Submission to the National Commission of Audit

November 26 2013

Contact:
[redacted], Policy Advisor
[redacted]

This submission

The Australian Osteopathic Association (AOA) appreciates the invitation to make this submission to the Commissioners.

The Australian Osteopathic Association

The AOA is the national professional body representing over 85% of osteopaths across Australia. This gives us a unique voice for representing the profession and lobbying to ensure high industry standards are established and maintained. Our core work is liaising with state and federal governments, regulatory or other statutory bodies, and key stakeholders throughout the healthcare landscape. We always welcome opportunities for input, collaboration, planning, and reform, such as this.

Background

Osteopaths provide safe, effective, and widespread health services to Australians.
They work almost exclusively in private practice, and the majority of fees are paid up front by patients at the time of consultation.

Private health insurance pays some benefits to members, and Medicare provides very limited rebates for sufferers of chronic diseases receiving osteopathic services under a GP's management plan.

Summary

A strong, sustainable health system is a key responsibility of the Commonwealth Government.

Allied health practitioners such as osteopaths play an important role in this system. Osteopaths provide clinical treatment to unwell patients, preventative care to healthy patients, and ongoing management of chronic diseases.

Osteopaths also provide general health and lifestyle advice, referring to other practitioners when clinically indicated.

The role of Medicare can be modified in ways that bring savings.

The role of private health insurance should be bolstered.

Each will be briefly treated here.

Medicare reform

1. **Expanded Chronic Disease Management** (CDM) plans would reduce the burden on GPs and emergency rooms, both of which involve direct Government expenditure

(via Medicare items for services provided by GPs, and by Commonwealth/state hospital funding).

The modest and controllable cost of managing a chronic disease in the community under an expanded Chronic Disease Management program should be set against the cost of expensive and uncontainable health care such as hospitalisation, emergency room use, ambulance/paramedic expenses, and Pharmaceutical Benefit Scheme expenditure.

Put another way, small increases in responsible investment can reduce the otherwise uncontrolled cost of hospitalisations, ambulance transport, acute surgical interventions, and pharmaceuticals.

Accordingly, the AOA strongly urges an expansion of the Medicare Allied Health Initiative: the number of annual consultations per chronic disease should be increased to a number that is clinically determined by the referring GP.

As important as GP involvement in CDM plans is, the remuneration for case planning is out of proportion. Right now, too much money is being spent on GPs writing the plans, and not enough on the provision of services in accordance with the plans.

2. There is scope for actual **savings in the reform of funding arrangements for diagnostic imaging**.

   Osteopaths are primary health care practitioners who are consulted on a wide range of medical complaints that relate to the entire body. Osteopaths do not use diagnostic imaging as a generalised screening tool. All use of imaging is diagnostic in nature or recommended because it may affect the course of treatment.

   (We have previously explained the desirability of collecting statistical information in a way that permits useful analysis of Medicare diagnostic imaging items. Representations have been made to the Department of Health and the Minister for Health. The data is collected across three professions—osteopathy, chiropractic, and physiotherapy—but has hitherto never been recorded in a way that permits comparison of requests by profession.)

   The AOA advocates increasing the very limited types of diagnostic imaging to which Medicare rebates currently pertain. The current system only permits Medicare-rebated diagnostic imaging requests for spinal, pelvis, and hip x-rays. This results in frequent referrals to GPs merely for the purpose of requesting images.

For instance, currently an osteopath referring a patient for a knee x-ray, ultrasound, or MRI must refer the patient to a GP in order for the clinically indicated diagnostic imaging to be accessed via Medicare.

This additional, inefficient step incurs unnecessary costs, delays treatment, and worsens GP waitlists. AOA analysis suggests that this is an additional cost burden of $3.7 million to Medicare and $5.7 million to patients.

Such changes, if applied collectively to osteopathy and other manual therapies such as chiropractic and physiotherapy, could result in savings far beyond the $3.7 million due to osteopathy alone, since osteopathy is numerically the smallest of the regulated health professions.

Reforming this will bring about a more efficient process, a more efficient use of Medicare funds, and quicker diagnoses. (Quicker diagnoses themselves will lead to savings from a reduced overall disease burden, reduced time away from work and related productivity gains, and less disease progression.)

3. **Direct referral reform**. Similar to the inefficiency inherent in the current restrictions on diagnostic imaging requests, there is an avoidable inefficiency in the current mandatory referral pathway. Right now, every visit to a specialist requires a current and specific referral from a general practitioner.

   A current and specific referral should always be required, but allied health practitioners such as osteopaths should be permitted to make them, within their scope of practice.

   Actual cash savings can result from eliminating the requirement for two regulated, experienced, highly trained health practitioners to be involved in making a referral when the professional opinion of one provides sufficient clinical information for the referral to be made.

   Direct referral reform applied across 80,000 allied health practitioners could have budget-significant savings.

Private Health Insurance

1. The AOA strongly encourages **extending of the role and scope of private health insurance**. Incentives for obtaining private health insurance, such as tax relief for choosing to obtain it, should apply to adults younger than 30. Moreover, the quantum of insurance sufficient to obtain such tax relief should be larger than it currently is.

2. Currently private health funds are prevented from using data collected via rebates to assist consumers (i.e. their members) with health promotion or prevention

information that could reduce potential chronic disease and increase the efficient deployment of other health resources. We understand that there may be privacy and confidentiality concerns, but appropriate case management of disease and prevention can be balanced with privacy.

3. The Government should remove or reduce restraints on the type of services that private health insurance can cover. There's no reason to prevent private health funds from covering primary care. Why wait until a patient is in need of hospital treatment before deploying their private insurance?

Other matters

1. The AOA urges the Commission accurately to see **osteopaths as independent small business people** operating in an increasingly complex and costly business climate. Osteopaths do not enjoy the benefits of Government subsidy or grants, yet each osteopath must comply with costly and burdensome regulatory requirements.

   The Australian Health Practitioner Regulation Agency is somewhat effective at promoting quality care and public safety, but it does so at unwarranted cost to practitioners and with substantial delays in processing applications.

   The nexus between recently increased regulation and heightened public safety has never satisfactorily been demonstrated. The AOA's members see all the disadvantages of dealing with a complex and clunky commonwealth bureaucracy and few of the purported benefits.

2. The Commission should encourage the Government efficiently to purchase appropriate services from already qualified and experienced osteopaths when expanding DisabilityCare from the trial locations to a truly national scheme.

Conclusion

Thank you for consulting the Australian Osteopathic Association. For further information or elaboration, please contact [redacted], Policy Advisor, on [redacted].