RESPONSE TO PRODUCTIVITY COMMISSION'S POSITION PAPER ON AUSTRALIA'S HEALTH WORKFORCE

Chiropractors' Association of Australia (National) Limited

This paper is a response to the Productivity Commission's Position Paper on *'Australia's Health Workforce'* Study by the Chiropractors' Association of Australia.

We welcome the position paper and the opportunity to comment on the proposals. The federal health bureaucracy has historically been an importer of productive policy ideas rather than an innovative producer of them. It is good to see the federal health bureaucracy taking the lead in cutting an innovative path to produce a new era of health policy.

Our comments are directed at arguing for a need to shift the health system policy compass away from hospitals to primary health care (to put the primary care horse in front of the hospital cart); to highlight different pathways of primary health care (GP and wellness); and to indicate the significance of the wellness pathway for health care reform.

In the conclusion we briefly raise an issue that is not addressed by the Commission's Position Paper:—the need for a strong regulator to police and penalize the trenchant anti-competitive behaviour of the dominant medical players. Without such a regulator we will not a competitive market.

The need for reform

We are in basic agreement with the Productivity Commission's case that, though Australia has a good health care system in terms of international standards, reform of our health care system is needed.

The delivery of health care in Australia is a tangle of public and private health systems that has been, and still is, marked by conflict, bickering and wrangling between the federal and state governments, between the health care professional and government, and between the various professions that deliver health care/treatment of disease. The health system is marked by a variety of pressure points such as: rising health costs; poor management and increasing inequity of access due to less comparability in the quality and availability of care for the rich and poor; and built on provider demarcations rather than patient and consumer needs.

Unfortunately reform to the health system lags behind that of the economy, universities, waterfront and industrial relations. It is the Australian consumer who suffers from the bickering and wrangling around "patch protection". The consequence has been poor health outcomes for many groups and difficulties in accessing services.

Most of what has passed as reform has been a tweaking and fiddling around restrictive trade practices which are designed to protect market share or privileged positions, which has little to do with the health needs of patients and consumers. There is little concern or commitment for root and branch reform, even though health workforce reform is essential, due to the boxes, silos and fortresses that are everywhere in the health system. If the health system is to work effectively and efficiently in the 21st century, then the traditional roles of medical practitioner, nurse and allied health care professionals need to be redesigned around patient and consumer needs, and more appropriate, efficient, cost effective and safer health care workforce resources.

All of this is widely acknowledged across the health system. Yet little has been done to break down the old 20th century boundaries to establish new ways of working through upskilling and multiskilling. Powerful sectional interests associated with allopathic medical and surgical thinking and dominance still call the policy shots, resist change initiated by the federal government, and seek to contain the non-medical allied health professionals.

So we welcome the intervention by the Productivity Commission and its acknowledgement that the pressing need to improve the practices of the health workforce reform need to be situated within broader health policy reform. We concur with the Commission's position that in the health work force study there is a need to identify mechanisms to promote health work force arrangements which:

- maximize the contribution and efficiency of the available health work-force at any point in time, and help reduce its mal-distribution; and
- are able to respond effectively, efficiently and in a timely manner to changing needs and pressures.

However, we do have some reservations with the broad policy framework the Productivity Commission accepts, and works within. Though Treasury has sketched a long-term assessment of the resources required to fund the health service in Australia over the next two decades, there is no modeling of different health scenarios. The indications are that consumers are expecting more choice in the future, higher quality health care across the whole of health service, a more patient/consumer centred service, and better information to allow them to take ownership of their health. This implies major changes in skill mix and the ways in which professionals work in the health service, including an enhanced role for primary health care.

The shift in focus to primary care is not about a single program that can be designed, developed and implemented. It is about a fundamental change across the entire health system in the sense of transforming the way that the health care system and the current disease treatment approach works today. It means shifting the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that exist between health care providers and putting the focus on consistent efforts to prevent illness and injury, and to improving health.

This means making primary health care the central point of our health care system. Australia currently spends very little of its health care budget on primary health care (less than 2% according the Australian Institute of Health and Welfare on public health) that is aimed at preventing illness. It also means thinking through the nature of primary health care and the way it has been conceptualized in terms of medical dominance and biomedicine.

Making the shift to primary health care

The broad health policy framework has been outlined by the Federal Treasury and developed by the Productivity Commission, and it is based on their demographic understanding of the future economic development of our health system over the next couple of decades.

This framework was mapped out in Treasury's *The Intergenerational Report 2002-2003*. This is an example of good long term policy and population planning by Treasury. In this *Report* it is stated that:

> "The overarching objective of the Government's economic policy is to improve the wellbeing of Australians in a way that can be sustained over time. This is related to both the current generation of Australians and future generations. The Government's policy framework aims to ensure that economic, social and environmental policies complement each other to bring about sustainable improvements in wellbeing." (p.13.)

We agree that the end result of public policy should be the wellbeing of the Australian population. The government has a responsibility to address the drivers of the projected budget blowout caused by rising public hospital costs, the escalating costs of drugs on the PBS and the significant costs of diagnostic imaging and pathology services**.**

The basic reason for this claim is that health is important for the economy. In the Winter 2005 issue of Treasury's *'Economic Roundup'* Janine Murphy usefully spells out the relationships between health, wellbeing and workforce participation:

> "Health is among the most important contributors to the wellbeing of the Australian people. Good health provides the capability to undertake employment, engage with friends, family and society more generally and enjoy recreational opportunities. Good health extends the expected length of life available, making new long-term goals achievable and long-term investments desirable, and reduces uncertainty."

Consequently, from a population perspective, poor or deteriorating health has a negative effect on workforce participation and productivity, especially within older age groups. Chronic health problems (cancer, neuro-musculo-skeletal disorders, diabetes

and depression and cardiac conditions) greatly interfere with the development and maintenance of a healthy and productive workforce.

As the Job Network Disability Support Pension Pilot Project in 2003-2004 indicated good health is a key in the welfare to work reform. This pilot was based on intensive training to reskill the long term unemployed who wanted to work in the form of intensive support customized assistance, but it found that 36% were placed in employment. What was disclosed was that 25-35% of the unemployed in the project could only get jobs if their bodies are not suffering from chronic pain and disability caused by neuro-musculoskeletal disorders. Yet little consideration was given in the pilot to a cost effective way of addressing neuro-musculoskeletal disorders or psychological disorders (35% of those in the pilot project) in the proposed work to welfare reforms.

We concur with the argument that there are other increasing pressures on the medical system. It is probable that demographics of an ageing population are not the main driver of health care cost and reform. Changing health needs and demands of the population, technological developments and medical advance, the widespread use of expensive "lifestyle" drugs, the inevitable costs of the side effects of allopathy and surgery, the current health care system and the use of the workforce and productivity are also drivers of increased pressure on the medical system.

The Productivity Commission in *its 'Impacts of Medical Technology in Australia'* Report identifies and highlights some of these diverse drivers. This Report argues that advances in medical technology are a major driver of increased private and public expenditure; that it is economically unsustainable to continue to use advances in medical technology as the principal way to improve health; and that some rationing will be required as the costs of medical technology per head of population are becoming too great.

We agree with Treasury's decision to tackle the problem of rising health costs through a series of small steps over the next decade. Good governance requires that the problem (federal budget blow out) is identified, the causes of the problem (rising future health care costs) are delineated, and steps are taken to deal with causes and not the symptoms of the problem.

However, we have two major reservations about this policy framework. The first can be sketched in terms of the following hypothetical policy scenario. Treasury's projected budget blowout, due to rising costs for health care of an ageing Australia, may well mean that economic or fiscal sustainability will be given greater priority than the wellbeing of the population. If fiscal sustainability becomes the overriding goal, then that may mean that the policy end of wellbeing is reduced to economic prosperity, and the economic policy goal of wellbeing (a healthier population) is thereby displaced. The danger of this fiscal approach is that the policy pathway to better health outcomes becomes medicine, hospital and PBS focused; and that just reducing costs (albeit in

small steps) becomes the driver of health policy, not primary care and the promotion of wellbeing.

Is this concern, that better economic outcomes and not health outcomes will become the pathway adopted a reasonable one? There are some early indications that the focus on economics has begun to displace better health outcomes into the background.

The emphasis in the Productivity Commission's recent '*Economic Implications of an Ageing Australia',* which looked at Australia's demographic transition to older population, is on escalating health costs on the grounds that sickness and disability rises with age. Its scenario is one of illness, the costs of hospital care and drugs skyrocketing, and increasingly bigger pressures on the health system from burgeoning health care costs. It is held that better health (well being) amongst the wealthy will not reduce expenditure; nor will burgeoning costs be lessened by a shift in service care from residential to community care.

The '*Economic Implications of an Ageing Australia'* report presents a policy scenario/agenda of substantial fiscal pressures that is addressed by increasing the labour participation rate; discouraging premature retirement and overcoming obstacles to work; and ensuring income gains from higher productivity through policy reform that enables firms to be more efficient and innovative. This creates more wealth and prosperity thereby easing the future burden of the rising costs of the health care system.

Wellbeing understood as a healthier population has slipped into the background in this economic scenario. Yet increased wealth is not identical to wellbeing or better health, as you can be wealthier and sicker. It is our view that the policy focus should also be on the way we provide better health care services as well as on prosperity and GDP. Should not the policy focus be on reforming the health care system to achieve the wellbeing of the population if we are to address the fiscal blowout from rising healthcare costs?

The policy goal should be to achieve a healthy ageing Australia to minimizing chronic illness amongst ageing Australians. If this health strategy is to be adopted to complement the economic one, then we suggest that the policy aim should be to contain and reduce health care costs over the next 20-30 years as well as to improve health outcomes or wellness through being innovative and clever about preventive health care and health promotion.

The second major reservation with the Treasury/Productivity Commission policy framework is the failure to place an emphasis on primary health care and preventive health care to achieve an increase in the wellbeing of the population and a healthy ageing Australia. Primary care aims to stop people from ending up acutely sick in our hospitals and from needing to take lots of drugs to treat illness. A focus on primary health care would lead to an overall healthier population, and, as people feel and function better, there will be an increase in labour force participation rates and labour

productivity; thereby improving the wellbeing of Australians and putting health care expenditure on a more sustainable path as the population ages.

Our argument is that the over-investment in public hospitals treating emergency/acute sickness and under-investment in primary care and well-being is placing the hospital cart before the primary health care horse. Consequently, the current approach to primary care has a philosophical and therefore an organizational bias towards attempting to combat (and eradicate) disease, rather than the enhancement of wellness: that is, it treats sickness rather than attempting to keep people healthy. Reform of the medical system to achieve better population health outcomes should aim to shift the focus of the health system to primary health care, and to rely more on a conception of primary health care as promotion of wellness rather than the treatment of sickness.

It is true that both the Productivity Commission and the Treasury imply that better preventative health care can reduce future costs, and that this is good public health policy. Yet both the Productivity Commission and the Treasury say very little about what better preventive health care means, or would need to look like over the next decade. The Productivity Commission's Position Paper states:

> The health behaviours of the population are driving some of these changes [towards chronic conditions including an increase in the number of people who are overweight or obese]. Many participants in the study have argued that a stronger emphasis on preventative health care is warranted, not only to improve the health status of Australians, but also as a means of containing the increase in demand for some care services.(p.xxlll)

The Position Paper gives little consideration to the mechanisms or instruments of governance that would shift the focus of the health system to preventative or primary health care that could prevent or delay people from developing acute and chronic illness, or delay their admission into public hospitals and/or being heavily reliant on an expensive drug treatment.

Though this is understandable, because these demographic analyses were undertaken by economists and not health economists, we are still left with the misleading image of the health system being a "cot case" in need of emergency economic surgery undertaken with the sharp knife of fiscal sustainability. This leaves us with a "black box" marked health system. Inside the black box we find an illness–centric model, medical dominance, over-investment in public hospitals, under-investment in primary care and wellbeing, and rigid and antiquated medical workforce boundaries and management that constrain the shift to an emphasis on positive health.

The failure to place an emphasis on better primary health care, as well as on reducing costs through a more flexible healthcare labour market and better coordination across services and jurisdictions, is a serious policy flaw in the Treasury/Productivity Commission's analysis of health care reform. If the aim of the economic approach to health policy is to improve the wellness of Australians through the efficient and

effective delivery of health services without compromising the wellbeing of future generations, then this policy hole should be addressed. It should be treated as a matter of priority.

Pathways of primary health care

Health reform to achieve better primary health care will not flow from the Council of Australian Governments' push for improvement through clarifying the roles and responsibilities between the states and commonwealth, reducing duplication and filling gaps in health services. Nor will it come from throwing buckets of money at the hospital system or from another round of restructuring the state health bureaucracies and making them more regionalized.

These are necessary steps, but they do not address the Australian health care system's strong focus on biomedicine, a reliance on medical practitioners treating health problems as disease; an emphasis on treating the symptoms of illness; the policy priority given to acute sickness in hospitals, the unwarranted patch protection; an extensive use of drugs to treat symptoms, general practitioners acting as the 'gate keepers' to the health system and the economic market distortions ensured by Medicare.

The question that should be asked here is: is whether the traditional approach of medical dominance and its disease conception of health care is the best and most effective way to deal with the future health care problems highlighted in the *Intergenerational Report* and the Productivity Commission's *Health Workforce Position Paper?* Is this the best way to deliver better primary health care?

Research by Starfield and her colleagues show that countries with well developed primary care systems have healthier populations and reduced health care costs. This reform strategy is more cost-effective than treating those who go on to develop disease because it aims to remove or reduce the underlying causes, which make the illness common and therefore expensive to treat.

Australia does understand how to do this. It has begun to put in place a wide range of national illness prevention strategies that aim to build public policy and create supportive environments that enhance the capacity of individuals and communities for physical activity. Its form of medical governance also has a number of instrumentalities that can be used to enable the required shift from an illness model to a wellness model of care and so achieve cost effective wellness. These include:

- a policy emphasis on the diverse pathways of primary health care, so as to prevent or delay people from getting sick and going to hospital, or enabling older Australians to delay the take-up of institutionalized aged care;

- instruments to introduce far more competition into health care industry to reduce monopolies and restrictive trade practices and to remove the constraints on competition and trade union-like closed shops;
- attempts to reduce dependence on drugs and high technology where possible and ways to improve today's health by using today's knowledge, skills and technology;
- a regulatory regime that fosters competition in the health industry to enable different models of primary health care to be created in response to consumer demand, and
- mechanisms to connect the supply of health services more directly to consumer demand.

The key problem is that these instruments are not being pulled together by the federal and state governments to place a focus on the promotion of health and wellness, rather than just on the treatment of disease.

Our clinical experience indicates that consumer demand for the wellness pathway approach to healthcare is happening across Australia. It is most evident in the way people are responding to cancer treatment by seeking out and evaluating complementary medicine. This has given rise to diverse models of primary health care, and these can be in terms of two distinct pathways to primary health care developing.

One pathway is offered by those adhering to the biomedical model with the GP as the entry point or gatekeeper. The traditional GP model of primary health care is one of the solo GP engaged in episodic treatment of whoever turns up at the clinic. This gate-keeping is conceptually attractive as it typically channels access to a variety of diagnostic services and to more expensive specialty care. This model is in transition due to insufficient GP numbers and it is moving to employ a variety of health care providers working as technicians under the GP's direction to complement the GP's traditional drug (allopathic) approach. The transformation involves a shift to a model of group practices in which the GP is 'crossing the boundaries' to work with others in the health system; nurses are upgrading their skills to perform specialist and junior doctor-in-training tasks, whilst allied health professionals are being employed as assistants to the GP. Corporate clinics are developing and 24 hour health services are being developed.

The other pathway is the wellness model of the drug free on-medical allied health professionals, with the entry point a co-operative clinic or network of independent professionals offering a variety of services to treat the whole person. Over the next 10 years the non-medical allied health wellness pathway would be structured in terms of a co-operative clinic offering a wide variety of drug free services—chiropractic, physiotherapy, nutrition and dietary advice, therapeutic massage, podiatry, acupuncture, complementary medicine for cancer, exercise/fitness regimes and mental health and others. The emphasis would be on the diagnosis of levels of wellness by a qualified multi-skilled person who would outline a health plan to enhance wellness. The plan is then delivered by professionally trained, single skill 'practitioners, is case managed,

and its effectiveness evaluated, with linkages and referral to biomedical specialists where necessary, and as required.

The policy aim is not just to achieve a lack of sickness symptoms in an individual body; it also involves the promotion of health to give people the ability and confidence to manage their own health. This wellness pathway would complement rather than replace medical physicians since treatment of established disease will remain a necessity for some people.

This wellness pathway is primarily consumer driven and its consumer shift in primary health care towards a more multi-disciplinary wellness model of care will continue. The consumer shift in primary health care towards a more multi-disciplinary wellness model of care beyond the Community Health Centres means that the non-medical allied health professionals working in the wellness model of primary health care will need to upskill and become multiskilled, more evidenced based, and more research oriented if they are to supply the health services demanded by wellness-oriented consumers.

This development towards a more multidisciplinary model of wellness care primarily arises from the dissatisfactions with, and failure of, the drug-orientated GP model of primary health care. This allopathic approach can deal with illness but it is not its primary focus. Referral to the allopathic, biomedical model comes about because that pathway is temporarily required for a better health outcome for that consumer at that time. The medical policy is to transform the divisions of general practice into division of primary care and to say that the only solution is to train more doctors and to keep those already in the system. The limitations to the policy of centering primary health care on GP's are:

- the current workforce crisis caused by a declining and ageing workforce, which gives rise to an increasing reliance on overseas trained doctors. The reducing supply coupled with an aging population requiring longer consultations probably means that the current primary care model will be unable to maintain high standards of care. Working backwards from the figures from Medicare Australia we can see that for a one minute increase in average consultation there is a requirement for an extra 750 GPs.

- the current system of primary care has limitations in that its allopathic model on which it is based is a treatment one that aims at the treatment of disease, not health enhancement. It relies on people getting sick before treatment – i.e, before attempted disease eradication through medical intervention begins.

- the drug-and-surgery orientated approach to disease treatment creates the possibility of further sickness and resultant morbidity, mortality and costs from the patient's negative reactions to the drugs and surgery

necessitating more interventions, hospitalisation and costs, including taxpayer subsidy of medical professional indemnity insurance.

There is the logic of rising costs and major dissatisfactions by both staff and patient with the present hospital centric system. The Manga Report indicated that *"the major savings from chiropractic management come from fewer and lower costs of auxiliary services, fewer hospitalizations, and a highly significant reduction in chronic problems, as well as in levels and duration of disability"*. However, there are few drivers for the hospital system to engage with primary care and primary care professionals are structurally disconnected from most of the public health system.

Clinical feedback suggests that the wellness pathway to primary health care that is being developed across the nation is in response to consumer demand for a wellness mode of healthcare not dependent on funding from Medicare. This pathway is not a substitute for medical care, as it may well be the case that as wellness care increases so does the more informed use of medical care. Wellness care places great emphasis on consumers being fully aware of and responsible for their health care and is based on widespread access to information through the internet and health care networks

The current instruments of medical governance can be reforged so that their aim is delivering cost efficient and effective primary health care. This means that, if the health system is to work efficiently and effectively in the 21st century, then the traditional hierarchical roles of doctor, nurse and allied health professional need to be redesigned around patient and consumer needs. Cost-effective reform to reduce the gaps is possible because a high proportion of health system resources are currently used to provide services to people with diseases and health conditions that are known to be preventable.

We suggest that the developing, and over-lapping or criss-crossing, pathways of primary health care will slowly loosen the frozen boundaries around the GP and hospital–centric system; ease the historical patch conflicts; and help enable a shift from disease and hospitals to primary care and wellness. This is the direction of health care reform over the next decade, and the instruments of medical governance should be working towards this as a rational way to reduce the budget blow-out from rising public hospital costs and drugs on the PBS.

Integrated reform package

We have highlighted the need to reform the primary health care system and argued that primary health care offers a sustainable approach to the challenges of waiting lists for specialized services and pressures on hospitals. We have also argued that an emphasis on primary health care is crucial to a renewal of health services; and have indicated the need to shift from an expensive, invasive and often iatrogenic drug and surgery based chronic disease management model of primary health care to a wellness one.

The current status of health system reform in the states and territories is one of pressures building for major system change. The issue is not whether primary care is the right approach to take but one of a removing the obstacles and making it happen.

From this perspective of reform of the health care system in Australia we concur with the Productivity Commission's analysis of the systematic impediments to efficient, responsive and sustainable health workforce arrangements. These impediments are: fragmented roles and responsibilities, inadequate coordination mechanisms, inflexible and inconsistent regulation, perverse funding and payments incentives, and entrenched workplace behaviours.

The pressing reform need is to directly tackle impediments to the efficient and effective deployment of available workers because the standards of health care do not currently meet expectations especially in terms of access, waiting times and quality of health care. We concur with the Commission that two reform strategies it identifies are needed: addressing perverse incentives but leaving the subsequent interactions between consumers and health care providers to determine the adjustment process; and a more interventionist approach that employs various strategies and mechanisms to move the system in a specific direction. The mix of both approaches is needed to refocus the health care system from hospitals to primary health care and shift the emphasis of primary health care to wellness.

The reform process up to the present has been undertaken within Treasury's long term assessment of the resources required to fund the health service in Australia over the next two decades. There has not been any economic modeling of the different reform scenarios over a decade or so time frame: tinkering with business as usual; steady progress based on medical dominance; integrative medicine (ie bringing allied health into the GP's clinic); and making a shift to the diverse primary health care pathways including the wellness pathway. Isn't the modeling of these different scenarios the next step for Treasury?

We see the modeling as important because we concur with the Productivity Commission's position that the reform of the health care workforce involves a suite of reforms across a range of areas of health workforce arrangements. We would like to illustrate this in terms of two difficult areas of health ---rural and regional Australia and indigenous Australia.

Rural and Regional Australia

A central concern is the inferior quality of health care services in regional, rural and remote Australia. It is largely the result of the limited access to the inadequate availability of health workforce services for primary health care in these areas. This reduction is understandable given the loss of critical mass in smaller communities; the drift of the population to metropolitan and larger regional centres; and the difficulties in enticing medical practitioners and health care workers from the cities with financial incentives.

It is the shortage of medical practitioners that has been the driver for the introduction of more nurse practitioners in regional Australia, the support given to the GP style primary care by the states and the commonwealth, and the idea of a rural primary care workers operating under the supervision of the GP.

Despite the shortage of almost all types of health professionals in rural and regional Australia, state governments have not ensured that their regional health authorities make the shift to a consumer-focused population health approach, and then give priority to primary health care (including mental health).

We fully support the Commission's judgement that the institutional frameworks of the health care system provide explicit consideration of rural and regional issues.

We fully support the Commission's pathway of improving access to the health work workforce by boosting workforce numbers in the bush through the provision of education and training opportunities in rural and regional Australia. Boosting numbers of health care workers is a medium term solution—5 to 10 years-- and it is not the only option.

If we put the "hub and spokes" GP model of primary health care aside for a moment, what comes into view is a network model of allied health care. It is very simple. If patient X comes to see a chiropractor for a disorder of neuro-musculoskeletal origin but is also depressed, or has a foot problem, a poor diet or needs massage, then the chiropractor treats the neuron-musculoskeletal condition, and refers the patient onto the appropriate allied health professional who treats the other condition(s). And the other allied health professionals would do the same in terms of their referrals.

Hence the network relies on known practitioner contacts, communications to transfer health records and data, and tacit consultations and health plans being put into place through informal discussions. Could not this be made more explicit and developed instead of concentrating on developing a private electronic health system solely based around sharing information amongst GP's.

A strength of the flexible and co operative allied health network model is that it breaks down the tendency towards patch protection that strongly works against the patient's interests. It also makes more efficient use of existing resources on the ground, as well as helping to deliver better health outcomes for patients.

This is not difficult to achieve because the existing resources on the ground are not being utilized. A number of health care professionals, including chiropractors, have been given a good broad undergraduate training that would enable them to work as primary care practitioners. This broad training is not used in the urban corner shop clinic where the emphasis is on limited techniques for specific conditions, but it can be utilized, and fostered, for primary health in rural and regional Australia An example to illustrate the point. . Chiropractors are trained to provide their patients with a broad

range of dietary and lifestyle recommendations, including nutritional advice, the prescription of exercise and even basic counseling strategies. They are well placed to assist in the co-management of the major causes of morbidity and mortality including smoking ,diabetes, obesity and physical inactivity.

The resources are there, but they are not being used because of patch protection, medical dominance and narrow professionalism. There are people working on the ground who would benefit from the Commission's proposal to *'create strong incentives within MBS for the delegation of less complex tasks to suitably skilled, but more cost-effective health workers'* (p. LVI). What we have are broad competencies of a general practice by the qualified health workers in rural and regional Australia.

The work of the health worker in rural and regional Australia is different from those working in the metropolitan centres. The former's practical on the ground job design is more a general design than a specialized one. In rural and regional Australia the professional boundaries are less rigid, the scope of practice is broader, a wider skill set is deployed and there is greater reliance on the exercise of independent judgement and decision making.

The key to achieving better health workforce outcomes through a more efficient use of existing resources on the ground is to recognize, accept and build on the competencies of the allied health primary care practitioner. We can facilitate a more efficient use of the existing resources on the ground to deliver better health outcomes for patients by helping to:

- change the registration and accreditation arrangements so that we can redesign jobs and develop wider scope of practice.
- develop on line courses that refresh the under utilized skills and top up existing skills.
- introduce accountability mechanisms and evidence-based clinical protocols that address the quality and safety issues and help to ensure that the care services that are provided maintain the appropriate levels of quality and safety.
- institute effective programme evaluation and the sharing of learnings.

This allied health network model, which provides a way to supplement the GP conception of primary health care, can ensure that funds to enhance both health workforce and better health outcomes are spent efficiently and effectively. The key is to break the professional silos, and to build an interdisciplinary team approach to treatment, management and communication based on mutual respect of each professional's scope of practice.

This allied health network model of health care is one example of how we can implement the Commission's call for system-wide reform being the central vehicle for pursuing better health workforce outcomes in rural and remote areas.

Indigenous Australians

We concur with the Commission's argument about the 'parlous state of indigenous health'. Aboriginal Australians are more likely to die at a considerably younger age and do suffer more extensive health-related pain and disability than their non-indigenous counterparts. We also agree with the Commission's judgement that the long standing gap in health status with other Australians remains unacceptable.

We concur with Aboriginal and Torres Strait Islander Health Workforce Strategy Framework that the aim of reform should be to build:

> "…a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait peoples…."

We concur with the Commission's view that a greater emphasis on preventative health strategies is especially important to ensure wellness as a healthy state. We would add that the current constraints on the capabilities of indigenous people limit their basic life choices, freedom and wellbeing.

Our argument is that our wellness focus on primary health care is the best approach to build up the capabilities of indigenous people. The wellness pathway is most appropriate here as it fits in with, overlaps, or connects to, indigenous conceptions of healthcare as healing. A wellness conception of primary health care is a culturally appropriate mode, if it provides greater indigenous participation in the health workforce.

A simple example. The Chiropractors' Association of Australia has been involved with an accredited community based and owned sports massage course and clinic in Kempsey, NSW, that has addressed the multiple musculoskeletal conditions that significantly impair the daily activities of the indigenous community. The initial approach by Hands on Health Australia was to conduct an accredited sports massage programme for Aboriginal health workers, as this type of hands on massage approach was deemed to be culturally acceptable to the community. The principles of managing musculoskeletal conditions in general are slowly incorporated into the course that provides accreditation for health workers who can then adapt the skills and knowledge to provide on-site care for people in their community.

This community-based and controlled model of promoting musculoskeletal health can, and is, serving as model of care for other regions. This model, which has been based on building trust over five years of regular contact with community, can be built on by introducing:

- a combination of soft tissue therapy, physiotherapy, chiropractic, and podiatry care by professional practitioners;
- health promotion skills (eg., dietary and lifestyle modifications) to manage co-morbidities including back pain, diabetes, obesity, and smoking cessation

- mentoring and ongoing practical skills training that would upgrade the skills, knowledge and qualifications of the aboriginal health workers to a diploma level

The long term aim is to upgrade the skills, knowledge and qualifications of the aboriginal health workers from diploma to a degree level.

This little model of care breaks new ground as the education modules are developed collaboratively, with local communities. It breaks the paternalism of the top down orthodox medicine by giving the local community a say in designing and managing their own health care. This mode of education delivers onsite, culturally appropriate vocational training, which is what national indigenous health forums have consistently advocated.

The significance of increasing the capabilities of the community is that it enables them to choose a life they value and it breaks with the current approach that supplements income through the welfare system. The welfare approach perpetuates the "incentive" structure that drives indigenous Australians into a poverty trap, and then onto the neglect of their community, family and themselves.

The strength of the capability approach is that it understands that the exercise of choice may be constrained by the range of choices available to people, and that this range of choices is dependent on indigenous capabilities, (or the personal and social resources) that indigenous people can bring to bear on improving their lives. The wellness health care reform pathway can then be expressed as ensuring that indigenous people have the capabilities to choose a healthy life they value. It is not about making choices *for* people, but is rather about expanding the range of choices people have available *to* them.

Addressing Special Needs

Though we have shown how the wellness pathway to primary health care offers an integrated package involving a suite of reforms to the health care system, shifting the focus of a national primary health care strategy to primary health care need not be seen as radical change. Admittedly it does go against the grain of the entrenched practices in the prevailing culture of our health care system; it runs into powerful interests and long–standing privileges; and it does come up against the fragmentation and responsibilities between the many bodies involved in health care.

However, it also offers simple interventions that make a lot of sense because it often highlights what is missing from current policy thinking. In Aged Care for instance, it is argued that recent policy initiatives in the aged care workforce (eg., the Australian Government's *'Investing in Australia's Aged Care: More Places Better Care'*, 2004) will not fully overcome current problems of workforce shortages. Suggestions are: that the shortages of trained nurses will be plugged by unpaid carers, (volunteers?), designating aged care industry as an area of need, and the need to reduce wage differentials.

What also can be addressed is the nature of care offered to the aged: to improve the quality of care - and quality of life - of aged care residents. This does depend on the availability of skilled and appropriately qualified staff, and on good management of the substantial funds provided by residents and their families, and taxpayers.

The quality of life of aged care residents also depends on them continuing to receive better high quality of care they need. This would include lessening the incidence of falls, improved nutrition, moderate exercise and chiropractic care. The aim is to delay the shift from retirement villages to intermediary care and from intermediary care into a complete or full care facility that requires trained nurses. This type of care would help reduce the overall costs of aged care to the tax payer and deliver better health care outcomes for the aged.

Another area of limited intervention is long term unemployed and the welfare to work reforms that aim to increase workforce participation and reduce welfare dependency for key target groups—including single parents, people with a disability, mature age Australians and the very long term unemployed.

The emphasis underlying these reforms is an effective labour market, higher productivity, higher pay workplaces and increased workforce participation. We know that people who are out of work for long periods of time are highly disadvantaged as they have significant obstacles to face to get a job – including the care of children, disabilities, low skills levels, lack of experience and lack of confidence.

The 2005 budget measures do include services to help the long term unemployed into work and new comprehensive work capacity assessment will be introduced to better assess and connect people with services. The services include offering an employer a wage subsidy for up to six months to employ a very long-term unemployed person so they can get work experience, and some vocational training services to increase their skill set. These rehabilitation services are limited, as there are limited places in the Job Network for intensive support and the Job Network Providers are already under-resourced with an allowance of just $900 for training and other assistance for most jobseekers and $1350 for people classified as highly disadvantaged.

These rehabilitation services fail to address the issue of physical disability [eg the neuro-musculoskeletal conditions] that impairs the ability of the long term unemployed to work. A simple health program involving allied health care professionals that was part of an investment in rehabilitation would address this in a cost effective manner.

Neuro-musculoskeletal disorders are a key in the welfare-to-work reform as these disorders do impact on around 30% of the unemployed population. As was noted earlier, the Job Network Disability Support Pension Pilot highlighted how intensive training to reskill the long term unemployed to return them to employment presupposes bodies that are not suffering from chronic pain caused by disorders of neuro-musculoskeletal origins. Yet little consideration was, or is, being given to a cost effective way of addressing musculoskeletal disorders in the welfare-to-work e reform

to facilitate the unemployed's return to the labour market. A simple care program by a chiropractor in association with the Job Network agencies could address this.

These examples show that shifting the focus of a national primary health care strategy to primary health care need not involve radical change. Its strength is that addresses the gaps and silences in current policy, that are sometimes acknowledged, but not then address because of the barriers of departmental boundaries.

Workplace Change and Job Innovation

We have shown the wellness pathway to primary health care does offer an integrated package involving a suite of reforms to the health care system. We would argue that a national primary health care strategy at the CoAG level is necessary, as primary health care goes against the grain of the entrenched practises in the prevailing culture of our health care system, runs into powerful interests and long–standing privileges, comes up against the fragmentation and responsibilities between the many bodies involved in health care.

Given the systematic barriers and impediments encountered by the chiropractic profession and described by the Productivity Commission, then workforce reform should aim to achieve an integrated, collaborative model of primary health care that recognizes the diverse pathways of primary health care, encourages consumer choice and has workforce planning built into it. This necessary reform should involve federal and state government providing support for the transitional costs associated with initiatives to address common barriers to collaborative primary care and to introduce new approaches to primary health care delivery.

We concur with the Commission that this reform should be two-fold: to remove constraints and impediments and initiatives involving work force and job re-design and innovation. The strategic policy reform aim should be to overcome work force shortages by expanding workforce supply to meet consumer demand, to better utilize the already existing on-the-ground allied health care workers, and to create a more modern health care professional.

The better utilization of existing workforce primarily involves removing the impediments to the utilization of market resources, and creating incentives to encourage the health care professionals to work more efficiently, effectively and cooperatively to meet consumer demand and achieve better health outcomes for patients. Our judgement is that the instruments of governance can achieve a more effective utilization of the on-the-ground allied health workers by harnessing competition and market disciplines. This can best be achieved through the development of national competition policy in order to counter the capture of the administration of the reform process by entrenched medical interests.

We concur with the Commission that it is unlikely that the market instruments to more effectively use existing workforce will be insufficient to guarantee the major job innovation required by shifting the focus of the health care system to primary health

care. From this perspective, the shift to primary health care and wellness requires job re-design and innovation to meet consumers' changing health care needs. This change and innovation involving job redesign within the current regime will encounter deep resistance by the medical profession defending its patch. The personal contacts between the health practitioners on the ground are overlaid by antagonism on the part of the AMA to the chiropractic profession and the autonomy of the non-medical professionals.

We support the Commission's proposal for a national health workforce improvement agency *'that would systematically examine major workforce innovation opportunities, particularly those which would cross current professional boundaries'* (p.xxxv). Our reasons are:

- There is no government planning around primary health care in relation to chiropractic care for conditions of neuro-musculoskeletal origin, even though around 30% of the population suffers from back pain at any one time, and this condition impacts on public hospital costs, the disability pension and welfare-to work reform.
- There is no planning and few linkages between the diverse pathways of primary health care, and between care in the different settings of primary, specialist and acute. Connections and collaboration are based on a professional basis rather than on the basis of required skills for treating particular conditions. The linkages are casual and rely on personal contact, rather than being fostered by any planning, coordination or programming.
- The reform focus up to the present has been on isolated, short term experiments in primary health care that are organized around fragmented silos, and are based on who delivers the service and where it is delivered.
- Most reform proposals for primary health care continue to remain focused on the GP as coordinator and gatekeeper, and not on the consumer's needs, nor fostering the diversity of primary health care pathways, or facilitating the capacity of allied health professionals to deliver primary health care. Consequently, the linkages that enable the systematic referral by the GP to the chiropractor and the consumer-driven wellbeing model, are absent.

In arguing for a national health workforce agency the Commission has tended to remain working with the job redesign and innovation within the medical field of the health care system. It has encouraged a shift to the advanced practice nurse role but it has not seriously considered the significant shift to non-medical allied health care. The use of "allied" is a hang-over from the last century. With the burgeoning of non-medical health care professionals the medical world defends its 'patch' by bundling all other health care professions into the "allied" category. The intention is to perpetrate a subservient image so that the medical practitioner can retain the "gate-keeper" role.

The commission has not considered the broadening of the latter's professional roles through an upgrading their basic skills where necessary with postgraduate education so they can conduct illness diagnoses (e.g., obesity) and develop health care plans, counsel on preventative healthcare, order tests and refer to GP' or specialists where necessary.

Yet it is this development that would facilitate a more competitive health market that rewards competition and cooperation between health care providers, create more consumer choice between the different pathways to primary health care, and enable innovation in the development of primary health care.

Education and Training

We concur with the Commission's diagnosis that coordination problems abound in the education of the health care workforce. There are rigidities, fragmentation and disconnections in the funding and delivery of education and training; and there are systematic impediments within health workforce education. If these are not addressed then effective and timely adjustment to the changing needs of health care demands of patients and consumers is unlikely.

Our analysis of primary health care indicates that though Australia needs more non-medical health professionals, the investment to address the shortages has been relatively modest. There are problems in the present and in the future:

- A weak link is the personnel and resources required to establish a substantive postgraduate and clinical research culture. The limited number of graduates undergraduates and rte small number of opportunities limit the number of people taking up this option;
- If undergraduates want to go further to do research at a postgraduate level, the research opportunities are too limited, as all research is self- funded by the profession even on worthwhile pilot projects;
- There is little crossover research as to the different interventions within the two primary care pathways;

A central problem is the need for an upgrade of skills to ensure the wellness clinics have personnel with the appropriate skill mix and the diagnostic skills for prescribing appropriate care in the new wellness clinics. As the university chiropractic courses have not yet consistently incorporated the large body of knowledge related to primary health care, wellness, and health promotion into their clinical training programs so a change in focus at undergraduate and postgraduate level will be necessary over the next decade. The way this is done will be mediated by the universities operating as businesses in an educational market.

One of the responses by the universities to the high cost of allied health undergraduate courses has been to develop the generic undergraduate degree with common programs for allied health care professionals, (e.g., nurses, physiotherapists, podiatrists etc), and additional streams for each of the individual allied health professions. There is further

specialisation (sports medicine, wellness diagnostics, paediatrics, regional & rural health) at a postgraduate level. The generic undergraduate course would provide education in interdisciplinary team dynamics and management, communication skills, goal setting, mutual respect and understanding of other professions and scope of practice. The professions see these generic courses as solving the universities problems through a dumbing-down of the specialised knowledges required by the profession.

The danger for the stand alone professional courses (e.g., chiropractors) is that over the next decade there will not be enough resources allocated by the universities to build the required postgraduate courses onto the undergraduate allied health courses – e.g., those currently run for the chiropractic profession. Some signs indicate an even worse scenario—the closure of some undergraduate allied health courses on the grounds of costs and small markets.

Building a postgraduate culture is needed because the current chiropractic degree is not enough to equip the students for the big shift to specialization, and the diagnostic qualifications required for the wellness model of primary health care. It is not clear that all the universities currently offering these courses will be able to devote the resources to this in the future as the trend is towards a dumbing-down and universities marketing themselves to segments of the education market. Only some universities will specialize in the niche market of allied healthcare at undergraduate and postgraduate levels, and it may be the case that undergraduate and postgraduate courses will be offered by different universities. Since it is likely that the professions and universities cannot afford chairs for the individual professions to help nurture a postgraduate culture, it may be necessary to think in terms of a chair in primary healthcare (community health wellness) as a way to develop the postgraduate research culture that is increasingly needed.

We envision that the on-the-ground shift to the collaborative wellness clinics will be constrained by the capacity of the universities to provide the upskilling and multiskilling required. It will take 6-10 years for the new generic undergraduate courses to be fully up and running, but it is clear that the universities will undertake this. Their preferred option may be to develop a broad Masters Degree in Diagnostics for a wide variety of allied health professionals. In the light of this a short-term or bridging solution would be to provide an interim Diploma program, to plug the gap for those who do not already have these diagnostic skills.

Vocational education and training (VET) is important as it is the educational vehicle to provide additional training to enable the allied health professionals to work more effectively in rural and regional Australia. They would need to be able to access a module in interdisciplinary team dynamics and management, communication skills, goal setting, mutual respect and understanding of other professions and scope of practice.

VET is also important to enable qualified Aboriginal health workers to build on their certificates in medical knowledge by acquiring appropriate allied health knowledge,

initially through intensive short courses in sports massage, to a diploma in allied health care and then onto a degree. These can be seen as levels in a generalized Aboriginal health workers programme provided online, in the community, and grounded in the needs and health practices of the local community. The training would acknowledge and incorporate traditional indigenous approaches and understandings to bush medicine. This "step-by-step" approach would avoid the difficulties associated with Aboriginal health workers needing to leave their local communities to do a 4-5 year degree in a metropolitan city. It acknolwedges, and is sensitive to, their need for respect, hope and motivation. Since they find this to difficult education needs to be bought to them with professionalized knowledges reconfigured as parts of an overall primary health care/indigenous degree customised for the needs of Aboriginal health workers and the health needs of indigenous communities.

Clinical training is a big problem for medical and non-medical healthcare professionals, especially chiropractors as they are denied clinical training in public and private hospitals. This is important because the provision of access to people who would be more appropriately treated by chiropractic is not there due to the lack of medical referrals from GPs and specialists. The study undertaken by Sarnat & Winterstein indicates that utilizing an integrative primary care approach utilizing a variety of therapies improved clinical outcomes and provided substantial cost reductions compared with primary care utilizing conventional medicine alone.

Though many Australians end up in public hospitals with acute back pain, we do not have a neuro-musclo-skeletal condition orientated clinic. The loose cartel between the medical profession and physiotherapists within the hospital system is flawed to the extent that physiotherapists may not always have the most appropriate skill set to treat certain neuro-musculo-skeletal conditions. Chiropractic has consistently been proven to be superior to both. The Meade study, for instance, concluded that low back conditions of neuro-musculoskeletal origin are best managed by a chiropractor, as this delivers better health outcomes. This is another indication that the focus of the reform process on greater co-ordination and cooperation with respect to skills portability and workforce substitution needs to break down patch protection.

Studies by the World Health Organization's Bone and Joint Decade reaffirm early studies that show around 25 to 30% of the population suffers from back pain at any one time and that one in five health consumers had received care from a chiropractor in the past five years. If cost containment is a key focus of the Treasury's Intergenerational Report, then we can address chiropractic care for the management of many low back conditions in addition to a number of other neuro-muscoskeletal conditions, as low back pain disability is a leading cause of disability in middle aged persons and an expensive source of worker's compensation costs. As mentioned before, a number of studies have shown that chiropractic management of low back pain is more effective than medical management.

The clinic patient trajectory is a movement from GP to physiotherapy to emergency departments in public hospitals then to chiropractors as last resort. A good solution

here is a multidisciplinary neuro-musculoskeletal clinic in the public hospital that would quickly and effectively treat these conditions and so help to prevent expensive hospital beds being taken up and lessen the use of anti-inflammatory drugs. And yet this is kind of intervention is effectively blocked by medical dominance. So the chiropractic profession is denied clinical experience they have been trained for and the hospitals continue with their ineffective and inefficient treatments.

The inference of this analysis in the light of the medical dominance is that we do not, and cannot, support the Commission's proposal to make Department of Health and Ageing responsible for the allocation of university–based health care places. The Department is too medically orientated and the shift to allied health would be captured and contained by the medical profession to ensure their dominance. The allocation of university places should be done by the Department of Education Science and Training and the Department of Health and Ageing.

Accreditation and Registration

We support the view that the existing accreditation agencies perform a necessary and worthwhile role. The chiropractic profession, for instance, already has one national accreditation agency, the Council of Chiropractic Education Australasia (CCEA), covering Australia and NZ, with international relationships with the CCE (US), CCE Canada, CCE Europe and CCEI.

However, we do accept that the current profession–based accreditation arrangements. These have given rise to inconsistencies; reinforce workforce rigidities; discourage the exploration of new professional roles and job redesign; and block the efficient and effective deployment of the health workforce. The current profession–based accreditation arrangements have been slow to recognize the value of the knowledge gained by postgraduate work including doctorates. Thirdly, the continual reinforcement of traditional workforce roles also hinder the evolvement of the wellness pathway of primary healthcare in response to consumer needs.

Consequently, we support the Commission's argument for national standards for accreditation and registration as a way to deal with the current fragmented and uncoordinated multiplicity of bodies that reduce workforce flexibility and unwarranted administrative costs. We accept that this is the best way to systematically examine workforce innovation opportunities that cross current professional boundaries. This implication of this movement of health workforce policy away from the current profession-based approach may well mean that the scope of state registration boards will be reduced to administration, oversight of practice and continuing professional development.

Our main concern with the recommended single national accreditation agency is that the interests of the chiropractic profession and other numerically smaller non-medical health care professions would be subjugated to the power and interests of much larger professions such as medicine in such a body. In the position paper the Commission says that national accreditation agency:

> "…should have the power to facilitate education and training changes on its own initiative and to refer proposals with broader implications to the workforce improvement agency and other relevant bodies."(p. 97)

We support this. Consider this scenario. The political interests of radiology might be able to argue that training of chiropractors in radiography and radiology was an unnecessary and costly duplication of the training of radiographers and radiologists and therefore should be eliminated.

It might be similarly argued about the high level and content of diagnosis in chiropractic training. Why spend money on training chiropractors in diagnosis when GPs do it, especially in, for example, pathology laboratory diagnosis?

This response to this situation is that it would limit the capacity of the other non-medical health care professions to develop their primary care practices along the wellness pathway. Yet it is not clear how the Commission will act to prevent medical dominance on the national accreditation agency, and to allow the different pathways of primary health care to develop in response to consumer demand. What is needed here is mutual recognition of the autonomy professions and the different primary health care pathways. This requires the broadening of the old professionals boundaries.

Since there will be a staged implementation of the national accreditation agency envisioned by the Commission, and some time before a complete package of national uniform standards was available for implementation by the registration boards, there are opportunities to prevent the concerns and interests of the smaller health care professions were not swamped and defined by others in terms of medical dominance. This is important given then the power of the agency to facilitate education and training changes in response to new scopes of work, job redesign and community health needs.

Consequently, our support for a national accreditation agency would depend on strong checks and balances to ensure the autonomy of the profession and the ability of the profession to influence its future through its education is not lost. We suggest that reviews are regularly carried out to ensure that a national accreditation agency was facilitating the shift to primary care and the development of diverse pathways of primary healthcare.

Funding mechanisms for health care services

We do accept that the levels and forms of funding for health care services have had a pervasive impact on demand for health workers, effects patient choices, and lessens workforce efficiency.

A classic example is the allied program under Medicare Plus. This makes the GP the gateway for the 5 allied health referrals for with patient's chronic conditions and complex care needs under the Enhanced Primary Care program. The allied health professional cannot refer the patient onto another allied health professional. The patient has to be rerouted back the GP for the next referral. This effectively undercuts the

autonomy of the allied health professional, whose fee for service practices routinely deal with private health funds, creates inefficiencies and increases costs.

This is all very cumbersome. The reason is that it has been designed to contain allied professionals and to ensure the medical dominance of the GPs; and they do so at a time when there is an acute doctor shortage, consumer demand works in terms of diverse pathways of primary health care, and there is mounting fiscal pressure on the federal budget from rising health care costs.

Examples of this kind of inefficiency abound and are well known. The restrictions and exclusions on allied health professionals who can refer patients for diagnostic tests (e.g., X-rays, blood tests etc,) and interpret the results for the patients induces some consumers to opt for subsidized treatment by a doctor. This situation applies even though the services provided by non-medical allied professionals (e.g., chiropractors) have been shown to be more cost effective (e.g., conditions of neuro-muscloskeletal origin). These restrictions impact on patients in rural and regional Australia where there are limited facilities and radiologists do not always interpret the X-rays for conditions of neuro-muscloskeletal origin. The shift to multidisciplinary models of care in the future is discouraged by the current structure of MBS rebates.

In the light of these examples about specific programs we support the Commission's view that the *'focus of reform should be on improving broad institutional and procedural frameworks, rather than on the potential role of more specific programs and approaches.'* (p.121) We do support the proposal for a single, broadly-based and independent body that would advise the Minister of Health on MBS coverage issues. We fully support the Commission's argument that the brief of such a body's is to *'provide advice on the benefits and costs of proposals to extend the coverage of MBS rebates to non-medical practitioners and for related extensions of referral and prescribing rights'*.(p.LI)

Our key reservation with the Commission's proposals for funding mechanism for health care services is that they do not go far enough. For instance, we find it surprising, given the difficulties faced by rural and regional Australia, that there is no evaluation of the proposal to shift national funding of health services so as to give greater autonomy to the regions. The suggestion for Rural and regional Australia is a Regional Health System with a pooled funding model. Money would come from the States, Territories and Commonwealth, and Aged Care and Health Budgets, into one pot, and the region decides how to spend it to meet the goals and targets set by the Commonwealth. The States would then monitor the quality and safety issues.

The Commission rightly spends a lot of time on evaluating the proposal to encourage greater delegation of less complex medical tasks to other health professionals. This works within the boundaries of medical dominance as it involves the devolution of 'medical'tasks' to other members of the health team under the local supervision and delegated authority of a medical practitioner. This is an important step within the

medical model of health and would help it to become more responsive to changing patient needs.

The limitations of this approach is highlighted by the argument of the Manga Report, which concluded that all low back conditions of neuron-musculoskeletal origin should be managed by a chiropractor before medical intervention in the form of surgery is attempted. This indicates that allied health practitioners as autonomous professionals can deliver health services that are not just substitute providers but as offering services not provided by the GP's.

The rationale for the GP gatekeeping operations is that it operates as a fiscal restriction designed as a budgetary control on health care costs. Government controls are necessary, but the effect of this kind of gatekeeping leads to inefficient substitution between healthcare providers that have often worked against the patient's best interests. We need to think of different instruments to ensure budgetary control, better health workforce policy and improved health outcomes.

Conclusion

We have argued that the time is right to become innovative in the reform of the health care system, and that we can do so by shifting the focus to primary health care and to the multidisciplinary role that can be played by the allied health care workers as autonomous professionals.

To make this case we have mapped a series of little reforms that show how health care costs can be reduced and better health outcomes achieved. These little reforms have addressed the fragmentation, poor coordination and inflexibility associated with current workplace conduct that impede the capacity of the health care system to respond to changing situation in health, patient needs and consumer health.

In making this argument we have supported the Commission's pathway of avoiding creating major new layers of bureaucracy and the consolidation and rationalisation of a number of existing institutions.

We have suggested that the mode of medical governance needs to shift to a greater use of market instruments and incentives to facilitate a more competitive health industry that would allow a much stronger role for normal market interactions. This would be the appropriate vehicle to drive the necessary change in the health care system.

We sympathetic and supportive of the Commission's approach to health care reform and we appreciate that it will not be politically easy to implement the suite of reforms proposed. The history of health care reform in Australia indicates that strong resistance to any challenged to the practices of medical dominance.

Our biggest disappoint here is the failure of the Productivity Commission to address the regulatory issues associated with the shift to a more competitive and better functioning health market. The Commission's thorough analysis of the health care system has

highlighted the widespread anti-competitive behaviour by the dominant medical players, yet it gives no consideration to how the anti-competitive behaviour is going to regulated, prevented and penalized.

The Commission talks in terms of the national accreditation agency having the power to facilitate education and training changes on its own initiative and then referring proposals with broader implications to the workforce improvement agency and other relevant bodies. A strong regulatory authority is not specifically mentioned. We are puzzled by the Commission's silence, given its awareness and understanding of the historical political difficulties associated with health care reform.

The silence poses the following questions. Why is the health care market being treated differently from say the telecommunications market? Why is the ACCC not empowered to ensure that the health market functions competitively in response to consumer demand? Why is the regulatory issue not addressed, given the shift to markets? Who can the non-medical groups appeal to when they are confronted by the blockages of substantive anti-competitive behaviour.

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Bibliography

Allen Consulting Group, '*Government's Working Together: A Better Future for All Australians'*, 2004, (www.allenconsult.com.au)

Australian Bureau of Statistics, *'Musculoskeletal Conditions in Australia: A Snapshot'* (http://www.abs.gov.au/Ausstats/abs@.nsf/525a1b9402141235ca25682000146abc/e275b7921da43c00ca256f15007b2023!OpenDocument), Canberra, 2004.

Australian Bureau of Statistics, *'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005'*, Canberra, 2005

Australian Institute of Health and Welfare, *'National Public Health Expenditure Report'*, 1989-99

Australian Government, *Be Active Australia: A framework for health sector action for physical activity 2005-2010,*

Australian Government, *Eat Well Australia: An agenda for action in public health nutrition 2000-2010*,

Commission on the Future of Health Care in Canada, 2002

Department of Workplace and Employment Relations (Evaluation and Programme Performance Branch Employment Analysis and Evaluation Group), Job Network Disability Support Pension Pilot: Interim Evaluation Report, Canberra, 2004

Editorial, *'Australian health policy research and development: where is it'*, The Medical Journal of Australia, vol. 177, December 2002, p.586

General Practice Division Victoria (GPVD), '*The Need for a National Primary Health Policy',* Policy Issues Paper No 22.

Hyland John K, & Hawke, Cheryl, *"Wellness in Practice",* Journal of the American Chiropractic Association, May 2004.

Manga, P., and Associates, 'Manga Report: *'The Effectiveness and Cost Effectiveness of Chiropractic Management of Low Back Pain'*, 1993

Meade TW, Dyer S, Browne W, Townsend J, *"Low back pain of mechanical origin: randomised comparison of chiropractc and hospital outpatient treatment",* British Medical Journal, 1990;300: pp. 1430-7.

McDonald J., & Hare L., *'Literature Review: the contribution of primary and community health services',* The Centre for Health Equity, Training, Research and Evaluation Centres for Primary Health Care, UNSW, September 2004.

Productivity Commission, *Overcoming Indigenous Disadvantage: Key Indicators 2005'*, Canberra, 2005.

Productivity Commission, *'Economic Implications of an Ageing Australia'*, Research Report, Canberra, 2005.

Productivity Commission, *'The Health Workforce'*, Issues Paper, 2005.

Productivity Commission, *'Impacts of Advances in Medical Technology in Australia*', Canberra, 2005.

Sarnat R.L., & Winterstein J., *'Clinical and Cost Outcomes of an Integrative Medicine IPA'*, Journal of Manipulative and Physiological Therapeutics, Vol. 27, No.5, 2004, pp. 336-47

Sen, A., *'Development as Freedom'*, Oxford University Press, Oxford, 1999.

Starfield B., *'Balancing Health needs, services and technology'*, Revised edition, Oxford University Press, New York, 1998.

SA Heath Department, *'DHS Submission to the Generational Health Review'*, August 2004. (http://www.dh.sa.gov.au//generational-health-review/documents/Submissions/00300.pdf), Adelaide, 2004

Walker Anne, *'Impact of Health on the Ability of Older Australians to Stay in the Workforce—with Possible Contributions to Economic Sustainability'* Online Conference paper December 2004, (http://www.natsem.canberra.edu.au/publication.jsp?titleID=CP0412)

Wanless Report, *'Securing Our Future Health: Taking a Long-Term View'*, UK Treasury, 2002

http://www.chiroweb.com/archives/ahcpr/chapter7.htm