RURAL ALLIED HEALTH

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Submission by OSTEOPATHY AUSTRALIA

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1 INTRODUCTION

Osteopathy Australia welcomes the opportunity to provide a submission to the National Rural Health Commissioner about rural allied health. We strongly support the commitment of the government to invest in allied health in rural areas and a number of the ideas discussed in the report have merit. Whilst we have cast a critical eye over some of the proposed policy options, we hope the government continues to share ideas so that we can all work towards the same goal – better health for rural Australians. We welcome further engagement as this process evolves from policy options to reality.

Osteopathy is one of the fastest growing health professions in Australia.[i] The health system needs osteopaths to play a key role in dealing with the burden of disease forecasts for musculoskeletal conditions. For example, about 4 million people are estimated to have back problems.[ii] A number of studies have noted a significant projected increase in the burden of chronic disease, particularly with regard to musculoskeletal conditions. [iii] [iv] [v] The prevalence of chronic pain is projected to increase as Australia's population ages – from around 3.2 million in 2007 to 5 million by 2050[vi]. 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.[vii]

Osteopaths in Australia are government regulated, university qualified allied health professionals. They complete a dual Bachelor or Bachelor/ Masters qualification covering functional anatomy, biomechanics, human movement, the musculoskeletal and neurological systems as well as associated evidence informed intervention approaches.

Osteopathy is playing an increasingly important role in chronic disease management. Since 2012, Medicare Chronic Disease Management osteopathic services have increased by 132%.

Table 3: Medicare osteopathic services: Item 10966, 2012-2019[viii]

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

As a defining characteristic, the osteopathic profession emphasises the neuromusculoskeletal system as integral to the body's function, a person's health and to patient care, and uses biopsychosocial and patient centred approaches to help patients manage their condition. Patients present to osteopaths with a range of musculoskeletal conditions, most commonly neck and back pain but also: hip, shoulder and limb pain; fibromyalgia, radicular pain and other neuropathic pain conditions; joint pain; headaches and migraines; postural disorders, degenerative spine conditions; and for many other chronic/ persistent pain issues.

Osteopaths conduct comprehensive physical examinations. They provide orthopaedic, biomechanical, movement, neurological and anatomical assessments. Evidence informed

reasoning is fundamental to diagnosis, treatment and case management. In terms of the techniques used to assist in clinical diagnosis, orthopaedic testing (97.6%) and neurological testing (92.5%) are the most frequent options reported amongst the osteopaths[ix].

Patients also consult osteopaths for treatment and clinical management. Patients most commonly see osteopaths for manual therapy. Manual therapy involves skilled 'hands-on' treatment provided by an osteopath. The term defines a very wide range of 'hands-on' techniques. Manual therapies are used to wherever possible:

- Improve tissue extension
- Increase range of motion in joints
- Reduce soft tissue swelling or tension,
- Reduce joint inflammation or swelling
- Improve or manage movement restrictions
- Change muscle function; and
- Manage pain

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.[x] [xi] [xii] [xiii] [xiv] [xv] [xvi] [xvii]

Osteopaths in Australia prescribe physical exercises and lifestyle advice so that patients can become empowered in managing their neuromusculoskeletal health outside formal practice settings. The driving consideration in osteopathic treatment planning is patient need and anticipated patient benefit.

Exercise prescription in chronic management has multiple conferred benefits. A review by Pedersen et al found reliable evidence for prescribing exercise in the treatment of 26 different chronic diseases[xviii]. 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. [xix] [xx] [xxi] [xxii] [xxiii] [xxiv] [xxv] [xxvi] [xxvii] [xxviii] [xxix] [xxx]

Osteopaths recognise that whilst there may well be a neuromusculoskeletal component in many patient presentations, osteopathic care may not be indicated or the principal modality in all cases. If the osteopath considers that a patient's needs are best met by other healthcare service providers, an appropriate referral is made.

We welcome any opportunity to work with you on rural workforce issues, as it is a strategic priority for us. Please contact Nicholas Bradshaw, Deputy CEO, if you have any questions about this submission or for any further opportunities to engage: nbradshaw@osteopathy.org.au or (02) 9410 0099.

2 CONSULTATION QUESTIONS

QUESTION 1.1.a

Some priorities for a Chief Allied Health Officer could include the following. Note, however, that the Chief Allied Health Officer would need some supporting funding and policy/ project support to initiate work in many of these areas:

Advocate for expanded access for rural patients to Medicare funding for allied health services. If Medicare continues to be viewed as largely a medical pool of funding, then alternative funding options should be investigated and discussed with the government. In this regard, some of the recommendations of the Allied Health Reference Group to the MBS Review may be useful for consideration, although they are generally pitched at a high level.

Spread quality information about the options available for rural patients – e.g. for many musculoskeletal problems a patient may choose to use the public or private sector, and could decide between an osteopath, physiotherapist and a chiropractor. Empowering rural communities to be aware of their options and to make informed decisions across both the public and private sector could be a longer-term goal.

Identify and/ or build support structures for rural health practitioners. We note the promising work of the Rural Doctors Network in this regard, which the Chief Allied Health Officer could help to promote.

Advocate for government funding to research and trial alternative models of care – e.g. a non-fee for service model for patients with chronic disease.

Advocate for non-medical/ surgical, non-pharmaceutical approaches to clinical care, e.g. pain management.

QUESTION 1.1.b

The CAHO could potentially act as a useful conduit between the public and private sectors, and advocate for the effective use of allied health professionals in the public system, private hospitals and with the private health insurance industry.

In order to be most effective, the CAHO would need to have some influence outside health, perhaps within the office of Prime Minister and Cabinet, so that the CAHO has knowledge and input of related portfolios such as health, NDIS, and aged care.

QUESTION 1.2a

Osteopathy Australia supports any effort to assist allied health professions to promote and support rural practice, and we generally support the concept of an entity of sorts providing some input into the training of rural generalist allied health practitioners. However, we do not support the College concept unless its role relative to existing organisations was very clearly defined.

The problem with a College approach is the challenge of bringing together a large number of disparate professions with different teaching, training and postgraduate support requirements.

The medical profession, whilst diverse, has consistent basic medical degree and early career PGY1 and 2 training, before doctors branch out into specialist training. Overseeing specialist curricula and the accreditation of hospitals/ training sites to deliver registrar training is different but is still recognisable across specialties. A college like the RACP has significant governance and support problems dealing with more than 20 different specialties even though at some levels the specialties could share administrative functions. How would an allied health college avoid similar problems?

Another challenge is that of duplication – would a college supplant, complement or duplicate the functions of those professional associations who provide accreditation, training or CPD services?

QUESTION 1.2b

It would be preferable to work with peak bodies to consider how a CAHO could complement or support what already exists. This would take some preliminary work to map out what each peak body does and how a centralised office could assist.

One possibility is to help coordinate rural clinical placements in the private sector by acting as a link between education providers, the public hospital system and rural private practices. However, this may be too complex across professions too, but worth investigating.

QUESTION 1.2c

Some suggestions:

- % graduates employed in rural areas 1,2,3 etc years after graduation
- There may be some qualitative or quantitative indicators around adherence of rural practices/ hospitals to a set of accreditation standards.

QUESTION 1.3.a

The main challenges with building and maintaining a unique dataset are the cost involved in setup and administration, and also the timeframe involved, unless it was being administered by an existing unit. At face value it would seem more time and cost effective to leverage existing datasets, such as a segmentation of AHPRA registrant data, and then identify any gaps in that data that further work could focus on.

QUESTION 1.3.b

AHPRA collects a wealth of data on registration, including “primary place of practice”. Segmenting this data based on the postcode of this variable, and coding this field to the Modified Monash model, could provide a good starting point. In fact, knowing that this data exists in a government agency already seems to suggest that a lot of effort and cost could be avoided by expanding the use of this dataset to assist in rural workforce planning. There

is plenty of software that can analyse such datasets and identify issues like coverage of health practitioners in certain areas.

Admittedly, AHPRA data do not include non-registered professions but it would be a great start!

Another potential source could be Medicare data. We acknowledge that there are often issues with the Medicare, but there is a huge amount of location specific service data that could be mined.

QUESTION 2.1.a

Before looking at quotas, we would need to look at medical training outcomes data and see if it works there. One encouraging study suggests that 74-91% of rural origin/ rural training medical graduates remain in rural areas during their first five years after completing training[xxxi], although it does not specifically mention whether the rural origin students were part of a quota system. Any quotas may also need to be backed up by an expansion of rural training opportunities which, across a large number of allied health professions, would cost the government a lot of money in addition to that already invested in medical workforce. Osteopathy Australia would welcome an expression of support from the government towards such a significant commitment.

QUESTION 2.1.b

The question would require a large amount of analysis across the allied health professions prior to any quotas being established. Some major considerations might be:

- The presence of a viable professional community in a rural centre earmarked as a potential rural training location. This means faculty (though some presumably can move there) and also those providing clinical supervision on training placements in local private practices. Professions which have some degree of crossover could learn in multidisciplinary environments – such as anatomy for medical, physiotherapy and osteopathy. Indeed, there are osteopaths who teach (or have taught) medical school anatomy at some medical schools.
- The infrastructure available. Though many allied health (or health more broadly) courses could share infrastructure and even faculty (as above), limits to residential school students would need to be considered depending on space available – i.e. quotas need to consider what the capacity of rural centres is to train. There are some large programs in allied health where capacity could be stretched if a 20-25% quota were established – e.g. there were 8,472 physiotherapy students and 8,079 occupational therapy students in 2017/18.[xxxii]
- Accommodation availability/ support for students if they are unable to train near home.

QUESTION 2.1.c

CAHO would need to consider whether any of the medical options have worked to any degree of success:

- Return of service obligations – hard to establish (essentially a contract for training etc) and difficult to monitor. Would it relate to HECS loans being payable/ non-payable for rural service or some other parameters? What would be the penalty for non-compliance?
- Rural incentives, but opening this to a huge number of allied health professionals would probably not be affordable, and we are not convinced they would work. Anecdotally, many of those accepted rural incentives are not working in rural areas because of the incentive – they would have worked there anyway.

QUESTION 2.2.a

We recommend that CAHO examine any pilot programs that may have worked or shown promise, and explore ways of supporting them further. We suggest that you contact Indigenous Allied Health Australia for comment.

QUESTION 2.2.b

Nil comment.

QUESTION 3.1.a

Some considerations may include:

- Quality faculty – recruitment and retention
- Accommodation support – how would an urban student in Melbourne be able to afford the additional expense of transport, accommodation and related expenses if they had to relocate for up to a year.
- Clinical supervision and placements – are there enough placements and are the supervisors comfortable enough with their role? What support would supervisors have from local faculty and/ or the main city campus? At what stage in training is it feasible to send students off the main campus to a rural training rotation?
- Is there a business case for the universities? What would be the break even point for each profession (this could vary)?
- Full course training would require a few years' lead in time in order to consider and fulfil course accreditation requirements

QUESTION 3.1.b

Nil Comment.

QUESTION 3.1.c

Support the development of profession-specific business cases to present to universities who may be well placed to deliver rural training for one or more allied health professions.

They need to know that the numbers stack up before they commit their own resources to the development of infrastructure, teaching faculty and accredited training.

QUESTION 3.2.a

Nil comment.

QUESTION 3.2.b

Nil comment.

QUESTION 3.2.c

As few osteopaths work in public hospital settings we would be interested to discuss governance options for how a public/ private model might work. Perhaps the NSW Health Rural Generalist medical model could be of assistance, where private practice GPs are trained in hospitals in procedural or emergency skills.

At this stage we support further exploratory work on whether such a model might work – for instance there may be scope to explore additional training for musculoskeletal practitioners. Many treatment techniques, such as manual therapy or exercise prescription, are shared across professions, but there may be scope for an osteopath to learn more about public sector post-surgical treatment protocols so that they could provide services to a rural public hospital in an area where physios are in short supply.

QUESTION 4.1.a

We support the concept of Integrated Allied Health Hubs. Some factors that would be critical to the success of the scheme could be:

- A receptive PHN
- Supportive local hospital district (such as LHD in NSW)
- Determining what the appropriate population catchment could or should be
- Local studies to determine workforce supply and demand factors across public and private healthcare
- Defining “allied health” for the purposes of the program – e.g. registered allied health professions plus all/some/ none of the self-regulating professions. This might change a little depending on the local supply and demand analysis
- A pilot program considering the above

QUESTION 4.1.b

Nil comment

QUESTION 4.1.c

Nil comment

QUESTION 4.1.d

Allied health assistants may be great for some professions, but we caution against the widespread use of AHA's in rural areas without assurances about appropriate supervisory arrangements, and clarity around delegated responsibilities.

We think that there are thousands of fully qualified allied health professionals who may not be being used by the health system to the capacity of their ability to contribute to primary care. This includes hospital and, in particular, community care. Allied health is marginalised in Medicare and restricted to a handful of items for a handful of consultations per year. Some professions have limited access to the NDIS.

We recommend further work to help bring professional groups together in rural areas so that referring GPS, for instance, know who is available and what they do. For example, many doctors may not be aware that exercise prescription is a significant part of osteopathic care. Note in particular the excellent early work being done by the NSW Rural Doctors Network to link professionals in rural areas through Rural Health Pro.

QUESTION 4.2.a

We support the proposition that MMM4-7 patients could be exempted from the Medicare CDM limit of 5 visits. However perhaps this is an opportunity to look beyond Medicare as a funding model, and research and trial innovative ways to manage chronically ill patients.

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