Issues paper to the Productivity Commission Health Workforce Study

Prepared by OT AUSTRALIA

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Background

Occupational therapy is an allied health profession. It differs from "alternative" or 'complementary" therapies in that it is taught at baccalaureate and post-baccalaureate levels at universities. Its practitioners, occupational therapists (OTs), assist individuals to regain or maximise their independence and function impaired by illness and disabilities. OTs are employed in both the public health system as well as in private practice in common with many other allied health professions. The 2001 census data showed that the occupational therapy workforce force made up 10% of the allied health professionals, with 25% of the OT workforce practicing in rural and remote regions of Australia. The vast majority of the OT workforce was female (over 90%), employed in the health and community service sectors and relatively young. Please refer to Appendix 1: The Australian OT Workforce April 2005 for more information on key workforce statistics.

OT AUSTRALIA (The Australian Association of Occupational Therapists) is the national body representing some 5000 OTs throughout Australia. The size of the active OT workforce in Australia is estimated to be over 11000. As a professional association, OT AUSTRALIA is responsible for the credentialing of OT courses in Australian universities, providing membership services such as Continuous Professional Development (CPD) as well as providing links with other relevant external bodies such as the Council of Occupational Therapy Registration Boards (COTRB) and the World Federation of Occupational Therapists (WFOT). COTRB is responsible for the assessment of overseas qualified OTs and their acceptance to practice within Australia.

This paper outlines issues in response to the Commission's Preliminary Areas of Interest. A formal submission will be made by OT AUSTRALIA upon the release of the Commission's Issues Paper at the end of May.

In response to the Commission's Preliminary Areas of Interest 1.

Workforce Planning

- According to Dept of Employment and Workplace Relations (DEWR), there was a 130% growth (or 18% p.a.) in the OT workforce from 1997-2001. However, the rate of growth has slowed to between 7-12% in recent years. Deakin University (Victoria) started an OT course in 2002, 55 new graduates are expected at the end of 2005. OT schools are planned in Monash (Victoria) and Edith Cowan (WA) universities, but they will have no immediate impact on the number of OT graduates.
- Despite their achievements to date on national coordination of workforce issues, current arrangements such as the Australian Health Workforce Advisory Committee (AHWAC) and the Australian Medical Workforce Advisory Committee (AMWAC) lack independence and transparency. Moreover, they have virtually no impact on the education funding for the health professions.
- Workforce data collection is ad hoc. For occupational therapy, the Australian Institute of Health and Welfare (AIHW) gathers data from state based registration bodies where they exist and rely on state health departments who in turn obtain their data from state based member associations of OT AUSTRALIA. The veracity of data collected are questionable at best, and certainly does not stand to the level of scrutiny and analysis required for workforce planning purposes at state nor Commonwealth levels.
- Even when workforce data is available, funds are not guaranteed for its analysis. The AIHW has the full set of OT workforce data for 2003 from every state and territory, but lacks the funds required from the Department of Health and Ageing to analyse the data and report on these findings.

2. Education and Training

- Clinical education or field work is a concern for OTs in Australia.
- WFOT requires graduates to have a minimum of 1000 hours of clinical education as part of their educational requirements. Currently this is undertaken throughout the students' course. The 3 year degree with 1 year internship option for occupational therapy was tried but failed due to the disassociation between course and clinical work.
- There is no funding of clinical education for OTs (or any other allied health professionals), which is in contrast to medical, dental and nursing.
- There are also compounding factors such as high percentage of part time employment of the workforce (over 50%), 19% leaving the profession each year and increasing number of OTs working in generic (e.g. mental health and vocational rehabilitation), part time and private practice settings.
- Increased numbers of students puts additional pressure on public hospitals, which are already "stretched" by increasing service demands. Vast majority of clinical education takes place in public hospitals. University educators have been forced to use ex-colleagues and other informal networks to secure student clinical education placements.
- Some universities are looking at other innovative models of clinical education such as project based placements, but they are costly and administratively

demanding on university staff with some universities reporting up to 200 hours spent per student on field work coordination, supervision and liaison.

- Some educators have reported that students were not able to graduate as a result of not meeting the 1000 hours field work requirement. In at least one instance, students were contemplating legal actions against their universities.
- There are currently no formal systems in place to re-train OTs to re-enter the workforce after a period of absence. This is despite data from the 2001 census that showed between 38-49% of those with OT qualifications not working at the time of the census.
- Please refer to the attached document "Solving the Crisis in Clinical Education for Australia's Health Professions - A discussion paper from the Health Professions Council of Australia" for further information.

3. Workforce Regulation

- Statutory registrations of OTs are currently required in NT, Qld, SA and WA, but not in Vic, NSW, Tas and ACT. This situation poses unacceptable risks to the health consumers where de-registered OTs can simply move to a state/territory with no registration requirements and continue to practice.
- Registration is self funding. It imposes no cost to the government/public.
- Stronger regulation is the hallmark of a vibrant workforce and its ability to meet future demands. Statutory registration for OTs must be in place in every Australian state and territory due to the increased specialisation of the profession. Practitioners are also increasingly employed in case management and roles where they prescribe or supervise treatments carried out by para health professionals such as therapy aides. The registration for OTs is also a feature of health systems in other major OECD countries.
- OT AUSTRALIA Victoria forwarded a submission to the Victorian Department of Human Services in 2004 outlining the case for full statutory registration for occupational therapists. The submission is attached to this issues paper for the Commission's consideration.

Workforce Participation

4.
- The workforce participation for OTs in the 30-40 age category is lower than that of other professions. A major contributing factor is the high percentage of females in the profession (over 90%).
- Short term cyclical conditions of the economy may impact the participation rate (e.g. partners engage in works part time due to increased interest rates and additional mortgage re-payment commitments). However, the underlying structural systems of taxation, welfare and child care arrangements provide disincentives for part time employment. Many OTs opting for part time work, where available, may be financially disadvantaged with existing taxation and childcare arrangements.
- Some employers provide flexible working conditions, but the demand of the healthcare system, partly driven by empowered consumers, means that there is very little room to provide appropriate work/life balance or part time employment opportunities.

5. Migration Issues

- Migration should only be used as a last resort measure. The Australian healthcare system is unique and many different programs at both the Commonwealth and state levels take time to learn and adjust to. For example, OTs wanting to access adaptive equipment for their clients can do so under Program of Appliances for Disabled People (NSW); Aids and Equipment Program (Vic); and the Department of Veterans' Affairs Rehabilitation Appliance Program just to name a few.
- The primary focus should be increasing workforce capacity to enable it to meet the demands. Migration is a short term answer to the chronic healthcare workforce shortage in Australia. Migration also threatens to "poach" practitioners from other, often developing countries, where they are most in need.

6. Productivity

- The vast majority of OTs work in multidisciplinary teams and often carry out "case management" tasks of therapy and/or service coordination.
- The current health system is more of a collection of programs, initiatives and arrangements between the Commonwealth, state/territory and sometimes local governments. This situation creates duplication and hinders coordination, cooperation and innovation within the system. For example, patients being discharged home after a total hip replacement surgery can access equipment such as shower chairs through the hospital, their local community health centre or via the Department of Veterans' Affairs depending on their circumstances. Each equipment centre has its own eligibility guidelines, waiting lists and procedural requirements. Productivity of the health workforce can be increased by addressing the above barriers. This will directly result in improved health outcomes for consumers and increased job satisfaction, which will in turn improve staff retention.
- In the private sector, the current Medicare Benefit Schedule (MBS) under the Enhanced Primary Care allied health program assumes a clinic based approach towards patient care. Many allied health professionals, including OTs, visit clients in their own homes to assess and prescribe treatments. There is no recognition for the travel and associated costs incurred by the practitioners in the delivery of their services to clients. While OTs can charge their clients higher "gap fees" to cover for their costs, the equity of access by clients to such services cannot be ensured. This is especially true for clients in rural and remote regions of Australia where a four hour return journey is not uncommon, and the $44 MBS schedule fee barely covers fuel costs.
- OT AUSTRALIA recognises that a small percentage of current activities undertaken by OTs may be carried out by para-health professionals such as therapy aides under the supervision and direction of qualified OTs. However, work substitution should never come at the expense of decreased existing workforce capacity to deal with demands of the health system, its consumers and the quality of care provided. This only reinforces the need for statutory registration for OTs in every state and territory throughout Australia to ensure the safety of the public is not jeopardised.

7. Demand

- Demand for OT services has risen dramatically over the last ten years due to
  - The ageing population putting pressure on the health system including the acute subacute/rehabilitation and community sectors.
  - Low retention rate. Females account for over 90% of the OT workforce and only 46% of the workforce worked full time in 2001.
  - High degree of professional mobility. Many OTs choose to practice in specialist areas such as hand therapy, paediatrics and third party compensation systems. Figures from DEWR estimate that 19% of the workforce leave the occupation each year.
  - Informed consumers with increased degree of autonomy to choose. For example, OT service providers for the Victorian WorkCover Authority are increasingly employed in the areas of injury prevention and manual handling rather than in traditional post injury rehabilitation.

8. Regional, Remote and Indigenous Issues

- Like all health professionals, OTs are under represented in rural and remote regions of Australia.
- Evidence suggests that rural field work placements can lead to practitioners working in rural locations after graduation. Data from regional universities such as Charles Sturt indicate that a higher proportion of their OT graduates work in regional centres than graduates from universities based in major capital cities. However, lack of funding is a major barrier for students and educators to find and coordinate rural placements.
- Greater incentives must be provided for allied health students and graduates. Some possible solutions include the expansion the allied health scholarship numbers and the expansion of the Commonwealth bonded rural scholarships to include allied health professionals.
- Please refer to the attached document "Solving the Crisis in Clinical Education for Australia's Health Professions - A discussion paper from the Health Professions Council of Australia" for further information.

9. After hours GP services adjacent to acute care hospitals

- Many OTs are currently employed in large public hospital emergency departments where they assess "social admissions" of the frail and elderly. This model of care will be increasingly utilised as the population ages and has the potential to be applied to after hours GP services.
- The emergence of OTs in emergency care is another area of specialisation. This further highlights the mobility of the profession, its increasing demands and the need for statutory regulation of its practitioners.

Appendix 1
The Australian OT Workforce
April 2005

The following key points are based on the 2001 Census Data, statistics from the OT AUSTRALIA National Membership Database and statistics from the OT registration boards of SA, Qld, WA and NT.

- 5345 respondents to the 2001 census stated their occupation as OTs.
- 51% of the people who were qualified to work as OTs were actually employed as OTs on census night 2001.
- OTs represent about 10% of the overall allied health workforce.
- OTs are subject to statutory regulation (i.e. registration) in WA, Qld, SA and the NT. The profession is not regulated in NSW, Vic, Tas and the ACT.
- The OT workforce is female dominated (93%) and young (55% aged under 35 and an additional 25% aged under 45).
- Approximately 75% of the OT workforce is in major capital cities and 25% in regional and remote areas of Australia.
- The OT workforce is well educated, with 91% possessing bachelor degree education and 20% possessing post graduate qualifications.
- Dept of Employment and Workplace Relations (DEWR) estimates that 97.6%of the OT workforce are employed in health and community services, 1.4% in education and 1% in personal and other services.
- Approximately 51% of the OT workforce is employed in the public sector and 49% in the private sector. There is a trend for more employment in the private sector in major capital cities (51%) than in regional and remote areas (average 42%).
- 17% of the workforce works less than 16 hours a week on average, with an additional 42% working between 16-34 hours and another 30% working between 35-40 hours a week.
- There were 2472 undergraduate OT students and 136 masters OTs in Australian universities in 2004.
- There is a national shortage of OTs, despite the growth of the workforce by 130% from 1997-2001.
- OT AUSTRALIA National has approximately 5000 members (5132 in 2001 and 4896 in 2005). Membership saturation averaged 61% in 2001 and 47% in 2004 for those states with registration.

Estimated size of the OT workforce

1. The estimated size of the OT workforce for 2005 is *approximately 11500.* 2.

This figure excludes those on leave, overseas, or not working as OTs. 3. The

future net growth of the profession is estimated to be at 7-12% pa.