



# Legislative Barriers and Legislative Changes for Physical Therapy During the Opioid Crisis in the US and Canada

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Legislative Barriers and Legislative Changes for Physical Therapy  
During the Opioid Crisis in the US and Canada

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A Thesis in the Field of International Relations  
for the Degree of Master of Liberal Arts in Extension Studies

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## Abstract

The opioid crisis has led to tens of thousands of deaths over the last couple of decades, most notably in the United States (US) and Canada. While the opioid problem may have begun in the US, it quickly crossed borders and is now a global health issue. This is an ongoing crisis resulting in the search for and implementation of solutions for preventing and treating addiction to these drugs. Physical therapy is one such treatment. The profession's focus on pain management, improvement of quality of life, and the patient's active participation in their own treatment without the use of medication is vital for improving pain treatment and reducing the need for opioids. Despite the profession's focus on pain management, the reason opioid prescribing became excessive, there has been little inclusion of physical therapy in treatment programs and few law changes to improve access to their services throughout the opioid crisis.

The case studies in this research focus on Ontario, Canada and Ohio, US which were chosen because of similarities in the demographics between the two regions as well as similar law changes that will help assess how the healthcare and political system affected the barriers presented to the physical therapy profession in each region. A comparison was conducted of the two most recent law changes for physical therapy in each respective region: the 1991 Physiotherapy Act and the 2009 revision of said Act in Ontario; and the 2004 and 2019 revisions to the Ohio physical therapy laws. The comparison of the laws within each distinct region will add to existing knowledge of

barriers to physical therapy by discovering what barriers exist for the physical therapy profession at the legislative level and how they have changed during the opioid crisis.

Interviews were conducted with physical therapists in Ohio that had varying experience with legislation. Additionally, one interview with a member of the College of Physiotherapists of Ontario was also conducted. In addition to interviews, an examination of other primary sources included the proposed laws at various stages of the process; government reports; official transcripts for debates and formal submissions to legislative committees in Ontario; and recordings of legislative sessions in Ohio. Secondary sources consisted of journal articles; academic books; newspaper articles; and news releases and reports from the Ohio Physical Therapy Association, the Ohio State Medical Association, Ontario Physiotherapy Association, and College of Physiotherapists of Ontario.

The healthcare system in which a health profession exists has a significant impact on the barriers they face for legislative change. Physicians had greater influence on legislation for physical therapy in Ohio and used that influence to block proposed law changes for physical therapy. Based on the comparison between the process in both regions, it was determined to be mostly due to the designation of physical therapy as a specialty care versus primary care and the differences in documentation of arguments. Ontario uses formal written submissions for arguments and considers physical therapists primary care, while in Ohio unrecorded meetings are the means of discussion and physical therapy is designated a specialty care. These two factors, specialty care and unrecorded arguments, create an environment in which physical therapists are unable to gain the political influence necessary to reduce barriers for physical therapy services.

## Dedication

To my husband, Derrick Hill, for his continued encouragement and support as I venture down a new career path. Our life together has been a great adventure that I would not change for the world.

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## Glossary of Acronyms

APTA- American Physical Therapy Association

CPA- Canadian Physiotherapy Association

DPT- Doctorate of Physical Therapy

HPRAC- Health Professions Regulatory Advisory Council

OSCA- Ohio State Chiropractic Association

OMA- Ontario Medical Association

OSMA- Ohio State Medical Association

OPA- Ontario Physiotherapy Association

OPTA- Ohio Physical Therapy Association

PT- Physical Therapist

RHPA- Regulated Health Professions Act 1991

## Chapter I.

### Introduction to Physical Therapy and Legislation During the Opioid Crisis

Tens of thousands of lives have been lost due to the opioid crisis that began with the release and heavy advertising of OxyContin for a myriad of common conditions in 1995 (Keefe, 2017). Before OxyContin, opioids were only recommended for cancer patients, palliative care, or end-of-life services, which is the current recommendation by the Centers for Disease Control and Prevention (CDC) (2016). As profits on opioids decreased in the United States (US) due to public backlash and continued legal challenges (Haffajee & Mello, 2017), pharmaceutical companies expanded into foreign markets making this a global health issue (Keefe, 2017). In Canada, the increase in opioid prescriptions, beginning in 1999 (Belzak & Halverson, 2018), led to tens of thousands of deaths over the last few years alone. In 2018, the US had 67,367 deaths from opioids (Center for Disease Control and Prevention, 2020) while Canada experienced the second highest number of deaths totaling 3,286 in 2018 (Government of Canada, 2019). As both countries try to move away from opioid prescriptions, other methods will be necessary for treatment and the prevention of future opioid addiction cases.

Physical therapy is a profession focused on improving physical functionality and pain management, in which it has proven to be effective (Bertozzi et al., 2013; Gellhorn et al., 2012). Physical therapy services have also been linked to a decrease in opioid use. Several studies find that patients that receive physical therapy early are less likely to be prescribed opioids or will use fewer opioids over a shorter period of time if prescribed (King & Liu, 2020; Sun et al., 2018; Sarpong et al., 2019; Thackeray et al., 2017). It even

has the potential to be financially cheaper than opioids. The CDC mentions the use of physical therapy as a viable alternative, even suggesting that the long-term cost of physical therapy can be less than that of opioid use (Centers for Disease Control and Prevention, 2016). This strongly suggests a greater use of physical therapy could decrease future opioid abuse and reduce total expenses. It could also benefit those currently in addiction programs. There are some physical therapists already seeing improvements in adherence to addiction treatment in facilities using their services (American Physical Therapy Association, 2018); however, there has been limited legislation passed to facilitate access to physical therapy and even less to assist with payment for their services (Ohio Rev. Code, 2017; Canadian Centre on Substance Use and Addiction, 2017).

Physical therapy has not been widely included in the fight against the opioid crisis to date. One possible reason is that the legal restrictions to accessing physical therapy continue to impede the ability of physical therapists to see patients that may benefit from their services (McCallum & DiAngelis, 2012; McCallum, 2010; Loignon et al., 2015). There have been very few changes to legislation regulating access to physical therapy despite the severity of the opioid crisis and evidence of the benefits of physical therapy. While many studies focus on identifying the barriers individuals face when trying to access physical therapy services (i.e., physician referrals and financial reimbursement), this thesis will focus on the obstacles the physical therapy profession faces at the legislative level that impede changes in law and whether the involvement of physical therapy professionals in policymaking has changed in light of the opioid crisis. It will do so through a comparison of policies regarding access to physical therapy in Ontario, Canada and Ohio, US.

The opioid crisis is a global health issue due to the fact that it has crossed international borders and continues to do so, thereby necessitating a global response (United Nations Office on Drugs and Crime, 2020). Understanding how legislative changes occur and the impact these changes have is especially important in times of crises while a search for effective treatment methods is ongoing (Marmor, Freeman, & Okma, 2005). As North America has been the most affected by the opioid crisis, there has been a greater amount of time for them to test various methods of treatment and prevention. A comparison between the US and Canada will provide a better understanding of the barriers facing the physical therapy profession and how this affects their inclusion in policymaking. The two countries maintain one critical difference: Canada has universal healthcare that financially covers physical therapy in hospitals while the US relies mostly on a wide variety of private insurance plans that do not necessarily cover the costs of similar care.

There has been a significant amount of research completed on the benefits of direct access to physical therapy (Ojha et al., 2014; Pendergast et al., 2012) but even with direct access, other barriers supported by legislative policy prevent the full benefits from being realized (McCallum & DiAngelis, 2012). While there has been an increase in scientific information supporting the inverse relationship between physical therapy and opioid use, there is no existing research on why other barriers, such as reimbursement for direct access, have not been addressed at higher levels of policymaking. This leads to several research questions. First, what barriers do physical therapists face at the legislative level? Without research identifying these barriers, it is difficult to understand what has changed. Once this information is clear, it will be easier to find the answer to

the second research question, have these barriers changed because of the opioid crisis to allow greater inclusion of physical therapists in the legislative process? There has been limited legislation over the last couple of decades concerning access to physical therapy, and many of the recent changes do not address the financial aspects of accessing their services. There are even laws specifically refusing to require reimbursement for legally accessed physical therapy services (S.B. 35, 2004). There have been some legislative changes in laws regulating the physical therapy profession since the opioid crisis began. Rich qualitative information on the processes behind policy creation regarding physical therapy is important for better understanding why these changes occurred and if inclusion of physical therapists increased in the process. Based on the previous research done by McCallum (2010), I expect to find that a lack of knowledge about the scope of physical therapy has led to the lower prioritization of reducing barriers to their services; however, it is likely that the inclusion of physical therapy in policymaking has increased over the course of the opioid crisis.

The third question attempts to broaden the context by asking, does the healthcare or political system affect the barriers the physical therapy profession faces in the legislative process? The barriers physical therapists face may vary under different healthcare and political systems. For example, physical therapy is not considered primary care in the US or even in some provinces in Canada. Therefore, policymakers may view the importance of addressing barriers to physical therapy differently if it is considered primary versus specialty care. I suspect that the type of healthcare system does influence how policymakers prioritize barrier reductions for physical therapy. This research will

not only determine if this is true but also how the healthcare system shapes the views of policymakers about physical therapy.

### Background

Most of the research concerning access to physical therapy focuses on the barriers for patients and lacks an explanation for why these barriers to physical therapy have not been reduced in light of the opioid crisis. The research comparing differences in the regulation of physical therapy internationally is even more limited. The opioid crisis has become a global health issue that requires global solutions. Therefore, it is important to understand what prevents an effective pain management treatment from being accessible to the populations most in need. Information provided from a comparison between the US and Canada, the countries most affected by the crisis, may provide insight on how different healthcare systems may affect policies regulating the profession of physical therapy.

There is a general consensus that the opioid crisis began in the mid-1990s when Oxycontin was heavily advertised for chronic noncancerous pain in the US (Macy, 2018). This advertising led to overprescribing of opioids as doctors sought to cure or eliminate the pain rather than manage it (Macy, 2018). The addictive quality of the medicine has created an international problem that now requires a multifaceted solution. In response to the crisis, the first line of treatment has been to reduce opioid prescriptions and treat patients suffering from addiction (Meisenberg et al., 2018). While this is a necessary step for treating the opioid crisis, it is not addressing the underlying cause that initially led to the prescription problem, chronic pain.



As mentioned previously, physical therapy is effective for pain management and is a viable alternative to opioids (Bertozzi et al., 2013; Gellhorn et al., 2012). The use of physical therapy has been linked to a decrease in opioid use and several studies find that patients that receive physical therapy early are less likely to be prescribed opioids at all or use fewer opioids over a shorter period of time if prescribed (King & Liu, 2020; Sun et al., 2018; Sarpong et al., 2019; Thackery et al., 2017). Additionally, there are some physical therapists already seeing improvements in adherence to addiction treatment in facilities using their services (American Physical Therapy Association, 2018). This research strongly suggests greater use of physical therapy could help in the treatment of addiction and prevent future opioid abuse.

Furthermore, physical therapy is effective for more than just the physical aspect of pain management. Good et al. (1992), found that in addition to physical causes, social, economic, and psychological factors can contribute to a person's experience of pain. Eric Fjeldheim, PT, DPT, a Fellow of Pain Science, in an interview explained "Pain is a whole human being biopsychosocial experience and sometimes we forget about that psychosocial piece." A pill such as an opioid or even a nonsteroidal anti-inflammatory drug (NSAID) will treat the physical aspect of pain, but it will not treat the other contributing factors. Through active participation in their pain management, patients begin to have a more positive outlook and a greater sense of control over their pain (Good et al., 1992). This active participation essentially provides treatment for some psychological factors contributing to the pain. Similarly, Miller (2016) also concludes that taking a biopsychosocial approach to pain, one that encompasses a patient's psychological and social aspects of their life in addition to the physical issue, is the most

effective way to achieve pain relief. This can be done, to an extent, through physical therapy. It was explained by Mark Bishop, PT, PHD, at an American Physical Therapy Association (2018) conference that “addiction resembles many of the same brain processes associated with the experience of chronic pain.” Physical therapists are well educated in treating chronic pain, but in plans to treat the opioid crisis very few efforts have been made to decrease the barriers to accessing this profession.

As alluded to previously, many barriers to accessing physical therapy services exist and are regulated at the state or province level, including structural, financial, and geographical barriers. One of the most obstructive barriers occurs after someone has decided to seek treatment; they often cannot do so directly and need a physician referral. Within the United States (US), Freburger et al. (2011) found that most referrals for physical therapy come from specialists and not primary health care providers. This suggests that many patients end up needing two referrals, one for the specialist and one for the physical therapist, leading to greater delays for treatment or foregoing treatment altogether. This is in addition to higher healthcare costs and greater demands on physicians. In all fifty states, direct access to physical therapy is legislatively allowed, but this access is often limited and there is no law requiring insurance companies to reimburse appointments that occurred without a referral. For example, Ohio law states that their policies on direct access to physical therapy “shall not be construed to require reimbursement” from any insurance program the patient may be using (S.B. 35, 2004). Physical therapy appointments paid out of pocket can be expensive especially if more than one appointment is necessary. Therefore, a patient’s potential access to physical therapy is often in the sole control of physicians who may not have a complete

understanding of physical therapy services. Numerous studies have found there is a lack of knowledge of the full scope of physical therapy treatments and services by both healthcare providers and patients (McCallum, 2010; Ojha et al., 2014). Consequently, physicians are less likely to refer patients to physical therapy. The evidence that physicians are insufficiently informed about physical therapy also suggests that legislators may have inadequate knowledge of the profession as well. Therefore, it is important to know how physical therapy professionals are included in policy decisions.

Global health issues notoriously ignore national borders, turning national diseases into international crises that require a global response to solve (Chen et al., 2020). This is most obvious in cases of infectious disease; however, non-contagious health issues, such as chronic pain and addiction, can be equally, or more, deadly. The opioid crisis has spread across international borders costing hundreds of thousands of lives and affecting over twenty-five countries of the Organization for Economic Co-operation and Development alone (OECD, 2019). What began with national policies has evolved into a global health crisis. This often leads to changes in international relations as countries need to coordinate their response to the crisis in order to find effective prevention to halt further spread as well as treatments for those already affected.

There have been few international comparisons of barriers to physical therapy and how the profession operates within different healthcare and political systems. The studies that do exist vary greatly in what they specifically look at, such as patient satisfaction, workforce size, clinical guidelines, and how the profession itself is regulated (Hush et al., 2012; Jesus et al., 2016; Van der Wees et al., 2007; Grimmer et al., 2017). Although limited in number, they do serve a purpose. In such studies, a comparison of policies

between countries provides a greater understanding of the policy options available as well as evidence supporting the lessons learned from their implementation (Blank et al., 2017; Marmor et al., 2009). At the time of writing, there has not been a comparison of policies regulating physical therapy in the context of the opioid crisis. Information sharing and medical comparisons have been coordinated internationally (Canadian Centre on Substance Abuse and Addiction, 2019), but there has not been comparative research examining the participation of physical therapy in the creation of legislation. This is despite the fact that the opioid crisis is a global health issue that could benefit from such a comparison by providing a greater understanding of what prevents the reduction of barriers to physical therapy services which are effective treatments for chronic pain.

As the details of the healthcare system in both the US and Canada are decentralized to an extent, a more localized comparison is necessary. Ohio and Ontario share enough similarities to warrant a fruitful comparison. They have a similar ratio of physical therapists to the general population as of 2019 with Ohio at 73.7 per 100,000 (American Physical Therapy Association, 2020, October) and Ontario at 67 per 100,000 (Canadian Institute for Health Information, 2020). They both have large populations that have become increasingly more urban over recent decades (Statistics Canada, 2018; Iowa State University, 2020). Additionally, physical therapy is financially covered similarly under their respective systems. While both regions have Medicare, many citizens must obtain healthcare coverage through private insurance. The one big difference under their healthcare system, is the designation of physical therapy as primary care in Ontario and a specialty in Ohio. Furthermore, both regions passed a law, within a decade of each other, that allows a physical therapist to diagnose, and both originally included the ordering of

diagnostic imaging and tests (H.B. 131, 2017; Physiotherapy Act, 2009). The inclusion of diagnostic imaging had very different results. It was passed in Ontario but not in Ohio. This difference is an important point of comparison for understanding how the healthcare and political system influences legislative change for the physical therapy profession.

The opioid crisis currently has caused the greatest devastation to the US and Canada. A comparison between the US and Canada is essential for understanding how the healthcare and political system can shape the views of policymakers as they create the policies and guidelines that are meant to treat the crisis. If the barriers for physical therapists prevent treatment of patients with chronic pain, then it is important to understand why they are not reduced at the legislative level for the sake of the opioid crisis. Furthermore, the comparison between the American and Canadian policymaking process will illuminate how the barriers physical therapists face at the legislative level may vary even in seemingly similar systems. The results will provide information that may be applicable in other countries allowing governments to address barriers to physical therapy more effectively.

## Methods

This thesis uses a comparative case study method examining law changes regulating the physical therapy profession in Ontario, Canada and Ohio, United States (US). This is a retrospective study as it examines the process and conditions that occurred on bills that have since been enacted into law. This comparison is to find how different healthcare and political systems influence how physical therapy is received in the legislative process of Ohio and Ontario, respectively.

The primary sources consist of a total of thirteen interviews conducted on a voluntary basis and contacted through email using the mailing list of licensed physical therapists from the Ohio Occupational Therapy, Physical Therapy, and Athletic Training Board and specific recommendations from the College of Physiotherapists in Ontario and the Ontario Physiotherapy Association.

Table 1. Interviewee Demographics.

Interviewee Demographics	Number
Practicing physical therapists (PT) with no legislative experience	7
PT involved in 2019 revision	2 (Neil and Laura)
PT involved in 2004 and 2019 revision	1 (Grant)
PT experience with other legislation	1
Member of the College of Physiotherapists in Ontario involved in 2009 Revision	1
Fellow of Pain Science	1
Total Interviews	13

Snowball interviewing led to one additional interview with a Fellow of Pain Science physical therapist that helped further explain the role physical therapy can have during the opioid crisis. These interviews were intended to help identify the barriers the profession faces in legislation and any changes that have occurred in the process due to the opioid crisis. Informed consent forms were signed by the participants before their scheduled interview. In order to protect the identities of the physical therapists that participated, pseudonyms are used throughout this thesis. Those pseudonyms are included in Table 1. All physical therapists involved in legislation received their Doctorate of Physical Therapy (DPT) along with other degrees and/or specialties. The one exception to pseudonyms is the Fellow of Pain Science who agreed to direct quotation.

In addition to interviews, an examination of other primary sources included the proposed laws at various stages of the process; government reports; official transcripts for debates and formal submissions to legislative committees in Ontario; and recordings of legislative sessions in Ohio. Secondary sources consisted of journal articles; academic books; newspaper articles; and news releases and reports from the Ohio Physical Therapy Association, the Ohio State Medical Association, Ontario Physiotherapy Association, and College of Physiotherapists of Ontario.

This thesis begins with a comparison of the barriers to the 2004 and 2019 revisions to the laws regulating physical therapy in Ohio in Chapter 2. Chapter 3 consists of a similar comparison between the 1991 Physiotherapy Act and the 2009 revision to said Act in Ontario. This is followed by Chapter 4 with a comparison between these barriers in Ohio and Ontario and how the respective healthcare and political systems influenced these barriers. This thesis ends with Chapter 5 concluding remarks, acknowledgement of limitations, and areas for future research.

All applicable protocols and policies of Harvard University's Institutional Review Board for the use of human subjects in research were complied with in this proposed thesis research.

#### Term definitions

*Diagnostic Imaging and Testing*- For the laws being proposed, this refers to ultrasounds, x-rays, MRIs along with any other diagnostic test that requires laboratory work.

*Direct Access*- According to the American Physical Therapy Association (2021), “Direct access means the removal of the physician referral mandated by state law to access physical therapist services for evaluation and treatment.” In other words, the ability of patients to choose to go directly to a physical therapist without a physician referral.

*Global health*- Global health consists of medical and health issues that require a global response (Chen et al., 2020) because they “transcend national boundaries and governments” (Kickbusch, 2006). It is a subset of international relations (IR) as it often affects many other areas of concern in IR such as security, global governance, international political economy, etc. (Davies et al., 2014). Additionally, research in global health strives to understand the issue and its global impact; determine the factors associated with the issue; and find “evidence-based global solutions, including strategies, frameworks, governances, policies, regulations, and laws” (Chen et al., 2020).

*Opioid Crisis*- While it has been determined to be an epidemic within the US, most other countries refer to it as a crisis including Canada. Therefore, this thesis will follow the least common denominator and refer to it as the opioid crisis.

*Physical Therapy*- The use of prescribed exercise, hands-on care, and patient education by physical therapists to improve movement, “reduce or manage pain, restore function, and prevent disability.” (American Physical Therapy Association, 2021). It should be noted that in many countries physical therapy is referred to as “physiotherapy.” Although the terms are slightly different in appearance, they



entail the same profession. For the purposes of this research, the term physical therapy will be used uniformly within; however, many sources will refer to it as physiotherapy.

*Physical Therapy Diagnosis-* This research refers to a physical therapy diagnosis as a diagnosis given by a physical therapist; however, when referring to the laws in Ohio, the specific definition is “a judgment that is made after examining the neuromusculoskeletal system or evaluating or studying its symptoms and that utilizes the techniques and science of physical therapy to establish a plan of therapeutic intervention.” (Ohio Rev. Code, 2019).

## Chapter II.

### Ohio: Barriers and Change

The US is the most affected by the opioid crisis. Their decentralized, pluralistic healthcare coverage makes them a complex case. Ohio was one of the last states to approve any form of direct access to physical therapy and did so through a law which also absolved insurance companies from any financial responsibility for such care. The most recent physical therapy law change in Ohio was simply a formalization of a practice already use. Interviews conducted with the three physical therapists involved in the 2004 and 2019 revisions were informative for uncovering barriers faced by the profession. They were essential as meeting notes and association positions on the proposed laws were not publicly available. This section will first discuss the content and context of the 2004 and 2019 revisions to Ohio's laws regulating physical therapy. This is followed by an examination of the barriers to the legislation, and the changes observed through the opioid crisis. It will end with a summary of the information found in the comparison.

#### Content and Context

There are two pieces of legislation that passed into law regulating the physical therapy profession at the time this research was conducted; the 2004 and 2019 revision to the Ohio physical therapy laws. The 2004 revision was a result of a long-fought fight for direct access to physical therapy in the state of Ohio while the 2019 revision was a formalization of the authority of physical therapists to make their own diagnoses and a

failed attempt to expand the scope of practice to include diagnostic imaging and tests. What passed and what did not help to identify what barriers are the most difficult to overcome for the physical therapy profession.

#### 2004 Revision: Direct Access

The 2004 revision legalized direct access to physical therapy provided that the physical therapist, with patient permission, notifies their physician and refers the patient out if no progress is made in 30 days. Insurance is explicitly, by law, not required to cover direct access to physical therapy services (Ohio Rev. Code, 2017, s. 4B; S.B. 35, 2004). This change had a focus on improving patient access while still limiting the profession with requirements of reporting to other healthcare professionals and not guaranteeing reimbursement of directly accessed services.

At the time of the 2004 revision, thirty-eight other US states had already allowed for direct access to physical therapy services through changes in legislation (American Physical Therapy Association, 2020 August). Furthermore, most of the states that allowed direct access to physical therapy made the law change in the 1980s and 1990s. That means that not only were there examples that Ohio legislators and opposition could look to, but that enough time had passed for research to be available about the effects of direct access. In Ohio, direct access was first introduced and passed in the Ohio House of Representatives in 1989 (Easter, 1989). In one interview conducted during this research, it was mentioned that direct access had been brought to the legislative assembly in the mid-1990s but was not passed until 2004. This indicates there were some large obstacles that needed to be overcome.

## 2019 Revision: Physical Therapy Diagnosis

The revision in 2019 formally changed the scope of practice of physical therapy to allow physical therapists to make diagnoses. This was already happening in practice, but the formalization further legitimized physical therapy as an autonomous profession. Additionally, the ordering of diagnostic imaging was originally included in the bill; however, it did not make it into the approved version.

Ordering diagnostic imaging was not an unheard of practice for physical therapists; those in the US military and some in the private health sector have had the ability for decades. Those populations have not seen any significant increases in litigation or license suspension and revocation due to ordering of diagnostic imaging (Boyles et al., 2011). It has also been found that allowing physical therapists this ability can reduce ordering of unnecessary images without compromising the accuracy of diagnoses (Moore et al., 2005). Although Ohio chose not to include diagnostic imaging in the modification of the physical therapy laws in 2019, in the years since, both North Dakota and Rhode Island have passed bills allowing physical therapists to order imaging (S.B. 2122, 2021; H.B. 5198, 2021). Following the pattern of direct access, it is plausible this ability will be brought to legislators again in the future.

## Barriers

At the beginning of this research, it was hypothesized that there was a lack of knowledge about the scope of physical therapy that led to a lower prioritization of changes for laws regulating the profession. This was hypothesized because research by McCallum (2010) found there was inadequate knowledge of the scope of physical therapy by physicians and patients themselves creating a barrier to access. The answer to

this question varied from yes to some but “most legislators have no idea what physical therapy is.” Despite the mixed answers, none listed limited understanding of the as one of the main barriers for passing legislation. Instead, the most common barriers mentioned for both bills were perceived cost, physician opposition, and politics. In one of the interviews, it was said that “evidence doesn’t always matter...It’s either who has the ear of the legislator or how the cost is going to be.” Meanwhile, among the practicing physical therapists not involved in legislation, it was believed by some that, in addition to concerns of cost, a lack of public awareness also contributed to limited advances for physical therapy in Ohio. This leaves us with four barriers to examine: perceived cost, physician opposition, public awareness, and politics.

### Perceived Cost

Money is often of grave concern when it comes to healthcare especially in terms of who will be paying for services. While physical therapy can lead to decreased medical costs overall (Sarpong et al., 2019; Frogner et al., 2018), it is initially more expensive in the short term than a simple pill. This often leads to short sighted views that focus on the immediate cost of implementation of new laws.

Insurance companies were the most interested in the impact of direct access. At the time this revision was made, 2004, there was not a lot of literature available about decreased costs from direct access; however, there were many case studies in the form of well-established direct access systems in other states. Ohio was one of twelve states that had yet to allow any form of direct access at the time of the revision (American Physical Therapy Association, 2020, August). Nevertheless, the evidence of mollifying the concerns of 3<sup>rd</sup> party insurance is apparent in section 4B of Chapter 4755.481 of the

physical therapy laws that explicitly explains that directly accessed physical therapy does not mean insurance must reimburse it (Ohio Rev. Code, 2017). Grant (interviewee involved in the 2004 revision) confirmed this stating, “That was put in there to kind of appease the 3<sup>rd</sup> party payers.” The OPTA agreed to this stipulation because they believed insurance companies would likely cover directly accessed physical therapy services anyway. Grant further explained, “We guessed that most (insurance companies) would pay for it because it’s cheaper for them. It’s cheaper for them to pay a physical therapist than an orthopedic surgeon.” The concern for increased healthcare costs, due to the 2004 revision, follows the idea that allowing direct access to physical therapy means that patients will unnecessarily seek physical therapy services, thereby adding to healthcare expenses. What is omitted in this argument is the fact that without direct access, patients schedule unnecessary appointments with physicians for the sole purpose of obtaining a referral to a physical therapist. In fact, research found that most physical therapy referrals come from other specialists, meaning the physical therapy is often the third appointment at the expense of the insurance company or the patient (Freburger et al., 2011). When referrals are no longer required from the physician for physical therapy, there is a corresponding decrease in overall healthcare costs because of fewer visits and quicker treatment of patients (Sarpong et al., 2019; Frogner et al., 2018). That reduced cost results not only from reduced treatment time, but also in fewer unnecessary visits to physicians.

The OPTA’s belief that insurance would cover most directly accessed physical therapy services appears to have proven true as there were no concerns about reimbursement for directly accessed physical therapy services in the seven interviews

with practicing physical therapists. Even the ones that had been practicing at the time this law was enacted expressed they had never been concerned about reimbursement; however, that does not mean that the reimbursement always reflects the effort in applying for it. Four of the eleven physical therapists interviewed in Ohio mentioned knowing clinics that operate on a cash basis, solely to avoid dealing with insurance. Two other physical therapists interviewed work at clinics that still require a physician referral for everyone rather than keep track of which insurance plans do and do not require the referral.

As for the 2019 revision, the financial concern remained with diagnostic imaging and tests. According to one interview, there was a concern that adding diagnostic imaging to the physical therapy scope of practice would increase healthcare costs. Diagnostic imaging for physical therapists is still in the early stages of research; however, of the physical therapists that have been allowed to order diagnostic imaging for decades, there have been no issues of reimbursement and there are few cases of imaging being ordered inappropriately (Boyles et al., 2011; Keil et al., 2019). Considering evidence does not support the fears of increased costs and some law changes do not require additional financing, such as a physical therapy diagnosis, it is evident that financial concerns are not always the deciding factor for legislative change.

### Physician Opposition

Landry et al. (2012), suggest that the greatest barriers to overcome may be other health professions as each profession advocates for limited resources for their own profession. The success of advocating may be influenced by how well established a profession is within the healthcare system. Physical therapy did not begin until World

War I and has developed a great deal over the last few decades (Moffat, 2003) while physicians have been at the top of medicine for centuries. The long-held view of physicians as the leading profession of healthcare was thought by a couple of the interviewees to have helped them form relationships with politicians, creating a barrier for the physical therapy profession in legislation. This suspicion was supported through the concessions made in both revisions. Of the three proposed changes to Ohio physical therapy laws that were brought to the general assembly in the last twenty years, physicians opposed them all. Furthermore, they opposed them for similar reasons, all of which boil down to concerns that physical therapists are trying to practice medicine.

In the third consideration for S.B. 35, which granted direct access to physical therapy (Senate Session, 2003), Senator Leigh Herington brings up that in the previous general assembly there had been a similar bill with concerns of misdiagnoses by physical therapists. Senator Scott Nein responded by repeating a point he made in his initial introduction that physical therapists are not trying to practice medicine. He also mentions that the majority of other states already had some form of direct access and their malpractice premiums have not changed, indicating there has not been any resulting problems of misdiagnoses. The question brought up by Sen. Herington confirms the assertion by Grant about the discussions for the 2004 revision, “There’s a lot of misinformation out there and a lot of it was anecdotal.” This unsupported concern suggests that physicians were protective of their authority as a first point of contact for patients. The concerns of the physicians were not brushed aside in the 2004 revision nor in 2019.



Direct access is allowed for physical therapy in the state of Ohio, but the official law requires physical therapists to inform the physician within five business days following the initial consultation (Ohio Rev. Code, 2017). Despite no longer being the first point of contact, this addition allows physicians to remain the leader of a patient's treatment. This requirement gave a couple of the interviewees a sense that they are reporting to the physician rather than acting as an autonomous profession stating, "We're supplementary care. I have to have a doctor sign off."

As for the physical therapy diagnosis, there were concerns from physicians that it would be considered a 'medical diagnosis.' Specific language was added to the law to allow physicians in Ohio to maintain a monopoly on the term 'medical diagnosis' even though there is no legal definition for this term in the laws regulating physicians (Ohio Rev. Code, 2021). It is further specified in the revised law that physical therapists would make a diagnosis using the "techniques and science of physical therapy." (Ohio Rev. Code, 2019, s.B). The language is very clear to leave no room for misunderstanding a 'physical therapy diagnosis' with a 'medical diagnosis.' The final definition of a 'physical therapy diagnosis' varied greatly from the one originally proposed, and the Ohio State Medical Association (OSMA) credited themselves for the change in the language used (Ohio State Medical Association, 2019). With the new physician approved language, the bill passed unopposed through the Ohio General Assembly.

The proposed addition of diagnostic imaging, according to interviews, anecdotal evidence was used to prevent the ordering of diagnostic imaging out of concerns that they would be interpreted incorrectly, and a serious diagnosis would be missed. There is no evidence to support this conclusion. The US military has been allowing direct access to

physical therapists with the ability to order imaging since 1972 without issue (Boyles et al., 2011). Missing a major diagnosis is uncommon. This could be because physical therapists are trained to recognize concerning symptoms and refer patients when it is outside of their scope of practice, additionally, patients are seen regularly by their physicians every year. This makes it less likely that something critical would be missed.

This argument of misinterpretation does not entirely make sense when examining the proposed law which states that tests ordered “are performed and interpreted by other licensed health care professionals (H.B. 131, 2017). Interviewed physical therapists explained that physicians would only agree to allow physical therapists to order diagnostic tests and images if it was done under physician supervision. Neil, remarked that physicians were “concerned it (diagnostic imaging ordered by physical therapists) would cut out the primary care physician.” Since physical therapy is an autonomous profession with direct access allowed, being under physician supervision was seen as a step back for the profession. According to Laura, the OPTA decided to have it removed rather than set the profession back stating, “We were like either take it out or leave it as it is.” Therefore, all the bill was intended to do was allow physical therapists to order diagnostic imaging and tests without sending the patient to an appointment with their physician for the sole purpose of a referral for a test at the request of the physical therapist, essentially eliminating the middleman.

Physician concerns had a significant impact on all three proposed changes. This resulted in conditions placed on direct access; significant language change in the definition of a ‘physical therapy diagnoses;’ and the failure of expanding the scope of practice to include ordering of diagnostic imaging and tests. More importantly, this was

achieved with little supporting evidence that the changes to the original proposals were necessary.

### Public Awareness

The general public has always been an important influence on legislative change as politicians are elected by the people and are done so to represent the interests of the people. Therefore, a law is more likely to be passed if there is large public support. Grant did claim that grassroots efforts of constituents calling the politician in their district helped pass the 2004 revision, “because then politicians could go back to the OSMA and say ‘hey, I’m getting a lot of calls from my constituents saying they want this, that this is a good thing for them.’” This contributes to the idea that public awareness does have an impact.

Unfortunately, there is very little research existing on public awareness of physical therapy, but a strong majority of the interviewees from Ohio believed there was a deficit in public awareness about the profession and access to their services. In seven of the eleven interviews with physical therapists in Ohio, the therapist stated that community outreach was important. To highlight the point, a couple shared stories of patients arriving for their appointment expecting a massage and passive participation. It is apparent misunderstandings about the physical therapy profession exist in the general population.

A contributing factor to this unawareness may be the lack of information on current issues shared with the public on the OPTA website. The advocacy page consists only of a login (Ohio Physical Therapy Association, 2021). Only physical therapists, physical therapy assistants and physical therapy students may become members and

login. This is in stark contrast to the national organization, the American Physical Therapy Association (APTA), which has their advocacy issues not only listed but explains the importance of them and ways the general public can help. There are a couple of possible explanations for the secrecy of the OPTA versus the APTA. One, it could be that many of the issues overlap, and the state chapter prefers to keep things simple by allowing the APTA to be the one voicing the concerns and providing the information. Two, it could also be that the APTA prefers to be the main voice on advocacy issues for the physical therapy profession. Three, there could be some political advantage to not publicly sharing all political goals at the state level that may not provide the same benefit at the national level. Despite the members only advocacy page for the OPTA, it is clear the APTA is trying to have national outreach especially in educating the public on the benefits of physical therapy in place of opioids. While it is unknown how much public awareness influences legislative change for physical therapy in Ohio. It is certainly a factor in improving access and utilization of physical therapy services.

### Politics/Lobbying

The politics of law making are a strong influence on policy. When asked what surprised him most about the legislative process, one physical therapist discussed the hyperbole and the creation of fear despite evidence to the contrary. When each organization is arguing their point, it matters who has the ear of the politician. One way that organizations try to build relationships with politicians and advocate for their profession is through lobbying.

While lobbying was not brought up as a concern with money by the physical therapists involved in legislation, a couple of practicing physical therapists suggest this as

an issue. They argued that many physical therapists are not members of the OPTA, therefore, they are not helping fund lobbying efforts for the profession. Fortunately, in the state of Ohio, lobbying groups must submit expenditure forms three times a year that are then available to the public through the Ohio Lobbying Activity Center (OLAC, 2021). These reports list the amount spent and whether it was on an event or on food. Additionally, it lists which bills were lobbied for in that four-month span and has the option for the organization to list for whom the money was spent on. Only one of the three organizations searched was found to have listed specifically which politician they approached. It is difficult to understand the effort exerted for any individual bill because these reports do not indicate for which specific bill the lobbying money was spent. Furthermore, some reports have no expenditures reported but do list bills for which the organization lobbied. Unfortunately, these reports are not publicly available prior to 2009, so this was only helpful for the 2019 revision.

There were two main health care professions mentioned in interviews as opposition to the OPTA: the OSMA and the Ohio State Chiropractic Association (OSCA). The OSCA was mentioned as opposition in two of the interviews, but no corroborating evidence could be found; it is unclear what they opposed in the proposed physical therapy bills. In analyzing the reports for these three organizations in January 2017 through December 2018, there were some obvious differences in lobbying expenditures between them. The OSMA spent a total of \$404.50 on meals in that time on reports that included H.B. 131, the 2019 revision to the physical therapy laws. On each expenditure report containing H.B. 131 as one of the bills concerned, a couple dozen other bills were also listed. It is unclear how much time or money was spent specifically

on H.B. 131 by the OSMA. The other opposition was the OSCA. They reported spending \$4,829.05 on reports that included H.B. 131. Most of that money was reported for May 4, 2017, listed under food and beverage. This association never had more than four bills listed on the expenditure report including on the most expensive report. Neither of these organizations listed a specific person they were lobbying, only the bills for which they were lobbying. The OPTA, conversely, had no expenditures during that time, but did file reports including the bills for which they were lobbying.

Table 2. Lobbying Expenditures.

Organization	Money Spent
Ohio Physical Therapy Association	\$0.00
Ohio State Medical Association	\$404.50
Ohio State Chiropractic Association	\$4,829.05

*Amounts from expenditure reports including H.B. 131 in Jan. 2017-Dec. 2018.*

It is difficult to know the true impact lobbying expenditures have on the political process; however, there is a great imbalance of money spent by healthcare organizations. This could be a barrier for the physical therapy profession when more well-funded organizations are in opposition.

### Changes

It seems likely that these barriers would change over the years, however, there is evidence to support the idea that arguments do not change so quickly. For over a decade before the 2004 revision in Ohio, starting as early as the late 1980s, the physical therapy profession had been advocating for direct access (Easter, 1989). The bill for direct access even passed in the House in 1989. It required multiple attempts to get direct access to

physical therapy passed. Grant claimed that when direct access passed in 2004, it was the third time it had been brought to the house. Similarly, Easter (1989) brings up common arguments that were used against direct access to physical therapy that were then repeated in 2004 and 2019 when physical therapists wanted to diagnose. These statements include the following claims:

Physical therapists: want to practice medicine; are not properly trained to establish a diagnosis; would over-utilize physical therapy rather than refer the patient for less expensive medical treatments thereby increasing the cost of health care; and would cause harm to patients if physician referral were not mandated.  
(p. 8)

The same arguments have been used to oppose proposed changes to the physical therapy laws in Ohio. While in practice physical therapy diagnoses have been happening in Ohio for years, the legal formalization of this did not occur until the 2019 revision passed into law. The same arguments are often repeated, and the most common ones are about perceived costs and physicians' concern of physical therapists trying to practice medicine.

The concern about perceived costs continues to present a barrier for physical therapy laws. This was seen in the 2004 revision for direct access and in 2019 when imaging was on the table; however, this does not appear to be the greatest barrier. This is likely because the proposed legislation did not require more government money and there was no evidence to suggest that direct access or allowing diagnostic imaging would increase overall healthcare costs. The greatest opposition to law changes granting physical therapy greater autonomy and abilities continues to be physicians in their consistent concerns of physical therapists stepping out of their scope of practice into medicine.

While the barriers do not seem to have changed over the last few decades, approaches to advocating for legislative change have. In the House vote for the 2019 revision, Rep. Reineke connects the importance of this law change for physical therapy with the opioid epidemic (Ohio House of Representatives, 2018). In two of the five Senate hearings for the 2019 revision, opioids or the opioid epidemic was mentioned in explaining the importance of the bill (Ohio Senate Health, Human Services and Medicaid Committee, 2018, June; Senate Health, Human Services and Medicaid Committee, 2018, May). In two of the interviews, it was mentioned that the lobbyists for the OPTA use the opioid crisis as an example, whenever possible, to explain why affordable access to physical therapy services is important for their constituents. This connection at the very least gets the ear of the legislator as one mentioned:

The legislators were very interested when I related it back to the opioid crisis. Because again, an opioid you can get for \$2 where you're going to have to pay \$40 for every time you go to see the physical therapist. Guess which one you're going to pick.

The rising co-pays for physical therapy services have become so great that many physical therapists are now operating on a cash-based system to avoid the hassle of even dealing with the insurance companies. Although no law has passed in Ohio to limit the amount insurance can charge the patient for physical therapy, connecting physical therapy issues to their impact on the opioid crisis represents a shift in tactics. Additionally, the evidence-based information available has changed. More research continues to come out connecting the benefits of early physical therapy intervention with decreased opioid use. This is information that was not available during the first revision in 2004 as the US was still discovering there was an opioid problem. This recent research



helps provide a stronger argument for why a law change is necessary for improving access.

### Summary

In both the 2004 and 2019 revision to laws regulating physical therapy in Ohio, perceived cost, physician opposition, public awareness, and the general politics influenced the outcome. While the majority of these barriers have not changed over the decades, the physical therapy approach with politicians has. As the opioid crisis continues, it will be interesting to see if these new strategies change the influence of the physical therapy profession on the laws regulating the profession.

## Chapter III.

### Ontario: Barriers and Change

Canada is the second most affected country by the opioid crisis. While Ontario has universal healthcare, the coverage of physical therapy is limited. Hospitals and the Ontario Health Insurance Plan will cover physical therapy expenses, but many Ontarians must obtain extended health benefit plans to cover physical therapy services. Although only one interview was obtained in Ontario during this research, there is formal documentation of interested parties' arguments and transcripts of hearings held for the proposed law change. When compared to the finalized law, it provides insight into which arguments were favored. This section will first discuss the content and context of the 1991 Physiotherapy Act and the 2009 revision. This is followed by an examination of the barriers to the legislation, and the changes observed throughout the opioid crisis. It will end with a summary of the information found in the comparison.

#### Content and Context

The two laws examined in Ontario are the 1991 Physiotherapy Act and the 2009 revision of the Act. The creation of the 1991 Physiotherapy Act was part of a restructuring of the healthcare system in Ontario while the 2009 revision was a formalization of abilities for physical therapists as well as changes to the scope of practice to better reflect the education of physical therapists in Ontario. These were the

two most significant direct legislative changes for the physical therapy profession in the last three decades.

### 1991 Physiotherapy Act

The 1991 Physiotherapy Act was created alongside and as a direct consequence of the Regulated Health Professions Act (RHPA) (1991, c. 18, sched. 1) which designated physical therapy as a self-governing profession. In the early 1980s a legislative review was created when, due to public pressures, it was determined the legislation regulating the health professions required structural change to adapt to societal changes and increased demands (Ontario, 1989). The purpose was to establish the scope of practice and the regulating body, e.g., the College of Physiotherapists, for each self-governing profession. This structural change was deemed necessary to regulate all health care professions and define their professions as they are known in Ontario today. Physiotherapy was one of the twenty-four professions affected (Pooley, 1992). According to the Ontario government, the RHPA, which required the creation of the Physiotherapy Act, was done to:

better protect and serve the public interest; be a more open and accountable system of self-governance, provide a more modern framework for the work of health professions; provide consumers with freedom of choice; and provide mechanisms to improve quality of care. (Ontario, 2018)

The Physiotherapy Act was created to meet those requirements and was in itself a replacement for the Drugless Practitioners Act in the form of a set of regulations for the physical therapy profession. This is noted in the section 12 of the Physiotherapy Act which states, “A person who, on the day this Act comes into force, was registered as a physiotherapist under the Drugless Practitioners Act shall be deemed to be the holder of a

certificate of registration issued under this Act” (Physiotherapy Act, 1991, c. 37, s.12).

The Physiotherapy Act was part of a great restructuring of the regulatory system for the health professions in Ontario.

#### 2009 Revision: Expanding Scope of Practice

The 2009 revision greatly expanded the scope of practice for physical therapists to formally allow physical therapy diagnoses, wound treatment, prescribed forms of energy, as well as several other treatment abilities. It also added the assessment of “neuromuscular, musculoskeletal and cardio respiratory systems” to the scope of practice definition (Physiotherapy Act, 2009, c.37, s.3). This law change was a formalization of the ability of physical therapists to diagnose as well as an attempt to improve patient access by expanding the scope of practice (Ontario Physiotherapy Association and College of Physiotherapists of Ontario, 2008). Many of the new expansions did not fully come into effect until 2011 (Ontario Physiotherapy Association and College of Physiotherapists of Ontario, 2017). Some are still not in effect at the time of this research due to changes required in other laws. One of the more difficult expansions was allowing “prescribed forms of energy” (Physiotherapy Act, 1991, c. 37, s.6). According to the College of Physiotherapists (2021), forms of energy include x-rays and “specified laboratory tests.” The ability for physical therapists to do this is still delayed, awaiting the required law changes to the Healing Arts Radiation Protection Act (2017) before a physical therapist may register as an individual authorized to order these. Additionally, changes to the Laboratory and Specimen Collection Centre Licensing Act (2017) have not been made to allow physical therapists to order diagnostic tests. It is clear there have been some issues with implementation.

## Barriers in Ontario

Despite the limited number of interviews in Ontario, it was possible to discover some barriers through documentation including debate transcripts, submissions to the Health Professions Regulatory Advisory Council (HPRAC), and available research articles. The one interview conducted in Ontario was with an individual involved in the 2009 revision to the Physiotherapy Act. When asked about arguments against the bill, there was no memory of strong opposition. Therefore, the barriers discussed here were discovered through documentation. Very similarly to Ohio, the greatest barrier to changes in legislation is the politics surrounding it and not the evidence that is provided; however, the barriers do differ somewhat. The most oppressive are physician opposition, existing laws, perceived cost, the political system, and public awareness.

### Physician Opposition

Health profession opposition can vary depending on the context in which it exists. No information was found to show great opposition to the 1991 Physiotherapy Act. There were some complaints that the physiotherapy scope of practice overlapped in some ways with others such as chiropractors (Pooley, 1992) but even in that article the great overall benefits of the RHPA were praised. This could be because the whole regulatory system for every healthcare profession was made over including acts for twenty-four other self-governing health care professions. There is documentation, however, on the opposition to Bill 179, the 2009 revision, which included the expansion of the scope of practice of physical therapy. This available documentation provides insight on the arguments for and against the proposed changes by organizations such as the Ontario Physiotherapy

Association (OPA), Ontario Medical Association (OMA), and the Registered Nurses' Association of Ontario (RNAO).

The Ontario Medical Association opposed many expansions for varying professions included in Bill 179. They were concerned that many of the proposed changes would lead to the “physicians no longer acting as team leaders, but rather as team consultants.” (Ontario Medical Association, 2008). Their concern that they may no longer be the leader, indicates there is a perceived hierarchy of importance. Furthermore, they thought the diagnosis definition for physical therapy was too broad and they did not support the ordering of diagnostic tests by other professions. This was said in their submission to the Health Professions Regulatory Advisory Council (HPRAC) to be due to concerns of costs on the system as well as lack of appropriate knowledge for interpreting the results (Ontario Medical Association, 2008). It was not only physiotherapy the OMA addressed; reportedly they went on an ad campaign questioning the qualification of nurse practitioners and pharmacists to perform proposed expansions as well (Closson, 2009; Boyle, 2009). There was clear concern of expanded scopes of practice for other healthcare professions infringing on the authority of physicians. Despite the physician opposition, there was a good deal of support for increasing the scope of physical therapy from other healthcare professions such as the RNAO (Registered Nurses' Association of Ontario, 2009). Moreover, their opposition appears to have had very little impact on the legislation. Every desired change by the physical therapy profession for the scope of practice, including the language used for diagnosis, was passed into law and, pending additional law change, they also obtained the ability to order diagnostic imaging.

## Laws as Barriers

Laws became too great a barrier to overcome without change in the 1980s as the existing regulations were not structured in a way that could accommodate comprehensive changes for the healthcare system. Before the changes in 1991, eight acts regulated eighteen professions (Pooley, 1992). This means some professions were unregulated and some others were not even specifically listed in the laws. Physical therapy was regulated under the Drugless Practitioners Act (1990) but there is no specific mention of physical therapy under this law. Providing a clearer understanding of the physical therapy laws, as well as other health professions, required complete structural change and a reliance on the Regulated Health Professions Act. Without this new regulatory system, there would not be the separation of physical therapy laws from other professions. This would make it difficult to pass law change solely affecting physical therapy.

According to the Scope of Practice Review submitted by the Ontario Physiotherapy Association and the College of Physiotherapists of Ontario (2008), several of the law changes requested, and passed, in the 2009 revision to the Physiotherapy Act required changes to other existing laws. These two physical therapy organizations made another submission to the Ministry of Health and Long-Term Care (Ontario Physiotherapy Association and College of Physiotherapists of Ontario, 2017) for the finalization of the few approved changes that did not come into effect in 2011. Most notably, changes to the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act are required to allow ordering of forms of energy including x-rays and diagnostic laboratory tests respectively (College of Physiotherapists of Ontario, 2021). The necessary law changes were brought up as a

concern during debates in the Legislative Assembly, and it was thought allowing diagnostic imaging was a “bit premature given the condition of the Healing Arts Radiation Protection Act” (Qaadri, 2009, 1520). This implies that in addition to the laws presenting a barrier to the implementation of the new physical therapy laws, it was a barrier for legislative change to the Physiotherapy Act. At the time of writing, physiotherapists were still unable to roster for these acts under the College of Physiotherapists.

Laws can and do present barriers as the health professions evolve and expand their scope of practice. This was the reason Ontario completely restructured the regulatory system for health professions in 1991. Additionally, separate laws are preventing physical therapy from practicing today, abilities that were approved under the Physiotherapy Act in 2009.

#### Perceived Cost

Fears of potential costs can greatly influence outcomes in legislation, especially in a system where the government funds some of those costs. The greatest concern with money in Ontario seems to stem from funding concerns. This did not apply to the 1991 creation of the Physiotherapy Act because there was a complete overhaul of the structure of the healthcare system in Ontario. Concerns in 1991 focused on the regulations for the new system and less on funding. Funding was, however, brought up with the revisions to the Physiotherapy Act in 2009.

In Ontario, physical therapy has mixed financial coverage. Physical therapy accessed in hospitals falls under the universal health care coverage, Medicare. For care accessed outside of hospitals, there is also the Ontario Health Insurance Plan (OHIP),



which is publicly funded, that covers residents over 64 years old or under 20 years old; “those that qualify for social support; residents of long-term care facilities; and those returning to the community following a hospital discharge.” (Hogg-Johnson et al, 2011). Despite the existence of this government program, in the interview conducted, it was suggested that the OHIP is underfunded and its restrictions on who is qualified leaves many citizens without government coverage. Those that do not qualify must obtain extended health benefit plans, whether personally or through employment, or pay out of pocket for physical therapy services. Therefore, when scope of practice expansion allows for ordering of diagnostic tests, answering the question of who foots the bill becomes incredibly complex.

In 2009, the scope of practice was greatly increased for physical therapists in Ontario, to include the “prescription of forms of energy” (Physiotherapy Act, 2009, c.37, s.6). In the OMA’s submission to the HPRAC (2008), they mentioned concerns of an increased burden on the healthcare system should other healthcare professionals be allowed to order imaging. This ignores the cost of the current system requiring a physician or other health care professional to order these tests not to mention the health cost for the patient due to delays on test results. In a survey conducted by the OPA it was found that 67% of responding physical therapists had difficulty getting the diagnostic imaging or lab test necessary to make a diagnosis (Ontario Physiotherapy Association and College of Physiotherapy of Ontario, 2017). This causes delays in treatment which can impede recovery, in turn leading to longer treatment times and increasing healthcare costs. Therefore, some concerns about increased costs may not account for the overall cost.

## Public Awareness

The Regulated Health Professions Act and subsequent Physiotherapy Act are clear examples of public awareness creating change. Rather than knowledge of the benefits of physical therapy, however, the catalyst was complaints. These complaints led to the legislative review that outlined suggestions for restructuring the entire regulatory system for the healthcare system in Ontario (Ontario, 1989). In contrast, according to submissions to the Health Professions Regulatory Advisory Council, the revisions to the Physiotherapy Act in 2009 were due to the physical therapy profession advocating for legislative changes that “are reflective of physiotherapy education, competencies and practice activities.” (Ontario Physiotherapy Association and College of Physiotherapy of Ontario, 2008, p. 3). This means that pressure from the public is not always necessary. It may depend more on the government’s willingness to seek out new solutions and accommodate professional suggestions.

## Politics/Lobbying

Lobbying and politicians are an important part of law changes. Lobbying helps a profession advocate for desired changes when speaking to politicians. Without support from politicians, a bill is not likely to pass.

Lobbying appears to be, from available documents, limited in Ontario. There is publicly available documentation on lobbying efforts for organizations through the Office of the Integrity Commissioner (2021), although it was not available at the time the Physiotherapy Act was created in 1991. Therefore, the documentation is only available for the time frame of the 2009 revision. Searching for any professional health organization reveals that most associations contract out their lobbying efforts to a public

affairs consulting firm. This would help explain the response of the OPA and the College of Physiotherapists when reached out to for interviews. They replied there would not be a large interest in this research nor many physical therapists that would have experience with legislation.

When searching the lobbying efforts of the Ontario Physiotherapy Association for the years leading up to the 2009 revision (2007-2009) only four lobbying efforts were officially documented (Table 3).

Table 3. Ontario Physical Therapy, lobbyists registry search Jan 1, 2007 - Dec 31, 2009.

Lobbyist	Last Amendment Date	Client Name	Company/Organization
Tim Weber	10-15-2008	Ontario Physiotherapy Association	CG Management & Communications Inc.
Darryl Wolk	08-29-2008	Ontario Physiotherapy Association	CG Management & Communications Inc.
Garth Bobb	11-21-2007	Ontario Physiotherapy Association	CG Management & Communications
Melanie Calandra	08-23-2007	Ontario Physiotherapy Association	CG Management & Communications

Source: Office of the Integrity Commissioner, 2021

In the same time period, various sections of the OMA lobbied on six separate occasions (Table 4).

Table 4. Ontario Medical Association, lobbyists registry search Jan 1, 2007 - Dec 31, 2009.

Lobbyist	Last Amendment Date	Client Name	Company/Organization
Murray Gold	12-07-2009	Ontario Medical Association	Koskie Minsky LLP
Dafna Strauss	11-25-2009	Ontario Medical Association - Chronic Pain Section	Connect Consulting Solutions
Gilbert Sharpe	09-28-2009	Ontario Medical Association	Fasken Martineau DuMoulin LLP
Yaron Gersh	11-30-2008	Ontario Medical Association - Chronic Pain Section	Connect Consulting Solutions
Stephen Skyvington	06-01-2008	Ontario Medical Association Section on Pediatrics	PoliTrain Inc.
Stephen Skyvington	01-13-2007	Section on General & Family Practice of the Ontario Medical Association	PoliTrain Inc.

Source: Office of the Integrity Commissioner, 2021

Unfortunately, when looking at this record of lobbying, there is no way to tell which bills were concerned; what side of the argument the association stood; nor how much, if any, money was spent on the effort. The available data only detailed when an association lobbied, with no additional information. This provides little public transparency in the lobbying process. It is also unlikely that associations advocate for their profession with so few attempts during a time of law revision. It is possible there are other methods used to advocate for legislative change.

### Changes

In the one interview conducted with a member of the College of Physiotherapists, the interviewee did not believe that the opioid crisis played a role in the legislation regulating physical therapy in Ontario. The OPA webpage does not provide much information on physical therapy's role in treating the opioid crisis, however, the Canadian

Physiotherapy Association (CPA) does (Canadian Physiotherapy Association, 2021). The CPA has collaborated with the American Physical Therapy Association (2017) to set goals for the profession to improve the opioid crisis. The CPA also laid out broad goals for the profession to strive towards throughout 2017 (Health Canada, 2017), so it is possible that the focus on the opioid crisis remains at the national level in Canada.

As for the involvement of physiotherapists, their involvement seems to be limited to start with. There were formal joint submissions to the HPRAC from the OPA and the College of Physiotherapists to advocate for specific changes for the profession; however, when both organizations were reached out to for interviews, they were quick to inform that there would not be a large interest in this research. Furthermore, they expressed that very few physical therapists would have any experience with the legislative process. This indicates that physical therapists do not typically get involved in the legislative process leaving that to other staff members.

### Summary

While the comparison of the 1991 Physiotherapy Act and the 2009 revision are limited by the documentation available, it is apparent that context matters a great deal for determining why legislative change comes about. The creation of the Physiotherapy Act of 1991 happened because of complaints about problems in regulating the entire healthcare system and in 2009 it was because of a discrepancy between what physical therapists were trained to do and what the law allowed them to do. Despite obstacles, physical therapists were successful in obtaining the changes they desired. While the documentation available varied between the two laws, it is clear the laws changed for similar reasons that they no longer appropriately regulated the profession. While the

interviewee did not believe that the opioid crisis had changed the legislative process for physical therapy, this could be because the barriers for change had little effect on the revisions. The documented opposition did not stop legislative change from happening for the physical therapy profession. The greatest barriers for the physical therapy profession in Ontario exist for implementation of the legislative change.

## Chapter IV.

### International Comparison Between Ohio and Ontario

There are important similarities and differences in Ontario's 2009 revision to the Physiotherapy Act and Ohio's 2019 revision to the physical therapy laws. Both revisions managed to change the definition of physical therapists' scope of practice to include diagnosis and proposed diagnostic imaging and tests. Despite its current issues with implementation, Ontario was able to gain approval for physical therapists to order diagnostic imaging and Ohio was not. This begs the question, why? What are the differences between the country's political and healthcare systems that influence the ability of physical therapists to reduce barriers for the profession that in turn improve access for patients and reduce health care costs? This chapter will begin with a comparison of the content of these two legislative actions and the influence the medical associations of the respective regions had on the approved versions of the bills. In order to better explain this influence, the next section will compare the physical therapy education, regional healthcare systems, lobbying and documentation, and the political systems in which they operate. It will end with a comparison of the changes that have occurred in physical therapy involvement due to the opioid crisis followed by a summary of the comparisons.

#### Law Content and the Medical Associations

The contents of the two revisions are very similar in their desired outcomes but differ in the extent to which they expanded the scope of practice for the profession and in the definitions chosen. There are three important topics covered in the two bills: physical therapy diagnosis, expanding abilities, and diagnostic imaging and tests. Since Ohio did not propose expanding abilities beyond diagnostic imaging and tests, this section will focus on the physical therapy diagnosis and diagnostic imaging and tests.

First was the ability of physical therapists to make a physical therapy diagnosis. Both regions differed in their definitions and how this clause was included in the law, indicating a difference in response to barriers in place.

Ohio law describes a “physical therapy diagnosis” under Section 4755.40

Physical Therapy Definitions as:

a judgment that is made after examining the neuromusculoskeletal system or evaluating or studying its symptoms and that utilizes the techniques and science of physical therapy to establish a plan of therapeutic intervention. "Physical therapy diagnosis" does not include a medical diagnosis. (Ohio Rev. Code, 2019)

While Ontario has a broader and more detailed definition:

the assessment of neuromuscular, musculoskeletal and cardio respiratory systems, the diagnosis of disease of disorders associated with physical dysfunction, injury or pain and the treatment, rehabilitation and prevention or relief of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function and promote mobility. (Physiotherapy Act, 1991, c.37, s. 3 )

There are differences between these two definitions, but they faced surprisingly similar opposition. These definitions faced controversy from the medical associations in both regions: the Ontario Medical Association (OMA) and the Ohio State Medical Association (OSMA). The OMA argued that the proposed language for a physical therapist’s ability to diagnose was too broad, stating in their Submission to the Health Professions Regulatory Advisory Council:



The act of diagnosing requires an understanding of not only the physical symptoms of an illness, but also the physiological and medical aspects of illness as well as the underlying psychological and social context. Incorrect diagnoses may lead to complications and conditions that are avoidable with appropriate medical assessment. The OMA suggests that consideration be given to allowing physiotherapists to communicate a diagnosis within appropriate profession-specific parameters. (Ontario Medical Association, 2008, p. 4)

However, their objections do not appear to have influenced the outcome considering all the proposed revisions to the scope of practice by the OPA and the College of Physiotherapists of Ontario (2008) were added to the 2009 revision of the Physiotherapy Act.

The OSMA had concerns about the possibility of inaccurate diagnoses given by physical therapists (Ohio State Medical Association, 2019). This concern was further evidenced in the way the OSMA claims on their website they were able to significantly change the language in the proposed bill. This change is quite evident when compared to the initial introduction of the bill:

"Physical therapy" means the evaluation and treatment of a person by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating physical impairments, functional limitations, and physical disabilities. "Physical therapy" includes physiotherapy.

With respect to the evaluation of a person, "physical therapy" includes determining a diagnosis in order to treat the person's physical impairments, functional limitations, and physical disabilities; determining a prognosis; and determining a plan of therapeutic intervention. "Physical therapy" includes ordering tests, including diagnostic imaging and studies, that are performed and interpreted by other licensed health care professionals. (H.B. 131, 2017, p. 1)

Originally, there was no definition of a 'physical therapy diagnosis.' When conducting interviews with physical therapists, there was an impression that physicians thought of diagnosing as an ability exclusive to their profession. More specifically, they were concerned about physical therapists making a 'medical diagnosis.' There is some

puzzlement about this concern as one Ohio physical therapist explained, “We’re not a medical doctor so we’re not performing a medical diagnosis. We’re physical therapists so our diagnosis is always going to be a physical therapy diagnosis.” The resulting compromise was to not only define the new concept of a ‘physical therapy diagnosis’ but add language to specify it does “not include a medical diagnosis” (Ohio Rev. Code, 2019, c.47, s.B). This clarification was included despite the fact that no definition for a ‘medical diagnosis’ nor the mention of said term was found in Ohio’s state laws regulating physicians (Ohio Rev. Code, 2021). This is a recurring concern of the physicians in Ohio as in 2003 during the Senate Session (2003) that passed S.B. 35 allowing direct access to physical therapy, Senator Scott Nein addressed a question regarding physician concerns of misdiagnoses that direct access did “not include a medical diagnosis of a patient’s disability” (32:08). More than once Sen. Nein expressed the idea that “Physical therapists do not want to practice medicine. They want to practice physical therapy.” (33:25). No physical therapist interviewed in Ohio thought allowance of ‘physical therapy diagnoses’ changed how they did their job; however, it was believed to be an important formalization for proving physical therapy as an autonomous profession. In regard to insurance, some hope was expressed that it could help that a ‘medical diagnosis’ by a physician may not be necessary for reimbursement. One physical therapist explained that it is difficult to see if the law change has impacted the reimbursement because “I always include the physician diagnosis along with the physical therapy diagnosis.” Since no interviews were able to be conducted with physical therapists in Ontario, it is unknown the extent to which this law change has affected the profession there.

Another difference in these definitions is the incorporation of pain treatment. Under the scope of practice for physical therapy in Ontario, it specifically states that physical therapy includes “the diagnosis of diseases or disorders associated with physical dysfunction, injury or pain” (Physiotherapy Act, 1991, c. 37, s.3). It is significant that Ohio does not mention the treatment of pain anywhere in the definitions or laws regulating the profession.

While the language describing a diagnosis by a physical therapist varied for each region, the overall result was the same, physical therapists are now allowed to make diagnoses within their scope of practice. The expansion of approved abilities, however, differed in their results. The most informative of their distinctive responses to barriers are diagnostic imaging and tests.

The benefit of allowing physical therapists to order diagnostic imaging and tests includes decreased wait times to initiate treatments and decreased overall healthcare costs. When a physical therapist needs a referral for diagnostic imaging or tests, they must send the patient to their primary care physician, or the appropriate specialist, to have the image ordered. The x-ray or MRI themselves are an additional appointment that may require a follow-up with the physician before the image is sent to the physical therapist to determine the appropriate course of treatment. This leads to unnecessary appointments with the physician that could have been avoided if the physical therapist had been allowed to order the diagnostic test themselves. This causes an increase in healthcare costs as well as further delay of treatment because of scheduling for the patient and availability of appointments. Often left unnoticed is the additional cost to the patient in their own time and resources to attend those extra appointments. It is notable that in areas

where physical therapists have been allowed to order imaging and tests, like the US military, there has not been a resulting litigation case (Boyles et al., 2011; Keil et al., 2019). This demonstrates that fears of improper ordering or increased healthcare costs are not supported by evidence.

The barriers faced for ordering imaging were again born out of opposition from the regional medical associations and fears of increased cost. House Bill 131 in Ohio, which included the physical therapy diagnosis, was originally introduced with language to allow physical therapists to order diagnostic imaging and tests. According to interviews, the OSMA opposed this addition. Their greatest arguments against the ability to order imaging are concerns about inadequate education and increased costs on the healthcare system. These arguments are based on the idea that if more healthcare providers are allowed to order imaging, it will result in a vastly increased number of images ordered, thereby increasing costs and burden on available resources. The OMA, in their submission to the HPRAC, made this concern very clear stating it “will undoubtedly place additional stress on resources in high demand.” and that they believed, “physiotherapists lack the training to interpret these test results” (Ontario Medical Association, 2008, p. 5). It is unclear what is the official stance of the OSMA; however, interviews revealed “there was a fear that costs would increase” should physical therapists be able to order imaging. There was an even greater concern about the capability of physical therapists to interpret imaging and test results. This is a surprising argument considering the proposed law stated that the ordered images and tests “are performed and interpreted by other licensed health care professionals.” (H.B. 131, 2017, p. 2). A couple of interviewees brought up physician concerns of misdiagnoses by

physical therapists. One interviewee clarified, “we follow the same guidelines that physicians do. It’s part of our curriculum.” There is no evidence to suggest misdiagnosis as a common occurrence.

Despite the different legislative outcomes of diagnostic imaging and testing within the two regions, the results in practice on this ability have ended very similarly for physical therapists. Ohio did not pass any ability to order imaging or tests while Ontario did, but implementation of this change has not yet occurred in Ontario due to the need for additional law changes in the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act. This was not the only issue with the 2009 revision. The additional scope expansions approved for physical therapy were not finalized until September of 2011 (Ontario Physiotherapy Association and College of Physiotherapists of Ontario, 2017). While other health care professions were the barrier preventing expanded scope for physical therapy in Ohio, the structure of the legislative regulatory system for healthcare in Ontario has been the most obstructive barrier for realizing these new additions.

Both regions faced opposition with similar concerns but the outcomes, despite implementation issues, have been different. Ordering imaging and tests are approved under the Physiotherapy Act in Ontario despite still awaiting law changes for implementation. In Ohio, diagnostic imaging and tests were scrapped from the bill altogether. The question is, Why was the passing of this bill successful in Ontario but not Ohio given that the same arguments were used against the approval of the proposed additions?

It is apparent that there is a difference in how the medical associations influence legislation for the physical therapy profession within these two regions. The opposition of the OMA resulted in little change. Physical therapists received inclusion of all their requests for diagnosing and were permitted to “prescribe forms of energy” meaning diagnostic imaging (Physiotherapy Act, 2009, c.37, s.4(1)6). The influence of physicians on legislation for the physical therapy profession was limited while in Ohio the medical association had a much greater impact. This is evidenced in how the language changed between the proposed bill and the final bill in a way that reduced the scope of physical therapy. The OSMA even credited themselves as the reason for the change (Ohio State Medical Association, 2019). Additionally, according to interviews, imaging was not passed because of oversight demands by physicians and desires to restrict the approved imaging to x-rays only. So, the question becomes, Why did the physicians in Ohio have a greater influence on physical therapy than in Ontario? There are four important factors to consider: physical therapy education, the healthcare system, lobbying and documentation, and the political system.

### Physical Therapy Education

One of the arguments used against physical therapists obtaining greater abilities such as the physical therapy diagnosis and diagnostic imaging and tests was that physical therapists did not have the right education to safely do so. In both regions, there were concerns of physical therapists being educated enough to warrant expanding approved acts. Therefore, this section will compare the education received by physical therapists in both Ohio and Ontario.

Both regions require advanced degrees to practice physical therapy. To be a physical therapist in the United States, a doctorate program must be completed at an accredited school while in Canada the requirement is a master's degree in physiotherapy. These are both followed by a national exam to acquire a physical therapy license. Additionally, continued education is required to maintain a physical therapy license in both regions. In Ontario, there is no required amount or type of continuing education required, but records must be kept and provided to the College of Physiotherapists when requested (College of Physiotherapists of Ontario, 2021). They must also meet additional training to perform controlled acts for which they must roster with the College of Physiotherapists. Regarding imaging specifically in Ontario, the number of physical therapists that pursued post graduate degrees or certificate programs for the skills necessary to order diagnostic imaging is increasing (Ontario Physiotherapy Association and College of Physiotherapists of Ontario, 2017). In Ohio, physical therapists are required to complete twenty-four continuing education units (CEUs) every two-years (Ohio Physical Therapy Association, 2021; Ohio Rev. Code, 2007). There is no requirement on the type of CEUs required; however, not all CEU courses offered by the American Physical Therapy Association are approved for credit in the state of Ohio (Ohio Physical Therapy Association, 2022). Some of the denied courses include ultrasounds and, surprisingly, a course called Addressing the Opioid Problem With Physical Therapy: Advocacy, Education, and Training.

This comparison shows that the level of education does not justify the disparity between the laws regulating physical therapy in Ohio and Ontario. Ohio maintains more rigid requirements for advanced education through a doctorate degree and a specific

number of continuing education hours, yet physical therapists in Ontario have a broader scope of practice and more autonomy as a profession. This is with a master's degree and no specific number of continuing education hours required. Therefore, this does not explain why laws have passed with few compromises in Ontario but only with significant changes to proposals in Ohio.

### Healthcare System

The designation of physical therapy as part of primary healthcare or as a specialty service could have an impact on how influential the profession can be in driving legislative change. The designation of primary care implies necessity, that physical therapy is important for an individual's health and needed by the whole population. A specialty care is more niche and implies only special populations will require their services. More importantly, a designation of primary healthcare would make physical therapy more autonomous, and less reliant on referrals and oversight.

Through interviews with the seven practicing physical therapists, not involved in legislation, there were mixed views on whether or not their profession was viewed as primary or supplementary care in Ohio. Five stated it was seen as supplementary; one stated that at their specific clinic, where over half of their patients are direct access, they were primary care but most physical therapy services in Ohio are supplementary; and finally, another did not answer directly but said that physical therapy services were necessary. This lack of consensus or certainty on the designation of physical therapy implies there is some confusion on where physical therapy stands in the healthcare system of Ohio. No official designation was found throughout this research but in an



interview with a member of the OPTA it was explained that under insurance, physical therapy is a specialty.

Table 5. Supplementary vs. Primary in Ohio.

Physical Therapists (PT)	Primary	Supplementary
PT 1		Overall
PT 2		Overall
PT 3		Overall
PT 4	At their Clinic (~65-75% Direct Access Patients)	Most of the time
PT 5	No Answer	No Answer
PT 6		Overall
PT 7		Overall

*How physical therapists think their services are viewed in Ohio.*

In Ontario, physical therapy has been designated as primary care since 1994 (Hogg-Johnson et al., 2011) and is one of only two Canadian provinces with this determination (The Conference Board of Canada, 2017). Physical therapy is included as part of primary care teams (Dufour et al., 2014); however, the universal healthcare, Medicare, does not cover their services outside of public hospitals or government funded programs such as the Community Physiotherapy Clinic Program under the Ontario Health Insurance Plan. Furthermore, these government programs are often limited and underfunded. The Community Physiotherapy Clinic Program limits who can participate to those younger than 20 or older than 64 years old with a valid Ontario health card unless receiving benefits under the Ontario Disability Support Program or Ontario Works (College of Physiotherapists of Ontario, 2021; Ontario, 2021). Since physical therapists are considered primary health care practitioners, a physician referral is not needed to see

one, but insurance reimbursement often requires one. Anyone wanting to qualify for these government funded programs must have a physician or nurse practitioner referral, which is in itself a barrier to access. Some extended health benefit plans, often obtained by citizens that do not qualify for publicly funded physical therapy, also require a physician referral. Without insurance, appointments often cost on average from \$50-120 per visit (Closing the Gap Healthcare, 2019). Despite the varied coverage of physical therapy in Ontario, direct access has been allowed in the province since the implementation of the 1991 Physiotherapy Act.

Ohio abides by the pluralistic healthcare system of the US. There are many third-party payers that physical therapists must work around in addition to some government insurance, Medicare and Medicaid. In all interviews conducted with Ohio physical therapists, health insurance was listed as one of the main barriers to patient access. Insurance was brought up for several reasons. There is the simple fact that there are so many different types of health insurance and insurance plans that physical therapists have to keep track of and those plans change regularly. In five of the seven interviews with practicing physical therapists the pre-authorizations, approval from the insurance company before beginning treatment, were mentioned as the greatest issue with insurance. These pre-authorizations may even require approval from the physician. The most common insurance mentioned to have this issue was Medicare (Center for Medicare & Medicaid Services, 2019). It was explained that these forms often delay treatment leading to many patients giving up before approval can be obtained. Even if these forms are filled out correctly, the number of visits the patient is allowed to schedule with the physical therapist may not be enough to fully treat the injury. Some interviewees talked

of concerns that some insurance plans only allow a limited number of visits to the physical therapist every year regardless of injuries. Moreover, insurance can decide to only allow a limited number of visits for a particular injury. One of the practicing physical therapists brought up, “a patient may have sixty visits allowed a year, but insurance can decide after four that they don’t need more.” Additionally, there are concerns about the rising cost for patients. This was said to be the driving force behind physical therapists switching to a cash-based practice. Of the eleven physical therapists interviewed in Ohio, four mentioned either working at or personally knowing someone that works in a cash-based clinic. The move to a cash-based practice is due to the rising co-pays and decreasing reimbursements for physical therapy services in Ohio leaving some physical therapists to find it not worth the trouble to deal with insurance companies as reimbursement may not fully cover the costs of treatment. Fair co-payments are currently an advocacy issue for the APTA to prevent insurance from requiring patients to pay more because physical therapy is designated as a specialty care under insurance (American Physical Therapy Association, 2021). These factors lead to greater financial barriers to accessing physical therapy services and can be traced back to the designation of physical therapy as specialty care.

In addition to the health insurance that shapes how physical therapy is prioritized in the healthcare system, there is a hierarchical pecking order that reinforces these positions. Ontario considers physical therapy a part of the primary health care team, but the OMA itself expressed concern that greater abilities given to professions like physical therapy, among others, will demote physicians from their position of leadership to being simply a team consultant (Ontario Medical Association, 2008, p. 3). The idea that

physicians are the leaders of health care has existed for centuries while physical therapy is a newer profession that has progressed and evolved in great measures over the last few decades. This is also seen in Ohio as physicians, according to interviews, did not want physical therapists to be able to order diagnostic imaging without being under physician supervision. Physical therapists must also, under the current law, notify the patient's physician within five business days that the physical therapist is treating them. A few physical therapists felt this was a clear indication that physical therapy is not considered primary care.

There is no similar requirement in Ontario that forces physical therapists to report to physicians. It should be noted that even though the law does not contain this requirement, the healthcare system has been evolving to assist collaborative care efforts (Health Professions Regulatory Advisory Council, 2008). Interprofessional communication is vital to these efforts. This lack of direct requirement is possibly due to the fact that they are considered part of the primary healthcare team. Being part of the primary healthcare team places their standing closer to that of physicians, likely reducing physician influence on physical therapy laws. There is also the fact that physical therapy is considered a "self-governing" profession in Ontario (Regulated Health Professions Act, 1991, c. 18, sched. 1). The College of Physiotherapists of Ontario was created because of the Regulated Health Professions Act requirement for a regulating body to monitor the profession. The College of Physiotherapists also has representation at some debates on proposed law changes for the profession (Qaadri, 2009). There is a licensing board in Ohio regulating the profession as well; however, it focuses on regulating the licensing process and investigating complaints, not necessarily advocating for law change

(Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board, 2018). The representation of the physical therapy profession comes from the OPTA while Ontario actively uses both the OPA and the College of Physiotherapists.

The difference of a primary or specialty care designation places the physical therapy profession in different positions for negotiating legislative change. It is plausible that because physical therapists are considered primary care in Ontario, as physicians are, the objections of physicians have less impact on proposed legislative changes regulating physical therapy. In contrast, physical therapy's designation under insurance as a specialty care in Ohio has provided a position of strong influence for physicians. This influence prevents changes to the physical therapy laws that do not have physician approval. This is not, however, the only explanation for why physicians are more influential in Ohio than Ontario.

### Lobbying and Documentation

One of the largest barriers for physical therapy in both Ohio and Ontario is opposition from other health professionals, specifically the medical associations. It has been mentioned that it is important to have the ear of the politician and that lobbying is one way to do that; however, there is a difference in how that is done in Ontario versus Ohio.

The differences in the lobbying process begins with the involvement of physical therapists. During this research, only one person involved in the legislation of physical therapy in Ontario agreed to participate and this person was not a physical therapist. When reaching out to the College of Physiotherapists and the OPA it was expressed that there was not believed to be great interest in this research; few would have experience to

share; and it was too specific to be of interest. While in Ohio, a contact list of all the licensed physical therapists was delivered by email soon after the formal request through the Ohio physical therapy licensing board was made. Since the recruitment emails issued did not differ between Ohio and Ontario other than in their designation of the opioid issue (it is an epidemic in the US and a crisis in Canada), and in fact even greater information was given at the request of the College of Physiotherapists and the OPA, it suggests there must be a difference in how legislative change is approached by the physical therapy profession in the distinctive regions.

The health profession associations such as the OPA, the OMA, the Ontario Chiropractic Association, etc., use public advocacy organizations such as the OPA's use of the CG Management and Communications Inc. This corporation then lobbies on behalf of the respective association, however, the number of documented lobbying efforts on behalf of the OPA is only eleven times since February 25, 2000, with the most recent occurring on January 28, 2021 (Office of the Integrity Commissioner, 2021; Table 6). Most surprising is the fact that only four lobbying efforts were registered at the time of the 2009 revision, between 2007-2009, and the last one occurred in October of 2008. The 2009 revision made its way through Parliament in 2009 and was passed in December. Considering the limited number of documented efforts, it is possible that lobbying does not account for all advocacies done on behalf of the physical therapy profession in the legislative process of Ontario.

Table 6. Ontario Physiotherapy Association, lobbyists registry search, all dates.

Lobbyist	Last Amendment Date	Client Name	Company/Organization
Donald Gracey	01-28-2021	Ontario Physiotherapy Association	CG Management & Communications Inc.
Nancy Coldham	08-24-2015	Ontario Physiotherapy Association	CG Management & Communications Inc.
Tim Weber	10-15-2008	Ontario Physiotherapy Association	CG Management & Communications Inc.
Darryl Wolk	08-29-2008	Ontario Physiotherapy Association	CG Management & Communications Inc.
Garth Bobb	11-21-2007	Ontario Physiotherapy Association	CG Management & Communications
Melanie Calandra	08-23-2007	Ontario Physiotherapy Association	CG Management & Communications
Jenny Hwang	08-02-2006	Ontario Physiotherapy Association	CG Management and Communications
Robert Batarseh	04-06-2004	Ontario Physiotherapy Association	CG Management & Communications
Jeff Graham	02-18-2003	Ontario Physiotherapy Association	CG Management & Communications
Adele Pellegrino	02-25-2000	Ontario Physiotherapy Association	C.G. Group
Utilia Amaral	02-25-2000	Ontario Physiotherapy Association	C.G. Group

Source: Office of the Integrity Commissioner, 2021

The OPTA lists lobbyists as part of their staff on their website. Although this lobbyist is a part of the Government Advantage Group, there are two specific lobbyists assigned to the OPTA while Ontario had a different lobbyist reported for each effort (Table 6). Additionally, the OPTA physical therapists reach out to politicians themselves. The president of the OPTA herself, Tonya Apke, PT, DPT, OCS, testified in front of the Ohio Senate Health, Human Services and Medicaid Committee (2018, June) advocating for the ability to make a ‘physical therapy diagnosis.’ Physical therapists also attend meetings to collaborate with other healthcare professions on the creation of a bill.

In addition to differences in who is approaching politicians, there is a difference in the reporting on lobbying efforts. In Ohio, it is publicly available how much money was spent lobbying. Organizations must submit expenditure reports three times a year that are publicly available (Joint Legislative Ethics Committee, 2021). These reports list those involved in the lobbying and which bills were lobbied for while Ontario’s documentation included only the dates and the organization (Tables 3, 4, & 6).

This difference in documentation extends past lobbying efforts to include advocating for legislative change. Most of the negotiations for Ohio legislation happens without public documentation. It was only possible to find one news release by the OSMA discussing their opposition to the ‘physical therapy diagnosis’ and acknowledgement that diagnostic imaging and testing did not make it into the final version (Ohio State Medical Association, 2019). They did not state their position on diagnostic imaging, but interviewees claimed they were opposed. The OPTA released short reports after various steps in the process of getting the 2019 revision passed (Government Advantage Group, 2017; 2018). No information could be found on the



position or involvement of chiropractors, but interviews mentioned them opposing the 2019 revision to the physical therapy laws.

Ontario had more formal documentation. Each interested organization made a written submission to the HPRAC that was later made available to the public. This gave a clear understanding of the views for and against the proposed changes to legislation. This could potentially account for the lack of extensive physical therapist involvement in legislation as the means of participation of the organizations appears to be through formal channels. There were also transcripts of hearings conducted over the bills (Peters, 2009, May 11; Peters, 2009, May 25; Peters, 2009, November 30; Qaadri, 2009). While Ohio has video recordings of the Ohio Senate Health, Human Services and Medicaid Committee hearings on HB 131, the 2019 revision to the physical therapy laws, available on The Ohio Channel website, it did not have recordings for the House Health and Aging Committee where the revision was negotiated, nor could any transcripts be found.

There is a clear difference in the lobbying documentation and involvement of physical therapists between Ontario and Ohio. Ontario uses more formal channels for arguing their positions through written submissions to committees and using a public affairs consulting firm. While Ohio also uses a lobbying firm, physical therapists are heavily involved in the discussions and lobbying for the profession as well. These approaches to legislation could help explain why physical therapy in Ontario has a broader scope than Ohio. Written submissions provide more public transparency of the debate and require greater evidentiary support for effective arguments than oral arguments conducted in an unrecorded meeting.

Interviews in both regions revealed that healthcare, like most other issue areas, is politicized. One physical therapist in Ohio even stated that “evidence does not always matter.” Evidence may exist indicating that a legislative change would be beneficial, but if there is limited public interest, great opposition, or it is costly to implement, the odds of it being approved are greatly decreased. Furthermore, how long politicians serve in office and sources of campaign funding can further influence legislative change.

Although no politicians were interviewed in this research, it is important to recognize a couple of key differences between Ohio and Ontario in their laws regulating campaign contributions and term limits. In Ontario, there are no term limits with elections occurring every four years. In fact, the current speaker is the longest serving member and has been in office for over thirty years (Legislative Assembly of Ontario, 2021). Politicians are also allowed to accept campaign contributions from companies in Ontario while this is not allowed in Ohio; however, the campaigns are much shorter, only lasting twenty-eight days in Ontario (Legislative Assembly of Ontario, 2021). This is unlike Ohio where companies cannot donate to campaign contributions and there are term limits for members of the legislative assembly. There was no limit found for the length of a campaign in Ohio, although the registration process of candidates indicates they are much longer than twenty-eight days. Party candidates must register ninety days before the primary elections and the general elections are then held six months later (Frank LaRose Ohio Secretary of State, 2021). Elected politicians are only allowed to serve four consecutive terms. Each term lasts four years in the Senate and two years for the House of Representatives meaning elections are held every two years. Research shows that term

limits do affect what issues politicians spend their time on and how responsive they are to constituent issues.

Term limits have been found to have some interesting effects on the behavior of politicians. Vandusky-Allen (2014) found that term limits result in less time spent on constituency issues and more time on fundraising for re-election or election to a new office after they reach their term limit. In Ohio, after term limits were put in place, some politicians stopped meeting with lobbyists all together until the speaker directly reached out to them (Farmer & Little, 2004). Therefore, term limits could partially explain the difference between Ontario and Ohio. This implies that without term limits, politicians in Ontario are likely to be more responsive to constituent concerns and meet with lobbyists. Term limits can also affect the length and quality of relationships between politicians and lobbyists.

Lobbyists have greater difficulty building good relations with politicians when they serve a limited number of terms (Farmer & Little, 2004). This could help even the playing field a little between lobbying organizations because every time a new politician comes into office all organizations must start building up a relationship. It may explain why little money was spent on lobbying efforts in Ohio since it is not a long-term investment. There is also evidence to suggest that lobbyists and organizations tend to spend less money on politicians in their final term which happens with more certainty in Ohio than Ontario (Norberg & Newton, 2015). It is not known how much this affected the proposed revisions in Ohio, but it is possible it influenced the outcome of the proposals.

The political system between Ohio and Ontario differs greatly in their regulations. Term limits have been found to have an impact on lobbying and the issues taken up by politicians. Even the way organizations lobby for change differs in strategy. The extent to which these differences impact legislation regulating the physical therapy profession is unknown.

### Changes During the Opioid Crisis

As noted in the Ohio and Ontario chapters of this thesis, there were few changes in the legislative process or physical therapy laws as a result of the opioid crisis. These changes are limited to how the profession and bill sponsors advocate for revisions to the physical therapy laws. In Ohio, the opioid crisis was mentioned several times during senate hearings for the 2019 revision and in one interview it was specifically stated, “We try to tie anything that we can to that (opioid crisis)... At least legislators tend to listen.” This tactic helps highlight the importance of making changes for the physical therapy profession. The one interviewee in Ontario, had not noticed any changes in their approaches to legislative change nor how the politicians regard the physical therapy profession. This could be explained in part by the perceptions of the profession through their own laws.

Pain is mentioned twice in the scope of practice for physical therapy in Ontario; once under the description of diagnosis and once for “treatment, rehabilitation and prevention or relief of physical dysfunction, injury or pain” (Physiotherapy Act, 1991, c. 37, s.3). This was not a recent addition either. Pain has been included in the scope of practice since the creation of the Physiotherapy Act in 1991. There is no mention of pain in the laws regulating physical therapy in Ohio. Therefore, it is possible that the opioid

crisis is brought up in Ohio because, aside from being a national issue, there is a need to associate physical therapy with the alleviation of pain since it is not explicitly stated in their laws. While the association of physical therapy and pain treatment has existed for over three decades in Ontario, it is not as definitive in Ohio.

### Summary

The comparison between the 2009 revision to the Physiotherapy Act in Ontario and the 2019 revision to the laws regulating physical therapy in Ohio have brought to light some clear barriers to legislative change that are influenced by the differing healthcare and political systems. The bills both proposed similar changes to the physical therapy scope of practice and opposition by physicians revealed similar concerns in each region. Despite these similarities, changes were made to the proposed revision in Ohio, because of physician opposition, and not for the revision in Ontario. It is clear that the designation of physical therapy as primary or specialty health care has an impact on legislation. Additionally, the way arguments are made is influential. Formal written documentation in Ontario requires each profession to provide evidence and clear arguments for their position on a particular bill. This differs greatly from the unrecorded meetings that occur in Ohio where arguments are made for and against the proposed legislation. These two key differences have a significant impact on what changes are approved in legislation.

## Chapter V.

### Conclusion

As mentioned in the recommendations of the Health Professions Legislation Review in Ontario (1989, p. 7) “virtually every regulatory system is the result of unique social, political and economic pressures experienced in the jurisdiction at the time of the system’s development.” The comparison of legislation in Ontario and Ohio has further supported this claim. Moreover, this comparison has illuminated some key differences between the healthcare and political systems that influence legislative change within the respective regions. While the barriers to the legislative change for the physical therapy profession varied slightly between the regions due their unique healthcare and political systems, the variation in responses to the same barriers greatly affected the laws put in place. This research set out to answer three questions.

1. What barriers do physical therapists face at the legislative level?
2. Have these barriers changed because of the opioid crisis to allow greater inclusion of physical therapists in the legislative process?
3. Does the healthcare or political system affect the barriers the physical therapy profession faces in the legislative process?

The barriers that most affect legislative change for the physical therapy profession include physician opposition, perceived costs of the change, and existing laws. Physicians in both regions made their opposition to the proposed changes known. In Ontario, it was through a formally submitted document while Ohio physicians did so in collaborative

meetings. The concern about costs varied depending on the proposed change. It was a concern in both regions that the addition of ordering diagnostic imaging and tests to the scope of physical therapy would result in increased costs; however, the greater concern expressed by physicians in Ontario was the additional burden on the healthcare resources the change may cause. The physicians were not the only ones concerned about cost. Insurance companies in Ohio were concerned about the cost of directly accessed physical therapy. This concern led to an addition to the revised law in 2004 relieving insurance companies of the responsibility to cover those services.

As for existing laws, this was a concern only in Ontario. Their regulatory system contains a separate law regulating the use of imaging and laboratory tests. By approving imaging under the Physiotherapy Act, further law changes to the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act are required in order to implement this new ability. This revision required further collaboration in the legislative assembly that could not be guaranteed. Although they passed the change in the Physiotherapy Act, these other laws are still preventing implementation to this day.

The first hypothesis held the expectation that a lack of knowledge about the scope of physical therapy has led to lower prioritization of reducing barriers to their services. The results were mixed on this front. In the three interviews conducted with those involved in the 2019 revision, the answers ranged from most understood to most did not. This was not named as one of the greatest concerns for the physical therapy advocates. Instead, they spoke more of the physicians' opposition to the proposal and the general politics that surrounded it. No concerns about knowledge of the scope of physical therapy were mentioned in the Ontario interview either. Although it is still possible that a lack of

knowledge on the scope of practice influences reception of physical therapy in the legislative process, it was not seen as a primary issue. Additionally, in the first hypothesis it was suspected that the inclusion of physical therapy in policymaking has increased over the course of the opioid crisis. It turns out the opioid crisis has had very little impact on the legislative process and the inclusion of physical therapists in it. Based on the response to interview requests in Ontario, physical therapists have never been widely involved in the legislative process. Lobbyists and staff represent and advocate for the profession. Ohio still follows the same process now that they did in 2004; however, tactics have changed. Some physical therapists and politicians now connect the importance of a proposed law change with the opioid crisis.

A comparison between the barriers in Ontario and Ohio answered the third research question, How does the healthcare or political system affect the barriers the physical therapy profession faces in the legislative process? The second hypothesis was strongly supported by this research. The healthcare system does influence how changes to physical therapy laws are prioritized in legislation. There is no greater evidence of this than the significant changes made in the proposed revisions to the physical therapy laws in Ohio in deference to physician concerns. Physicians in Ontario and Ohio had similar complaints about the proposed additions of diagnoses under the physical therapy scope of practice. They also both opposed the physical therapists having the ability to order diagnostic imaging or tests. The significant impact this opposition had on the laws in Ohio demonstrate the arguments of physical therapists were prioritized below those of physicians. Conversely, in Ontario, where physical therapists are part of the primary healthcare team, these concerns led to no changes to the proposal in Ontario.



The greatest explanation for this difference in physicians' influence on legislation is through the healthcare system. The designation of physical therapy as primary care in Ontario places physical therapists on more equal footing with physicians. Ohio has no clear legal designation for physical therapy, but insurance designates the profession as specialty care. This designation relegates the profession to a secondary role in the healthcare system and simultaneously supports physicians in a position of leadership. This position of leadership could influence how politicians process and act on arguments for a proposed bill. If politicians perceive physicians as a greater authority figure on healthcare matters, they are less likely to approve a bill that physicians oppose. Whereas when both professions are primary care, the focus shifts to the suitability of the proposed change and the potential impact on patients.

The process in which these arguments are made may also have a significant influence. The formal submissions in Ontario are public and permanent. This requires greater care in presenting arguments. In contrast, the collaborative meetings in Ohio are not publicly documented or available. This lack of available documentation prevents transparency of the arguments to the public allowing for greater hyperbole and misinformation.

While there are other factors that help explain the influential position of physicians, the healthcare system's designation of physical therapy as primary or specialty care, along with the types of documentation used during the legislative process, greatly influence legislative outcomes. In order to improve access to physical therapy through legislation more effectively, the physical therapy profession needs to be placed in the same category as physicians: primary care. Additionally, transparency in

documenting the process will likely deter the use of misinformation in arguments made by healthcare professionals.

### Limitations

As this was a retrospective comparative case study, the laws occurred decades apart from each other, putting them at different points throughout and prior to the opioid crisis. This makes the context all the more important in the comparison as information and cultural climate is constantly changing. The availability of documents has also changed over the decades.

As these laws were created and passed in two separate countries at different times, documentation varied in what was publicly available. This leaves some gaps in this analysis that could not be covered. For example, there was very limited information available surrounding the 1991 Physiotherapy Act while in 2009 there were debate transcripts, written submissions, and online news articles providing information on the revision. This resulted in a limited comparison in Ontario that may have left some of the barriers unknown. Additionally, some information on the OPA and OPTA, such as advocacy issues, required membership to view. As there was no physical therapist working on this research, this information, that may have provided greater insight into proposed law changes, remained unavailable. This was one of the ways positionalities affected the research.

According to Walt et al. (2008), I am an outsider in two ways: profession (not a physical therapist) and geographical location (not a citizen of either location with the exception of being a US citizen [not residing in Ohio]). While it was easy to get a list of physical therapists in the US, many people seemed hesitant to trust and I was asked in

several interviews if I myself was a physical therapist. Snowball sampling was attempted, but only one physical therapist supplied additional contact information. Only one interview was scheduled through this method, and it was with a Fellow of Pain Science, physical therapists, that was not licensed in the state of Ohio. This hesitancy likely resulted in fewer interviews further restricting insights and available information on the barriers that the profession faces in Ohio.

While I was able to reach out to each physical therapist licensed in the state of Ohio, I was not able to do the same in Ontario. In Ontario, I relied on the OPA promoting this research in their biweekly email which they did twice. No responses to these emails were received. I was also told through the College of Physiotherapists and the OPA that this research was not believed to be of great interest to the majority of physical therapists. These organizations did not think many people would have relevant information. They each provided a short list of potential participants. I only received a response from one volunteer. The great difference between the number of interviews conducted in each location clearly presents an imbalance of information making it possible that some relevant information may have been missed. Also, since I am not a physical therapist or resident of these locations, but solely an interested party, I had no contacts prior to beginning this research.

Furthermore, three decades have passed since some of the events occurred. This resulted in trying to contact people that are no longer working in the field of politics or physical therapy. This was especially difficult in Ohio where their legislators have term limits. There was very little overlap of individuals involved between the two laws researched in each region. Sometimes contact information for legislators or physical

therapists that were involved was unavailable leaving potential sources unused.

Politicians were not able to be interviewed in this research. I made several inquiries, but no responses were received. This eliminated the possibility of understanding the legislative barriers from their perspective, precluding an important point of view.

Lastly, the pandemic has created difficulties in recruitment as the world is currently in a transition. With fewer people in offices and others missing work due to illnesses, it is likely that fewer responses were received than would have occurred outside of a global pandemic. The extent to which the pandemic has impacted this research is unknown.

#### Areas for Future Research

As this research did not include politicians, future studies could improve the understanding of barriers by obtaining their point of view. Landry et al. (2012) suggests that it may not be a lack of understanding of politicians but rather an issue of limited resources to allocate and the struggle “to seek a balance between competing interests.” (p. 64). Interviewing politicians would shed light on this theory.

It would also be beneficial to further research any of the barriers uncovered to gain a clearer understanding of their true impact on regulations for the physical therapy profession. Several of the barriers that prevent legislative change for physical therapy are not unique to physical therapy, such as opposition of other healthcare professions. This type of research could be applied to other professions to better understand what prevents political change for health professions in general. This research also did not investigate in detail the barriers of implementation which can be a long and difficult process. For example, ordering diagnostics was approved for physical therapists in Ontario in 2009,

but the details for how physical therapists are allowed to do so is still not approved at the time of this research.

Lastly, it was found in this research that the designation of physical therapy in Ohio as a specialty care is a major factor explaining why physicians have considerable influence over laws regulating the profession. A comparison between legislative barriers in Ohio and another US state that designates physical therapy as primary care would better confirm whether or not this is the case.

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