REPORT ON ACCESS TO ADJUSTABLE HEIGHT EXAMINATION TABLES BY PEOPLE WITH DISABILITY AT GENERAL PRACTITIONERS

Physical Disability Council of NSW

Ordinary People Ordinary Lives

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Introduction

In 2003, a survey undertaken by Sheila King, from *Access for All Alliance*, found that of 3, 553 medical centres across Australia only 719 (5%) provided adjustable height tables. Ms King presented that information to a Health Access Forum organised by the Australian Human Rights Commission in 2004 and a number of advocacy organisations agreed to pursue the issue.

Over the following years People with Disability Australia and Women with Disabilities Australia worked to improve the situation by calling on the Federal Government and the Royal Australian College of General Practitioners (RACGP) to make the availability of height adjustable examination tables mandatory in all general practices. While this advocacy resulted in some success, in that the RACGP General Practice Standards recommend practices have a height adjustable examination table, the goal of having them mandatory is yet to be achieved.

In 2007 the Australian Human Rights Commission issued an Open Letter on this matter which referred to the survey, its findings and the implications for people with disability. The Commission made it clear that it saw a move to mandatory requirements being the next step when it concluded:

> *While I welcome the actions the RACGP has taken and look forward to continuing to work with them to ensure equitable access to health care services I will continue to advocate for adjustable-height examination beds to be mandatory under the Standards for General Practices.*

In this context, in 2008/09 the Physical Disability Council of NSW (PDCN) undertook a survey of people with disability in NSW to ascertain the extent to which they encountered barriers to medical examination through the lack of provision of adjustable height tables in the surgeries of general practitioners (GPs).

This report examines the findings of this later survey, with reference to the King survey, in the context of the issues raised by the Australian Human Rights Commission and that of a review of the international literature on physical access to medical care offered by general practitioners. In this report 'general practice' is defined according to the guidelines of the RACGP as "the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities". However, as pointed out by the RACGP, the term 'general practice' is not consistently used in the international literature (RACGP, 2009:1).

Literature Review

Physical barriers to accessing full physical examination

One issue raised by the Australian Human Rights Commission involved the physical barriers experienced by people in accessing medical services from general practitioners. These barriers created by fixed height examination tables create the potential for misdiagnosis or non-detection of serious medical conditions.

This view was reflected in the research in the literature review which indicated that regular medical examinations are regarded as effective in the early diagnosis and prevention of serious medical conditions. One American review of the research on periodic health evaluation (one or more visits to a health care provider, for the primary purpose of assessing patients' overall health and risk factors for disease that may be prevented by early intervention) (Boul ware et al, 2007: 289), found that not only patients but also doctors benefit from regular medical examinations because regular examinations allow time for doctors to consider the results and strategies to improve the health of patients (Boulware et al, 2007).

There was evidence from the literature that physical barriers to access for people with disability led to less likelihood of access to primary preventative medical measures than the rest of the population (Kroll, Jones, Kehn and Neri, 2006; Hwang.et al, 2009). The review found that variation in the degree of access to primary preventative medical measures was due to a range of factors such as severity of disability and access to physical examination (Diab & Johnston, 2004 in Kroll, Jones, Kehn and Neri, 2006: 285); type of insurance (Sutton & Dejong, 1998; Chan et al, 1999 in Kroll, Jones, Kehn and Neri, 2006; 285) and the nexus between disability and gender (Thierry, 1998; Welner, 1998; Iezzoni et al, 2000; Thierry & Cyril, 2004 in Kroll, Jones, Kehn and Neri, 2006: 285). Several other studies have documented the architectural barriers to access in physicians' offices (Carlson, 1994; Nosek, Young, Rintala, Howland, Foley and Bennett, 1995 in Grabois and Nosek, 2001). Such barriers can be conceptualised as 'structural-environmental' because they form part of the structural dimension of the social model of disability and exacerbate disparities in health between people with disability and other people (Iezzoni et al, 2000; Phillips et al, 2000; Shabas & Weinreb, 2003: Kroll & Neri, 2004 in Kroll, Jones, Kehn and Neri, 2006: 285). In this way, these barriers increase the social exclusion of people with disability (Kroll, Jones, Kehn and Neri, 2006: 285).

Occupational health and safety

The Australian Human Rights Commission also pointed out in its open letter that the lack of adjustable height tables could create occupational health and safety issues for health practitioners involving injury and associated costs as well as higher insurance costs. One study, undertaken in America, identified musculoskeletal injury risk factors for physicians at a

hospital, arising primarily from poor design of workplace components. The study indicated a fixed height examination table limited the extent of the physicians' reach and increased the stress to the shoulder and neck muscles (Habes and Baron, 1999). Other studies on occupational health and safety indicated that nursing staff ranked fifth in 1984 among all workers who claimed workers' compensation for back injuries with an increase in the rate in 1995 to 17.8 injuries per 100 nurses (US National Centre for Health Statistics, Healthy People 2000 Review 1997, 98-1256 in Owen, 2000). The lifting and transferring of patients was found to be the most frequent precipitating trigger of back and shoulder overexertion problems in nurses (Personick, 1990; Knibbe, Friele, 1996; Smedley et al, 1995; Owen et al, 2000 in Owen, 2000). Even though the circumstances of physicians working in a hospital and that of nurses lifting patients from wheelchair to bed differ from those in which general practitioners undertake medical examinations, it is argued that the effort involved in lifting and transferring patients from a wheelchair to a fixed height examination table also creates potential for injury.

Legal responsibilities for equitable access

There is clearly a legal responsibility of general practitioners (under Federal Disability Discrimination Act 1992) to ensure equal access for people with disability to the same range and quality of medical care as other people. Complaints of discrimination in relation to inaccessible examination beds and the consequence of that inaccessibility could, for example, be lodged under section 24 of the Disability Discrimination Act which is concerned with equitable access to Goods, services and facilities.

It should also be noted that Australia has responsibilities under the recently ratified UN Convention on the Rights of Persons with Disabilities which requires State parties to:

> *Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;*

Universal access to health care

The Australian Human Rights Commission raised the issue of universal access and quality standards of care for all patients. In this way, the lack of height adjustable tables also affects other people who may be older or temporarily unable to access fixed height tables.

This issue has particular relevance as the data indicates that the Australian population is ageing at an increasing rate. The Australian Bureau of Statistics projects population growth in Australia from 21 million in 2006 to between 31 and 43 million in 2056 (ABS, 2009: 1). These projections foresee the ageing of the population from 13 % of people 65 years and over in 2007 to 23% to 24% in 2056 (ABS, 2009: 2).

In NSW, the number of people aged 65 years and over is projected to increase from 0.9 million in 2006 to an estimated 1.8 million in 2030 and 2.4 million by 2051 of whom 600,00 will be aged 85 years and over by 2051 (NSW Department of Premier and Cabinet, 2008:7).

Methodology

In 2008/09, the Physical Disability Council New South Wales (PDCN) conducted a survey of people with disability across New South Wales to gain insights into the degree of access to height adjustable tables in the surgeries of general practitioners. The survey also contained open-ended questions which aimed to discover which strategies are being employed by both people with disability and their doctors in situations where the tables are not available.

The survey was distributed both manually and electronically. The manual distribution and data collection was undertaken at the Daily Living Expo through the distribution of sample bags containing the survey. The same sample bags were also distributed in some regional areas of New South Wales, namely Lismore, Orange and Wagga Wagga. An executive member of the PDCNSW also distributed copies of the survey through one region of the Post Polio Network.

The survey was available electronically between November 2008 and the end of May, 2009 and was advertised on the website of the PDCN.

Findings from survey

The data collected from the survey has been analysed quantitatively to determine the geographic spread of respondents in the survey and the extent of the lack of height adjustable examination tables across New South Wales. In addition, there is descriptive information about the administrative nature of general practice surgeries involved in the study. Pseudonyms have been used to provide confidentiality for respondents.

The findings also provide indications of the type of strategies employed by people with disability and their doctors when adjustable height tables are not provided for medical examination.

In total 123 people started the survey and 118 people (95.9%) completed the survey.

In terms of the geographic spread of respondents, of those who provided a postcode, 66% were from the metropolitan areas of New South Wales, 3% from the regional areas of New South Wales and 31% of respondents from the rural areas.

The metropolitan areas included: Northern Sydney (22%); Central Sydney (6%), South Western Sydney (11%); South Eastern Sydney (7%), Nepean (12%) and Cumberland/Prospect (8%). Three percent of respondents came from regional areas. The rural areas were represented by 6% of respondents from Western region, 3% of respondents from Southern region and 22% of respondents from Northern region.

It is apparent that most respondents live in the metropolitan areas of New South Wale with only about 31% in rural areas.

Of the general practitioners mentioned in the survey, 19.1% are sole practitioners, 39.1% are sharing premises with other doctors and 40% are located in medical centres and 1.8% said they did not know.

In relation to the availability of height adjustable tables, 82.4% of respondents stated that their general practitioner did not have an adjustable height examination table; 9.2% stated that their general practitioner had an adjustable table, 8.4% were unaware as to whether or not the examination table was adjustable.

Of the people who were unable to be examined without an adjustable table surveyed 28.4% are examined in their wheelchair, approx 10.2% are not examined at all, 10.3% are examined at home, 6.8% are required to attend a hospital or specialist where adjustable tables are available. Of the respondents who managed to access the fixed height table, 19.3% of people are physically assisted by the doctor and/or carers and 10.2% manage to use steps or a stool. 14.8% were able to access the table without assistance

Thus it appears that 2 in 10 people have access to an adjustable height table, 1 in 10 people with a disability are not examined, whereas almost 3 in 10 are examined in their wheelchair, almost 1 in 10 need to make other arrangements, 3 in 10 manage with assistance to climb onto or be lifted onto the fixed height table. Only 1 in 10 could access the table without assistance.

At this point, it is useful to gain some insights into the personal examples of people who are experiencing difficulty in gaining physical access to medical examination.

Barriers to access for preventative health examinations

Some respondents experienced great difficulty in accessing a regular health evaluation. One respondent, David, whose mobility has decreased, spoke of his inability to undergo regular physical examinations that enable preventative health measures:

> *I used to be able to transfer to his (doctor's) high table for him to check for bowel cancer, haemorrhoids, pressure areas etc. He is now unable to do these checks due to my inability to do high transfers.*

As did another respondent, Rebecca:

> *Half hearted exam of groin rash while seated in my wheelchair. Poor attempt at exam for haemorrhoids while I stood up out of my wheelchair and leaned against an exam bed.*

Another respondent, Carol, who regularly undergoes physical examination to prevent breast or cervical cancer, needed to either be examined in her wheelchair or be lifted by 2-3 people onto the fixed height table.

As did Pauline:

> *Try having a pap smear test sitting in a wheelchair – quite an acrobatic act.*

Eva, also spoke of her inability to receive a Pap smear examination for 7 years

> *I became a paraplegic in 2001 and spoke to various doctors and Clinical Nurse Consultants at the hospital over the years with no success. Finally, I was able to have a pap smear in early*

2008 when a CNC looked further into it for me and found that one of the outpatient clinics had just started providing the service for people with mobility issues.

Barriers to access for examination for acute medical conditions

Eva was also examined in her wheelchair for a pressure sore.

> *I had a pressure area on my groin that needed professional attention and had to slide forward in my wheelchair, take down my slacks and pants (this was so degrading) to show the doctor. He advised me to contact Community Nursing.*

Another respondent, Peter, experienced difficulty in the examination of a fracture and cut on his foot:

> *Fracture and deep cut of 2 toes on right foot. Had to raise my leg onto seat to allow examination of underside of foot. Examination light mounted to wall could not light up underside of foot.*

Evan, another respondent, spoke of difficulty in examination for respiratory problems:

> *Well, when I need my chest listened to, I have to lean forward to put my head on knees for dr to listen and it's tricky as I don't have head control.*

It is apparent from the foregoing that people with physical disability are facing difficulty in accessing medical examinations, be it either for acute medical conditions or for full regular preventative health. This finding supports the literature on the increased risk of people with disability for poor health outcomes as they face multiple barriers to accessing quality primary preventative services (Branigan, Stewart, Tardir & Veltman, 2001; Iezzoni, Davis, Soukup & O'Day, 2002; Kroll, Jones, Ken & Neri, 2006; Long, Coughlin & Kendall, 2002; Veltman, Stewart, Tardif & Branigan, 2001 in Hwang et al, 2009); have poorer overall health outcomes (Campbell, Sheets & Srong, 1999: Thompson, 1999 in Hwang et al, 2009) and more preventable emergency room visits and hospitalisations (Bindman et al, 1995; Campbell et al, 1999; Langendoen, 2004; Thompson, 1999 in Hwang et al, 2009).

Occupational health and safety

It became apparent from the data that not only patients but GPs and other health care staff are potentially at risk in terms of injury and associated costs.

Roberta spoke of how she accessed a fixed height examination table:

> *I would have to be lifted onto the bed by 2 people. Cannot attend drs without a carer.*

Deidre spoke of how her doctor examines her:

> *With me standing against or leaning on the table or a chair.*

As did Phillip:

> *I leave my shoes on (and orthotics) and use a foot stool to climb on and off the table. My GP stands behind me in case I lose my balance.*

Both Deidre and Phillip could access the fixed table with assistance but Lisa could not.

> *I have severe M.S. unable to move without assistance.*

Neither could Robert.

> *I am wheelchair bound and have great difficulty transferring.*

Peter spoke of the assistance he received from his grandson.

> *I lean over and they swung my feet around and I landed on my tummy! Once my grandson picked me up and put me on the table.*

Millie relies on her husband:

> *Have to be lifted onto table if my husband is with me.*

Eunice needs to lift her child onto the examination table.

> *The child can still be lifted onto the table. The problem is getting the child up three steps into the surgery.*

Paula also lifts her child with the doctor's assistance.

> *Offers to help get my child onto bed, which when he is sick, he is extra heavy.*

The literature review provides evidence that physicians are at risk of injury from both working on fixed height tables (Habes and Baron, 1999) as well as nurses from lifting and transferring patients from wheelchairs to beds (Personick, 1990; Knibbe, Friele, 1996; Smedley et al, 1995; Owen et al, 2000 in Owen, 2000). From the findings, it is apparent that the patient, carers and the examining doctor incur the risk of injury or accident when attempting to lift the patient or assist the patient.

Universal access

However, the limited availability of adjustable height examination tables affects not only people with disability. Some older respondents, like Barbara, discussed the need for adjustable height tables with her doctor:

> Prior to completing this survey I discussed my inability to access the examination table with my GP, and he agreed that with an ageing population there was an increased need for this to be available and that he would speak to the Doctor who owns the practice.

Currently, Barbara goes to hospital if she requires medical assistance for a serious condition.

> As I am fairly familiar with my health, if I am that sick I will attend a Public Hospital Emergency Department.

Discussion

This survey aimed to gain indications of the extent to which people with disability face barriers to medical examination in the surgeries of general practitioners.

The findings indicate that the survey was predominantly undertaken by people living in metropolitan areas of New South Wales who largely consulted GPs in either shared practices or medical clinics. However, the overall figures have salience for rural areas as well, as they reflect the findings of King (2006).

In relation to the extent to which the 'environmental-structural' barriers posed by fixed height examination tables preclude people with disability from examination or allow only partial examination, the findings show that nearly1 in 10 are not examined, while approximately 1 in 10 people need to make other arrangements. Three in 10 are inadequately examined, and 3 in 10 require physical assistance to access a fixed height table.

Evidence was cited in the literature review for the hypothesis that regular health examinations are effective in the early diagnosis and prevention of serious medical conditions. The literature also provided research on the poorer health rate of people with disability compared to the rest of the population owing to barriers to medical care arising from lack of physical access to examination. As mentioned, even though the international literature does not always employ the term 'general practice' there are salient similarities in the nature of primary care received from some physicians in the studies reviewed. In addition, it was apparent from the examples provided by respondents that they faced barriers to examination both in the instance of requiring acute medical attention and in the case of requiring preventative examination. Thus, it could be extrapolated from the findings that in both cases people with disability are at greater risk of misdiagnosis and non-detection of serious medical conditions than the rest of the population.

In terms of occupational health and safety, there was research that indicated health care workers are at risk of injury from non-ergonomic equipment especially when lifting and transferring patients from wheelchair to bed. The strategies employed by respondents who cannot access an adjustable height table involve physical assistance from both doctors and carers in sometimes precarious examination situations such as standing in the wheelchair against the table. Such situations create risk of accident and injury not only for the patient but also for doctors and carers who assist.

In addition, not only people with early onset disability are disadvantaged by the lack of adjustable height tables, but also, older people with limited mobility, pregnant women, and other people who temporarily have limited mobility. In the context of an ageing Australian population, in which the percentage of people aged 65 years and over is projected to increase by at least 10% from 2007 to 2056, there are implications in terms of universal access to medicine offered by general practitioners.

In terms of civic rights, people with disability should have access to full and thorough medical examination. In terms of social inclusion, people with disability should have equal access to the same quality and range of medical care as other people.

To this end the New South Wales Government has prioritised both prevention in service delivery and commitment to initiatives that encourage healthy ageing. The NSW State Plan embodies these priorities in relation to State administered health facilities (NSW Department of Premier and Cabinet, 2008). In addition, the Commonwealth Government provides financial assistance for general practitioners who are seeking accreditation under the Royal Australian College of General Practitioners under the Practices Improvement Program (PIP).This funding can be used to purchase equipment necessary to provide quality care for all patients. It appears that General Practitioners have used PIP funding in a number of different ways. An article by Ferguson in 2006 reported that one doctor uses his PIP income to buy luxury items for his practice, hold staff meetings at a good restaurant, and sponsoring talented children. Another GP practice purchased a new vaccine fridge, and other practices absorb the PIP funds into regular expenses. The Appendix contains a description and contact details for PIP funding as well as for independent distributors of rehabilitative equipment.

The advocacy undertaken by People with Disability Australia, and Women with Disabilities Australia a number of years ago focused on the RACGP including height adjustable examination tables as a mandatory item within their GP Standards. This involved working directly with RACGP in their review of their Standards and with the Federal Department of Health to try and secure 'one off' additional funding through the PIP to assist general practices to purchase the equipment.

The then Minister for Health appeared to recognise the concerns of the disability community, and he encouraged RACGP to address the matter. Work with the RACGP resulted in a number of important developments including:

- An information and education program aimed at GP's
- An agreed set of technical criteria for height adjustable examination tables
- Access to suitable equipment through centralised purchasing at *gpdirect*
- Listing height adjustable examination tables as an 'unflagged' item in the GP Standards – an unflagged item essentially means that GP's are recommended to have an adjustable bed but not required to have one. Moving from an unflagged to a flagged (mandatory) item is a question raised during review of the Standards.

While there appears to be Government and professional body support of equitable health outcomes for all Australian's the survey undertaken by PDCN shows that there has been little change in the availability of height adjustable examination tables and a continuing danger of inequitable health outcomes for patients with physical disability. While the RACGP is recognised for previous work, the PDCN survey shows that more action needs to be taken.

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Appendix

Resources for general practitioners

Funding for adjustable height examination tables is available from the Practice Incentives Program which is currently administered by Medicare Australia:

Full details are available at
http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp.

Medicare

General public enquiries
Phone
132 011*
Mail
Medicare
GPO Box 9822
in your capital city
Email
medicare@medicareaustralia.gov.au

What is the Practice Incentives Program (PIP)?

The PIP delivers financial incentives with the aim of recognition of general practices that provide comprehensive, quality care, who are either accredited or working towards accreditation for the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices*.
The PIP is part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by the general practitioners and the practice, such as patient payments and Medicare rebates.
The PIP aims to compensate for the limitations of fee-for-service arrangements. Under these arrangements, practices that provide numerous quick consultations receive higher payment than those that take the time to look after the ongoing health care needs of their patients. High throughput of patients can be associated with unnecessary prescribing, tests and referrals.
Medicare Australia assesses all applications from general practices for participation in the program. The Department of Heath and Ageing manages the program policy development, including eligibility criteria. In line with the Practice Incentives Program Review Group recommendations, access to the PIP is available only to practices that are fully accredited or new practices that are registered for accreditation and must be fully accredited within 12 -months of joining.
PIP payments are mainly dependent on practice size, in terms of patients seen. The basis for the PIP payment formula was developed in consultation with the General Practice Financing Group (GPFG). The GPFG is a negotiating body comprising the Royal Australian College of General Practitioners, Australian Medical Association, Rural Doctors Association

of Australia, Australian Divisions of General Practice, and the Australian Government. More information is provided in the Formula section of this site.

Payments focus on aspects of general practice that contribute to quality care, including:

- the use of Information Management/Information Technology (IM/IT)
- provision of after-hours care
- student teaching and better prescribing
- payment of a rural loading to practices in rural and remote locations.

Practices may spend their payment as they wish, though the usual taxation rules apply.

Suppliers:

www.gpdirect.net.au

Independent Rehabilitation Suppliers Association of NSWinfo@irsa.org.au Website: www.irsa.org.au