

**2021-22 BUDGET**

**Pre-budget submission by OSTEOPATHY AUSTRALIA**

**JANUARY 2021**

**1 SUMMARY**

Thank you for the opportunity to provide a pre-budget submission for the 2021-22 financial year. There are many areas of the health sector that need reform and support. We ask that you consider the recommendations in the interests of equitable support for all health practitioners as they provide essential care and support to millions of vulnerable Australians.

**MEDICARE**

We are asking the Government to reform Medicare so that allied health practitioners have equitable access when treating chronic disease management patients. This includes the following measures:

**Recommendation 1:** That the Government provides the means to conduct trials of alternative funding mechanisms for allied health Medicare CDM services. This may include:

- A Medicare version of the Department of Veterans Affairs Allied Health Treatment Cycle

- A model where flexibility is maintained such as 5 + 5/ 7 visits, where the additional 5/7 are allocated after consultation between the allied health provider and the GP.

**Recommendation 2:** Continue to fund Medicare Chronic Disease Management telehealth items 93000, 93013, 93048 and 93061.

**Recommendation 3:** Introduce initial assessment appointments of more than 40 minutes for allied health professional services under Medica Chronic Disease Management referrals. This should be funded at an appropriate increment above the standard fee – e.g. 20-30%.

**Recommendation 4:** In line with GP case conferencing items for MBS, the Government makes funding available to add an allied health case conferencing item to the Medicare Benefits Schedule.

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

**Recommendation 6:** That Medicare recognizes Osteopath referral rights for MBS Items 55802, 55806, 55810, 55814, 55818, 55822, 55826, 55834, 55838, 55842

**Recommendation 7:** A feasibility study to determine appropriate referral pathways for a limited range of musculoskeletal MRI for osteopaths.

**COVID-19 ECONOMIC SUPPORT**

Whilst we support the Government’s initiatives to date in helping the economy manage and recover from the impact of COVID-19, we ask that you recognise this as an ongoing issue into the 2021-22 financial year. The impact on small business is profound and it continues.

**Recommendation 8:** That the Government continue to pursue tax relief, GST exemptions, grants or other mechanisms to support small businesses into 2021-22.

**Recommendation 9:** Extend Jobkeeper and Jobseeker

**ACCESS TO OSTEOPATHY**

**Recommendation 10:** That the Government continues to fund professional development and support schemes such as Rural Health Pro and expands rural practice incentive programs (such as GP support) to allied health professionals.

**Recommendation 11:** That the Government funds a national cultural safety program for health professionals.

**PRIVATE HEALTH INSURANCE**

**Recommendation 12:** Review the private health insurance industry and its sustainability. If the industry is indeed unsustainable, then plan now for what might happen going forward, and whether there are alternatives. This review could form part of the Primary Care 10 Year Plan work and could be part of a broader strategic review of private health effectiveness, regulation and sustainability. This could be under the auspices of APRA or another regulatory body.

**Recommendation 13:** That the government imposes financial penalties on private health insurers who introduce policies and services that distort the patient’s right to choose their own practitioner.

**Recommendation 14:** That the Government commission a Taskforce to investigate preferred provider schemes, including their impact on competition and consumer choice.

**PRIMARY CARE RESEARCH**

**Recommendation 15:** Increase funding pools available to allied health researchers through bodies including the National Health and Medical Research Council and Primary Health Networks (PHNs). Ensure criteria for funding access is equitable for all allied health professionals, enabling projects to occur for existing and emerging/new interventions with potential to inform how the global impact of musculoskeletal disease could be managed or minimised.

**Recommendation 16:** Fund the development of a national allied health primary care dataset.

**Recommendation 17:** Fund a primary care research stream focused on how primary care and conservative management of musculoskeletal conditions can positively impact on hospital costs.

**DEPARTMENT OF VETERANS AFFAIRS**

**Recommendation 18:** Raise the DVA schedule fees OM10 and OM11 for osteopathy by 10%

**Recommendation 19:** DVA increases the schedule fee for initial consultation (OM10), by 20%

**AGED CARE/ NDIS**

**Recommendation 20:** The Commonwealth Government should ensure residential aged care facilities engage allied health practitioners able to prescribe exercise, give lifestyle advice and offer education as first line providers. Allied health providers should be engaged at an early point whenever a pain condition does not require specific surgical intervention or pharmacological management prior to surgery. The Aged Care Funding Instrument (ACFI) should be revised to link this recommendation to facility funding allocations.

**Recommendation 21:** The Commonwealth Government should increase the number of administrative non clinical and clinical personnel working for the My Aged Care gateway. This would provide the infrastructure necessary to lessen the time lost between eligibility assessment and funding allocation.

**Recommendation 22:** Create a broker education program giving all NDIS and home care package brokerage and care planning organisations consistent training on the rights of clients to select providers of their choice and the process involved in selecting providers. All people deserve a consistent service experience.

**Recommendation 23:** Dedicate funding to publish a transparent and streamlined process for all health and allied health professions wishing to qualify for approval in specific service support streams of the NDIS, Commonwealth residential care and home care services. Osteopathy Australia is aware of an undocumented process specific to the NDIS, for example, but this awareness was formed only after several discussions and no published information was given to follow.

**Recommendation 24:** Give clients of ageing and disability support schemes broader choice to consult an osteopath for musculoskeletal, functional and movement based clinical outcomes in moving toward a competitive marketplace with reduced costs and greater provider supply. With the prevalence of disability both due to ageing and inherited factors set to remain steady or increase in coming years, provider supply issues must be managed now to prevent future untimely delays and backlogs.

Please contact Nicholas Bradshaw, Deputy CEO, if you have any questions about this submission: nbradshaw@osteopathy.org.au or (02) 9410 0099.

**2 MEDICARE REFORM**

**2.1 OSTEOPATHY AND CHRONIC DISEASE MANAGEMENT**

Osteopathy is playing an increasingly important role in chronic disease management, increasing by 71.5% between 2021 and 2017[[1]](#endnote-1).

GPs are rightly at the centre of the CDM program and manage the care plans for their patients. Increasingly they are seeing the utility of osteopaths to work with them to manage CDM patients and are forming strong local working relationships. Osteopathy Australia understands that increasing numbers of osteopaths are working in multidisciplinary clinics with GPs and other health professionals. In a recent study, 89.3% of respondent osteopaths reported receiving referrals from GPs[[2]](#endnote-2).

The *Better Outcomes Report*[[3]](#endnote-3) outlines the need to strengthen primary care to better manage the large and increasing numbers of patients with multiple chronic conditions. The *National Strategic Framework for Chronic Conditions*[[4]](#endnote-4) considers the necessity of continuity of care and equity of access, and person-centred holistic care. Medicare is the logical vehicle through which to make this happen in a way that supports all health practitioners.

**2.2 CHRONIC DISEASE MANAGEMENT – SERVICE LIMITATIONS**

Osteopathy Australia, along with many other allied health professions, has been heavily involved in and ultimately disappointed by the outcomes of the Medicare Benefits Schedule Review, in particular the Chronic Disease Management items for allied health care under Team Care Arrangements.

For some patients with chronic or pain related conditions, the current upper limit of five Medicare rebated allied health sessions is adequate. For other patients, however, the allowance is inadequate due to complexities, multimorbidity and/or biopsychosocial issues.

Chronically ill patients often have a variety of complex needs, and therefore the point of providing the opportunity for some patients to extend treatments beyond five per year is to provide some systemic flexibility so that the managing GP can work with the patient and allied health providers on the best outcome for that patient. Many patients (and this is borne out to a degree by usage data) may not require many visits, although there may be other reasons for this (e.g. access, mobility, cost).

In their experience of treating CDM subsidised patients, 61.2% of osteopaths in a recent study stated that these patients would require an average of 8-10 consults per annum to provide optimal benefits from osteopathic treatment, and 9.4% said 5-7 consults per annum. The reasons stated were that CDM patients are different from the usual patient group, the most commonly nominated factors were that they are in financial difficulty (50.6%) or have co-morbidities (38.8%).[[5]](#endnote-5)

**Recommendation 1:** That the Government provides the means to conduct trials of alternative funding mechanisms for allied health Medicare CDM services. This may include:

- A Medicare version of the Department of Veterans Affairs Allied Health Treatment Cycle

- A model where flexibility is maintained such as 5 + 5/ 7 visits, where the additional 5/7 are allocated after consultation between the allied health provider and the GP.

**2.3 MEDICARE CDM TELEHEALTH ITEMS**

Osteopathy Australia supports the continuation of telehealth CDM items beyond March 2021. Rural, remote and regional patients have long benefitted from telehealth consultations, and the COVID-19 pandemic has showed that these consultations can be used across the country to commence or continue quality health care with potential travel savings for patients and greater flexibility. Telehealth in musculoskeletal practice often involves advice, education and exercise prescription and review, all of which are core components involved in growing patient self-efficacy and empowerment.

Flexibility, choice and control are core objectives to be achieved for patients in modern health care services and we strongly advocate that telehealth broadens this choice and control.

**Recommendation 2:** Continue to fund Medicare Chronic Disease Management telehealth items 93000, 93013, 93048 and 93061.

**2.4 INITIAL CONSULTATION FEE**

In line with the MBS Taskforce recommendation, we are calling for the introduction of an initial item number to accompany Item 10966. This item should be at least 20% higher than any subsequent appointment.

Osteopaths on average conduct an initial appointment of 45-60 minutes, with average subsequent consultations of 30-45 minutes. With complex patients, the average may be longer.

Private health insurers and other funded schemes (e.g. Workcover, Transport Accident Insurance) often recognise the time differential in many of their products, offering a higher rebate to offset patient out of pocket costs, and we feel that the MBS should recognise that the initial appointment requires more time to be done well, so that allied health practitioners can review the referral, assess and initiate treatment without forgoing income.

**Recommendation 3:** Introduce initial assessment appointments of more than 40 minutes for allied health professional services under Medica Chronic Disease Management referrals. This should be funded at an appropriate increment above the standard fee – e.g. 20-30%.

**2.5 CASE CONFERENCING ITEM FOR ALLIED HEALTH**

The *Chronic Diseases in Australia* report[[6]](#endnote-6) highlights the potential, and as yet underused, role of the allied health professions in the management of chronic and long-term conditions through the need for health care to be coordinated, sequenced and connected. There is further evidence specifically supporting the use of inter-professional teams for chronic disease management.[[7]](#endnote-7)

We note with frustration that case conferencing has been addressed by both the General Practice Primary Care Committee (GPPCC) Phase Two report (Recommendation 9) and the Specialist and Consultant Physician Committee report (Recommendation 10) of the MBS Review. Given the strong agreement on the need for this change, we contend that government should move quickly to implement a new item, with an appropriate consultation period prior to its release.

Osteopaths are often called upon to be part of the case conferencing process for CDM patient management; however, **they are not remunerated for their time**. This prevents the health sector from functioning in a collaborative and inter-professional way, and thereby reducing opportunities to communicate effectively, share work, and prevent the further physical, mental and functional decline of individuals, groups and communities. The system also undervalues the current and potential role that osteopaths and other allied health professions play in health care.

As the care of people with complex needs is increasingly delegated to the private sector, with people providing different aspects of that care through disparate channels, the risk is the client will experience dislocation and sub-optimal outcomes. It is therefore vital to support mechanisms that increase and maintain cohesion, with case conferencing being crucial to this process. Osteopathy Australia supports the recommendation of Allied Health Professions Australia to promote equity in case conferencing remuneration for all health practitioners involved in the process.

**Recommendation 4:** In line with GP case conferencing items for MBS, the Government makes funding available to add an allied health case conferencing item to the Medicare Benefits Schedule.

**2.6 DIRECT REFERRAL FROM OSTEOPATHS TO MEDICAL SPECIALISTS**

Any costs of implementing direct referrals would theoretically be offset by a reduction in GP consultation fees. However, we accept that this should be the subject of detailed research to establish the potential economic impact in a set of defined test referral relationships - for example between an osteopath and an orthopaedic surgeon, or between an osteopath and a radiologist, perhaps using the examples below.

Osteopathy Australia recommends that the Taskforce supports amendment of Explanatory Note GN.6.16 of the Medicare Benefits Schedule, such that a referral can be made by an osteopath to a medical specialist for conditions within their scope of practice. Consideration should be given to direct referrals from osteopaths to sports physicians, rheumatologists and orthopaedic surgeons, for example. This will avoid unnecessary costs and time for patients, who currently have to navigate through allied health, GPs and specialists.

Initially, we support detailed research to establish the potential economic impact in a set of defined test referral relationships - for example between an osteopath and an orthopaedic surgeon.

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

**2.7 EXPANDED MEDICAL IMAGING REFERRAL RIGHTS FOR OSTEOPATHS**

Medical imaging referrals for MSK is commonly regarded by our members as a barrier to timely patient care.

There is evidence from Australia[[8]](#endnote-8) and overseas[[9]](#endnote-9) that ultrasound (US) is indicated for atraumatic shoulder pain, where rotator cuff disorders (tendinosis, tear, calcific tendinitis) are suspected and where initial X-ray is normal or inconclusive.

**Table 1: Example of cost savings – shoulder ultrasound**

|  |  |
| --- | --- |
| **Existing referral pathway**1. Osteopath refers to GP - $37.05 standard consult MBS item 23
2. GP refers for US Shoulder “? rotator cuff tear” – MBS item 55808 $109.10
3. Radiology report to GP - $37.05 standard consult MBS item 23
4. Patient returns to osteo/ physio for management plan

**Total cost to MBS: $183.20** | **Direct referral**1. Osteo/ physio consultation – patient expense (private health fund or out of pocket)
2. Refer for US Shoulder “? rotator cuff tear” – MBS item 55810 $37.85
3. Radiology report to osteo/physio to inform management plan
4. Osteo/physio consultation – patient expense

**Total cost to the MBS: $37.85**  |

Osteopaths manage a broad range of musculoskeletal conditions which includes the upper and lower limbs. To diagnose fractures or other pathology, and to commence timely management and recovery, we recommend thatMBS Schedule 5, Subgroup 1 is expanded to provide access to MSK allied health practitioners. The following as examples of where X-ray is indicated as a diagnostic tool:

* Chronic ankle pain[[10]](#endnote-10)
* Chronic elbow pain, initial test[[11]](#endnote-11)
* Chronic foot pain, initial test[[12]](#endnote-12)
* Atraumatic shoulder pain, initial imaging (unless suspected rotator cuff disorders indicate an ultrasound/ MRI[[13]](#endnote-13)
* Beyond conservative management, ultrasound is an indicated modality[[14]](#endnote-14) where the patient has anterior knee pain and the clinician suspects tendinopathy or bursitis.

In the last example regarding anterior knee pain, the MBS item number 55828[[15]](#endnote-15) is for medically referred knee ultrasound, including for abnormalities of tendons or bursae about the knee. We recommend that an allied health item is included with the same criteria. Implementation should be subject to a good quality research project to test the process (per the AHRG recommendations for further research into allied health).

There are some ultrasound item numbers for which there is already access for non-medically referred examinations, to which osteopaths could be added as approved referrers, after an appropriate period of review and consultation:

* 55802 – Hand or wrist
* 55806 – Forearm or elbow
* 55810 - Shoulder or upper arm
* 55814 – Chest or abdominal wall
* 55818 – Hip or groin
* 55822 – Paediatric hip exam for dysplasia
* 55826 – Buttock or thigh
* 55834 – Lower leg
* 55838 – Ankle or hind foot
* 55842 – Mid foot or fore foot

**Recommendation 6:** That Medicare recognises osteopath referral rights for MBS Items 55802, 55806, 55810, 55814, 55818, 55822, 55826, 55834, 55838, 55842

**Recommendation 7:** A feasibility study to determine appropriate referral pathways for a limited range of musculoskeletal MRI for osteopaths.

**3** **COVID-19 ECONOMIC IMPACT**

**3.1 TAX RELIEF OR CONTINUED SUPPORT FOR PRIVATE PRACTICE**

The COVID-19 pandemic has resulted in many osteopathy clinics increasing their outlay on consumables such as facemasks and disinfectants, whilst at the same time suffering from reduced turnover from patients reluctant to seek treatment or unable to attend due to lockdown restrictions. The burden on small business needs to be recognised and government support, through GST exemptions, tax deduction flexibility, grant schemes or other programs should be considered throughout 2021 and into 2022.

**Recommendation 8:** That the Government continue to pursue tax relief, GST exemptions, grants or other mechanisms to support small businesses into 2021-22.

**3.2 CONTINUATION OF JOBKEEPER AND JOBSEEKER**

Osteopathy Australia considers that the Jobkeeper scheme has been relatively successful in helping many thousands of businesses retain staff and avoid insolvency.

We support an urgent government review into whether some industries or businesses (based on turnover versus 2019) should continue to receive Jobkeeper payments beyond March 2021. Consideration should be given to implementing a flexible model for those businesses temporarily impacted by lockdowns in localised hotspots, such as the Northern Beaches of Sydney.

The same flexibility should apply to Jobseeker, especially in casualised industries where layoffs can occur in direct response to local lockdowns.

**Recommendation 9:** Extend Jobkeeper and Jobseeker

**4 ACCESS TO OSTEOPATHY**

**4.1 RURAL AND REMOTE PRACTICE SUPPORT**

Osteopaths in rural areas are often professionally isolated, and the costs of leaving their practice unattended is a disincentive to travelling for professional development opportunities. Osteopathy Australia is filling his gap to a degree with a comprehensive webinar and e-learning program, but more help is needed.

Rural patients rely on their osteopath even more than in cities because of a lack of proximity to referred medical and hospital services.

**Recommendation 10:** That the Government continues to fund professional development and support schemes such as Rural Health Pro and expands rural practice incentive programs (such as GP support) to allied health professionals.

**4.2 CULTURAL SAFETY TRAINING**

The *Aboriginal and Torres Strat Islander Health Strategy* focuses on achieving patient safety for Aboriginal and Torres Strat IslanderPeoples as the norm.

Osteopathy Australia supports the aims of the strategy. However, there has been no indication that AHPRA intends to provide the training to practitioners. We advocate for a nationwide program of cultural safety training to be provided to all health professionals, to ensure that the training is high quality and consistent across the Board, rather than relying on private training providers who may have varying degrees of quality and course depth. We firmly believe that this course should be free rather than expecting health professionals to pay out of pocket. Completion could also be easily tied to registration renewals if necessary.

**Recommendation 11:** That the Government funds a national cultural safety program for health professionals.

**5 PRIVATE HEALTH INSURANCE**

**5.1 SUSTAINABILITY**

Some observers have suggested that many private health insurance funds are on an unsustainable trajectory[[16]](#endnote-16). The Government needs to urgently investigate the veracity of this observation and workshop what the impacts of an imploding or heavily consolidated sector might be.

The Government should consider whether the current PHI rebate is sufficient, whilst at the same time making sure that the insurers are not making excessive profits or charging consumers excessive gaps.

**Recommendation 12:** Review the private health insurance industry and its sustainability. If the industry is indeed unsustainable, then plan now for what might happen going forward, and whether there are alternatives. This could be under the auspices of APRA or another regulatory body.

**5.2 PREFERRED PROVIDER SCHEMES**

The primary concern for Osteopathy Australia in this industry is preferred provider schemes.

They may appear to be more affordable for customers but may not be if someone looked closely at the relationship between premiums, rebates and out of pocket costs. Another risk is that they distort local markets for allied health services.

Small professions like osteopathy are excluded because there is no business case for the health funds to set them up. Therefore, customers are led to the big professions where the allied health professionals can provide the service, but at usually much lower fee than they can charge otherwise. It could also be argued that “preferred providers” creates a misleading impression to consumers that they are clinically of higher quality than non-preferred providers, when the central mechanism at work is cost.

**Recommendation 13:** That the Government commission a Taskforce to investigate preferred provider schemes, including their impact on competition and consumer choice.

**5.3 TELEHEALTH EQUITY**

Many health funds have taken the view that some professions have an evidence based justification for providing some services via telehealth where others do not. In the musculoskeletal health space, a physiotherapist can provide a rebated service with most funds, for example, by providing exercise advice for an injury rehabilitation. Osteopaths have been excluded, even though the musculoskeletal conditions are within the scope of practice, the intervention is exactly the same, and the outcome is the same. This is not equitable and restricts patient choice. It distorts the market and allows consumers to select health care based on rebates and not on quality of care.

**Recommendation 14:** That the government imposes financial penalties on private health insurers who introduce policies and services that distort the patient’s right to choose their own practitioner.

**6 PRIMARY CARE RESEARCH**

**6.1 DEDICATED PRIMARY CARE RESEARCH FUNDING FOR MUSCULOSKELETAL HEALTH**

Given limits on international student arrivals due to COVID-19, Australian universities should be incentivised to grow international standing through sound research into issues with a global impact or interface. Identifying quality allied health interventions and treatments is one such issue with global significance; in particular, musculoskeletal and related interventions for the growing portion of musculoskeletal disease of all global injury or disease types. The World Health Organisation has concluded time and time again that musculoskeletal conditions and low back pain are the leading cause of global disability and activity limitation.

Further, research into primary care interventions can also be aimed at prevention of hospital emergency department presentation, or ward admission and/ or readmission. We already know that rehabilitation is often a much better alternative than knee arthroscopy or spinal fusion surgery, which cost far more than a program of physical rehabilitation. Ultimately, a focused research effort and a commitment to implementing the findings could save the hospital system significant costs.

**Recommendation 15:** Increase funding pools available to allied health researchers through bodies including the National Health and Medical Research Council and Primary Health Networks (PHNs).

Ensure criteria for funding access is equitable for all allied health professionals, enabling projects to occur for existing and emerging/new interventions with potential to inform how the global impact of musculoskeletal disease could be managed or minimised.

**Recommendation 16:** Fund a primary care research stream focused on how primary care and conservative management of musculoskeletal conditions can positively impact on hospital costs

**6.2 ALLIED HEALTH DATASET**

Osteopathy Australia has long argued for investment in datasets for non-government primary cares services to help with service and workforce planning, and also to stimulate research. Ultimately such datasets could help

**Recommendation 17:** Fund the development of a national allied health primary care dataset.

**7 DEPARTMENT OF VETERANS AFFAIRS**

Osteopathy Australia is broadly supportive of the new Allied Health Treatment Cycle. The only impediment to osteopaths is the continued reluctance of the government to support an equitable fee structure. Much of the DVA budget is tied up in high end medical and surgical care, while the millions of allied health services are offered to practitioners at a rate well below what they are able to charge a private patient.

As with Medicare, there is no allowance for the extra history taking discussion and assessment process in the initial osteopathy consultation. Unlike Medicare, there is no ability for osteopaths to charge a gap to DVA clients. We support this approach but ask that the consultation fee is increased to compensate.

**Recommendation 18:** Raise the DVA schedule fees OM10 and OM11 for osteopathy by 10%

**Recommendation 19:** DVA increases the schedule fee for initial consultation (OM10) by 20%

**8 NDIS AND AGED CARE**

**8.1 NON-PHARMACOLOGICAL INTERVENTIONS FOR PAIN**

Non-pharmacological interventions for persistent musculoskeletal pain are widely acknowledged as best practice first line approaches for maximising mobility and function across age groups, including older people in residential care. The Commonwealth Government has already acknowledged this general point in its *National Strategic Plan for Pain Management (2019*), developed conjointly with Pain Australia. *[[17]](#endnote-17)* Good early management approaches can cap the long- term higher costs associated with more intensive interventions.

**Recommendation 20:** The Commonwealth Government should ensure residential aged care facilities engage allied health practitioners able to prescribe exercise, give lifestyle advice and offer education as first line providers.

Allied health providers should be engaged at an early point whenever a pain condition does not require specific surgical intervention or pharmacological management prior to surgery. The Aged Care Funding Instrument (ACFI) should be revised to link this recommendation to facility funding allocations.

**8.2 MY AGED CARE GATEWAY**

To control the overall costs of Australian aged care services and allow older people to ‘age in place’ for longer without the disruptions of accommodation transfers, the Commonwealth Government should be seeking to improve the responsiveness of services existing to service older people within the community, living in their own homes.

**Recommendation 21:** The Commonwealth Government should increase the number of administrative non clinical and clinical personnel working for the My Aged Care gateway. This would provide the infrastructure necessary to lessen the time lost between eligibility assessment and funding allocation.

**8.3 OVERALL FUNDING AND PRACTIONER ELIGIBILITY**

Osteopathy Australia recognises the significant funding contribution made by the Commonwealth toward the National Disability Insurance Scheme (NDIS) and co-contributions toward home based and residential aged care services.

We strongly support the Commonwealth's expected increase to real funding levels proposed in forward estimates for the NDIS. We would home ageing related service funding levels keep apace to assure no disparity along the disability/ageing service delivery continuum.

 Under models of consumer or person directed care, the emergent role of government is to facilitate a diverse marketplace of providers from which consumers can select services in keeping with the fundamental principle of 'choice' and a light touch regulatory role. Despite the many successes of the NDIS and aged care services for many Australians, Osteopathy Australia's position is that there remains some distance before consumers can fully enjoy the benefits of a diversified provider marketplace. Clients of funded services, whether of specific ageing or disability services often do not enjoy the choice of provider they would wish for, including for arbitrary and inconsistent reasons like limited broker or scheme knowledge, misconceptions, or lack of awareness of scheme rule flexibilities.

**Recommendation 22:** Create a broker education program giving all NDIS and home care package brokerage and care planning organisations consistent training on the rights of clients to select providers of their choice and the process involved in selecting providers. All people deserve a consistent service experience.

**Recommendation 23:** Dedicate funding to publish a transparent and streamlined process for all health and allied health professions wishing to qualify for approval in specific service support streams of the NDIS, Commonwealth residential care and home care services. Osteopathy Australia is aware of an undocumented process specific to the NDIS, for example, but this awareness was formed only after several discussions and no published information was given to follow.

**Recommendation 24:** Give clients of ageing and disability support schemes broader choice to consult an osteopath for musculoskeletal, functional and movement based clinical outcomes in moving toward a competitive marketplace with reduced costs and greater provider supply. With the prevalence of disability both due to ageing and inherited factors set to remain steady or increase in coming years, provider supply issues must be managed now to prevent future untimely delays and backlogs.

**9 ABOUT OSTEOPATHY AUSTRALIA**

Osteopathy Australia is the peak body representing the interests of osteopaths, osteopathy as a profession and consumer's right to access osteopathic services.

Our core work is liaising with state and federal government, all other statutory bodies regarding professional, educational, legislative and regulatory issues as well as private enterprise. As such we have close working relationships with the Osteopathy Board of Australia (the national registration board), the Australasian Osteopathic Accreditation Council (the university accreditor and assessor of overseas Osteopaths) and other professional health bodies through our collaborative work with Allied Health Professions Australia. Our role is also to increase awareness of osteopathy and what osteopaths do.

Osteopathy Australia members are committed to continuing professional education and we require all members to comply with our standards. Osteopathy Australia signifies a standard of professional and ethical behaviour over and above the requirements of registration.

**REFERENCES**

1. Medicare data, accessed from [www.mbsonline.gov.au](http://www.mbsonline.gov.au) [↑](#endnote-ref-1)
2. Adams J, Sibbritt D, Steel A, Peng W. 2018. A workforce survey of Australian osteopathy: analysis of a nationally-representative sample of osteopaths from the Osteopathy Research and Innovation Network (ORION) project. BMC Health Services Research 18:352. Accessed from <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3158-y> [↑](#endnote-ref-2)
3. Primary Health Care Advisory Group. 2016. Better Outcomes for people with chronic and complex health conditions. Australian Government Department of Health. Canberra. [↑](#endnote-ref-3)
4. Australian Health Ministers Advisory Council. 2017. National Strategic Framework for Chronic Conditions. Australian Government. Canberra. [↑](#endnote-ref-4)
5. P.J. Orrock\*, K. Lasham, C. Ward. 2014. Allied Health practitioners’ role in the Chronic Disease Management program: The experience of osteopathic practitioners. International Journal of Osteopathic Medicine (2015) 18, 97-101 [↑](#endnote-ref-5)
6. Willcox, S. (2014). Chronic diseases in Australia: The case for changing course, Australian Health Policy Collaboration Issues paper No. 2014-02. Melbourne: Australian Health Policy Collaboration. [↑](#endnote-ref-6)
7. Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice‐based interventions on professional practice and healthcare outcomes. The Cochrane Library. [↑](#endnote-ref-7)
8. Government of Western Australia, Department of Health. 2013. Diagnostic Imaging Pathways – Shoulder (Pain or Instability). Accessed 29 May 2018 from <http://www.imagingpathways.health.wa.gov.au/index.php/imaging-pathways/musculoskeletal-trauma/musculoskeletal/shoulder-injury#pathway> [↑](#endnote-ref-8)
9. American College of Radiology, 2012. ACR Appropriateness Criteria: Shoulder Pain – Atraumatic. Accessed 29 May 2018 from <https://acsearch.acr.org/docs/3101482/Narrative/> [↑](#endnote-ref-9)
10. American College of Radiology, 2012. ACR Appropriateness Criteria: Chronic Ankle Pain. Accessed 31 May 2018 from <https://acsearch.acr.org/docs/69422/Narrative/> [↑](#endnote-ref-10)
11. American College of Radiology, 2012. ACR Appropriateness Criteria: Chronic Elbow Pain. Accessed 31 May 2018 from <https://acsearch.acr.org/docs/69423/Narrative/> [↑](#endnote-ref-11)
12. American College of Radiology, 2012. ACR Appropriateness Criteria: Chronic Elbow Pain. Accessed 31 May 2018 from <https://acsearch.acr.org/docs/69424/Narrative/> [↑](#endnote-ref-12)
13. American College of Radiology, 2012. ACR Appropriateness Criteria: Atraumatic Shoulder Pain. Accessed 31 May 2018 from <https://acsearch.acr.org/docs/3101482/Narrative/> [↑](#endnote-ref-13)
14. Government of Western Australia, Department of Health. 2013. Diagnostic Imaging Pathways – Knee pain (non-traumatic). Accessed 31 May 2018 from <http://www.imagingpathways.health.wa.gov.au/index.php/imaging-pathways/musculoskeletal-trauma/musculoskeletal/non-traumatic-knee-pain#pathway> [↑](#endnote-ref-14)
15. Medicare Benefits Schedule. May 2018. Accessed 30 May 2018 from <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=55828> [↑](#endnote-ref-15)
16. Grattan Institute. <https://grattan.edu.au/report/saving-private-health-2/> [↑](#endnote-ref-16)
17. *National Strategic Plan for Pain Management (2019*) <https://www.painaustralia.org.au/static/uploads/files/national-action-plan-11-06-2019-wftmzrzushlj.pdf> [↑](#endnote-ref-17)