OSTEOPATHY AND AGED CARE

Submission by OSTEOPATHY AUSTRALIA

On the proposal for a new residential aged care funding model

MAY 2019

1 PURPOSE

The purpose of the submission is to:

- Provide feedback to the government on the proposed changes to the residential aged care funding model, as outlined in the discussion paper.
- Recommend osteopathy as part of the solution to ongoing aged care workforce issues
- Inform decision makers about modern osteopathy and the evidence base supporting the primary modalities used in osteopathic practice

2 OSTEOPATHS SHOULD BE AN-ACC ASSESSORS

Osteopathy Australia supports the efforts of the government and the developers or the RUCS study and associated reports. It is a timely recognition of the need for reform in aged care services, workforce and funding. Whilst we support the proposed model in principle, the key issue we have is the proposed restriction of assessors to only three professions.

We believe that there are other professions, including osteopaths, who have the skills and (for those working in aged care facilities) experience to perform assessment. At a time where ongoing workforce problems are apparent and recognised, we feel that a more flexible approach is warranted. With adequate safeguards and credentialed training in FIM, the model could avoid restricting assessor status by profession – rather, it should be an assessment of the individual health care provider's experience and credentials.

We support credentialed training in FIM, noting that some courses are only one day long (for example the University of Wollongong course[i].

Regarding experience, we know of a growing number of osteopaths who provide services to aged care facilities, some of whom have had long and productive working relationships. We support the inclusion of the experience criterion for assessors.

Osteopaths receive undergraduate training in aged care. For example, Victoria University teaches specifically about aged care in a Master level course, as part of the pre-registration qualification for osteopaths. The problem-based learning includes the assessment and management of common and more specialised gerontological disorders and their musculoskeletal implications. Students also learn to consider aged care patients within a social, familial and health professional support context[ii].

Our focus is obviously on osteopaths, but in general terms the aged care industry should look more broadly into multi-disciplinary assessment and service models, so that it can obtain some flexibility in the face of ever-increasing demand.

3 MANAGE THE RISKS WITH ASSESSMENT AND CARE PLANNING

We agree with the separation of assessment and care. One potential risk is that the assessment for funding is taken on by external assessors (we support the proposal to separate vested interests, in particular the facility and aged care services which have a natural interest in increasing funding) while the care planning assessment component post funding allocation is undertaken by the facility or service – where the risk of retaining entrenched vested interests remains. Potential risks may include:

- Planning and care provision services are kept in-house with known providers
- Facilities seek out low cost service providers at the expense of quality care

In a time of workforce crisis, the aged care system needs to look beyond traditional referral models and consider:

- What is best for the patient (and agreed with patients/ families) – i.e. patient choice of the service they want should be a factor
- What is available in the local area

We recommend that good assessors should also be astute at recognising the skills available both within a facility but also beyond it. Safeguards should be in place against narrow or self-interested referral patterns.

4 LOOK BEYOND THE FACILITY FOR SERVICES

Care planning and clinical management should be supported by staff beyond a facility itself, like having independent advocates involved to support the client's right to local choose services aligned with a specific funded need domain. There is potential for good outcomes beyond what a planner may know or understand as having 'clinical benefit' and what a planner may know to be an in-scope service. Many aged care providers believe musculoskeletal concerns in the elderly to be the realm of physiotherapists only, however, it is a multidisciplinary practice area, which includes osteopathy.

Low back pain increases in its prevalence with obesity and ageing and we know osteopaths are regularly assessing and managing low back pain. Osteopaths are applying functional capacity assessments, neurological, exercise based, ergonomic and other assessments to address issues of bodily motion and function in specific environments posed by low back pain. The clinical exercise programs osteopaths offer, including stretching, strengthening and mobilisation exercises can reduce pain, dysfunction and increase movement in the short to medium term for adults with common types of low back pain. Additionally, spinal degeneration is a problem for older people, in particular kyphosis[iii]. Stretching and other targeted exercise programs for the back, neck and shoulders may support postural improvement in middle aged and older adults with kyphotic structural problems.

Manual therapies, including mobilisation, manipulation, deep and soft tissue massage of an impacted area in combination with clinical resistance, strengthening, aerobic and range of motion exercises may reduce pain in osteoarthritis of the hip, foot and knee while improving motion[iv][v][vi][vii].

5 EXERCISE AND PAIN MANAGEMENT

There is no apparent funding allocated for pain management or exercise programs. It appears as though they are paying now for the level of care a client needs rather than the actual provision of care. This was the case with the funding instrument used prior to ACFI. During this time most treatments and exercises were provided by physio aides rather than an allied health practitioner. We believe the proposed assessment tool may encourage nursing facilities to return to this level of care, further reducing the requirement for allied health in aged care.

6 OSTEOPATHS ARE PART OF THE SOLUTION TO THE AGED CARE WORKFORCE PROBLEM

The primary reason you should be thinking about osteopaths having a broader role in aged care is that you need them. Osteopathy is one of the fastest growing allied health professions in Australia[viii]

A number of studies have noted a significant projected increase in the burden of chronic disease, particularly with regard to musculoskeletal conditions. [ix] [x] [xi] The *Better Outcomes Report*[xii] outlines the need to strengthen primary care to better manage the large and increasing numbers of patients with multiple chronic conditions, many of whom are elderly. The *National Strategic Framework for Chronic Conditions*[xiii] considers the necessity of continuity of care and equity of access, and person-centred holistic care.

The Senate Inquiry[xiv] identified a number of systemic workforce problems in the aged care industry, including:

- High turnover
- Difficulty attracting talent
- Key capability gaps and skills in competencies misalignment

Osteopaths are university trained, AHPRA registered neuromusculoskeletal allied health professionals, who are trained in a range of manual therapy, exercise prescription and other evidence-based techniques to help patients manage their condition(s). The aged care industry needs osteopaths and other allied health professionals to continue to work with other primary care professionals to help manage the projected increase in demand.

Osteopaths are recognised providers of clinical services for approved clients in all state motor accident insurance schemes, all state WorkCover schemes, the Department of Veterans Affairs, Medicare Chronic Disease Management and most private health insurance funds.

7 OSTEOPATHIC APPROACH TO CARE

In line with the holistic philosophy of osteopathy, osteopaths typically combine multiple management approaches in providing care to chronic patients. A recent Lancet Review[xv] recommends that a range of therapies used in osteopathy for low back pain are considered as first line (2) or second line/ adjunctive (2) treatment options, including: Exercise therapy (1), CBT (1), spinal manipulation (2), massage (2), acupuncture (2), yoga (2), education and self-care (1). Some of these are discussed below.

The National Institute for Health and Care Excellence[xvi] guideline for low back pain also illustrates broadly what osteopaths do, using a range of techniques including exercise to manage chronic conditions:

> *Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise. Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.*

7.1 MANUAL THERAPY

Manual therapy is the primary method of patient care employed by osteopaths. It is a conservative management approach that defines a very wide range of hands-on techniques that might be applied to the body of a patient for therapeutic relief. Manipulation and soft tissue mobilisation are two manual therapy approaches, for instance. Manual therapy is central to the practise of osteopathy, physiotherapy and chiropractic.

Manual therapy, both overall and in terms of specific techniques, is effective in the management of neuromusculoskeletal disorders, biomechanical strains and related pain – acute, sub-acute and chronic.[xvii] In the context of Medicare rebated or funded services, osteopaths provide manual therapy specifically for neuromusculoskeletal conditions, mechanical and muscular disorders, adhering with the evidence base.

Manual therapies alone are more effective than no treatment, at least as effective as other conservative treatments for neuromusculoskeletal disorders and are maximally effective when combined in a multimodal clinical intervention including exercise and patient education[xviii] [xix], as per the practise of Australian osteopaths.

In clinical evaluations of manual therapy alone for chronic neuromusculoskeletal disorders, patients experience short and long-term benefits. Key outcomes are: improved range of motion; reduced functional impairment; reduced pain thresholds; pain intensity; pain duration; and reduced relapse frequency.[xx] [xxi] [xxii] [xxiii] [xxiv] [xxv] [xxvi] [xxvii]

Importantly, these outcomes are consistently replicated across neuromusculoskeletal disorders in variable areas of the body, and across patient groups. Manual therapy achieves

beneficial changes without pharmacologic interventions, associated side effects and medication dependency- key concerns in the prescription of contemporary pain medications.[xxviii] [xxix] There is a low rate of adverse events in manual therapy clinical research.

It is beyond question that manual therapies are indicated for chronic neuromusculoskeletal management and the highest levels of clinical evidence, systematic reviews and meta-analyses of controlled trials justify its use. The issue in health literature is not whether manual therapy has a role, but instead, which techniques will be most effective for specific conditions, in what doses and combinations. These are not problems specific to osteopathy, but to all manual health professions and each individual practitioner in those professions.[xxx]

7.2 EXERCISE

Exercise prescription can include provision of general exercises or targeted exercise repertoires aimed at improving specific capabilities in patients, for instance, strength, stability, balance, or gait. Approximately 74% of osteopaths report regularly using exercise in their patient management techniques, making it the second most commonly used clinical management approach following manual therapy.[xxxi]

The reliability of exercise as a treatment modality is reflected in the Commonwealth Government's own recommendations for the prevention and management of chronic conditions in the 2017 *National Strategic Framework for Chronic Conditions*[xxxii]. This framework puts exercise front and centre in both the prevention of chronic health conditions and management post-onset.

Provision of exercise by osteopaths meets the objective of the framework to minimise the burden of disease in Australian society. Given the integral nature of clinical exercise prescription in Australian osteopathic chronicity management, the osteopathic profession has a governance framework for clinical exercise provision, specifying clinical reasoning skills and approaches indicated for musculoskeletal acute and chronic management.

Exercise prescription in chronic management has multiple conferred benefits in patients for whom exercises have been prescribed. A review by Pedersen et al found reliable evidence for prescribing exercise in the treatment of 26 different chronic diseases[xxxiii]. The specific conferred benefits include: reduced pain on physical movement; improved muscular flexion; reduced joint tenderness; postural improvement; reduced pain thresholds; reduced fatigue; reduced pain recurrence; immediate pain relief post treatment to next follow-up; functional and activity participation improvement; and improved quality of life. [xxxiv] [xxxv] [xxxvi] [xxxvii] [xxxviii] [xxxix] [xl] [xli] [xlii] [xliii] [xliv] [xlv]

7.3 PATIENT EDUCATION

There is a large and growing body of evidence indicating that patient education and related program delivery assists in reducing unhelpful patient beliefs, anxiety, fears, and catastrophising. [xlvi] [xlvii] [xlviii] Unhelpful patient beliefs are a major predictor of long term disability and incapacity in chronic patients. [xlix] [l] In addressing such beliefs via patient education, complex causes and maintaining factors in chronicity are managed.

Patient education also encourages active self-monitoring and care, patient adherence to and compliance with clinical recommendations when offered in tandem with multimodal clinical interventions, as occurs in osteopathy. [li] [lii] [liii] [liv] [lv]

In encouraging self-monitoring and care, patient education has been shown to reduce unnecessary and avoidable hospital admissions, pain, pain related disability and increase patient function toward recovery.[lvi lvii lviii]

8 OSTEOPATHY IS SAFE

Osteopathy is one of 14 Government regulated professions under the Australian Health Practitioner Regulation Agency (AHPRA). The Osteopathy Board of Australia publishes a range of codes and guidelines to ensure professional competence and patient safety.[lix]

Osteopaths are university trained for 4-5 years through either a double bachelors or bachelors/ master's program. University courses must be accredited by the Australasian Osteopathic Accreditation Council.[lx]

Statistics from the AHPRA Annual Report indicate that there were only 14 notifications made about osteopaths in 2016/17 and 11 to HPCA. This is out of 6,898 notifications made in total to AHPRA and 4,111 to HPCA. There was only 1 mandatory notification. This indicates that patient safety is less of an issue for osteopaths than for most registered professions. Further, Osteopathy Australia is unaware of any osteopath being referred to the Professional Services Review.

Table 1: AHPRA mandatory notifications by profession 2016/17[lxi]

Profession	No. practitioners1			Rate / 10,000 practitioners
	AHPRA	HPCA[2]	Total	
Aboriginal and Torres Strait Islander Health Practitioner	2		**2**	**32.9**
Chinese medicine practitioner		1	**1**	**2.1**
Chiropractor	8	4	**12**	**22.7**
Dental practitioner	18	6	**24**	**10.7**
Medical practitioner	189	64	**253**	**22.8**
Medical radiation practitioner	5	2	**7**	**4.5**
Nurse/midwife[3]	440	164	**604**	**15.4**
Occupational therapist	4	2	**6**	**3.1**
Optometrist	1		**1**	**1.9**
Osteopath	-	1	**1**	**4.5**
Pharmacist	47	13	**60**	**19.8**
Physiotherapist	5	3	**8**	**2.6**
Podiatrist	3	1	**4**	**8.1**
Psychologist	25	15	**40**	**11.4**
Total	**747**	**276**	**1,023**	**15.1**

9 GET IN TOUCH

We are keen to be involved in the conversation about the aged care workforce, funding reform and aged care service provision. Please add us to any relevant consultation or regular news updates.
If you would like to discuss any aspect of our submission, please contact Nick Bradshaw, Deputy CEO (nbradshaw@osteopathy.org.au). We can put you in contact with osteopaths who have worked in aged care for a number of years and are passionate about the care they provide their patients and the relationships they have built with aged care facilities.

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