A Global View of Direct Access and Patient Self-Referral to Physical Therapy: Implications for the Profession

Tracy J. Bury, Emma K. Stokes

Background. International policy advocates for direct access, but the extent to which it exists worldwide was unknown.

Objective. The purpose of this study was to map the presence of direct access to physical therapy services in the member organizations of the World Confederation for Physical Therapy (WCPT) in the context of physical therapist practice and health systems.

Design. A 2-stage, mixed-method, descriptive study was conducted.

Methods. A purposive sample of member organizations of WCPT in Europe was used to refine the survey instrument, followed by an online survey sent to all WCPT member organizations. Data were analyzed using descriptive statistics, and content analysis was used to analyze open-ended responses to identify themes.

Results. A response rate of 68% (72/106) was achieved. Direct access to physical therapy was reported by 58% of the respondents, with greater prevalence in private settings. Organizations reported that professional (entry-level) education equipped physical therapists for direct access in 69% of the countries. National physical therapy associations (89%) and the public (84%) were thought to be in support of direct access, with less support perceived from policy makers (35%) and physicians (16%). Physical therapists’ ability to assess, diagnose, and refer patients on to specialists was more prevalent in the presence of direct access.

Limitations. The findings may not be representative of the Asia Western Pacific (AWP) region, where there was a lower response rate.

Conclusions. Professional legislation, the medical profession, politicians, and policy makers are perceived to act as both barriers to and facilitators of direct access. Evidence for clinical effectiveness and cost-effectiveness and examples of good practice are seen as vital resources that could be shared internationally, and professional leadership has an important role to play in facilitating change and advocacy.
Attaining professional autonomy is a high priority for physical therapists and their professional organizations. Since the mid-1990s, the position of the World Confederation for Physical Therapy (WCPT) on autonomy is that physical therapists “are able to act as first contact practitioners, and patients/clients may seek services directly without referral from another health care professional.”

Direct access and patient self-referral to physical therapists are manifestations of professional autonomy. If another profession is seen to dominate or control access to physical therapy services, it limits or weakens professional autonomy. The extent to which physical therapists have autonomy varies within and between health systems internationally.

Of the 2 terms, “direct access” and “patient self-referral,” the former is more recognizable across the profession globally and among other health professionals, politicians, and government officials. It is usually the term used to refer to patients seeking the services of a physical therapist without referral from a third party (usually a physician). However, in some instances, it may be used to describe the situation where physical therapists have direct access to assess and treat patients without a medical referral, for example, in an intensive care unit where physical therapists determine which patients can benefit from physical therapy. This situation is distinct from patient self-referral, which implies that patients are able to refer themselves to a physical therapist without having to see anyone else first, or without being told to refer themselves by another health professional (this situation can relate to telephone and face-to-face services, as well as those delivered via the Internet).

The WCPT’s MOs in order to develop a global picture of direct access to physical therapy. Given the desire of WCPT to assist with policy development and implementation nationally, it also was considered important to understand the potential barriers and facilitators of direct access and, where relevant, to learn from the experiences of those countries where direct access was available. Due to the policy focus, the study was placed in the context of professional practice and national legislation, health systems, financial models, and educational requirements.

Method
Participants
The WCPT is a confederation of MOs. It has 106 members, representing more than 350,000 physical therapists worldwide. A country may only have one organization belonging to WCPT; therefore, 106 countries were represented in the participant sample. The survey was open to all MOs, including new members up for approval at the General Meeting in June 2011 (8 of the 106 members). Each MO has a primary contact registered with WCPT, who was contacted with the survey details and invited to participate. Only one response was permitted per organization, and the named contacts were advised to collect any necessary information and consult with others prior to completing the survey in order to provide a national perspective on behalf of their organization. The WCPT also has a regional structure of 5 regions through which the survey was promoted (for a list of MOs by region, visit http://wcpt.org/regions).

Study Design and Protocol
The study was a nonexperimental descriptive study utilizing both quantitative and qualitative methods. We developed a pilot survey tool using SurveyMonkey (Palo Alto, California, available at http://www.SurveyMonkey.com). The questions were informed by the findings of previous studies, discussions at the international policy summit, and inquiries to WCPT. English is the working language of WCPT and in all communications with its members,
A second iteration of the survey was sent to an international reference group of 11 individuals knowledgeable in the subject to provide feedback, 2 of whom also had been at the European workshop and, therefore, were privy to the discussions. Based on this feedback and responses from the workshop, content validity was established and the survey instrument was finalized (Appendix, available at ptjournal.apta.org).

The WCPT does not have an ethical review committee, but the WCPT Executive Committee gave its approval of the study, recognizing that the study was developed in line with the Declaration of Helsinki and other international guidelines.58–40

The purpose of the survey and how the data were to be used were set out in the survey invitation. Participants were assured of the confidentiality of contact information, and respondents were followed up to ensure consent for the release of data and given the opportunity to decline consent on the whole submission or specific questions if countries were to be identified in any reporting. Every effort was made to ensure anonymity of the respondents.

Participants were invited to complete the survey in July 2010, and the survey was kept open for 12 months to allow for follow-up with nonresponders. Several reminders were sent via e-mail during this period. Survey data were exported into Excel (Microsoft Corporation, Redmond, Washington), which was used for analysis.

**Data Analysis**

Descriptive statistics, including frequencies, percentages, and chi-square analysis, were used to summarize quantitative data. *Post hoc* cross-tabulations were completed using chi-square tests to examine the relationship between legislation and direct access and the relationship between direct access and scope of practice; the significance level was set at .05.

Qualitative data were categorized and analyzed using content analysis. Both authors independently reviewed the responses to open-ended questions, coding them to develop categories, and they then reviewed assessments together. Where categories differed, the authors reached agreement on labels through discussion and consensus. They then reviewed the allocation of responses against the categories to review any differences and reach consensus.

A subset of the data relating to the MOs of WCPT in the EU has been analyzed in the context of workforce migration issues in the EU, which supports the free mobility of professionals across national boundaries, as it is required of all member states of the EU.41

**Results**

Seventy-two of the 106 MOs completed the survey, a response rate of 68%. The size of organizations belonging to WCPT is wide ranging, and Table 1 gives details of participants and respondents, including response rates by region (range = 38%–85%). The WCPT has had members since 1951, so some are longstanding and well established, whereas others are relatively new and still developing; the sample included 8 new MOs approved in 2011.

Forty MOs (40/69, 58%) reported that direct access and self-referral were permitted in their countries, either occurring where it was permitted, by legislation, or by professional practice in the absence of national legislation. There were variations on a regional basis, as shown in Figure 1. Of the 57 MOs (n = 57/71) who reported that national legislation existed, 57% (n = 30/57) reported that direct access was permitted. Of 14 MOs who reported an absence of legislation, 71% (n = 10/14) reported that there was direct access (P = .2). In 2 countries with state or provincial legislation, availability was determined on a state-by-state basis.

Of those acknowledging the permission for direct access, 19 (19/40, 48%) indicated that direct access was available in both public and private health settings, with 17 (17/40, 43%) indicating that it was present only in private health settings. In addition, 15 MOs reported that direct access did occur in the private setting, even though it did not appear to be supported by legislation or professional practice. Free-text explanations for this disparity suggested it occurred and patients and physical therapists took the risks in the absence of legislation, the application of legislation to the private practice was unclear, or only preventative advice was given. This global variation is shown in the Appendix. Where there was direct access in the private setting, respondents reported that reim-
bursement for individuals with insurance policies was dependent on the policy (30/51, 59%), and 14 indicated that the insurance did not cover physical therapy.

Respondents reported that private physical therapy services might be self-funded (67/71, 94%) or funded through private or voluntary insurance premiums (54/71, 76%), compulsory insurance premiums (23/71, 32%), or a public tax-funded system (25/71, 32%), none of which were mutually exclusive. In the public health system, services were most frequently funded through public taxation (54/71, 76%), but this funding was often supplemented by patients self-funding (19/54, 35%), private or voluntary insurance premiums (21/54, 39%), and compulsory insurance premiums (19/54, 35%).

Respondents identified some limitations affecting direct access where it was available, including: conditions were mainly limited to those of a musculoskeletal nature (n = 1); only prevention and health education, not treatment (as defined by national legislation), were permitted (n = 2); some specific interventions were restricted (eg, manipulation, wound debridement), and electrophysical agents were excluded (n = 4); a phy-

Table 1.
Participants

<table>
<thead>
<tr>
<th>WCPT Region</th>
<th>No. of Member Organizations</th>
<th>Surveys Completed</th>
<th>Response Rate</th>
<th>Size of Member Organization (Reported Member Numbers [Median and Range])</th>
<th>Length of Membership in WCPT (y)</th>
<th>Size of Member Organization (Reported Member Numbers [Median and Range])</th>
<th>Length of Membership in WCPT (y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>16</td>
<td>11</td>
<td>69%</td>
<td>84 (15–3,254)</td>
<td>16 (4–60)</td>
<td>66 (25–650)</td>
<td>16 (0–33)</td>
</tr>
<tr>
<td>Asia Western Pacific</td>
<td>26</td>
<td>10</td>
<td>38%</td>
<td>471 (30–59,586)</td>
<td>22.5 (0–60)</td>
<td>515 (80–21,511)</td>
<td>16 (0–44)</td>
</tr>
<tr>
<td>Europe</td>
<td>40</td>
<td>34</td>
<td>85%</td>
<td>1,050 (64–38,375)</td>
<td>37 (4–60)</td>
<td>290 (42–974)</td>
<td>14 (0–23)</td>
</tr>
<tr>
<td>North America Caribbean</td>
<td>13</td>
<td>10</td>
<td>78%</td>
<td>45 (24–52,342)</td>
<td>30 (4–60)</td>
<td>30 (20–124)</td>
<td>12 (4–20)</td>
</tr>
<tr>
<td>South America</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>310 (30–5,215)</td>
<td>41 (4–52)</td>
<td>128 (40–1,124)</td>
<td>4 (0–16)</td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>72</td>
<td>68%</td>
<td>552 (15–59,586)</td>
<td>31 (0–60)</td>
<td>200 (20–21,511)</td>
<td>12 (0–44)</td>
</tr>
</tbody>
</table>

a WCPT—World Confederation for Physical Therapy.

b Data from 2011 reported member numbers per member organization (not the same number as practising physical therapists per country).

c 1 new member organization in 2011.

d 2 new member organizations in 2011.

Figure 1.
Patterns of direct access globally by region of the World Confederation for Physical Therapy (WCPT). AWP = Asia Western Pacific, NAC = North America Caribbean, SA = South America.
sician referral was required in public settings (n=2); and institution-based policies and commissioning determined whether direct access and self-referral services were permitted, irrespective of national legislation (n=5).

Both legislation and direct access appeared to have an influence on physical therapists’ scope of practice. Where there was national legislation governing the physical therapy profession, physical therapists were more likely to be able to treat (100% versus 88%, n=70, P=.01) and offer preventative advice (96% versus 81%, n=70, P=.04), but their freedom to refer on to other specialties was less (35% versus 69%, n=70, P=.02). Where direct access was permitted, it was seen to have a positive bearing on the scope of practice of physical therapists in terms of assessment, diagnosis, and referral to specialists, as shown in Table 2.

Respondents were asked to comment on whether physical therapy qualifying education equipped physical therapists for direct access. Sixty-nine percent of the respondents (n=45/65) said that it did equip them compared with 31% (n=20/65) who said no. Not all WCPT MOs are based in countries with qualifying education programs. In those countries (n=20) where further educational measures were required prior to physical therapists having the necessary competencies for direct access, 60% (12/20) indicated that a period of supervised practice or continuing professional development was required, and 35% (7/20) indicated that a master’s-level qualification was necessary. These options were not mutually exclusive.

Seventy-two percent of the respondents (n=46/64) felt that the national physical therapy association was completely supportive of direct access, 17% (n=11/64) felt there was limited support, 6% (n=4/64) were unsure, and 5% (n=3) felt there was no support. This latter finding was explained by 2 respondents as a reflection of the profession not being educationally equipped for direct access. Member organizations perceived there to be support for direct access from patients, with 84% (54/64) reporting that they thought patients were supportive. This finding contrasted with MOs’ perception of the level of support from politicians and policy makers, where 35% (22/63) of respondents felt there was support. Only 16% (10/63) of the respondents felt there was support from the medical profession, with 59% (37/63) reporting that they felt the medical profession did not support direct access.

Respondents were asked to rate potential barriers to and facilitators of direct access and self-referral on a scale of 1 to 5, where 1 was a minor barrier and 5 was a major barrier, and 64 responded. Recognizing that items may work as both barriers and facilitators, there was some overlap in the topics across the questions. Fifty-nine respondents (n=59/64, 92%) identified medical support as a barrier, with 54% rating it as a strong factor (rated 4–5); it also was reported to be a facilitator by 45 respondents (70%), with 67% rating it strongly (rated 4–5). Factors were perceived to have the potential to be both barriers and facilitators, as shown in Figure 2, with the strength of effect being perceived to be stronger when acting as a facilitator.

Respondents were asked to identify what resources they felt would help them in taking forward direct access and self-referral as a policy nationally, and 68% (49/72) responded. A number of themes emerged, which are presented in Table 3. Generally, respondents identified more than one resource or activity that they thought would be beneficial.

Ten MOs (n=10/72, 14%) commented on their experience of implementing direct access and self-referral policies nationally. Advocacy activities such as lobbying, campaigning, and advertising were reported by 5 respondents. Securing the engagement from the medical profession and health service commissioners was reported by 3 respondents, and 2 referred to engagement with politicians as important. One respondent had undertaken a focused knowledge translation initiative led by the national professional organization. Four respondents thought that rais-

<table>
<thead>
<tr>
<th>Physical therapists are able to:</th>
<th>Direct Access and Self-Referral Permitted (n=40)</th>
<th>No Direct Access and Self-Referral (n=29)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess</td>
<td>40 (100)</td>
<td>24 (83)</td>
<td>.01</td>
</tr>
<tr>
<td>Diagnose</td>
<td>35 (88)</td>
<td>9 (31)</td>
<td>≤.000*</td>
</tr>
<tr>
<td>Treat (ie, interventions, advice, and evaluation of outcome)</td>
<td>40 (100)</td>
<td>27 (93)</td>
<td>.09</td>
</tr>
<tr>
<td>Refer on to other specialties/services (eg, x-ray/ultrasound/specialist)</td>
<td>28 (70)</td>
<td>4 (14)</td>
<td>≤.000*</td>
</tr>
<tr>
<td>Offer preventative advice</td>
<td>38 (95)</td>
<td>26 (90)</td>
<td>.4</td>
</tr>
</tbody>
</table>

* Asterisk indicates significant at .0001 level.
Table 3.

Resources Identified as Required by World Confederation for Physical Therapy (WCPT) Member Organizations to Help Progress Direct Access

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Responses (n)</th>
<th>Example Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence</td>
<td>Evidence demonstrating clinical effectiveness and cost-effectiveness of direct access</td>
<td>18</td>
<td>“Evidence supporting effectiveness of direct access in other . . . countries”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“More evidence for the cost-effectiveness of self-referral”</td>
</tr>
<tr>
<td>Knowledge translation/</td>
<td>Requests for examples of models of good practice and service delivery exemplars</td>
<td>15</td>
<td>“Best practice models from research outcomes”</td>
</tr>
<tr>
<td>knowledge-to-action resources</td>
<td></td>
<td></td>
<td>“Information on the implementation and success of direct access/self-referral”</td>
</tr>
<tr>
<td>Education</td>
<td>Improvements in the education of physical therapists at both entry level and post-qualifying level to equip them with the competencies required for direct access and self-referral</td>
<td>11</td>
<td>“If the entry-level education is improved toward diagnostic skills, then this will aid direct access”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Workshops with other specialists”</td>
</tr>
<tr>
<td>Legislation</td>
<td>Review and changes to national legislation and regulatory requirements to permit direct access and self-referral to physical therapists</td>
<td>11</td>
<td>“Proper legislation and act/law on physiotherapy profession”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“To include the ‘direct access’ in the law”</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Initiatives aimed at securing political support</td>
<td>13</td>
<td>“Awareness campaign and public relations with Ministry”</td>
</tr>
<tr>
<td></td>
<td>Medical and other health professional support</td>
<td>10</td>
<td>“If the physicians can view it as a means of getting the assistance to the patient early and so reduce their workload . . . can see the benefit in terms of dollars and cents”</td>
</tr>
<tr>
<td></td>
<td>Raising awareness and support among the public</td>
<td>9</td>
<td>“Creation of more public awareness”</td>
</tr>
<tr>
<td>Professional leadership</td>
<td>From WCPT internationally and member associations nationally, in the form of policy statements, guidance on education, and regulation and the collation of evidence and best practice models</td>
<td>11</td>
<td>“Professional organization agreements”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Policy statement from WCPT on direct access”</td>
</tr>
</tbody>
</table>

Figure 2.

Barriers and facilitators to direct access as reported by the World Confederation for Physical Therapy (WCPT) member organizations (MOs). PT=physical therapist.
ing educational standards of qualifying professional (entry-level) physical therapist education and containing professional development had been successful. Only 1 respondent noted success with legislation changes. A limited number of MOs had resources on direct access available on their websites, although they were not all open access and restricted to members-only areas.

Respondents were provided with the opportunity to make any additional comments at the end of the survey. No new themes emerged, but those associated with the successful implementation of direct access and resources thought to be necessary were reinforced. There were requests for assistance in implementing legislative change that recognized the autonomy of the physical therapy profession and the inclusion of direct access (n = 4). The role of national professional organizations and WCPT in facilitating change in favor of direct access and self-referral was highlighted, along with a desire for a network of experts (n = 4). The need for terminology to be clear in defining direct access and self-referral was identified as important in the collation of evidence to ensure that true clinical effectiveness and cost-effectiveness could be evaluated (n = 2).

Discussion
This survey set out to develop a global profile of direct access and patient self-referral for physical therapy to identify where it was available and to investigate the context of practice, factors influencing it, and the resources that were thought necessary to further advance and develop services. The participants were selected to provide a national rather than an individual perspective, representing a collective opinion from a professional physical therapy association.

Previous studies have focused on clinical effectiveness and cost-effectiveness, medical and public acceptance, and, to a limited extent, barriers and facilitators, usually in the context of individual practice. As noted by McCallum and DiAngelis, comparing studies on direct access is difficult because of the way in which direct access to physical therapy has been defined across studies and the data collection applied.

Direct access and patient self-referral is not a new model for providing physical therapy services. In 1976, the Australian Physiotherapy Association repealed its first ethical principle, which stated that “physiotherapists would only treat patients referred to them by a registered medical practitioner.” At the time, the widespread model of physical therapist practice was one where physical therapists took direction from a physician. The initiative from Australia was taken to the meeting of WCPT in 1978 to facilitate this move in other MOs, and a motion was passed that “the issue of primary practitioner status be interpreted by each country in terms of their own standards.” Since then, progress across the MOs of WCPT has been varied, and the issue is now a high-profile advocacy issue for many. Some have already reaped the benefits of advocacy initiatives and legislative change, and many more strive to make the changes and are keen to learn from their international colleagues. Member organizations responding to the survey offered to share experiences of implementing direct access, suggested developing a network of experts, and identified the need for guidance on legislative change to support direct access and self-referral. A limited amount of online resources and other education material also was identified.

The findings build on what is known at a national level in a limited number of countries, providing a diverse picture of direct access. It would appear that direct access and self-referral as an objective requires strategic coordinated action. This objective is unlikely to be achieved at an individual level and requires leadership from professional physical therapy associations and service leaders working on a number of strategies. Advocacy strategies with all stakeholders, including physical therapists, politicians and policy makers, the medical profession, and service users, such as the use of awareness campaigns using a variety of media, tailored to different stakeholder groups, with which some are already engaged, are likely to be important. The role of advocacy strategies is supported by a small study, which included both members and nonmembers of APTA. Securing professional support and empowering individual physical therapists are likely to be achieved with leadership from national associations and opinion leaders. Other strategies identified included raising the standards of physical therapist entry-level education to equip physical therapists for autonomous practice and direct access, and reviewing legislation.

The perceived barriers to and facilitators of direct access, surrounding the views of key stakeholders (the medical profession, policy makers, and the public), represent the views of physical therapists and may not be an accurate representation of those stakeholder groups. The fact that all appear to some extent as both barriers and facilitators shows how important they are to the profession and, whether real or perceived, that they need to be addressed. The perceived influence of policy makers on the availability of direct access, irrespective of whether it was permitted under legislation, was evident from the respondents and is consistent with previous studies. In a UK
study, Holdsworth et al.23 found that both physical therapists and general practitioners (family physicians) supported patient self-referral and stressed the importance of raising awareness both within and external to the profession. Webster et al.26 found that self-referral was viewed positively by service users, supporting the perceptions reported in the current study. These studies should help inform advocacy efforts.

Although WCPT has produced guidelines for physical therapist entry-level education, they remain aspirational for some members of WCPT, whereas others exceed them. As noted by the respondents, education plays a vital part in equipping physical therapists with the requisite competencies to accept patients who self-refer. If the graduate competencies are not appropriate at entry level, additional measures are needed. The role of continuing professional development in preparing physical therapists for direct access has been identified in other studies, even where entry-level education should provide the necessary competencies.23,31

Legislation that recognizes physical therapy as an autonomous profession, able to accept patients via direct access and self-referral, is perceived as a significant facilitator and as a barrier when it is absent. However, the results show that in many countries where MOs reported there was an absence of legislation, direct access was permitted or occurred. There appears to be greater freedom for physical therapists to refer on to other specialities or services where direct access exists. Certainly, if legislation is introduced in those countries currently without it, it will be important to retain these professional autonomy roles. As noted by Kruger,12 legislative change may bring about positive change, but challenges to implementing direct access and self-referral remain that are cultural (eg, the relationship with the medical profession) and structural (eg, funding models). The findings of this study support these observations.

Health service funding models and reimbursement policies appear to have an impact on the availability of direct access. Although some private physical therapy services accept patients via self-referral, there are instances where insurance policies will not provide reimbursement without a physician referral. This situation manifests itself in the same countries where public services support self-referral without a physician referral. In this situation, it is likely to require the physical therapy profession to actively engage with the insurance companies and medical profession to challenge the insurance companies’ policies so that practice reflects contemporary service delivery models available in a variety of settings.31 This strategy is likely to be more successful when the clinical effectiveness and cost-effectiveness business case is presented. The case for direct access and self-referral for physical therapy is supported by growing evidence showing that patient safety is not put at risk, that it is likely to result in reduced health service costs as a result of less physician care, and that quality of care is likely to be enhanced.12,20,22–24,46 This evidence, along with the results of this study, should be useful in informing policy decisions and advocacy efforts regarding direct access and self-referral.

**Limitations**

Although this study achieved a high response rate overall, the response rate varied across the 5 regions of WCPT. There was a much high response rate from Europe, which could be attributed to the workshop prior to data entry sensitizing respondents to the survey, or the fact that direct access was a significant policy issue for many of the organizations represented in the European region. Ideally, it would have been valuable to have carried out the same workshop in each of the regions. It is unclear why there was such a low response rate in the Asia Western Pacific region; therefore, caution should be applied in extrapolating the findings in that region.

Participants were requested to respond on behalf of their MOs to provide a national perspective, but there is a risk that respondents might have replied based on personal opinion. The survey language was English, and although English is the official language of WCPT, some MOs may have had difficulty understanding the questions and completing the survey and, therefore, may have failed to complete it. However, based on the responses, there was a large number of respondents from countries for whom English was not the first language.

Despite these limitations, we believe the study provides a benchmark profile of direct access to physical therapy globally, with useful data to inform future developments.

**Conclusion**

To assist future research studies on the clinical effectiveness and cost-effectiveness of physical therapy direct access services, it will be important to clearly define the terms “direct access” and “self-referral.” The term “patient self-referral” more accurately reflects the practice being described, but “direct access” is the term more widely understood, both within the profession internationally and with other stakeholders. Further clinical effectiveness and cost-effectiveness studies for different client groups (eg, patients with neurological disorders or gynecologic
problems) across a variety of settings will further strengthen the business case and should incorporate the views of service users.

There appears to be a perception of widespread support for direct access and patient self-referral for physical therapy, not just from within the profession; however, it is not universal. Professional leadership and advocacy from national professional organizations and WCPT are important in facilitating change in health policy and service implementation. Resources to support those countries that want to develop direct access services are needed. These resources may include advice on reviewing legislative changes, developing education and advocacy initiatives, drawing on the evidence of clinical effectiveness and cost-effectiveness to support the business case, and the development of good practice case studies illustrating implementation strategies and service delivery models.

The WCPT has developed guidelines for physical therapist entry-level education and for professional regulation and legislation,55,56 all of which underpin the autonomous practice of physical therapists and the right to accept patients via direct access, so long as they have the competencies to do so. These guidelines are set out in the new policy on direct access approved by the MOs of WCPT in 2011.55 In the course of this survey, lessons learned from implementation experiences have been shared and provide guidance for those starting out on developing and implementing direct access. Further work is now needed to collate the resources identified and make them as widely accessible as possible.

Both authors provided concept/idea/research design and contributed to writing, data collection and analysis, and project management. Ms Bury provided study participants and institutional liaisons.

Both authors are involved with the work of WCPT. Ms Bury is an employed member of staff, and Dr Stokes is currently Vice President and sits on the Executive Committee; at the time of the study she was the European regional representative on the Committee.

The views expressed in the article are those of the authors and do not necessarily represent the views of WCPT. The authors acknowledge the support of all delegates to the European Region of WCPT Workshop on Direct Access, the external reference group for assistance in developing the survey instrument, and the respondents from WCPT’s member organizations.

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References
6 Domholdt E, D’urcholz AG. Direct access use by experienced therapists in states with direct access. Phys Ther. 1992;72:569–574.

17 Tepper DE. Reimbursement victories: direct access and others. PT Magazine. 2003;11(3):42–45, 61.
20 Holdsworth LK, Webster VS, McFadyen AK. Are patients who refer themselves to physiotherapy different from those referred by GPs: results of a national trial. Physiotherapy. 2006;92:26–33.
A Global View of Direct Access and Patient Self-Referral to Physical Therapy


44 Efficiency and Health Human Resources: A Submission to the House of Commons Standing Committee on Health. Ottawa, Ontario, Canada: Canadian Physiotherapy Association; 2009.


Appendix.
Global Map of Direct Access and Self-Referral

Those countries not colored either did not respond to the survey or do not have a World Confederation for Physical Therapy (WCPT) member organization.

* Those countries not colored either did not respond to the survey or do not have a World Confederation for Physical Therapy (WCPT) member organization.