4th November 2005

Mr. Mike Woods
Commissioner
Productivity Commission
Locked Bag 2 Collins Street East
Melbourne Vic 8003

Dear Mr. Woods,

On behalf of the osteopathic profession in Australia, the Australian Osteopathic Association as the peak body representing osteopaths wishes to provide a response to the Productivity Commission Position Paper which has recently been released for public opinion concerning the Australia Health Workforce.

The Association congratulates the Commission on the extensive content of the document and looks forward to further dialogue with the Federal Government to assist with the proposed changes and represent our interests as a major stakeholder in the context of any roundtable discussions in the future.

The Association shares the government's ambitions regarding the future success with which health services are delivered across the nation and is delighted to be given the opportunity to provide input at this point of consultation to express our views relating to the supply and demand for osteopathic services and solutions to ensue the continued delivery of quality health care over the next 10 years.

Throughout this response, the AOA will attempt to stay within the confines of the terms of reference as they have been stated, however we acknowledge that some issues will have a flow on effect to key elements that may not be within the paper.

In line with the scope of the document, the Association will identify and provide our input under the seven main headings as specified by Mr. Costello in his instruction to the Commission. Namely:

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention.
2. Consider the structure and distribution of the health workforce and its consequential efficiency and effectiveness.

3. Consider the factors affecting demand for services provided by health workforce professionals.
4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term.
5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.
6. Consult widely, including with the peak industry representative and community organisations, and relevant government agencies and public authorities.
7. The Commission is to produce an issues paper by May 31 2005, provide a draft report, and produce a final report by February 28 2006.

The Association trusts this information is of assistance in producing the final report and considers this initiative a vital review process for both the future of osteopathy in Australia and a major benefit to the community in terms of affordable access to quality health care.

Yours faithfully

Stephen Robbins
Executive Director

Refer attached:

Submission to the Productivity Commission

by the

Australian Osteopathic Association

Dated: November 4th 2005

1. **Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention.**

The Association strongly supports the initiatives to boost numbers of education and training places for health professionals and in particular osteopathy placements in order to obtain better equity of workforce demands in the community. The osteopathic profession is concerned with the current productivity and effectiveness of its available workforce and urgently requests a government review on a national, systematic and timetabled basis.

Based upon past and present experiences our profession is eager to deliver responsive education and training with the consideration of an independent body to assess new models and greater transparency and contestability of funding for clinical training.

The AOA encourages the existing osteopaths' registration boards to develop uniform national registration and accreditation guidelines, which are currently in place (adopted by all registration boards subsequent to an annual Australian Combined Osteopaths Registration Board (ACORB) meeting); however a further evolution towards integrated workplace reform by way of a single national accreditation regime and agency would enhance this process considerably.

Clearly there are still further refinements to be made to derive complementary reform of registration including improvement of the mutual recognition process.

The consideration of a changing responsibility for the allocation of university places is an acknowledgement of the current lack of forethought into community health care needs, particularly given the clear trend towards spending in the allied health area.

The AOA would submit that the current mix of university based health care places is distorted for osteopathy by comparison to other manual therapies. Due to the significant lack of co-ordination within the education and training system we find that only three courses are currently available within Australia with one of those under immediate threat of possible cancellation. The Association acknowledges that the public hospital physiotherapy departments pressure to provide undergraduates with the experience they need to be job ready and that the system largely functions on the goodwill of clinicians; and is unsustainable according to the Australian Physiotherapy Association.

Further we note that the Australian Private Hospitals Association believes there is a need to ensure medical, nursing and allied health practitioners receive training in both private and public hospital sectors.

The AOA would welcome a study to assess the benefit of additional training places for osteopathic students and the likely benefit derived by the community and public hospital savings through treatment in private practice and the introduction of osteopaths into the public health system.

One major restriction for expansion or continuance of quality osteopathic care in rural and remote areas is the difficulties encountered by osteopaths living in those areas attracting locums and associates. These are further discouraged by the existing registration costs and processes from other states.

The Association supports the establishment of an advisory health workforce improvement agency and believes it is worth pursuing to either shift responsibility for quantum of funding from DEST to DOHA or at the very least a mutual responsibility.

The Association also supports the establishment of an advisory health workforce education and training council and welcomes the opportunity to create a system which will enhance transparency and contestability of funding.

As mentioned earlier a move towards a single consolidated national accreditation agency for university based education and training is something that the osteopathic profession would readily adopt through its existing national accreditation guidelines.

By introducing nationally uniform registration standards with a more focused role for registration boards including the improvement of operation of the mutual recognition mechanism the Association would support an amendment to the current registration legislation that exists today.

Should the Productivity Commission require further information concerning the current Osteopathy National Accreditation Guidelines or seek details on the current development of the assessment process for overseas osteopaths, we would be happy to assist.

A key element of registration is clearly protection of the public and uniform national standards in order to promote this adherence to public safety through consistent legislation and “plain English” processes. A consideration of waiver of fees for mobile practitioners such as locums who wish to apply for registration under the mutual recognition act enables a more flexible workforce to address the ongoing needs of the community.

The Association wishes to highlight that for many professions national standards considerations should also take into account Trans Tasman Mutual Recognition legislation.

Whilst the AMA is supportive of delegated practice rights to appropriately trained nursing and allied health professionals, it needs to reconsider the education process to see that medical practitioners are sufficiently informed as to the competency and scope of practice of these individual professions.

All Osteopaths Registration Boards currently have a composition which includes representation of consumer groups, independent appointment of individuals through a transparent process and an independent chairperson; however the Association would welcome an increase in the representation of consumer groups for enhancement of the Boards’ responsibilities and transparent processes.

There is clearly evidence to support the Commission's recognition of a pervasive influence on the health workforce. In our experiences referral patterns of GP's and limited access to diagnostic imaging referral rights has the osteopathic practitioner hamstrung when in fact the patient is expecting quality care and treatment for a condition which is outside these parameters. This translates out as increased cost both to the health care system and in most case out of pockets expenses to the patient. There is also a relegation of care in so much as the Osteopathic practitioner must rely on the goodwill of the GP to agree the requested diagnostic test is appropriate and therefore performs the test as requested.

Workforce planning is limited by legislative constraints in some jurisdictions. There is separate and distinct registration of osteopaths who are regulated in all states and territories of Australia, however in some instances osteopaths are registered under a Chiropractors Act (SA) which the Association considers is in contravention of the National Competition Policy and still awaits an appropriate outcome in order to adequately reflect osteopaths in South Australia. The South Australian government has not addressed our concerns nor complied with the National Competition Commission for a number of years.

Remote and rural areas are clearly recognised as major deficiencies within the osteopathic profession, however due to limited numbers nationally and the current availability of university places it is unlikely this situation will change for several years. Improvements in the provision of education and availability of placements will lend itself towards assisting existing practices that are currently overwhelmed.

One key self help initiative is Long Distance Learning Education to assist practitioners with continuing professional development.

The Association would also support preferred placements for rural and remote area candidates who are likely to return home after graduation to establish a practice or join an existing practice.

2. **Consider the structure and distribution of the health workforce and its consequential efficiency and effectiveness.**

It is imperative that a more transparent process to review funding related incentives to extend coverage of MBS to new services and professional groups be addressed. (In other words, diagnostic referring, more specialised services or prescribe drugs subsidised under PBS.

In order to measure the efficiency and effectiveness of the health workforce the Association through its own research has concluded there is a need for a progressive orientation of care toward chronic conditions, and hopes to focus future research in these areas.

As described by the Commission there are likely overlaps in scopes of practice and the processes influencing workforce deployment Fig 5 Page 34 are evident.

Making education and training more responsive to changing care needs is a clear goal which government and professions alike will need to collaborate on in order to address the future health needs and demands as a result of an aging population and predicted skills shortage.

The AOA supports the establishment of an independent review body to advice on services to be covered by MBS and on referral and prescribing rights. As a result of determining appropriate education and training to refer and prescribe, encouragement and influence on the community would make way for progressively introducing discounted rebates for a wider range of delegated services.

It would be apparent and undoubtedly supported by the majority that in order to ascertain the criteria and establish clear processes, there will be a need to concentrate formal projections on key workforce groups and rationalise structure through abolition of AMWAC and AHWAC.

In line with rural and remote issues there should be explicit provision for consideration of this cross section of the community and the AOA would be happy to participate in any cross program evaluation exercise as appropriate.

The Association asks the Commission to take note of the restriction and financial disincentive for patients who could be treated by osteopaths for musculoskeletal conditions however this has no support under the MBS program.

The Australian Osteopathic Association questions the statement by the Australian Physiotherapy Association that in arguing for an MBS rebate for physiotherapy services, states “In many cases the specialist refers the patient for physiotherapy instead of undertaking a surgical procedure. In such cases physiotherapy intervention is the best available care for the patient, it is substantially cheaper than surgery, and places less pressure on the health workforce.”

Whilst the AOA appreciates the primary point that the APA is making relates to cost and time comparisons, the AOA does not consider, nor has it seen any evidence to support that physiotherapy intervention is the best available care for the patient. Herein lies a major issue when examining the current health workforce and the appropriate access to quality care. The AOA reiterates its concern that no consultation has been afforded to the osteopathic profession other than this paper being posted on the web and considers itself disadvantaged with lack of education and understanding of each profession by both the government and the medical profession.

3. **Consider the factors affecting demand for services provided by health workforce professionals.**

The true measuring stick for shortage of supply is obviously to consider demand. Based on current output, as noted earlier, all graduates are obtaining immediate employment either in self employed private practice or as an associate in private practice. Further surveys have indicated that a large majority of osteopaths are at or near 100% capacity in terms of patients. This is verified by the number of new graduates entering an existing practice to begin with an immediate patient base.

All states and territories of Australia are reporting a strong demand for more practitioners to deal with the growing demand. Unfortunately, rather than developing opportunities for further educational institutions to be established to feed not only remote and rural areas but quite simply the smaller states, we are now in search of other institutions willing to consider a health science program which by its own nature must carry the burden of clinical science in order to gain accreditation.

The demographics of the osteopathic patient as described in our recent osteopaths census 2004, would suggest an aging population seeking the services of osteopaths. This coupled with prediction of more than 25% of the population will be over the age of 65 by 2045 suggests that osteopathy has not been thoroughly investigated nor considered in the interests of the community.

The AOA supports:

- Those living in outer metro, rural and remote should benefit from these system wide initiatives.

- Rural and remote provider number status for higher rebates/broader access to PBS.

- Improving indigenous health care

- Increased health workforce education and training opportunities for indigenous students

- All broad institutional frameworks to make explicit provision to consider the needs of special needs groups.

The AOA endorses some of the ways in which the health system could be improved as identified by CoAG. It is important to simplify access to care services for the elderly, people with disabilities and people leaving hospital and the osteopathic profession would welcome the opportunity to assist in the public health sector. The profession can demonstrate its educational and training for providing such care, however the demands currently outstrip supply in private practice and fairer university placement models need to be addressed first.

Helping public patients in hospital waiting for nursing home places is also a process which the osteopathic profession is trained, particularly in whole of body health. Helping younger people with disabilities in nursing homes is feasible as Osteopaths currently treat a number of individuals with disabilities and has demonstrated its support as a major sponsor at the 2000 Paralympics in Sydney.

Improving supply, flexibility and responsiveness of the health workforce can only be feasible for osteopathy provided there is a direct correlation to the increase in the health system’s focus on prevention and health promotion.

The AOA supports the following initiatives as key benefits to the health system and in turn the community within Australia:

- Accelerating work on a national electronic health records system
- Improving the integration of the health care system
- Continuing work on a National Health Call Centre Network
- Addressing specific challenges of service delivery in rural and remote Australia

4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term.

The Association recognises that the osteopathic profession represents a minor percentage of allied health and certainly a much smaller percentage of the overall health workforce (of which Allied Health accounts for about 9%). None the less, the AOA wishes to identify the major issue of workforce shortages and extensive training (5 years) to catch up with demand for osteopaths in the community.

Osteopathic treatment is integral to improving health through investment in disease prevention, self management by individuals and integrated health education. If the Government is providing itself with an extensive opportunity for reform it must become educated and informed on what osteopaths do and how addressing the identified skills shortage can greatly assist the future aging population.

The AOA also recognises that with an aging population comes an aging workforce and would estimate a significant number of osteopaths retiring from practice by 2015.

Identification of systemic blockers in the workforce and unwarranted 'patch protection' have been highlighted by the profession to the Diagnostic Imaging department of HIC on several occasions and standard policy protocol and public purse short sightedness have seen the patient referred back to the GP for a basic x-ray (which is not of the spine or pelvis). This condones inappropriate care and produces greater costs in order for a suitably qualified osteopath to effectively diagnose and treat.

This indicates policy constraints with regard to workforce innovation in so far as diagnostic imaging referral rights to confirm diagnosis and commence treatment within reasonable timeframes and acceptable costs to the community.

Stakeholders working in collaborative and cooperative fashion can only be facilitated by an open and informed process that includes adherence to good regulatory and governance practice.

The National Health Workforce Strategic Framework
AOA agrees with the Commission that this should be an evolving process and shares its concern that whilst the document has been endorsed by the Health Ministers, the framework does not have sign off from their counterparts in education and training or from Ministers responsible for Finance or central policy coordination.

It should be noted that UK Osteopaths are part of the National Health Services and have been for a number of years. The acceptance and role of osteopaths in the public health sector has demonstrated a definitive need for community osteopathic care in the public health system.

The Association supports the caution when considering workforce innovation as suggested by the medical profession in response to the prescribing rights of nurse practitioners. Training and education to adequately provide a differential diagnosis and interpret the individual's healthcare needs based upon the whole body are paramount.

An active approach to job redesign is appropriate providing it is evidence based and educational and training elements indicate that quality care will be maintained. It is also essential that smaller stakeholders who none the less represent a distinct health professional group must be consulted and actively participate in such proposals, rather than being considered as part of a representative group or allied health professionals collectively.

The AOA would like to suggest that indigenous health programs and access to remote locations could be facilitated by a component of undergraduate and post graduate training incorporating field work which is funded by the Australian government and has appropriate considerations for registration in the relevant jurisdiction.

At this time similar barriers to osteopathic care exist within residential aged care as per the public and private hospitals. These are non specific but collectively reduce this opportunity under university placements, MBS itemisation and government education.

5. **Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.**

The Association has no comment on this issue.

6. **Consult widely, including with the peak industry representative and community organisations, and relevant government agencies and public authorities.**

The Association one again raises its concern over the lack of consultation or consideration as a stakeholder offering equal health care provision to the community. No notification or invitation for representation at roundtable discussions was proposed to the AOA nor any direct notification of these processes being undertaken.

Should the Productivity Commission require more accurate and detailed information regarding the three universities offering the Osteopathy program or its current configuration as a 5 year undergraduate qualification, the Association would be pleased to provide.

The AOA highlights that as a University based education and training discipline osteopathy is in the same circumstances as that of podiatry where the University of Western Sydney unilaterally deciding to suspend or possibly close the osteopathic program without any form of consultation, coincidentally as is embarks on a medical program scheduled for 2007. The funding clause proposed to be introduced by the Minister for Education does not preclude the university from any excuses as to its lack of cooperation with the profession or delay in providing reasonable (if any) proposals for the redevelopment of the program.

Osteopathy suffers significant national workforce shortages as detailed to the Minister and evidenced by the 100% uptake of all graduates into private practice as soon as they have obtained registration.

Clear and transparent processes are required in addition to the Minister's clause of agreement and based upon the outcome of the recent External Course Advisory Committee for Osteopathy at UWS, the university executive has not made any attempt to reflect such an attitude, leaving the Board of Trustees with insufficient information to make an informed decision regarding the future of the program.

There is no doubt in the minds of the osteopathic profession that the University in this instance lacks good documentation and consultation processes and has done so deliberately in order to bring about a predetermined result.

Access to clinical training: There are limitations to quality clinical training within the three current university programs offering osteopathy. Each institution has established its own 'on campus' clinic which required the students themselves to establish a patient base. This in itself can be a positive thing in that it forms part of the training required to introduce a private practice into the community. However, there is little evidence to suggest any reasonable funding in establishing or promoting such community clinics and the location of being 'on campus' is in fact limiting to the breadth of patient that is likely to attend, which can quite often be students from within the campus.

In some circumstances an 'off campus' clinic may also be established and whilst this has a much broader range of patient care required and the community gains immediate benefit to services provided, there is again a distinct lack of funding from the university or government to establish what can be a reasonably immediate and affordable access to health care for the community.

It is also worthy of mention that like Podiatry, "under the Commonwealth Grant Scheme, universities receive just under half the amount of annual pre-student funding for the education of an osteopathic student, than for a student in dentistry or medicine. Yet the cost of the course delivery is comparable, particularly with regard to the integrated clinical component of training."

It is an Interesting perspective from Professor Wayne Gibbon in relation to the establishment of state health colleges, however these could only be sustained with funding from either the state or federal government as the main beneficiary of health professionals who could adequately service the changing demographic of community. As there would be variable infrastructure overheads to that of a university, funding could be scaled based upon establishment costs and on going funding which would be proportionate with a scale of overheads in relation to universities.

A health education and training council would have several advantages as highlighted, however the AOA would be sensitive to specific representation as a distinct profession and no alliance with any specified allied health group. The concept of appointment of individuals as members rather than as formal representatives of the various stakeholder groups is desirable, however naïve given that health care is encouraged to be a competitive marketplace under National Competition Policy.

As this proposal would likely yield an over populated council with multiple agendas and priorities, it could be segmentally structured to form sub committees which would address relevant or crossover issues.

7. **The Commission is to produce an issues paper by May 31 2005, provide a draft report, and produce a final report by February 28 2006.**

The Australian Osteopathic Association tenders its views on the Paper for consideration by the Commission.

End document