MASSAGE & MYOTHERAPY AUSTRALIA

Diversified services for self-determined care and contemporary need

A submission in response

to

Our Healthcare Future

Immediate actions and consultation paper

December 2020

Our Healthcare Future
Health Planning
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To whom it may concern

Thank you for the opportunity to add our perspective to 'Our Health Future'.

We have focused on the areas where the further integration of remedial massage therapy and myotherapy, by professional qualified therapists, could make a difference and help improve access and delivery of Tasmania's health services. These include:

- Aged care
- Palliative care
- Pain and chronic pain management
- Mental health
- Pregnancy and services for women.

We outline why massage therapy and myotherapy play a vital role in health outcomes and how making this information available through medical and allied health care practitioners would be of benefit to community wellbeing.

Yours sincerely

Ann Davey
CEO

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Background

Who is Massage & Myotherapy Australia?

Massage & Myotherapy Australia (the Association) is the massage sector's leader and driving force towards evidenced-based massage and myotherapy services.

Massage & Myotherapy Australia is a not-for-profit organisation formed in 2003. As the leading representative body for massage therapists, remedial massage therapists and myotherapists nationwide, we currently serve over 8,600 professionally-qualified member therapists. Members must:

- hold a current qualification from an Australian Registered Training Organisation (RTO)
- hold current Senior/Level 2 First Aid Qualifications
- hold current Malpractice, Public Liability Insurance (minimum $2,000,000)
- complete a statutory declaration, indicating that they have not been charged with or convicted of an offence of harm to a person nor been subject to disciplinary proceedings with a Private Health Fund or other association
- undergo continuing professional education to a specified number of hours each year.

Why is the Association making this submission?

Professional qualified therapists work in both clinical and non-clinical health.

Our submission only refers to remedial massage therapists and myotherapists who have recognised qualifications such as Bachelor Degrees in Health Science, Advanced Diploma or Diploma, are a registered member of a professional association and who undertake at least 1,000 hours of specialty training.

It is with these professional therapists that the opportunity lies to augment access to community preventative, residential, rehabilitation and palliative care services in partnership with Primary Health Tasmania.

Many qualified therapists work in integrated settings, involving hospitals, general practice, community health centres, private clinics, palliative care, aged and residential care facilities, and in the home. However, their contribution is rarely understood by the wider health community, despite patients regularly seeking out their services, in preference to other care and treatments.

This is because Allied Health practitioners such as midwives, nurses, physiotherapists or chiropractors administer a form of massage as an adjunct modality, and rarely document in their patient or client notes or any other data collection or public record, the specific massage modalities and interventions used.

Patient responses concerning how they feel or the evaluation of massage techniques and modalities used, are rarely gathered, measured, or assessed through follow-up patient evaluation by Allied Health professionals or General Practitioners. Hence, the value of massage treatments in these settings is unclear and unacknowledged.

This highlights three limitations:

i. our understanding of the benefit that massage and myotherapy affords

ii. the veracity of any informed decision about the value and efficacy of massage to improve health and wellbeing

iii. the potential positive effects and outcomes of massage-specific modalities applied by qualified remedial massage therapists and myotherapists.

We point out that Allied Health practitioners can administer massage under Medicare subsidies and many state-funded programs with as little as 200 hours of training and limited massage qualifications and experience, which is likely to limit the benefit that massage treatments afford. This has implications for all state-run health services.

We are not suggesting that massage therapists or myotherapists depose the role of Allied Health services. However, specialist remedial massage therapists and myotherapists already provide a valuable and underutilised role in helping people maintain mobility, achieve pain reduction and aid in reducing stress.

For the review of health services in Tasmania, we provide evidence to highlight that where appropriate, massage and myotherapy administered by professional qualified therapists can play a greater more integrated role in Tasmania's health services and assist to improve access and delivery at the local level and in the right setting.

We propose that massage and myotherapy administered by qualified myotherapists, remedial therapists and massage therapists involve a preapproved schedule of specific modalities and scope of practice for given conditions.

Responses to the consultation questions

Reform Initiative 1

Increase and better target our investment to the right care, place and time to maximise the benefits to patients.

1. How can we target better our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

Qualified remedial massage therapists and myotherapists provide an opportunity for GPs and other primary care health professionals to access staff with specialist skills who can assist in the management of chronic and complex healthcare conditions.

Importantly, the growing body of evidence supports the use of complementary massage and myotherapy services and growing community choice to use these services to help manage their health conditions.

During the past decade, much has happened to improve the professionalism of the massage and myotherapy sector and bring it more in line with the professional expectations and standards of Allied Health professionals and Medical Practitioners. These changes include:

- National Code of Conduct for Health Workers
- State-based health complaints commissioners and health ombudsmen with cross-jurisdictional information-sharing powers
- Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance for Natural Therapies which recommended the continued inclusion of massage
- Creation of a complementary therapies research program – UTS – ARCCIM International Complementary Medicine Research Leadership Program
- Creation of a new ACCC-endorsed national Quality Assurance program for professional massage therapists and myotherapists
- A considerable number of newly published papers attesting to the efficacy of massage in alleviating symptoms of pain and stress and as an aid to maintaining and improving mobility in the aged, those with injuries and those suffering chronic pain or stress
- An online national massage directory funded by the Association.

2. How can we shift the focus from hospital-based care to better community care in the community?

A 2018 survey that sampled the Australian population found bodywork therapists were the most commonly consulted complementary practitioners, with massage therapists representing 20.7% of consultations, compared to allied health chiropractors 12.6%.

This is an opportunity to improve access to care in the community. Qualified therapists, with the appropriate clinical training and skills, provide a state-wide, local complementary health care work force to assist in the management of conditions through integrated clinics and healthcare services.

A 2017 Australian study looked into the practice characteristics of Australia's complementary medicine workforce in Australia and found that the skills and training of many qualified therapists are underutilised with a sizeable proportion of this workforce also engaged in other nonclinical roles. For example, the average number of hours per week in which therapists are engaged in massage therapy was 18.6, and myotherapy was 21.3 hours per week.

A national workforce survey found that there are high levels of support for massage therapies among Australian GPs, relative to other CAM professions, with low levels of opposition to the incorporation of these therapies in patient care.

- GPs (76.6%) referred to massage therapy at least a few times per year
- 12.5% of GPs referred at least once per week
- 95% of GPs believed in the efficacy of massage therapy
- 95% of GPs perceived a lack of other treatment options
- 95% of GPs who had prescribed any complementary and alternative medicine previously were all independently predictive of increased referrals to massage therapy
- GPs were more likely to refer a patient to a massage therapist if they had obtained their medical training in Australia.

Additionally, a 2019 USA study reported that massage is the most often recommended therapy at 30%, with women being the highest referrals. Researchers found that *'overall, more than half of office-based physicians recommended at least one CHA to their patients. Female physicians recommended every individual CHA at a higher rate than male physicians except for chiropractic and osteopathic manipulation. These findings may enable consumers, physicians, and medical schools to better understand potential differences in use of CHAs with patients*'.

Anecdotal evidence is also supportive. During 2018/2019/2020, Massage & Myotherapy Australia displayed information brochures through the brochure dispensing facilities located in the waiting rooms of GP clinics. Distributed by Tonic Health Media, and titled '*The benefits of Massage & Myotherapy*. Tonic Health Media reported that the take up rate by patients of the massage and myotherapy brochures is the highest ever recorded, compared to all other brochures that they have distributed.

7. How can we improve integration across all parts of our health system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?

Introducing more competition to address current limitations

The presence of massage in private and public care settings often occurs on an ad-hoc basis as organisations either respond to consumer demand, or massage is championed by key personnel within the organisation. These personnel are motivated by the effectiveness of massage therapy as evidenced in the scientific literature or from anecdotal and personal experiences related by clients.

However, there are specific circumstances in which the judicious introduction of competition at the manipulation/bodywork service associated with musculoskeletal and other chronic conditions delivered at the local level is likely to improve outcomes for patients and reduce costs to the system.

Currently, the health system perpetuates a lack of competition and user choice where it is needed.

The most obvious area where competition and contestability would provide benefit is in services where Allied Health professionals such as nurses, osteopaths, physiotherapists and physical

rehabilitation specialists, replace qualified massage therapists as part of these services, as an adjunct service to a treatment plan.

While massage is most effective when combined with education and exercise, and when administered by a qualified therapist, massage therapy can be provided by any Allied Health professional for which government funding is available, without specific documentation and reporting in terms of its efficacy. This contravenes best practice and perpetuates a lack of:

- appropriate scrutiny in terms of who, when and how massage is applied
- documentation about the results that these therapies achieve in helping improve a client's condition
- accurate and specific data collection and reporting pertaining to the practitioner who delivers massage and myotherapy treatments
- accurate and specific reporting and data collection concerning the massage modalities used to treat given conditions
- any clear understanding of the contribution massage makes to recovery and management of conditions treated
- accurate data or evidence to support legislative reform.

It also means that the value and contribution of massage in relation to patient outcomes in various health settings can be reduced because the quality of massage provided is lower than if administered by a fully-qualified and accredited massage therapy specialist.

The AIHW 2018 cites the Australian Physical Activity and Sedentary Behaviour Guidelines which recommend that people aged 18 to 64 exercise at least 150 minutes, over 5 sessions per week; and over 65 years, at least 30 minutes per day. These Guidelines include:

- some types of yoga or Pilates
- resistance-band training
- high-intensity activities (for example, cycling, dancing, gymnastics or gardening that requires digging or lifting)
- climbing stairs or hills.

These activities can reduce premature death by as much as 23% and cancer-related mortality by up to 31% (Stamatakis, E. et al. 2017). They may also reduce the associated pain symptoms of chronic conditions,, such as osteoporosis and sarcopenia (loss of muscle mass and strength) in older Australians—conditions that may limit functional capacity and increase the risk of falls (Seguin, R. & Nelson, M.E., 2003).

Unfortunately, limited functionality and increased pain translates to a limited ability to exercise or undertake the recommended exercises and activities as outlined in the Australian Physical Activities and Sedentary Behaviour Guidelines.

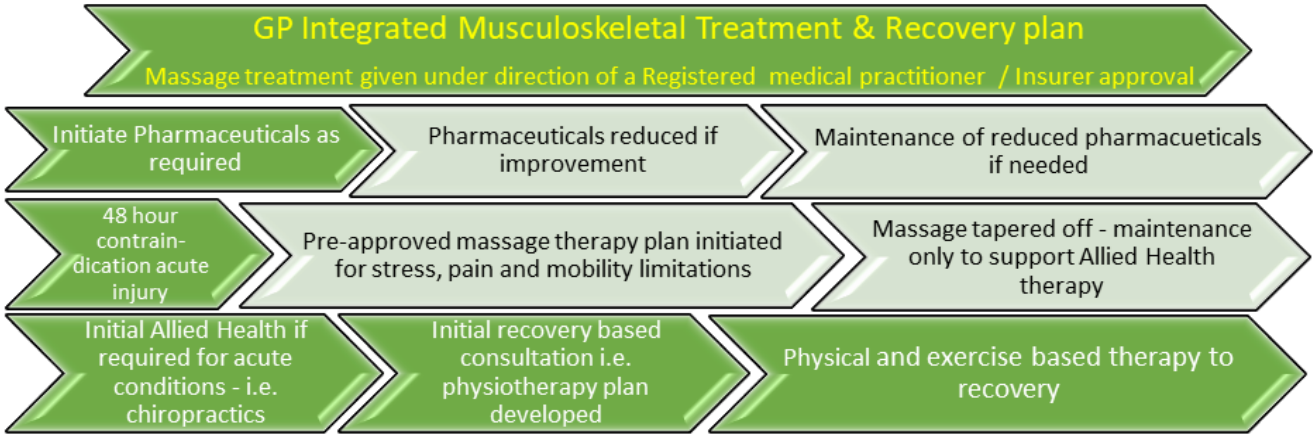
In response to these systemic limitations, we submit the following integrated model which can enable a more efficient, effective and cost-effective result.

An improved model of integration

In Figure 1, we propose an integrated approach where the role of remedial massage therapy in helping recovery is acknowledged and implemented by qualified massage therapists and myotherapists.

Within this integrated program of care, separating remedial massage delivery to dedicated remedial therapists, a reduction in Allied Health costs could potentially be achieved.

Figure 1: **GP Integrated massage care plan**



The qualifications and conditions treated by massage and myotherapists are listed in Table 1, which also provides an initial guide as to the conditions when Allied Health practitioners apply massage.

Table 1 Massage qualifications and conditions treated

Condition	Cert IV	Diploma	Advanced Diploma or Degree
Stress	✓	✓	✓
Relaxation	✓	✓	✓
Tension	✓	✓	✓
Headaches	✓	✓	✓
Muscular tears	✓	✓	✓
Postural dysfunction	✓	✓	✓
Neck dysfunction and pain		✓	✓
Thoracic dysfunction and pain		✓	✓
Lumbar dysfunction and pain		✓	✓
Sacroiliac dysfunction and pain		✓	✓
Shoulder dysfunction and pain		✓	✓
Hip dysfunction and pain		✓	✓
Tendonitis/Tendinopathy		✓	✓
Muscular strain		✓	✓
Reduced range of motion		✓	✓
Palliative conditions such as cancer		✓	✓
Neural tension			✓
Reduced fitness			✓
Reduced strength			✓

Fee structures that can save on costs

Rather than setting fees based on the qualifications of the practitioner or therapist, and time applied, fees could also be indexed according to the risk involved to the patient because of the therapy and modality applied.

A US econometric analysis examined how the inclusion of massage therapy services as part of an integrative care approach can help lower costs for certain conditions and types of treatments. The 2014 study found that of the 19 outpatient treatments studied, massage is associated with lower overall treatment costs in 16 of these treatments.

Given this, there are specific circumstances in which the judicious use of increased provider competition is likely to improve the delivery of manipulation/bodywork service associated with musculoskeletal disease, a variety of conditions and chronic diseases.

In the Table 2 example of the NSW SIRA payments for workers compensation and automobile injury, the approximate costs and consultation times, alongside the compounding effects and potential cost savings if massage is administered by SIRA-approved massage therapists or myotherapists is compared with the prescribed involvement of Allied Health practitioners. As illustrated, the cost of remedial massage is considerably higher if delivered by a physiotherapist, while the duration of the massage would be half of that compared to a massage therapist.

Table 2 Cost comparison — Massage delivered by Allied Health/Massage therapy in NSW SIRA

Suggested staged care plan involving Allied Health Care plan and standalone therapists delivery							
Therapy	Duration minutes	Average number of sessions	SIRA rebate	Total payment based on average number of sessions	Average cost based on average number of consults	Compounding effect x 1 initial AH consults & 1 subsequent consults; & 4 X 1 hour MT consults	SIRA Approved session - up to 8 including 1 Initial AH consults & 7 MT consults
Initial physiotherapy Consultations	45	1	$145.00	$145.00			
Standard Physiotherapy Consultations	30	5	$122.70	$613.50	$758.50	$390.40	$1,003.90
Remedial massage	30	5	$42.00	$210.00			
Remedial massage	45	5	$61.50	$307.50			
Remedial massage	60	5	$83.80	$419.00	$419.00	$419.00	$731.60
						$809.40	

We propose that fees for remedial massage therapy that are paid to Allied Health professionals are equivalent to the fees paid to remedial massage therapists and myotherapists, and hence they should also be recognised and funded as standalone healthcare providers.

To receive payment for massage services, all health practitioners should be required to keep accurate records regarding the modalities, duration of massage consultations, client responses and outcomes achieved, which are reported to GPs overseeing the care provided.

In recent times, a considerable body of new evidence has emerged that attests to the value of massage therapy and myotherapy in relieving pain and stress for a range of conditions and in cases of serious disease or illness.

Research supports the further integration of massage

The following provides a considerable array of clinical evidence concerning the merits of broadening the assessment base with a view to involving qualified professional massage therapists and myotherapists standalone modality therapies to reduce chronic pain and stress.

Musculoskeletal disease

While massage is not a cure for musculoskeletal disease it does provide symptom relief for pain sufferers allowing for a higher degree of mobility and exercise.

The NHMRC 2012 found that massage may be more effective than control (no treatment, sham) in reducing pain in people with acute/subacute low back pain in the short term.

A randomly controlled 2018 trial involving 200 patients in an 8 and 52-week assessment found that the efficacy of symptom relief and safety of a weekly massage make it an attractive short-term pain treatment option for knee osteoarthritis. '*As expected, while the additional benefit beyond the usual care 8-week treatment provided no additional improvement, the longer-term bi-weekly dose over 52 weeks maintained the improvements achieved in the first 8 weeks*.'

A Massage & Myotherapy Australia commissioned 2013 study by the International Centre for Allied Health Evidence, University of South Australia, found that massage therapy is effective in managing subacute/chronic low back pain delayed onset muscle soreness (DOMS), anxiety, stress and relaxation, and helps support the wellbeing of patients with chronic diseases, life-threatening diseases such as cancer, and/or terminal illnesses.

A Massage & Myotherapy Australia commissioned RMIT University 2011 study that looked into the Effectiveness of Massage Therapy found an emerging body of evidence, albeit small, that supports the effectiveness of massage therapy for the treatment of non-specific low back pain, especially in the short term.

Stress and cardiovascular disease related symptoms

The body of research that investigated the effects of massage on symptoms of cardiovascular disease and surgery, such as hypertension and blood pressure during the past 10 years suggest that massage could be a useful intervention.

A massage research review (2014) found that when moderate and light pressure massage have been compared, moderate pressure massage reduced depression, anxiety and heart rate, altered EEG patterns and increased vagal activity, as in a relaxation response.

Findings of the study in 2013 that investigated durability of the effect of massage therapy on blood pressure indicated that massage therapy was a safe, effective, applicable, and cost-effective intervention in controlling blood pressure of pre-hypertension women and can be used in health care centres and even at home.

A 2013 study into the effects of Swedish Massage Therapy on blood pressure, heart rate and inflammatory markers in hypertensive women, found that Swedish Massage Therapy or resting for an hour weekly, significantly reduced blood pressure, heart rate and vascular endothelial adhesion molecules. However, the effect of rest on blood pressure does not extend to four weeks as compared to Swedish Massage Therapy. In addition, massage also reduces the resting heart rate in hypertensive women.

Researchers investigated the effect of massage therapy on pain, anxiety, relaxation, and tension after colorectal surgery. The randomised study concluded that massage may be beneficial during post-operative recovery for patients undergoing abdominal colorectal surgery. Further studies are warranted to optimise timing and duration and to determine other benefits in this clinical setting.

A 2016 meta-analysis titled '*Massage therapy reduces pain and anxiety after cardiac surgery: A systematic review and meta-analysis of randomised clinical trials* concluded that massage therapy might be a useful method to reduce pain and anxiety in patients undergoing cardiac surgery.

Based on the findings of a 2016 study to learn more about the effect of massage therapy on physiological responses in patients with congestive heart failure, researchers concluded that massage therapy was effective in blood pressure, heart rate, respiration rate and oxygen saturation in patients with Congestive Heart Failure, and suggested that massage therapy be used as a complementary method to stabilise their vital signs.

Research during 2016 that investigated the effectiveness of massage therapy on the mood of patients after open-heart surgery found that the use of massage therapy as an effective nursing intervention can improve the patient's mood after open-heart surgery. Due to the low cost and simplicity of this method, it can perhaps be used as a complement to drug therapy and post-operative interventions used in these patients.

Researchers of a study titled 'The long-term effect of massage therapy on blood pressure in prehypertensive women' concluded that although massage therapy seems to be a safe, effective, applicable, and cost-effective intervention to control blood pressure of prehypertensive women, its effects do not persist for a long time.

A 2016 systematic review of the effects of massage on blood pressure in patients with hypertension and prehypertension: A meta-analysis of randomised controlled trials found a medium effect of massage on systolic blood pressure and a small effect on diastolic blood pressure in patients with hypertension or prehypertension. High-quality randomised controlled trials are urgently required to confirm these results, although the findings of this study can be used to guide future research.

A 2012 randomised controlled trial that investigated massage therapy for cardiac surgery patients concluded that massage therapy significantly reduced the pain, anxiety and muscular tension and improved relaxation and satisfaction after cardiac surgery.

The short-term effects of myofascial trigger point massage therapy on cardiac autonomic tone in healthy subjects were reported in a study that found that in normal healthy subjects, myofascial trigger-point massage therapy to the head, neck and shoulder areas is effective in increasing cardiac parasympathetic activity and improving measures of relaxation.

The authors of a 2018 study titled 'Effects of Manual Lymphatic Drainage Massage associated with physical exercise program in morphological-functional blood pressure parameters', reported that manual lymphatic drainage massage may be a valuable nonpharmacological auxiliary therapy in the control of arterial hypertension, also indicating that when performed in association with a regular program of aerobic physical exercises, it significantly increases the reduction of values blood pressure of hypertensive subjects. In view of these findings, it is suggested that new studies be carried out with a larger sample and with new experimental designs to ratify the results of this research and extend this line of research.

Surgery pain mobility and anxiety

A 2018 Study that sought to determine the value of myofascial massage to address surgery pain and mobility limitations found that myofascial massage is a promising treatment to address chronic pain and mobility limitations following breast cancer surgery. Further work in several areas is needed to confirm and expand on the study findings.

During 2017, researchers assessed the effects of massage therapy on pain management among post-operative patients by conducting a systematic review and meta-analysis and reported that the effect of single dosage massage therapy on post-operative pain showed significant improvement and the

anxiety subgroups showed substantial heterogeneity. They conclude that the findings of this study revealed that massage therapy may alleviate post-operative pain, although there are limits on generalisation of these findings due to low methodological quality in the reviewed studies.

Fatigue and depression

A 2017 study evaluated the efficacy of weekly Swedish massage therapy versus an active control condition (light touch) and waitlist control on persistent cancer-related fatigue in breast cancer survivors. The authors concluded that Swedish massage therapy produced clinically significant relief of cancer-related fatigue. The findings suggested that six weeks of a safe, widely accepted manual intervention causes a significant reduction in fatigue, a debilitating sequela for cancer survivors.

General symptoms relief

During 2017 researchers published the results of their study which sought to learn about the effects of the use of therapeutic massage in children with cancer, and concluded that therapeutic massage improves the symptoms of children with cancer, but there is a need for more research that may support the effects attributed to it. Techniques used included Swedish massage, effleurage, petrissage, frictions, pressures which reportedly obtained benefits in the symptoms present during the illness, such as decrease of pain, nausea, stress, anxiety and increase of white blood cells and neutrophils.

The 2004 study referenced previously to the Cancer Council involved the Memorial Sloan-Kettering Cancer Centres' examination of changes in symptom scores and the modifying effects of patient status (in- or outpatient) and type of massage. Over a three-year period, 1,290 patients were treated. Symptom scores were reduced by approximately 50%, even for patients reporting high baseline scores. Outpatients improved about 10% more than inpatients. Benefits persisted, with outpatients experiencing no return toward baseline scores throughout the duration of a 48-hour follow-up. They concluded that these data indicate that massage therapy is associated with substantive improvement in cancer patients' symptom scores.

Pain and stress

A 2017 study that explored the experiences towards aromatherapy massage use, and examined the perceived benefits and adverse effects of aromatherapy massage among adult female cancer patients, reported that the perceived benefits included physical and psychological dimensions: overall comfort, relaxation, reduced pain, muscular tension, lymphoedema and numbness, improved sleep, energy level, appetite and mood.

A 2015 meta-analysis, which aimed to investigate the effects of massage therapy for cancer patients experiencing pain, indicated a beneficial effect of massage for relief of cancer pain. Further well-designed, large studies with longer follow-up periods are needed to be able to draw firmer conclusions regarding the effectiveness.

The purpose of a 2009 study was to describe the feasibility of massage therapy and to examine the effects of massage therapy on present pain intensity, anxiety and physiological relaxation over a 16- to 18-hour period in 30 Taiwanese cancer patients with bone metastases. Researchers reported that clinically, the time effects of massage therapy can assist health care providers in implementing MT along with pharmacological treatment, thereby enhancing cancer pain management. Randomised clinical trials are needed to validate the effectiveness of massage therapy in this cancer population.

10. How can we build health literacy, self-management and preventative health approaches into the day-to-day practices of our health services across the whole of the health system?

Improving massage and pain literacy among health professional and policy makers

There are many confusing terms used to describe massage therapy and myotherapy services that assist in achieving physical and mental health.

The confusion of terms has blurred the lines between quasi-massage and massage administered by a qualified professional therapist.

For example, in recent announcements about COVID 19 lockdown actions, the Prime Minister referred to massage parlours, yet the term '*massage parlour*' has long been associated with the illegal sex trade.

Lumping qualified massage therapists in with poorly qualified or untrained quasi-massage providers, is inappropriate and caused considerable confusion in the industry during the COVID 19 lockdown. Many qualified therapists were confused about the stages of lockdown and when and where it was appropriate to practice, especially if they were engaged in clinical settings or in integrated clinics with GPs and Allied Health professionals.

Defining professional clinical massage services

Professional massage services can be clearly defined.

Massage & Myotherapy Australia describe therapeutic and remedial massage, and myotherapy as manual manipulation therapies involving the deep or shallow soft tissues of the body including muscles, tendons, and ligaments.

Professional remedial massage and myotherapy is delivered by therapists who have recognised qualifications such as Bachelor Degrees in Health Science, Advanced Diploma or Diploma, are a registered member of a professional association and who undertake at least 1,000 hours of specialty training. They should also be members of a professional association and:

- hold a current qualification from a Registered Training Organisation (RTO)
- hold current Senior/Level 2 First Aid Qualifications
- hold current Malpractice, Public Liability Insurance (minimum $2,000,000)
- complete a statutory declaration, indicating that they have not been charged with or convicted of an offence of harm to a person nor been subject to disciplinary proceedings with a Private Health Fund or other association
- undergo continuing professional education to a specified number of hours each year.

Adjunct services and techniques that extend beyond hands-on direct physical contact and that combine the use of devices or supplementary techniques, such as myofascial dry needling or aromatherapy, augment massage or soft tissue manipulation therapies, but they are not massage.

Clinically-focused massage modalities which, depending on the condition and circumstances of the patient, can combine a variety of massage techniques to help address and describe the appropriate and effective massage techniques for conditions or lifestyle issues. As with all health-related therapies, no two people respond in the same way.

As a guide, therapeutic massage assists with the relief from aches, pains, and stress-related symptoms. Remedial massage and myotherapy are useful therapies in pain management *arising from* chronic musculoskeletal conditions, postural conditions, sporting, and occupational injuries.

Myotherapists, and remedial therapists with the appropriate training, apply the higher-level skills required for advanced assessment and treatment protocols. Massage and myotherapy are used for both therapeutic and remedial needs in response to pain and stress caused by chronic disease, injury and life style issues.

Qualified therapists generally use an integrated approach, drawing on a variety of techniques and adjunct services to assist in addressing a specific condition. *These conditions include disease and injury, dysfunction and pain, and emotional issues as listed in Table 3:*

Table 3: Conditions for which massage and myotherapy are applied

Disease and injury	Dysfunction and pain	Emotion
palliative conditions, i.e. cancer	postural & thoracic	neural tension
muscular tears & strains	sacroiliac, lumbar & hip	tension & stress
tendonitis & tendinopathy	neck & shoulder	relaxation
surgery recovery	reduced range of motion	headaches
	reduced fitness & strength	restlessness

Table 3: Conditions for which massage and myotherapy are applied

Addressing barriers and strengthening the role of GPs within the health system

The 2020 May Infocus published by the Australian Institute of Health and Welfare reports that in 2017–18, 23.7 million procedures were performed in Australia's hospitals, 1.4% (322,000) of which were associated with a chronic pain diagnosis (principal or additional). The most common groups of procedures associated with chronic pain were:

- allied health interventions, such as physiotherapy and occupational therapy (52%, or 167,000 procedures)
- general anaesthesia or sedation (8%, 25,800 procedures)
- procedures to deliver local anaesthetic to a small nerve (6%, 20,100 procedures).

The role of GPs in informing their clients about how they can access alternative pain relief is of relevance here.

Advice provided by authoritative sources refer to massage as an alternative pain management option to opioids. For example, the Opioid Management Team which presented *Alternative options to codeine, said that while heat and massage are contraindicated in the first 48 hours following musculoskeletal injury,* the team also suggested that *practitioners discuss non-pharmacological options including heat, massage, psychotherapies, physiotherapies, osteopathy, etc., for clients suffering from chronic pain*.

The Therapeutic Goods Administration website offers 'Talking tips for Pharmacists', that include flagging a number of non-medication and therapeutic options, including massage as part of a client's pain management strategy.

Correlating evidence also supports the use of massage as an alternative pain management therapy. A 2018 analysis found that using massage therapy instead of opioid medication for client conditions where massage is proven effective can reduce overall addiction rates in the United States.

A 2012 USA study asked individuals seeking primary care treatment with buprenorphine-naloxone in order to block the effects of opioid medication, including pain relief or feelings of wellbeing that can lead to opioid abuse. Respondents reported interest in a wide range of conventional, complementary, and alternative pain-related treatments for pain management services.

As low risk, frequently used efficacious therapies, massage and myotherapy would be afforded a higher level of recognition and support for patients to access non-emergency clinical services locally.

Better outcomes for patients through improved massage and pain literacy

The Canadian Pain Task Force: October 2020 found that one of the greatest barriers is the absence of an appropriate chronic pain definition and precise diagnostic codes within administrative data, which can be used for its identification. The taskforce noted that monitoring pain in the community is often difficult because of challenges in registering pain-related events due to the lack of pain-specific health professional diagnostic codes or the low use of codes that do exist due to lack of implementation and/or training.

'Such limitations can often cause health care professionals to underdiagnose or misdiagnose chronic pain. Without a coordinated effort to implement the most up-to-date classification system, surveillance and monitoring efforts, chronic pain will continue to lag behind other chronic disease surveillance systems in Canada. Lack of comprehensive data and surveillance infrastructure inhibits federal and provincial monitoring of the health care and societal costs associated with chronic pain, as well as the policies and programs needed to sufficiently resource these challenges.'

According to Painaustralia 2019, measuring chronic pain is difficult due to the subjective nature of pain, lack of a national definition, and variation in questions measuring chronic pain in surveys. The subjective and ongoing nature of pain results in variation in reported pain intensity, pain persistence and pain-related disability.

'A person can experience several types of pain (for example, cancer, neuropathic and musculoskeletal pain). The surveys and data collections examined in this report do not measure these distinct types but measure them collectively, which makes it difficult to explore the different types of chronic pain experienced in Australia.

Limited data are available on Aboriginal and Torres Strait Islander people's experience of chronic pain, as there are currently no national surveys of Indigenous people that include a question about chronic or long-term pain. Older Australians, those with disabilities and those in residential care are at higher risk of experiencing chronic pain.

However, there are additional barriers to identifying and treating their pain, as care facilities are often out of the scope of national reporting measures and cognitive or communication disabilities, such as dementia or hearing loss, may prevent people from reporting their experience of pain (Savvas & Gibson 2015). It is also difficult to measure the treatment of chronic pain in Australia, as insufficient data are available measuring primary care services (including allied health and alternative health services) used for chronic pain.'

A 2020 US Association for the Study of Pain report, found that over 50% of U.S. adults aged 30 to 49 report pain. Overall, more educated Americans report substantially less pain than the less educated. However, adults with a high-school equivalency diploma and those with some college education, report more pain than other groups. Understanding the causes could help illuminate the mechanisms through which social factors influence pain.

A 2018 Study which explored the effect of pain education on chronic pain patients' expectation of recovery and pain intensity found that participants who observed changes in their pain cognition and

self-management following pain education reported lower pain intensity and greater expectation of recovery than participants who did not observe changes to cognition and management.

11. How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private?

Pain education and mindfulness programs associated with pain and stress management are already available.

However, the 2020 National Pain Survey found that patients rated the management of their pain condition by General Practitioners as 5/10. Hence it is understandable that respondents also wanted GPs to put them in touch with other resources and pain management options, not just medication.

Patients also indicated that one of the most important things GPs could do for them was to understand that ongoing pain is not just due to biological factors but also psychosocial factors and therefore needs a wider treatment plan.

We all expect GPs to provide medical advice with a high degree of confidence, but in the absence of over the counter opioids, and an effort to avoid addiction, this is not always available.

Unfortunately, few complementary or allied health pain management therapies produce a volume of research that meets the strict Cochran criteria of eliminating all variables to deliver a high level of confidence in the efficacy of these therapies.

There are many reasons for this, but foremost, when applying tactile and exercise-based therapies it is impossible to eliminate all other variables. For example, it is not possible to provide a double-blind remedial massage or physiotherapy treatment, where both the therapist and patient are unaware of the placebo and the real therapy, yet this is required to achieve the highest level of certainty in the findings.

A lack of standardised and optimised massage modalities and controls also leads massage therapists involved in trials to subjectively employ a variety of modalities and adjunct services tailored to the individual, often making it difficult to interpret the results (2018).

The purpose of massage therapies is to help people feel better by relieving pain (2016) and stress and thereby feel more motivated to participate in life productively. Given these limitations, persisting with RCTs alone is counterproductive, and the cause of so many inconclusive findings (2019).

Consequently, medical science has yet to fully understand how these therapies work, and how they might be best applied to a given condition. This compounds the challenge for GPs in providing medical advice with the required degree of confidence in the efficacy of these therapies.

These limitations must be addressed in health literacy if regard to pain and stress management are to be improved.

The benefits of massage can be accurately measured

Providing GPs and other medical practitioners with a better understanding of the complex relationship between physical and mental health, when touch-based therapies can play a role in prevention, and early intervention among adults, will add depth to the mental health responses and opportunities available to them and to their patients.

The evidence is unequivocal, but equally important is understanding how and when to apply massage and other touch therapies, through the application of standardised massage intervention protocols.

A 2020 study by Meier M. et al, investigated whether standardised massages are capable of reliably inducing physiological and psychological states of relaxation. They successfully established two massage protocols focused on psychophysiological relaxation induced through massage.

They measured significant higher effects because of the two nerve and shoulder massage protocols, compared to the resting control group. Measured effects included significantly improved heart rate and subjective relaxation.

Another 2020 German study by Arnold M.M. et al., looked at the effects of psychoactive massage in outpatients with depressive disorders reporting that the emotional distress of anxiety was often accompanied by sweating, dizziness, shortness of breath, insomnia, restlessness, and muscle aches.

Consequently, they investigated the effects of a specially developed affect-regulating massage therapy (ARMT) versus individual treatment with a standardised relaxation procedure of progressive muscle relaxation in 57 outpatients with depression. '*The standard psychiatric instruments used to measure the effects and feedback from patients show a clear and statistically significant superiority of the specifically regulating massage therapy. They reported that the stronger impact of massage therapy on depressive mood, stress/tension, emotional retardation, sleep disorders, and hopelessness was particularly impressive.'*

12. How do we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?

There are many opportunities to create clearer pathways and treatments, particularly in the area of mental health for example.

The Australian Institute of Health and Welfare 2018 (AIHW) reported an upward trend in the use of mental healthcare services and associated costs with expenditure growing from $2.6b in 1992/93 to $9.0b, accounting for 12.4% of GP visits during 2016/17.

However, the complex relationship between physical health, pain, addictions and mental health are well recognised but not fully understood.

Improved integration of therapies to help address the challenges of pain management and related mental health is an important area for consideration.

We propose that massage and myotherapy administered by professional therapists offers another significant layer of options for clinicians and institutions managing the care of people who are at risk of falling into long-term depression and mental illness due to pain and stress caused by chronic disease, addiction or injury.

Poor mental health is often associated with physical pain

Many studies now show that health and disease are strongly linked to psychophysiological states.

The National Institute of Mental Health risk factors for depression advise that the origins of mental health issues include a family history of mood disorders, major life changes, trauma, other physical illnesses and medications.

The Australian Pain Management Association reports that people living with pain are more prone to psychological distress, such as anxiety and depression, than those in the general community.

> *Long-term pain puts a lot of stress on the brain and cognitive issues such as low mood, difficulty with memory or concentration, no matter what the underlying pain condition is.*

Chronic pain and depression are frequently comorbid (2013). The presence of depression in a patient with chronic pain is associated with decreased function, poorer treatment response and increased health care costs.

An accurate diagnosis of major depression can be challenging in the setting of comorbid chronic pain. Antidepressants and psychological treatments can be effective and are best delivered as part of a coordinated, cohesive, multidisciplinary pain management plan.

The AIHW's Mental health services—In brief 2018 report stated that 45% of Australians will have a common mental disorder in their lifetime. This includes anxiety disorders such as post-traumatic stress disorder and social phobia.

Researchers Haftgoli N. et al 2010, found that a higher prevalence of depression, anxiety, and somatoform (not fully explained) disorders among primary care patients was associated with a physical complaint. Patients with an accumulation of psychosocial stressors were more likely to present anxiety, depression, or somatoform disorders.

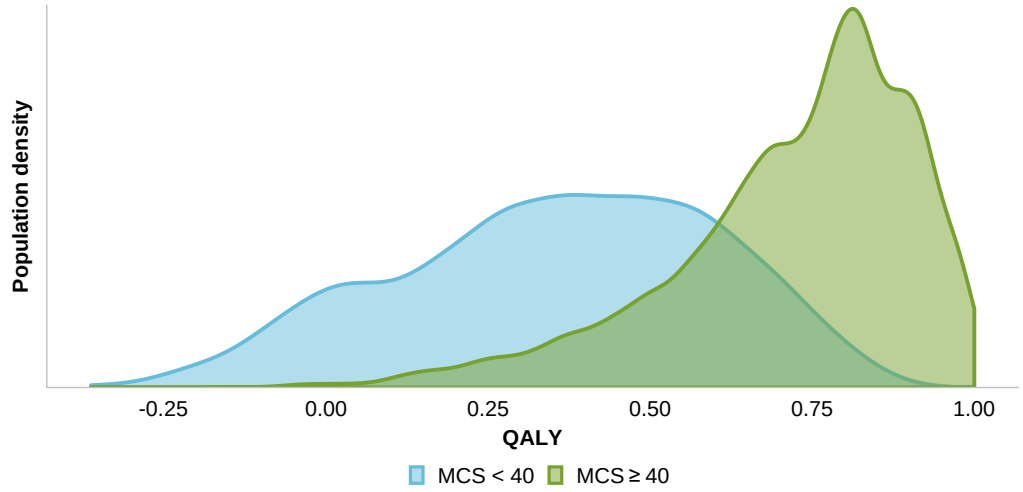
The Productivity Commission's 2019 draft report into mental health cites that those with mental illness are 18–36% more likely to have musculoskeletal problems and suggests that a single care plan developed by the individual's primary treating clinician and covering physical and mental health can help address the issues raised by comorbidity.

Qualitative measures provide a better understanding of pain, poor health and emotions.

The Productivity Commission report quotes the HILDA survey undertaken by the Melbourne Institute, which derives a measure for quality-adjusted life-years (QALYs) by combining a person's answers to physical and mental health-related questions involving the effect of physical pain, health or emotional problems on social and vigorous activities, bathing or dressing, work or regular daily activities, personal goals energy, or feeling down

The figure below shows that people with poor mental health experience much lower overall health than those without mental ill-health. Poor mental health in this case is defined as having a mental components summary (MCS) score of less than 40.

Distribution of QALYs in 2017 over the populations of people with and without mental ill-health:



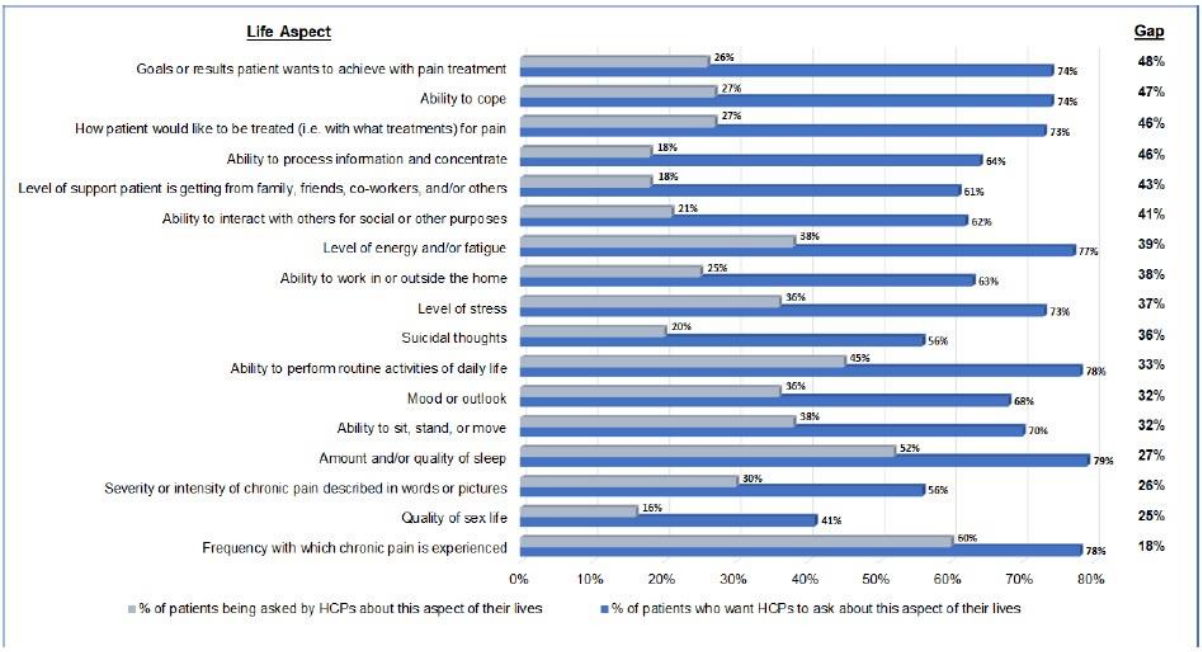
***Source*: Melbourne Institute (2019); Productivity Commission estimates using HILDA (appendix F).**

Additionally, the US Pain Collaborative Report (2019), driven by survey data on patient awareness and satisfaction with current chronic pain assessment instruments, provides patient-informed recommendations that should be taken by physicians, patients and advocacy organisations immediately to improve the lives of people living with chronic pain.

The figure below is from the Collaborative report. It underscores that comprehensive chronic pain assessment methods should reflect the multiple aspects of the patient's pain experience and capture chronic pain's impact on daily life, which in turn can impact their mental health.

Figure 2: Life Aspect Assessment US Collaborative Pain Report

Figure 5: Life aspects health care providers routinely ask chronic pain patients, compared to the frequency with which patients would like to be asked (highest to lowest differential, n = 1,527).



The experiences listed in the two assessments are not dissimilar and suggest that broader criteria of assessment and treatment options can have a positive effect on understanding the complex relationship between physical ill health and improving mental health.

Hence, qualitative measures involving sustained attitudinal and behavioural change alongside self-assessed feelings of wellbeing can provide clinicians with a more holistic understanding of the relationship between physical and mental health.

Massage and touch therapies can help to improve emotional states

Despite science not yet fully determining the physiological effect of massage, examinations of pressure, movement, friction, touch and human interaction as experienced by patients in a massage or myotherapy setting delivers consistent conclusions—that massage makes people feel better, by offering a sensory experience that relieves feelings of pain and mood, and other health-related quality of life issues (Crawford, C. et al. 2016).

Importantly, hundreds of studies indicate that short-term and more profound improvements in the state of one's mental health occur following professional massage treatment for people with high blood pressure, after surgery, during cancer treatment, palliative and injury care.

The evidence indicates that improving the quality of people's daily lives through massage can have profound effects on their mental health. For example, improvements in a patient's ability to walk with less pain (2018), drive (2006), engage in social activities (2016), engage in work or avoiding absenteeism, improve mobility (2017) and maintain social ties for older people or people with chronic disease such as diabetes (2017). Easing the debilitating symptoms of cancer (2015) or improving sleep after cardiac surgery (2017) in order to achieve a more positive disposition and normal functions are also profound improvements for seriously ill patients that warrant deeper investigation.

Reform Initiative 3b

2. How do we work with the private sector, as well as other levels of government, to ensure our combined workforce serves the future needs of our community?

Listening to the voices of consumers and carers in aged care

In recent times, the Royal Commission into Aged Care and Safety, and the effects of COVID 19 on older Australians, has highlighted an important need involving a deeper level of cooperation and integration of complementary health services in aged care. This has implications for all levels of government involved in aged care funding and/or administration.

Many witnesses who appeared before the Royal Commission into Aged Care Quality and Safety shared a common issue: the need to provide more effective pain and stress management and comfort for older people in care.

Among the personal accounts, feelings of frustration and helplessness were repeatedly expressed about the suffering of loved ones and how the system failed them. Their comments were also supported by the testimony of numerous health industry experts.

Associate Professor S. MacFarlane commented on staffing issues and reported that: '*a primary contributing factor is under-recognised or under-treated pain in between 60 and 70% of all our referrals'. An inability to communicate the areas of pain and the intensity of the pain are common and compounding factors in some cases'*.

Professor Elisabeth Beattie said: '*Unrecognised, unrelieved pain is a major identified reason for discomfort, particularly in those residents who aren't able to communicate well, which happened quite quickly in a number/several of these cases.*'

Professor Joseph Elias Ibrahim, on describing the different needs of older people, reported that they need somewhere to live because they need help with their personal care and they need to be able to have a purpose to their lives. '*Other people are frail, needing palliation and palliative care with high-end nursing care and pain management. And then there is a large group of people who have multiple chronic diseases that need fine-tuning, regular clinical assessment to make sure that they're in optimal health to enjoy their life.*'

Professor Edward Strivens, a geriatrician and President of the Australian and New Zealand Society for Geriatric Medicine, referred to a Dutch study that found 80% of people in residential aged care were being prescribed psychotropic medication with 10 to 20% efficacy rate. Data from the Australian Institute of Health and Welfare indicates the prescribing of psychotropic medication among older Australians is on the increase, with rates increasing by age group to 31.5% for those aged 65 years and over.

Professor Strivens said that, '*the starting point should always be non-pharmacological management based around identification of the areas of unmet needs, person-centred care and enablement principles.*

Staffing issues, particularly at night, the cost of continuous care, the ability of medical practitioners to see the patient more frequently and consistently and conduct more thorough assessments of their pain and condition, were also issues raised at the Commission'.

Massage and myotherapy services have a greater role to play

For older people in care, massage and myotherapy does not displace medical or allied health services.

However, they do fill the gap when older people seek or need alternative care to medications and other therapies and when they feel that massage is more appropriate to their needs.

Globally, massage and myotherapy provides relief from the symptoms of pain and stress and improves feelings of wellbeing in millions of people of all ages. Massage therapy is the most used

complementary therapy for both therapeutic and remedial needs in response to pain and stress caused by chronic disease, injury and life style issues.

As considerably lower-cost therapies with a qualified skilled workforce that is readily available locally, massage and myotherapy can play a more vital role in stretching health dollars further to help older Tasmanians.

Improving care for older Tasmanians and palliative patients

Among the palliative care community, massage is well known for improving the quality of life of patients, however many professional therapists are often asked to provide their services for free.

A 2008 examination of the prevalence of under treatment in cancer pain found that people with cancer-related pain have their own needs which are often not well met, despite effective techniques that are known to relieve their burden.

There is, however, plenty of evidence to suggest that improving accessibility and increasing the number of massage therapists with specialist palliative care skills and training rather than leaving it up to palliative care patients or their carers to find a qualified professional will have a direct impact on the quality of life of palliative care patients.

In public and private settings, massage therapy already occupies a valuable place in an integrated approach to palliative and end-of-life care in some settings.

For example, Eastern Palliative Care Victoria reports the benefits of massage may include, but are not limited to: reducing the side effects of chemotherapy, radiotherapy and some medications; easing the discomfort of fluid retention (Oedema/Lymphoedema); lessening the impact of pain and shortness of breath; improving mobility; and reducing tension, anxiety and depression. Like many other cancer treatment centres, the Olivier Newton John Cancer and Wellness Centre integrates massage with pharmaceuticals and medical care.

A systematic review of studies on aromatherapy and massage for relieving symptoms in people with cancer looked at 10 studies including 8 randomised controlled trials. It found that massage consistently reduced anxiety and depression. Massage also helped lower nausea and pain, but not as consistently.

A 2009 article briefly describes research illustrating the promise of integrative approaches for the treatment of cancer-related neuropathic pain. The authors concluded that the advantage of complementary approaches such as massage therapy, acupuncture, and mind–body therapies such as meditation and self-hypnosis is that they are inexpensive, safe, non-invasive, and absent of side effects, in contrast to pharmaceuticals administered for pain management. Evidence for the efficacy of these approaches continues to accumulate. Furthermore, these techniques should be especially welcome considering current and pending health care realities, especially increasing costs and the decreasing availability of physicians.

A large study published in 2004 looked at the effects of massage therapy on almost 1,300 people with cancer over three years. People in hospital had a 20-minute massage, and people treated as outpatients had a 60-minute session. The study found that overall, massage therapy reduced pain, nausea, fatigue, anxiety and depression. The benefits lasted longer in the patients who had the 60-minute session.

The results of a study aimed at describing the experience of massage for breast cancer patients during chemotherapy treatment revealed five themes: The patients experienced distraction from the frightening experience, a turn from negative to positive, a sense of relaxation, a confirmation of caring, and finally they just felt good. The findings of this study showed that massage offered a retreat from uneasy, unwanted, negative feelings connected with chemotherapy treatment. It is an intervention that can be added to the arsenal of treatment choices available to the oncological staff.

A 2011 Study exploring the extent that massage therapies are able to reduce the amount of pain, anxiety and depression that cancer patients feel while in palliative care, found that massage therapy reduces the subjectively perceived symptom of pain in oncological patients receiving palliative care. Reduction of the symptoms of anxiety and depression was also achieved.

A 2014 study that looked at integrating massage therapy within the palliative care of veterans with advanced illness found that all short-term changes in symptoms showed improvement and all were statistically significant. Pain intensity decreased, anxiety decreased, patients' sense of relaxation increased, and inner peace improved. The authors concluded that massage is a useful tool for improving symptom management and reducing suffering in palliative care patients.

A 2009 study which sought to demonstrate how people with incurable cancer experienced soft massage in a palliative care setting in which massage was used as an established and integrated part of the nursing care, found that during the massage the patients felt dignified, while memories from past massage sessions were about becoming free. These experiences of dignity and freedom brought hopes for the future. The authors concluded that soft massage ought to be offered in the ordinary palliative care. More research is needed to understand what is required to integrate and establish methods such as soft massage in palliative care.

Many studies support integration

Older Australian women experiencing chronic bodily pain prefer a concurrent multimodality approach (accessing conventional treatments alongside massage therapy) to cope with their condition (Walker, B.F. et al. 2004).

A 2017 study by Akerman I.N., et al. concluded that, based on recent dispensing trends of opiod prescriptions for osteoarthritis, dispensed opiod prescriptions will triple to over 3.0 million between 2015/16 to 2030/31 and rise from an estimated annual cost to the health care system from $25mil to $72.4mil.

A review of 64 research papers explored the extent that massage therapies can reduce the amount of pain, anxiety and depression that cancer patients feel while in palliative care. The reviewers found that massage therapy is a cost-efficient, and non-invasive intervention that positively influences and contributes to the reduction of pain, anxiety and depression in seriously ill cancer patients:

- *'In four studies, the amount of pain reduction reached a statistically significant value in the short term.*
- *Two studies found that while the decrease in the consumption of analgesics was not statistically significant, the dosage of analgesics was subject to less fluctuation.*
- *Four studies found physiological relaxation to be closely connected with the immediate reduction of anxiety, and they also found it to be important for a lasting effect.*
- *Two studies provided evidence of an improvement in the depressive mood through massage therapy, one of which showed that a gentle touch massage or full-body massage provides for clearly better results in easing symptoms.*
- *Despite the different characteristics of the population, similar results with respect to reducing pain were achieved in four out of six studies.'*

Another 2014 study described the integration of massage therapy into a palliative care service and examined the relationship between massage and symptoms in patients with advanced illnesses. The study found that massage is a useful tool for improving symptom management and reducing suffering in palliative care patients.

During 2017, William G. Elder et al. investigated the efficacy of massage and other nonpharmacological treatments for chronic low back pain in real world primary healthcare. They

found measured improvement at 12 weeks and 24 weeks of massage treatments. Of those with clinically improved disability at 12 weeks, 75% were still clinically improved at 24 weeks. Those with physical and mental components showed clinically meaningful improvement at 12 weeks, and 46.1% and 30.3% at 24 weeks. For bodily pain, 49.4% were clinically improved at 12 weeks and 40% at 24 weeks. Adults older than 49 years had better pain and disability outcomes than younger adults.

A narrative literature review which looked into the use of massage therapy for reducing pain, anxiety, and depression in oncological palliative care patients found that massage therapy has been shown to reduce the subjectively-perceived symptom of pain in oncological patients receiving palliative care and remission of the symptoms of anxiety and depression (Falkensteiner, M. et al. 2011).

During 2018, Madalina Boitor et al. conducted a randomised controlled trial to investigate the effects of massage in reducing the pain and anxiety of the cardiac surgery critically ill patients. They concluded that the results suggest that a 20-minute hand massage in addition to routine post-operative pain management can concomitantly reduce pain intensity, pain unpleasantness and anxiety by two points on average on a 0–10 scale.

During 2016, Marie Cooke R.N. et al. investigated the impact of therapeutic massage on adult residents living with complex and high-level disabilities. They reported that the results of the pilot indicated that massage may be of benefit to people living with high care needs and represents a practical innovation providing tactile stimulation that may be integrated into care.

A study titled 'Massage Therapy and Quality of Life in Osteoarthritis of the Knee: A Qualitative Study (2017)' by Ali A. et al. concluded that participant responses noted empowerment with an improved ability to perform activities of daily living after experiencing massage therapy. The majority of statements were consistent with their quantitative changes on standard osteoarthritis measures.

3. What steps can be taken to improve the State's ability to attract and retain health professionals in regional areas, particularly the North West?

Importantly, myotherapists and remedial massage therapists with advanced training can undertake clinical assessments and accurately gather information in order to provide specific massage and myotherapy treatments; recognising and adjusting to contraindications for treatment, and the application of appropriate treatment protocols.

Therapists with advanced training can communicate effectively with medical and allied health practitioners in regard to age-related clinical issues and the health management plans of older people. Some of these issues include a reduced range of motion, palliative conditions such as cancer, neural tension, and reduced fitness and strength.

Additionally, many General Practitioners (GPs) already use the skills of massage therapists and myotherapists. A national workforce survey showed that GPs in rural areas are supporters of professionally-qualified massage therapists (Wardle, J. L. et al. 2013).

However, the skills and training of many qualified therapists are underutilised with a sizeable proportion of this workforce also engaged in other nonclinical roles (Steel, A. et al. 2017).

By offering secure employment that recognises their skills and qualifications would help to attract more professional therapists to the regional areas of Tasmania. This could be augmented with supplements or support to engage in further education related to clinical practice.

4. What innovations or changes are needed to our health workforce to align our professional health teams more closely with the future needs of Tasmanians?

The evidence supports policies that improve access to qualified remedial massage therapists and myotherapists, particularly in meeting the needs of women.

The Australian Institute of Health and Welfare reports that females experience a higher proportion of osteoarthritis compared with males (66% females/34% males), rheumatoid arthritis (64% females/36% males) and 'other musculoskeletal conditions' (52% females/48% males) Not surprisingly, women access massage services at a ratio of 2:1 to men[i].

A significant Australian longitudinal study indicates that over 50% of women visited a massage therapist in the previous 12 months.

Women with lower quality of life scores in terms of bodily pain and/or emotional health are more likely to consult a massage therapist than those with higher scores. Additionally, older Australian women experiencing chronic bodily pain prefer a concurrent multimodality approach (accessing conventional treatments alongside massage therapy) to cope with their condition.

Professional, qualified therapists often fill the gap when clients seek alternatives to medications and other therapies because they feel that massage and myotherapy provide a level of relief that is appropriate to their needs. For example, this occurs frequently in perinatal and post-natal care, and has been shown to help maintain mobility, manage pain and stress and reduce complications during birth.

The recommended advice for all antenatal visits includes encouraging women to undertake moderate level exercise based on the Australian Physical Activity and Sedentary Behaviour Guidelines for pregnant women. This involves physical activity every day and the accumulation of 150–300 minutes of moderate-intensity physical activity each week.

Understanding that different types of self-motivation contribute to exercise behaviour. Research has shown that regular exercise is linked to the prevention of cardio-vascular disease, type 2 diabetes, cancer, hypertension, obesity, osteoporosis, and depression.

The physical barriers to exercise during pregnancy include nausea, fatigue, lack of time, physical limitations, lack of social support, and lack of access to exercise facilities which can also translate to a limited ability or desire to exercise or undertake the recommended exercises. A 2017 literature review found that barriers to physical activity were predominantly intrapersonal, such as fatigue, lack of time and pregnancy discomforts. Frequent enablers included maternal and foetal health benefits (intrapersonal), social support (interpersonal) and pregnancy-specific programs.

Member respondence to a survey conducted by the Association, titled *Australian Association of Massage Therapists: Practitioner Survey 2012*, found that between 6 and 8% of therapists provided specialist services of maternal and pregnancy-related services.

An open-label, assessor blind, randomised controlled trial involving two public hospitals in Sydney, Australia, evaluated the effect of an antenatal integrative medicine education program in addition to usual care for nulliparous women on intrapartum epidural use. Researchers found:

- epidural rate—from 68.7% to 32.9%
- caesarean section—from 32.5% to 18.2%
- lessened likelihood of artificially accelerating labour—from 57.8% to 28.4%.

A study into the effect of perineal massage during the second stage of birth on nulliparous women perineal: A randomisation clinical trial, found that perineal massage during the second stage of labour can reduce the need for an episiotomy, perineal injuries, and perineal pain:

- frequency of episiotomy was 69.47% in the intervention group compared to 92.31% in the control group
- a 23.16% of first-degree perineal laceration
- 2.11% of second-degree perineal laceration in the intervention group, 5.13% of vestibular laceration
- no vestibular laceration or third and fourth-degree lacerations in the intervention group.

However, there were 7.69% of first-degree laceration, 2.56% of second-degree laceration, and 1.05% of third-degree laceration (one woman) in the control group.

Based on the results, the postpartum perineal pain was significantly different in both groups.

A randomised controlled study into the e*ffect of perineal massage on the rate of episiotomy and perineal tearing* found:

- episiotomy was performed among 44 (31.0%) women in the massage group and 99 (69.7%) in the control group.
- lacerations were recorded among 13 (4.2%) women in the massage group and 6 (4.2%) in the control group.

The extensive lists of studies regarding the use of massage during pregnancy and birth demonstrates that the body of evidence supporting the use of massage to improve the outcomes for mothers and babies has grown significantly during the past 15 years.

Making complementary programs available to new mothers through pre-natal education and in hospitals would greatly enhance birthing outcomes and promises to significantly reduce the cost and need for interventions.

More advanced training in massage during childbirth for nurses and midwives; and/or the presence of a qualified complementary therapy/massage specialist in the birthing wards of Victoria's hospitals, would also provide many positive benefits for new mothers and, importantly, reduce demand on hospital resources.

References

[i] *AAMT Practitioners Survey 2012* – Massage & Myotherapy Australia