Occupational Therapy Australia

Australian Government
Productivity Commission

Inquiry into compensation and rehabilitation for veterans

Occupational Therapy Australia (OTA) submission

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Introduction

Occupational Therapy Australia (OTA) welcomes this opportunity to make a submission to the Productivity Commission's inquiry into compensation and rehabilitation arrangements for veterans, now and into the future.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of March 2018 there were more than 20,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia.

Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities. They provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

As such, occupational therapists are ideally placed to work with veterans undergoing a process of rehabilitation. In fact, occupational therapy developed into a recognised health profession immediately after the First World War, when physically and mentally damaged veterans returning home from war had to be assisted to relearn and perform the functions of everyday living.

Given the demands and impact of military service, on both physical and mental health and well-being, a sizeable proportion of Australian veterans require the services of an occupational therapist, and this number grows as our veterans age.

While occupational therapists derive enormous professional satisfaction from working with veterans and war widows, it has become increasingly difficult work to sustain. This is because remuneration for such work has, in effect, been frozen for more than a decade.

This is leading to a significant change in the nature of the workforce treating our veterans. As veterans are a group with often complex needs, those treating them must understand their scope of practice and should have access, when necessary, to supervision. Regrettably, experienced clinicians are increasingly being replaced by less experienced practitioners, often new graduates, and if these choose to work as sole practitioners they can be inadequately supervised. This is of particular concern given the very complex conditions with which many veterans present. A veteran experiencing functional impairment as the result of mental illness needs and deserves a highly experienced occupational therapist or, at the very least, an occupational therapist with recourse to highly experienced colleagues.

While the Department of Veterans' Affairs (DVA) may report no decline in the total number of occupational therapists treating veterans, OTA is aware of the changing make-up of that number and the potential repercussions of this change.

OTA welcomed the announcement in last year's federal budget that the indexation of the DVA fee schedule for allied health services would resume from 1 July 2018. It is important to note, however, that during the period in which indexation was paused there was no attendant pause in the costs of running a business. Those of our members working with veterans have experienced a prolonged period in which, as a result of government policy, their outgoings have risen while their income has stagnated.

In the case of occupational therapists working with veterans and war widows, there has been no increase in the rebate, beyond adjustment in line with the CPI, since 2007. That increase was modest and applied to only one item on the schedule of fees. And, of course, there has been no adjustment

in line with the CPI since 2013. Despite this, those therapists who own a private practice are still required to give their staff an annual pay increase in accordance with the Health Professionals and Support Services Award 2010 (National Award).

Those experienced occupational therapists still doing veterans work, do so at a loss; they only keep doing it out of loyalty to longstanding clients and by cross subsidies from more profitable work.

A thorough initial assessment by an occupational therapist can take up to two hours, but only part of this time is effectively remunerated by the DVA. It should also be noted that the fee schedules for other allied health professions pay more generous rebates.

Our members often identify mental health issues while actioning referrals initially based on physical impairment, and are subsequently expected to perform a case management role which is not remunerated. An updated fee schedule should reflect the wide landscape in which occupational therapists work. It should remunerate them for the time it actually takes to perform increasingly complex consultations.

In order to do their job with the utmost professionalism, occupational therapists must spend much more time with clients than is paid for by DVA under its schedule of coded items. The nature of their work (liaising with GPs, prescribing and arranging home modifications and appliances) is absolutely essential to the proper care of clients but is not currently remunerated by DVA.

Furthermore, legislation dictates that private practice owners must pay their staff for all hours worked and their time spent travelling. These therapists are now having to pay out of their own pockets in order to comply with the legislation, as DVA fees will simply not allow for this. An increasing number of OTA members find it untenable to employ staff, and this will result in fewer veterans having access to occupational therapy services.

It must also be noted that occupational therapy is different from other allied health professions. It approaches the client within the context of their environment, and their need to function in that environment. Accordingly, occupational therapists usually travel to and from the place in which the client is trying to function (eg. their home or residential facility). In the case of those working with veterans, this travel is inadequately subsidised.

Similarly, occupational therapists are required to complete much more written reporting than other allied health professionals. Initial clinical assessments, the design of home modifications and the prescription of assistive technology all involve extensive written reporting. Significantly, the DVA's audit requirements necessitate careful written reporting but the time spent completing necessary documentation is not subsidised.

Comparison to other fee schedules

The DVA Schedule of Fees for Occupational Therapists, effective 1 November 2013, pays $87.00 for initial and subsequent consultations undertaken at a therapist's rooms or the veteran's home. This fee is not time-based, meaning occupational therapists will be paid a flat rate regardless of how long the consultation actually takes.

By comparison, speech pathologists are paid an hourly rate of $105.80, and clinical psychologists are paid $174.25 for out-of-rooms consultations lasting more than 50 minutes. It makes no sense at all that the payment rate for occupational therapists is so low when they are required to do more administrative work than other health professionals. Later in this submission we list some of the

expenses that occupational therapists incur but for which they are not, or are inadequately, remunerated for.

Occupational therapists often find themselves resolving clinical issues over the phone in the interests of client safety. It is the professional and ethical responsibility of therapists to progress these issues as soon as possible, even if this is outside of traditional working hours.

2018-19 federal budget

OTA outlined these issues in a letter to the new Minister for Veterans' Affairs, the Hon. Darren Chester MP. This letter was sent on 2 March 2018, however no response has been forthcoming. We also raised this in our 2018-19 pre-budget submission to Treasury, however the release of the budget failed to provide any reassurance to service providers.

Instead, the federal budget was potentially a hammer blow for our members. More than $40 million is to be cut from funding for allied health services over the next four years as part of what is termed a 'new treatment cycle' model of care. While the federal government refers to this measure as a means of 'achieving efficiencies', occupational therapists could be forgiven for concluding that the cuts are yet another fiscal assault on soft targets – namely veterans and the allied health practitioners who care for them.

An information sheet published on the DVA website following the budget stated that trials of new funding approaches for 'selected professions' would be developed during 2019-20, and implemented from February 2021 until 2022. If these trials include occupational therapy, this essentially means that providers will have to wait at least another three years for any sort of real pay increase.

Actual costs of providing services to veterans and war widows

A member of OTA recently provided us with a comprehensive case study of the actual costs of running a business. Private providers are being forced out of the veterans service market as a result of the fees paid by DVA, and it is our veterans who are being short-changed as a result.

The list below, though not exhaustive, provides an overview of the items and services that private practice owners may be required to pay for. DVA fees simply do not cover all these expenses. For those occupational therapists who rely primarily on DVA work as a source of income, owning and operating a business is becoming increasingly unsustainable.

- Staff wages;
- Superannuation;
- Long service leave – this needs to be paid to employees with over ten years' service;
- Annual leave (or casual leave loading);
- Sick leave;
- Continuing professional development (CPD) training – occupational therapists are legally required to undertake 30 hours of training per year;
- IT costs – therapists no longer work without an iPad, iPhone or similar. Builders are expecting photos (for home modifications) and are no longer satisfied with just diagrams;
- IT-based client management system – this is required by DVA, as providers are not permitted to just use any cloud-based system. These are very expensive and an annual fee per therapist is required;

- Office phone and fax machine – a fax system is still required by DVA providers for secure communication with GPs;
- Mobile phones for staff – cost of phones and calls;
- Time spent reporting back to GPs. Occupational therapists are not reimbursed for any of the time spent reporting back to the referring GP or other health professionals. It is important, as well as courteous, to report back to the GP and enable them to perform their role of case manager effectively;
- Time spent on the phone and providing extra information to Occupational Therapy Advisers employed by DVA;
- Scheduling appointments – this is not a quick process;
- Speaking to family members of clients over the phone;
- Travel costs, including the expenses incurred as a result of driving on a daily basis;
- Accounting;
- Bookkeeping and claiming for visits;
- Electricity costs;
- Office fees – reception, computers, stationery, etc.;
- Professional indemnity insurance;
- Police checks;
- Professional association membership fees;
- Supervision – this is expected to be provided by more senior therapists;
- WorkCover insurance;
- Business insurance for equipment;
- Phone calls to re-order or replace items where no visit is required or wanted, or there is no referral;
- Dealing with grief over the phone after the loss of a loved one, or person going into care;
- Organising urgent replacement of equipment or repairs;
- Spending extra time with clients as they feel very grieved by DVA – ensuring that they are being well looked after;
- Safety – sometimes two therapists should be visiting a veteran at home. It is vital that this is factored into the fee schedule, even if permission is first required from DVA for two therapists to attend; and
- The risk of running a private practice and being responsible for staff in the organisation.

The therapist who sent us this list reported that they currently spend between one and two days per week doing unpaid work – this is simply unavoidable.

With regard to DVA work, this therapist concludes: “It is no longer possible to employ and pay appropriate wages and run a professional business. We also need to know how we can afford redundancies – which by law we are required to pay”.

Conclusion

If the exodus of experienced occupational therapists from DVA work is to be staunched, the federal government must act to render the provision of occupational therapy services, at the very least, modestly profitable. This must involve an increase in the rebates to occupational therapists that is well above and beyond the mere reintroduction of indexation.

In contrast to the fees paid to occupational therapists working with veterans and war widows, which have not increased in real terms since 2007, the Commission is reminded that between 2007 and the current day the Prime Minister’s salary has risen from $330,356 to $527,854, the Treasurer’s salary

has risen from $238,237 to $380,662, and the Minister for Veterans' Affairs salary has risen from $200,119 to $319,772.

It should be a source of national shame that occupational therapists with longstanding clinical relationships with wounded, disabled and ageing veterans are having to cut these ties because the DVA is unable or unwilling to pay them a living wage.

And it is unconscionable that the 2018-19 budget requires those clinicians still doing this work, but at a loss, to endure at least a further three years without a real increase in pay.

OTA reminds the Commission that the inadequate rate of remuneration for this work has clinical repercussions, as experienced clinicians are forced to cease working with veterans and war widows. This does not bode well for the future of rehabilitation services and does our veteran community a profound disservice.

This is not the way a grateful nation treats the people who treat its veterans.