was done on all English versions of the interviews (appendix G).

5.4 Stakeholder interview results

The results of the interviews outlined expert opinions on the strengths and gaps of the current physiotherapy policy frameworks. From the interviews several issues were derived as important aspects towards the policy framework in the opinions of the experts. The analysis will first focus on the strengths and gaps for Belgium and South Africa separately. Secondly the strengths and gaps of the systems in both countries will be compared to identify similarities and differences.

5.4.1 Belgian interviews

Three key stakeholders in the Belgian physiotherapy policy process were interviewed. The three selected Belgian stakeholders are qualified physiotherapists. Table 5.1 shows the participants' role in the physiotherapy policy process alongside the participant's idenfification code for anonymity.

Table 5.1 Belgian interview participants demographics

Role in the policy process	Interview code
Leadership in advisory board towards minister of Public health.	A
Leading the physiotherapy professional association.	B
Leadership in policy development towards the minister of Social Affairs.	C

The outcomes of the analysis are presented to show the theme, the emerging categories and the related quotes. The reference of the quote from the interview is added in the last column on the right. A brief comment on the findings is added below the tables. Although the categories were often addressed more than once in a single interview, the table only contains the most appropriate quote relating to the category. Table 5.2 outlines the key results derived from the interviews with the Belgian experts on the policy development structure.

Table 5.2 Key findings Belgian policy development structure

Theme	Category	Quote	Reference
Policy development structure	*Stakeholders*	*First, we have the government ... Secondly the professional association ... And thirdly the universities and institutes for higher education in physiotherapy ...*	(A/66-69)
		... we have representatives of the professional association for physiotherapists and representatives of the insurance companies.	(C/159-161)
		This could also be the administration, the National Institute for Health and Disability Insurance (RIZIV) or ... the college of physician directors making a decision ...	(A/102-105)
	Organisational structure	The RIZIV is in fact the civil service of the ministry of Public health. This is the administration of the Minister making all decisions relating to healthcare in Belgium and constructing them into laws.	(B/97-99)
	Federal Council for Physiotherapy	*So, if we are talking about public health, the Federal Council for Physiotherapy, there are representatives of universities, of the professional association and even physicians.*	(C/148-149)

Within the structure of the policy development there are identified stakeholders. The instances interacting in the policy process are the government, the professional association and universities. Furthermore, the National Institute for Health and Disability Insurance *(Rijksinstituut voor ziekte – en invaliditeitsverzekering)* (RIZIV) as government organisation is mentioned with a specific reference towards the college of physician directors and references towards the insurance companies as stakeholders. Within the FRK, physicians are also mentioned as stakeholders in the policy process.

The experts provided insight on the positive aspects of the framework. The strengths of the described policy framework are outlined in Table 5.3.

Table 5.3 Key findings of the Belgian policy framework strengths

Theme	Category	Quote	Reference
Policy framework strengths	*Physiotherapy financing*	*Because of the system of the healthcare in Belgium there is always a finance for physiotherapy. [Budget for physiotherapy services within the general health care budget]*	(B/191-192)
	Stakeholder involvement	*It is positive that there is a finance [for physiotherapists treating patients], where the profession can for some parts make decisions on the budget.*	(B/195-196)
		... we have the chance of being in a system where healthcare is regulated with the healthcare professionals	(C/234-236)
	Separate professional statute	*Physiotherapy has a professional statute with a separate chapter in the coordinated law relating to the exercise of health care professions off 10 May 2015.*	(A/229-231)
	Accessible physiotherapy	*Physiotherapy is embedded in the system of social security*	(A/235-236)
		Belgium ... has a very beautiful health system. It has a solidarity principle.	(B/78-79)
	Interest in quality in physiotherapy	*The policy instances are showing a common interest for qualitative application of physiotherapy in practice and for qualitative education and research in physiotherapy.*	(A/236-238)

Five key issues were evident. A strong point of the current policy system, identified by the participants, is the importance of being part of a regulated system. This system, within subsidised national health care allows physiotherapists to have, to a certain extent, an influence on the distribution of the physiotherapy budget. Furthermore, physiotherapy is separately regulated as a profession. Physiotherapy services are embedded in the Social Security, allowing access to all citizens. Finally, in order to maintain an accessible physiotherapy service to the community, the policy instances show interests in quality physiotherapy services, backed up by a high standard of education and research.

The experts identified gaps in the policy framework. These outlined gaps are presented in Table 5.4.

Table 5.4 Key findings on the Belgian policy framework gaps

Theme	Category	Quote	Reference
Policy framework gaps	*Inadequate budget*	*The insufficient budget is the biggest problem.*	(B/225)
		For now, inevitably, the Achilles heel remains money.	(C/351-352)
		There are also gaps relating to the use of supplements materials used in therapy. At this point this isn't even allowed to be billed.	(B/275-276)
	No power to allocate budget	*... we have little decisive powers on our budget itself.*	(C/244-245)
	Oversupply of physiotherapists	*... the group of physiotherapists is getting too big.*	(B/227)
	Physiotherapist Shortage in geriatrics	*In a certain sector there is a problem of finding physiotherapists. This is in the sector of the elderly. In this sector there is a need for physiotherapists.*	(B/239-241)
	Inadequate remuneration	*The biggest problem is that physiotherapists working in this sector [geriatrics] are working below their pay grade.*	(B/241-242)
	Scope of practice	... people were all working here partly with many things unrelated to physiotherapy: animation, feeding patients, restoration of wheelchairs.	(B/255-256)
	Inflexible strict regulating framework	*The gap is perhaps that the legislative framework needs to be created to allow treatments outside the national Insurance for sickness.*	(B/270-271)
	Inadequate power and influence	*... we have too little influence and not enough experts around us to influence the government.*	(B/328-329)
		There is no central organ for physiotherapy policy development.	(A/262-263)
	Professional standing	Physiotherapy cannot be classified again under the paramedical professions as was the case in the recent Collective Labour Agreement (collectieve arbeidsovereenkomst) (CAO) for healthcare professions, ...	(A/397-399)

	Limits of the professional association	*... I believe this is one of the difficulties of the technical council, in the end we only have but the time spent.*	(C/88-89)
		Manpower and finances are failing short to really establish this.	(B/308)
	Insurance companies powers	*... we are in a system where they [insurance companies] offer care and in the same spirit, they are controlling healthcare workers.*	(C/289-290)
	Influence and role of physicians	*The dominant position of the physicians on the RIZIV level has grown historically.*	(B/289-290)
		The policy framework encompassing physiotherapy was strongly formed by physicians.	(A/353-354)
		... physicians safeguard a big piece of the power in different places.	(C/313)

The Belgian interview participants outlined several gaps in the current system. First and foremost, the issue raised by the participants was the insufficient allocated budget towards physiotherapy services to the community. Attached to the budget, the issue of limited decisive powers of physiotherapy to influence allocation of the budget was mentioned.

Furthermore, the experts stated that there are many graduating physiotherapists, therefore resulting in supply outstripping demand. The statement on the overall size of the workforce was thereafter nuanced as one expert expressed that in fact more physiotherapists are needed in the field of geriatrics. Due to the outdated working conditions and remuneration, graduating physiotherapists do not choose a career in geriatrics.

Problems identified for self-employed physiotherapists focus on a outdated framework of service provision. The outdated framework relates to the scope of practice and the inflexible rigid regulated framework for physiotherapy services.

In relation to other involved stakeholders in the policy process, there is the fact that the professional association and its representatives still do not have sufficient weight

in the executive decisions. The possible influence and the weight of the physiotherapists as representatives is further described in relation to the possible time allocated to fulfil the representation task. Physiotherapy representatives all have a primary job and advocating is done during their own free time.

Finally, the role of the insurance companies and the physicians is experienced as a gap. Insurance companies can act as controlling mechanisms and at the same time offer care. Physicians play a central role in the National Institute for Health and Disability Insurance (RIZIV).

Experts provided possible solutions to the experienced gaps. Table 5.5 outlines the expert proposed solutions.

Table 5.5 Expert proposed solutions to Belgian policy gaps

Theme	Category	Quote	Reference
Policy framework solutions	*Communication*	*Only on the basis of smooth and efficient communication during this legislative work can we avoid missing important elements.*	(A/373-375)
		Physiotherapy needs to continue to strive towards positive attention of the government ...	(A/401-402)
	Collaboration	*Important realisations were always together with an important effort of politicians and physiotherapists and were branded by a smooth and efficient communication.*	(A/475-477)
		... if we want this to function in an efficient way, I believe that for sure members must keep talking to each other.	(C/116-117)
		I believe it is very important to approach the political world so they can support our propositions.	(C/182-184)
	Research underpinning collaboration	Much research is multidisciplinary conducted so research can be a catalyst for modern multidisciplinary collaboration between the medical professions.	(A/428-429)
	Advocacy	*We have to demonstrate our competences and our ability to be complementary.*	(C/380-381)

		It is therefore important to provide general knowledge on what nowadays physiotherapy means and how this is supported by scientific research.	(A/457-458)
	Professionalising	... employ a healthcare economist, guiding us towards policy developments.	(B/305)
		I believe we have to make sure that we professionalise... we have experienced people ... that could be better supported to be more efficient.	(C/269-270 / 271-273)
	Representation	... at that point we need to act as fast as possible and make sure a physiotherapist is present at that level. In that way, we can help govern.	(B/348-349)
	Duty and objective	... a deontology organ enables physiotherapy to better act within European legislation.	(A/446-447)
		... in fact, we should create a better legal framework for this all to proceed in a legal manner.	(B/272-273)
	Direct access for physiotherapy	... it is my opinion to demand direct access immediately.	(C/410-411)
		... in my opinion, we will get there step-by-step, but that is probable because I am a man of consensus ... we also have to try to understand the position of the physician.	(C/411-413)
		... in this project of direct access, limit the authorised treatment session to 4 or 5. We can reassure the physicians at first.	(C/413-415)
	Recognition of education level	... they cannot find physiotherapist who want to work there if they're not paid at the Masters level.	(B/252-253)

	Spread of the physiotherapy workforce	*There has to be a relocation within the profession ... In a certain sector there is a problem finding physiotherapists. This is the sector of the elderly. In this sector there is a need for physiotherapists.*	(B/228-229 B/239-241)
	Comparison to other countries	I believe that it is necessary without a doubt to make some analysis on what is happening in our neighbouring countries.	(C/334-335)

One of the possible solutions outlined for the gaps, identified by the interviewed stakeholders is open and honest communication between stakeholders in the policy process.

Linked to clear communication is the identified need to keep collaborating with other stakeholders such as the government and institutions for physiotherapy education. Effective communication also encompasses advocating for physiotherapy on a corporate level.

The participants suggested that more professionalism in the association is needed. A part of the professionalisation process would entail supporting physiotherapists active in the policy development to be more efficient. A second solution presented was for the professional association to employ a health care economist for more professional guidance. Another solution mentioned on a corporate level, was the creation of a physiotherapy deontology (duty and obligation) organ.

Another important aspect outlined by the experts is the improvement of the working conditions. For the self-employed physiotherapist, a complete new and adapted policy framework is needed according to the interview participants.

Furthermore, solutions were presented towards practical day-to-day experienced gaps. An important issue is the fact that direct access to physiotherapy services is still prohibited by law in Belgium. A possible solution outlined was to proceed in a stepwise fashion rather than trying to achieve all at once. One of the experts outlined

a proposition to start with a limited amount of treatment sessions as a first step towards full scale direct access.

Another practical solution offered to better spread the physiotherapy workforce, is the possibility to orientate newly graduates towards specific fields of interest which are lacking the interest of capable physiotherapists. Attached to this orientation is the suggestion to finally make sure all employed physiotherapists are remunerated commensurate with their educational level. Finally, one last suggestion towards solving Belgian experienced gaps in the policy development system was to analyse situations in other countries.

5.4.2 South African interviews

Three key stakeholders in the South African physiotherapy policy process were interviewed. The three selected South African stakeholders are all qualified physiotherapists. Table 5.6 shows an outline of the participants' role in the physiotherapy policy process alongside the participant's identification code for anonymity.

Table 5.6 South African interview participants demographics

Role in the policy process	Interview code
Leadership in policy development and adaptation advice for the professional society.	D
Former leadership of the professional society.	E
Leadership of regulatory body.	F

Similar to the Belgian participants, the South African experts shared their opinions on the four issues. The results offer the theme, the emerging categories and the related quotes. The reference of the quote from the interview is added in the last column on the right. A brief comment on the findings is added below the tables.

The first theme is the structure of physiotherapy policy development. Table 5.7 outlines the key results derived from the interviews with the South African experts.

Table 5.7 Key findings South African policy framework structure

Theme	Category	Quote	Reference
Policy framework structure	*Stakeholders*	*The first is the national department of Health.*	(D/100)
		The second regulating entity is the Health Professions Council of South Africa (HPCSA)	(D/103)
		... the policy-making body for health in South Africa is the HPCSA.	(E/64)
	Hierarchical structure	The Council is the highest decision-making body of Council.	(F/34-35)
		The HPCSA consists of several boards. One of them is the physiotherapy and biokinetics board.	(E/93-94)
	Centrally controlled	Our board is chosen by the minister of health.	(E/109)
		The minister of health will send out a notice and say a new board is due.	(E/109-110)
	Policy process	... any issues that we need to discuss must be approved by the board. Then the board goes to the council meeting ... And the council is going to the minister.	(D/196-198)
		The board identifies a regulation gap and the matter gets debated by a Task team of the board. ... The Board takes the matter to the stakeholders for input and comments. ... it is taken to other 11 Board for further comments. ... send it to legal department for legislative input, then it serves at Council for ratification.	(F/104-111)

The two identified major regulating stakeholders in South African policy structure are the National Department of Health and the HPCSA. In the regulating bodies, several instances are described as interacting and hierarchically structured. The Council within the HPCSA is the highest decision- making body under the governing Minister.

The participants provided an overview of the hierarchical structure by stating the professional boards reside under the HPCSA. The Physiotherapy, Podiatry and Biokinetics board (PPB) is one of twelve boards of the HPCSA. In relation to the

structure, board members are selected by the Minister. The selection follows the input provided by stakeholders after publication of the notice.

The South African participants of the interviews outlined that a policy proposition needs to follow a certain outlined path to reach the Minister of Health. A policy needs to be debated by the board and the Council before it can go to the Minister. Even on board and on Council level the proposal is judged and can be amended several times.

The experts provided insight in the positive aspects of the health system towards physiotherapy policy development. The strengths identified in the policy framework in South Africa are outlined in Table 5.8.

Table 5.8 Key findings of the South African policy framework strengths

Theme	Category	Quote	Reference
Policy framework strengths	*Access to the Minister*	*... our [physiotherapy society] president has direct access to the minister of health.*	(D/176-177)
	Access to the professional board	*The other strong point that we have is the access to the professional board at our health professions council.*	(D/194-195)
	Stakeholder involvement	*Suggestions are done through stakeholder engagements ...*	(F/115)
	Active and knowledgeable board	I must say with the new board especially, he has chosen 4 or 5 people that are really knowledgeable and do actually have a heart for the profession.	(E/112-114)
		The new board is already there for two years and they have done quite a lot	(E/181)
	Self-regulating profession	*Physiotherapists are self-regulating, at any given point in time there is an opportunity to amend rules ... policies may also be amended ...*	(F/123-125)
		... all other professions within the HPCSA have an opportunity to comment and give input without dictating what physiotherapy can do or not.	(F/127-129)
	Direct access and first-line practitioner status	*We are first-line practitioners and have direct access and we are the only group within rehabilitation with that privilege.*	(D/254-256)

The first strong point that emerged from the interviews with the South African experts, was that of access and the possibility for the SASP and its president to directly approach the Minister of Health. A second perceived strength of the current system by the experts was the possible access and interaction with the current active HPCSA professional board. Another strength in the expert's opinion was the possibility of interacting as a stakeholder in the policy development process.

Furthermore, an identified strength is the direct access patients have to access physiotherapy services. The fact that physiotherapists are self-regulated was also mentioned as a strength of the South African policy framework. Self-regulation

implies that at any time legislation and policies governing physiotherapy can be amended. In addition, this also means that other professions can give input towards physiotherapy policy but can never dictate what physiotherapists can or cannot do.

The South African experts identified gaps in the policy framework. These gaps are outlined in Table 5.9.

Table 5.9 Key findings on the South African policy framework gaps

Theme	Category	Quote	Reference
Policy framework gaps	*Outdated rules*	*The overall rules and regulations of HPCSA were developed long ago and we think they are a bit behind of time.*	(E/95-96)
	Regulators' lack of knowledge on policy	The area of policy and or regulation is very underdeveloped in SA. For one to serve at the HPCSA or the Board, does not need any specific qualification. There are no institutions that train regulators.	(F/197-199)
		... the people that have developed it didn't have enough insight in the profession itself.	(E/303-304)
		... since 1994 a lot of people have been put into places with almost no knowledge of what they are supposed to do.	(E/156-157)
	Limits of the professional association	... as a membership organisation we really do not have a say. We can just advise the board [HPCSA] what to do ...	(E/160-161)
		... the frustration is that we go through policy development and dictation from the outside.	(D/303-305)
	Disharmony between structures	They [the professional board] get stuck at the main HPCSA.	(E/181-182)
		... none of the national departments are really talking to each other.	(D/279-280)

	Slow processes	... it takes ages to get something done. Because, it takes a long time to get past the main committee.	(E/183-185)
		That is quite a lengthy process. This whole process takes between three and four years to complete. Legislation in South Africa takes quite a while.	(D/144-145)
		... it does take time due to the varying meeting times of the different Boards.	(F/144-145)
		The process of approval by the Minister of Health through to Parliament takes even a longer period, up to 5 years, ...	(F/147-148)
	Decentralised decision making	Provinces can identify their own priorities, guidelines and policies. Which makes it very difficult if you want to get anything implemented ...	(D/218-219)
	Lack of stakeholder involvement	... there is not much input from the profession and from a person ...	(D/51-52)
		... the stakeholders are coming in at a very late stage.	(D/79)
		... stakeholders do not always adhere to the required timelines.	(F/139-140)
	Representation	When it comes to policy development it is very difficult because we are such a small group. The doctors and the nurses have the bigger voice.	(D/173-175)
		... they [the doctors and the nurses] also get circulated documents much earlier than what we would get.	(D/175-176)
	Communication chain	... some of the policies are going to the deans of the faculties, but the deans do not circulate it down to the relevant professionals or the relevant departments.	(D/285-287)
	Physiotherapy specific policy	*There is no policy only pertaining to physiotherapy in South Africa.*	(D/201-202)

	Lack of supportive data	We don't have any data really to support policy development.	(D/236-237)
		When we have discussion with the national department or with medical funders and so on, they are throwing data at us and we can't counter this and can't accept, agree with it or reject it because we don't have any data.	(D/241-243)
	Political agenda	... that policies in South Africa, particularly in an election year, are political driven rather than looking at the clinicians and what is really necessary.	(D/262-263)
		... if you do not have posts for physiotherapists how can the work improve in those areas?	(E/240-241)

The experts provided insight into the gaps in the current system. A first gap brought forward was the fact that the general rules and regulation of the HPCSA are outdated.

A second expressed gap in relation with the HPCSA is the historical position fill-ups with people without specific knowledge on physiotherapy or policy development. The experts stated the relationship between the HPCSA and the SASP is professional and more smoother today. The interview participants outlined that in the past, the relationship was not this good because former professional boards were not so supportive towards physiotherapy and they experienced problems due to a lack of physiotherapy specific policy knowledge.

Furthermore, the experts also stressed that a major gap in the policy development system in South Africa today is a time-consuming lengthy process in itself. Policy development takes a long time in South Africa, up to five years when the Parliament is involved. The experts outlined that the decentralised decision making, the fact that provinces have the legal right to adapt, amend and identify their own policies, does complicate advocacy.

Another gap identified was the fact that governing departments do not communicate. The lack of communication is in a horizontal way from department to department but

also vertically towards stakeholders during the policy development process. The experts elaborated on the communication aspect and identified not receiving information or not receiving information in due time as involved stakeholders in the policy process as a gap. The experts addressed the reason for this lack of timely reception of information to the fact that physiotherapists are a small group in relation to doctors and nurses.

Furthermore, the experts outlined the gap perceived in relation to the lack of physiotherapy specific policies. The interlink with other professions makes it more difficult to adapt a policy on behalf of physiotherapists in the professional board according to the experts.

The next identified gap in the current South African policy development system is the lack of available data to support physiotherapy policy development. The absence of data is making it difficult for people advocating for physiotherapy to interact on an equal level with government officials or medical funders. Finally, the expert stakeholders outlined a gap related to political issues. The participants stated that policies in South Africa often are political driven rather than based on necessity.

The stakeholders proposed solutions to the experienced gaps in the policy framework. Table 5.10 outlines the suggestions.

Table 5.10 Expert proposed solutions to South African policy gaps

Theme	Category	Quote	Reference
Policy framework solutions	*(Inter)professional collaboration*	*... because of the numbers if we really want to make a difference, we need to stand together with the rehabilitation groupings.*	(D/258-260)
		... we work together with this group, the public sector group and sometimes also with the occupational therapists and speech therapists. In that case we have a stronger say in our letters to the minister and to the department of health.	(E247-249)
	Intensified collaboration with the board	I do think that the board should make more use of the professional society.	(E/312)
		... I believe that if the professional board is less separate from the professional societies, we would develop more applicable regulations and guidance of the professions.	(E/325-327)
	Individual stakeholder involvement	Through the use of website, emails, sms, the Board can reach all the physiotherapists in seeking opinion.	(F/189-191)
	Timely stakeholder involvement	*We would really like to see, as stakeholders, and as individual stakeholders, providing health services in South Africa, that we are considered much earlier in policy development.*	(D/329-332)
	Data collection	*... we have to have proper data collection, of services and of HR*	(D/335-336)
	Communication	*That all departments are talking to each other.*	(D/340)
	Policy knowledge education	*... there is a suggestion at Council to train all health professionals in regulation before they assume office.*	(F/210-211)
	Interprovincial collaboration	The nine provinces working independently is also a change in legislation ... This means that the act needs to change. That might be a first project we as a society will take on and influence the minister ...	(D/341-343)

The South African expert stakeholders provided general solutions to the identified gaps. A first possible solution was on the importance of belonging to a stakeholder-group advocating for a large group. In relation to this a thought of solution was to remain linked with other rehabilitation professions.

Another possible solution offered by the experts was the suggestion towards the Professional Board to make more use of the SASP. The experts also suggested a possibility of interacting with individual physiotherapists to raise awareness on policy matters and increase participation.

Other solutions implied by the experts cover the more practical gaps in the current system. Firstly, one of the possible solutions of interacting more efficiently would be if policy adaptation is shared earlier in the process. Secondly, the physiotherapy representative's access to relevant data is pertinent to engage on an equal level with other stakeholders in the policy process. Thirdly, the importance of smooth communication between departments could ensure less time-consuming policy development processes.

The suggestion is made towards the training of health care professionals before they can assume office. The solution of educating experienced regulators addresses the gap of lack of knowledge of physiotherapy policy development.

Finally, the suggestion is made to change the Health Act in order to limit the provinces in their ability to individually adapt health care policies. The experts outlined that the decentralised decision-making process makes it more difficult for them to engage in policy development and advocacy.

5.5 Discussion.

Section 5.4 outlined a picture of the expert's views on the country's policy system. The participants provided insight on the experienced strengths. The identified gaps were outlined and in their role as key stakeholders, the experts provided possible solutions to the gaps. These four topics were all addressed from the physiotherapist point of view.

The most important strength outlined by the Belgian and the South African experts is the aspect of being part of a regulated health system with stakeholder involvement. Yoder-Wise (2019) conducted a study about stakeholder involvement of nurses in the United States. The study showed that the viewpoints from the stakeholders, together with the cost are important components to consider before constructing a policy. Stakeholder involvement is also addressed in the study conducted by McIntosh (2018) on the role of physicians in Canadian medicare. Evidence suggests that physicians are the best actors to insist and enforce changes in physician behaviour (McIntosh, 2018). This evidence implies that involving physiotherapists as enforcers of physiotherapy policies can contribute to physiotherapist adhering to the policies. Relating to the outcomes of the expert interviews, both in Belgium and in South Africa, physiotherapists should be involved more intensively in the policy development process. For Belgian physiotherapists this implies being able to be active and of influence on more executive levels of policy development. The South African physiotherapists on the other hand, need to be engaged much earlier in the policy process.

The Belgian experts expressed the view that having a separate legal statute in the *coordinated law of 10 May 2015,* can ensure the possibility of specific regulation tailor-made for modern physiotherapy services. Sandvoll, Bjordal, Hollekve and Johnsen (2019) conducted a study on nurses' interventions with older people with dementia in Norway. An outcome of the study was that tailor-made services through close collaboration, implied flexibility, accessibility and availability. For Belgian physiotherapists with a separate legal professional statute, working towards available resources and accessible services, with a professional flexibility could lead to specific physiotherapy regulation adapted to an updated scope of practice.

The South African experts suggested that being a self-regulating profession is an important strength. Self-regulation restricts entry of other professionals into the profession and limits competition as found by Van Den Bergh and Faure (1991) in their study on free flow of professional services in the European Economic Community. Belgian physiotherapists should therefore analyse the outlines of the self-regulatory aspects of the South African system to facilitate advocacy in Belgium towards implementation of self-regulation. Working towards a Belgian legislative

framework for physiotherapy as a self-regulating profession will be important to achieve professional autonomy.

Physiofirst, the United Kingdom professional association advocating for physiotherapists in private practice has developed a data collection system with the University of Brighton. The collaboration is called *Data for impact project* (Physiofirst, 2019) and provides the physiotherapist members with benchmarking data on clinical skills and the professional association with up to date relevant data for advocacy. Policy advocacy is defined by Spenceley, Reutter and Allen (2006) as knowledge-based action intended to uplift health by influencing decisions on system-level. For knowledge-based action, relevant up to date data is imperative. South African and Belgian physiotherapists could benefit from learning from the United Kingdom *Data for impact projects.* This will particularly be beneficial as Belgian and South African physiotherapists lack data to back up and facilitate discussions with other stakeholders. As legislative frameworks differ in each country, the data system developed by Physiofirst will need to be adapted and contextualised to serve Belgian and South African data collection.

Furthermore, in the area of policy change, the outdated rules and legislation was addressed by the Belgian and the South African experts as a gap. Changing policies and legislation is a time-consuming and long term process as outlined by the experts. Greener (2002) described the difficulty of policy change due to the preservative nature of organisations and the protective attitude of people involved. The National Mental Health Policy of the Maldives encompasses the years 2015 to 2025 (World Health Organization, 2017). The policy in place is only achieved through persistent advocating and improving awareness (Mohamed, 2015). Therefore, active and ongoing engagement on all levels possible should be a priority for Belgian and South African physiotherapist in policy advocacy. Nelson and Webb Yackee (2012) argued that coalition lobbying is employed frequently by stakeholders. Lobbying with a consensus across the coalition is an important influence for policy advocacy. For Belgian and South African physiotherapists forming coalitions with other stakeholders such as physicians could prove to facilitate positive change in legislation. Physicians in San Francisco were able to lobby successfully on several occasions. The success related to the use of coordination and focus by professional associations. The

advocacy for physicians was focussed through the lens of the patients (Kushel & Bindman, 2004). Including patients concerns and the need for care in propositions of policy change for physiotherapy, should appeal to the regulators and provide for possible change in Belgium and South Africa.

Linked to time-consuming policy change, is the need for more professionalism in the Belgian professional physiotherapy association. According to the experts, physiotherapy representatives all have a primary job and advocating is done during their free time. Physiotherapists are negotiating policy adaptation with other stakeholders such as physicians employed by the insurance companies who are able to devote their time exclusively on policy development. We found no literature on the importance of full-time professional policy advocacy. Research on the use of voluntary advocacy was also not found.

Relating to the necessity of policy change, an important gap only outlined by the Belgian experts was the lack of professional autonomy. The central and dominant position of the physician (as health care stakeholder and as a representative for the insurance companies) in physiotherapy policy development is expressed as a major contributing factor for the lack of progress. Physicians acting as regulators, need to understand that physiotherapy role expansion in the sense of direct access for patients towards physiotherapy services is not likely to stimulate discussion on the practising physician's scope of practice (Ritchey, Pinkston, Goldbaum & Heerten 1989). Furthermore, Ritchey et al. (1989) concluded that in order to achieve more professional autonomy it is important to make physicians aware of physiotherapist's capabilities rather than through legislation enforcing status enhancement. Continuing open communication was stressed by the key stakeholders as one of the most important advocacy elements. Open and continuous communication and collaboration between stakeholders in the Belgian policy development framework should, therefore, be central. We found no studies that looked at the impact of professional autonomy in physiotherapy. The lack of available literature on this topic could be seen as an important research gap.

Additional to the role of the physician in the policy development process, the conflict of interest that emerges when looking at the role insurance companies play also

raises questions in the experts' opinions. Experts stated that the insurance companies are regulatory organisations and at the same time are allowed to provide health care services of their own. The European Commission (2019) states that the separation of powers should be embedded in the member states' political structure. Therefore, Belgian physiotherapists active in policy advocacy should address the legal conflict of interest in the current roles of the insurance companies.

The South African experts highlighted the aspect of the decentralised decision making as a gap in South African policy development. The perceived gap of decentralised decision making is supported by the research done by Mureithi, Burnett, Bertscher and English (2018). The research on general practitioners shortage in the public sector, used the Walt and Gilson health policy analysis triangle, similar to our study. Although the aim of the study was different from ours, similar methods were used (document review, key informant interviews). The study concluded that decentralisation should be considered only after other important issues such as purchaser capacity or institutional knowledge. These conclusions are important to South African physiotherapists who are active in policy advocacy. Following the suggestions of the study by Mureithi et al. (2018), South African physiotherapist should focus on the perceived policy gap of the decentralised decision making.

In addition to the elements outlined by the physiotherapy key stakeholders, we searched for other professions' engagement to policy advocacy and policy development. Available research on health professional's policy engagement is scarce. We did, however, find some references. Galletti et al. (2018) found that nurses in Italy only participated in policy-making processes on occasion and with little intensity. Research involving hospital managers in Lebanon concluded that training and continuous education was identified as crucial for the initiation and advancement of informed decision making (Hilal, Harb, Jamal & El-Jardali, 2019). In Iran the study on patient involvement in the doctor-patient relationship outlined the benefits of patient empowerment (Vahdat et al., 2014). Patients' participation results in a more careful monitoring of their own care. Hence, patients must participate in decisions associated with planning, performance and evaluation of health care. Findings from

the additional search provided similar elements as outlined by the physiotherapy key stakeholders.

5.6 Conclusion

Through the individual interviews conducted with selected experts we were able to provide a picture on the perceived strengths of the policy framework in Belgium and South Africa. Besides the strengths, the experts also outlined the gaps of the Belgian and the South African physiotherapy policy framework.

The experts confirmed literature findings and provided additional insight and detail on the current policy development systems in Belgium and in South Africa. The strength that was outlined for both countries is:

- Being a part of a regulated system with stakeholder involvement.

Besides the strengths, the experts provided information on pitfalls in the current system. The gaps appearing in both policy systems are:

- The outdated policies and legal framework encompassing physiotherapy
- The lack of available data.

In the final chapter the summary of the findings from the literature review and the additional information gathered through the interviews with the selected key stakeholders, will be outlined. The findings will be used to present final conclusions of this study and the following important recommendations.

CHAPTER SIX – CONCLUSION

6.1 Introduction

The aim of the study was to analyse current rehabilitation policies underpinning physiotherapy services in Belgium and South Africa. The objectives of the study were:

- Describe selected policy documents through the scoping review to physiotherapy in Belgium and South Africa.
- Identify key role players in the policy process relating to physiotherapy in Belgium and South Africa.
- Compare structure, content and level of inclusion of physiotherapy within the legislative framework between Belgium and South Africa using the Walt and Gilson framework.
- Compare outcomes of the policy documents relating to physiotherapy in Belgium and South Africa with the proposed minimum standards of the World Confederation for Physiotherapy (WCPT).
- Identify similarities and differences in the policies that could be strengths or gaps to physiotherapy practice.

To the best of our knowledge this research is the first study of its kind. Identification and categorisation of the issues found will contribute to recommendations for improvement in physiotherapy policy for practice, education and future policy changes.

Physiotherapists in Belgium and South Africa need to understand the possibilities to change the legislative framework in which they operate. Once there is a clear understanding of this, more physiotherapists can participate in the legislative processes, advisory boards or think tanks to contribute significantly to the process of policymaking and adaptation of legislation.

The study conducted is a qualitative study. For the qualitative study procedure, we started with a scoping review on existing policy frameworks in Belgium and South Africa. The second step in the qualitative process was to perform an analysis of

legislation governing physiotherapy in Belgium and South Africa, using the policy triangle framework developed by Walt and Gilson (1994). Validation of the findings and identifying further gaps was thereafter sought through interviews with selected key stakeholders.

6.2 Results

In the sections 6.2.1 to 6.2.3, the summary of the key results of each of the three qualitative study components is outlined. The summary will provide detail of the analytic process used to arrive at the result.

6.2.1 Summary of the findings of the scoping literature review

The aim of the scoping review was to identify from the literature, policy research and policy related to physiotherapy (in relation to context, actors, content and processes) in Belgium and South Africa. The scoping review covered polices from 2003 to August 2018. The year 2003 was the first year after the major reformation of physiotherapy service delivery was imposed in Belgium due to a substantial structural budget cut by the governing Minister of Social Affairs (RIZIV, 2018a).

The key results of the scoping review are presented in relation to the objectives of the review. First, we determined the availability of policy and policy-related literature in physiotherapy. We can conclude that there is, in fact, a paucity of available articles addressing the topic of this research. Out of 84 articles retrieved from the PubMed database on 21 October 2018, the Web of Science database on 27 October 2018 and the Scopus database on 28 October 2018, only three articles were found eligible for inclusion in the analysis.

Secondly, we determined the quality of the selected literature. For the critique of the selected articles, the Critical Appraisal Skills Programme (CASP) was used. The CASP uses a checklist with ten questions appraising three categories: rigour, credibility and relevance (CASP, 2018). The results from the CASP critique outlined that the three selected articles scored above 50%. In addition, contributing to the quality aspect, the articles were published and peer-reviewed. Finally, we found that all selected articles were cited at least once.

Thirdly, we determined the policy-related elements in the literature related to physiotherapy in terms of context, actors, content and process, to describe the retrieved and selected articles and to identify key role players. The selected articles addressed the lack of professional autonomy in Belgium because of the mandatory prescription (Hannes et al., 2009). Furthermore, the dominant position of the physicians in physiotherapy policy development, as prescribers of physiotherapy and as representatives of the insurance companies, was highlighted (Demoulin et al., 2017) (Hannes et al., 2009). Lack of protection of the Belgian physiotherapists scope of practice by the government was also found in the articles. The lack of uniformity in primary health care allied health services (PHC AH) was found in the selected South African article (Dizon et al., 2016).

After analysis of the available literature we can conclude that we found no articles addressing the physiotherapy policy development process in Belgium and South Africa. The three selected articles provided some insight into the lack of involvement of physiotherapist in physiotherapy policy development. We have to acknowledge that the sample size of the retrieved articles matching the inclusion criteria is very small and therefore generalisation is difficult.

6.2.2 Summary of the findings of the analysis of current policies pertaining to physiotherapy

The analysis of current policy and legal documents underpinning physiotherapy in Belgium and South Africa was conducted to identify similarities and differences. The differences and similarities identified gaps and strengths to physiotherapy practice within each country.

Firstly, we did a comparative analysis of a Belgian law (*the coordinated law of 10 May 2015*) and a South African Act (*National Health Act No 61 of 2003*). Simultaneously, we did a comparative analysis of a Belgian policy document (*the professional competence profile of the physiotherapist anno 2020*) and a South African policy document (*the standards of practice of physiotherapy 2012*). Comparing the selected documents was possible because the documents are situated on the same level structurally and in terms of scope and purpose.

Secondly, we benchmarked selected policy and legal documents from Belgium and South Africa to proposed minimum standards of the World Confederation of Physical Therapy (WCPT). The proposed minimum standards of the WCPT are a set of outlined standards pertaining to various specific elements of physiotherapy education, professional issues, professional practice and social issues. The benchmark conducted was to establish a framework on gaps relating to the content of the available policy and legal documents in Belgium and in South Africa.

After analysis of current legal and policy documents we can conclude that South African documents form the basis of a more elaborate framework of scope of practice compared to the Belgian physiotherapy documents. The Belgian law provides a strict and limiting framework for physiotherapists working in a supportive role towards the physician as the prescriber of physiotherapy. The South African Act encompasses all regulated health professions in a uniformly structured health system, without mentioning physiotherapy specifically.

The Belgian policy and legal documents outlined a picture of not meeting required proposed minimum standards of the WCPT. The Belgian outcomes of the documents' content fell short of meeting autonomy and autonomy related aspects. The South African policy and legal documents' content was able to meet all WCPT proposed minimum standards.

6.2.3 Summary of the findings after interviews with selected key stakeholders

The interviews with selected key stakeholders in the physiotherapy policy development process were conducted to explore expert opinions on strengths and gaps of the current policy frameworks. The stakeholders were selected to ensure comparable persons in specific positions of responsibilities within professional organisations. In the individual interviews the stakeholders were able to provide their expert opinion on the general outlines of the physiotherapy policy process in their country. The experts also addressed strengths and gaps of the policy processes. With their experience in policy development, the experts provided us with possible solutions to the perceived gaps.

The strength experts from both countries expressed as important, is the aspect of being a part of a regulated health system with stakeholder involvement. The Belgian experts hinted that a separate legal statute for physiotherapist in the *coordinated law of 10 May 2015* could ensure specific tailor-made regulation for modern physiotherapy services. The important strength addressed by the South African experts entails the self-regulatory aspect of the physiotherapy profession in South Africa. Being self-regulating makes it impossible for other South African regulated professions to dictate physiotherapy policy development.

The gap outlined by both the Belgian and the South African experts was the lack of available data pertaining to quality and to help quantify discussions with other stakeholders. Furthermore, the outdated rules and legislation encompassing physiotherapy in Belgium and South Africa were seen as another important gap.

The Belgian experts expressed the lack of professional autonomy as another gap. The South African experts on the other hand, outlined that the decentralised decision making is a gap in South African policy advocacy.

After analysis of the interviews with selected key stakeholders we can conclude that the experts confirmed literature analysis findings and provided additional insight and detail on the current policy development systems in Belgium and South Africa.

6.3 Final conclusions of the study

Belgium and South Africa have similar legislative structure outlines. Physiotherapy is a regulated health profession in both countries and governed by policies and a legal framework. From the literature, the policy analysis and the interviews we constructed two flowcharts addressing the findings of the study. Figure 6.1 provides a schematic concise overview of the research findings of the literature review and the policy analysis. Figure 6.2 outlines the key findings of the stakeholder interviews, including the outlined gaps, the strengths of the current policy framework and the suggested expert recommendations.

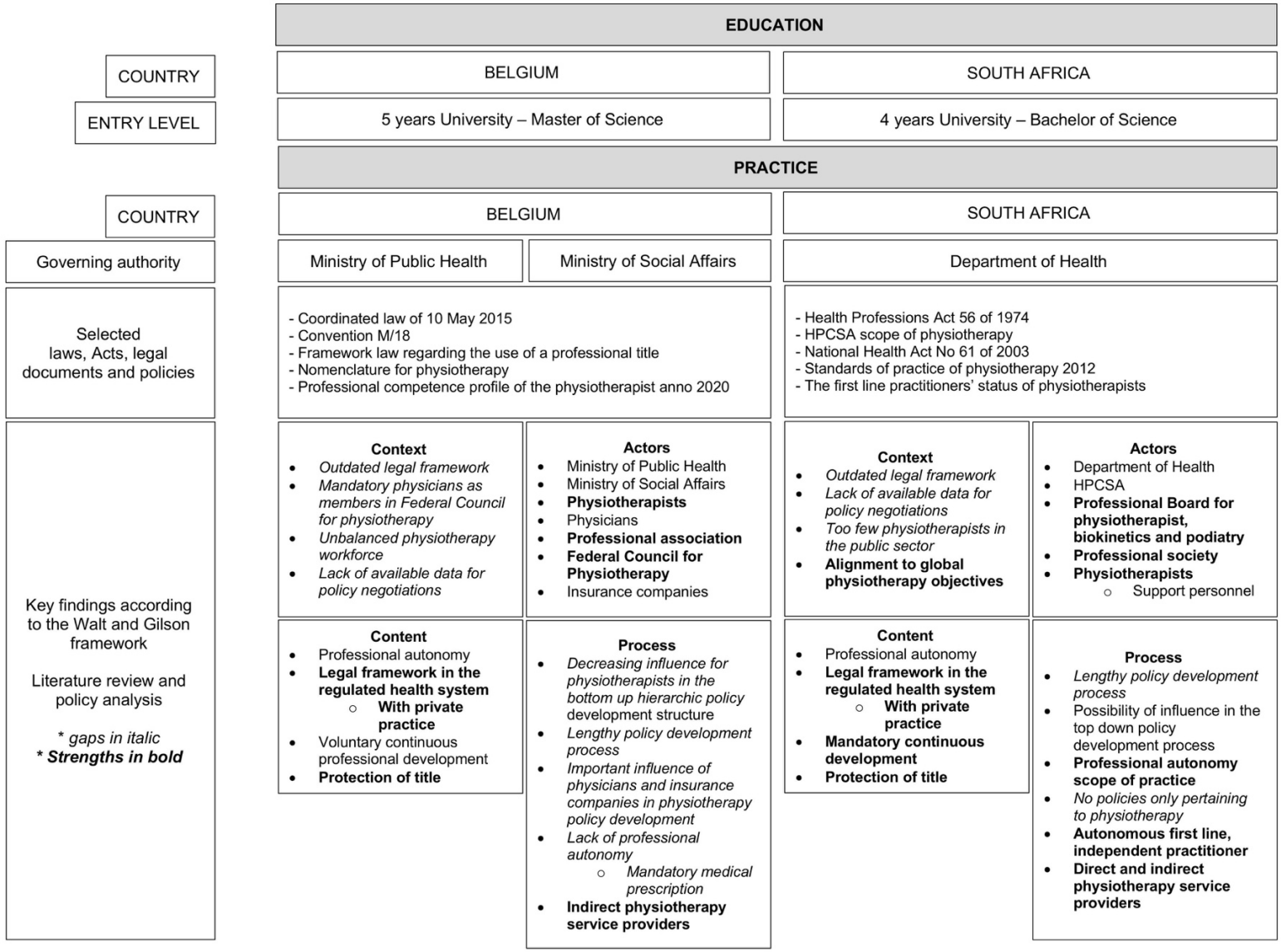

Figure 6.1 Key findings of the literature review and policy analysis

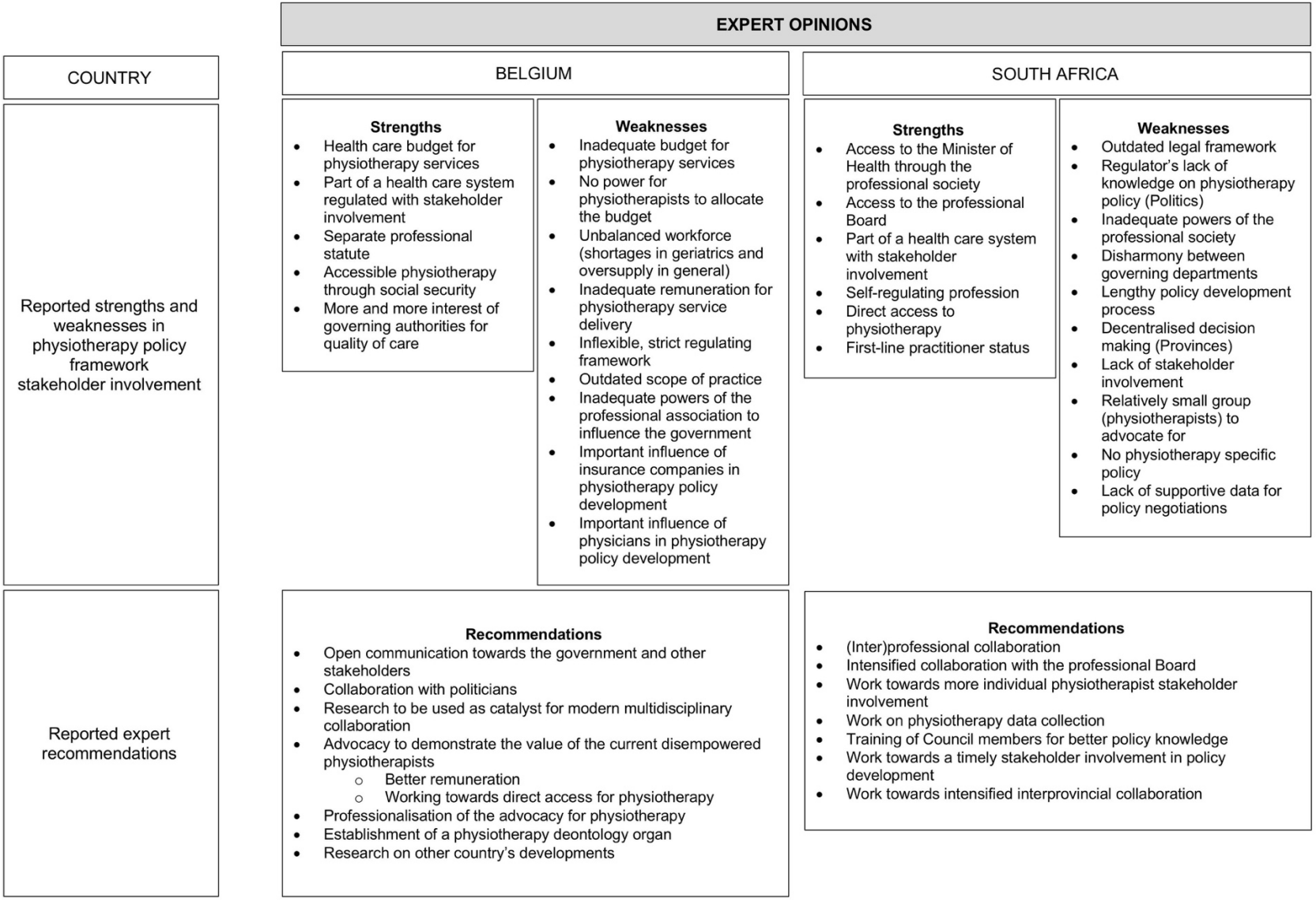

Figure 6.2 Key findings of the expert interviews

In both countries the legal framework is situated at government level. Physiotherapy is enacted through various laws, Acts and policies as shown in Figure 6.1. The literature review and the policy analysis outlined the strengths and gaps which could be categorised in the four themes of the Walt and Gilson policy analysis framework.

The Belgian and South African key stakeholders provided additional insight in strengths and gaps of the current policy structure. The experts also addressed possible solutions which are included in Figure 6.2 as the expert recommendations.

6.4 Limitations and strengths of the study

Due to a lack of prior research on the topic, building further on known foundations was not possible. The lack of available published data made it difficult to draw comparisons in the use of other frameworks. The adaptation of the Walt and Gilson framework to the physiotherapy scope may need to be tested further. This may be a strength in that this study is one of the first to apply it to rehabilitation and physiotherapy. The weakness is that there was no process of validation. The sample size of retrieved published documents was very small. Although all means were utilised to avoid cultural bias, the focus of the study picture framed the differences and similarities of two health policy systems.

6.5 Recommendations

As no similar study was found, this research is an innovative addition to the literature. Comparing legislative structures for the purpose of a policy analysis, creates the possibility of identifying similarities and differences to address perceived gaps. Further and broader research encompassing other stakeholder such as patients, insurance companies and the government can build on the findings of this study. The distinct view of each of the other stakeholders will contribute to nuance and details necessary in policy development analysis. Identifying if and how countries, regulators and key stakeholders in policy development addressed the outlined gaps, can enable physiotherapists to better focus advocacy efforts on cost-effective and time-efficient solutions. Knowledge sharing on physiotherapy policy development processes and education for those representing physiotherapists can enable physiotherapy advocacy. Furthermore, the sharing of information and better communication may lead to valuable and accurate data sets to use for policy-related work and advocacy.

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APPENDICES

APPENDIX A

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/49 Mr T Nemeth

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M180852

NAME: (Principal Investigator)	Mr T Nemeth
DEPARTMENT:	School of Therapeutic Sciences Department of Physiotherapy Medical School University
PROJECT TITLE:	A policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa
DATE CONSIDERED:	31/08/2018
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Professor H Myezwa
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	17/10/2018

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date of the meeting when the study was initially reviewed. In this case, the study was initially reviewed in **August** and will therefore reports and re-certification will be due early in the month of **August** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

24/10/2018
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX B

CONSENT FORM: Interview key stakeholder in South Africa
Study title: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

I_____ (e-mail address:_____ and cell phone number:_____) hereby agree to participate in the study as described to me in the information sheet.

I am aware that I can withdraw from the study at any time without suffering any repercussions. I understand that there are no monetary rewards for my participation and that participation is voluntary and I am not in any way obliged to take part.

Signature _____ Date _____

Signature of researcher _____

For office use only:
Study number:_____

CONSENT FORM: Recording - interview key stakeholder in South Africa
Study title: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

I_____ (e-mail address:_____ and cell phone number:_____) hereby agree to the recording of the required interview.

Signature _____ Date _____

Signature of researcher _____

For office use only:
Study number:_____

CONSENT FORMULIER: Interview key stakeholder Belgium (Dutch)

Titel van de studie: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

Ik_____ (e-mail adres:_____ en telefoonnummer:_____) ga hierbij akkoord om deel te nemen aan de studie zoals beschreven in het informatie document.

Ik ben me ervan bewust dat ik mijn deelname aan de studie op elk moment kan beëindigen zonder nadelige gevolgen. Ik aanvaard dat er geen financiële vergoeding voor mijn deelname wordt gegeven en dat mijn deelname op vrijwillige basis is. Ik ben op geen enkele manier verplicht om deel te nemen.

Handtekening _____ Datum _____

Handtekening van de onderzoeker _____

Voor intern gebruik:
Studie nummer:_____

CONSENT FORMULIER: Opname - interview key stakeholder Belgium (Dutch)
Titel van de studie: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

Ik_____ (e-mail adres:_____ en telefoonnummer:_____) ga hierbij akkoord met de opname van het noodzakelijke interview.

Handtekening _____ Datum _____

Handtekening van de onderzoeker _____

Voor intern gebruik:
Studie nummer:_____

FORMULAIRE DE CONSENTEMENT: Interview Belgium (French)

Titre d'étude: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

Moi_____ (adresse email:_____ et numéro de téléphone:_____) j'accepte par la présente de participer à l'étude décrite dans le document d'information.

Je suis conscient que je peux mettre fin à ma participation à l'étude à tout moment sans conséquences négatives. J'accepte qu'il n'y ait pas de compensation financière pour ma participation et que ma participation soit volontaire. Je ne suis nullement obligé de participer.

Signature _____ Date _____

Signature du chercheur _____

Pour usage interne:
Numéro:_____

FORMULAIRE DE CONSENTEMENT: enregistrement - Interview Belgium (French)
Titre d'étude: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

Moi_____ (adresse email:_____ et numéro de téléphone:_____) Je suis d'accord avec l'enregistrement de l'interview nécessaire.

Signature _____ Date _____

Signature du chercheur _____

Pour usage interne:
Numéro:_____

APPENDIX C

INTERVIEW GUIDE FOR KEY STAKEHOLDER

The interview will be semi structured. This guide is provided to the interview participant beforehand. The questions below serve as a preliminary guide through the interview. Other follow through questions will be asked on receiving answers to the structured questions.

General information

What: Research on policy development frameworks regarding physiotherapy in Belgium and South Africa.

Procedure: The researcher will hint the subject(s) of discussion after which the participant can give his / her expert opinion.

Conditions: I have stated that the interview will be voice recorded. You have given your written consent to this recording. Are you still comfortable with this procedure?

Purpose: I will use this interview as part of a research at WITS University.

Initiation: Do you have any further questions before we begin the interview?

1. Introduction

- Please state your age and your key role position in the policy development process in your country.
- What is your profession?
- What are the key responsibilities in your position?

2. Policy development framework

- Can you please describe how policy for physiotherapy is developed?
- Please describe what you think are the strengths of the current process.
- In addition can you pinpoint what, in your opinion, are the gaps in the process of policy development?

3. Matching findings of the literature

In the literature the findings showed …..

Can you please provide me with your expert opinion on the differences between your experiences and the searched information?

4. Expert Opinion

Now you have provided me with your personal insights on the strengths and gaps of the system, can you provide me with your possible solutions to the gaps you have described in relation to the literature findings?

5. End of the interview

- You have answered all my questions and I would like to thank you for your willingness to participate.
- Is there anything else you would like to add to your story?
- I want to reassure you that all date in this interview will be used only in regards to the outline of this study.
- After transcription of the recording you will receive a copy to verify your answers.

INTERVIEW GIDS VOOR DE SLEUTELFIGURR

Dit interview is semi gestructureerd. Deze gids wordt op voorhand gegeven aan de deelnemer aan het interview. De onderstaande vragen dienen als een eerste gids door het interview. Andere bijvragen zullen worden gesteld na antwoorden op de gestructureerde vragen.

Algemene informatie

Wat: Onderzoek naar kaders van beleidsontwikkeling rond kinesitherapie in België en Zuid Afrika.

Procedure: De onderzoeker zal het onderwerp ter discussie aanbrengen waarna de deelnemer zijn / haar expert opinie kan geven.

Voorwaarden: Ik heb uitgelegd dat het interview nopgenomen zal worden. U heeft uw schriftelijke toestemming hiervoor gegeven. Bent u nog steeds akkoord met deze procedure?

Doel: Het interview wordt gebruikt als onderdeel van een onderzoek aan de Universiteit van WITS.

Start: Heeft u nog vragen voor we starten met het interview?

1. Introductie

- Kan je a.u.b. je leeftijd en je sleutelrol in het beleidskader geven?
- Welk beroep oefen je uit?
- Wat zijn de belangrijkste verantwoordelijkheden in je positie?

2. Raamwerk voor beleidsontwikkeling

- Kan je a.u.b. omschrijven hoe beleid voor kinesitherapie wordt ontwikkeld?
- Beschrijf a.u.b. wat u denkt dat de sterke punten zijn in het huidige systeem.
- Aanvullen, kan u aangeven wat in uw opinie de lacunes zijn in het proces van beleidsontwikkeling?

3. Linken van de bevindingen uit de literatuur

De literatuur toonde …..

Kan u me a.u.b. uw expert mening geven over de verschillen tussen uw ervaringen en de gevonden informatie?

4. Expert opinie

Nu u me uw persoonlijke inzichten over de sterkten en de lacunes van het systeem heeft gegeven, kan u hierbij ook uw mogelijke oplossingen geven voor de beschreven lacunes in relatie met de bevindingen in de literatuur?

5. Einde van het interview

- U heeft al mijn vragen beantwoord en ik wil u bedanken voor uw bereidheid om deel te nemen.
- Is er nog iets dat u wil toevoegen aan uw verhaal?
- Ik wil u nogmaals verzekeren dat de gegevens uit dit interview enkel zullen gebruikt worden zoals vermeld in het kader van deze studie.
- Na de transcriptie van de opname ontvangt u een kopie om uw antwoorden na te kijken.

GUIDE D'ENTREVUE POUR LES RESPONSABLE

L'entrevue est semi structurée. Ce guide est donné en avance au participant. Les questions suivantes servent comme première guide pour l'entrevue. D'autres questions peuvent suivre les réponses sur les questions structurées.

Des renseignements généraux

Quoi: Recherche sur le processus du cadre politique en ce qui concerne la kinésithérapie en Belgique et l'Afrique du Sud.

Procédure: Le chercheur va introduire les sujets des discussions, après ça le participant peut donner son avis d'expert.

Conditions: J'ai expliqué que l'entrevue sera enregistré. Vous avez donné votre consentement écrit. Vous êtes encore d'accord avec la procédure?

But: L'entrevue sera utilisée comme part du recherche à l'université WITS.

Départ: Avez-vous encore des questions avent nous commençons avec l'entrevue?

1. Introduction

- Pouvez-vous s.v.p. donner votre âge et votre responsable rôle dans le processus en ce qui concerne la kinésithérapie et le cadre politique?
- Quelle est votre profession?
- Quelles sont les responsabilités les plus importantes dans votre position?

2. Cadre politique pour le processus

- Pouvez-vous décrire comment le cadre politique en ce qui concerne la kinésithérapie est développé?
- Pouvez-vous s.v.p. décrire quels sont, pour vous, les bons points dans le système d'aujourd'hui?
- Supplémentaire, pouvez-vous décrire quels sont les écarts dans le processus existant?

3. Matching avec les résultats de la littérature.

La littérature a montré …

Pouvez-vous s.v.p. donner votre avis d'expert sur les différences de votre expériences et l'information trouvée?

4. Opinion d'expert

Après vous avez me donné vos idées personnelles sur les forces et les écarts du système, pouvez-vous aussi me décrire vos solutions possibles pour les écarts en relation avec les résultats de la littérature?

5. Fin de l'entrevue

- Vous avez répondu à toutes mes questions et je veux sous remercier pour votre volonté de participer.
- Voulez-vous ajouter quelque chose à votre mots?
- Je veux vous encore one foie rassurer que tous les résultats de l'entrevue seront seulement utilisés dans le cadre de cette étude.
- Après la transcription de l'enregistrement vous recevez une copie pour vérifier vos réponses.

APPENDIX D

INFORMATION DOCUMENT: Interview key stakeholder in South Africa

Study title: Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa.

Dear (title) (Surname) (Name),

I, Tim Németh, am doing research on policy frameworks regarding physiotherapy in Belgium and South Africa. I am a physiotherapist applying for my masters degree as a student at the Witwatersrand University in Johannesburg. The answer to pending questions is learned by doing research. In this study we want to learn how policy governing physiotherapy is structured. We also want to learn how different stakeholders contribute in policy development to the process, the content and the surrounding context. Comparison between literature findings and interview outcomes will establish possible gaps and similarities in the policies and the policy framework that could be barriers or facilitators to physiotherapy practice.

With this letter I am inviting you to be a voluntary participant in my study. Refusal to take part will be without any consequences. If you are participating and during the study you will no longer wish to take part, you can withdraw at any time without any consequences. If you wish to withdraw during the process of the study, all data acquired from your participation will be deleted immediately.

What is involved?

An individual interview via the teleconference platform GoToMeeting will be conducted. You will be given the questions beforehand to be able to structure your answers. Answers to questions may lead to subsequent questions not provided beforehand. The interview will approximately take one hour. I will ask for your permission to audio-tape the interview. For this permission a separate consent form will be provided that needs to be signed.

A transcript of the interview will be sent back to you to verify the answers and to award your final consent to use the information from the interview.

What are the benefits of taking part in this study?

There are no direct benefits to the participant. You will be able to give your professional opinion on policy development frameworks governing physiotherapy. Generalised results will be made available to all participants at the end of the study. No monetary award will be given for taking part in this study. Your acknowledgment of the no monetary award statement will be formally asked for in the consent form.

Confidentiality.

Absolute confidentiality cannot be guaranteed. All efforts will be made to keep personal information confidential. Personal information may be disclosed if required by law. To ensure confidentiality of participants, each person interviewed will be assigned a number. The key to the numbers assigned will be kept by the researcher only. Names of participants are only to be written on the consent form. All information will be used only for the purpose intended in this study. The data will be stored on a separate hard drive which is not online accessible. All data will be destroyed permanently after two years if the report is published or otherwise after six years if there is no publication.

For any query or complaint about the ethics of the research process please contact Prof. Clement Penny as the HREC (medical) Chairperson via clement.penny@wits.ac.za or any of the administrative officers of the Human Research Ethics Committee (Medical) via 011 717-1234/2656/2700 or via zanele.ndlovu@wits.ac.za, rhulani.mkansi@wits.ac.za, charmaine.khumalo@wits.ac.za or josh.ndlangamandla@wits.ac.za.

For further information you are welcome to contact me on [redacted] or send an email to 1973920@student.wits.ac.be

Kind regards

Tim Németh
Physiotherapy department
University of the Witwatersrand,
Johannesburg, South Africa

Appendix E

Request to participate in the study and the study outline

Dear [redacted],

I am conducting a study with the title "Policy analysis of legislative frameworks relating to physiotherapy in Belgium and South Africa." For this study at the University of the Witwatersrand in Johannesburg, I am required to do interviews with key stakeholders in the policy process encompassing physiotherapy. With this e-mail I would like to ask your approval to participate in an individual interview. The interview will be semi-structured, which means you will be getting the questions beforehand. This study is under the supervision of Prof. Hellen Myezwa, Mr. Kganetso Sekome and Prof. Raf Meesen.

If you decide to participate, I will e-mail you further information.

Looking forward to your answer.

Kind regards

Tim Németh
student number: 1973920
protocol number: M180852

APPENDIX F

Coordinated law of 10 May 2015

Theme	Category	Code English	Code Dutch	Quote	Reference
Context (Cultural)	Education	deviating approval of recognition of a 3 years education	afwijkende toestemming voor erkennining van een 3 jarige opleiding	In afwijking van artikel 43 … bedoelde erkenning … de personen in het bezit van een inschrijvingsbewijs uitgereikt door de minister bevoegd voor Volksgezondheid … die houder zijn van mijn diploma in de kinesitherapie dat opleiding bekroont, die overeenstemt met een opleiding van minstens drie jaar ...	chapter 13 - art 154
	Legal requirements	Illegal practice of medicine	onwettige uitoefening van de geneeskunde	Wordt beschouwd als onwettige uitoefening van de geneeskunde ... stellen van de diagnose...	chapter 2 - art 3
	Policies and procedures	Medicine	Geneeskunst	De geneeskunst omvat de geneeskunde, de tandheelkunde inbegrepen, uitgeoefend ten aanzien van menselijke wezens, en de artsenarijbereidkunde onder een preventief of experimenteel, curatief, continu en palliatief voorkomen.	chapter 1 - art 1
		physiotherapy prescription	het kinesitherapeutisch voorschrift	Dit voorschrift is schriftelijk …	chapter 3 - art 43
		deviating Royal decission	afwijkend koninklijk besluit	Indien een … koninklijk besluit afwijkt van het advies verstrekt door de Federale Raad voor de Kinesitherapie, moet dit advies samen met het verslag aan de Koning dat de afwegingen tussen het koninklijk besluit en het advies rechtvaardigt, en met de tekst ervan, worden bekendgemaakt.	chapter 13 - art 143
		influence of the sixth reformation of the State on health care	invloed van de zesde staatshervorming op gezondheidszorg	De zesde staatshervorming heeft een invloed gehad op diverse bepalingen die voorkomen in de gecoördineerde tekst. Een aantal bevoegdheden inzake de gezondheidszorg beroepen werden immers overgeheveld van de federale overheid naar de gemeenschappen.	annexes - 3.4

Context (Structural)	Education	physiotherapist recognition after 4 years education	erkenning kinesitherapie na 4 jarige opleiding	Deze erkenning mag enkel toegekend worden aan de houder van een universitair diploma in de kinesitherapie of een diploma van hoger onderwijs buiten de universiteit in de kinesitherapie dat een opleiding in een kader van een voltijds onderwijs bekroont dat tenminste vier studiejaren omvat.	chapter 3 - art 43
	Legal requirements	practice of profession after certification of diploma	uitoefenen van gezonheidszorgberoep na visering van diploma	De beoefenaars van een gezondheidszorgberoep morgen hun beroep enkel uitoefenen: indien zij hun diploma hebben laten viseren door het Directoraat-generaal Gezondheidsberoepen	chapter 2 - art 25
	Policies and procedures	recognition procedure	erkenningsprocedure	De erkenning … wordt toegekend overeenkomstig de door de Koning vastgestelde procedure en voor zover is voldaan aan de erkenningscriteria die zijn vastgesteld door de minister bevoegd voor Volksgezondheid …	chapter 8 - art 88
		keeping of records in a federal data bank	bijhouden van gegevens in een federale databank	Voor elke beroepsbeoefenaar van een gezondheidszorgberoep … worden identificatiegegevens en gegevens in verband met hun erkenning en bepaalde aspecten van hun beroepsactiviteit in een permanente federale databank van de beoefenaars van de gezondheidszorg beroepen geregistreerd en bijgehouden	chapter 8 - art 97
		period for advise from the Federal Council for Physiotherapy towards the minister	periode voor advies aan de minister door de FRK	De Koninklijke besluiten ... worden genomen na raadpleging door de minister bevoegd voor Volksgezondheid, van de Federale Raad voor de Kinesitherapie en van de Koninklijke Academiën voor Geneeskunde. De minister kan deze adviezen inwinnen binnen een termijn die niet langer dan drie maanden mag zijn. Na het verstrijken van deze termijn wordt het advies geacht te zijn gegeven.	chapter 13 - art 143
	Professional bodies	the Federal Council for Physiotherapy	de Federale Raad voor kinesitherapie	De Federale Raad voor de kinesitherapie bestaat uit …	chapter 3 - art 44

Actors (Influence and power)	Legal requirements	determining the list of activities outside medicine, nursery, physiotherapy and paramedic professions	vaststelling van de lijst van activiteiten buiten geneeskunde, verpleegkunde, kinesitherapie en paramedische beroepen	De Koning kan … de lijst van activiteiten vaststellen die tot het dagelijkse leven behoren en die niet tot de uitoefening van de geneeskunst, de verpleegkunde, de kinesitherapie of een paramedisch beroep behoren …	chapter 2 - 23.
		** physiotherapy only on prescription	kinesitherapie enkel op voorschrift	… mogen enkel kinesitherapie uitoefenen ten aanzien van patiënten die op grond van een voorschrift door een persoon worden verwezen die … gemachtigd is om de geneeskunde uit te oefenen …	chapter 3 - art 43
	Professional collaboration	Physicians have the possibility to assign tasks to others	Artsen kunnen anderen belasten met bepaalde handelingen	De Koning kan … de voorwaarden vaststellen waaronder artsen … op eigen verantwoordelijkheid en onder toezicht, personen die een paramedisch beroep uitoefenen kunnen belasten met het verrichten van bepaalde handelingen …	chapter 2 - art 23
Actors (Interests and concerns)	Legal requirements	recognition of special professional title and competence	erkenning van bijzondere beroepstitel en beroepsbekwaamheid	Niemand kan een bijzondere beroepstitel dragen of zich beroepen op een bijzondere beroepsbekwaamheid, dan na door de minister … hiertoe te zijn erkend.	chapter 8 - art 86
		recognition of the professional qualification of a migrant	erkenning van beroepskwalificatie van een migrant	De migrant die houder is van een beroepskwalificatie … en die in België één van de gezondheidszrogberoepen wenst uit te oefenen … laat deze beroepskwalificatie … erkennen.	chapter 9 - art 104
		migrant with recognised professional qualification is subjected to the law	migrant met erkende beroepskwalificatie is onderworpen aan de wet	De migrant die een erkenning van zijn beroepskwalificaties krijgt, is ook onderworpen aan de andere bepalingen van deze gecoördineerde wet …	chapter 9 - art 104

	Legal structures	the purpose of the Federal Council for Physiotherapy on federal level	het doel van de FRK op federaal niveau	De Federale Raad voor de Kinesitherapie heeft tot taak aan de minister … advies te verstrekken over alle aangelegenheden in verband met de kinesitherapie.	chapter 3 - art 44
		the purpose of the Federal Council for Physiotherapy on regional level	het doel van de FRK op gemeenschapsniveau	De Federale Raad voor de Kinesitherapie kan ook de rergeringen van de gemeenschappen … advies verstrekken over alle aangelegenheden in verband met de studies en opleiding van kinesitherapeuten.	chapter 3 - art 44
		assignement of the plannification committee	opdracht van de planningscommisie	De opdracht van deze commissie bestaat erin: 1° de behoeften inzake medisch aanbod na te gaan … Bij het bepalen van deze behoeften dient rekening gehouden te worden met de evolutie van de behoeften … de kwaliteit … demografische en scociologische evolutie van de betrokken beroepen.	chapter 8 - art 91
		assignement of the High Council for Healtcare professions	opdracht van de Hoge Raad voor de Gezondheidsberoepen	De Koning ... Bepaalt de opdrachten ervan, welke er inzonderheid in bestaan advies te verstrekken met betrekking tot de kwaliteit, de evaluatie en de organisatie van de medische praktijk …	chapter 8 - art 96
		assignment of the medical committee	opdracht van de geneeskundige commissie	De geneeskundige commissie heeft tot taak …: a) aan de overheid alle maatregelen voor te stellen die tot doel hebben bij te dragen tot de volksgezondheid; … a) de echtheid na te gaan van en het visum te hechten aan de titels van de beoefenaars van de geneeskunde ... b) het visum in te trekken ... 2. het opsoren en mededelen aan het parket van de gevallen van onwettige uitoefening van de gezondheidszorgberoepen ...	chapter 9 - art 119
		assignment of the cel medical guardiance	opdracht van de cel medische bewaking	De cel heeft als taak: … ervoor te zorgen dat alle beoefenaars .. Doeltreffend samenwerken …	chapter 9 - art 120

	Personal professional developmen	structures for evaluation	structuren van evaluatie	De Koning … duidt de structuren aan die de evaluatie van de praktijk en van het onderhouden van de professionele bekwaming organiseren of begeleiden en bepaalt de algemene regels van de werking ervan.	chapter 8 - art 94
		rules and modalities for evaluation	regels en modaliteiten van evaluatie	De Koning … bepaalt de regels en de modaliteiten inzake de evaluatie … van de praktijk en het onderhouden van de professionele bekwaming …	chapter 8 - art 94
	Physiotherapy profession	recognised practice of physiotherapy	uitoefening van de kinesitherapie met erkenning	… zonder de betekenis van het begrip "de geneeskunde" … te beperken, mag niemand de kinesitherapie uitoefenen die niet houder is van een erkenning …	chapter 3 - art 43
		professional title	beroepstitel kinesitherapeut	Niemand mag de beroepstitel van kinesitherapeut dragen die niet houder is van de … erkenning.	chapter 3 - art 43
		illegal practice of physiotherapy	onwettige uitvoering van de kinesitherapie	Als onwettige uitoefening van de kinesitherapie wordt beschouwd, het gewoonlijk verrichten door een persoon die er niet toe gemachtigd is … van: 1° systematische handelingen met als doel functieproblemen … te verhelpen …	chapter 3 - art 43
	Professional collaboration	responsibility to refer patients	verantwoordelijkheid om patiënten door te verwijzen	Elke beoefenaar van een gezondheidszorgberoep heeft de verantwoordelijkheid om de patiënt te verwijzen naar een andere ter zake bevoegde beoefenaar … wanneer de gezondheidsproblematiek … de grenzen van het eigen competentiegebied overschrijdt.	chapter 2 - art 31/1
	Professional conduct	treatment continuance	niet onderbreken van behandelingen	… beoefenaars mogen een aan de gang zijnde behandeling van een patiënt niet bewust en zonder wettige reden van hun kant onderbreken …	chapter 2 - art 27
Content (Specific mechanisms)	Information Technology	central database	kruispuntbank	kruispuntbank	chapter 8 - art 99

		eHealth platform	eHealth platform	eHealth platform	chapter 2 - art 42
		permanent federal data bank	permanente federale databank	De permanente federale databank van de beoefenaars van de gezondheidszorgberoepen	chapter 8 - afdeling 7
	Legal requirements	rules and modalities for evaluation	regels en modaliteiten van evaluatie	De Koning … bepaalt de regels en de modaliteiten inzake evaluatie … van de praktijken en van het onderhouden van de professionele bekwaming van de individuele beroepsbeoefenaars …	chapter 8 - art 94
Content (objective)	Legal stuctures	creation of medical committee	oprichting geneeskundige commissie	In elke provincie wordt een geneeskundige commissie opgericht.	chapter 10 - art 118
		installation of the Federal Council for Physiotherapy	instellen Federale Raad voor de Kinesitherapie	Bij de minister bevoegd voor Volksgezondheid, wordt een Federale Raad voor de kinesitherapie ingesteld.	chapter 3 - art 44
	Legal requirements	prohibition of attaching fees to efficiency	verbod koppeling honorarium aan doelmatigheid	Is verbonden iedere vooraf gesloten overeenkomst die het honirarium koppelt aan de doelmatigheid van een behandeling.	chapter 2 - art 36
		registration objectives	registratie doelen	De registratie … heeft als doel: 1° de gegevens te verzamelen die noodzakelijk zijn voor de uitvoering van de opdrachten van de planningscommissie … 2° de uitvoering van de reglementaire opdrachten van de administraties alsook de uitwisseling van gegevens … 3° de mogelijkheid te creëren om de communicatie met en tussen de beoefenaars van de gezondheidszorgberoepen te verbeteren.	chapter 8 - art 97
Content (Policy design)	Policy outline	Table of contents	Inhoudstafel	Inhoudstafel …	page 1

Actors	Stakeholders	Belgian health organisation collaborators	de minister bevoegd voor Volksgezondheid	chapter 2 - art 10
			Vestigingscommissie	chapter 2 - art 11
			Administrateur-generaal van het Federaal Agentschap voor Geneesmiddelen en Gezondheidsproducten	chapter 2 - art 11
			Koninklijke Academieën voor Geneeskunde	chapter 2 - art 23
			Federale Raad voor vroedvrouwen	chapter 2 - art 23
			Federale Raad voor verpleegkunde	chapter 2 - art 23
			Federale Raad voor kinesitherapie	chapter 2 - art 23
			Federale Raad voor paramedische beroepen	chapter 2 - art 23
			de Nationale Commissie geneesheren – ziekenfondsen	chapter 2 - art 31
			de nationale raad	chapter 2 - art 34
			een nationale paritaire commissie geneesheren - ziekenhuizen	chapter 2 - art 35
			de Technische Commissie voor Verpleegkunde	chapter 4 - art 55
			erkenningscommissie voor de Vroedvrouwen	chapter 5 - art 64
			Nationale Raad voor dringende geneeskundige hulpverlening	chapter 6 - art 66
			Federale Raad voor geestelijke gezondheidszorgberoepen	chapter 6/1 - art 68/2/2
			Erkenningscommissie voor de beoefenaars van de klinische psychologie en de klinische orthopedagogiek	chapter 6/1 - art 68/4
			Technische Commissie voor de paramedische beroepen	chapter 7 - art 84
			Planningscommissie medisch aanbod	chapter 8 - art 91
			Hoge Raad voor de Gezondheidsberoepen	chapter 8 - art 96
			de minister bevoegd voor Sociale Zaken	chapter 8 - art 96
			verzekeringsinstellingen	chapter 8 - art 96
			RIZIV	chapter 8 - art 99
			Rijksdienst voor Sociale Zekerheid	chapter 8 - art 99
			Rijksinstituut voor de Sociale Verzekering der Zelfstandigen	chapter 8 - art 99
			Federale Pensioendienst	chapter 8 - art 99
			ziekenfondsen	chapter 8 - art 100

			Verzekeringsmaatschappijen	chapter 8 - art 100
			geneeskundige commissie	chapter 10 - art 118
			cel medische bewaking	chapter 11
			Raad voor Medische Esthetiek	chapter 13 - art 142
			het Coördinatiebureau	bijlagen - art N4
		Belgian legal collaborators	De Koning	chapter 2 - art 3
			Ministerraad	chapter 2 - art 6
			rechtbank van eerste aanleg	chapter 2 - art 13
			arbeidsrechtbank	chapter 2 - art 13
			de Commssie voor de bescherming van de persoonlijke levenssfeer	chapter 2 - art 29
			Provinciale en Plaatselijke overheidsdiensten	chapter 8 - art 99
			de Raad van State	bijlagen - art N4
			de Eerste Minister	bijlagen - art N4
		Health care professional	vroedvrouw	page 1
			hulpverlener - ambulancier	page 1
			apotheker	chapter 2 - art 6
			arts	chapter 2 - art 6
			zorgverstrekkers	chapter 2 - art 7
			tandheelkundige	chapter 2 - art 20
			kinesitherapeut	chapter 3 - art 43
			verpleegkundige	chapter 4 - art 45
			teamleider	chapter 4 - art 45
			zorgkundige	chapter 4 - art 59
			psychotherapeut	chapter 6/1 - art 68/2/1
			klinisch psychologen	chapter 6/1 - art 68/3
			klinisch orthopedagogen	chapter 6/1 - art 68/3

		Health education collaborators	Docenten	chapter 4 - art 45
			verpleegkundige in opleiding	chapter 4 - art 45
			universiteiten	chapter 8 - art 96
			wetenschappelijke verenigingen	chapter 8 - art 96
		International organisations	de Europese Commissie	chapter 2 - art 31
			het Europees parlement	chapter 2 - art 42
		Patient/client or their legal representatives	Europees onderdaan	chapter 1 - art 2
			patiënt	chapter 1 - art 2
			het publiek	chapter 2 - art 9
			groeperingen	chapter 2 - art 28
			wekgevers	chapter 2 - art 28
			de bevoliking	chapter 2 - art 29
			arbeiders	chapter 2 - art 34
			migrant	chapter 9 - art 114
			de Staat	chapter 2 - art 28
		Professional organisations	beroepsverenigingen	chapter 2 - art 28
			representatieve beroepsverenigingen	chapter 8 - art 96

Professional competence profile of the physiotherapist anno 2020

Theme	Category	Code English	Code Dutch	Quote	Reference
Context (cultural)	International	WCPT subgroups	WCPT subgroeps	De ontwikkelingen binnen het beroep heeft binnen de World Confederation of Physical Therapy ook aanleiding gegeven tot de profilering van diverse subgroepen …	page 4 - paragraph 3
	Legislation	BCP taking into account the devision of responsibilities of the governments	BCP rekening houdend met taakverdeling tussen de overheden	Rekening houdend met recente ontwikkelingen in de gezondheidszorg en de welzijnszorg en rekening houdend met taakverdeling tussen de federale overheid enerzijds en de overheden van de taalgemeenschappen anderzijds, is er in het nieuwe BCP aandacht besteed aan de uitoefening van het beroep in alle lijnen en settings in de gezondheidszorg, in de gezondheidszorg buiten de ziekteverzekering en buiten de gezondheidszorg.	page 3 - paragraph 6
		the influence of the sixth reform of the State	de invloed van de zesde staatshervorming	In het kader van de zesde staatshervorming wordt rekening gehouden met het gegeven dat normerende bevoegdheid inzake gezondheidszorg federaal is en de implementering van talrijke aspecten tot de bevoegdheden van de gemeenschappen behoort.	page 4 - paragraph 6
		illegal practice of medicine	onwettige uitoefening van de geneeskunde	Het verstrekken van informatie en advies … of het toedienen van eerste hulp of noodzakelijke zorg zonder medisch voorschrift wordt … als onwettige uitoefening van zijn beroepstitel beschouwd.	page 14 - paragraph 1
	Physiotherapy profession	Physiotherapy as medical profession	kinesitherapie als medisch vakgebied	Kinesitherapie is een medisch vakgebied dat verakerd is in de biomedische wetenschappen … die in hoofdzaak functiebehoud, functieverbetering of functieherstel … beogen.	page 6 - paragraph 1
		patient/client focused health care profession	patiënt/cliënt gericht gezondheidsberoep	Kinesitherapie is een patiënt/cliënt gericht gezondheidsberoep …	page 6 - paragraph 2

		development of new models of care	ontwikkeling van nieuwe zorgmodellen	De huidige evolutie naar steeds meer anticiperende, persoonsgerichte en geïntegreerde zorg … heeft nieuwe zorgmodellen ontwikkeld waarbij kinesitherapeuten niet enkel hun dagelijks denken en handelen in monodisciplinaire context uitvoeren, maar ook in overlegstructuren en samenwerkinsverbanden ...	page 6 - paragraph 4
	Professional Association	Axxon as representative of the physiotherapists	Axxon als vertegenwoordiger van de kinesitherapeuten	Axxon, Physical Therapy in Belgium, vertegenwoordigt de kinesitherapeuten bij de verschillende overheidsinstellingen, raden en commissies. Axxon behartigt de belangen van haar leden op beroepsinhoudelijk, sociaal-maatschappelijk en economisch vlak en dit zowel regionaal, nationaal als internationaal.	page 33 - paragraph 4
		specific interest groups besides associations	specifieke belangengroepen naast de verenigingen	Naast deze verenigingen bestaan er verschillende specifieke belangengroepen die zich uitsluitend richten op een bepaald deelgebied van de kinesitherapie. Hun opdracht bestaat erin om de noden van de kinesitherapeuten binnen dit domein te bepalen en hun beroepscompetenties kenbaar te maken.	page 33 - paragraph 6
	Professional Ethics	advise regarding a deontology organ	advies betreffende een deontologisch orgaaan	De werkgroep Deontologisch orgaan van de FRK heeft een advies ingediend betreffende de ontwikkeling van een viertraps deontologisch orgaan …	page 4 - paragraph 4
	Quality of care	development en implementation of quality of care	ontwikkeling en implementatie van kwaliteitszorg	Kwaliteitszorg werd in de kinesitherapie gedurende de voorbije jaren sterk ontwikkeld en wordt in toenemende mate geïmplementeerd in de beroepspraktijk.	page 4 - paragraph 5
		evaluation in a bio-psycho-social context	evaluatie binnen een bio-psycho-sociaal model	Het menselijk functioneren … worden dan opgevat als de uitkomst van een dynamische wisselwerking tussen iemands gezondheidsproblemen … en de context waarin de problemen zich voordoen. De kinesitherapeut ontwikkelt aldus een specifieke manier van functionele evaluatie binnen een bio-psycho-sociaal model.	page 8 - paragraph 1

		personal treatmentwishes as point of interest for patients	persoonsgebonden behandelwensen als aandachtspunt van patiënten	Patiënten/cliënten en patiëntenverenigingen besteden meer aandacht aan kwaliteitscriteria die gerelateerd zijn aan persoonsgebonden behandelwensen en de mate waarin daaraan wordt voldaan.	page 30 - paragraph 1
		8 quality criteria for professionals	8 kwaliteitscriteria voor professionals	Zorgverleners, zorgorganisaties, instellingen en overheden richten zich meer op de 8 criteria van een kwaliteitsvolle zorg die ieder opzicht meetbaar zijn: doeltreffendheid, doelmatigheid, patiëntenveiligheid, billijkheid, veiligheid, tijdigheid, continuïteit en integratie.	page 30 - paragraph 1
		quality assurance for physiotherapists meeting quality criteria	kwaliteitsgarantie voor kinesitherapeuten die voldoen aan de kwaliteitsvereisten	De kinesitherapeut die voldoet aan de kwaliteitsvereisten binnen het kwaliteitsbevorderend systeem staat garant voor een kwaliteitsvolle zorg en dit wordt gewaardeerd door de patiënt/cliënt, artsen, andere zorgberoepen, Riziv en verzekeringsinstellingen.	page 31 - paragraph 6
	Scope of practice	description of physiotherapy now and in the future	beschrijving van kinesitherapie nu en in de toekomst	Dit profiel beschrijft ook wat de competenties, vaardigheden, rollen en verantwoordelijkheden zijn van de kinesitherapeut, voor de door hem/haar te leveren zorg, producten en diensten zowel in het actuele gezondheidssysteem als in de gezondheidszorg van de toekomst en buiten de gezonheidszorg.	page 4 - paragraph 7
		providing education, advise and care to maintain quality of life	vestrekken van educatie, advies en zorg om levenskwaliteit te behouden	Als deskundigen ... verstrekken zij educatie, advies en zorg … om de levenskwaliteit te behouden van zowel patiënt/cliënt als hun formele en informele zorgverleners, om zelfmanagement te stimuleren en het uitvoeren van dagelijkse activiteiten (ADL) of instrumentele activiteiten (IADL) te optimaliseren.	page 5 - paragraph 2
		physiotherapy care	de kinesitherapeutische hulp- en zorgverlening	De kinesitherapeutische hulp- en zorgverlening is van toepassing op mensen met een variabele zorggraad en zorgbehoeften, ongeacht de leeftijd en de levensfasen waarin zij zich bevinden.	page 6 - paragraph 3

		confronted with direct questions to provide care	confrontatie met rechtstreekse hulpvragen	In dat toegankelijke Belgische zorgsysteem worden kinesitherapeuten in de eerstelijnsgezondheidszorg elke dag geconfronteerd met een rechtstreekse hulp vragen …	page 14 - paragraph 1
Context (Situational)	Physiotherapy profession	broad description of physiotherapy in rapid changing environment	brede beschrijving van het domein van de kinesitherapie binnen snelle veranderingen	Om binnen alle snelle veranderingen de samenhang van het beroep te bewaken werd het van belang geacht dat de beschrijving van het domein van de kinesitherapie adequaat en breed zou zijn.	page 3 - paragraph 2
		imortance of BCP to have concensus on the competences of the profession	belang van BCP om consensus over de kern van het beroep	Voor de Federale Raad voor de Kinesitherapie is een BCP van belang … om consensus te hebben over de kern van het beroep …	page 3 - paragraph 2
		importance of BCP to guide education	belang van BCP om onderwijs richting te geven	Voor het onderwijs is het BCP van belang om de opleiding in te richten en aan te geven waartoe deze kan leiden.	page 3 - paragraph 2
		importance of BCP to acknowlegde the broad spectrum	belang van BCP als kennisname van het brede spectrum	Voor de beroepsbeoefenaar zelf biedt het BCP als basis voor kennisname met het brede spectrum waarin het eigen handelen kan geplaatst worden …	page 3 - paragraph 2
	Professional collaboration	interventions aimed at self-management of the patient/client	interventies gericht op autoresponsabilisering van de patiënt/cliënt	De kinesitherapeutische interventies zijn - daar waar mogelijk - toegespitst op autoresponsabilisering van de patiënt/cliënt teneinde de fysieke capaciteiten te herwinnen die nodig zijn om te participeren in het sociale leven, werkmilieu, vrijetijdsbesteding en/of sport.	page 7 - paragraph 3
		patient as co-actor in health care	de patiënt/cliënt als co-actor in de zorg	Rekening houdende met alle aspecten van de zorg waarin de patiënt/cliënt moeten worden betrokken, wordt hem een hoofdrol toebedeeld met de bedoeling hem "co-actor" te maken van het management van zijn functionele capaciteiten, zijn autonomie en zijn gezondheid.	page 7 - paragraph 3

		growth of interdisciplinary practices answering higher health care demands	groei van groepspraktijken om aan de toenemende zorgvraag te voldoen	Door de toenemende zorgvraag, de continuïteit van de zorg en de complexiteit van de zorg, is het aantal groepspraktijken met een gedifferentieerd aanbod van kinesitherapeutische expertise toegenomen.	page 9 - paragraph 6
		assistance of a physiotherapist with a special competentce	assistentie door een kinesitherapeut met een bijzondere beroepsbekwaamheid	De behoefte van zeer technische multidisciplinaire teams vragen mogelijks om de assistentie van een kinesitherapeut met bijzondere beroepsbekwaamheid of om de behandeling van een patiënt door tweede kinesitherapeut met bijzondere beroepsbekwaamheid voor een bijkomende probleemstelling.	page 13 - paragraph 3
	Professional policy	transparancy in the work field through policies	transparantie in het werkveld door regelgeving	De regelgeving van de bijzondere bekwaamheden biedt in het werkveld, in interdisciplinaire en multidisciplinaire context, transparantie en valorisatie van de professionele competenties van de kinesitherapeut-omnipracticus en de kinesitherapeut met bijzondere beroepsbekwaamheden.	page 4 - paragraph 3
	Quality of care	house visits for immobile patients/clients	ambulante verstrekkingen bij immobile patiënten/cliënten	Wanneer de patiënt/cliënt wegens een medische of sociale redenen in de onmogelijkheid verkeert om zich naar de praktijk te verplaatsen … worden ambulante behandelingen verstrekt.	page 10 - paragraph 1
		quality criteria for the protection of the profession	criteria voor kwaliteitsbescherming van het beroep	De beroepskwaliteit wordt beschermd door vastgelegde criteria zoals o.m. daadwerkelijke beroepsuitoefening en lifelong learning in het betrokken deel domein.	page 15 - paragraph 6

	Scope of practice	the origin of special competences in physiotherapy	de oorsprong van de bijzondere beroepsbekwaamheden	De bijzondere beroepsbekwaamheden in de kinesitherapie vinden hun oorsprong in het gegeven dat de body of knowledge in de kindertherapie de voorbije decennia een sterke evolutie heeft doorgemaakt, waardoor het quasi onmogelijk is wat elke kinesitherapeut alle kennis, inzichten en vaardigheden tot in detail kan opvolgen in de verschillende deelgebieden van de kinesitherapie.	page 15 - paragraph 4
Context (Strutural)	Communication	digitalisation of health care	digitalisering van de gezondheidszorg	Digitalisering van de gezondheidszorg voorkomt verspilling, vereenvoudigt de administratieve taken en faciliteert de operationele, inter-, multi- en transdisciplinaire communicatie en gegevensdeling	page 5 - paragraph 1
	Education	basis education meeting international benchmarks	basisopleiding die beantwoordt aan internationale benchmarking	De kinesitherapeut geniet een basisopleiding als kinesitherapeut-omnipracticus, die beantwoordt aan internationale benchmarking.	page 4 - paragraph 3
		evaluation and application of acquired competences	evaluatie en toepassing van verworven competenties	De opleiding en (na)vorming moet leiden tot het verwerven van de behoorlijke competenties in de vooropgestelde beroepsrollen, gevolgd door een evaluatie van de verworven competenties en hun toepassing in het werkveld.	page 31 - paragraph 4
	Legislation	nomenclature and forfait system	nomenclatuur en forfaitair stelsel	De meeste kinesitherapeuten … zijn gebonden aan de wettelijke bepalingen inzake nomenclatuur indien zij prestaties leveren die leiden tot een tegemoetkoming door de ziekteverzekering en we zijn ook gebonden aan de conferentie. Andere kinesitherapeuten werken in een forfaitair stelsel …	page 10 - paragraph 2

	Physiotherapy profession	follow up and implementation of innovations	opvolgen en integreren van innovaties	Gebruik maken van performante medische beeldvorming, het opvolgen van revalidatieprotocollen … zijn maar enkele van de vele voorbeelden van medisch-technologische ontwikkelingen waarvan de kinesitherapeut de evolutie moet opvolgen en innovaties integreren in de dagelijkse zorg.	page 5 - paragraph 1
		physiotherapy geographic spread	geografische spreiding van kinesitherapeuten	Kinesitherapeuten zijn geografisch goed verspreid, leveren zorgen dewelke voldoen aan inrichtings- en toegankelijkheidsnormen, waarbij ook ambulante thuiszorg in specifieke situaties kan worden verstrekt.	page 5 - paragraph 2
		physiotherapy in second line	kinesitherapie in de tweede lijn	Kenmerkend voor de kinesitherapeutische zorgverlening in de tweede lijn is een groot volume aan patiënten met gelijkaardige complexe problemen.	page 10 - paragraph 3
		physiotherapy in third line	kinesitherapie in de derde lijn	Kinesitherapeuten in de derde lijn zijn meestal werkzaam in een multidisciplinair team, gericht op nauwkeurig afgebakende doelgroepen in een meer gespecialiseerd intramuraal kader …	page 10 - paragraph 3
		acute and chronic physiotherapy	acute en chronische kinesitherapie	Qua activiteiten verleent de kinesitherapeut niet enkel de nodige acute, tijdelijke en kortdurende zorg … maar ook de chronische en langdurende kinesitherapeut is de zorg zowel binnen de gezondheidszorg (care) als het buiten de gezondheidszorg zoals advies, begeleiding en ondersteuning in de sport en win bedrijven.	page 10 - paragraph 5
		cure	cure	"Cure' omvat de curatieve of probleemoplossende zorg die erop gericht is gezondheidsproblemen en aandoeningen de behandelen, te genezen of te verbeteren. De zorg is meestal van tijdelijke aard, al kan het soms noodzakelijk zijn om een onderhoudsbehandeling in te stellen.	page 11 - paragraph 1

		Care	care	… ligt de focus bij "care" meer op de zorg- en hulpverlening bij functioneringsproblemen en aandacht voor het opvolgen en begeleiden van het welzijn en welbevinden op fysiek, psychisch, sociaal en moreel … vlak.	page 11 - paragraph 4
		important role in primary and secondary prevention	waardevolle taak in primaire en secundaire preventie	De kinesitherapeut heeft in zijn academische opleiding de kennis, de vaardigheden en de attitudes verworven ... Hiermee kan hij hele waardevolle taak vervullen in het primaire en secundaire preventiebeleid.	page 11 - paragraph 5
	Professional collaboration	taking into account the patient	rekening houden met de patiënt	De kinesitherapeut houdt ten allen tijde rekening met de fysieke conditie en het gezondheidsprofiel, alsook met de individuele mogelijkheden, voorkeuren, wensen en verwachtingen van de patiënt.	page 7 - paragraph 3
		efficient collaboration through thinking and working together	efficiënte samenwerking wanneer alle betrokkenen meedenken en meewerken	Wanneer alle medewerkers en betrokkenen binnen praktijk, organisatie, instelling of netwerk rechtstreeks meedenken en meewerken aan kwaliteitsprojecten, kunnen de systematische zelfevaluatie, systematisch (groeps)overleg, consensus en samenwerking veel gerichter, dynamischer en efficiënter verlopen.	page 31 - paragraph 2
	Quality of care	attention for quality of care and evidence based practice	aandacht voor kwaliteitszorg en evidence based practice	De kinesitherapeutische deskundigheid kenmerkt zich door het kunnen toepassen van vakcompetenties in concrete en complexe situaties, voor verschillende doelgroepen en in verschillende werksettings, met de nodige aandacht vooor kwaliteidszorg en evidence based practice.	page 7 - paragraph 4
		scientific substantiated diagnostic models as basis	wetenschappelijke onderbouwde diagnostische modellen als basis	De kinesitherapeut baseert zich op actuele en wetenschappelijk onderbouwde diagnostische modellen.	page 7 - paragraph 6

		choices based on expertise and EBP	keuze op basis van expertise en EBP	In zijn behandeling gebruikt de kinesitherapeut diverse therapeutische middelen. Hij maakt zijn keuze op basis van klinische expertise, Evidence Based Practice (EBP) en richtlijnen, met respect voor de rechten van de patiënt en efficiënt gebruik makend van de middelen van de gezondheidszorg.	page 8 - paragraph 3
		EBP based on therapeutic expertise and patient's values	EBP op basis van therapeutische deskundigheid en waardeoordeel van de patiënt	EPB vergt een kritisch-constructieve houding van de kinesitherapeut, waarbij gestreefd wordt om de meest doelmatige en doeltreffende behandeling toe te passen. Hierin worden de beste argumenten uit het wetenschappelijk onderzoek met de klinische deskundigheid van de therapeut en het waardeoordeel van de patiënt geïntegreerd.	page 8 - paragraph 4
Actors (Influence and power)	Financial implications	under-use of physiotherapy due to high out-of-pocket payment	kinesitherapie onderbenut door het hoge remgeld	Kinesitherapie wordt vaak onderbenut door het hoge remgeld.	page 13 - paragraph 3
	Scope of practice	involvement in the creation of multi-disciplinary guidelines	betrokkenheid bij het opstellen van multidiciplinaire richtlijnen	Kinesitherapeuten worden betrokken bij het opstellen van multidisciplinaire richtlijnen, waarbij je hun rol in multidisciplinaire context duidelijk wordt aangetoond.	page 12 - paragraph 3
		physiotherapy on medical prescription	kinesitherapie op medisch voorschrift	In de gecoördineerde Wet van 10 mei 2015 ... wordt bepaald dat kinesitherapeutische verrichtingen worden uitgevoerd op voorschrift van de arts of tandarts (art 43 §6).	page 14 - paragraph 1
		evaluation of and guiding of health care	evaluatie van en richting geven aan gezondheidszorg	Binnen een continue wijzigende gezondheidszorg kan de kinesitherapeut-leider het bestaande zorgsysteem evalueren en bakens uitzetten en ideeën aangeven van de richting waarin veranderingen moeten gaan.	page 31 - paragraph 5

Actors (Interests and concerns)	Communication	shared health data	gedeelde gezondheidsgegevens	Op het e-Healthplatform worden de gezondheidsgegevens gedeeld met de patiënt en met de andere bevoegde zorgverleners.	page 5 - paragraph 1
		a performant data exchange amongst stakeholders	een performante gegevensuitwisseling tussen actoren	Dit vereist niet enkel een goede beoordeling van de ondersteuningsbehoefte maar ook een performante gegevensuitwisseling tussen alle actoren ...	page 6 - pargraph 4
		shared decision making	gezamenlijke besluitvorming	De kinesitherapeut neemt de verantwoordelijkheid voor zijn interpretaties en legt deze voor aan de patiënt. Hij wijst de patiënt daarbij op eventuele risico's. Samen besluiten ze hoe het gezondheidsprobleem zal worden aangepakt (shared decision making).	page 9 - paragraph 1
	Cultural requirements	aspects included when maken decissions	aspecten bij het nemen van beslissingen	Bij het het nemen van beslissingen zal de kinesitherapeut naast vele vakinhoudelijke, ook maatschappelijke en financieel-economische aspecten in overweging moeten nemen.	page 9 - paragraph 5
	Informed consent	agrement on an informed consent	afsluiten van een informed consent	... wordt in samenspraak met de patiënt/cliënt of zijn wettelijke vertegenwoordiger, een informed consent afgesloten voor een kinesitherapeutische behandeling, desgevallend in samenwerking met andere gezondheidzorgverleners en/of andere direct betrokkenen, of wordt de patiënt/cliënt doorverwezen.	page 8 - paragraph 2
	Personal professional development	life long learning attitude	grondhouding van levenslang leren	Kinesitherapeuten bezitten deze grondhouding van levenslang leren	page 30 - paragraph 4
		quality professional practice	kwaliteitsvol professioneel handelen	Op het niveau kwaliteitsvol professioneel handelen zal de kinesitherapeut, als professional met eigen beroepscompetenties, zijn kwaliteitszorg versterken door (na)vorming, praktijk richtlijnen e.a.	page 30 - paragraph 7

		improvement of professional competences through life long learning	verbeteren van professionele competenties door levenslang leren	De professionele competenties die in de initiële kinesitherapieopleidingen werden verworven, moeten door levenslang leren behouden en verbeterd worden.	page 31 - paragraph 4
	Professional collaboration	interventions directed towards responsibilisation of the patient/client	interventes toegespitst op autoresponsabilisering van de patïent/cliënt	De kinesitherapeutische interventies zijn - daar waar mogelijk - toegespits op autoresponsabilisering van de patiënt/cliënt.	page 7 - paragraph 3
		respectful and responsive information towards the patient	respectvolle en responsieve informatie aan de patiënt	Hij betrekt de patiënt in het zorgproces, levert doel- en patiëntgerichte informatie en zorg dat die respectvol is voor en responsief is aan de individuele mogelijkheden, voorkeuren, wensen en verwachtingen van de patiënt.	page 8 - pragraph 6
		intra-muros and extra-muros physiotherapy	intramurale en extramurale kinesitherapie	Zowel in de intramurale als extramurale zorg wordt kinesitherapie aangeboden aan specifieke doelgroepen.	page 12 - paragraph 1
		inter-, multi-, transdisciplinary team approach	inter-, multi-, transdisciplinaire team aanpak	Vaak vereist zorg echter een inter-, multi-of transdisciplinaire aanpak waarbij een team van zorgverleners vanuit hun vakgebied samenwerken om het functioneren in het dagelijks leven en participeren van een patiënt in zijn omgeving te optimaliseren of aanpassingen in zijn omgeving door te voeren.	page 12 - paragraph 3
		referral from a physiotherapist	doorverwijzing door de kinesitherapeut	De kinesitherapeut moet ook kunnen doorverwijzen of taken toevertrouwen aan andere zorgprofessionals en vice versa wanneer dit nodig of wenselijk blijkt volgende patiënt.	page 13 - paragraph 2
	Quality assurance	evidence based parctice	evidence based practice	Het gaat bij EBP om het toepassen van wetenschappelijke gegevens, rekening houdend met relevante professionele overwegingen gebaseerd op klinische ervaring en in relatie met de voorkeuren, wensen en verwachtingen van de patiënt.	page 8 - pragraph 5

		systematic quality control	gesystematiseerde kwaliteitscontrole	… controleert de kinesitherapeut zijn kwaliteitszorg d.m.v. specifieke instrumenten en technieken voor het meten, analyseren en verbeteren.	page 30 - paragraph 7
		integrated quality of care	integrale kwaliteitszorg	Op het niveau integrale kwaliteitszorg worden alle aspecten van kwaliteit geïntegreerd, rekening houdend met alle relevante betrokkenen …	page 31 - paragraph 1
		minimum quality criteria for admission in the quality register	minimale kwaliteitscriteria voor opname in het kwaliteitsregister	Om in het kwaliteitsregister opgenomen te belijven moeten kinesitherapeuten jaarlijks voldoen aan de minimale kwaliteitscriteria welke door de "werkgroep kwaliteit" werden bepaald.	page 32 - paragraph 3
	Scope of practice	competences for a more elaborate role in prevention and health promotion	competenties voor een sterkere rol in preventie en gezondheidspromotie	Naast de betrokkenheid van kinesitherapeuten in de *cure* en *(chronic)* care zorggebieden bezitten zij de competenties en vaardigheden om een sterkere rol inzake *preventie en gezondheidspromotie* in te vullen.	page 5 - paragraph 2
		experts of movement and function	deskundigen van het bewegen en functioneren	Als deskundigen van het bewegen en fuctioneren, verstrekken zij educatie, advies en zorg om het functioneren in de omgeving en in de gemeenschap te verbeteren.	page 5 - paragraph 2
		competent judgement as health care profesisonal	vakkundig oordeel als zorgprofessional	Als zorgprofessional vormt de kinesitherapeut een vakkundig oordeel over het gezondheidsprofiel van de patiënt en zijn functionele situatie in bredere zin.	page 7 - paragraph 1
		professional duties	takenpakket	Tot zijn takenpakket behoren o.a. Informeren/voorlichten, begeleiden/coachen, adviseren/motiveren, educeren/trainen, het uitvoeren van kinesitherapeutische behandelingen en het ondernemen van preventieve interventies.	page 7 - paragraph 2

		the physiotherapists screens, assesses and evaluates the health status	de kinesitherapeut screent, onderzoekt en evalueert de gezondheidstoestand	De kinesitherapeut screent, onderzoekt en evalueert de gezondheidstoestand, hij analyseert en beoordeelt de beweging-en functioneringsmogelijkheden van de patiënt en hij bepaalt de oorzakelijke en beïnvloedbare factoren van de vastgestelde stoornissen en beperkingen.	page 7 - paragraph 6
		competence of the physiotherapist as individual professional	deskundigheid van de kinesitherapeut als individuele professional	De kinesitherapeut bezit de deskundigheid om als individuele professional gezondheidsproblemen op te lossen of om preventief advies te verlenen.	page 12 - paragraph 3
		optimalisation of health care outside social security and health care	optimaliseren van gezondheid buiten de sociale zekerheid en gezondheidszorg	De kinesitherapeut is een zorgprofessional die de gezondheid ook kan optimaliseren buiten het kader van de sociale zekerheid en buiten de gezondheidszorg	page 16 - paragraph 2
		professional physiotherapy help (examples given)	professionele hulp van de kinesitherapeut (voorbeelden worden gegeven)	De kinesitherapeut biedt professionele hulp in de vorm van onderzoek …, behandeling … en preventieve handelingen in het kader van het preventiebeleid, gezondheidsbevordering en gezondheidsbescherming.	page 17- pargraph 3
		physiotherapist as manager	kinesitherapeut als manager	De rol van kinesitherapeut als manager heeft betrekking op organiseren, leiden en ondernemen.	page 21 - paragraph 1
		organisor of activities and business projects	organisatie van activiteiten en werkzaamheden	De taak van de organisator heeft betrekking op de inrichting en de organisatie van de activiteiten en werkzaamheden binnen de eigen praktijk.	page 21 - paragraph 1

		organisation and entrepreneurship important points	aandachtspunten bij organiseren en ondernemen	Aandachtspunten bij organiseren en ondernemen zijn: effectiviteit, kwaliteit en doelmatigheid van de organisatie en werkprocessen; continuïteit van zorg; coördinatie met derden; afstemming van de vraaggestuurde zorg; positionering van de eigen organisatie; verantwoord ondernemen in relatie tot kwalitatief hoogwaardige hulp-en dienstverlening; deontologisch en ethisch kader voor een nieuwe zakelijke zorgmodellen.	page 21 - paragraph 1
		striving towards quality improvement as professional developer	streven naar kwaliteitsverbetering als beroepsontwikkelaar	In de rol van beroepsontwikkelaar streeft de kinesitherapeut naar het behouden, het verbeteren en het waarborgen van de kwaliteit van de eigen hulp-en dienstverlening.	page 26 paragraph 1
		contribution to social profiling as professional innovator	bijdragen aan maatschappelijke profilering als beroepsinnovator	In de rol van beroepsinnovator zal de kinesitherapeut bijdragen aan de inhoudelijke ontwikkeling, profilering en maatschappelijke legitimering van het beroep door middel van het implementeren van kwaliteitsverbeteringen en het waarborgen van innovatieprocessen.	page 26 paragraph 1
		collaboration to scientific advancement as researcher	meewerken aan wetenschappelijke vernieuwing als vorser	In de rol van wetenschappelijk vorser zal de kinesitherapeut door stimuleren van onderzoeksopdrachten en het verspreiden ervan meewerken aan de wetenschappelijke vernieuwing van het beroep en haar bijzondere bekwaamheden en/of aanverwante disciplines.	page 26 paragraph 1
Process (Dealing with actors)	Education	scientific based education with regular quality controls	wetenschappelijk onderbouwde opleidingen met regelmatige kwaliteitscontroles	De academische opleidingen Revalidatiewetenschappen en Kinesitherapie zijn gestoeld op een wetenschappelijke onderbouw. Zij bezitten een jarenlange traditie van wetenschappelijk onderzoek … en ondergaan regelmatig kwaliteitscontroles …	page 30 - paragraph 2
	Personnal professional development	competent practice through experience and education	competent handelen door ervaring en scholing	De weg die de kinesitherapeuten individueel volgen, in hun competent handelen of op gevorderd niveau, veronderstelt een combinatie van zowel ervaring als gerichte scholing.	page 17 - paragraph 1

	Physiotherapy	professional physiotherapy (examples given)	professionale kinesitherapeutische zorg (voorbeelden worden gegeven)	De kinesitherapeut biedt professionele zorg aan in de vorm van onderzoek … behandeling … en preventieve handelingen in het kader van gezondheidsbevordering, het preventiebeleid en de gezondheidsbescherming.	page 7 - paragraph 2
	Professional collaboration	collaboration as an imortant element in efficient health care	samenwerken als belangrijk element voor efficiënte zorgverlening	Het samenwerken en overleggen met andere gezondheidswerkers in de lokale zorgnetwerken is een belangrijk element voor efficiënte zrogverlening.	page 31 - paragraph 3
	Quality assurance	implementation of innovations	implementatie van innovaties	De kinesitherapeut volgt de *medisch wetenschappelijke en technologische ontwikkelingen* op de voet en implemteert innovaties in haar kinesitherapeutischee handelen en haar kwaliteitszorg.	page 5 paragraph 1
		personal quality portfolio	persoonlijke kwaliteitsportfolio	Elke practiserende kinesitherapeut met een RIZIV-nummer kan op de website van PE - Online (Permanente Educatie) een persoonlijk kwaliteitsportfolio samenstellen waarop hij alle gevolgde opleidingen en (na)vormingen kan registreren.	page 32 - paragraph 1
Process (Stages)	Policy stages	analysis and adaptation of existing professional competence profile	analyse en herwerking van het bestaande BCP	Ingevolge de vraag van de minister … werd het bestaande BCP kritisch geanalyseerd, en waar van toepassing grondig herwerkt in toekomstig perspectief.	page 3 - paragraph 4
Content (objective)	Communication	evolve with IT	mee evolueren met de IT	De kinesitherapie evoleert mee met de *informatie- en communicatietechnologie* in de zorgsector.	page 5 - paragraph 1
	Cultural requirements	Tripple Aim model	Tripple aim model	Tripple Aim model: verbetering van de gezondheidheid van de bevolking, personen en groepen met zorgnood (prventie, care & cure), verbetering van de kwaliteit van de zorg zoals de patiënt die ervaart (rechten van de patiënt) en efficiënter gebruik van de toegewezen middelen (more value for money).	page 5 - paragraph 2
	Ethical requirements	benefit of a deontology organ	baat bij een deontologisch orgaaan	De beoefening van kinesitherapie als vrij beroep en de beoefening van kinesitherapie in Europese context zouden gebaat zijn bij de ontwikkeling van een deontologisch orgaan.	page 4 - paragraph 4

	General goal	information on quality, efficiency and effectiveness of physiotherapy	informeren over kwaliteit, doematigheid en doeltreffendheid van kinesitherapie	Dit BCP heeft tot doel alle beleidsmensen van de verschillende overheden … alle zorgverleners met wie de kinesitherapeuten multidisciplinair en transdisciplinair samenwerken en alle burgers te informeren over de kwaliteit, de doelmatigheid en de doeltreffendheid van de kinesitherapeutische zorg.	page 4 - paragraph 7
	Physiotherapy	physiotherapy care characteristics	karakteristieken van kinesitherapeutische zorgverlening	Karakteristiek voor die zorgverlening zijn: een methodische werkwijze, handelen in overeenstemming met de principes van Evidence Based Practice en gerichtheid op het beschermen en bevorderen van de gezondheid en het vergroten dan wel behouden van de functionele mogelijkheden en de zelfredzaamheid van de patiënt.	page 6 - paragraph 4
		physiotherapy care objectives	beoogde doelstellingen door kinesitherapeutische zorg	De kinesitherapeutische zorg beoogt doelstellingen te bereiken: - zorg die afgestemd is op de hulp- of de zorgvrgaag van de patiënt - voorkomen van het ontstaan, onderhouden en recidiveren van functioneringsproblemen - opheffen, verminderen of in balans brengen van gezondheidsproblemen - creëren van mogelijkheden tot het verbeteren of het in stand houden van het participatieniveau van de patiënt en zijn levenskwaliteit	page 6 - paragraph 5
		physiotherapy method	kinesitherapeutische werkwijze	De werkwijze van de kinesitherapeut kenmerkt zich door een bewuste, procesmatige, systematische, doelmatige en doelgerichte aanpak.	page 7 - paragraph 5
		physiotherapist's objectives	doelstellingen van de kinesitherapeut	Qua doelstellingen richt de kinesitherapeut zich zowel op het herstel van stoornissen … als op het normaliseren of verbeteren van bewegingen en functies, het voorkomen of verminderen van beperkingen … en het voorkomen van participatieproblemen …	page 10 - paragraph 5

		active in levels of prevention	actief in preventieniveaus	De kinesitherapeut kan actief zijn in verschillende preventieniveaus.	page 11 - paragraph 4
		purpose of special professional competences	doel van de bijzondere beroepsbekwaamheden	Bijzondere beroepsbekwaamheden hebben in de kinesitherapie essentieel tot doel om voor patiënten, voor artsen en voor collega's kinesitherapeuten … transparantie te creëren …	page 15 - paragraph 6
		physiotherapist as health care worker	kinesitherapeut als zorgverlener	De kinesitherapeut als zorgverlener.	page 17 - under title 3.1.
		physiotherapist as manager/entrepeneur	kinesitherapeut als manager/ondernemer	De kinesitherapeut als manager en ondernemer	page 21 - under title 3.2.
		physiotherapist as researcher	kinesitherapeut als onderzoeker	De kinesitherapeut als beroepsontwikkelaar, beroepsinnovator en wetenschappelijk vorser.	page 26 - under title 3.3.
	Professional collaboration	a multidisciplinary framework in which the physiotherapist is active	multidisciplinair kader waarin de kinesitherapeut actief is	Deze commissie heeft met het oog op dit BCP het multidisciplinair kader uitgetekend, waarin de kinesitherapeut actief kan zijn.	page 4 - paragraph 3
		integrated healtcare	geïntegreerde zorg	Hierdoor wordt geïntegreerde zorg mogelijk en wordt de zorg efficiënter, kosteneffectiever, kwalitatief beter en beter toegankelijk.	page 5 - paragraph 1
		patients as soon as possible towards primary health care	patiënten zo snel mogelijk naar de eerstelijnszorg	Hierbij wordt gestreefd om patiënten zo snel mogelijk naar de eerstelijnszorg over te kunnen laten gaan, waarbij aandacht besteed wordt aan een professionele wederzijdse informatiedoorstroom over doelstellingen en behandelplan.	page 10 - paragraph 3

		encouragement of referrals between physiotherapists	aanmoedigen van doorverwijzingen tussen kinesitherapeuten	Ook doorverwijzingen tussen kinesitherapeuten moeten aangemoedigd worden.	page 13 - paragraph 3
		local collaboration networks	lokale samenwerkingsverbanden	Kinesitherapeuten werken samen in kringen en/of in samenwerkingsverbanden van waaruit ze een Lokale Kwaliteitsgroep van kinesitherapeuten (LOKK) kunnen oprichten.	page 30 - paragraph 5
		frameworks and tools for collaboration	kaders en instrumenten voor samenwerking	Om interdisciplinaire en multidisciplinaire samenerking te bevorderen en te optimaliseren worden kaders en instrumenten aangereikt …	page 31 - paragraph 3
	Quality assurance	EPB guidelines	EPB richtlijnen	Evidence based practice (EPB) wordt nagestreefd in alle kinesitherapeutische praktijkvoering, wat onder andere tot uitdrukking komt in de ontwikkeling van richtlijnen om het kinesitherapeutisch handelen op klinisch niveau te ondersteunen.	page 8 - paragraph 4
		Pro-Q-Kine objective	doelstelling van Pro-Q-Kine	De doelstelling van Pro-Q-Kine is het verbeteren en transparanter maken van de kwaliteit van de kinesitherapeutische zorg.	page 31 - paragraph 6
		quality criteria for involved physiotherapists	kwaliteitscriteria voor deelnemende kinesitherapeuten	De deelnemende kinesitherapeuten werken en voldoen aan vooropgestelde kwaliteitscriteria …: - kennis en competentiemanagement - organisatie van de zorg en de praktijk - kwaliteit van de zorg - automatisering en informatisering	page 32 - paragraph 1
	Scope of practice	connection between education and profession	aansluiting tussen opleiding en werkveld	Het beroepscompetentieprofiel positioneert de kinesitherapie binnen de gezondheidzorg en vormt de sleutel voor aansluiting tussen opleiding en werkveld.	page 3 - paragraph 2

		basis for professional competences and special professional titles	basis voor de bijzondere beroepsbekwaamheden en bijzondere beroepstitels	Het is tevens een vertrekbasis om bijzondere beroepsbekwaamheden en bijzondere beroepstitels te ontwikkelen en de aanvullende beroepscompetenties ervan te omschrijven.	page 3 - paragraph 2
	The patient	patient-centered awerness	aandacht voor het centraal plaatsen van de patiënt	Er is …. aandacht besteed aan het centraal plaatsen van de patiënt, autonomie en empowerment van de patiënt …	page 3 - paragraph 5
		equity-principle	equity-principe	Kinestherapeuten eerbiedigen het *equity-principe* en stellen de patiënt altijd centraal. Zij bieden betaalbare, toegankelijke en persoonsgerichte gezondheidszorg aan.	page 5 - paragraph 2
Content (Policy design)	Policy design	Policy structure outline	Inhoud van het document	Inhoudstafel …	page 2
Content (Specific mechanisms)	Communication	e-healthplatform	e-Healthplatform	e-Healthplatform	page 5 - paragraph 1
		e-learning	e-learning	e-learning	page 5 - paragraph 1
	Ethical requirements	positive approach to deontology	positieve deontologie	positieve deontologie (adviseren, informeren en sanctioneren)	page 4 - paragraph 4
	Personal profesisonal development	European Qualification framework for life long learning	EKK	Het Europees Kwalificatiekader voor een leven lang leren (EKK)	page 30 - paragraph 2
	Professional collaboration	local multidsiciplinary networks	lokale multidisciplinaire netwerken	lokale multidisciplinaire netwerken	page 6 - paragraph 4

		palliative networks	palliatieve netwerken	palliative netwerken	page 6 - paragraph 4
		plan of care	zorgplan	zorgplan	Page 6 - paragraph 4
		systematic collaboration structures	gesystematiseerde overlegstructuren	gesystematiseerde overlegstructuren zoals geïntegreerde dienst voor thuisverzorging (GDT), multidisciplinair overleg (MDO) en e-zorgplan …	page 31 - paragraph 3
	Quality assurance	Tripple Aim model	Tripple aim model	Tripple Aim model	page 5 - paragraph 2
		electronic patient file	EPD	het elektronisch patiëntendossier (EPD)	page 31 - paragraph 3
		physiotherapy patient file	kinesitherapeutisch dossier	kinesitherapeutisch dossier	page 31 - paragraph 3
		quality portfolio	kwaliteitsportfolio	kwaliteitsportfolio	page 31 - paragraph 6
	Scope of practice	the taskforce for direct access	werkgroep directe toegang	een werkgroep directe toegang	page 4 - paragraph 2
		the taskforce for special profesisonal competences	werkgroep bijzondere bekwaamheden	een werkgroep bijzondere beroepsbekwaamheden	page 4 - paragraph 3
		the scientific committee	wetenschappelijke commissie	een wetenschappelijke commissie	page 4 - paragraph 3

Actors	Stakeholders	Belgian health organisation collaborators	Nationale Raad voor kinesitherapie	page 3 - paragraph 1
			werkgroep algemeen kader	page 3 - paragraph 1
			De Federale Raad voor Kinestherapie	page 3 - paragraph 2
			FOD Volksgezondheid	page 3 - paragraph 3
			Minister	page 3 - paragraph 4
			de federale overheid	page 3 - paragraph 6
			de overheden van de taalgemeenschappen	page 3 - paragraph 6
			de verschillende overheden (federaal, gemeenschappen en gewesten)	page 4 - paragraph 7
			verzekeringsinstellingen	page 5 - paragraph 1
			OCMW	page 13 - paragraph 3
			WCZ	page 13 - paragraph 3
			CLB	page 13 - paragraph 3
			CAW	page 13 - paragraph 3
			diensten voor gezinszorg	page 13 - paragraph 3
			LDC	page 13 - paragraph 3
			dagverzorgingscentra	page 13 - paragraph 3
			centra voor kortverblijf	page 13 - paragraph 3
			diensten voor oppashulp	page 13 - paragraph 3
			uitleendiensten voor hulpmiddelen	page 13 - paragraph 3
			ziekenfondsen	page 13 - paragraph 3
			consultatiebureaus voor personen met een handicap	page 16 - paragraph 5
			NGO's	page 16 - paragraph 5
			Vluhr	page 30 - paragraph 2
			Aeques	page 30 - paragraph 2
			RIZIV	page 31 - paragraph 6
		Health education collaborators	het onderwijs	page 3 - paragraph 2
			een wetenschappelijke commissie	page 4 - paragraph 3
			leerkracht	page 16 - paragraph 4

			Universiteit	page 16 - paragraph 4
			opleidingen	page 30 paragraph 3
		Health professionals	de beroepsbeoefenaar	page 3 - paragraph 2
			artsen	page 4 - paragraph 3
			collega's kinesitherapeuten	page 4 - paragraph 3
			kinesitherapeut	page 4 - paragraph 3
			zorgverleners	page 4 - paragraph 7
			zorgprofessionals	page 5 - paragraph 1
			diëtist	page 9 - paragraph 6
			logopedist	page 9 - paragraph 6
			ergotherapeut	page 9 - paragraph 6
			psycholoog	page 9 - paragraph 6
			multidisciplinair zorgteam	page 10 - paragraph 1
			Artsen	page 12 - pargraph 3
			verpleegkundigen	page 12 - pargraph 3
			thuisverpleegkunidigen	page 13 - paragraph 2
			tandarts	page 14 - paragraph 1
			manager	page 21 - paragraph 1
		International organisation	de World Confederation of Physcial Therapy	page 4 - paragraph 3
		patients/clients or their legal representatives	patiënt	page 3 - paragraph 5
			patiënten	page 4 - paragraph 3
			burgers	page 4 - paragraph 7
			cliënt	page 6 - paragraph 2
			patiënt/cliënt of zijn wettelijke vertegenwoordiger	page 8 - paragraph 2
			ouderen	page 10 - paragraph 1
			palliatieve patiënten	page 10 - paragraph 1
			werknemers	page 11 - pargraph 5

			patiëntenverenigingen	page 12 - pargraph 1
			mantelzorgers	page 13 - paragraph 2
			de maatschappij	page 31 - paragraph 4
		Physiotherapy association	beroepsverenigingen	page 30 paragraph 3
			lokale kringen	page 31 - paragraph 4
		Practice settings entities	wijkgezondheidscentra	page 9 - paragraph 6
			Woon en Zorgcentra	page 10 - paragraph 2
			solo- en groepspraktijken	page 11 - pargraph 2
			private poliklinieken	page 11 - pargraph 2
			poliklinieken van de zorginstellingen	page 11 - pargraph 2
			centra voor sportgeneeskunde	page 11 - pargraph 2
			revalidatiecentra	page 11 - pargraph 2
			sport- en vakantiecentra	page 16 - paragraph 5
			rugscholen	page 16 - paragraph 5
		Quality entities	een deontologisch orgaan	page 4 - pargraph 4
			LOKK	page 30 paragraph 4
			een onafhankelijk kwaliteitsorgaan	page 31 - paragraph 6

National Health Act No 61 of 2003

Theme	Category	Code	Quote	Reference
Context (Cultural)	History	past injustices, imbalances and inequities	RECOGNISING - the socio-cultural injustices, imbalances and inequities of health services of the past	preamble
	Legal / justice requirements	confidentiality of user information	All information concerning a user … is confidential.	chapter 2 - 13.
		fee variations	When determining a schedule of fees, the fee for a particular services may not be varied in respect of users who are not ordinarily resident in a province.	chapter 6 - 41.
	Policies and procedures	validation of a certificate of need	A certificate of need is valid for a prescribed period, but such period may not exceed 20 years.	chapter 6 - 37.
Context (Situational)	Communication	infomed consent	For the purpose of this section "informed consent" means consent for the provision of a specific health service given by a person with legal capacity to do so and who has been informed …	chapter 2 - 7.
	Policies and procedures	agreements in order to achieve objects of the Act	The national department, any provincial department or any municipality may enter into an agreement ... in order to achieve any objects in this Act.	chapter 6 - 45.
	Quality of life	improving quality of life	RECOGNISING - the need to improve the quality of life of all citizens …	preamble
Context (Structural)	Education	ensuring adequate resources for education and training	… ensure that adequate resources are available for the education an training of health care personnel to meet the human resources requirements of the national health system.	chapter 7 - 52.
	Health system	establishement of a health system	establish a health system based on decentralised management, principles of equity, sound governance, internationally recognised standards of research …	preamble
		health districts boundaries	The system consists of various health districts, and the boundaries of health districts coincide with district and metropolitan municipal boundaries.	chapter 5 - 29.
	Legal rights	rights and duties	establishing a health system which - setting out the rights and duties of health care providers, health workers, health establishments and users	chapter 1 - 2.

		protecting, respecting, promoting and fulfilling rights	establishing a health system which - protecting, respecting, promoting and fulfilling the rights	chapter 1 - 2.
	Policies and procedures	apply to the Director-General	A person who whishes to obtain or renew a certificate of need must apply to the Director-General … and must pay the prescribed application fee.	chapter 6 - 36.
	Professional collaboration	promotion of co-operation and shared responsibility	promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors …	preamble
	Quality assurance	compliance with quality requirements and standards	All health establishments must comply with the quality requirements and standards prescribed …	chapter 6 - 47.
	Research	burden of disease as research priority	In identifying health research priorities, the National Health Research Committee must have regard to - the burden of disease	chapter 9 - 70.
		cost-effectiveness as research priority	In identifying health research priorities, the National Health Research Committee must have regard to - the cost-effectiveness of interventions aimed at reducing the burden of disease	chapter 9 - 70.
		available resources as research priority	In identifying health research priorities, the National Health Research Committee must have regard to - the availablility of human and institutional resources	chapter 9 - 70.
		health needs of vulnerable groups as research priority	In identifying health research priorities, the National Health Research Committee must have regard to - the health needs of vulnerable groups …	chapter 9 - 70.
		communities' needs as research proority	In identifying health research priorities, the National Health Research Committee must have regard to - the health needs of communities	chapter 9 - 70.
		conducting research or experimentation	Research or experimentation … may only be conducted - in the prescribed manner and with the written consent of the person …	chapter 9 - 71.
Actors (Influence and power)	Policies and procedures	closure of health establishment or health agency	The Office of Standards Compliance may order the total or partial closure of a health establishment or health agency …	chapter 10 - 79.

		appointment of a national health officer	The Minister may appoint any person in the employ of the national department as a health officer of the national department	chapter 10 - 80.
		appointment of a provincial health officer	The relevant member of the Executive Council may appoint any person in the employ of the provincial department …	chapter 10 - 80.
		appointment of a municipal health offcieer	The mayor … may appoint appoint any person in the employ of the council …	chapter 10 - 80.
		entering of premises	A health officer may enter any premises, excluding a private dwelling, at any reasonable time	chapter 10 - 82.
		entering of premises with a police official	A health officer, accompanied by a police official may … enter eny premises specified in the warrent, including private dwellings	chapter 10 - 84.
		delegation of duties and powers	the Minister may assign any duty and delegate any power imosed or conferred upon him or her by this Act, except the power to make regulations	chapter 12 - 92.
Actors (Interests and concerns)	Communcation	informing a user (details provided)	Every health care provider must inform a user of: the user's health status, the range of diagnostic procedures and treatment options …, the benifits, risks, cost and consequences … and the user's right to refuse health services …	chapter 2 - 6.
		informing the user in understandable language	The health care provider must … inform the user … in a language that the user understands …	chapter 2 - 6.
		informing users capable of understanding	A user who is capable of understanding must be informed … even if he or she lacks the legal capacity to give the informed consent …	chapter 2 - 8.
		informing users unable to participate in decisions	If a user is unable to participate in a decision … he or she must be informed … unless the disclosure of such information would be contrary to the user's best interest.	chapter 2 - 8.

		ensuring communication between registered professions	The Forum of Statutory Health Professional Council must - ensure communication and liaison … upon matters affecting more than one of the registered professions	chapter 7 - 50.
		interprofessional liaison and communication	The Forum of Statutory Health Professional Council must - … promote interprofessional liaison and communication …	chapter 7 - 50.
	Duties of National Department	ensuring guidlines and implementation of policy	The Director-General must - ensure the implementation of national health policy … and issue guidelines for the implementation of national health policy	chapter 3 - 21
		adherence to norms and standards	The Director-General must - issue, and promote adherence to, norms and standards on health matters	chapter 3 - 21
	Duties of the Forum of Statutory Health Professional Council	protection of public and users	The Forum of Statutory Health Professional Council must - protect the interest of the public and users	chapter 7 - 50.
		advise to the Minister and the professional councils	The Forum of Statutory Health Professional Council must - advise the Minister and the individual statutory health professional councils	chapter 7 - 50.
	Duties of users	adherence to the rules of health establishments	A user must - adhere tot the rules of the health establishment …	chapter 2 - 19.
		provision of accurate information and co-operation	A user must - … provide the health care provider with accurate information pertaining to his or her health status and co-operate …	chapter 2 - 19.
		treating health care providers with dignity and respect	A user must - treat health care providers and health care workers with dignity and respect	chapter 2 - 19.
		signing of a discharge certificate	A user must - sign a discharge certificate or release of liability if he or she refuses to accept recommended treatment	chapter 2 - 19.

	Education	establishment of academic health complexes	The Minister may … establish - academic health complexes … to educate and train health care personnel and to conduct resarch in health services	chapter 7 - 51.
	Human resources	regulations on human resources	The Minister may make regulations regarding human resources within the national health system	chapter 7 - 52.
	Legal obligations	medical emergency treatment	A health provider, health worker or health establishment may not refuse a person emergency medical treatment	chapter 2 - 5.
		obtaining informed consent	A health care provider must take all necessarys steps to obtain the user's informed consent.	chapter 2 - 7.
		providing a discharge report	A health care provider must provide a user with a discharge report at the time of the discharge of the user …	chapter 2 - 9.
		informing users of experimental or research purpose services	Before a health establishment provides a health service for experimental or research purposes … the health establishment must inform the user … that the health service is for experimental or research purposes …	chapter 2 - 11.
		certificate of need	A person may not - … provide prescribed health services … without being in possession of a certificate of need.	chapter 6 - 36.
		private health establishments insurance cover	Every private health establishment must maintain insurance cover sufficient to indemnify a user …	chapter 6 - 46.
		announcement of authority and purpose of entering	A health offcier who has obtained a warrant … must immediately before entering the premises in question - audibly announce that he or she is authorised … and notify the person in control … of the purpose	chapter 10 - 85.
	Legal rights	examination of user's health care records	A health care provider may examine a user's health records	chapter 2 - 16.
		complaints about treatment	Any person may lay a complaint about the manner in which he or she was treated at a health establishment ...	chapter 2 - 18.

		no discrimination of health care personnel	Health care personnel may not be unfairly discriminated against on account of their health status	chapter 2 - 20.
	Minister's duties	health of the population (outline provided)	The Minister must … endeavour to protect, promote, improve and maintain the health of the population	chapter 1 - 3.
		promotional obligations of the Minister (outline provided)	The Minister must … promote the inclusion of health services in the socio-economic development plan of the Republic	chapter 1 - 3.
		ensuring essential health services	The Minister must … ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic …	chapter 1 - 3.
		equitable prioritising of health services	The Minister must … equitably prioritise the health services that the State can provide	chapter 1 - 3.
		prescription of conditions for free health services	The Minister … may prescribe conditions subject to which categories of persons are eligible for such free health services …	chapter 1 - 4.
		classification of health establishments	The Minister may by regulation - classify all health establishements into such categories as may be appropriate	chapter 6 - 35
		determining the range of health services provided	The Minister … may - detremine the range of health services that may be provided at the relevant public health establsihment	chapter 6 - 41.
		making of regulation (details are provided)	The Minister … may make regulations regarding - anything which may or must be prescribed in terms of this Act … (more detail provided)	chapter 11 - 90.
		establishment of necessary advisory and technical committees	The Minister may … establish such number of advisory and technical committees as may be necessary to achieve the objects of this Act	chapter 12 - 91.
	Policies and procedures	determining policies and measures (details provided)	The Minister must … determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population	chapter 1 - 3.

		disclosure of information in health care records	A health worker or any health care provider that has access to the health records of a user may disclose such personal information … as is necessary … in the interest of the user.	chapter 2 - 15.
		prescription of minimum standards outside health service locations	The Minister may prescribe - minimum standards and requirements for the provision of health services in locations other than health establishments …	chapter 6 - 43.
		coherent policy development	The Forum of Statutory Health Professional Council must - advise the Minister on the development of coherent policies …	chapter 7 - 50.
		monitoring and advising on policy implementation	The Forum of Statutory Health Professional Council must - monitor and advise the Minister on the implementation of health policy …	chapter 7 - 50.
	Professional collaboration	user's right to participate in decisions	A user has the right to participate in any decision affecting his or her personal health and treatment	chapter 2 - 8.
		transfer of users to appropriate public health establishment	If a public health establishment is not capable of providing the necessary treatment or care, the public health establishment … must transfer the user … to an appropriate public health estabblishment …	chapter 6 - 44.
		good practice and information sharing	The Forum of Statutory Health Professional Council must - promote good practice in health services and sharing of information …	chapter 7 - 50.
		consulting relevant authority	The Forum of Statutory Health Professional Council must - consult and liaise with relevant authority on matters collectively affecting all registered health professions	chapter 7 - 50.
	Quality assurance	information on quality of health services	The Office of Standards Compliance must - keep the Minister informed of the quality of health services provided throughout the Republic	chapter 10 - 78.
		advise on quality norms and standards	The Office of Standards Compliance must - advise the Minister on norms and standards for quality in health services	chapter 10 - 78.

		recommandations on new systems to promote quality services	The Office of Standards Compliance must - recommend to the Minister new systems and mechanisms to promote quality of health services	chapter 10 - 78.
Content (implementation plan)	Legal requirements	legal date this Act takes effect	This Act is called the National Health Act, 2003, and takes effect on a date fixed by the President by proclamation in the *Gazette*.	chapter 12 - 94.
Content (Objectives)	Communication	dissemination of information	The national department and every provincial department, district health council and municipality must ensure that appropriate, adequate and comprehensive information is disseminated …	chapter 2 - 12.
		facilitation, interaction, communication and information	… facilitate interaction, communication and sharing of information on national health issues …	chapter 3 - 24.
			… facilitate interaction, communication and the sharing of information on provincial health issues …	chapter 4 - 28.
	Legal requirements	provision of a framework for a structured health system	To provide a framework for a structured uniform health system within the Republic …	preamble
		regulation of a uniform national health	The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation	chapter 1 - 2.
		ensurance of health records	… the person in charge of a health establishment must ensure that a health record … is created and maintained …	chapter 2 - 13.
		provision of provincial committees	Provincial legislation must at least provide for the establishment … of a committee for - a clinic or group of clinics, a community health centre or a clinic and a community health centre of a group of clinics and community health centres.	chapter 6 - 42.

		provision of health establishments other than hospitals	Provincial legislation must provide for the provision of health services at health establishments in the province in question other than hospitals.	chapter 6 - 43.
		monitoring and evaluating compliance to this Act	An Inspectorate for Health Establishments must - monitor and evaluate compliance with this Act …	chapter 10 - 77.
		submission of a quarterly report	An Inspectorate for Health Establishments must - submit a quarterly report on its activities and findings …	chapter 10 - 77.
		inspections by Office of Standards Compliance	The Office of Standards Compliance … must inspect every health establishment and health agancy at least once every three years …	chapter 10 - 79.
		monitoring and enforcing compliance with this Act	A health officer must monitor and enforce compliance with this Act	chapter 10 - 81.
		publication of proposed regulations	The Minister must publish all regulations proposed to be made under this Act in the *Gazette* for comment at least three months before the date contemplated for their commencement.	chapter 11 - 90.
	Policy and procedures (advisory)	policy matters (details provided)	The National Health Council must advise the Minister on - policy concerning any matter that will protect, promote, improve and maintain the health of the population	chapter 3 - 23.
			A Provincial Health Council must advise the relevant member of the Executive Council on - policy concerning any matter protect, promote, improve and maintain the health of the population within the province	chapter 4 - 27.
		proposed legislation	The National Health Council must advise the Minister on - proposed legislation pertaining to health matters …	chapter 3 - 23.
			A Provincial Health Council must advise the relevant member of the Executive Council on - proposed legislation relating to health matters …	chapter 4 - 27.
		norms and standards	The National Health Council must advise the Minister on - norms and standards for the establishment of health establishments	chapter 3 - 23.
			A Provincial Health Council must advise the relevant member of the Executive Council on - norms and standards for the establishment of health establishments	chapter 4 - 27.

		health district guidelines	The National Health Council must advise the Minister on - guidelines for the management of health districts	chapter 3 - 23.
		national health policy implementation	The National Health Council must advise the Minister on - the implementation of national health policy	chapter 3 - 23.
		integrated health plans	The National Health Council must advise the Minister on - the national and provincial integrated health plans …	chapter 3 - 23.
		health research integrated strategy	The National Health Council must advise the Minister on - an integrated national strategy for health research	chapter 3 - 23.
	Policies and procedures	set up controle measures	The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access …	chapter 2 - 17.
		ensurance of policy, norms and standards implementation	The relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province.	chapter 4 - 24.
		establishment of district health councils	The relevant member of the Executive Council … must establish a district health council for every health district in his or her province.	chapter 5 - 31.
		ensurance of appropriate municipal health services	Every metropolitan and district municipality must ensure that appropriate municipal health services are effectively and equitably provide …	chapter 5 - 32.
		presenting a district health plan	Each district and metropolitan health manager must … present … a district health plan …	chapter 5 - 33.
		devlopment of human resources	The National Health Council must develop policy and guidelines for, and monitor the provision, distribution, devlopment, management and utlisation of, human resources within the national health care system.	chapter 7 - 48.
		determining implementation guidelines	The Minister … must determine guidelines to enable the provincial departments and district health councils to implement programmes for appropriate distribution of health care providers and health workers.	chapter 7 - 49.

	Professional collaboration	liaision with other countries and international agencies	The Director-General must … - liaise with national health departments in other countries and with international agencies	chapter 3 - 21.
		prescription of co-ordinated private and public health relationship	The Minister must prescribe mechanisms to enable a co-ordinated relationship between private and public health establishments in the delivery of health services.	chapter 6 - 45.
		facilitation and co-ordination of health information systems	The national department must facilitate and co-ordinate the establishment, implementation and maintainance … of health information systems … in order to create a comprehensive national health information system	chapter 9 - 74.
	Research	identification of research priorities and advise to the Minister	The National Health Research Committee must identify and advise the Minister on health research priorities	chapter 9 - 70.
		health research ethics committees	Every institution, health agency and health establishment at which health research is conducted must establish of have access to a health research ethics committee …	cahpetr 9 - 73.
		review of research proposals and protocols	A health research ethics committee must - review research proposals and protocols …	chapter 9 - 73
		approbation for research	A health research ethics committee must - grant approval for research …	chapter 9 - 73.
Content (Policy design)	policy design outline	policy content	Table of contents ...	
Content (Specific mechanisms)	communication	informed consent	informed consent	chapter 2 - 7.
		discharge report	a discharge report	chapter 2 - 10.
	Legal requirements	certificate of need	certificate of need	chapter 6 - 36.
		inspections by Office of Standards Compliance	Inspections by Office of Standards Compliance	chapter 10 - 79.

		appointment of health officers	Appointment of health officers	chapter 10 - 80.
		entry and search of presmises with warrant	Entry and search of premises with warrant	chapter 10 - 83.
	Research	research on or experimentation with human subjects	Research on or experimentation with human subjects	chapter 9 - 70.

Actors	Stakeholders	Health education collaborators	health research ethics committee	chapter 2 - 11.
			Academic health complexes	chapter 7 - 51.
			National Health Research Committee	chapter 9 - 69.
			National Health research Ethics Council	chapter 9 - 72.
		Patients/clients or their legal representatives	The State	preamble
			the people of South Africa	preamble
			vulnarable groups	chapter 1 - 2.
			parent or gardian of the child	chapter 9 - 71.
		Physiotherapy practice collaborators	Public and private health professionals	preamble
		South African Health organisation collaborators	Province	preamble
			Municipality	preamble
			Health District	preamble
			President	preamble
			Public and private providers of health services	chapter 1 - 2.
			The parliament of the Republic of South Africa	preamble
			health workers	chapter 1 - 2.
			health establishments	chapter 1 - 2.
			the minister	chapter 1 - 3.
			National Health Council	chapter 1 - 3.

			National Department	chapter 1 - 3.
			Provincial Department	chapter 1 - 3.
			Minister of Finance	chapter 1 - 4.
			The head of the provincial department	chapter 2 - 9.
			Executive Council	chapter 2 - 18.
			Municipal council	chapter 2 - 18.
			Director-General	chapter 3 - 21.
			Deputy Minister of Health	chapter 3 - 22.
			municipal councillor	chapter 3 - 22.
			Deputy Directors-General	chapter 3 - 22.
			the Head of the South African Military Health Service	chapter 3 - 22.
			National Consultative Health Forum	chapter 3 - 24.
			Provincial Health Council	chapter 4 - 26.
			Provincial consultative bodies	chapter 4 - 28.
			Inspectorate for Health Establishements	chapter 6 - 47.
			Forum of Statutory Health Professional Councils	chapter 7 - 49.
			Office of Standards Compliance	chapter 10 - 78.
			police official	chapter 10 - 84.
			health officer	chapter 10 - 84.

Standards of practice of physiotherapy 2012

Theme	Category	Code	Quote	Reference
Context (Cultural)	Physiotherapy practice	physiotherapy practice basis	These standards provide the basis for physiotherapy practice in all settings, including but not limited to, clinics, hospitals, schools, and commercial premises.	page 4 - paragraph 2
		recognised required interpretation	It is recognised that some interpretation will be required based on the setting, resources and support systems available.	page 4 - paragraph 4
	Human resources	South African management and employment criteria	Criteria related to management and employment in South Africa	page 7 - under 3.4.3
	Ethics	working within SASP Code of Ethics	All clinical staff works within the SASP Code of Ethics	page 9 - under 3.11.5
		practice according to Code of Ethics	The physiotherapist must practice according to a Code of Ethics that is consistent with the WCPT, SASP's and HPCSA Ethical Principles	page 14 - under 9.1
Context (Situational)	High standards of physiotherapy	importance of standards development	the SASP recognises the absolute importance of the development and documentation of agreed standards for the practice of physiotherapy, in order to improve the health of the nation.	page 3 - paragraph 1
	Communication	communication links to optimise service qualities	Communication links exist between staff, the director/manager of the service, and the organisation to optimize the quality of the patient/client services provided.	page 6 - under 3.3.1
		effective and appropriate services facilitated through communication	communication … facilitates the provision of effective and appropriate physiotherapy services.	page 10 - under 4.1

		patient / client awereness of findings	Patients/clienst … are given information … so that the patient/client is: aware of the findings of the examination/assessment	page 15 - under 10.3.1
		patient's opportunity to ask questions	Patients/clienst … are given information … so that the patient/client is: Given an opportunity to ask questions and discuss the preferred interventions/treatments, including any significant side effects, with the physical therapist	page 15 - under 10.3.2
		patient's right to decline treatment modalities	Patients/clienst … are given information … so that the patient/client is: Given the opportunity to decline particular modalities in the plan of intervention/treatment	page 15 - under 10.3.3
		patient's opportunity to discontinue intervention/treatment	Patients/clienst … are given information … so that the patient/client is: Given the opportunity to discontinue intervention/treatment	page 15 - under 10.3.4
		patient/client involvement and volunteering information	Patients/clienst … are given information … so that the patient/client is: Encouraged to be involved in the examination/assessment process and to volunteer information that may have a bearing on the physical therapy programme	page 15 - under 10.3.5
	Professional collaboration	meeting patients needs	The intervention/treatment: Is inter professional when necessary to meet the needs of the patient/client	page 17 - under 12.3.2.6
	Policies and procedures	discharge of patient/client (outline provided)	The physiotherapist discharges … when the anticipated goals or expected outcomes for the patient/client have been achieved.	page 18 - under 12.5.1
		treatment discontuance (details provided)	The physiotherapist discontinues ... when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy …	page 18 - under 12.5.2
Context (Structural)	Communication	corteous and considerate communication (examples given)	All communication must demonstrate privacy, transparency, respect, acknowledgment, collegiality and a spirit of mutual support. Communication should be courteous and considerate at all times.	page 11 - under 4.7
		discretion in discussion	The discretion of the physiotherapist is used in the discussion of the diagnosis with the patient/client	page 11 - under 4.3.2

	Cultural requirements	physiotherapy assesement based on … (examples given)	The physiotherapist's assessment of the patient's physical problems, while based on an analysis of movement and function, also takes account of the patient's culture, psychological and social status. The physiotherapist also assesses the environmental conditions affecting the client's functioning and well-being.	page 3 - paragraph 3
		cultural values in physiotherapy	Physiotherapy is planned and delivered in a way that respects cultural values, requirements and variations	page 13 - under 6.3
	Fiscal management	sound accounting principles	Fiscal planning and management of the service is based on sound accounting principles.	page 6 - under 3.4.1
		fair and reasonable fee schedule	Uses a fee schedule that is consistent with the cost of physiotherapy services and that is within customary norms of fairness and reasonableness	page 7 - under 3.4.2.5
	Global	WCPT objectives alignment	in line with the objectives of the World Confederation for Physiotherapy (WCPT)1	page 3 - paragraph 1
	High standards of physiotherapy	high standards encouragement	… by encouraging high standards of physiotherapy education and practice.	page 3 - paragraph 1
	Informed consent	treatment after receiving consent	Once consent has been received, the intervention/treatment plan may be instituted	page 15 - under 10.2
	Legal requirements	safe and accessible environment	a safe and accessible environment that facilitates fulfilment of the mission, purposes, and goals of the physiotherapy service.	page 7 - under 3.7.1
		safe and sufficient equipment	The equipment is safe and sufficient to achieve the purposes and goals of physiotherapy	page 7 - under 3.7.1
		physical setting (outline details provided)	The physical setting is planned, constructed, and equipped to provide adequate space and the proper environment to meet the professional, educational, and administrative needs of the service with safety and efficiency	page 8 - under 3.7.2
		health and safety legal requirements	The physical setting shall: meet all applicable legal requirements for health and safety	page 8 - under 3.7.3.1
		fire exit instructions	The physical setting shall: have fire exits that are clearly marked and kept free of obstruction	page 8 - under 3.7.3.2

		physical setting space requirements	The physical setting shall: meet space needs appropriate for the number and type of patients/clients served	page 8 - under 3.7.3.3
		physical setting reception requirements	The physical setting shall: provide reception and waiting facilities with consideration to people with disabilities	page 8 - under 3.7.3.4
		treatment areas (details provided)	The physical setting shall: provide treatment areas that offer privacy, security and comfort	page 8 - under 3.7.3.5
		relevant legislation	Legislation relevant to the practice of physiotherapy.	page 10 - under 3.12.3.3
		content of documentation is according to HPCSA regulation	Physiotherapists ensure that the content of documentation is according the HPCSA regulations (Booklet 15) so that the records are accurate, complete and legible, in permanent black ink, corrections to the record are initialled and finalised in a timely manner	page 13 - under 7.2
		legal storage of documentation	Documentation is … stored securely at all times in accordance with legal requirements for privacy and confidentiality of personal health information	page 13 - under 7.3.1
		retainment of records according to policies and legislation	Records are retained in accordance with existing policies and current legislation	page 13 - under 7.3.2
		obtaining consent	The physiotherapist obtains the consent of the patient/client prior to touching the patient/client in any part of the patient/client management process	page 15 - under 10.4.1
		written consent before teaching / research paricipation	The physiotherapist obtains written consent of the patient/client for participation in teaching of physical therapy and in physical therapy research	page 15 - under 10.4.2
	Physiotherapy practice	structured and managed physiotherapy services	Physiotherapy practice is more than direct patient/client contact; it includes how services are structured, managed and delivered and collaboration is essential to delivering high quality physiotherapy services. These standards reflect this.	page 4 - paragraph 5
	Policies and procedures	application of standards (details provided)	These standards apply to all physiotherapists, whether newly qualified or highly specialist, in direct or indirect contact with patients/clients, carers, and other professional colleagues.	page 4 - paragraph 5

		supervision policies and directives	Supervision of physiotherapy assistants, community rehabilitation workers, students and support staff is arranged in accordance with national policies and directives	page 7 - under 3.4.3.1
		annual revision of the mission statement, purposes and goals	The statement of mission, purposes, and goals: Is reviewed annually	page 7 - under 3.5.2.2
		regular review and revision of policies	The written policies and procedures: Are reviewed regularly and revised as necessary	page 8 - under 3.9.2.1
		legal requirements for written policies	The written policies and procedures: Meet the legal requirements	Page 8 - under 3.9.2.2
		patient details recording	Patient/client details are recorded on each sheet of the document	page 13 - under 7.2.2
		access to health records	The relevant person(s) is (are) aware that records may be accessed in accordance with health authority policy.	page 13 - under 7.3.2
		physiotherapy examiniation (details provided)	The physiotherapist examination: Is documented, dated, and appropriately authenticated by the physical therapist who performed it	page 16 - under 12.1.2.1
			The physiotherapist examination: Identifies the physical therapy needs of the patient/client	page 16 - under 12.1.2.2
			The physiotherapist examination: Incorporates appropriate tests and measures to facilitate outcome measurement	page 16 - under 12.1.2.3
			The physiotherapist examination: Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the establishment of a plan of care/interventions/treatment	page 16 - under 12.1.2.4
			The physiotherapist examination: May result in recommendations for additional services to meet the needs of the patient/client	page 16 - under 12.1.2.5
			The physiotherapist examination: Provides written evidence of the reasons why no further management has been given to the patient/client and, when appropriate, to the carer	page 16 - under 12.1.2.6

		plan of care/intervention (outline provided)	a plan of care ... based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions/treatments for identified disabilities (impairments, activity limitations and participation restrictions) and/or for prevention, health promotion, fitness, and wellness.	page 16 - under 12.2.1
			A plan of care/intervention/treatment: Is based on the examination, evaluation, diagnosis, and prognosis and informed by current evidence.	page 16 - under 12.2.4.1
			A plan of care/intervention/treatment: Identifies goals and outcomes	page 16 - under 12.2.4.2
			A plan of care/intervention/treatment: Describes the proposed intervention/treatment, including frequency and duration	page 17 - under 12.2.4.3
			A plan of care/intervention/treatment: Includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan	page 17 - under 12.2.4.4
			A plan of care/intervention/treatment: Appropriate and relevant outcome measures are identified at the initiation of intervention to be used in the monitoring of patient outcomes and informs the continued use of the intervention applied (critically assess the nature/suitability/appropriateness of the intervention)	page 17 - under 12.2.4.5
		intervention/treatment (outline provided)	The intervention/treatment: Is based on the examination, evaluation, diagnosis, prognosis, plan of care/intervention/treatment and informed by current evidence.	page 17 - under 12.3.2.1
			The intervention/treatment: Is provided by or under the ongoing direction and supervision of the physical therapist.	page 17 - under 12.3.2.2
			The intervention/treatment: Is provided in such a way that directed and supervised responsibilities are commensurate with the qualifications and the legal limitations of support personnel.	page 17 - under 12.3.2.3
			The intervention/treatment: Is altered in accordance with changes in response or status	page 17 - under 12.3.2.4
			The intervention/treatment: Is provided at a level that is consistent with current physiotherapy practice.	page 17 - under 12.3.2.5

			The intervention/treatment: Is dated and appropriately authenticated by the physical therapist	page 17 - under 12.3.2.8
			The intervention/treatment: cost and time effectiveness	page 17 - under 12.3.2.10
			The intervention/treatment: support the existing base of knowledge and research for the choice of intervention, including counselling, education, exercise, physical modalities, functional re-education and social integration.	page 17 - under 12.3.2.12
		re-examination (outline provided)	The physiotherapist re-examination: Is documented, dated, and appropriately authenticated by the physical therapist who performs it	page 18 - under 12.4.2.1
			The physiotherapist re-examination: Includes modifications to the plan of care/intervention/treatment	page 18 - under 12.4.2.2
		serviced and maintained equipment	Equipment in use is adequately serviced and maintained;	page 19 - under 12.10.8
		improvement plan (outline provided)	The improvement plan: provides evidence of ongoing review and evaluation of the physical therapy service	page 21 - under 14.4.1
			The improvement plan: provides a mechanism for documenting improvement in quality of care/services and performance	page 21 - under 14.4.2
			The improvement plan: is consistent with requirements of external agencies, as applicable	page 21 - under 14.4.3
			The improvement plan: includes specification of contracts with purchasers	page 21 - under 14.4.4
	Practice management	statutory requirements compliance	Ensure compliance with statutory requirements	page 5 - under 3.1.2.1
		compliance with current professional documents	Ensure compliance with current professional documents, including Standards of Practice for Physiotherapy and Code of Ethics	page 5 - under 3.1.2.2

		ensurance of physiotherapy service consistancy	Ensure that services are consistent with the mission, purposes, and goals of the physiotherapy service	page 5 - under 3.1.2.3
	Professional collaboration	health promotion prevention co-operation	In health promotion prevention physiotherapists co-operate with other professionals to improve environmental factors which may limit function and well-being.	page 3 - pargraph 4
		awareness of other professionals qualifications and roles	The physiotherapist shall be aware of the qualifications and roles of other professionals involved in comprehensive patient/client care/management ...	page 6 - under 3.2.2
		patient/client - physiotherapist agreement	Treatment plans, goals, and predicted outcomes are agreed upon between the patient/client and the physiotherapist and any changes in previously agreed intervention/treatment plans are discussed and agreed upon with the patient/client	page 11 - under 4.3.3
	(Support) personnel	staff appointment in accordance with Acts	The physiotherapy service has staff that: Are appointed in accordance with good employment practice and the Basic Conditions of Employment Act no 75 of 1997 and the BCE Amendment Act no 11 of 2002	page 9 - under 3.11.2.2
		supervision according to national policies and directives	supervised in accordance with national policies and directives and written evidence of this supervision is provided.	page 10 - under 3.11.6
		formal staff orientation	All staff are formally orientated to the work environment and practice procedures.	page 10 - under 3.11.9
		staff development plan (details provided)	The staff development plan: Includes self-assessment, individual goal setting, and organisational needs in directing continuing education and learning activities	page 10 - under 3.12.2.1
		life long learning strategies for staff development	The staff development plan: Includes strategies for lifelong learning and professional and career development.	page 10 - under 3.12.2.2
		mentorship in staff development mechanisms	The staff development plan: includes mechanisms to foster mentorship activities	page 10 - under 3.12.2.3

		support personnel (details provided)	The term support personnel is used in a generic sense to encompass a range of employment classifications such as assistant, aide, technician or helper;	page 22 - under 16.1
	Quality assurance	quality assurance program (outline provided)	A QA programme is a systematic evaluation of physiotherapy service, which facilitates continuous improvement. QA strives to achieve optimum care by means of the most appropriate and effective level of training, education, practice and ethical conduct in physiotherapy	page 20 - under 14.1
		service user satisfaction monitoring	Quality assurance activities focus on service user satisfaction by ensuring that: a system is in place for monitoring service user satisfaction	page 21 - under 14.5.1
		service user suggestions	Quality assurance activities focus on service user satisfaction by ensuring that: service users are invited to make suggestions about services provided	page 21 - under 14.5.2
		service user complaints procedure	Quality assurance activities focus on service user satisfaction by ensuring that: a complaints procedure exists including a system for response	page 21 - under 14.5.3
Actors (Interests and concerns)	(Support) personnel	support personnel training	Provide for training of physiotherapy support personnel that ensures continued competence for their job description	page 5 - under 3.1.2.5
		competend personnel	The physiotherapy personnel affiliated with the physiotherapy service have demonstrated competence	page 9 - under 3.11.1
		employee responsibilities	Staff members are aware of their responsibilities as employees ... and attend training sessions as necessary.	page 9 - under 3.11.3
		participation in QA programme	Staff participates in the quality assurance programme	page 9 - under 3.11.4
		working within training scope	All staff work within the scope of their training and job description.	page 10 - under 3.11.8
		appropriate insurance	All staff have the appropriate malpractice and public liability insurance cover.	page 10 - under 3.11.11

	Aspired standards of practice	details on covered standards (examples given)	Detail is provided on standards covering: administration and practice management, communication, community responsibility, cultural competence, documentation, education, ethical behaviour, informed consent, legal, patient/client management, personal/professional development, quality assurance, research and support personnel.	page 4 - pargraph 3
		achievable standards of practice	These standards are considered to be achievable Standards of Practice.	page 4 - pargraph 4
		ideal standards to aspire	ideal standards to which all physiotherapists should aspire to as part of their professional responsibility.	page 4 - pargraph 4
		collaboration to achieve standards	Some of these standards cannot be achieved without collaboration with appropriate colleagues from other professions and health service managers.	page 4 - pargraph 5
	Communication	ensurance of appropriate communication and availability (details provided)	The physiotherapy director/manager ensures the appropriate communication and availability of service specific and organisational policies, procedures and documents	page 6 - under 3.3.2
		knowledge of communication as integral part of every encounter	The physiotherapist knows that communication is an integral element of every patient/client and professional encounter	page 10 - under 4.1
		patient/client management communication / coordination	The physiotherapist communicates and coordinates all aspects of patient/client management	page 10 - under 4.2
		providing information to (details provided)	The physiotherapist provides the patient/client or parents, guardians, carers, or others designed to act on the behalf of the patient/client who is not competent, with relevant clear, concise written and verbal information	page 11 - under 4.3
		communication between colleagues	The physiotherapist communicates with other physiotherapists to ensure continuity of effective patient/client services	page 11 - under 4.5

		multi - professional team communication	The physiotherapist, when communicating with members of a multi professional team providing services for the patient/client, ensures that information is both sought and communicated promptly and clearly within the team	page 11 - under 4.6
		bridging language / communication barriers	The physiotherapist must acknowledge and attempt to bridge any language and communication difficulties which may present	page 13 - under 6.6
		education / consultation to professionals	The physiotherapist educates and provides consultation to other health professionals regarding the purposes and benefits of physical therapy.	page 14 - under 8.1
		education / consultation of general public	The physical therapist educates and provides consultation to the general public	page 14 - under 8.2
		treatment information to the patient/client	The physiotherapist shall inform the patient/client verbally and where required in writing, of the nature, risks, expected duration, and cost of intervention/treatment	page 15 - under 10.1
	Community physiotherapy services	physiotherapy in community settings	the physiotherapist should provide services in community settings with specific focus on rural, remote and other under-resourced areas	page 12 - under 5.3
	Cultural requirements	respect and sensitivity to people and communities	Physiotherapists must show respect and sensitivity to people and communities, taking into account their spiritual, emotional, social and physical needs	page 13 - under 6.2
	Documentation	patient/client management documentation	The physiotherapist clearly documents all aspects of patient/client care/management	page 13 - under 7.1
		health record elements at first entry	At the first entry on any health record by a physiotherapist, physiotherapy student or physiotherapy assistant, the full name and initials are clearly written.	page 13 - under 7.2.1
		proper use of documentation	Physiotherapists make sure that documentation is used properly	page 13 - under 7.3
	Fiscal management	resource planning and allocation	The director/manger of the physiotherapy service, in consultation with physiotherapy staff and appropriate administrative personnel participates in planning for, and allocation of, resources.	page 6 - under 3.4.1

	Legal requirements	legal complience in the jurisdiction	The physiotherapist complies with all the laws and legal requirements of the jurisdiction in which they practice and the body which regulates the practice of physical therapy	page 15 - under 11.1
		reporting of violations	The physiotherapist with first-hand knowledge shall report violations by physical therapy personnel of laws	page 16 - under 11.4
		Display of National Patient's Right Charter	The National Patient's Rights Charter is clearly displayed;	page 19 - under 12.10.6
		acces to protective clothing	Staff have access to protective clothing when necessary;	page 19 - under 12.10.9
		a safe practice environment	The physiotherapist provides an environment, which is clean and safe for patients and has equipment appropriate for the interventions being provided.	page 20 - under 12.11.1
	Patient rights	respecting wishes	the physiotherapist should respect the wishes of both the patient/client and carer.	page 11 - under 4.4
		patient's right to voice concerns	The patient has the right to voice any concerns regarding the state and quality of the service.	page 15 - under 10.5
		right to ask about treatment alternitives	The patient has the right to ask about treatment alternatives and to be told what is available in a manner, which they can understand.	page 15 - under 10.6
	Personnal professional development	professional devlopment and continuing education	Ensures professional development and continuing education	page 6 - under 3.2.3.3
		up to date professional skills and knowledge	The physiotherapist has a duty to keep up to date with professional skills and knowledge	page 10 - under 3.12.3
		regular self - evaluation	The physiotherapist engages in self evaluation on a regular basis	page 14 - under 8.4
	Practice management	provision of services according to policies	Review and updates policies and procedures and ensures that services are provided in accordance with them	page 5 - under 3.1.2.4
		in-service safety training and inspection	Provide for continuous in-service training on safety issues and for periodic safety inspection of equipment by qualified individuals	page 5 - under 3.1.2.6

		clinical practice evaluation	Undertake an evaluation of clinical practice	page 5 - under 3.1.2.7
		documentation of audit recommendations	Recommendations following audit are documented	page 5 - under 3.1.2.7.5
		availability of policies and procedures	All policies and procedures are available to staff	page 5 - under 3.1.3.5
	Professional collaboration	appropriate collaboration with professionals	The physiotherapy service collaborates with all professionals as appropriate.	page 6 - under 3.2.1
		awerness of other professional's qualifications	The physiotherapist shall be aware of the qualifications and roles of other professionals involved in comprehensive patient/client care/management	page 6 - under 3.2.2
		team approach	Uses a team approach to the care of patients/clients	page 6 - under 3.2.3.1
		providing instructions	Provides instruction of patients/clients and families	page 6 - under 3.2.3.2
		in-team prompt communication	Relevant information is sought and communicated promptly and clearly within the team	page 6 - under 3.2.4.1
		in-team cross-referral	cross referral to other professionals in the team, discharge, and transfer of patients/clients	page 6 - under 3.2.4.3
		professional participation (examples given)	participation in case conferences, rounds, individual patient/client programme meetings, discharge planning, and collaborative patient/client records	page 6 - under 3.2.4.4
		other collaboration (examples given)	Physiotherapists also need to collaboration with non-profitable organizations, municipal managers and community leaders.	page 6 - under 3.2.4.6
		care/intervention/treatment collaboration	The physiotherapist collaboratively involves the patient/client and others as appropriate in the planning, implementation, and assessment of the plan of care/intervention/treatment.	page 16 - under 12.2.2
		physiotherapy outcome education	The physiotherapist: educates physical therapists, students, other health professionals, and the general public about the outcomes of physical therapist practice	page 21 - under 15.4

	Research	application of research findings	The physiotherapist applies research findings to practice and encourages, participates in, and promotes activities that establish the outcomes of patient/client management provided by the physical therapist	page 21 - under 15.1
		conduncting and/or supporting research activities	conducting and/or supporting research activities by assisting those engaged in research	page 21 - under 15.2
	Scope of practice	interaction for physiotherapy service provision	The provision of physiotherapy services requires interaction between physiotherapist, patients or clients, families and caregivers	page 3 - paragraph 2
		skilled physiotherapist	The physiotherapist needs to be skilled … to prevent, cure and alleviate physical manifestations of somatic and psychological disease	page 3 - paragraph 4
		care/interventions/treatments plan establishment	The physiotherapist establishes a plan of care/interventions/treatments and manages the needs of the patient/client	page 16 - under 12.2.1
		discharge planning	The physiotherapist, in consultation with appropriate disciplines, plans for discharge of the patient/client ...	page 16 - under 12.2.3
		patient re - examination	The physiotherapist re-examines the patient/client as necessary ...	page 18 - under 12.4.1
		discharge from physical therapy service	The physiotherapist discharges the patient/client from physical therapy services	page 18 - under 12.5.1
		discontinuance of intervention/treatment	The physiotherapist discontinues intervention/treatment	page 18 - under 12.5.2
	Students	respect and consideration of students	Students are treated with respect and consideration at all times	page 12 - under 4.12.2
		respect for educators	Students have the responsibility of treating educators with respect and on a professional level	page 12 - under 4.12.3
		participation in student education	The physical therapist participates in the education of students	page 14 - under 8.5

Actors (Influence and power)	Practice management	physiotherapist responsibility of physiotherapy service direction	A physiotherapist is responsible for the direction of the physiotherapy service.	page 5 - under 3.1.1
	Scope of practice	promotion, prevention, treatment and rehabilitation	Physiotherapy focuses on maximising movement potential within the spheres of promotion, prevention, treatment and rehabilitation.	page 3 - paragraph 2
		physiotherapy view to diagnose and strategy planning	The physiotherapist's distinctive view of the body ... is central to determining a diagnosis and an intervention strategy	page 3 - paragraph 3
		initial examination/assessment	The physiotherapist performs an initial examination/assessment and evaluation to establish a diagnosis and prognosis prior to intervention/treatment.	page 16 - under 12.1.1
		provision / direction / supervision of intervention/treatment	The physiotherapist provides, or directs and supervises, the physical therapy intervention/treatment	page 17 - under 12.3.1
Process (Dealing with actors)	Cultural requirements	community responsibility	The physiotherapist takes an active part and demonstrates community responsibility	page 12 - under 5.1
		identification of cultural realities, knowledge and limitations	Physiotherapists should identify their own cultural realities, knowledge and limitations	page 13 - under 6.4
		recognition of patient's right (details provided)	The physiotherapist recognises that the patient/client has a right to discontinue treatment/intervention at any time.	page 18 - under 12.5.3
	Health data protection	Confidentiality of patient information	Physiotherapists must make sure that patient/client information and documentation is kept confidential in line with the HPCSA Booklet 9	page 13 - under 7.4
		patient's consent on information release	The physiotherapist shall not release patient information to a third party without consent of the patient/client or legal authorisation.	page 15 - under 11.3
	Legal requirements	HPSCA registration	The physiotherapist is registered at the HPCSA as independent practitioner that is granted for the legislative jurisdiction in which the physical therapist practices	page 15 - under 11.2

		confirmation with Act no 85	The physiotherapist (and/or physiotherapy service provider) conforms with the Occupational Health and Safety Act no 85 of 1993	page 19 - under 12.10.2
	Personal professional development	life long learning commitment	The physiotherapist demonstrates commitment to life long learning	page 14 - under 8.3
		individual professional development responsibility	The physiotherapist is responsible for individual professional development and must maintain a high level of professional competence	page 20 - under 13.1
		continuous knowlegde and skills update	The physiotherapist continues to update and extend their knowledge and skills	page 20 - under 13.3
		active participation in peer review system	The physiotherapist is an active participant of an appropriate peer review appraisal system in their workplace	page 20 - under 13.4
	Quality assurance	quality assurance commitment	The physiotherapist shall demonstrate commitment to quality assurance by peer review and self-assessment	page 21 - under 14.3
	Research	current literature knowledge	The physiotherapist: ensures that their knowledge of research literature related to practice is current	page 21 - under 15.3.1
		protection of rights and integrity	The physiotherapist: ensures that the rights of research subjects are protected, and the integrity of research is maintained	page 21 - under 15.3.2
		research participation	The physiotherapist: participates in the research process as appropriate to individual education, experience, and expertise	page 21 - under 15.3.3
		recognising research as professional development tool	The physiotherapist recognises research as an integral part in the continuing growth and development of the profession	page 21 - under 15.5
	Scope of practice	approches and techniques in the scope of practice	all approaches and techniques applied being in the scope of physiotherapy practice.	page 17 - under 12.3.2.13
		referral to other practitioner/professional for findings outside scope of practice	Where the examination, diagnostic process, or any change in status reveals findings outside the scope of knowledge, experience, and/or expertise of the physical therapist, the patient/client shall so be informed and referred to the appropriate practitioner/professional	page 18 - under 12.7.1

		qualified management of patients needs	the patient shall be informed and assisted in identifying a qualified person to provide the necessary service and/or the physiotherapist will seek the advice of a senior colleague to assist with the patient's management	page 20 - under 13.6
	Support personnel	attending of safety training	Staff attends necessary health and safety training sessions, according to the relevant act	page 19 - under 12.10.11
		support personnel identification	Support personnel must be clearly identified as 'support personnel'	page 22 - under 16.2
		supervision of support personnel	Support personnel must at all times be under the direction and supervision of the physiotherapist when implementing direct interventions/treatment.	page 22 - under 16.3
		prohibition of delegating physiotherapy activities to support personnel	The physiotherapist should not delegate any activity that requires the unique skill, knowledge, and judgment of the physical therapist.	page 22 - under 16.4
Process (Strategy)	Quality assurance	quality improvement plan	The physiotherapy service has a written plan for continuous improvement of quality of care and performance of services	page 21 - under 14.2
		Quality assurance focus on service user satisfaction	Quality assurance activities focus on service user satisfaction	page 21 - under 14.5
	Support personnel	support personnel training	training of physiotherapy support personnel that ensures continued competence for their job description	page 5 - under 3.2.1.5
Content (Policy design)	Policy Design	Policy structure outline	Table of contents ...	page 2
		usable tool	The Standards of Practice document is a tool that may be used by physiotherapists, patients/clients2 members of the public, managers, and others who have an interest in providing or receiving high quality physiotherapy services.	page 5 - paragraph 1
Content (Objectives)	(support) personnel	sufficient staff	The physiotherapy personnel … are sufficient in number to achieve the mission, purposes, and goals of the service.	page 9 - under 3.11.1

		staff meeting legal requirements (details provided)	The physiotherapy service has staff that: Meet all legal requirements regarding licensure, registration and certification of appropriate personnel	page 9 - under 3.11.2
		level of expertise appropriate to service needs	Ensure that the level of expertise within the service is appropriate to the needs of the patients/clients served	page 9 - under 3.11.2.3
		provision to CPD activities	There is evidence that employers provide opportunity for employees to develop and grow professionally, and to attend accredited courses and/or other CPD activities	page 20 - under 13.5
	Communication	coordination and communication of all aspects of patient/client management	The physiotherapist communicates and coordinates all aspects of patient/client management …	page 10 - under 4.2
		provision of written information	Appropriate written information must be provided to all relevant parties.	page 11 - under 4.8
		communication links	There is evidence of clear communication links between employing body, management and members of staff.	page 11 - under 4.9.1
		communication of policies and procedures	All policies and procedures of the organisation are communicated to staff.	page 11 - under 4.9.2
		communication procedure	There is a procedure for communication between the different organisations and bodies.	page 12 - under 4.10.1
		communication links	There is evidence that the role of physiotherapy is maximised through links between the profession, public and the media.	page 12 - under 4.13.1
		intervention/treatment information	Patients/clients, wherever possible, are given information as to the physical therapy interventions/treatments proposed	page 15 - under 10.3
	Cultural requirements	corporate social responsibility	Corporate Social Responsibility is an ethical or ideological theory that an entity whether it is a government, corporation, organization or individual has a responsibility to society. Where possible, physiotherapists should contribute to this concept.	page 12 - under 5.2
		attention to vulnerable groups	Special attention should be given to vulnerable groups such as those displaced by political violence, victims of crimes, rape, domestic abuse, HIV/AIDS sufferers and orphans and all persons with disabilities	page 12 - under 5.4

		outcomes through cultural understanding	The physiotherapist should acquire skills to better understand people from differing cultures in order to achieve the best possible health outcomes	page 13 - under 6.1
		acknowlegdement of physiotherapists' cultural values	The cultural values of the physiotherapist are acknowledged and respected	page 13 - under 6.5
	Education	equiped to provide evidence based training	The physiotherapist must: be equipped to provide training to physiotherapy assistants, community rehabilitation workers and students which is based on researched evidence of good practice.	page 14 - under 8.6.1
		equiped to supervise and / or assess	The physiotherapist must: be equipped to supervise and / or assess physiotherapy assistants / technicians and students in clinical areas by attending relevant information and training sessions	page 14 - under 8.6.2
		adequate control and responsibilities	The physiotherapist must: have adequate control and be responsible for the effectiveness and safety of patient care of evaluations and treatments done by physiotherapy assistants / technicians and students under his/her supervision.	page 14 - under 8.6.3
	Equipment	equipment's legal requirements	The equipment meets all applicable legal requirements for health and safety and accessibility.	page 8 - under 3.8.1
		equipment's inspection and maintanance	The equipment is inspected and maintained routinely.	page 8 - under 3.8.2
	Fiscal management	fiscal managagement plan (examples provided)	The fiscal management plan: Includes a budget that provides for optimal use of resources	page 7 - under 3.4.2.1
		financial recording and reporting	Ensures accurate recording and reporting of financial information	page 7 - under 3.4.2.2
		compliance with legal requirements	Ensures compliance with legal requirements	page 7 - under 3.4.2.3
		cost-effectiveness	Allows for cost-effective utilization of resources	page 7 - under 3.4.2.4
		consideration of pro bono service	considers option of providing pro bono service	page 7 - under 3.4.2.6

		transport and indemnity arrangements	Legal opinion regarding transport arrangements and indemnity is obtained	page 7 - under 3.4.3.3
	Mission statement	physiotherapy service mission statement, purposes and goals	The physiotherapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the patients/clients served, the physiotherapy personnel affiliated with the service, and the community.	page 7 - under 3.5.1
	Organisation plan	physiotherapy service written organisational plan (outlines provided)	The physiotherapy service has a written organisational plan ...	page 7 - under 3.6.1.1
	Personnal professional development	appropriate management training	Appropriate management training.	page 10 - under 3.12.3.4
		identification of learning needs	The physiotherapist identifies their learning needs	page 20 - under 13.2
	Physical setting	safe accessible setting	The physical setting is designed to provide a safe and accessible environment that facilitates fulfilment of the mission, purposes, and goals of the physiotherapy service.	page 7- under 3.7.1
	Policies and procedures	alligment of policies to services mission, purposes and goals	The physiotherapy service has written policies and procedures that reflect the mission, purposes, and goals of the service, and are consistent with the WCPT Member Organisation's standards, policies, positions, guidelines, and Code of Ethics.	page 8 - under 3.9
		policies and driectives of supervision (examples gviven)	Physiotherapy assistants/technicians, community rehabilitation workers, students and support staff are supervised in accordance with national policies and directives and written evidence of this supervision is provided.	page 10 - under 3.11.6
		early and respectful communication	Communication with the patient's family, caregivers and/or community leaders is recommended and should be made at the earliest opportunity and the physiotherapist should respect the wishes of both the patient/client and carer.	page 11 - under 4.4
		reference to health policies relevant to physiotherapy	There is evidence of reference to the national, provincial and district health policy documents relevant to physiotherapy.	page 12 - under 4.11.2
		appropriate partnerships	There is evidence of partnerships with appropriate non-government health organisations	page 12 - under 4.11.3

		operational policies (examples given)	Operational policies should exist for the following: Cross-referral to other professionals in the team, including colleagues with specific interests, Transfer/Discharge	page 11 - under 4.6.3.1 and 4.6.3.2
		intervention documentation consistent with guidelines	Documentation of the intervention is consistent with established guidelines	page 17 - under 12.3.2.7
		intervention/treatment according to primary health care	intervention/treatment: should be according primary health care: accessibility, affordability and appropriateness	page 17 - under 12.3.2.11
		patient/client management collaboration process	Within the patient/client management process, the physical therapist and the patient/client establish and maintain an ongoing collaborative process of decision-making that exists throughout the provision of services.	page 18 - under 12.6
		referral system to specialists	A referral system should be in place to other clinical specialists.	page 18 - under 12.7.2
		procedure for patients/clients transfer	A procedure should be in place for the transfer of patients/clients.	page 18 - under 12.7.3
		promotion of individual well-being	There is evidence that: The optimal well-being of each individual is promoted.	page 18 - under 12.8.1
		identification of needs	There is evidence that: Group or individual needs and potentials are identified and agreed upon.	page 18 - under 12.8.2
		identified, implemented and monitored program	There is evidence that: A program is identified, implemented and monitored.	page 18 - under 12.8.3
		appropriate means of communication	There is evidence that: Appropriate media for means of communication are identified and utilised.	page 19 - under 12.8.4
		evaluation of program	There is evidence that: The effect of the program is evaluated	page 19 - under 12.8.5
		established structures for program sustainability	There is evidence that: Structures are established to sustain the programme.	page 19 - under 12.8.6

		strategies for prevention (examples given)	There is evidence that: Strategies for the prevention of the development of potential impairment in individuals or groups at risk exist.	page 19 - under 12.9.1
			There is evidence that: Strategies for the prevention of primary, secondary and tertiary complications, disability or disease exist.	page 19 - under 12.9.2
		identification of risk factors	There is evidence that: Group or individual needs or risk factors are identified and agreed.	page 19 - under 12.9.3
		wheelchair access	Access is suitable for all consumers including those in wheelchairs	page 19 - under 12.10.3
		parking for disabled people	Parking for disabled people is available in close proximity to the entrance to the facility	page 19 - under 12.10.4
		accessible toilet facilities	Toilet facilities are easily accessible;	page 19 - under 12.10.5
		weapon safety	All weapons are secured in a safe place;	page 19 - under 12.10.7
	Policy objectives	policy objectives summary	ADMINISTRATION AND PRACTICE MANAGEMENT COMMUNICATION COMMUNITY RESPONSIBILITY/SOCIAL RESPONSIBILITY CULTURAL COMPETENCE AND SAFETY DOCUMENTATION EDUCATION ETHICAL BEHAVIOR INFORMED CONSENT LEGAL REQUIREMENTS PATIENT / CLIENT MANAGEMENT AND CARE PERSONAL/PROFESSIONAL DEVELOPMENT QUALITY ASSURANCE RESEARCH	page 5 page 10 page 12 page 13 page 13 page 14 page 14 page 15 page 15 page 16 page 20 page 20 page 21

	Practice management	available job descriptions	Job descriptions are available for all members of staff.	page 10 - under 3.11.7
		staff performance apprailsal	Staff performance appraisals are conducted at least annually.	page 10 - under 3.11.10
		mentorship activities	Includes mechanisms to foster mentorship activities	page 10 - under 3.12.2.3
		faciliating available clinical expertise	facilitates the use of available clinical expertise.	page 11 - under 4.5
		information on communication channels and procedures	There is evidence that all registered physiotherapists, physiotherapy students and physiotherapy assistants are informed of the communication channels and procedures.	page 12 - under 4.10.2
	Professional collaboration	referral system	A referral system is in place to ensure that patients/clients can access a physiotherapist either by direct access or from an appropriate referral source.	page 9 - under 3.10.1
	Quality assurance	high standards of physiotherapy education	The South African Society of Physiotherapy (SASP) … strives to improve the quality of South African healthcare by encouraging high standards of physiotherapy education and practice.	page 3 - paragraph 1
		high quality physiotherapy	The Standards of Physiotherapy Practice are the SASP's statement of performance and conditions that it expects physiotherapists to aspire to in order to provide high quality physiotherapy professional services to society.	page 4 - paragraph 2
	Research	physiotherapy science advancement	The physiotherapist shall advance the science of physical therapy	page 21 - under 15.2
		knowledge of research principles and methodology	The physiotherapist conducting a research project has sufficient knowledge of research principles and methodology and adheres to international standards for performing research on human subjects.	page 21 - under 15.6
Content (Specific mechanisms)	(support) personnel	staff performance apprailsal	Staff performance appraisals	page 10 - under 3.11.10

		plan for staff development	The physiotherapy service has a written plan that provides for appropriate and ongoing staff development.	page 10 - under 3.12.1
		mentorship mechanisms	mechanisms to foster mentorship activities	page 10 - under 3.12.2.3
	Communication	team communication system	A system is in place for written communication with other members of the team	page 6 - under 3.2.4.2
		framework for communication	a written framework for communication with other members of the team.	page 11 - under 4.6.2
		procedure for communication with authorities	There is a procedure for communication with national, provincial and district health authorities.	page 12 - under 4.11.1
	Guidelines	SOPP guidelines (examples given)	This SOPP also establishes guidelines for basic and reasonable practice in terms of physiotherapy practice, as well as the proposed scopes of practice for the two-year physiotherapy technician training and four-year physiotherapy degree training.	page 4 - paragraph 3
	Legal requirements	imposed malpractice and liability insurance	the appropriate malpractice and public liability insurance cover.	page 10 - under 3.11.11
		documentation of consent	The physiotherapist shall document in the clinical notes when consent is received, implied, or expressed	page 15 - under 10.2
	Organisation plan	written organisational plan	The physiotherapy service has a written organisational plan	page 7 - under 3.6
	Personal professional development	continuous professional development	professional development and continuing education	page 6 - under 3.2.3.3
		professional and career development	professional and career development	page 10 - under 3.12.2.2
		HPCSA's CPD initiative	The HPCSA’s continuing professional development CPD initiative	page 10 - under 3.12.3.1
		life long learning (outline provided)	life long learning by participating in continuous professional development activities related to their specific field of practice, ethical and medico legal practice and basic life support	page 14 - under 8.3

		self evaluation	self evaluation	page 14 - under 8.4
		evidence based practice	evidence based practice	page 20 - under 13.3
		peer review appraisal system	peer review appraisal system	page 20 - under 13.4
		accredited courses	accredited courses	page 20 - under 13.5
	Policies and procedures	quality assurance programme	the quality assurance programme	page 9 - under 3.11.4
		quality assurance activities	quality assurance activities	page 9 - under 3.11.4
		treatment plans	Treatment plans	page 11 - under 4.3.3
		operational policies	Operational policies	page 11 - under 4.6.3
		case conference	case conference,	page 11 - under 4.6.4
		ward rounds	ward rounds	page 11 - under 4.6.4
		student in training communication procedure	There is a procedure for communication between all involved in student training.	page 12 - 4.12.1
		consent procedure for 'not competent patients'	For patients/clients who are determined not competent to give informed consent ... consent is obtained wherever possible from parents, guardians, carers, or others designed to act on their behalf	page 15 - under 10.4
		procedures prior to treatment	INITIAL EXAMINATION/ASSESSMENT, EVALUATION, DIAGNOSIS, AND PROGNOSIS	page 16 - under 12.1

		outcome measurement	outcome measurement	page 16 - under 12.1.2.3
		intervention/treatment	INTERVENTIONS/TREATMENT	page 17 - under 12.3
		biopsychosocial model	biopsychosocial model	page 17 - under 12.3.2.9
		re-examination	RE-EXAMINATION	page 18 - under 12.4
		termination of intervention/treatment	DISCHARGE/DISCONTINUATION OF INTERVENTION/TREATMENT	page 18 - under 12.5
		patient/client collaboration	PATIENT/CLIENT COLLABORATION	page 18 - under 12.6
		referral	REFERRAL	page 18 - under 12.7
		emergency call system	An emergency call system is in place;	page 19 - under 12.10.10
		documentation and reporting of staff related patient injuries	All accidents, injuries and potential injuries to patients and staff to be reported and documented	page 19 - under 12.10.13
	Practice management	in-service stafety training	in-service training on safety issues	page 5 - under 3.1.2.6
		safety inspections	periodic safety inspection of equipment by qualified individuals	page 5 - under 3.1.2.6
		multi-professional audit	multi-professional audit	page 5 - under 3.1.2.7.4

		staff job description and appraisal system	A job description for each staff member and a formal appraisal system	page 5 - under 3.1.3.1
		staff meetings	Regular staff meetings	page 5 - under 3.1.3.2
		annual report	Annual report	page 5 - under 3.1.3.3
		organisation chart	an organisation chart	page 5 - 3.1.3.4
	Professional collaboration	operational policies	Operational policies exist for cross referral to other professionals in the team, discharge, and transfer of patients/clients	page 6 - under 3.2.4.2
		consultation to other professionals	consultation to other health professionals regarding the purposes and benefits of physical therapy.	page 14 - under 8.1
	Quality assurance	systematic evaluation of physiotherapy service	a systematic evaluation of physiotherapy service	page 20 - under 14.1
		improvement plan	The improvement plan	page 21 - under 14.4

Actors	Stakeholders	Health education collaborators	students	page 7 - under 3.4.3.1
			educational institutions	page 12 - under 4.12
			educators	page 12 - under 4.12.3
		International organisation	the World Confederation for Physiotherapy (WCPT)	page 3 - paragraph 1
			international organisations	page 11 - under 4.10
		Patients/clients or their legal representatives	patients	page 3 - paragraph 2
			clients	page 3 - paragraph 2
			families	page 3 - paragraph 2
			caregivers	page 3 - paragraph 2
			society	page 4 - pargraph 2

			members of the public	page 5 - paragraph 1
			parents	page 11 - under 4.3
			guardians	page 11 - under 4.3
			vulnerable groups	page 12 - under 5.4
			consumers	page 14 - under 8.2
			patients/clients who are determined not competent to give informed consent	page 15 - under 10.4
			purchasers	page 21 - under 14.4.4
		Physiotherapy association	The South African Society of Physiotherapy (SASP)	page 3 - paragraph 1
		Physiotherapy practice collaborators	physiotherapist	page 3 - paragraph 2
			support personnel	page 4 - paragraph 3
			The physiotherapy manager	page 5 - under 3.1.3
			staff	page 5 - under 3.1.3.1
			administrative personnel	page 6 - under 3.4.1
			physiotherapy assistants	page 7 - under 3.4.3.1
			support staff	page 7 - under 3.4.3.1
			The physiotherapy service	page 7 - under 3.5.1
			physiotherapy personnel	page 9 - under 3.11.1
			Physiotherapy assistants/technicians	page 10 - under 3.11.6
			a multi professional team	page 11 - under 4.6
		South African Health organisation collaborators	health service managers	page 4 - paragraph 5
			managers	page 5 - paragraph 1
			non-profitable organizations	page 6 - under 3.2.4.6
			municipal managers	page 6 - under 3.2.4.6
			community leaders	page 6 - under 3.2.4.6
			community rehabilitation workers	page 7 - under 3.4.3.1
			community rehabilitation workers	page 10 - under 3.11.6

			HPCSA	page 10 - under 3.12.3
			statutory bodies	page 11 - under 4.10
			agencies	page 11 - under 4.10
			employment bodies	page 11 - under 4.10
			governmental and non-governmental organisations	page 12 - under 4.11
			national, provincial and district health authorities	page 12 under 4.11.1
			government	page 12 - under 5.2
			corporation	page 12 - under 5.2
			organization	page 12 - under 5.2
			community organisations	page 14 - under 8.2

APPENDIX G

Interview A

20190114_Interview transcript.
Number: 01

Abbreviations used:
Q: Interviewer
R: Respondent

(Introduction)
Q: Good evening, I wish to thank you for participating in this interview for my study at the university of the Witwatersrand. I am Tim Németh, physiotherapist, private practitioner in Belgium and as mentioned a student at the university in Johannesburg.

This is a qualitative research focusing on the physiotherapy policy framework in Belgium and South Africa. I have explained the recording of this interview. You have given your written consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as frowning of the eyebrows or explicit head movements will be observed too. For this observation Prof. Raf Meesen is present. Prof. Meesen is one of my promotors and he will function as an observer during the interview. He will register the non-verbal communication.

The recorded interview will be transcribed, and the non-verbal communication will be integrated. Afterwards the text will be e-mailed to you for verification. After your final approval the written document will be used in my study. Do you agree with this procedure?

R: Yes, I still agree.

Q: Do you have any other questions before we start with the interview?

R: One question relating to your promotor present, but you have answered this in your introduction.

(opening question)
Q: In that case I suggest starting with the interview. Can you please state your age and profession?

R: Yes, I am 67 years and my profession is professor emeritus in anatomy and applied biomechanics, former director in institutes for higher education for physiotherapy in Belgium and Switzerland, former vice-dean and dean of the faculty Sports Education and Physiotherapy at the VUB and for many years coordinator of the master after master course in manual therapy at the VUB.

(Introduction questions)
Can you describe your key role / position / mandate in the physiotherapy policy framework in Belgium?

R: I want to limit myself to the most recent. This is the key role in the period 2013 – 2018 as president of the Federal Council for Physiotherapy (FRK). The task to, in this function, advise, the minister of Public Health in matters relating to physiotherapy. The offered advises included amongst others, policy elements to create a deontology organ for physiotherapy, the installation of the special professional competences in physiotherapy, a plan for direct access in physiotherapy in certain circumstances, the reformation of the Royal Decree (RD) number 78, care paths in physiotherapy, evidence-based physiotherapy application and the physiotherapy professional competence profile anno 2020.

Q: Thank you. You have in the meantime answered my planned next question to find out what your main responsibilities are in your mandate. I will therefor continue with one of my core questions.

(core questions)
Q: It is important, in light of my study, to know the policy development process for physiotherapy in Belgium. I would like you to elaborate on the process of policy development for physiotherapy. How can suggestions be done? What is the procedure for adaptations in current legislation?

R: Which instance wishes to develop physiotherapy policy? First, we have the government, wishing to adapt health care to the needs of today. Secondly the professional association striving towards and optimal application ***(nods in approval)*** and decent remuneration of the profession. And thirdly the universities and institutes for higher education in physiotherapy wanting to streamline the physiotherapy education in function of progress and innovation, with the implementation of findings from scientific research in the field. Each of the mentioned instances strives towards a qualitative application of the profession. This they have in common.

Physiotherapy in our country does not ***(emphasises)*** have a unique or central organ responsible for policy development in physiotherapy. On the other hand, certain policy aspects, also for physiotherapy, are developed on a federal level and on the level of the language communities. ***(Very short pause)*** Besides the mentioned instances diverse stakeholders could be interested in physiotherapy policy development such as organisations for physicians, the High Council for small enterprises and self-employed professions, patient associations and possible others.

For the implementation of physiotherapy policy, you need a fine balance between top down and bottom up streamlined policy elements. Finally, in one way or the other ***(emphasises)*** you need political initiative and/or political support, because policy should result in the end in rules and legislation.

I want to start with the top down policy. Standard setting in Public Health is mainly a federal competence, in casu the Federal Government Service (FOD) Public Health, Safety of the Food chain and Environment. Since the sixth reformation of the state, the language communities are responsible for the application of the norms relating to Public Health. For example, regulation regarding special professional competences in physiotherapy are ordained by RD and ministerial decrees, the recognition of the special competences however, happens through the recognition commission of the Flemish and French Community.

Just as is the case for a number of other health care professions, physiotherapy is regulated through Chapter 3, Art 43-44 of the 'Coordinated Law regarding the practice of health care professions' of 10 May 2015. This law is the successor of the better-known KB no 78, a royal decree with legislative powers. Since the law on the exercise of physiotherapy, sometimes abbreviated WUK, was in-acted in 1995, physiotherapy has a professional statute and physiotherapy was put in a separate chapter of the KB no 78, later the coordinated law. As such physiotherapy does no longer belong to the para-medic professions. ***(Looks up affirmative)*** A physiotherapist needs to follow at least an education of 4 years at a university or an institute for higher education and he is responsible for conceiving the physiotherapy treatment. In the WUK, the National Board for physiotherapy was installed, an advisory board advising the minister of public health whenever he or she has question relating to physiotherapy or providing advice on its own initiative. This could also include advice relating to physiotherapy education, a competence belonging to the language communities. In 2014, the National Board was converted to the Federal Council for physiotherapy after the sixth reformation of the state. In the council physiotherapists and physicians have a mandate,

appointed by KB after put up for candidacy by the professional associations and/or the universities. Through this council policy advices could emerge from the health care profession, taking into account the evolution in the field and scientific research. Input and expertise from physiotherapists towards the government is a must. ***(emphasises with short hand gestures)***

The WUK has provided the physiotherapist in our country with a legal statute. In the field however it is a pity that physiotherapists are still repeatedly seen as para-medic, a recent example is of this is the description and classification of physiotherapy in the Collective Work. ***(frowns eyebrows in doubt)***

Agreement (CAO) of 11 December 2017 regarding the new fee scale model for health care services. The Federal Council for physiotherapy, OVUNOKI and Axxon have together reacted on this, illustrating the possibility of a good collaboration relating to policy elements for physiotherapy between the Federal Council, professional associations and universities. ***(nods in agreement)***

The current Minister of Public health States that the formal Royal decree number 78, adapted in the coordinator law regarding the exercise of healthcare professions of 10 May 2015, on many issues it's not accurate any more. This statement we can fully support relating to physiotherapy. **(sighs)** The Federal Council has documented this in numerous ***(emphasises)*** advices.

For the execution of the coalition agreement the services of the minister are working on new regulation relating to the health care professions on one hand and qualitative exercise of the professional practice in healthcare on the other hand.

A couple of predetermined attention points relating to top down policy elements: a thorough reformation in line with the current and the future approach of healthcare including the exercise in a preventive context ***(emphasises)***, a central position and autonomy of the patient, 'patient empowerment', valorisation of the professional competences of the healthcare professionals, Quality and safety in care, a framework for interdisciplinary exercise and the creation of professional competence profiles with a positive description targeting the competences of the profession aligning as much as possible with the European tendencies, undiminished the international insights, encompassing a sufficient broad basis, looking after a broad employability, with attention to collaboration with other healthcare professionals, with the tension for healthcare in all lines and settings, thinking of chronic diseases, poly-pathology and long during to lifelong care trajectories, addressing the possible autonomous exercise of the profession leaving enough space for future revolution. What I have just now indicated is from the letter of the Minister of Public health to the federal councils de dato 5 November 2015 and can be notulated as documentation relating to top-down policy elements.

These policy elements ***(looks up)*** were applauded in the Federal Council and were given detailed form in 'the professional competence profile of the physiotherapist in Belgium anno 2020', which was approved by the Council on April 14, 2016.

A second Federal governmental arena, and this kind of relates to your question on nomenclature, is the federal governmental service of social affairs, where physiotherapy is a part of the technical council where amongst other things issues relating to the Nomenklatura are treated. RIZIV and insurance companies are authority stakeholders ***(looks up)***.

Although the federal government service public health and the federal government service social affairs at this moment reside under the competences of the same minister, there is a strict separation of competences between the departments and the professionals regret ***(emphasises)*** there isn't more communication between both instances when it comes to policy development for physiotherapy. ***(sighs)*** The federal government services public-health

discourage the Federal Council, or discouraged I should say, to formulate advisors on the matter mainly situated in the competences of the federal government services social affairs. For example, the advisors we have formulated relating to care paths.

Governmental competences relating to education are then again residing under the language communities, more particular under the respectively ministers of education. This made it necessary to adapt of the contents of the professional competence profile of the physiotherapist in Belgium anno 2020 for the ministry of education of the Flemish community in a professional qualifications dossier ***(emphasises strongly)*** which is a totally different format.

Many initiatives relating to physiotherapy policy will only fully succeed when physiotherapy expertise was sought. ***(spoken in a determined voice!)***

This brings me to the second part, bottom-up advice relating to policy. Seeing that within the governments, opposed to some of the other healthcare professions, no civil servants all advisors are functioning with a physiotherapy background. Bottom up the advice relating to physiotherapy is very important. In current days it is essential ***(emphasises)*** that expert, responsible and well substantiated advice is transmitted from the professionals.

There are several ways for bottom up advice relating to physiotherapy and I will give you some examples.

Relating to Dutch education and research: Flemish universities with OVUNHOKI as umbrella of the University educational institutes for physiotherapy directed to the Flemish inter-University Council, directed to the minister of education or directly from OVUNHOKI or the universities towards the Flemish minister of education.

Relating to French education and research a slightly different pattern, but also from universities and the high schools of the French community towards their *Académie de Recherche et d'Enseignement Supérieur (ARES)*; this umbrella organisation is not exclusively for physiotherapy; directed to the ministry of education of the French community. But also, directly from the ARES working group physiotherapy or from the educational institutes directed to the ministry of education.

We also have the technical council directed to the federal government services social affairs.

There is the working group physiotherapy of the planification commission in public health which advises the planification commission Medical Fields and then again towards the federal government services public-health.

There is our Federal Council for physiotherapy directed to the federal government services public-health. The Federal Council is composed out of physiotherapists nominated by a professional associations and educational institutes and has also composed out of physicians, nominated by their professional associations. It is important to mention ***(looks up)*** that the Federal Council for physiotherapy has different working groups, to which experts can be invited. The scientific commission of the Federal Council for physiotherapy is one of the working groups of the council.

Then there is also the possibility for the professional associations work directly towards the cabinets of the involved ministers.

There are different ad hoc commissions dealing with certain themes with representatives from diverse Health care professions; for example, for the implementation of eHealth.

Q: In this outlined elaborate framework there are no doubt strong points. I am now in particular interested in aspects which are favourable for physiotherapists. Can you please

give me your opinion on these strong points, in favour of physiotherapists in the outlined system?

R: I have counted 4 strong points. Physiotherapy has a professional statute with a separate chapter in the coordinated law relating to the exercise of health care professions off 10 May 2015. This was a positive evolution for a profession. Physiotherapy education in Belgium is regulated on a master level, in other words on level 7 of the European qualification's framework, so EQF 7. The physiotherapist is highly qualified. Belgium participates strongly in scientific research. ***(emphasises)*** One can see this as two points, but I see it as one because everything is linked to each other. Physiotherapy is embedded in the system of social security. This is also a strong point. ***(nods affirmatively)*** The policy instances are showing a common interest for qualitative application of physiotherapy in practice and for qualitative education and research in physiotherapy. ***(looks up and emphasises)***

Q: You have now outlined a reasonable number of points which are elements in favour of physiotherapy. Can you please provide me with your expert opinion on the system itself? The system of you have just described with the different councils and commissions. Do you find some strong points which can be used by physiotherapists within the framework?

R: Can you please reformulate to the question?

Q: For the strong points I have asked for, you have provided me with elements in the current system. Besides that, I am in particular interested in the system itself. How can this be experience as a good system through the eyes of the physiotherapists? What are the possibilities for a physiotherapist within the system? To aid you I will formulates my next question. In every system, also on the system you have outlined, there are gaps for procedures which are less favourable. Within all councils and commissions on the current system here in Belgium there are no doubt some gaps which cannot be filtered by physiotherapists in their current functions on current statutes. It was in that same regards I wanted to know some of the positive aspects of the system.

R: Yes, I have developed the positive items relating to the system any expert opinion mostly in point 4. Are we coming back to that later?

Q: We can certainly do that.

R: In that case I will describe the gaps. There is no ***(emphasises)*** central organ for physiotherapy policy development. Which insures on one hand a pretty large accent on top down policy and are bottom-up advises relating to physiotherapy policy development handed in through diverse channels ***(raises his shoulders)***, either on demand of the Minister or out of initiative of the professionals. The fact that this is organised out of different channels isn't positive. ***(looks up and emphasises)*** Following different channels comes from the fact relating to matters treated: for instance issues relating to policy within public health, which is the federal mater, aspects relating to policy within social affairs, also federal matter, what has to be through a different channel, aspects relating to structural changes of education and to the formulation offer domain specific teaching results, this is a policy on the domain of the ministries of education. There is a consultation between the governments, but this leads me to a second point which is a gap, and which is negative.

Certain policy elements demand consultation between the federal governments and the community governments. The fragmentation of competences in our country makes it difficult or is an inhibitory factor. ***(sighs)*** A real-life example as the reformation of physiotherapy education. In Flanders in the periods 2007-2013 a reformation was executed in which universities and High school works towards a five years uniform education for physiotherapy with orientation graduation. In the French community they are building on a similar project, but the realisation keeps getting postponed; this leads to the fact that the French community

has Master degree is on the university level and masters degrees on a high school level, with the duration of four years. ***(looks doubtful)***

Q: Thank you for this outline. For these interviews I have consulted literature. Literature showed a paucity of studies addressing the physiotherapy policy framework in Belgium. In my search for peer reviewed published articles I haven't found one single publication describing research conducted on the framework itself. In the selected studies one of the problems surfacing relating to physiotherapy policy development was the dominant position of the physicians. Is it possible to give your expert opinion on these issues? I am in particular interested in, why is according to you, you no or very little research is conducted relating to the possible influence of physiotherapists in the policy development process. Secondly, I am also asking your opinion towards the statement of the dominant position of the physicians. In your expert opinion is this a reliable statement?

R: Firstly, I want to address the paucity of studies addressing the physiotherapy policy framework. I am acknowledging that the number of studies relating to the physiotherapy policy framework is limited, on the other hand I am assuming that studies relating to physiotherapy policy ***(emphasises)*** do exist. Physiotherapy is in that matter a relatively young profession which could account for one of the explanations. I would like to divide this question into two parts, firstly the situation in our own country and secondly international.

In our country the paucity of studies relating to the physiotherapy policy framework is probably connected to the effect that physiotherapy only in 1995 with the law on the exercise of physiotherapy gained the legal statute. Only then was defined what was regarded as the legal practice of physiotherapy ***(looks up)***. The bachelors degrees were abolished. High schools evolved to HOBU-education of the long type, Flemish universities evolved to two candidate and tree license years. Later the Bachelor Masters reformation followed. Parallel to this in the last decennia a strong revolution in the work field and in education took place, with a turn from authority-based physiotherapy to evidence-based physiotherapy. This enormous evolution in physiotherapy was the trigger internationally and also in our country for the creation of difference competences or specialisations in physiotherapy, acknowledge in the World Confederation for Physical Therapy. For more details

We direct you to the annexes of the special official confidence of the physiotherapist in Belgium anno 2020, Federal Council for physiotherapy April 2016. The scientific outputs in relation to physiotherapy increased significantly, mostly addressing biomedical and clinical research. This is according to me a partial answer your question. ***(nods affirmatively)*** No explicit accent on humane orientate scientific research. During my professional career I was a privileged witness of this evolution and I was able to help build these physiotherapy educational reformations on the Dutch site. We have experienced moments, and it is very important ***(looks up and emphasises)***, of intensive communication and collaboration between the government and institutes for higher education, leading to an effective realisation educational policy. Realisations always follow moments of smooth and efficient communication ***(strongly emphasised)*** with the government, I cannot stress this enough. There is no doubt scientific research relating to policy aspects in physiotherapy. The PhD work of Etienne De Groot, physician and lawyer comes to mind: 'research on proficient disciplinary law for healthcare professions. This treats a broader area then physiotherapy and dates from 2013. On the other hand, legal bills relating to an order of physiotherapists are already published, bearing witness to policy related work. The government itself organisers research relating to the planning of the medical possibilities. Also, the Knowledge Centre it's conducting policy-oriented research. The Federal Council for physiotherapy tries to, when possible and when necessary ***(emphasises)***, built advises on literature data. This happens for instance with the advice relating to the reasons and circumstances in which can be diverted from the medical prescription, in this advice a literature study was included, to the advice on physiotherapy in perinatal care and in the creation of a professional competence profile of the physiotherapists in Belgium anno 2020. ***(nods affirmatively)*** These are three advices where in typical, literature substantiation was used. Questions on a specific policy

framework for physiotherapy are surfacing more and more in this country and could contribute to the autonomy of the profession, the realisation of it is better generic knowledge for what the physiotherapist nowadays is capable of, and to boosts the actual needs relating to policy in physiotherapy.

Internationally there are several International scientific magazines relating to physiotherapy and parts of physiotherapy with science Citation index. In these magazines biomedical and clinical orientated research is mainly published. I haven't looked for it specifically, but I am convinced that these magazines also have publications relating to physiotherapy policy aspects, such as competence profiles, Studies relating to direct access to physiotherapy, cost efficiency and much more.
(short pause)
Then we have the surfacing problem of the dominance of physicians relating to the development and control of the policy framework for physiotherapy. In the 70s of the previous century, the physiotherapist was mostly a paramedic age of the physician. The policy framework encompassing physiotherapy was strongly formed by physicians. The K-nomenclature is a remains of that. ***(looks up)*** The law relating to the exercise of physiotherapy placed more responsibility with the physiotherapist, determined amongst other things that physiotherapy treatments is conceived by the physiotherapist himself. ***(emphasises very clearly)*** As the owner of the medical prescription or referral the physician remained an important stakeholder. Nevertheless, the relation physician- physiotherapist in the care team has strongly evolved throughout the years, giving a totally different character to multidisciplinary collaboration in all lines and sectors well physiotherapy is encompassed. Certain physicians have put their shoulders under the development and recognition of physiotherapy, as for education and scientific research in physiotherapy. On the other hand, there also physicians who kept treating physiotherapy stepmotherly and physicians who, just as other people in society, still relates to stereotypical ancient ideas when dealing with physiotherapy. This duality exists. ***(sighs)*** But just like the minister herself states, the Royal decree number 78 is outdated and does not follow the evolution of the healthcare professions. This is <u>certainly</u> ***(emphasises)*** true for physiotherapy. It is why it is of great importance that with the re-formation of the Royal decree number 78 one takes into account the full potential off nowadays physiotherapy. This takes good an intensive negotiation of the physicians and lawyers advisors of the minister wit physiotherapists <u>during</u> ***(emphasises)*** the process of the Reformation of this Royal decree number 78, especially seen in the light of the enormous evolution physiotherapy has gone through. Only on the basis of <u>a smooth and efficient communication</u> ***(strongly emphasised)*** during this legislative work we can avoid missing important elements.

Q: At this point you have answered all my questions. You have indicated that you would perhaps circle back to the positive aspects and the strong points within the current system. Do you wish at this points to add something to that, or do you believe to have sufficiently answer that question?

R: My story isn't complete without the addition of certain elements which two my opinion needs to be stressed. Firstly, physiotherapy needs to strive to the <u>preservation</u> ***(emphasises)*** of what was realised in 1995. The statement relates to the current re-formation of the coordinated law relating to the exercise of healthcare professionals of than May 2015. The Federal Council for physiotherapy as always declared to be willing to negotiate, intensively negotiate, relating to the chapter of physiotherapy. Huge was our dismay ***(opens his eyes in disbelieve)*** when we learned, during the proposition of the new project, that the Federal Council for physiotherapy would be merged in a Federal Council for rehabilitation professions. Not only we are convinced that advises relating to physiotherapy should be formulated in an <u>own</u> ***(emphasises)*** Federal Council, but we are also of the opinion that emerging physiotherapy underneath rehabilitation professions is lacking vision towards the fact that physiotherapy it's not only rehabilitation. Physiotherapy therefor needs to keep a separate peddle in the proposed daisy-model of the multidisciplinary healthcare. A second point in this context is scientific research in physiotherapy which amongst other

things also involves patients. This issue has also been forgotten in the re-formation of the Royal decree number 78 and needs to be kept. Physiotherapy cannot be classified again ***(firmly)*** under the paramedical professions as was the case in the recent CAO for healthcare professions, under IFIC.

Physiotherapy needs to continue to strive towards positive ***(emphasises)*** attention of the government relating to a number of formulated advices by the Federal Council for physiotherapy. We started this conversation with a list of advices relating to physiotherapy policy. ***(raises his shoulders)*** Physiotherapy world in our country is still awaiting the treatment of numerous advices handed in by the council in the period 2013-2018. Repetitively we have asked to treat the dossiers handed in relating to the special competences in Sports physiotherapy, physiotherapy in geriatrics and psychomotor physiotherapy. We experience comprehension of the authority relating to the advice relating to situations and circumstances in which we can deviate of the stipulations of the medical prescription ***(looks up)***, but up until now nothing is realised. Probably in the next legislative period there will be some room for the development of the deontology organ after the re-formation of the order of the physicians.

The Federal Council for physiotherapy asks to strike article 154 from the coordinated law of 10 May 2015. It was a transitional matter for graduates during implementation of the WUK in 1995, which in a next healthcare law gained a permanent character. ***(determined)*** It has little use to put forward a four-year education as a general rule and at the same time create a permanent backdoor possibility for diplomas with three years education. ***(nods affirmatively)*** The Flemish community this also a demanding party to find a solution for this problem 40 recognition committee to be able to treat all relating dossiers meaningful. The strike of this article was agreed. We are waiting for the execution. ***(sighs)***

Thirdly and this is unfortunately a whole list. Physiotherapy needs to continue on the path of the evolution of the last decennia. Physiotherapy in the last decennia has become stronger and more performant and needs to resolutely follow that road. Much research still lies ahead, but the academic teams in recent times are firmly grown and are more and more recognised internationally and as we experience today also more interests in humane oriented subjects. Much research is multidisciplinary conducted so research can be a catalysator for modern multidisciplinary collaboration between the medical professions. Special competences are an exponent of the broadening and the deepening of physiotherapy in the past decennia. In 2014 six special competences were ordained by a royal decree and ministerial decree. It is of great importance ***(lays accents in tone)*** that the three remaining dossiers of special competences advance. ***(frowns his eyebrows)*** It is difficult to comprehend that's a physiotherapist can have a special competence in paediatrics but nowadays nothing geriatrics, a physiotherapy work field gaining importance in relation to ageing of the society. It is difficult to comprehend the physiotherapist can have a special competence in the musculoskeletal field, but not just yet in sports physiotherapy, a musculoskeletal related work domain also earnt its place in nowadays physiotherapy and in nowadays society.

Physiotherapy needs a deontology organ. Administering qualitative physiotherapy implies sufficient communication and information on the contents of qualitative physiotherapy but on the other hand that there is also a possibility to react against the ones colouring outside the lines and by that threatening to give the profession a negative image. ***(firm)*** The Minister of Public health, the educational institutes and the Federal Council for physiotherapy are all in favour of the application of as much as possible evidence-based practice. ***(frowns)*** In reality this is unfortunately not always the case and a deontology organ enables physiotherapy to better act within European legislation.

The burial of ancient stereotypical images and ideas relating to physiotherapy, deals with what some physicians need to be doing. ***(looks up)*** The professional competence profile of the physiotherapist anno 2020 strongly contrasts with physiotherapy from the years and 50, 60 and 70 from the previous century. Still, now and then these ancient stereotypic images

and ideas surface, hardening negotiations on the modern professional framework, for instance relating to social affairs. We see images appear on television which aren't images of nowadays physiotherapy but instead images from one another archive from ancient history. Physiotherapy as outgrown the phase of authority-based physiotherapy and all relating matters. It is therefore important to provide general knowledge on what nowadays physiotherapy means and how this is supported by scientific research. This is also important for certain physiotherapists to emphasise this seeing they also keep thinking within the framework of authority-based physiotherapy. ***(looks up)***

Physiotherapy must enforce recognition for the profession. Physiotherapy needs to, on the basis of evidence-based practice, competence, qualitative and deontological correct practice enforce a broad respect for any profession with all ***(emphasises)*** stakeholders crossing paths in top down policy and bottom of policy advices relating to physiotherapy. These were the points I wanted to add.

Q: Thank you for these additions which you regarded as important for your story. Is there at this point anything else you wish to add in general without going into specifics on the question I asked or a statement I proposed?

R: Yes, importance of policy decisions relating to physiotherapy, in this case we can think of the WUK, we can think of the educational reformulation are often grown out of professional associations and educational institutes, or a place where representatives of both collaborated, like the Federal Council for physiotherapy. Important realisations were always together with an important effort of politicians and physiotherapists ***(repeats both words)*** and were branded by a smooth and efficient communication. ***(firm)*** Only then things were realised. A central communications organ for physiotherapy policy development, where professional associations and educational institutes and if possible, other stakeholders can meet, would very well prove to be a plus towards further autonomy of the profession.

I really hope for the coming generations that the Federal Council for physiotherapy will remain, with the scientific commission as one of the working groups. Dossiers do not only need to be handed in, they need to be treated and one needs to keep advocating for them. ***(looks up and emphasises)***

Q: Thank you very much. I want to reassure you that all the data derived from this interview will only be used as mentioned in the outlines of this study. After the transcription of the recordings you will receive an email to verify your answers. Thank you for your collaboration. This is the end of the interview.

Interview B

2019 0111_interview transcript.
Number 02

Abbreviations used
Q: interviewer
R: respondent

(introduction)
Q: Good evening, I would want to thank you for your participation in this interview for my study at University of the Witwatersrand. I am Tim Németh, self-employed physiotherapist in Belgium and as mentioned, student at the University in Johannesburg.

This is a qualitative research focusing on the physiotherapy policy framework in Belgium and South Africa. I have explained you the recording of this interview. You have given your written consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as frowning of the eyebrows or explicit movements will be observed to. For this observation prof. Meesen is present. Prof. Raf Meesen is one of my promoters and he will function as an observer during this interview. he will register the non-verbal communication.

The recorded interview will be transcribed, and the non-verbal communication will be integrated. Afterwards the text will be emailed to you for verification. After your final approval the written document will be used in my study. Do you agree with this procedure?

R: Yes, I agree.

Q: Do you have any other questions before we start the interview?

R: I've had some questions on the questions ***(laughs and is happy)***.

Q: These will probably be dealt with during the interview.

R: Okay.

(starting question)
Q: In that case I suggest we start the interview. Can you start by saying your age and your profession?

R: I am 52 years and I'm a self-employed physiotherapist, besides this I am the president of Axxon, the Belgian professional association for physiotherapists. Axxon, physical therapy in Belgium.

Q: Thank you, that was already the answer to my next question.

(Introduction questions)
Q: Can you describe what your key position, your mandate or your role in the physiotherapy policy framework in Belgium is?

R: My key role as president is to keep a helicopter view on all matters relating to the physiotherapy, relating to professional advocacy and professional organization. And besides that, in one specific aspect, I have a very important task within the convention commission, where price settings for the honoraria for Belgian physiotherapists happen.

Q: As I understand from your answer your most important responsibility is safeguard the helicopter view?

R: As presidents keeping the helicopter view on everything related to physiotherapy, meaning professional organization ***(leans back and uses many hand gestures)*** for the physiotherapists and their practices and professional advocacy towards the governments, all stakeholders relating to physiotherapy.

Q: Can you please explain the difference between professional organisation and professional advocacy?

R: Professional organisation is directed towards our members: what and how they use to build their practices, ***(uses hand gestures to count)*** the magazine we publish, operational support, an information point where they can reach us with questions. Professional organisation is actually everything relating to the profession as such. Professional advocacy is defending the <u>interests</u> **(emphasises)** of the physiotherapist in Belgium on all levels.

(core questions)
Q: Thank you. It is important, in light of my study, to know the policy development process for physiotherapy in Belgium. I would like you to elaborate on the process of policy development for physiotherapy. How can suggestions be done? What is the procedure for adaptations in the current legislation?

R: This is a very broad topic. ***(laughs)*** Before I begin, I want to say that Belgium, to my judgement, has a very beautiful health care system. It has a solidarity principle. We can ask ourselves the question if this all is sustainable in the future? Besides this we have a very complicated country. ***(leans forward, many hand gestures)*** We have a federal government. We have the community governments. We have Flanders. We have Wallonia. We have Brussels and we have a little part of German-speaking Belgium. Each region has a minister making up for, I think I've heard it somewhere before, we have 12 ministers of healthcare in Belgium. So, on all those levels we must defend the interests of the physiotherapists. That is very complicated ***(leans back)***.

Your question relating to changes in the nomenclature, you are aware of them. Do I have to explain this?

Q: I am interested in your expert vision.

R: The physiotherapist treats his patients according a certain legally established nomenclature. The treatment acts are stipulated. Besides that, which treatments he performs and in which setting, he will receive a certain fee. If we want to change something to the nomenclature, suggestions are formulated in the technical Council for physiotherapy, residing within the RIZV. The RIZIV is in fact the civil service of the ministry of Public health. This is the administration of the minister making all decisions relating to healthcare in Belgium and constructing them into laws. The RIZIV law is phenomenally elaborate at this point. Who makes the proposition? The propositions come from different stakeholders. This could be physiotherapists believing we should change something. And This could be the governments itself, the minister saying something needs to be changed. This could also be the administration, the RIZIV. Or, and this I find, I want to say here, this could happen <u>dictatorial</u> ***(chops his hand powerful on the table)***. Meaning, the college of physician directors making a decision, look, in this manner we will change something in physiotherapy, and this is how it's going to happen, and no one can oppose to that! They construct a law for that.

Then we have the legislative framework in Belgium. This is first approved within the RIZIV in the highest organ which is the insurance committee. From there it goes back to the cabinet, the minister has to approve this. Besides that, the ministers of budget control have to

approve this. Various legislation in Belgium. Finally, I believe, for certain laws, the Council of States has to approve. And this will be published in the statute book. After two months it is applicable ***(looks affirmative)***.

Q: I hear you say a number of things can be imposed within the legal framework. This makes me conclude there is a sort of hierarchic structure?

R: Yes!

Q: Can you please outline this hierarchic structure briefly? I heard you talking about a technical council and insurance committee.

R: Yes. The highest organ in the RIZIV is the general council ***(frowns his eyebrows)***. There is no physiotherapist within this council. The government commissioner, the top civil commissioners of the RIZIV, Insurance companies who are in effect unions. This is the highest organ. Under this we have insurance committee with in fact all healthcare workers residing under the financial system in Belgium. We have an equal division between the insurance companies and the employers on one hand, on the other hand the Healthcare workers. This is 50/50 divided. All decisions are taken with the majority on both sites. This is changed last year ***(looks up briefly)***.

Under that we have different agreement commissions and convention commissions. For physicians the medico-mut and for dentists the dento-mut. They work with agreements. Besides that, we have the convention committees, where physiotherapists, nurses, speech therapists, *bandagists* and also pharmacist resides.

Under this level we have the different technical councils dealing with the description of the nomenclature and the treatment acts for the different healthcare professions.

Then we have several control systems. The Service for medical control and evaluation, when certain healthcare workers make exuberant expenses or are doing things which are not allowed, are supervised here. Fines can be issued which can be appealed by the healthcare workers in the commission of appeal ***(both hands ostentatious beside his body)***. This is a control organ. This is all within the RIZIV, the administration of the minister.

Q: Just now you were mentioning a change in relation to the interests in the insurance committee. Can you please elaborate on this a little bit more?

R: Until February 2017, it is because of physiotherapy that the change happened, when something was voted on, there had to be a majority within the whole insurance committee. In both camps so to speak. Now a majority per camp is installed. This is changed in 2017 because the cabinet, the government, the Minister, had in agreement for physiotherapists, an agreement on fees, it isn't an agreement, instead an imposed honorarium to physiotherapists. This was voted off in the insurance committee because the certain Insurance company voted with the healthcare professionals. The consequence was, something that has been voted off, cannot return to the insurance committee. The responsibility was again within the convention commission to make an agreement on the fees. The minister didn't have a save any more. The minister then evoked a certain juridical procedure to overrule this and to come up with another proposition which was approved. Because of the installed changes the situation isn't likely to happen anymore.

Q: You just talked about the federal level of social affairs. Physiotherapy also resides on the federal level public health. Is there also a hierarchic structure? Are there also structures aiding in the legal propositions and policy decision making?

R: On the level of public health we have little influence relating to the legislative framework. The only thing physiotherapy has in public health, is the Federal Council for physiotherapy

which is an advisory body to the Minister. In the strict ***(emphasises)*** sense they can only provide advice on questions from the minister. To speed things up in the profession the Federal Council for physiotherapy, composed out of people from the work field besides people from the academic world, from education formulating advice, has formulated many advices without the minister asking about them to be able to better regulate the profession. This is an advisory board. Besides this on the level of public health we have a control organ. These are the so-called provincial medical commissions treating cases. Complaints of Belgian civilians or complains of governments towards certain healthcare workers, in our case physiotherapists, who have done things out of the ordinary. This isn't usually about to many treatments, but usually about issues, we would say "drunken stupid". Colleagues with drinking problems who cannot treat patients any more, will get a notification or their license can be invoked.

Q: This is dealing with patient safety?

R: Yes, they control the safety of the patient and the Belgian civilians.

Q: The outline of the framework has no doubt strong points. I am in particular interested in the aspects that are positive for physiotherapists. Can you please provide your opinion on the positive aspects, in favour of the physiotherapists, in the current system of policy development?

R: Strong points? ***(repeats with emphasis)*** Because of the system of the healthcare in Belgium there is always a finance for physiotherapy. It is actually perverse; the sector is subsidized by government. This is a good point. This is unique to Belgium. In other countries the private insurance control the finances. Here it is the governments who control the system through taxes and income through Social Security. It is positive that there is a finance, where the profession can for some parts make decisions on the budget. That is positive ***(looks up and sits back)***.

Negative is the size of the budget ***(laughs)***.

Q: That was my next question. Every system has also aspects or procedures less favourable. I am interested in your opinion regarding the gaps and weaknesses in the current system, as described by you, relating to physiotherapy or physiotherapist involvement. Can you please outline the gaps and weaknesses for me?
(short pause)
R: We have to step back a little to what the weakness is for physiotherapy in the system. The RIZIV exists since 1965. It is created by and for physicians. ***(laughs)*** The next ones included were the dentists and then the pharmacists. In the whole system the physicians are the ones calling the shots with the biggest budget. Physiotherapy was included somewhere in the 70ies, I believe. Starting with a budget like the psychologists are starting now. At this point it is €20 million, I don't know what it was in the beginning of physiotherapy. On the basis of certain calculations by the RIZIV and the expenses and extrapolation and recalculations, like looking in a glass ball, thinking of what the sector possibly needs next year. For years it has systematically grown but not grown enough relating to the needs of the population. Population is ageing and there are more surgical interventions. The population is ageing and there is more need for physiotherapy. The government doesn't take this into account. The budget is insufficient. If we would've been included in the system in the year '65 our budget would have been much bigger. In times of economic uncertainties, the government has fewer income and there is less social security. The system is under enormous pressure and we can ask ourselves which solutions we are going to find for this.

Q: Am I understanding it correctly that the biggest gap in the current system is the finance of the system?

R: For the moment yes. Not the legislation. The insufficient budget is the biggest problem. Do we have to, we are catching up, but it is just a drop on a hot plate. And besides that, I am not pleased to say this, the group of physiotherapists is getting too big. There has to be a relocation within the profession ***(looks worried)***. The situation cannot continue. Every year 1700 physiotherapists are graduating ***(raises his shoulders)***. The available budget isn't rising, and the population isn't growing.

Q: Is physiotherapy still mentioned on the list of endangered professions?

R: Unfortunately, yes.

Q: How does this fit in your professional opinion?

R: This is totally wrong ***(emphasises)***. In a certain sector there is a problem of finding physiotherapists. This is the sector of elderly. In this sector there is a need for physiotherapists. The biggest problem is that physiotherapists working in the sector are working below their pay grade. The fees are way too low which makes it not interesting for physiotherapists to start working in the sector. This is why there is the lack of physiotherapists working in the sector. This has to be looked at from a different angle. How can we make this sexier. Making the physiotherapists say: "I want to work there". We are currently thinking about a different role for the physiotherapist working in geriatrics. This is very important. I am thinking about the fees as a problematic situation. Physiotherapists working there are mainly the former A1 graduated physiotherapists. This is now a bachelor's level, but soon, within the next 10 years, those colleagues will be extinct, at least retired. At that point this problem will be even bigger. The sector which is probably under-subsidized, and lacking off enough income, relating to the daily management of these retirement homes, will also be lacking funds for the care and treatment of the elderly residing there if they cannot find physiotherapist who want to work there if ***(emphasises)*** they're not paid at the Masters level.
(pause)
You can ask yourself the question, people were all working here partly on things unrelated to physiotherapy: animation, feeding patients, restoration of wheelchairs. These are all tasks outside the physiotherapy scope of practice. This has to change. In the sector it is also true the physiotherapists are at the nurse's level. This has historically grown. Physiotherapy was un-existing. Who was working in the retirement homes: the nurse took care of the care, the nurse was the head chief of staff. Suddenly the physiotherapist was added and controlled by the head nurse. Physiotherapy has grown since then and wants to set out its own trajectory, its own scope of practice and its own competences. The physiotherapist is saying: "I am not the same as nurse". The same goes for the hospitals. Hospital law still states physiotherapists reside under nurses. These are gaps in legislation of hospital physiotherapists and physiotherapists working in geriatrics.

Q: Do you also have specific gaps for self-employed physiotherapists in Belgium, or does this resides for the most part under the chapter RIZIV and budget as main gap?

R: The gap is perhaps that the legislative framework needs to be created to allow treatments outside the national insurance for sickness. At this point everybody is sort of filling this up as he goes along and follows tax legislation as he sees fit. But in fact, we should create a better legal framework for this all to proceed in a legal matter. What you're doing as a physiotherapist within the health insurance, the RIZIV and the acts outside the health insurance. There are also the gaps relating to the use of supplements, materials used in therapy. At this point this isn't even allowed to be billed. These are all matters which need to be discussed in the RIZIV, with the government to give this all a legal framework.

Q: Continuing on that. The literature showed a paucity of studies underpinning physiotherapy policy framework in Belgium. In my whole search for peer-reviewed published literature I did not find a single study describing conducted research on the framework itself. In the selected

studies one of the problems in relation to physiotherapy policy development surfacing was the dominant position of physicians. Is it possible to provide me with your expert opinion on this? I am in particular interested in why according to you no, or very little research has been conducted relating to the possibilities to Influence the policy development process as a physiotherapist. Secondly, I also ask for your opinion relating to the predisposition of the dominant position of the physicians. Is this accurate according to your expert opinion?

R: These are a lot of questions at once. The dominant position of the physicians on the RIZIV level has grown historically. If we as physiotherapists would have been included since the year '65, the physician wouldn't have been so dominant. The physician… ***(short pause)*** societies context Is changing in a way that years ago that physician was dominant and the prescriber. This is perhaps another point we do not have, direct access. We are still working on prescription.

The physician is still the central gatekeeper of the patients file. He decides what happens with the patience. This is changing in a community context. The patient is taking responsibility of his own care. At least some patients. But it is happening more often. Patients are saying: "I want to go to the physiotherapists directly" or "I am going to the specialist directly".

Relating to the few studies are conducted, I can understand that, how policy is developed for physiotherapy. We are a young profession 1 and 2 yes, ... ***(pauses, thinks)*** We as a professional organisation do not have the financial means to, I am just saying something, employ a healthcare economist, guiding us towards policy developments.

We are going to develop a study centre to establish the economic value of physiotherapy. Manpower and finances are failing short to really establish this ***(sighs)***.

Q: I hear you are circling back to budget and finances? It seems to me in your opinion this is a very important issue or am I mistaking?

R: Yes, perhaps so ***(laughs affirmative)***.
(keeps laughing)
Q: Okay. At this moment you have answered all my questions. Is there something you wish to add to specific item or in general?

R: No, I do not know, the dominant position of the physician ... ***(pauses long, sighs, doubts and looks at the ceiling)*** In fact, we are chasing our tails as a professional organisation, because we are not enough supported by experts. I am saying, this healthcare economists, would be very important in this, because in other sectors, and I'm going to talk about money again ***(sighs and laughs)***, certain matters are executed in healthcare towards things we say what's the use, and where physiotherapy would be a better alternative. For instance, we cannot do prevention. Legislation, Royal decree 78, adapted in May 2015, on request of Europe, the Royal decree doesn't allow us to do preventive treatment, although we as physiotherapists today for certain pathologies can give decent advice and work in a preventive way resulting in a diminishing of the governmental costs for certain patient groups. But because we have too little influence, not enough experts around us to influence the government. "Look this is something physiotherapy can have meaning in". We cannot enter this terrain.

Q: Can I please circle back to something. You were saying:" because we have to little influence". Is this a reference towards the legislator framework with the hierarchic structure?

R: Yes! ***(powerful)*** Yes!

Q: Can you please pinpoint exactly how are you experience this?

R: If the leading Commissioner of the RIZIV would be a physiotherapist, we would be making progress much faster. Or if on certain levels within the RIZIV ***(laughs)*** physiotherapists would be employed this would help us also. I personally, one big mistake, this Is a personal observation, one big mistake the professional organisation did make, during the current legislation of this minister. The legislation of minister Mrs. De Block. When she was appointed, we didn't send a physiotherapist to her cabinet. Somebody who would be there a couple days a week to advise the Minister in all matters relating to physiotherapy. I believe we cannot make the same mistake this year when the new government is installed. I hope it isn't Mrs. De Block anymore because she is not going to invite a physiotherapist. Hopefully it is somebody else at that point we need to as fast as possible make sure a physiotherapist is present at that level. In that way we can help govern. This mistake, I have told my board is this couple weeks ago, we cannot repeat. This is important.

Q: Thank you for this extra explanation. I want to reassure you again that all data from this interview will only be used as outlined in the study. After the transcription of the recording you will receive a copy to verify your answers. Thank you for your collaboration. This is the end of the interview.

Interview C

20190201_Interview transcript.
Number: 05

Abbreviations used:
Q: Interviewer
R: Respondent

(Introduction)
Q: Hello, I want to thank you for your participation in my interview for my study at the University of the Witwatersrand. I am Tim Nemeth, self-employed physiotherapist in Belgium and as mentioned student at the University in Johannesburg.

This is a qualitative study relating to physiotherapy policy development in Belgium and in South Africa. I have explained the recording of the interview. You have given me your consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as movements of your head or hands will be noted and recorded. For the observation of of the non-verbal communication prof. Meesen is present. Prof. Raf Meesen is one of my supervisors. He will function as an observer during the interview of today.

The recording will be transcribed, and the non-verbal communication will be integrated. This text will be emailed to you for verification. After your final approval the text will be used in my study. Do you still agree with this procedure?

R: Yes, no problem.

Q: Do you have any other questions before we start the interview?

R: No.

(Opening question)
Q: Can you please state your age and your profession?

R: So, I am 57 years and I work as an employed physiotherapist ***(sits up straight)***.

(Introduction question)
Q: Thank you, can you please explain to me your responsibilities / your position / your mandate within the physiotherapy policy process in Belgium?

R: Yes, so, I am a member of the professional associations for physiotherapists since the 90'ies, beginning of the 90'ies, when I started as board member in the association off physiotherapists working in hospitals. In the setting I became very quickly member of the technical Council. The professional associations did progressively group in Belgium. To form one single association ***(emphasises)***, 10 years ago. Axxon, in which I participated since the beginning as board member in Axxon, Qualité en Kinésithérapie, the French Association. And very quickly, after a few months I became a board member on the level of PTIB, which is the national umbrella.

Relating to the professional defence I have several mandates. Being a member of the technical council since the beginning of the 90'ies. Afterwards I became president in 2013. This function I now exercise for the last five years, President of the technical Council for physiotherapy in the RIZIV ***(leans back)***.

I have also participated in the work of the Federal Council for physiotherapy these last four years ***(looks up)***.

I am also a member of the planification commission. In this commission I was nominated as the expert by the Minister for the knowledge on physiotherapy related matters. I have participating in the working group of this planification commission to *[not understood]* plan K, effective since 2013 to 2016. The tasks of planification commission will recommence in February because now we are going to analyse different scenarios to study the consequences of this plan K. ***(puts both hands on the table)*** In relation to representing the profession I think, in principle on the level of the Association, I also participated in different internal working groups and amongst others on the level of social affairs. This is more internal kitchen of the Association.

Q: Thank you, these are quite a few mandates.

R: Yes, yes, for sure ***(laughs)***. Perhaps too many but new candidates are not presenting themselves, so it is what it is.

Q: Can I ask you to please give me some details relating to your responsibilities in your position or mandate? Which are the most important responsibilities you have?

R: Yes, I believe that without a doubt the mandate as President of the technical council is for sure the most important one between all the mandates I've just cited. So, well, it is a position which is not always very easy ***(raises shoulders)*** because I believe that sometimes, like I have already explained, there is my past as board member in the professional association and the willingness to defend the politics of the Association and besides that the necessity being the president to safeguard a sort of neutrality. So, well, I tried to reconcile those as good as possible. **[Pause]**. This necessity of being neutral as the president of the technical council ***(sits up straight)*** I tried to make everything work efficient. You know it is off course not always easy in regards to conflicts of interests between the insurance companies and the professional organisation. For sure I try to progress the ideas of Axxon and have them accepted by insurance companies, which is not very easy. It is important to find compromises ***(frowns his eyebrows)*** which are acceptable for all. To keep progressing to professional physiotherapy. So, you have to take into account, and I believe this is one of the difficulties of the technical council, in the end we only have <u>but</u> ***(emphasises)*** the time spent. We have these meetings of working groups, once a month meetings of two hours, which are not always an example of efficiency. And also, with the people coming to the meetings without repairing the dossiers. So, I want to say what I see; this is in the end if nobody takes initiative the dossier doesn't advance ***(raises shoulders)***. I think the last couple of years I was involved in quite a few dossiers; to make them in advance. Taking things in hands, means making syntheses, presenting things in the meeting, making counterproposals, listen to the banks, try to make a synthesis and presenting a project acceptable to all partners ***(talks a bit louder)***. So, I believe it is a very important role. I love it very much. I believe I have certain sense of diplomacy to arrive at a coherence between those banks which is often <u>difficult</u> ***(emphasises)***. I hope I am capable of making thinks advance. I believe that in the previous years in a rather positive atmosphere even if some of the issues remain difficult, I believe there is <u>really</u> ***(emphasises)*** the will to change things for the better and advance. So, this is for this mandate. For the other mandates, ***(leans back)*** on the level of the planification commission it's always the same. We have to prepare files relating to the plan K, study them, imagine a scenario. Here also I believe we get a professional association must present a hypothesis to work with. Afterwards we have to defend this in the working group. ***(talks a bit louder)*** So, well, I believe the difficulty remains with the time people can spend in the professional organisation to prepare files. So, to be more efficient we must <u>professionalise</u> ***(sits up straight and emphasises)***. Create a file in the technical council, is a real work in need of expertise, competences and time. We do not often have sufficient time.

Q: Thank you. Did I understand it correctly that within your mandate as president of the technical council the most important function is organise the work to arrive at a political consensus? ***(looks in doubt)***

R: ***(chooses his words)*** I believe the President tries to preside in the assembly in an efficient manner. So, if we want this to function in an efficient way cannot I believe that for sure members keep talking to each other. ***(looks up)*** I want to say, if we are in a permanent war, people will camp and defend of their positions. Diplomacy is trying to make both sides understand the position of the other side and arrive at a compromise. ***(puts his arms on the table)*** So, sometimes we do, and sometimes we don't. ***(frowns)*** I am thinking on an example of the group sessions, a proposition of the professional association. We are in a total blockage of the insurance companies. We have tried everything, we made an analysis, we have conducted meetings with experts to demonstrate and to scientifically built this proposition. But still we are in the blockage of insurance companies. This is for sure a blockage out of principle ***(emphasises)***. So, we don't have any more means to make this dossier advance. I mean the file created and proposed by the professional association. So, well, on the other hand there are other dossiers where in general I arrive in making progress towards a consensus between both banks.

(Core Questions)
Q: Thank you. You have already talked a bit about it. For the study I am conducting, it is important to know how physiotherapy policy development is instructed in Belgium. I would like you to explain to me the policy development process relating to physiotherapy dossiers. How can one make suggestions? What is the procedure to make legal adaptations?

R: So, on the level of policy development for physiotherapy to explain it in a comprehensible manner one can say there are two organs where the professional association has representatives and by that a power to make propositions. ***(leans forward)*** On one hand we have everything concerning social affairs, the RIZIV, the insurance for sickness and invalidity. And this is in fact everything concerning in the end matters relating to physiotherapists and the obligation to apply healthcare, the agreements on fees and on the functioning.

On the other hand, we are all relating to public health. Here we are working more on the definition of the competences of the physiotherapists this is mostly on the level of the Federal Council for physiotherapy.

So, if we are talking about public health, the Federal Council for physiotherapy, there are representatives of universities, of the professional association and even physicians ***(looks up)***. So, here of course we have a bowl of giving advice ***(emphasises)***. For sure, we can give advice to the Minister on everything relating to physiotherapy. This is not a decisive ***(emphasises)*** power. Meaning, suggestions made by the Federal Council are directed towards the minister what can do whatever she wants. Perhaps she can modify or construct a royal decree, or she does nothing. So, what I'm saying, here it is just a power of making suggestions.

On the level of social affairs, the RIZIV, here we have no doubt some decisional powers. You have to understand, of course not on our own, it is always within councils. We have the convention commission and the technical council where we have representatives of the professional association for physiotherapists and representatives of the insurance companies. So, we do need to reach a compromise ***(emphasises and leans forward)***. So, the difficulty we are facing is in fact the blockage of the insurance companies. So, if the insurance companies do not see the necessity of a proposition this proposition will not go far beyond the commission where it was proposed. And even if this is accepted in the technical council or in the convention commission the difficulty is the proposition has to follow yes, a long way. You have the commission of budget control, the insurance committee and on this level, we are not very well represented. ***(moves arms agitated)*** It is to say in the Insurance

committee we have got one ***(emphasises)*** representative seating besides representatives of the physicians and other professional healthcare workers. But we are very much a minority. So, if insurance companies have the will to block a file, if they didn't succeed in blocking it in the technical council ***(leans forward)*** or the convention commission, very often they will succeed in blocking it on the level of the insurance committee. If a dossier doesn't pass the insurance commission, it is not accepted ***(looks up)***. So, we are confronted with difficulties relating to representation on the different levels with true decisive powers on a higher level ***(leans forward)***.

On the level of public health, I've already said this, we only have the power to make suggestions and so in the end the difficulty is there, most of the decisions are taken on political level. Within the RIZIV, in the insurance committee at least we have the power to discuss, on the level of public health it is very clear ***(emphasises)*** that decisions are in principal political. I think that here, it would be better if the professional association could do more. It is relating to this and that we have engaged a lobbyist the last few years. Because I believe it is very important to approach the political world so they can support our propositions. I think this is very important ***(leans back)***.

Q: Did I understand you correctly that within public health physiotherapists have a direct line towards the minister and the political responsible, being an advisor? Within social affairs one is confronted with a true hierarchic structure with commissioners where one can very well make suggestions, but on a certain level, physiotherapists do not have sufficient power?

R: Yes, I think this is a very good resume. The RIZIV is a pyramid structured organisation, in the commissions at base level we have many representatives but if we climb up the pyramid, we have fewer and fewer representatives. In the insurance committee we have got one representative amongst I don't know how many others. It is necessary that all propositions are supported by the insurance companies ***(talks a bit louder)***, if we want them to pass. If not, we have no chance they will pass. Because you don't even have the support of the physicians. I am saying, it is a game. You have to know it is a game ***(emphasises)*** with an equilibrium of power. Sometimes even if the physicians could support our dossier, they will not place themselves in a position against the insurance companies for our file and taking the risk of having the insurance companies blocking their dossiers. The way we are representative puts us in a difficult and minority position. You see, in effect on the level of public health is just a power of advice ***(emphasises)***. So, we are consulted but that's all. You see, the minister is at the moment occupied with the reformation of the so-called Royal decree 78. But very clearly, she has made some propositions, we have made some counter propositions, what we do not know is too which extend she will take into account our remarks we've made in the counter propositions.

Q: The proposed reformation of the minister of the Royal decree 78 does it have manifest repercussions on the way physiotherapists needs to work? So, would this mean that the political framework encompassing physiotherapy will change profoundly?

R: Yes ***(very clearly spoken)***, that it could be. For sure. It is to say the current proposition of the minister is to put, so to speak, because she has made schematics in the form of a flower, ***(uses arms to gesture)*** with the central level containing certain things surrounded by different disciplines. And for sure on one side you have everything concerning rehabilitation including physicians specialised in rehabilitation. So, rehabilitation medicine is everything related to rehabilitation, it is to say in principle they ***(looks up)*** direct everything related to this topic. And amongst others the medical and paramedical professions are added to this. So, in this case I believe it contains the risk of losing autonomy. The difficulty of our position as physiotherapists is always to recover this autonomy ***(talks a bit louder)*** in the different professions. So, we could be independent, is, I would say, for instance we would create deontology organs for each profession. You can easily imagine one deontology organ for everything relating to physical medicine. I think this is really the opposite of the principal of a deontology organ well one can be judged by peers. So, these are the problems which we

encounter. ***(leans forward)*** The fact that we could be placed under the title of physical medicine. Putting things in that perspective means one is not listening very well to the propositions of the physiotherapists ***(leans back)***.

Q: The framework you have described has no doubt some strong points. I am interested to know which aspects are favourable for physiotherapists. Could you please provide me with the positive aspects for physiotherapists in Belgium in the current political legislative framework?

R: Yes. I believe that one of the positive points is that, we have to be very aware of this, we have the chance of being in a system where healthcare is regulated ***(leans forward)*** with the healthcare professionals. This is a political system installed by the RIZIV. And with this it is decided to manage the budgets of healthcare in consultation with the healthcare workers. There are at least some organs where we are represented, where we exist. The technical Council for physiotherapy who creates a nomenclature. Physiotherapists can make propositions there. And we have a true power in the convention commission ***(raises eyes)***.

(talks louder) Besides this we are in a system which is very closed. In which we experience many obstacles. And probably the most important obstacle within social affairs is no doubt the budget ***(emphasises)***. So, we have a chance of being represented but here again we have little decisive powers on our budget ***(emphasises)*** itself. So, this means in effect the repartition of the healthcare budget is part of a technical calculation. And we notice that the utilised manner is not always very honest. It is necessary they change things because we are within a budget of healthcare in a limited envelope. It is evidence if they do not give more to certain healthcare workers we are heading towards trouble. In fact, we will experience fewer and fewer healthcare workers willing to give their agreements on a accorded budget which isn't sufficient. We have, it is historically grown, a budget allocated which is probably, no it's more than probably ***(emphasises)***, not adapted to cover all physiotherapy needs. This is what I believe to be the first complicated issue. The other thing appearing to be difficult to me is that everything I've just told has to be arranged in consultation with the insurance companies. ***(uses arms to gesture)*** I believe we have a difficulty in this regard too because the insurance companies are, how should I say it, insurers. So, they want to assure their clients, defend their clients. In some cases, they even are healthcare workers. There are hospitals defending the insurance companies. And finally, we notice we are in financial system allowing the insurance companies to take initiatives. But also ***(emphasises)***, on the level of social affairs. An example is, you have the insurance companies proposing at this moments free health care for children. And we see that they are taking many initiatives in relation to this. Besides ***(louder)*** everything already existing in the RIZIV. I believe this is not a situation which is very normal because, imagine, we have just decided to increase out-of-pocket payments for physiotherapy where we will experience a moderation of consummation. Put this in relation to the insurance companies who on the other hand are promoting accessibility to healthcare for free. This leaves us with two different politics. I believe this is a big problem ***(looks up)***.

I have already explained the problem of available time. I believe we have to make sure that we professionalise ***(emphasises)***. In that way people working in commissions will be more efficient. You see, I believe these are the principal points. At this moment we have also experienced people within the professional association that could be better supported to be more efficient. ***(frowns eyebrows)*** This is hard work. We have a complex nomenclature. You have to understand it very well. And also understand the limits of power of the technical council. I believe that very often young physiotherapists attending these meetings do not know that not everything is decided here. And we do need competent people willing to attend the technical Council. One must also know and understand the dynamics of the insurance companies. I believe this is a craft one should master ***(leans back)***.

Q: Thank you, you have already answered to what would be my next question. Every system has also procedures which are less favourable. If I understood you correctly you have said

that physiotherapists do have a position in the system in place. So, they can react, they can make propositions. But the disadvantage that I heard in your resume is the duality of the role of the partners, the insurance companies, in the negotiations. Is this a correct assumption?

R: Yes, yes, yes. Totally right ***(pronounced with force)***. I personally don't have any problems with the insurance companies and the role they are playing to defend patients who are their members. In the spirit off accessible healthcare for all. This in effect seems normal and why they are there. On the other hand, we are in a system where they offer care and in the same spirit, they are controlling healthcare workers. Here, you know, we have a conflict of interest. ***(talks a bit louder)*** Because, in effect, they control, they act and at the same time they are the defender of their members. You see, this is sometimes a difficult situation ***(chooses his words)***. Another difficult situation base within public health. I am circling back to our role to make propositions within the Federal Council. In the bylaws ***(emphasises)*** of this council it is stipulated that if its advice is adopted by the Federal Council it has to have approval of at least one physician. ***(leans forward)*** You see, we have a Federal Council what is certain number of members. I think there are normally tree places for physicians. So, if there isn't one physician giving his agreement the advice is not accepted. This is, in my opinion, not at all democratic. So, you see, we are also in a difficult situation ***(looks up)***. We have to take this into account. ***(raises his shoulders)*** In the end often do physicians safeguards a big piece of the power in different places.

Q: Thank you. This explanation directs us to my next question. The literature has shown a paucity on studies focusing on the legislative framework surrounding physiotherapy in Belgium ...

R: Sorry Tim. I have a problem with my computer. I do not hear the question. I have just picture. One minute ... **[pause] [computer connection problems]**
... Can you please repeat the question because I didn't understand it?

Q: Of course, no problem. I will repeat the question. The literature has shown us there is a paucity of existing studies focusing on physiotherapy policy development in Belgium. In my whole research I haven't found a single study published as a peer review article. In the selected studies for my work one of the surfacing elements relating to gaps in the system is the dominant position of the physicians in the policy framework you have just described. Can you please provide me with your professional insights on these two issues? One, I am at first interested in why, in your opinion, there aren't any studies conducted relating to the possibilities for physiotherapists to enlarge their influences in the legal framework encompassing physiotherapy. And a second issue, in your professional opinion, is the declaration relating to the dominant position of positions in the physiotherapy policy framework process correct?

R: Not easy questions ***(sighs)***. I would say, in relation to the policy framework and its analysis in fact I think we did progress somewhat over the course of history. ***(raises his shoulders)*** So, I think it is probably that we were happy in functioning as it is. You see, and at this stage the national Council has become the Federal Council. This is for sure something relatively heavy. So, I think it is not easy to have everything right now. We are progressing no doubt in the rights way within the organs proving to be efficient. If for instance we are looking at the competence profile of physiotherapists, created by the Federal Council. ***(talks very decisively)*** This is really an important work of consequence. And so, I believe, you see, the committees are efficient, and they work, but in effect, of the analysis of the system relating to the question on how we can change to do things in a better way or to better position ourselves. ***(raises shoulders)*** So, I think this is probably something that is missing. And I believe there are only a few researchers exploring this. I believe that it is necessary without a doubt to make some analysis on what is happening in our neighbouring countries. And to have a look how things are done there ***(leans back)***.

Do the physicians hold a dominant position? Like I've already said, without a doubt yes ***(leans forward)***. But here again I believe one must remain a realistic and understand the history of medicine. Physiotherapy is a young profession, introduced into the universities in the years '60 or '70. The history of medicine predates that by many decades. And it is very obvious that physicians are at the centre of healthcare ***(uses gestures)***. And they will probably make every effort in staying there, in the centre of healthcare. For now, I think there are also things evolving, in a sense, alright for different reasons, it is to say, I think more and more amongst other but also for reasons of ancient profiles, one is staking into account there is also the necessity of being complementary ***(emphasises)*** between different healthcare professions. And we are seeing that even physicians, very slowly, are trying to give prerogatives to other professions. So, I'm taking off of an example from the midwives who achieved a number of choses relating to normal pregnancies. You see, so I believe if physicians are taking into account that there are a series of acts, I would say, simple ones, ***(looks up)*** that could be administered by other medical professions. For now, inevitably, the Achilles heel remains money ***(emphasises)***. And so also here in terms of budgets, healthcare budget is approximately 3 billion, physiotherapy represents 800 million. It is evident that the medical budget reserved for physicians is enormous. And medical nomenclature is constructed in a way to always place the physician in the centre ***(leans forward)***. Starting from the moment where, for example in a surgery act, they say the surgery itself, the fees of the act will return to the physician because he is the ones signing off the paper stating he is billing the act for all. ***(talks louder)*** Meaning he is recovering money and afterwards he will distribute it amongst the other collaborators in function of physical medicine. So here we have a construction which isn't correct. We are at the moment in revolution completely the opposite of this. For instance, ***(gestures)*** the latest way of financing care within the RIZIV is actually gave a certain amount for a certain pathology and it is the RIZIV who will be sides on this repartition amongst difference healthcare workers. The ***(raises his shoulders)*** RIZIV wasn't very courageous because ineffective they have taken existing fees and distributed them a bit with a certain percentage. So, everything stayed the same. I believe that, yes, it was necessary probably to change the system more. We have to rethink everything ***(emphasises)***. So, one can imagine for instance a prosthesis for the hip where a certain amount is allocated to the surgical act, a certain amount is allocated to the use material, the surgery room, a certain amount is allocated towards the anaesthetics, towards nurses working in intensive care. This is how it works at this moment. So, defacto, the physicians are in central place. Physicians will always participate because they are in the centre and other professions do not exist. Afterwards the others have to replace themselves in already existing organs and for sure ***(emphasises)*** physicians there have a great power. ***(sits up straight)*** Why does the Federal Council as a mandatory ***(louder)*** position for a physician who has to sign because otherwise it is not accepted? Probably because they have a will to control in their regards. It is them who have created to the law and it is them that are elected is on a political level. So, I believe the problem is there ***(loud)***.

Is it because of this we have to back down and do nothing? Certainly not! We have to demonstrate our competences ***(emphasises)*** and our ability to be complementary. I believe that by demonstrating this it is in the interest of everybody. I Think this will give more autonomy ***(talks louder)*** to other professionals because this is a work for all. I think that everybody is going to win in the system with a greater deal of complementary and respects towards each profession. I believe that this is very important.

Q: Thank you. Did I understand it correctly, and this is already my next question, with strong points and less favourable points, the autonomy is one of the issues we should be better regulated for all professions; and in this case especially for physiotherapists?

R: Yes, I believe this is without a doubt correct. We have to go towards more autonomy ***(gestures)***. At this moment much work is put into direct access by the professional association with dossier put together by the Federal Council. So, I think its again history ***(frowns)***. The goal isn't to start playing the role of the physician. The goal is simply to say,

give direct access to the patients of physiotherapists. Have faith in the physiotherapist ***(strongly)*** who has the competence to assess the severenes of the problem of the patient. He will treat everything within his scope of competence and all the rest he will refer the patient to the physician. If the physiotherapists is allowed to assess the patient and there is a doubt in the diagnosis, if in that case you refer this patient with a document of his findings it will certainly facilitate ***(emphasises)*** the physicians work. And so, let's be reasonable, in the domain of physiotherapy which I know very well, which is the musculoskeletal, I honestly believe a physiotherapist went for instance the nearest of experience with a special education in my eyes he has more confidences in this musculoskeletal field and Then a general physician. I believe this is normal because the physiotherapists has his experience and he is only seeing patients within this scope. ***(leans forward)*** I, I have the utmost respect for the medical profession, and it seems almost normal the day Safeguard diagnostics. ***(louder)*** However, for well-defined cases I believe the physiotherapists can play it is important role.

So, in my position in the Federal Council it is my opinion to demand Direct access immediately. I have the feeling that, in my opinion we will get there step-by-step, but that is probably because I am a man of consensus. I believe that we also ***(emphasises)*** have to try to understand the position of the physician. And so, I would, for example in this project of direct access, limit the authorised treatment sessions to 4 or 5. We can reassure the physicians at first. I believe if we would arrive to Direct access where are we would be able to do four all five treatments without medical prescription. And if the patient afterwards goes to his physician with a report, we can have complementary diagnostics with if it's necessary a prescription to continue treatment. I think we need to find consensus ***(leans forward)*** ensuring the whole world to clarify the position of the physiotherapist. The physiotherapist is not a physician, these are ***(talks louder)*** two completely different professions. If a patient can access physiotherapy care we will be a able to save by not having a physician's consultation, perhaps not even making radiographic diagnostics ***(leans back)***.

(closing questions)
Q: Thank you, for this example. At this moment, you have answered all my questions. Is there something you wish to add in general or within a specific item you have described?

R: No, the only thing I want to say is that I am very curious to see your work ***(laughs)*** because I think it's very interesting ***(gestures)*** to study the structure in which one has to function and to see which measures one can effectively change. It is interesting to see if we would start from a white page, how ***(emphasises)*** are we would construct a system work every Health care worker finds his place, a balanced place. For this I believe this study is very interesting.

Q: Okay. I want to reassure you that all information derived from this interview will only be used as mentioned in the outlines of the study. After the transcription of this recording you will receive a copy to verify answers. Thank you for your cooperation. This is the end of the interview.

Interview D

20190120_interview transcript
Number: 03

Abbreviations used:
Q: Interviewer
R: Respondent

(Introduction)
Good evening, I wish to thank you for participating in this interview for my study at the university of the Witwatersrand. I am Tim Németh, physiotherapist, private practitioner in Belgium and as mentioned a student at the university in Johannesburg.

This is a qualitative research focusing on the physiotherapy policy framework in Belgium and in South Africa. I have explained the recording of this interview. You have given your written consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as frowning of the eyebrows or explicit head movements will be observed too. For this observation Prof. Raf Meesen is present. Prof. Meesen is one of my promotors and he will function as an observer during the interview. He will register the non-verbal communication.

The recorded interview will be transcribed, and the non-verbal communication will be integrated. Afterwards the text will be e-mailed to you for verification. After your final approval the written document will be used in my study. Do you agree with this procedure?

R: Yes.

Q: Do you have any other questions before we start the interview?

R: One question I have is regarding the policy documents. Are you referring to South African policy development on a national level or policy documents from the South African society of physiotherapy (SASP) that we developed?

Q: It is both. I am looking at the national level and what the professional association is doing in regards of the existing framework.

R: Okay.

(Opening question)
Q: Can you please state your age and your profession?

R: I am 61 years old and I am a physiotherapist by trade. I qualified in 1978.

(Introduction questions)
Q: Thank you. Can you describe your key role / position / mandate in the physiotherapy policy framework in South Africa?

R: I have e-mailed you sort of my job description ***(laughs)***. It will help you to just add some background information. In the policy framework in South Africa I do not have much to do with that. In the sense that, if we come later on how the policies are developed in South Africa on a national level, there is not much input from the profession and from a person ***(emphasises)***. What I do is, I am permanently employed by the SASP as the professional liaison consultant. And my key role, if you just glance through all the activities that I am doing, is basically to look strategically at any legislation, any policies, anything that is coming out from medical funders, from the government, from our health professions council

(gestures with hands) and how that influences the physiotherapy profession in South Africa. I am permanently employed by the society and looking after the profession strategically. That is in a nutshell what I am doing.

I am also quite involved, ***(leans back in the chair)*** I was one of the previous presidents of the society, and because of that and because of my permanent role as consultant in the office I am on the society policy committee. That is developing policies or looking at policies and what the society then does is then doing operational guidelines or supporting documents to give the finer details of how the policy should be implemented on a ground level. ***(leans forward)*** So, in a nutshell that is basically my main mandate and my influence. I am much more influential on the profession directly in the sense of the society representing the physiotherapy community in South African rather than on a national level. Unfortunately (***sighs)***.

Q: Did I understand you correct when you said that for the national policy development there isn't any person or professional organization that has sufficient or even remote influence?

R: What I meant by that is that the SASP represents over about 4600 physiotherapists in South Africa. The figures from our regulating body are not that trustworthy. ***(pauses)*** We believe that we are representing about 65 to 70% of the physiotherapy population in South Africa. And as that, if there is any consultation with stakeholders ***(emphasises)***, we would be one of the stakeholders. But the stakeholders and one of your other questions is coming to what is the current process in South Africa, in developing polices and so on. So unfortunately ***(frowns and leans forward)***, the stakeholders are coming in at a very late stage. So, in that sense, I would be the person that would receive and look at the legislation that is coming out for comments, like our national health insurance bill. This came out last year. I would be the person that is liaising with all the different constituencies within the physio community. And I am normally the one that is collating the policy document. So, then we as SASP would be the stakeholder when it comes to policy development. But not me in person necessarily. I am the liaison person getting all the information and drafting the documents and sending them out. But they are officially signed off by the president of the society.

(Core questions)
Q: In light of this and going further on this, for my study It is important to know the policy development process for physiotherapy in South Africa. I would like you to elaborate on the process of policy development for physiotherapy. How can suggestions be done? And listening to your story I imagine it is very difficult to do suggestions. What is the procedure for adaptations in current legislation? Can you please elaborate on the process and where you come in? Or more accurate where the physiotherapy department comes in?

R: In this case you are talking about the national level, like our national department of Health. ***(gestures with hands)*** Basically, there are two big regulating entities in South Africa that would do policy development for the physiotherapy profession.

The first is the national department of Health. That is regulated with the national health act. That is regulating all ***(emphasises)*** health services in South Africa.

The second regulating entity is the Health Professions Council of South Africa (HPCSA). Where it is necessary for us as physiotherapists to register. That is a compulsory ***(emphasises)*** registration every year that needs to be renewed. Obviously the HPCSA has ethical rules. We also fall under the health professions act. That is relating to our conduct of how we do our practice every day.

I think it is slightly easier to influence the HPCSA ***(looks up)***. Let me just say that the HPCSA is appointed by the Minister of Health. So, the HPCSA is also falling under the department of Health. So, the Minister of Health is the overseeing person looking after health services in South Africa. The HPCSA has 12 boards of which physiotherapy, podiatry ad

biokinetics is one. Obviously, the board members, there is 10 physiotherapists ***(nods, raises shoulders)***, so we have the majority because of that group we are the biggest. There are 10 physiotherapists that are on the board and then a few others of the other professions that we represent. There is a more direct influence on the board if there is any change to the ethical rules or anything. So, it is a little bit easier ***(emphasises and nods)*** to work with the HPCSA than it is with the Minister and the Ministers portfolios.

My role towards the HPCSA is I am the person that is drafting the e-mails and looking at changes in ethical rules that needs liaising with the board on behalf of the society and trying to influence if there are any changes to be made.

The Minister and department of Health is much more difficult ***(sighs)***. What happens at the moment is that if the national department identifies a policy to be made. If it is a national policy, like similarly I can use the national health insurance or in your country I would be called universal health coverage. That is the philosophy from the World health Organization (WHO). It is just different mechanisms in different countries. In our country they are using the national health insurance. That legislation came out in June last year as a bill ***(emphasises)***. For an external ***(emphasises)*** big legislation like that, first of all a committee within the department is identified. Then internal comments will first circulate within the department. Then it would go to all 9 provinces in South Africa. All of them have a head of Health. So that legislation will first go to them ***(uses hand gestures a lot)***. Then it will go to other management within the Province even down to the districts. And once it circulated within the national department of Health it will be going out for public comments to stakeholders and the public and so on. So, there is no interaction ***(emphasises and repeats)*** with the stakeholders during that process. It is only the employees and the national department of health. Then normally the bill is published and there is normally a three months period of sending in comments. The comments will come in and after the closing date it takes about 3 to 6 months in which they look at the comments, make changes and sometimes a second bill will come out. Once it goes through the stakeholders and everyone is happy it goes back to parliament and there is a parliamentary health and other committees it is discussed there. It goes to parliament who approves it and then it is approved by the president of the country. That is quite a lengthy process. This whole process takes between three and four years to complete. Legislation in South Africa takes quite a while ***(laughs and sighs)***.

There are two places basically where we could influence or make changes. It's obviously in that 3 months period when its open for comments. And also, in the parliamentary process we could request to attend the parliamentary committee and address and submit something to that committee. Unfortunately ***(emphasises)***, any other internal ***(emphasises)*** policies like e.g. the department will come up with a referral policy which is an internal national department of health policy. That never comes to stakeholders. And most of the time ***(looks and frowns)***, as I said by the time that it is published everyone has set their mind to it and we did not have any chance to influence before ***(emphasises)*** it is published.

Q: That is quite a process. Can I just ask you for my better comprehension; I know South African physiotherapists have a large scope of practice. But just as an example: if you did not have direct access or self-referral possibilities for the patients. If this would be an idea of the professional association to draft a policy and to get this into legislation. Could you briefly say which steps you would have to take in order to get this to the right person, the minister and in which timeframe if the idea would come from the society.

R: Obviously we do have direct access in certain circumstances. ***(laughs)*** If there is any new .... ***(pauses)*** The other thing in South Africa that is very difficult is the fact that we are a very small group ***(sighs)***. According to the HPCSA we are 7700 registered physios in South Africa. It is not known how many of those physios are working overseas. But they are still registered in South Africa. And how many are active? ***(leans forward)*** If we look at the doctors are about 30.000 and the nurses in South Africa is about 40.000. Unfortunately, physiotherapy per se is grouped with rehabilitation (occupational therapists, speech

therapists and so on). We actually recent started an indaba group to make our numbers a little bit bigger so that we have a bigger voice. ***(looks up)*** Although they realise and if you have a direct discussion with them, they realise that they can't do health services without physiotherapy and without rehabilitation services. When it comes to policy development it is very difficult because we are such a small group. The doctors and the nurses have the bigger voice. ***(gestures with hands)*** They get heard and they also get circulated documents much earlier than what we would get. If I think of any legislation if we as a society, our president has direct access to the minister of health. ***(speaks louder***) So, we do not need to go through the normal hierarchy of managers like if you were working for the department of health. Because as an association and as a stakeholder we could write a letter directly to the minister of health and say this is an urgent issue that we feel needs attention. We had a case were the protection of the physiotherapy title, which was in discussion and in legal process for the last three years adding animal health to physiotherapy. We battled about 8 months or was it more than a year to get an appointment with the minister. Eventually we did. So, if we feel strongly enough about it we could have a meeting with the minister and do a submission of a proposal directly to the minister.

Q: Hearing this, I think this is sort of a partial answer to my next question. You have outlined the elaborate framework which has no doubt some strong points. I am very interested in which aspects are very positive for physiotherapists. You have provided me with information on how you have direct access to the minister of health. Are there any other strong points within the legal system in place for you as physiotherapists to have influence on policy development?
(long pause)
R: The other strong point that we have is the access to the professional board at our health professions council. Ultimately the process is actually that we need to go to our professional board, any issues that we need to discuss must be approved by the board. Then the board goes to the council meeting where all the different professions are sitting. And the council is going to the minister. But in this case for instance with the protection of title issue, we didn't get any feedback or support from our board ***(emphasises)***, so we jumped, and we went to the minister immediately. That would be another avenue, is to go by the HPCSA. To also strongly motivate why a certain aspect or something needs to change in policy. There is no policy only ***(emphasises)*** pertaining to physiotherapy in South Africa. It is always on health professionals. And then to a certain extend to the disability and rehabilitation group together. So, whatever is policy for us will be policy for occupational therapists and speech therapists and so on. There is no specific policy only for physiotherapy on a national level.

Q: When you say there is no specific physiotherapy policy on a national level. If we go a level down to the provinces or even to the district level. Is there a specific physiotherapy legislation?

R: No! In the whole ***(uses hand gestures to draw a big circle)*** national department of health going from the national department to the provinces, and what is one of the big disadvantages in South Africa. Is that the 9 provinces are completely independent from each other and from the national department ***(speaks the words very clearly distinct from each other)***. Even if the national department has certain guidelines or they are making the policies, the provinces individually, the ministry of health of the province and the head of health and the whole structure within that province going down to district level, to the hospitals and down to primary health care. Provinces can identify their own priorities, guidelines and policies. Which makes it very difficult if you want to get anything implemented it doesn't help to only work with the national department ***(sighs)***. You have to go to all 9 provinces and get the buy in from them.

Q: Do I understand this correct that this is definitely a gap in the current system in place for policy development?
(very short pause quick answered)

R: Yes, for sure! Because all 9 provinces have provincial policies also. They may differ from one and another. So, they may be an idea from the national level saying you have to develop a referral policy. But then the 9 provinces will have 9 different referral policies.

Q: Can you think of any other gaps that are related to physiotherapy or the rehabilitation professions? Or did you just describe the main and most important gap encompassing all?

R: That is one of the most important ones ***(nods)***. But another one that came out now with our discussions with the national health insurance policy and bill that we had to comment on is the fact that we don't have any data available ***(lowers voice and looks up)***. The data that is available, particularly for rehabilitation as a group, and physio is even worse. We don't have any data really to support ***(emphasises)*** policy development. We don't have a national data hub to collect any data. There are individual provinces that are doing better than others. ***(raises voice)*** And of the rehabilitation groupings the physiotherapists are the best in keeping our own manual sort of data to at least have something. But it is a frustration for us as a professional association as well. When we have discussion with the national department or with medical funders and so on, they are throwing data at us and we can't counter this and can't accept, agree with it or reject it because we don't have any data. And obviously, and I think you know that our private sector is very strong in South Africa. We as an association would like to have data of all ***(gestures with hands)*** the services of physiotherapy. On a public sector side, in school health in private health and so on. So that we have the knowledge and also to make decisions. A simple example is that the ICD10 coding that can determine your disease profile, the national department is the custodians of ICD10 of South Africa but yet the public sector professionals working for the government it is not compulsory for them to use ICD10. The private sector side uses ICD10 a lot because they won't be paid if they do not ***(laughs)*** use an ICD10 code. The majority of people in South Africa are making use of public health and not private sector. So that is one of the gaps that we have identified.

The fact that we are grouped with rehabilitation. We are the biggest group. We are first line practitioners and have direct access and we are the only group within rehabilitation with that privilege. ***(leans forward)*** We are on duty 24/7 and 365 days of the year or services are required. Where other rehab professionals don't need that necessarily. We actually feel that is a determent in a sense that we are grouped. But because of the numbers ***(emphasises)*** if we really want to make a difference, we need to stand together with the rehabilitation groupings. I have made a few notes ... ***(short pause)***

The other gaps is, that policies in South Africa, particularly in an election year, are political driven rather than looking at the clinicians and what is really necessary. Some of the policies are pushed through because of politics and not really looking after the actual health needs ***(sighs)***.

We weren't aware of it, but they did recently a cost analysis of what the cost of rehabilitation services would be. That is part of the politics side of the NHI to be rolled out. The unfortunate thing is that rehabilitation was not part of the data. According to them they didn't collect any data for rehabilitation services and physiotherapy, so we were not included in the costing ***(laughs)*** which was very concerning.

Linking on to that is research protocols. How can we prove that we are making a difference? ***(raises shoulders)*** Using that as a bargaining tool. We are embarking on a process at the moment. Even if it is small research activities in the clinical fields. Particularly in the rural areas in the public sector. We can use that as a marketing tool and as a bargaining chip when we engage with the minister.

I think the last thing that can be seen as a gap is that none of the national departments are really talking to each other. They are working in isolation. The national department of health is working in isolation. The department of education is working in isolation. A simple example is transport. Patients are battling to get to health services because there is no public

transport and if there is, they pay double because they are disabled, and they have to use the wheelchair. There is no communication between the departments to try and sort it out. Another example is that it seems that some of the policies are going to the deans of the faculties, but the deans do not circulate it down to the relevant professionals or the relevant departments. And making decisions on our behalf. ***(frowns)*** These are a few of the gaps that I am thinking of that can be mentioned.

Q: Thank you. I am going to circle back to my literature review now. The literature showed a paucity of studies underpinning the physiotherapy policy framework in South Africa. In my whole search for peer reviewed published literature I did not find a single study describing conducted research on the framework itself. Although I am aware of several policy documents produced by the South African Physiotherapy Society. In the selected study, one of the problems surfacing was the lack of full possible engagement and use of physiotherapy knowledge in the existing policy development framework. I believe this confirms what you have described to me. Is there anything else that you would like to add to that? I am in particular interested, why, according to you, no published research has been conducted on the possibilities to have more influence as physiotherapists on the policy development process?

R: That is a difficult question ***(laughs)***. I do agree with your findings. On ground level and being involved in the society, really closely for the last 10 years particularly, the frustration ***(firm)*** is that we go through policy development and dictation ***(short pause, sighs)*** from the outside. I can't answer your question on why there are not more studies. I can say that it is actually over the last 10 to 15 years that in South Africa, post-graduate studies are getting momentum. The only thing that I can think of is that it was not in fashion or that is was not something that was driven in South Africa to do post-graduate studies. We were always quite happy to work and do daily activities and see your patients and so on. ***(looks up)*** Luckily it is changing, there is more and more research coming out. From a society point of view, we have a research committee. Most of the universities have a research forum. Where all universities providing post-graduate studies are sitting on. We try to influence and suggest topics for research going forward. At the moment the biggest need is to show the relevance of physiotherapy services and what the difference is that we can make. Because HR is a problem all over the world ***(emphasises)***. And so much so in South Africa as well. Our reasoning is if there is only one post available why must it be a physio? That is our focus at the moment with the national health insurance. A little bit on the clinical side. I think it's really important. Going forward that would certainly become more and more of a focus point. And you have highlighted it now so that is definitely a topic we can investigate.... ***(short pause)*** I do not have a clear answer on why there is no research on the topic.

Q: If there was a clear answer this study didn't have much added value. It is the input I get from people that I can collate which can probably direct stakeholders to possible solutions.

(Closing question)
At this point you have answered all my questions. Is there something you wish to add in general or to a specific item you have outlined?
(pauses)
R: I think that if you know what the gaps are that you also know what the solutions are. We would really like to see, as stakeholders, and as individual stakeholders ***(emphasises)***, providing health services in South Africa, that we are considered much earlier in policy development. So, by the time that it gets to the politicians and to the parliament and to the HODs that we on ground level would have given input.

Something that has been identified in South Africa on a national level is that we have to have proper data collection, of services and of HR. ***(gestures with hands)*** How can you develop policies and make decisions if you do not have data that is backing that up? That is one of our big concerns. And then obviously the different departments that are influencing our service, getting our patients to our services. How many students are training, how many are

placed? That all departments are talking to each other. These are some of the suggestions I had following the gaps. The 9 provinces working independently is also a change in legislation because it's written in our national health act. This means that the act needs to change. That might be a first project ***(laughs)*** we as a society will take on and influence the minister because it is a big frustration. And it's not just for physio as all other health professions complain about the same thing.

Q: Thank you very much for this. I want to again reassure you that the data derived from this interview will only be used as mentioned in the outline of this study. After transcription of the recordings, you will receive a copy to verify your answers. Thank you for your cooperation. This is the end of the interview.

Interview E

20190122_interview transcript
Number: 04

Abbreviations used:
Q: Interviewer
R: Respondent

(Introduction)
Good evening, I wish to thank you for participating in this interview for my study at the university of the Witwatersrand. I am Tim Németh, physiotherapist, private practitioner in Belgium and as mentioned a student at the university in Johannesburg.

This is a qualitative research focusing on the physiotherapy policy framework in Belgium and in South Africa. I have explained the recording of this interview. You have given your written consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as frowning of the eyebrows or explicit head movements will be observed too. For this observation Prof. Raf Meesen is present. Prof. Meesen is one of my promotors and he will function as an observer during the interview. He will register the non-verbal communication.

The recorded interview will be transcribed, and the non-verbal communication will be integrated. Afterwards the text will be e-mailed to you for verification. After your final approval the written document will be used in my study. Do you agree with this procedure?

R: I agree, yes.

Q: Do you have any other questions before we start the interview?

R: No, I don't have any questions. I am just saying beforehand that I am answering as a person, as a member of the society, because I am no longer the president of the society. I speak from my experience, but I cannot speak for the president of the society.

Q: Okay. Thank you for this elaboration and it is noted.

(Opening question)
Q: Can you please state your age and your profession?

R: I am 65 years old and I am a physiotherapist.

(Introduction questions)
Q: Thank you. Can you describe your key role / position / mandate in the physiotherapy policy framework in South Africa? In this case we would be talking about your former role to be exact?

R: Okay. I have been the deputy president for a year and then the president for two years and then the deputy president again for one year. And all that time you are on the policy committee, and you have quite a say ***(emphasises)*** in the policy of the society, while in that role.

Q: Can you please elaborate a little bit more on the details of the responsibilities attached to that role?

R: The responsibility is that the policy committee take the policies that are out there and interpreted it for the members and more or less write a ***(leans forward)*** user-friendly version

of the policy for the members. If any other policies come up or any other issues come up, we look at what the HPCSA, our health professions council, and we try to answer in a policy based on what they are saying.

Q: Am I understanding this correct by saying that you read the policies that are issued and then you transcribe them so they are better comprehensible for the physiotherapists in South Africa.

R: Yes. I must say that the policy-making body for health in South Africa is the HPCSA. We do not ***(emphasises)*** make any regulations as a membership society. ***(looks up)*** So, we merely interpret what they say, to our members. There are certain policies in which we try to make a stance, but it is always ***(emphasises with hand gestures)*** according to the laws and regulations of the HPCSA.

(Core questions)
Q: It is important, in light of my study, to know the policy development process for physiotherapy in South Africa. I would like you to elaborate on the process of policy development for physiotherapy. How can suggestions be done? What is for instance the procedure for adaptations? How can you influence the legislation? I am interested in the procedure itself.

R: I first want to start and say that for a few years we had an HPCSA that was dead ***(nods in confirmation)***. I can call it dead. It was dead. Nothing happened. When I became the deputy president, we went to them with things that we asked them for advice on. Questions that we got from members we weren't able to answer because we were waiting for the answer from the HPCSA. So, we went there in 2015 and we saw things that were still outstanding from 2007. But after that we got a new board for physiotherapy and they are more up and alive and they are more on top with what is going on. So, it takes much shorter to get something done. They are more interested in what we ask them. And actually ***(emphasises)***, every now and them we tell them we think it is time you take a stance as our members are asking this and this question.

Q: Can you please explain to me, because you said the previous board didn't do as much work as you would have liked them to do and this board is more active. Can you say how this board is chosen and composed? Do you have any influence on which physiotherapists are on this board?

R: I will try not to talk too much politics. ***(laughs)*** The HPCSA consists of several boards. One of them is the physiotherapy and biokinetics board. I can't remember how many boards there are. The overall rules and regulations of HPCSA were developed long ago and we think they are a bit behind of time. ***(leans forward and gestures)*** Specifically, on modern things like advertising. Health care professional, especially in the private health care system, are allowed now to advertise. .....
[failing connection]
Q: Apologies, I am going to have to stop you for a little bit. The connection failed briefly. The last sentence was lost.

R: Okay, I do not know what you didn't get. I will just go on. The important thing is that since the new board is there, we would advise them certain things especially based on questions and queries that are submitted to us by members. And they will see and look back at all the regulations and see if it is not addressed well enough and then they will take it to the HPCSA.

Our board is chosen by the minister of health. The minister of health will send out a notice and say a new board is due. Everybody ***(frowns)*** can send him some proposals for people. In the end, and we usually try very hard ***(emphasises)*** to send names of people that are knowledgeable with experience towards the profession. I must say with the new board

especially, he has chosen 4 or 5 people that are really knowledgeable and do actually have a heart for the profession.

Q: So, you are saying, the minister sends out a notice that there is a new board needed and therefor new names need to be put forward. Is this notice sent to the professional association?

R: It is published in the 'Staatskoerant' and also sent by e-mail to all the professional associations. So, it is, yes.

Q: So, you do get direct information from the minister in relation to this subject.

R: Yes, we do.

Q: In the framework you have outlined, I am now in particular interested, in what are the strong points for physiotherapists to have possible means of influence. Are there any key elements you can say are very well structured for physiotherapists?

R: ***(sighs)*** I think there are a few things that should have been addressed years ago but because of the previous board it wasn't. So, the current board is looking at prescription rights for physiotherapists. ***(leans forward)*** For the first time in about 8 years they have again picked up on it and are going to work, most likely, towards a post-graduate diploma. I do not know how far they are with this now. The key issue is that years ago the group of biokineticists were taken into our board. I think the older physios thought it would be better to have them on our board, to keep an eye on them. ***(laughs and frowns)*** But this resulted in this group thinking they can take the place of physiotherapy. So, we had, for about 4 years, a lot of people laid claims against that because they were doing passive work. Now that is sorted out. The new scope of practice is almost there to be published. This has taken a lot of time ***(emphasises)*** of the previous and the current board.

The other thing that is currently, and that we are very enthusiastic about, we have asked for more than 20 years now to have a slight specialisation. Or not even call ourselves specialised but have a slight advanced scope of practice. The previous board just no, no, no. I was on that committee for a very long time. Now, with the new committee, with the new board there is talks of it, that we will get something either like extended or advanced scope and that we will get that with a post-graduate diploma most likely ***(leans forward)***.

Q: You have now provided me with two excellent examples in which physiotherapy is advancing in South Africa. My main interest is, how do you get this far. What are the positive sides in the legal framework? I think you have to talk a bit politics now. How can physiotherapists achieve this advancement through the legal outlines?

R: Okay. My name is not on this ***(laughs)***. The problem is that we have a new board. In South Africa since 1994 a lot of people have been put into places with almost no knowledge of what they are supposed to do. ***(talks passionately)*** So, for a long time if we talked to the legal people of the HPCSA they sort of didn't have a clue on what we were talking about because they weren't medical orientated, they didn't know about issues at all. So as a body, as a membership organisation we really do not have a say. We can just advise the board what to do and we can complain if the members want to know something and we can't answer them as long as the board doesn't answer it. But legally the road to get there is: write a letter from the SASP, especially from the president or the deputy president, and we have somebody in the office too who worked with us and knows the legal roads a little bit more. We would write that letter stating, this is our problem and we think we need to take a legal stance on this, can you please help us. ***(looks up)*** I also want to explain to you or make an example to you as to why we do not have a say. We have a college in the southern cape that has started with a new course, a Bac in veterinary physiotherapy. Without ***(emphasises)*** being registered at the HPCSA they know there is a collusion to the veterinary council. We

fought it for millions in court just to hear: who are you? You are just a membership organisation. Where is your HPCSA? ***(frowns)*** Where is your minister of health? Up to then, with the new HPCSA they didn't want to go with us, so which means they didn't really supported us or gave legal assistance and give us the stance we needed to fight our fight. That is a huge lack that we experience ***(raises shoulders and leans back)***.

Q: That is already an answer to my planned next question on what are the gaps, you are experiencing in the current legal system. When you said, it was the previous board that wasn't quite as effective as you wanted to, and the current board is still a young board in terms of office. Is this a gap in the legal process or is that an advantage to you?

R: The new board is already there for two years and they have done quite a lot ***(firm)***. They get stuck at the main HPCSA. The board must take all issues to the main HPCSA. All the chairs of the boards must sit together and decide on things. It tends to get stuck there. So, it takes ages ***(prolongs the word)*** to get something done. Because, it takes a long time to get passed the main committee.

Q: Is that the major gap point of view physiotherapy association and individual member? Because you said, we have an advisory role. Is that the maximum you can achieve with the society or is there some why you can step out of the boundaries put on you as an advisory board and push towards something else?

R: I would say that the main gap, as a membership organisation, is we can decide on something and we can actually bring it to work within three ***(uses three fingers to point number 3)*** months. If you put something to the board it takes a year to happen. I think that is the main thing stopping the oiled wheels of the process.

Q: Do you have a legal power, within the professional association to take a policy on rehabilitation services and transform that into a policy for physiotherapists and have it enacted. Can you put that on your members as a society?

R: No, we don't have any ***(emphasises)*** legal power. We realised about five years ago that in the health documents of the government rehabilitation is not even mentioned ***(sighs)***, let alone physiotherapy in that rehabilitation. So, we immediately got together, the public sector and the private sector, we had a paper and a letter to the minister, which he put in a white paper that he put out. It is still far from what it should be ***(leans forward)***. Now we must wait for the wheels to turn in the government sector so we can get new input. We are also hampered a lot by the number of posts in the public sector. We realise that 80% of people in the country are served by 20 to 30% of physios working in the public sector. And about 20% of people are served by a huge number of private practitioners. Not because they do not want to ***(emphasises)***, but because there are no posts in the public sector. That is a huge hampering of what we want and how the society really wants to get rehabilitation going in the country. But we have no legal say in it. We can just ask the minister of health ***(raises shoulders)***.

Q: I heard you talking about a white paper. Is that a legal document or is that a law? How can I interpret that?

R: Is it a law? ***(pauses shortly)*** I think it is more or less a law once it gets changes from a green paper to a white paper. I am not absolutely clear how that works. But I am sure that when the minister signs a white paper, the next step will be for it to become a law.

Q: It is kind of a proposition where everybody can have their say on and then it goes back to the minister. Is that correctly outlined?

R: Yes, you can say it like that. It is something that is send out, to the profession where it is applicable. Usually through the professional society, but here and there are also smaller groups of physiotherapists that will comment on it and give their input.

Q: Smaller groups as in physiotherapists outside the society?

R: They are members ***(firm)***, but they will rather answer as a public sector group, or they will answer as a rural clinic group. There is a really strong rural group, and we use them a lot because they have a very strong say with the minister ***(leans forward)***.

Q: Can you please elaborate a bit more on why and how they have a strong say with the minister?

R: Now you will see my face ***(laughs)***. It is politically correct to work rural. We ***(emphasises)*** also realise that we should work rural, meaning there should be better services in the rural areas. But if you do not have posts for physiotherapists how can the work improve in those areas? ***(raises shoulders)*** That is why I say it is often just a political, correct term to use. It doesn't really come to practical output.

Q: They still are affiliated to the society?

R: I am not sure they are officially affiliated but in all our discussions when it is about rehabilitation, rural development, rural services, we work together with this group, the public sector group and sometimes also with the occupational therapists and speech therapists. In that case we have a stronger say in our letters to the minister and to the department of health ***(leans back)***.

Q: I now wish to circle back to my literature review. The literature showed a paucity of studies underpinning the physiotherapy policy framework in South Africa. In my whole search for peer reviewed published literature ***(nods in consent)*** I did not find a single study describing conducted research on the framework itself. Although I am aware of several policy documents produced by the South African Physiotherapy Society. In the selected study, I only found one partially addressing the structured framework in South Africa. In this study one of the problems surfacing was the lack of full possible engagement and use of physiotherapy knowledge in the existing policy development framework. Would you please, from your expert perspective provide me with an opinion on this? I am particularly interested why, according to you, no published research has been conducted on the possibilities to have more influence as physiotherapists on the policy development process.

R: I am aware of that ***(nods)***. I think that the biggest reason, it is quite sad, is that the majority of physios are in the private sector. ***(raises shoulders)*** And they are actually not interested in doing research in that area. So, you would think that universities would push it, and we have seen quite a lot of master studies in the last years on work in the public sector ***(uses hand gestures to count)***, on rehabilitation and on development of guidelines for certain things which are very relevant for South Africa. But I do not think it will come from a learner or from a student. I think if we do not get a university interested in this, or sensible for this, I do not think it will happen. The society doesn't have money ***(emphasises)*** for that. The society has had a lot of issues on which they wanted research done, for instance, what is the evidence for physiotherapy, what is the evidence for protecting the name for physiotherapy, for harm to the public, and things like that. These were much more important than to have an input to the framework ***(leans back)***.

Q: Isn't it logical to, also as a society, to investigate how you can influence that legal framework when you are spending a lot of money on issues to possible elaboration of scope of practice or protection of title, as all these issues go through the legal framework. So, that was kind of a surprise for me going over the literature.

R: I think you are right ***(nods)***. I think there is a huge gap and I think that the society should look at that. I think that we have gone through a period in South Africa, where we thought we have no say. ***(leans forward)*** Do you know that the other physiotherapy society that was started because we were too white? I was president at that time. I worked very hard to get them back in, because I realised that if black people are with us, we would get much further with the minister. They were not interested in that and now they have actually died to about 50 members. ***(looks up)*** So, I hope that the next president is very aware ***(emphasises)*** of this and he will take it up. I know he is also a person that if we take this up with him, he will take it up with part of the university too. And I am almost sure that the university will say, let's work on this. Once you have advised it and it is part of your conclusion on what your findings are.

Q: Thank you. Furthermore, I would like you to outline your opinion on the predisposition I found on the lack of full possible engagement of physiotherapists. Is this a valid statement according to your view on the matter as a key role player?

R: What is the statement that I must comment on?

Q: Does the legal policy framework use the full potential of the physiotherapy knowledge available?

R: No ***(firm)***, I do not think the legal framework does. Because the people that have developed it didn't have enough insight in the profession itself. I think politics play a much bigger role than the real medical professions that are there. ***(chooses words carefully)*** So no, I don't think so.

Q: Thank you. You have provided me with your professional insights on the strengths and on the gaps of the system. Can you perhaps provide me with possible solutions to the gaps you did describe? And it is noted these are your personal opinions.

R: I do think that the board should make more use of the professional society. I think there is a lot of expertise on the boards of the national executive committee. Meeting ***(emphasises)*** with them would inform them a lot on what is really ***(emphasises)*** going on the ground level and what are the real issues for the profession. It would be a solution for the board to meet with the professional societies, all the professional societies. We ourselves have started to meet with the biokineticists and other allied workers to be able to have a strong voice. But we have never been asked to come together once a year for a meeting with the health professions council ***(frowns and leans back)***.

(Closing question)
Q: At this point you have answered all my questions. Is there something you wish to add in general or to a specific item you have outlined?

R: No, I don't. I just want to say again that I believe that if the professional board is less separate ***(emphasises)*** from the professional societies, we would develop more applicable regulations and guidance of the professions. There really is a big split and a big gap between the board and the society. But I must immediately say that it is already better the last year ***(leans forward and raises voice a little)*** and a half than it was before, and I hope that it will improve even further.

Q: Is this referring back to your statement on the advisory role the society has?

R: Yes, our advisory role for the reason that we have our ear on the ground and we work with the problems of both the private and the public sector every day ***(emphasises)***. We have all of them under NEC and we have meetings with them. We realise very well what their problems are, which I am not sure is realised by our board ***(raises shoulders and leans back)***.

Q: Thank you very much for this. I want to again reassure you that the data derived from this interview will only be used as mentioned in the outline of this study. After transcription of the recordings, you will receive a copy to verify your answers. Thank you for your cooperation. This is the end of the interview.

Interview F

(Introduction)
Good evening, I wish to thank you for participating in this interview for my study at the university of the Witwatersrand. I am Tim Németh, physiotherapist, private practitioner in Belgium and as mentioned a student at the university in Johannesburg.

This is a qualitative research focusing on the physiotherapy policy framework in Belgium and South Africa. I have explained the recording of this interview. You have given your written consent for your participation and for the recording.

Besides the text analysis of your professional opinion, the latent information such as frowning of the eyebrows or explicit head movements will be observed too. For this observation Prof. Raf Meesen is present. Prof. Meesen is one of my promotors and he will function as an observer during the interview. He will register the non-verbal communication.

The recorded interview will be transcribed and the non-verbal communication will be integrated. Afterwards the text will be e-mailed to you for verification. After your final approval the written document will be used in my study. **Do you agree with this procedure?**

Do you have any other questions before we start with the interview?

(Opening question)
Can you please state your age and profession?
Age: 56 years
Profession: Physiotherapist

Can you describe your key role / position / mandate in the physiotherapy policy framework in South Africa?

Position: Chairperson of the Physiotherapy, Podiatry & Biokinetics Board (PPB)
The PPB Board is one of the 12 professional Boards of the HPCSA, responsible for the Physiotherapy profession matters.

As the Chairperson of the PPB Professional Board, I serve in the Council of the HPCSA which is constituted by 32 members. The Council is the highest decision-making body of Council.

Mandate: The PPB Board is mandated to protect the public & guide the profession.
The Board is governed by the legislative framework of the National Health Act as well as the Health Professions Act.

Therefore, my role as the Board chairperson is to preside over the Board as well as the executive committee in decision making on matters pertaining to the profession.

Can I ask you to provide some details on the responsibilities attached to this position / mandate?

The Board is the custodian of the Scope of Practice of Physiotherapy in South Africa.

The areas of responsibility are as follows:
1:
For anyone to practice Physiotherapy, the legislation requires that an individual be registered with the HPCSA. Registration occurs at different levels, for example, as a trainee (physiotherapy student), as Community service graduate and as a qualified physiotherapist.

If a physiotherapist fails to pay annual prescribed fee, they get suspended from the register.

For restoration process includes having to pay the restoration fee and to work under supervision.

2:
Accreditation of institutions that trains physiotherapy students. The institutions are accredited every 5 years. This is done by a panel that visits the institution to review the curriculum to check if what is taught to the students is within the prescribed scope of practice. The training facility is inspected, that is the lecture hall, practical training rooms, laboratories, libraries, Clinical facilities, staff rooms and any other facility that is used for training students. The facilities are inspected for the size, to see if they are able to accommodate the number of students accepted within the institution. Health and safety issues are also considered during site visits.

3:
Registration of Foreign qualified physiotherapists who wish to practice in SA, is a function of the Board. The Board sets Board exams which the Foreign qualified graduate physiotherapists is expected to write to determine if they may practice in South Africa or not. The Board exams have two parts, the theory and the Clinical part. The clinical part is done on patients in a hospital similar to the final year physiotherapy student set up.

Before they sit for Board exams, the application is scrutinized for curriculum compliance, that is, if the qualification is equivalent to the SA one, and that they have covered the clinical hours whose content will enable them to work with the SA population.

4:
CPD: The physiotherapists, like all Health professionals, have to comply with continuous professional development. The Board has an oversight role that the physios need to comply with CPD through an audit process.

The Board also accredits institutions and training entities that offer CPD courses. This is done on an annual basis, through an application process.

5:
Professional conduct: When the physiotherapists have been deemed to have transgressed the ethical rules, they are reported by colleagues or members of the public. There is a Committee that deals with complaints against practitioners that determine the nature of transgression. The reports of the complaints serve at the Board, that allows the Board to determine the trend of transgressions committed by physiotherapists. Awareness of such transgression is communicated via the newsletter.

(Core questions)
It is important, in light of my study, to know the policy development process for physiotherapy in South Africa. **I would like you to elaborate on the process of policy development for physiotherapy. How can suggestions be done? What is the procedure for adaptations in current legislation?**

The board identifies a regulation gap and the matter gets debated by a Task team of the board. The task team would comprise of Board members who are knowledgeable with the subject matter. The recommendations thereof serve at the Board. The Board takes the matter to the stakeholders for input and comments. The matter then goes back to the board for discussion to consider the input of stakeholders. Then the matter once finalized by the Board, it is taken to other 11 Board for further comments. Then it comes back to the Board to consider the input of the other boards. The Board then finalize on the matter, send it to legal department for legislative input, then it serves at Council for ratification. From Council it goes

from legal department to the Department of Health for legislation. The Minister is the one who signs it off to be sent to Parliament for legislation.

Suggestions are done through stakeholder engagements which include the universities, South African Society of Physiotherapy, Public sector physiotherapy forum members.

This outline of the framework has no doubt strong points. I am in particular interested in the aspects that are positive for physiotherapists. **Can you please provide your opinion on the positive aspects, in favor of physiotherapists, in the current system of policy development?**

The positive aspect is that, Physiotherapists are self-regulating, at any given point in time there is an opportunity to amend rules that govern the profession. The policies may also be amended through the process outlined above.

The system of policy development is elaborate, but it has an added advantage in that all other professions within the HPCSA have an opportunity to comment and give input without dictating what physiotherapy can do or not. Thus, affords an opportunity for the profession to reflect.

Every system has also aspects or procedures less favorable. I am interested in your opinion regarding the gaps and weaknesses in the current system, as described by you, relating to physiotherapy or physiotherapist involvement. **Can you please outline these gaps and weaknesses for me?**

The weakness of the process is that it takes a very long time to influence policy. The stakeholders face to face meeting takes place once a year. Although the request for input on policy items is circulated well before the meeting with deadlines, the stakeholders do not always adhere to the required timelines. Then at the meeting the stakeholder's questions input presented. Then more input is added, the Board has to go back and consider additional input. This then further prolongs the policy development process as it gets deliberated at the next Board meeting. The Board meetings takes place twice a year.
The policy for consideration circulates through to all Boards for input, that is valuable, but it does take time due to the varying meeting times of the different Boards.

The process of approval by the Minister of Health through to Parliament takes even a longer period, up to 5 years, as the policy must be published in the government gazette after it has gone through various committees in parliament.

The literature showed a paucity of studies underpinning the physiotherapy policy framework in South Africa. In my whole search for peer reviewed published literature I did not find a single study describing conducted research on the framework itself. Although I am aware of several policy documents produced by the South African Physiotherapy Society. In the selected study, one of the problems surfacing was the lack of full possible engagement and use of physiotherapy knowledge in the existing policy development framework. **Would you please, from your expert perspective, provide me with your opinion?** I am in particular interested, why, according to you, no published research has been conducted on the possibilities to have more influence as physiotherapists on the policy development process?

I would not be very sure why there are no studies undertaken to review the policy. I guess the researchers had always focused on clinical aspect of physiotherapy rather than Policy. It could be the matter of interest of physiotherapists. I also think the research focus of each institution does contribute to the lack of policy focus of the researchers. Also, it could be that there is less awareness of how policy is developed, or the physiotherapist are less concerned about policies.

Furthermore I would like you to outline your opinion on the predisposition found on the lack of full possible engagement of physiotherapists. **Is this a valid statement according to your vision as a key role player?**

The current structure of engagement of the regulator (HPCSA) and the stakeholder presents limitations. The formal engagement is through the Physiotherapy Society and the universities. The individual physiotherapists are only encouraged to report ethical transgressions to the general complaints section of the HPCSA and there has not been a time when the opinion of physiotherapists has been sort on a matter for policy review.

Perhaps as the HPCSA upgrades the ICT there is an opportunity to communicate more with individual physios rather than through the Society or universities only as it is the current scenario.

Therefore, the statement is valid, there is lack of full engagement of individual physiotherapist who are registered with HPCSA.

You have provided me with your expert insights on the strengths and gaps of the system in place. **Can you please provide me with possible solutions to the gaps you have described in relation to the literature findings?**

The engagement of individual Physiotherapists is pertinent in policy development. Through the use of website, emails, sms, the Board can reach all the physiotherapists in seeking opinion. This in turn can raise awareness on policy issues and increase participation.

(Closing question)
U have answered all my questions. **Is there something you wish to add in general or to a specific item you have outlined?**

The area of policy and or regulation is very underdeveloped in SA. For one to serve at the HPCSA or the Board, does not need any specific qualification. There are no institutions that train regulators. The nomination to serve on the Board is done by colleagues who put forward the name of the physiotherapist to be selected by the Minister of Health. That person needs no prior knowledge of policy nor having studied regulation, they learn on the job. This is a major deterrent to policy development because to learn how regulation functions and to behave like one, you need to be in the system for about two years. The term of office is five years. By the time one wakes up to policy issues, it is mid term already and have lost out on time.

This is my second term in the Board, so I carry an advantage of the lessons from the previous term.

However, there is a suggestion at Council to train all health professionals in regulation before they assume office. That has not taken place as yet. If it does occur, it will really move policy development in a proper direction.

I want to again reassure you that the data derived from this interview will only be used as mentioned in the outline of this study. After transcription of the recordings, you will receive a copy to verify your answers. Thank you for your cooperation. This is the end of the interview.