PRIMARY HEALTH REFORM DRAFT RECOMMENDATIONS

Submission by OSTEOPATHY AUSTRALIA

For the PRIMARY HEALTH REFORM STEERING GROUP

JULY 2021

1 SUMMARY

Osteopathy Australia welcomes the opportunity to provide a submission to the Primary Health Reform Steering Group, and is broadly supportive of the recommendations made in the discussion paper. While offering in principle support, we would need to see actual details of the implementation plan to provide more meaningful feedback and engage in a fulsome conversation about implementation. We are keen to ensure that allied health professionals are recognised as essential members of the Primary Health Care (PHC) team, and as such, continue to be fully consulted regarding implementation of all recommendations. Our submission focuses on some key issues raised by the discussion paper, but a few more specific comments on some of the recommendations are also provided.

Given that terminology around "allied health" has been contentious, we would recommend inclusion of a clear definition of "allied health professionals" in documentation going forward, that includes both AHPRA regulated and self-regulated allied health professionals. This would be consistent with the terminology used by the Australian Government Department of Health.[i] "Allied health" covers a broad range of professions, and it is important that each of these professions is supported to work to their fullness of scope so that the allied health workforce contributes maximum value to the delivery of PHC.

The paper recognises the limited ability of the current PHC system to address the challenges of a growing burden of chronic disease, an ageing population, inadequate workforce development and various equity issues. There is an urgent need to tackle the longstanding health disparities between Indigenous and non-Indigenous Australians, and to ensure affordable access to health services for all, including people in rural and remote communities. A multidisciplinary approach is needed to address these issues, drawing on the skills of the whole health care team. Patient-centred care needs to remain the focus, and simplification of the health care system should still allow consumers to make informed choices from a wide range of health care options.

It is pleasing to see specific reference to supporting and expanding the role of the allied health workforce in a well integrated and coordinated PHC system (Recommendation 11). However, the role of allied health professionals in promoting health and managing chronic disease is still largely overlooked. Osteopaths could make a core contribution to preventive health, but they have been underutilised. There also needs to be greater attention given to how allied health professionals could be more effectively utilised to meet patient needs in indigenous, rural and remote communities and to improve the patient experience of care. Osteopaths have a valuable role to play in the management of many chronic conditions; in therapeutic management and rehabilitation to address physical injury, trauma and disease; as well as in prehabilitation and preventive care to enhance health and wellbeing. Allied health professionals more broadly can make important contributions to PHC delivery and should be supported to work to their fullness of scope across health and related sectors (e.g. aged care, disability, mental health).

The paper also refers to delivering funding reform to support integration and a one system focus, which includes the long-awaited development of innovative funding models for allied health services (Recommendation 3.2.2). These funding models have been talked about often, but there still has been no departmental or federal input into the development of such models. We would be very happy to contribute to further consultations/discussions to inform

the development of these new funding models. It is important to ensure that any new funding model facilitates access to allied health services and supports allied health professionals in the context of multidisciplinary care, particularly with regard to the management of chronic conditions. In the meantime, we seek guarantees of existing funding for allied health services until new funding models are trialled and their implementation funded.

2 Chronic disease

The Australian Government is well aware of the need to strengthen PHC in order to deal with the growing burden of chronic disease. The *Better Outcomes Report*[ii] outlines the need to strengthen primary care to better manage the large and increasing numbers of patients with multiple chronic conditions. *The National Strategic Framework for Chronic Conditions*[iii] considers the necessity of continuity of care and equity of access, and person-centred care. Significant reform of the PHC system is needed to address the burden of chronic disease, and action is required now.

With approximately 1.71 billion people globally having musculoskeletal conditions, the 2019 Global Burden of Disease Study showed that musculoskeletal conditions are the leading cause of global burden of disease when expressed as years of life lived with disability, and that low back pain is the main contributor to overall burden of musculoskeletal conditions.[iv] Low back pain has also been identified as the main reason for premature exit out of the workforce.[v] While musculoskeletal conditions are associated with relatively few deaths, the economic impact of these conditions also needs to be considered. Furthermore, as disability becomes an increasingly larger component of both disease burden and health expenditure, more effective strategies, including effective utilisation of osteopaths and other allied health professionals, need to be developed to improve the cost-efficiency of the health system.

Musculoskeletal conditions also cause more than 85% of chronic pain in Australia[vi], so chronic pain is another area where allied health workers trained in musculoskeletal disorders, including osteopaths, can contribute to providing more cost-effective quality health care. The prevalence of chronic pain in Australia is projected to increase as the population ages – from around 3.2 million in 2007 to 5 million by 2050[vii]. Arthritis and back problems, both associated with chronic pain are the most common causes for people of working age (between 45 and 64) to drop out of the workforce, accounting for 40% of forced retirements – around 280,000 people in 2012.[viii] The current health system is not equipped to effectively manage the growing burden of chronic pain. GPs are currently not well-placed to treat chronic pain, with evidence suggesting that graduating primary care physicians have not learnt the necessary skills to deal with chronic pain cases.[ix] Inappropriate prescribing may also occur when the physician is unaware of appropriate treatment options.

The Australian health system needs as many neuromusculoskeletal health professionals as possible, including osteopaths, to help treat projected increases in the burden of musculoskeletal conditions and chronic pain. Musculoskeletal disorders are estimated to be Australia's most costly health condition in terms of health expenditure, costing over $12.5 billion and accounting for 10.72% of expenditure allocated to disease groups in 2015-16.[x] Having the right workforce in place to meet emerging health challenges is not resolved by simply increasing the number of GPs and practice nurses. PHC is much broader than this, and the role of osteopaths and other allied health professionals in preventive health needs to be acknowledged and supported. Currently there is not an effective system to manage preventive health in the musculoskeletal space, and virtually no funding to support those with musculoskeletal conditions, beyond the chronic and pharmacological aspects. Osteopaths

and other allied health workers could be making a significant impact on reducing hospitalisations in this area. There needs to be a proper assessment of how the whole health workforce, including all types of allied health professionals, can be best utilised. Ideally, there should be an independent agency to oversee this work. Related to this, there needs to be support for conducting systematic allied health specific workforce planning, to ensure that the allied workforce can meet future demands, particularly in rural and remote areas.

While the current COVID-19 pandemic is rightly occupying the Government's attention at the moment, it is worth noting that chronic health conditions are a risk factor for severe COVID-19, and 72.7% of those who died of the coronavirus in Australia up to 31 August 2020 had at least one pre-existing chronic condition listed on their death certificate.[xi] The Australian health system needs to be better equipped to manage the growing burden of chronic diseases in their own right and as risk factors for other diseases. This requires consultation and respectful engagement with all members of the PHC team (including allied health professionals) to establish genuine collaborative care arrangements as part of the necessary multidisciplinary approach to the management of chronic disease.

The *Chronic Diseases in Australia* report[xii] highlights the potential, and as yet underutilised, role of the allied health professions in the management of chronic and long-term conditions. The need for health care to be coordinated, sequenced and connected is critical. There is further evidence specifically supporting the use of inter-professional teams for chronic disease management.[xiii] Osteopathy is the fastest growing allied health profession in Australia[xiv], positioning the profession well to help the health system to cope with the increasing burden of chronic disease.

Osteopathy is playing an increasingly important role in chronic disease management, evidenced by the significant growth in GP-led referrals for osteopathic services since 2012. The data indicate that GPs, who are at the centre of the Medicare Chronic Disease Management (CDM) program, are increasingly trusting osteopaths to deliver clinical appropriate services to the patients they manage. Osteopathy CDM services have increased by 139.2% between 2012 and 2020, as outlined in Table 1 below.

Table 1: Medicare osteopathic services: Item 10966, 2012-2021[xv]

2012/2013	96,312
2013/2014	113,651
2014/2015	134,929
2015/2016	150,520
2016/2017	165,201
2017/2018	192,917
2018/2019	223,063
2019/2020	230,393
2020/May 2021	258,263

The growth in osteopathic CDM consultations is the direct result of increasing referral rates from GPs to osteopaths for their patients, which indicates a growing understanding and recognition of the value of osteopathic care for neuromusculoskeletal chronic conditions. Osteopathy Australia understands that increasing numbers of osteopaths are working in multidisciplinary clinics with GPs and other health professionals, and referral rates from GPs have increased significantly in recent years. In a recent study, 89.3% of respondent osteopaths reported receiving referrals from GPs, and 23.9% reported regularly receiving

patient referrals from medical specialists[xvi]. Increasingly GPs are seeing the utility of having osteopaths work with them to manage CDM patients and strong local working relationships are being developed. Unfortunately, the requirement for the allied health needs of chronic disease patients to be managed through just five appointments across all allied health services in a calendar year limits the impact osteopaths and other allied health professionals could have on the management of chronic disease. There could also be significant savings to primary health if reforms to the MBS were supported to allow allied health professionals to make direct referrals to relevant specialties and to expand their imaging referral rights (see Section 4 below).

3 Rehabilitation, Preventive Health and Prehabilitation

Coordination of health services across the continuum of care is important to ensure a satisfactory patient experience. It is disappointing that there is no specific mention of rehabilitation services in this paper, even though the Alma-Ata Declaration has made it clear that PHC should include rehabilitative services. Provision of effective rehabilitation services requires coordination of a diverse range of health professionals, including allied health professionals. Reforms to the PHC system designed to enable a “one system focus” needs to include strategies to support allied health professionals to deliver care aimed at keeping people well and limiting time spent in hospital.

With the increasing focus on preventive health, improving access to preventive rehabilitation (prehabilitation or “prehab”) within the PHC system also needs to be supported. Prehabilitation focuses on reducing the risk of injury by improving strength, flexibility and motor control in areas most vulnerable to injury. It is also used as a pre-surgical intervention for those requiring operations. Prehabilitation initiatives are important for improving postoperative outcomes and have the potential to significantly reduce the length of hospitalisation, thus reducing direct hospital costs as well as other indirect costs.

Rehabilitation and prehabilitation are both areas where osteopathy can add value, as part of a multidisciplinary team. Osteopathy Australia would welcome the opportunity to contribute to the development of appropriate solutions for effective management of collaborative rehabilitation and prehabilitation services in an integrated care system. Determining appropriate referral pathways in this regard could help improve the efficiency of the health system and lead to better patient experiences if the number of consultations required to access necessary services is reduced.

4 Funding Reform

Funding reform is urgently required to address existing access and equity problems associated with the fee-for-service approach. This issue has been discussed frequently in the past, but to date there has not been enough action from the government to progress these reforms. The fee-for-service approach has particularly adverse impacts on continued and coordinated care for people with chronic and complex health needs. The patient journey for many of these patients is unnecessarily convoluted and costly, given the prohibitive out-of-pocket costs often involved in receiving appropriate ongoing care. Wealthier patients may be able to afford the necessary levels of private health insurance to reduce their out-of-

pocket costs, but this then raises the equity issue. All members of the population need to be able to access quality care for chronic conditions, and with the growing burden of chronic disease in Australia, this issue needs to be addressed as a top priority. Given the access and equity issues plaguing the current health system, truly innovative funding reform is required now. In the interim, however, there are some reforms that could be made to Medicare that could at least enable better access to allied health services.

Medicare reform

Access to allied health services would be significantly strengthened by expanding the number of allied health treatments allowed under CDM plans (MBS items 10950 to 10970) to levels that adequately meet the needs of patients. A total of five sessions across all allied health services in CDM plans is totally inadequate for patients with complex and chronic needs, and this restriction actually sets up allied health treatment plans to fail, which in turn undermines the value of these services. In order to assess the true value of allied health treatments, delivery of the full recommended treatment programme should be supported. Ideally, the number of annual allied health CDM consultations should be increased to whatever number is considered appropriate by an inter-professional CDM care team to increase the quality and continuity of care for complex patients.

Funding reforms should also ensure that an appropriate claimable amount is included in MBS items for allied health participation in case conferencing to support multidisciplinary care. This should apply regardless of whether the multidisciplinary care is GP-led or not. Osteopaths and other allied health professionals should be granted new MBS items for attendance at case conferences and for involvement in team care arrangements, in the same way that GPs are remunerated under items 735, 737 and 739, so that current inequities in remunerated time are addressed.

Research has demonstrated that telehealth consultations can be effective in the management of chronic musculoskeletal conditions (including exercise programs) and dietary/ lifestyle advice.[xvii] [xviii] [xix] Osteopathy Australia believes telehealth should be approved as an alternative to face to face for osteopathic consultations wherever direct patient contact is not required (e.g. involving exercise prescription follow up). At a minimum, this option should be available for patients living in regional and remote areas, where travel costs to access appropriate services can be prohibitive.

Osteopathy Australia believes there is also an urgent need to consider alternatives to traditional referral pathways in the interests of both the patient and for the cost-effectiveness of the MBS. There are a number of small adjustments that could be made to MBS items in order to enhance inter-professional collaborative practice and improve the efficiency of the health system. For example, significant efficiencies could be achieved by allowing osteopaths to make clinically appropriate imaging referrals, within their scope of practice. There is also an argument for allowing osteopaths to make direct referrals to musculoskeletal specialists such as orthopaedic surgeons in the case of acute or serious injury, where there are clear signs of nerve pain or damage, or where the clinician suspects serious pathology of the neuromusculoskeletal system. A change to the MBS requirement for a GP referral would allow allied health professionals to directly refer to the most suitable medical practitioner (e.g. orthopaedic surgeons, rheumatologists, sports physicians) and would be safe, cost effective and reduce red tape for patients, allied health professionals and GPs. This would allow allied health practitioners to have similar rights as optometrists,

dentists, midwives and nurse practitioners, who can each refer within their sphere of expertise.

There is a need to ensure that consumers are better able to navigate the health system. Allowing allied health professionals to make direct referrals to appropriate medical specialists (while keeping GPs informed of treatment) would be one way of reducing the complexity of the health system and improving the patient experience. This approach would also have the advantage of relieving GPs of some of the administrative burden associated with being the central coordinators of care. GPs should rightly be informed about their patient's care across primary, tertiary and social care settings, but there is no need for GPs to be involved in facilitating access to each required service if there is professional respect between members of the collaborative health care team. The patient experience of the "one system of health care" would also be enhanced by seeing that health professionals trust each other and are working together in a cooperative manner to deliver patient-centred care.

In summary, with regard to Medicare reforms, Osteopathy Australia recommends that:

1 The Government provides the means to conduct trials of alternative funding mechanisms for allied health Medicare CDM services. This may include:
   i) A Medicare version of the Department of Veterans Affairs Allied Health Treatment Cycle
   ii) A model where flexibility is maintained such as 5 + 5/ 7 visits, where the additional 5/7 are allocated after consultation between the allied health provider and the GP.

2 Telehealth arrangements introduced during the COVID-19 pandemic be adopted as a permanent option – i.e. continue to fund Medicare Chronic Disease Management telehealth items 93000, 93013, 93048 and 93061.

3 The Government makes funding available to add an allied health case conferencing item to the MBS, in line with GP case conferencing items, so that current inequities in remunerated time are addressed.

4 Initial assessment appointments of more than 40 minutes be introduced for allied health professional services under CDM referrals. This should be funded at an appropriate increment above the standard fee – e.g. 20-30%.

5 The Government provides direct project funding to Medicare to study the cost/ benefit of direct referral from allied health practitioners to appropriate medical specialists.

6 Medicare recognises Osteopath referral rights for MBS Items 55802, 55806, 55810, 55814, 55818, 55822, 55826, 55834, 55838, 55842.

7 A feasibility study be undertaken to determine appropriate referral pathways for a limited range of musculoskeletal MRI for osteopaths.

5 Comments on Selected Recommendations

1.3.5: PHN capability and accountability AND 9.2.6: Utilise existing structures

PHNs have been funded to achieve many of the objectives discussed in the paper, so a review of their effectiveness more broadly would be useful to identify what reforms are necessary. Findings from any existing reviews or evaluations of PHN programs should be applied across all PHNS to ensure consistency nationally. It would also be worth exploring strategies for better integration of allied health professionals within PHNs. The governance arrangements in PHNs should also be reviewed, particularly if the PHNs are to take on a more active role in relation to allied health services, as governance arrangements would need to reflect this and include allied health representation at both the Board level and on clinical committees.

3.2.4: Private Health Insurance

Osteopathy Australia is supportive of this recommendation, but we have some concerns about how the term “evidence based” primary care could be applied to exclude some services. For example, many health funds have taken the view that some professions have an evidence based justification for providing some services via telehealth where others do not. In the musculoskeletal health space, a physiotherapist can provide a rebated service with most funds, for example, by providing exercise advice for injury rehabilitation. Osteopaths have been excluded, even though the musculoskeletal conditions are within the scope of practice, the intervention is exactly the same, and the outcome is the same. This is not equitable and restricts patient choice. It distorts the market and allows consumers to select health care based on rebates and not on quality of care.

Osteopathy Australia also believes there is a need for a broader review of the private health insurance industry and its sustainability. This review could form part of the Primary Care 10 Year Plan work and could be part of a broader strategic review of private health effectiveness, regulation and sustainability. In particular, we believe preferred provider schemes are anti-competitive, and that an investigation of the impact of these schemes on competition and consumer choice should be included in such a review.

The primary concern for Osteopathy Australia in this industry is preferred provider schemes. While preferred provider schemes may appear to be more affordable for customers, they may not be once the relationship between premiums, rebates and out of pocket costs is examined. Another risk is that they distort local markets for allied health services. Small professions like osteopathy are excluded because there is no business case for the health funds to set them up. Therefore, customers are led to the big professions where the allied health professionals can provide the service, but usually at a much lower fee than they can charge otherwise. It could also be argued that “preferred providers” creates a misleading impression to consumers that they are clinically of higher quality than non-preferred providers, when the central mechanism at work is cost. Often these schemes actually lead to a diminished quality of care. When there are a significant number of patients paying a discounted fee, it becomes unsustainable for an allied health service to provide adequate

length consultations with experienced staff, so this generally results in shorter appointment times being offered and/or more junior staff being utilised in preferred provider schemes.

11.1.1: Case conferencing

Osteopathy Australia fully supports this recommendation and believes equity should be promoted in case conferencing remuneration for all health practitioners involved in the process. Osteopaths are often called upon to be part of the case conferencing process for CDM patient management; however, they are not remunerated for their time at all. This prevents the health sector from functioning in a collaborative and inter-professional way, and thereby reduces opportunities to communicate effectively, share work, and prevent the further physical, mental and functional decline of individuals, groups and communities. The system also undervalues the current and potential role that osteopaths and other allied health professions play in health care.

As the care of people with complex needs is increasingly delegated to the private sector, with people providing different aspects of that care through disparate channels, there is a risk that the client will experience dislocation and sub-optimal outcomes. It is therefore vital to support mechanisms that increase and maintain cohesion, with case conferencing being crucial to this process.

11.1.2: MBS Review Taskforce

Osteopathy Australia would like to express our disappointment in the MBS Review Taskforce response to the Allied Health Reference Group (AHRG) report, which stated that many of the recommendations made by AHRG were either outside the Taskforce's remit or that "further research" would be required. Many of the issues raised by the AHRG have been raised many times in the past. We believe it is important to take action now on several issues that would contribute to ensuring equitable support for allied health practitioners to contribute maximum value to the delivery of essential care and support, as valued members of the PHC team.

The MBS needs to adapt to the increased burden of chronic disease and changing patient needs. The small changes to Medicare suggested earlier will not solve the broader problem of inadequate funding mechanisms to support the utilisation of allied health services, which is required as part of necessary multidisciplinary care arrangements to address the chronic and complex needs of patients. However, it would be worth implementing these changes as an interim measure while more effective and flexible mechanisms are being developed. It might also be seen as a gesture of respect to the allied health workforce, signalling a culture shift and genuine commitment toward establishing inter-professional cooperation in the interests of patient needs.

11.2: Digital infrastructure AND 15.1: Interoperable infrastructure

Osteopathy Australia supports this recommendation, and believes as a matter of urgency that allied health professionals need to be given full access to MyHealthRecord (MyHR) in order to function effectively as part of the health care team. There have been considerable delays with providing this access – over a decade of promises with no implementation. This has caused a number of problems for allied health professionals working in the aged care sector in particular, as they need access to the digital software to function properly in the multidisciplinary team. The technology already exists to allow allied health professionals to be able to have input into MyHR. Consumers can access and edit their own record, so why

can’t allied health have access to the editing function? It is hoped that the Implementation Action Plan will include clear timelines for providing allied health professionals with access to digital health infrastructure.

11.3: Data

Osteopathy Australia supports this recommendation and has long argued for investment in datasets for non-government primary cares services to help with service and workforce planning, and also to stimulate research. There is a need for a complete overhaul of the Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes as the data collected and published on health professions from the last census demonstrated that use of the ANZSCO data is misleading and inaccurate. For example, the osteopathy data published by ABS accounted for only half the known osteopaths, as published on the extremely accurate AHPRA register. The use of ANZSCO codes for workforce planning is therefore completely inappropriate.

11.7: Research and translation AND 18: Research

Funding for translational research focused on allied health interventions would help level the playing field among health professionals and allow allied health professionals to more actively contribute to the sharing of knowledge with the PHC team to improve quality of care for patients. Funding pools available to allied health researchers through bodies including the National Health and Medical Research Council and PHNs should be increased, and the criteria for accessing funding should be equitable for all allied health professionals.

There is a strong and growing evidence base for the primary interventions (manual therapy, exercise prescription, needling, health promotion and patient education) used in the management of CDM patients by osteopaths and other allied health professionals. These interventions have often been shown to be at least as effective as some orthopaedic surgical options and at a fraction of the cost, but these interventions have not been funded or supported. We would very much welcome dedicated primary care research funding for musculoskeletal health, given that musculoskeletal conditions is the leading cause of disability globally.

Research into primary care interventions could also be aimed at prevention of hospital emergency department presentation, or ward admission and/ or readmission. We already know that rehabilitation is often a much better alternative than knee arthroscopy or spinal fusion surgery, which cost far more than a program of physical rehabilitation. The benefits of prehabilitation could also be examined in a program of research into how primary care and conservative management of musculoskeletal conditions can positively impact on hospital costs. There should also be a commitment to implementing the findings of such research if it shows significant cost savings for the hospital system.

20: Implementation

In order to ensure all stakeholders are engaged throughout implementation, evaluation and refinement of PHC reform, we believe stakeholders, including allied health peak bodies, should be able to provide feedback on the Implementation Action Plan when developed.

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