

Patients' attitudes about physiotherapists and self-referral to physiotherapy in Croatia – a pilot cross-sectional study

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Iva Lončarić Kelečić ^{1D}

Clinic for Rheumatic Diseases and Rehabilitation, University Hospital Centre Zagreb, Zagreb, Croatia

Abstract

Introduction. Research from developed European countries shows that self-referral to physiotherapy can provide adequate clinically and financially effective care for musculoskeletal disorders and is supported by most healthcare stakeholders. This pilot cross-sectional study aimed to investigate Croatian patients' attitudes about physiotherapists and self-referral to physiotherapy and to determine whether specific characteristics of the respondents influence attitudes.

Methods. The study involved 125 subjects, outpatient physiotherapy patients. Sociodemographic and medical data were collected at the end of the physiotherapy cycle. At the same time, the respondents filled out a survey questionnaire on attitudes about physiotherapists and self-referral to physiotherapy, which was created for this research.

Results. The respondents' attitudes show that physiotherapists possess and practice the necessary competencies in the health care of musculoskeletal disorders and that they are insufficiently represented in health care. The results implicate that physiotherapy is a patient-centred, effective and well-accepted health service. Self-referral to physiotherapy has potential socio-economic implications for the individual and the health system. The results show ($p < 0.05$) that attitudes do not differ concerning sex, level of education or the number of previously attended cycles of physiotherapy. Still, increasing age decreases a positive attitude towards the effectiveness of physiotherapy and the professional autonomy of physiotherapists.

Conclusions. The attitudes of Croatian patients towards physiotherapists and the possibility of self-referral to physiotherapy are positive and negatively correlated only with the characteristic of age.

Key words: primary health care, physical therapy specialty, self-referral and consultation

Introduction

Health conditions and epidemiological priorities of the 21st century are conditioned by the modern way of life and represent a challenge for the health system. Chronic non-communicable diseases stand out as a priority problem in Croatia, and musculoskeletal disorders (MSDs) [1, 2] along with connective tissue diseases are the leading cause of sick leave [3]. The most common MSDs are low back pain, neck pain, and osteoarthritis [4, 5]. Although they do not result in severe and specific pathology, MSDs lead to significant disability and financial burden on the individual and load on the health system [6]. Therefore, there is a need to implement an effective strategy to manage these leading health problems.

MSDs can be managed through the modern practice of referral to physiotherapy at the primary level of health care; so-called direct access, which refers to a term used for patients seeking the services of a physiotherapist without the recommendation of a third party or a health professional, usually a physician [5, 7–11]. Self-referral is an opportunity to receive a clinical evaluation and physiotherapy advice plan aimed at disabling and preventing possible future dysfunction at an early stage [12] without a referral from a physician [13], usually a specialist, which is contrary to the current practice of the traditional referral model in Croatia. Evidence supports physiotherapeutic management and other specific conditions at the primary level rather than in acute hospitals, such as neurological conditions and women's health problems [14]. Still, the same has been insufficiently researched and described in the literature. Physiotherapists at the primary level

of health care contribute to addressing the rapidly growing needs of the population, which represent direct demands on the health system and are directly related to rising health care costs in Europe [14]. In Finland, the Netherlands, Norway, Sweden and the United Kingdom, the self-referral model or direct access to physiotherapy in primary care is standard, thoroughly evaluated and recommended by the National Institute for Health and Care Excellence [12, 14]. European studies show that patient self-referral to physiotherapy has proven to be feasible, appropriate, clinically and financially effective, and supported by patients, physiotherapists and family physicians [15], who are considered 'gatekeepers' at the primary level of health care. In England, pilot studies have shown that allowing patients with back pain, arthritis, and other MSDs to self-refer to physiotherapists based in general practitioner (GP) practices cut the proportion needing a GP consultation for back pain and hospital care [16].

Direct access to physiotherapy at the primary level can justifiably be seen through the principle of subsidiarity, which, according to The Croatian Health Care Act, ensures the provision of health services at the lowest possible level of health care provision [17]. Still, such a model has not yet been implemented in the practice of our country, despite the dominance and continuous increase of chronic non-communicable diseases and chronic shortage and misdistribution of health personnel, especially physicians [1]. Among the various factors, waiting lists for a physician's appointment are cited as one of the factors why self-referral to a physiotherapist should be enabled for people with functional disability or risk of disability [18] due to MSDs.

Correspondence address: Iva Lončarić Kelečić, University Hospital Centre Zagreb, Clinic for Rheumatic Diseases and Rehabilitation, Physical Therapy Department, Božidarevićeva 11, Zagreb 10 000, Croatia; e-mail: iva.loncaric.kelecic@gmail.com; <https://orcid.org/0000-0003-2517-3082>

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To examine the potential implications of implementing a new organisational model in the health system or an existing one, it is essential to explore the attitudes and experiences of the users of these health services. Thus, for example, Webster et al. [19] investigated the perspectives of service users towards physiotherapy, referral, and the behaviour of patients in their independent search for health services. The study showed that the examined groups positively evaluated physiotherapy, especially patients who self-referred to a physiotherapist. No study has been conducted in Croatia to explore the attitudes or experiences of patients related to physiotherapists and different models of referral to physiotherapy, which is needed to identify views and needs and to stimulate organisational thinking and health policy planning.

Thus, this study aimed to examine patients' attitudes about physiotherapists, self-referral to physiotherapy, and whether the sex, age or level of education of the respondents and their previous involvement in physiotherapy affect the attitudes expressed.

Subjects and methods

Design

This pilot cross-sectional study was conducted in a physiotherapy outpatient setting, in units for musculoskeletal physiotherapy, from April to June 2021.

Participants

Due to the epidemiological and organisational restrictions and period limitations imposed by the COVID-19 pandemic during the study and the situation's unpredictability, the plan was to offer participation in the survey at the end of the physiotherapy cycle to all available patients who met the study criteria. Inclusion criteria were: persons > 18, musculoskeletal disorders not associated with severe or potentially severe causes or specific pathology (i.e. work-related and individual-related), and preserved cognitive, mental and physical abilities for informed consent and self-completion of survey questionnaires. Exclusion criteria were: persons < 18, musculoskeletal disorders associated with severe or potentially severe causes or specific pathology, impaired cognitive abilities, inability to follow verbal instructions and failure to give informed consent, physical and mental problems that could reduce reliability in self-completion of questionnaires (deafness, illiteracy, behavioural disorders, cognitive problems, etc.). An invitation to participate in the survey was offered to 125 patients, and all responded without dropping out. Therefore, the final sample consisted of 125 subjects (45 males and 80 females).

Methods

Patients' attitudes about physiotherapists and self-referral to physiotherapy were examined using a survey questionnaire created for this study. At the end of the physiotherapy cycle, the respondents filled in the questionnaire independently. The survey questionnaire consisted of 12 assertions (A1–A12) positively and negatively designed to avoid stereotypical responses. The answers were recorded on a Likert scale in the range of 1–5, i.e., from 'I entirely disagree' to 'I entirely agree'. The characteristics of the respondents related to sex, age and level of education, location of musculoskeletal disorders, number of cycles of physiotherapy so far and data on the ability to work while attending physiotherapy were also collected.

A review of the literature of interest was conducted by studying the papers available in the MEDLINE/PubMed, Pedro, Cochrane, and Google Scholar databases using keywords related to direct access or self-referral of patients to physiotherapy.

Statistical analysis

Statistical data processing was performed in the PSPP program (GNU Project, ver.1.4.1/5 September 2020). Categorical variables are presented as numbers and percentages, and continuous variables with arithmetic mean (*M*) and standard deviation (*SD*). In order to ascertain assertion differences between different groups of patients, the *T*-test and Cohen's size effect were used for sex differences, analysis of variance (ANOVA) for educational levels and physiotherapy cycles, and Pearson's correlation coefficient was used to investigate age correlation. The defined level of statistical significance is a two-sided *p*-value < 0.05.

Ethical approval

The research related to human use has complied with all the relevant national regulations and institutional policies, has followed the tenets of the Declaration of Helsinki, and has been approved by the Ethics Committee of the University Hospital Centre Zagreb (Class: 8.121/59-2, No.: 02/21-JG).

Informed consent

Informed consent has been obtained from all individuals included in this study.

Results

A total of 125 subjects with musculoskeletal disorders participated in the study, mean age *M* = 48.67; *SD* = 14.494.

Table 1 shows that the majority of the respondents in this study were women (64%), had secondary education (54.4%) with problems related to the spine dominating (39.2%), and had attended five or more cycles of physiotherapy (39.2%). At the time of attending physiotherapy and conducting this research, almost the same number of respondents were on sick leave (36.0%) and working (37.6%), while the rest of the respondents were unemployed (26.4%).

All 125 questionnaires were fully completed. The distribution of answers is shown in Table 2. The total number and the percentage of respondents who agree and entirely agree, those who disagree and entirely disagree, and those who did not express their evident attitude will be commented on.

One hundred and twenty-four (99.2%) respondents agreed or agreed entirely with statement A1 and one (0.8%) respondent did not express an apparent attitude. One hundred and twenty-two (97.6%) respondents agreed or agreed entirely with statement A2, and three (2.4%) respondents did not express an apparent attitude. One hundred and twenty (96%) respondents agreed or agreed entirely with statement A3, four (3.2%) showed indifference and one (0.8%) respondent showed a negative attitude. One hundred and twenty (96%) respondents agreed with statement A4 and five (4%) respondents showed indecision. One hundred and twenty-five (100%) respondents agreed with statement A5. One hundred and twenty-three (98.4%) respondents agreed with statement A6 and two (1.6%) were undecided. One hundred and twenty-four (99.2%) respondents agreed or entirely agreed with statement A7 and one (0.8%) remained indifferent. Conversely interpreting, 80 (64%) respondents agreed or agreed entirely with statement A8, 23 (18.4%) respondents disagreed

Table 1. Sample characteristics

	Number (%) of respondents
Sex	
Male	45 (36.0)
Female	80 (64.0)
Total	125 (100)
Level of education	
Unqualified	2 (1.6)
Secondary	68 (54.4)
Higher	23 (18.4)
Graduate	32 (25.6)
Total	125 (100)
Location of problem	
Spine	49 (39.2)
Upper extremity	10 (8.0)
Lower extremity	26 (20.8)
Multiple location	40 (32.0)
Total	125 (100)
Cycle of physiotherapy	
1	18 (14.4)
2	27 (21.6)
3	17 (13.6)
4	14 (11.2)
5 or more	49 (39.2)
Total	125 (100)
Working status	
Working	45 (36.0)
On sick leave	47 (37.6)
Unemployed	33 (26.4)
Total	125 (100)

or disagreed entirely, and 22 (17.6%) were indifferent. Ninety-six (84%) respondents agreed or agreed entirely with statement A9 (T9), six (4%) disagreed or disagreed entirely, and 22 (19.2%) respondents were indifferent. This interpretation is also the opposite of the stated assertion. One hundred and two (81.6%) respondents agreed with statement A10, 10 (8%) disagreed or disagreed entirely, and 13 (10.4%) were undecided. One hundred and sixteen (92.8%) respondents agreed or agreed entirely with statement A11, two (1.6%) respondents disagreed and seven (5.6%) were indifferent. Finally, one hundred and fourteen (91.2%) respondents agreed or agreed entirely with statement A12, two (1.6%) respondents disagreed, and nine (7.3%) respondents were undecided.

Looking at the significance of *p*-values higher than the defined level of *p* > 0.05 and the Cohen effect (Table 3) in all observed assertions, we can conclude that sex did not significantly affect the respondents' responses.

When analysing the variance for each assertion concerning the respondents' level of education and the number of cycles of physiotherapy (Table 4), we found no significant difference in the answers.

Table 3. T-test and Cohen's effect size for each assertion concerning sex

Assertion	Sex	Number	Mean	SD	<i>d</i>	<i>p</i>
A1.	male	45	4.91	0.288	0.014	0.458
	female	80	4.86	0.381		
A2.	male	45	4.71	0.506	0.014	0.483
	female	80	4.78	0.477		
A3.	male	45	4.80	0.548	0.012	0.465
	female	80	4.73	0.551		
A4.	male	45	4.69	0.557	0.000	0.989
	female	80	4.69	0.542		
A5.	male	45	4.89	0.318	0.003	0.820
	female	80	4.88	0.333		
A6.	male	45	4.84	0.367	0.031	0.071
	female	80	4.70	0.513		
A7.	male	45	4.91	0.288	0.029	0.088
	female	80	4.80	0.433		
A8.	male	45	2.27	1.031	0.009	0.613
	female	80	2.38	1.205		
A9.	male	45	1.73	0.863	0.024	0.192
	female	80	1.95	0.899		
A10.	male	45	4.44	0.918	0.025	0.179
	female	80	4.20	0.999		
A11.	male	45	4.51	0.661	0.002	0.853
	female	80	4.49	0.693		
A12.	male	45	4.44	0.785	0.020	0.276
	female	80	4.59	0.650		

SD – standard deviation, *d* – Cohen's effect size, *p* – statistical significance

Table 4. Analysis of variance for each assertion concerning the level of education of the respondents and the number of cycles of physiotherapy

Assertion	<i>F</i> ^(E)	<i>p</i> ^(E)	<i>F</i> ^(PT)	<i>p</i> ^(PT)
A1.	2.123	0.101	1.265	0.288
A2.	0.422	0.737	0.393	0.814
A3.	0.651	0.584	1.693	0.156
A4.	0.442	0.723	2.271	0.065
A5.	0.388	0.762	0.851	0.496
A6.	1.258	0.292	2.323	0.061
A7.	0.998	0.397	1.431	0.228
A8.	2.2090	0.091	0.976	0.423
A9.	0.888	0.450	2.149	0.079
A10.	1.246	0.296	2.249	0.068
A11.	0.622	0.602	2.402	0.054
A12.	1.603	0.192	0.371	0.829

F – result of analysis of variance for the level of education (E) and number of cycles of physiotherapy (PT), *p* – statistical significance for the level of education (E) and number of cycles of physiotherapy (PT)

Table 2. Distribution of responses

Assertion	Response	Number (%) of respondents
A1. The physiotherapist showed interest in my musculoskeletal problems, the nature of the occurrence and the way I deal with them	I neither agree nor disagree	1 (0.8)
	I agree	13 (10.4)
	I agree entirely	111 (88.8)
	Total	125 (100)
A2. Based on the physiotherapy assessment and medical documentation, the physiotherapist explained to me the cause of my problems clearly and understandably	I neither agree nor disagree	3 (2.4)
	I agree	25 (20.0)
	I agree entirely	97 (77.6)
	Total	125 (100)
A3. The physiotherapist explained the planned content of the physiotherapy program to me clearly and understandably	I disagree	1 (0.8)
	I neither agree nor disagree	4 (3.2)
	I agree	20 (16.0)
	I agree entirely	100 (80.0)
Total	125 (100)	
A4. I gave informed consent to the planned physiotherapy based on a clear explanation of what it refers to	I neither agree nor disagree	5 (4.0)
	I agree	29 (23.2)
	I agree entirely	91 (72.8)
	Total	125 (100)
A5. The physiotherapist provided me with effective physiotherapy treatment for my musculoskeletal problems	I agree	15 (12.0)
	I agree entirely	110 (88.0)
	Total	125 (100)
A6. I learned from my physiotherapist how I could manage my musculoskeletal problems on my own	I neither agree nor disagree	2 (1.6)
	I agree	27 (21.6)
	I agree entirely	96 (76.8)
	Total	125 (100)
A7. The physiotherapist empowered me in therapeutic exercise and comprehensive resolution of my musculoskeletal problems	I neither agree nor disagree	1 (0.8)
	I agree	18 (14.4)
	I agree entirely	106 (84.8)
	Total	125 (100)
A8. A physiotherapist cannot make independent decisions about whether I am capable of returning to daily life and work activities	I entirely disagree	32 (25.6)
	I disagree	48 (38.4)
	I neither agree nor disagree	22 (17.6)
	I agree	17 (13.6)
	I agree entirely	6 (4.8)
	Total	125 (100)
A9. Physiotherapists do not know how to act if the problem and health condition exceed their competencies and scope of work	I entirely disagree	51 (48.6)
	I disagree	45 (36.0)
	I neither agree nor disagree	24 (19.2)
	I agree	4 (3.2)
	I agree entirely	1 (0.8)
	Total	125 (100)
A10. In case of new musculoskeletal problems, I could self-refer to a physiotherapist, without a prior referral and a visit to a specialist	I entirely disagree	1 (0.8)
	I disagree	9 (7.2)
	I neither agree nor disagree	13 (10.4)
	I agree	32 (25.6)
	I agree entirely	70 (56.0)
	Total	125 (100)
A11. Physiotherapists are underrepresented in health care, and access to physiotherapy is difficult	I disagree	2 (1.6)
	I neither agree nor disagree	7 (5.6)
	I agree	43 (34.4)
	I agree entirely	73 (58.4)
	Total	125 (100)
A12. Self-referral to physiotherapy could reduce the cost of time and money at the level of the patient and at the level of the health system	I disagree	2 (1.6)
	I neither agree nor disagree	9 (7.2)
	I agree	34 (27.2)
	I agree entirely	80 (64.0)
	Total	125 (100)

Two significant correlations were observed between the responses to assertions and age. Between age and response to T5, 'Physiotherapist provided me with effective physiotherapy treatment for my musculoskeletal disorders', $r = -0.187$, $p < 0.05$, the correlation is weak and negative, which indicates that increasing age decreases the perception of the respondents that physiotherapists provide them with effective physiotherapy treatment. The other statistically significant correlation is between age and T8 'Physiotherapist cannot independently decide whether I can return to daily life and work activities', $r = 0.184$, $p < 0.05$. The correlation is weak and positive, which indicates that with increasing age, the perception increases that the physiotherapist cannot independently make decisions about the patient's ability to return to everyday life and work activities.

Discussion

Demand for MSD care services is growing steadily, and studies show that direct access to physiotherapy can provide adequate [15, 20] clinically and financially effective care [15]. Our population has not yet been subjected to a systematic study that would examine patients' attitudes about physiotherapists and different models of approaches to physiotherapy, which was the reason for conducting our research. A total of 125 subjects with MSDs participated in this study, with an average age of 49 years, generally considered middle age and associated with an increased incidence of health problems and lifestyle-related diseases.

Despite the convenience sample, the results of our research are positive, encouraging and above all objective, given that they are based on the experience of the respondents. Our respondents believed the physiotherapists showed interest in their MSDs, the nature of their occurrence and the way they dealt with them, which is in line with the findings of Mudge et al. [21]; physiotherapists show an increasing degree of understanding and application of patient-centred principles of health care, respect the patient's value system and preferences, provide hope, manage expectations, and build a positive partnership relationship with the patient in physiotherapy.

In the communicative, interactive process of physiotherapy, the fears and other contextual information of the patient, and the knowledge of the physiotherapist on diagnostic and therapeutic procedures and anatomical and physical data are interrelated [22]. Our respondents' experiences show that physiotherapists explain to patients clearly and understandably the causes of problems and the planned content of the physiotherapy program. Given that most patients do not have basic medical knowledge and differ in their cognitive, motivational and emotional level of behaviour, all patient information must be clear and understandable.

The right to co-decision in physiotherapy refers to the consent of a physiotherapist to undertake a particular diagnostic or therapeutic procedure based on his or her knowledge [23]. Ninety-six per cent of our respondents gave informed consent to planned physiotherapy based on a clear explanation of what it refers to. This result indicates that physiotherapists know informed consent as a legal and professional requirement. At the same time, contrary to our conclusion, Roman et al., in a sample of 148 respondents, proved that in Romania, only about 40% of physiotherapists always seek informed consent at the beginning of physiotherapy. As many as 16% of them never meet this professional-legal requirement [24].

Physiotherapy in which the patient is supported and empowered [25] to act as a co-producer can positively affect clinical outcomes [26]. Almost all of our respondents believe that physiotherapists empower them in therapeutic exercise and comprehensive resolution of their musculoskeletal problems. This is an essential indicator of the physiotherapist's efforts and focuses on the patient and the desired outcome of the physiotherapy.

In their work, physiotherapists face many challenges for each patient attending physiotherapy, with the main one being how to achieve the best possible outcome [27]. It is important to emphasise that the intention is to achieve and maintain the patient's outcome. Our respondents believe that the physiotherapists provided effective treatment for their MSDs, and almost all of them learned how to self-manage their conditions. Although this study was conducted on a suitable number of subjects, our results show the effectiveness of physiotherapy and physiotherapists. It is consistent with the research results by Webster et al. [19], in which, in a sample of 2,177 subjects, the effectiveness of physiotherapy was supported by > 90% of respondents.

Physiotherapists work within a body of solid clinical evidence linked to measurable outcomes, support the self-management of common and complex health conditions and promote independence, considering all aspects of the patient's life [28]. Physiotherapy ensures knowledge transfer, clinical decision-making, and uncertainty to avoid exacerbating disability [29] caused by musculoskeletal disorders, which ultimately involves co-decision to return to daily life and work activities. Similar to the Croatian experience, Ristimäki et al. [30] state that the physician makes a decision that depends on the assessment and agreement with the patient, but it is clear that it does not always have to be satisfactory for both parties. About two-thirds of our respondents agree that a physiotherapist can independently decide whether a patient is capable of returning to daily life and work activities. Although most respondents view the physiotherapist positively as an autonomous expert on this issue, a small proportion of them do not share the same opinion or did it. Webster et al. [19] believe that the reason for this is not ambivalence but that patients may not have a clear position on who actually makes such decisions and therefore accept the suitability of either a physiotherapist or a physician taking on this role. Baste-meijer et al. [31] have shown that patients think that a physiotherapist must have control and responsibility in making decisions within their discipline. The loss of supervision of a physiotherapist due to health policy regulations leads to overly generalised and protocolised treatment, to the detriment of individual care quality.

To access physiotherapy properly in the self-referral model, patients should, among other things, adopt autonomic health behaviour [19], which is defined as any action taken on their initiative by persons who believe they have health problems or are ill to find an appropriate remedy or methods of treatment [32]. More than three-quarters of our respondents could self-refer to a physiotherapist without prior instruction and a visit to a specialist doctor. Although low, the number of those who could not self-refer or were indifferent may be due to any or all of the following: lack of knowledge about physiotherapy, lack of self-confidence, lack of awareness of self-referral, and reluctance to adopt autonomic health behaviours [19].

Exact information on the number of qualified physiotherapists employed in the public health sector is unavailable in Croatia. The only exact figure is the minimum requirement in terms of staff in physiotherapy, which is '1 bachelor of physiotherapy per 10 patients for 8 hours of working time' [33]. This

standard in actual practice far exceeds the population's health needs, and almost all respondents in our research agree that the representation of physiotherapists and physiotherapy within the public health system does not meet the needs of patients.

Growing evidence of the clinical efficacy and potentially significant economic viability of patient self-referral to physiotherapy implies that this approach is supported by patients [19, 34, 35]. Goodwin and Hendrick's [34, 35] economic analyses of physiotherapy as a primary health care contact have shown significant potential health savings. Piscitelli et al.'s [7] systematic review has shown that a direct approach in physiotherapy is feasible, taking into account the clinical and economic points of view. Bishop et al. [36] point out that the positive impact of direct access on the workload of general practitioners is inconsistent but that there are visible changes in the number of requirements and needs for X-rays and magnetic resonance imaging in patients. Almost all of our respondents agree with the statement that self-referral to physiotherapy could reduce the cost in terms of time and finances at the level of the patients themselves and the level of the health system. This result is significant for the profession and for health policy to reflect effective strategic planning.

In our study, age was negatively correlated with the respondents' perceptions of the effectiveness of physiotherapy treatment and the physiotherapist's autonomy in making decisions about a patient's ability to return to everyday life and work circumstances. There is no evidence in the available literature to compare this finding. Still, the fact is that pain is lower in younger adults compared to the elderly population due to apathy, muscle cramps [37] and other individual factors, which are sometimes very challenging to manage with physiotherapy, making it reasonable and expected to assume the perception of reduced efficiency in the elderly. The perception of older people about the autonomy of physiotherapists in decision-making can be analysed through the prism of personal knowledge of physiotherapy, which is influenced not only by age, gender and race but also by individual attitudes and beliefs [19], which are known to differ in general and different matters between age groups.

Limitations

As a limitation, we can point out the sample size of respondents, but since this is a pilot cross-sectional study, perhaps we can consider this shortcoming not so significant. In future research, it would be desirable to include questions that examine attitudes directly related to the traditional referral model, such as waiting time for physiotherapy, which we did not. Since this cross-sectional study is more observational in nature, the survey questionnaire created for this study was not previously tested for reliability and validity, which would be necessary for possible future research, especially on a larger sample. As another shortcoming, we could point out the time of the study, being the period of the coronavirus pandemic (COVID-19), when strict epidemiological measures were in place. Still, since the availability of physiotherapy was further reduced at that time, we can add this to the factors explaining why physiotherapy must be directly available to people in need.

Conclusions

This study examined patients' attitudes about physiotherapists and self-referral to physiotherapy and the relationship with patient characteristics. The respondents' attitudes show that physiotherapists possess and practice the neces-

sary competencies in the health care of musculoskeletal disorders and that they are insufficiently represented in health care. Physiotherapy is patient-centred, an effective and well-accepted health care service, and self-referral of the patient to physiotherapy has potential socioeconomic implications for the individual and the health care system. Attitudes do not differ concerning sex, level of education or previous involvement in physiotherapy, but with increasing age, a positive attitude towards the effectiveness of physiotherapy and the professional autonomy of physiotherapists decreases. As the primary health contact for patients with musculoskeletal disorders, physiotherapists could contribute to the current challenges facing the public health sector in the health care system. The contribution of this research to clinical practice is manifested in the findings gained, which reflect the competence and strong potential of physiotherapists from the perspective of the most critical stakeholders in healthcare – patients.

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Disclosure statement

The author has no financial interest or received any benefits from this research.

Conflict of interest

The author states no conflict of interest.

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