OT AUSTRALIA

Australian Association of Occupational Therapists

Partnership

Vision

And

Commitment

Submission by OT AUSTRALIA to
the Productivity Commission
Health Workforce Study

Executive Summary

Occupational therapists are allied health professionals that assist individuals to regain or maximise their independence and function impaired by illness and disabilities. The 2001 census data showed that the occupational therapy workforce force made up 10% of allied health professionals, with 25% of the workforce practicing in rural and remote regions of Australia. The vast majority of the workforce are female, relatively young and employed in the health and community service sectors.

OT AUSTRALIA (Australian Association of Occupational Therapists) contends that a skilled and competent workforce is the foundation for providing quality health care to consumers. The need for workforce evolution must be balanced against the provision of quality health care, health outcomes and health status for consumers. There is a threshold, below which, will pose a level of unacceptable risk to consumers.

There are many factors that contribute to the current crisis in the health workforce. These factors are interrelated and cannot be examined and dealt with in isolation from one another.

Federalism has created many opportunities for blame and cost shifting between the Commonwealth and state/territory governments. It also fostered a fragmented healthcare system that hinders the continuity of care of clients and productivity of the health workforce. A concerted effort in identifying and addressing these systemic barriers will lead to increased productivity and job satisfaction of the existing workforce, which will ultimately lead to better health outcomes for consumers.

The sheer lack of workforce intelligence is yet another legacy of Federalism. A central workforce agency established jointly between the two principal levels of government charged with responsibilities to collect, analyse and disseminate health workforce data will be a positive step in addressing this issue. The agency will also be providing key advice to other government departments to foster a whole-of-government approach towards health workforce planning.

Closer ties must be established between key government departments such as the Department of Health and Ageing (DoHA) and the Department of Education, Science and Training (DEST) to ensure that there is a logical connection between the supply and demand of the health workforce.

A nationally consistent process of statutory regulation or registration for occupational therapists is required. The status quo of partial regulation of the profession poses unacceptable levels of potential harm to the Australian public. This is especially significant as the workforce is growing rapidly and the profession is advancing into non-clinical or consultancy based services in the private sector.

The workforce profile of occupational therapists provides a good case study for the rest of the health workforce. Various innovative projects have been undertaken by member associations of OT AUSTRALIA to sustain workforce recruitment and retention and to facilitate workforce re-entry. These include mentoring to link experienced therapists with those seeking to enhance their professional skills and the pilot of a framework for workforce re-entry. Both projects were successful and there is scope to expand them nationally with appropriate levels of funding.

Allied health professionals such as occupational therapist are highly trained and competent practitioners. However, their areas for professional practice, especially in primary care, are still limited by the outdated medical model of health where medical practitioners still play the roles of referrers or “gate keepers”. This situation must be

addressed as it hinders workforce productivity and encourages allied health practitioners to advance to other areas of services where they can operate with greater professional independence, flexibility, recognition and remuneration, which further exacerbates the current workforce shortages.

OT AUSTRALIA acknowledges that it is not in the scope of this study to address all issues identified in this submission. However, the contributing factors to the current health workforce crisis must be acknowledged for no solutions can be found if the problems are not identified first.

OT AUSTRALIA looks forward to providing additional information to the Commission's study upon the release of the Draft Report in November/December 2005.

Recommendations

1. **That the Australian Health Ministers' Advisory Council (AHMAC) commissions a study to identify systemic barriers towards effectiveness of health service delivery across the continuum of client care. The study should consult widely with industry stakeholders and identify opportunities to reduce or eliminate duplication that will improve current workforce productivity, increase job satisfaction and ultimately improve health outcomes for clients and carers.**

2. **That the Department of Health and Ageing (DoHA) immediately release the necessary funds to the AIHW for the analysis and reporting of allied health data collected in 2003/2004.**

3. **That a central workforce agency is established and funded by the Commonwealth and state/territory governments to collect, analyse and disseminate health workforce data at a national level. This agency should be charged with liaison and consultation with key industry stakeholders such as employers, professional association and universities on workforce issues and proposed initiatives. In addition, the agency should provide advice to key government departments such as the Department of Science, Education and Training, Department of Treasury and Finance and the newly formed Department of Human Services on whole-of-government approach towards workforce planning.**

4. **That allied health professions identified as skills in shortage by both DIMIA and DEWR are immediately classified as national priorities for education funding by DEST similar to that of nursing and teaching. In addition, DEST to reclassify education funding for these allied health professions from Cluster 6 to Cluster 9 to ensure clinical education for allied health professionals is not compromised at the expense of quality of health care to the Australian public.**

5. **That AHMAC formally initiate a consistent process of statutory registration for occupational therapists in every state/territory in Australia in consultation with key stakeholders including OT AUSTRALIA.**

6. **That health workforce reform measures are included in future Australian Health Care Agreements between the Commonwealth and the states/territories. Specifically, these workforce reform measures should examine and implement award and career structures for allied health professionals in order to retain experienced clinicians in the public health system through recognition of advanced and specialised areas of practice.**

7. **That a health industry workforce innovation fund is established jointly between DoHA, DEST and DEWR to examine and pilot industry solution projects at a national level to overcome barriers towards workforce participation.**

8. **That an additional MBS items for allied health is created for travel allowances used for home visits to clients in the community as part of the EPC.**

9. **That incentives such as targeted bonded scholarships and student loan reimbursement schemes are offered to allied health students wishing to practice in rural and remote regions of Australia upon their graduation**.

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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, are employed in both the public health system as well as in private practice in common with many other allied health professions.

OT AUSTRALIA is the professional association representing occupational therapists in Australia. It is not a “guild” or a “college” and does not restrict or limit the number of occupational therapists entering the workforce. On the contrary, OT AUSTRALIA supports its members by actively promoting Continuous Professional Development (CPD) to practitioners that focus on life-long learning. Commitment to CPD by employers and practitioners not only facilitates workforce recruitment and retention, it also builds a quality framework to aid workforce re-entry. This is especially pertinent to occupational therapy, where females comprise over 90% of the workforce.

OT AUSTRALIA is also responsible for accreditation of occupational therapy schools in Australian universities in accordance with requirements set out by the World Federation of Occupational Therapists (WFOT). The entrance scores for occupational therapy course are set by the universities. OT AUSTRALIA reviews, refines and develops core competencies for practitioners to ensure a knowledgeable and skilled occupational therapy workforce. Workforce competencies and CPD will ensure that the safety of health consumers are protected at all times. To this end, OT AUSTRALIA supports statutory regulation or registration for occupational therapists throughout Australia.

The following occupational therapy workforce profile is based on data from the 2001 Census, the OT AUSTRALIA Membership Database and statistics from the occupational therapists registration boards of South Australia (SA), Queensland (Qld), Western Australia (WA) and the Northern Territory (NT).

- 5345 respondents to the 2001 census stated their occupation as occupational therapists.
- 51% of the people who were qualified to work as occupational therapists were actually employed as occupational therapists on census night 2001.
- Occupational therapists represent about 10% of the overall allied health workforce.
- Occupational therapists are subject to statutory regulation (i.e. registration) in WA, Qld, SA and the NT. The profession is not regulated in other jurisdictions.
- Approximately 75% of the occupational therapy workforce is in major capital cities and 25% in regional and remote regions of Australia.
- The occupational therapy workforce is well educated, with 91% possessing bachelor degree education and 20% possessing additional post graduate qualifications.
- The Department of Employment and Workplace Relations (DEWR) estimates that 97.6% of the occupational therapy workforce are employed in health and community services, 1.4% in education and 1% in personal and other services.

- Approximately 51% of the occupational therapy 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 occupational therapy students and 136 masters occupational therapy students in Australian universities in 2004.

There is a national shortage of occupational therapists, despite the growth of the workforce by 130% from 1997-2001. This is for several reasons. DEWR estimates that 19% of the workforce leaves the occupation each year. Over 90% of the occupational therapy workforce is female with 55% aged under 35 and an additional 25% aged under 45. There is also a high degree of mobility within the profession, with many occupational therapists choose to practice in specialist areas such as hand therapy, paediatrics and third party compensation systems. These factors have resulted in chronic recruitment and retention difficulties for occupational therapist, especially in rural and remote regions of Australia.

Research by OT AUSTRALIA estimates that the size of the active occupational therapy workforce for 2005 is approximately 11500, with future net growth of the profession estimated to be at 7-12% per annum.

Current Challenges

A fragmented healthcare system hindering workforce productivity

The current Australian healthcare system can be best described as a collection of programs, initiatives and arrangements between the Commonwealth, state/territory and sometimes local governments. Much has already been written about the cost and blame shifting of Commonwealth versus state/territory responsibilities in health care. It is not the intention of OT AUSTRALIA to outline its vision for the Australian healthcare system in this submission. However, it should be noted that the current arrangements between the various levels of government in relation to funding responsibilities, the "flow" or continuity of care of clients and carers create unnecessary duplications, discourages cooperation between clinicians and innovation within the system. Barriers are created in between the public hospitals, community health centres and private service providers. Unfortunately these systemic barriers lead to an increasingly demoralised health workforce that is struggling to cope with increased demands and clients and carers missing out on vital services, especially in rural and remote Australia.

Case Study 1

Two elderly women were admitted for emergency total hip replacement surgery after they fell at home. Both lived alone in the community except one has a Department of Veterans' Affairs (DVA) Gold Card. After a brief period of post surgical rehabilitation, both were to be discharged back to the community with support. An occupational therapist from the hospital assessed each client in need for the ongoing use of a shower chair and an over toilet frame for their safety. The occupational therapist now has at least three options to access such equipment:

Option A: The hospital occupational therapist supplies each client with equipment from the hospital equipment pool for a period of 28 days. The hospital occupational therapist would then make referrals to a community health centre so that the clients can either access equipment subsidised by the state/territory governments, usually under their Home and Community Care (HACC) programs; or in the case of the DVA client, under the DVA's Rehabilitation Appliances Program. A health worker from the community health centre (usually another occupational therapist) would then apply for the same equipment under the two different programs, each with its own eligibility criteria and issuing guidelines. Depending on waiting lists, the clients may have their replacement equipment changed over in 6-12 months. In the meantime, the client may need to hire their original equipment from the hospital after 28 days.

Option B: The hospital occupational therapist makes direct contact with the HACC coordinator and the DVA to see if they can supply equipment directly to the clients. Strictly speaking, this would not be possible as hospitals are responsible for equipment for up to 28 days post discharge. Both the HACC coordinator and the DVA are aware of the 6-12 months waiting lists in the community health centres and agreed to the hospital occupational therapist's suggestion. The hospital occupational therapist then spends 2 hours completing the two sets of equipment forms and forwarding them to the relevant agencies. However, dependent on funding available to the agencies, there may be a waiting list for such equipment.

Option C: The hospital occupational therapist issues the equipment from the hospital equipment pool and then negotiates for HACC and the DVA to "re-stock" the equipment back to the hospital so that the clients can keep the hospital equipment. If both agencies agree, the occupational therapist would still need to spend the 2 hours or so required for the relevant paperwork.

It is a sad fact that the above case study is repeated daily at various scales across Australia, with different government agencies competing against one another over limited resources and blaming each other when things go wrong. As the population continues to age, demand for health care will place more pressure on cooperative working relationships between hospitals and community care. Until this bottleneck is resolved, clinicians will continue to experience frustration, money will continue to be wasted and clients and carers continue to fall through the gaps.

RECOMMENDATION: 1

Lack of workforce intelligence

The Productivity Commission's Issues Paper (2005) made three important observations in relation to workforce data collection, analysis and usage.

1. *"Until the implementation of the* 2004 National Health Workforce Strategic Framework*, there appears to have been no overarching national vehicle for driving comprehensive workforce change" (p11);*
2. *"There is no single dataset that provides a comprehensive picture of the current and expected balance between workforce demand and supply" (p13), and;*
3. *"A tendency for planning to occur in a vacuum" (p29).*

These three statements speak volumes of the sheer lack of health workforce intelligence in Australia. The current crisis in workforce shortages can be partially attributed to this lack of accurate and up-to-date statistics. However, as the Commission also noted, Australia is not alone in its lack of centralised workforce planning (2005, p16).

The Australian Institute of Health and Welfare (AIHW), as the national agency for collection, analysis and dissemination of health and welfare information appears to be the ideal authority on key workforce data. Indeed, the AIHW has published a series of national health labour force reports including the Occupational Therapy Labour Force (1998) and the Health and Community Services Labour Force (2001).

However, workforce data collection appears to be ad hoc and under-funded. The 2001 Health and Community Services Labour Force survey was funded by the Australian Health Workforce Advisory Council (AHWAC) utilising data from the 2001 census data. One major limitation in using the census data is that it only sought respondents' highest qualifications rather than any relevant initial qualifications (AIHW, 2001 p17). Research by OT AUSTRALIA indicates that some 30% of its members possess one or more post graduate qualifications in relevant fields of study and that the majority of these continue to work as clinicians. This raises serious doubts on the veracity of the data reported.

For its 1998 occupational therapy workforce study, the AIHW approached OT AUSTRALIA and its member associations in Victoria and the ACT as well as occupational therapists registration boards in Queensland, Western Australia and the Northern Territory. South Australia, Tasmania and New South Wales did not participate in the survey. The same methodology was also used in 2003 for a follow up workforce study. A concerted effort by OT AUSTRALIA and the relevant occupational therapists registration boards again cooperated with the data collection process and ensured that datasets from every Australian state and territory were forwarded to the AIHW. Unfortunately, OT AUSTRALIA was informed by the AIHW in early 2005 that it lacks the required funding to undertake the analysis and reporting of the completed datasets. OT AUSTRALIA understands that several other allied health disciplines are also in the same situation.

RECOMMENDATION: 2

Occupational therapists are in demand, as are many other health professionals. These shortages were identified by the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) as well as the Department of Employment and Workplace Relations (DEWR) and outlined in the Productivity Commission's Issues Paper (2005, p14).

It is unacceptable that while these shortages are causing delays to delivery of health services and frustrations to the health professionals, very little attention and funding have been allocated to examine and address their underlying causes. Without accurate and up-to-date workforce statistics, there can be no overall plan to address the crisis of health workforce shortages in the long term. To repeat an often-used saying "failure to plan is planning to fail".

The demand for health care has risen and will continue to rise in line with the ageing population including that of the healthcare workforce. Clients and carers are now more empowered to seek alternative opinions and demand access to services. When these demands are analysed in the context of the occupational therapy workforce profile and that of the health workforce in general, it raises an apparent contradiction:

How can the health workforce, increasingly feminised, in search for more flexible working conditions and greater work-life balances, adequately respond to the increasing needs for equally flexible and prompt health services demanded by empowered and informed clients and their carers?

While workforce reform, realignment and greater role sharing among clinicians may provide some answers, they cannot take place in absence of accurate and reliable health workforce data.

As the Commission noted, skills importation may not be a viable long term strategy (2005, p16). The Australian healthcare system is unique and in many instances, such as the issues outlined in Case Study 1, clinicians need to take time to learn the guidelines associated with various programs. The primary focus should be increasing workforce capacity to enable it to meet current and projected demands of the Australian population. Targeted migration also threatens to "poach" from other, often developing countries.

RECOMMENDATION: 3

Lack of connection between the education and the health systems

The Commission's Issues Paper highlighted the chasm between the education and health systems and its consequences for the latter (2005, p29). However, of particular concern to OT AUSTRALIA in relation to this issue is the chronic under-funding of entry-level education for occupational therapists.

Under the Department of Education, Science and Training (DEST) high education policy (2005), occupational therapy is classified under health in Cluster 6. Unlike medicine, dentistry and nursing, which have their own funding clusters, each occupational therapy student only attracts Commonwealth contribution of $7,212. This is less than half of the amount the Commonwealth contributes to medicine, dentistry and veterinary science ($15,047) and 30% less than nursing ($9,511). In addition, universities can set maximum contributions for occupational therapy students at $6,849, almost double that for nursing students ($3,847). OT AUSTRALIA acknowledges that nursing is currently a national priority for education funding, but contends that such priorities should also apply to allied health professions including occupational therapy identified by both DIMIA and DEWR as area of skills shortage.

The under-funding of allied health professions such as occupational therapy has direct implications for their workforce supply. This is most evident in clinical education, which is an integral part of training for all healthcare professionals. Clinical education provides individuals with opportunities to observe experienced clinicians in action, acquire professional skills and practice these skills in controlled environments. Evidence supports the notion that clinical education should be "hands on" and that it can be enhanced, but never replaced by technological innovations such as computer simulated training methods.

The international benchmark for clinical education for occupational therapy students as part of their entry level education is identified as 1,000 hours by the World Federation of Occupational Therapists (WFOT). This amount of clinical education is in common with many other allied health professions.

Clinical education for occupational therapy students is currently undertaken throughout their entry level courses. An "internship" model for clinical education was tried but failed due to its disassociation with theoretical coursework. Unlike some other health professions, host health services taking on occupational therapy students are doing so under "professional obligations" without any financial compensation for staff time lost in student supervision. This makes some smaller healthcare providers such as community health centres reluctant to take on students.

Feedback from university staff indicate that they are finding it increasingly difficult to find students placements, especially in their first and second years, where they are less likely to contribute to clinical work as third and fourth year students. University staff are also reporting that the under-funding of courses limits both the quality and the quantity of support for students on placements.

Moreover, occupational therapy students on clinical placements do not receive any financial assistance, even if they opt to take placements in rural and remote areas. This makes rural and remote placements unattractive, even punitive to students. The lack of occupational therapy courses in rural and regional centres further exacerbates the problem of workforce supply in these areas.

Case Study 2

Joanne is a third year occupational therapy student planning to undertake her 8-week clinical education in a rural hospital 4 hours away from home to experience "working in the bush". Prior to her placement, Joanne arranged with the hospital to stay at their "nurses' quarters" during her placement for $40 a week. The hospital occupational therapy department decided to fund a return bus ticket for Joanne's placement. Joanne also has a part time job in a café and informed her employer that she'd be unavailable for any work for 8 weeks. Her employer stated that he cannot keep her job open for that long and she is unlikely to have her job back upon her return. Despite this, Joanne went on to successfully complete her placement. After her placement, Joanne estimated that her lost income and living expense for the 8 weeks amounted to over $2000. Joanne has vowed never to take another rural placement again and shared her story with her fellow students to discourage them to do so in the future.

It is most disappointing that when the issue of under-funding of clinical education for allied health is brought up at the Commonwealth and state/territory levels, the standard response is passing the blame, at the expense of students and the Australian public.

The Department of Health and Ageing (DoHA) accuses the state/territory health departments for not passing the appropriate funds to hospitals for clinical education. The state/territory health departments blame both the Commonwealth for under-funding of their health services as well as the hospitals for mismanagement of their funds. And both DEST and DoHA insist that the other department is accountable for this issue.

In the meantime, university staff continue to struggle to find placements for students. 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. These extra demands on university staff are not reflected in the low level of education funding from DEST compared with other health professions.

RECOMMENDATION: 4

Fragmented regulation of the profession

Occupational therapists are subject to statutory registration in the Northern Territory, Queensland, South Australia and Western Australia, but not in other jurisdictions. This situation poses unacceptable risks to the community. It is simply unknown how many de-registered occupational therapists have moved to a state/territory with no registration requirements and continued to practice and caused public harm.

Registration is self funding. It imposes no cost to the government or to the public. OT AUSTRALIA is concerned that the current situation of partial regulation of the profession leaves the door open not only to incompetent or de-registered practitioners to "border hop" and continue to practice unabated, but also to unscrupulous individuals to hold themselves out to be occupational therapists when they do not possess the relevant qualifications. The mobility of the occupational therapy workforce internationally adds a further dimension to this.

These concerns are heightened by the fact that occupational therapy is a rapidly growing profession with an increasing number of specialist areas of practice as outlined in the Background section. Practitioners are increasingly employed in case management and roles where they prescribe or supervise treatments carried out by health care assistants. The registration for occupational therapists is critical in ensuring that the quality of care of clients is of an appropriate standard and that possible harm to the public is minimised.

Strong professional regulation is the hallmark of a vibrant workforce and its ability to meet future demands. Statutory registration for occupational therapists is in place in all major OECD countries, with Australia being the exception. This situation requires urgent action by all levels of government.

Furthermore, there has been increasing public attention and regulatory scrutiny on the safety and quality of services provided by practitioners and the facilities in which they operate in. Healthcare facilities undergoing accreditation processes are asked to demonstrate that their care providers are delivering services at acceptable standards. There is a clear link between the competencies of care providers, the standard of care delivered and the health outcomes of consumers. It is therefore necessary to develop statutory regulation for occupational therapists to ensure that they meet these standards in a clearly demonstrable way and to minimise potential for harm to the public.

OT AUSTRALIA contends that statutory registration for occupational therapists must be in place in every Australian state and territory.

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. Rather than reiterating the issues, that submission is attached to this paper for the Commission's consideration.

RECOMMENDATION: 5

Disincentives to participation in the health workforce

Workforce issues cannot be examined purely in supply/demand terms. There are a number of contributing factors that impact on the current shortage. These are manifested in the following disincentives to workforce participation in the health sector by occupational therapists:

1. Limited career opportunities and remuneration as clinicians,
2. Advancement and specialisation of professional practice,
3. Limited opportunities for workforce re-entry after a period of absence,
4. Inflexible working arrangements in the health sector, and
5. Inflexible taxation, welfare and employment arrangements.

In the 2001 Health and Community Services Labour Force study, the AIHW found that less than 2% of occupational therapists had annual income of greater than $78,000. In contrast, almost 10% of clinical psychologists and podiatrists and over 20% of chiropractors had the same level of income. For other health professionals such as medical scientists and ambulance officers, the figure is in the order of 6%. Unsurprisingly, the figure for medical practitioners and specialists are nearer to 60%.

While these statistics can be partially explained by the higher rate of part time employment for occupational therapists, they cannot ignore the fact that as clinicians, occupational therapists are among the poorest paid allied health professionals in Australia. The increased financial burden of student debts on new graduates means that they are increasingly turning towards areas of greater remuneration, mainly in the private sectors, rather than pursuit of professional practice in the public health system. This explains the difficulties faced by public hospital employers in recruiting and retaining staff.

There is also a general lack of recognition of advanced and specialist practice by allied health professionals in the public health sector, which further detracts from the retention of experienced staff, leading to the “experience drain” to the private sector.

In the United Kingdom, the National Health Service has recognised this as a major issue and has implemented initiatives such as therapist consultants to work alongside their medical and nursing consultant colleagues. This initiative should be examined closely by health departments at both the Commonwealth and the state/territory levels as a possible way to retaining experienced staff and to attract more staff to the public health sector.

RECOMMENDATION: 6

Australian occupational therapists are highly trained and much sought after by international standards. Data from the Australia’s Health 2002 published by the AIHW revealed that between 1999 and 2000, there was a net migration loss of 12% for occupational therapists. This is in direct contrast of net migration gains of 8% for podiatrists, 9% for physiotherapists and 68% for optometrists. In the latest Australia’s Health 2004 by the AIHW, the net migration loss for occupational therapists between 2001 and 2002 have more than doubled to 26%. There was a small migration loss for physiotherapists of 3% while podiatrists and optometrists both gained 6%. General practitioners and pharmacists enjoyed the biggest migration gains, 27% and 35% respectively.

Occupational therapists find it difficult to re-enter the workforce after a period of absence, especially in the health sector, where they often have to balance the inflexible working hours with professional development requirements and family commitments. The existing taxation arrangements and child care costs further discourage part time employment in the public health sector. As a result, many occupational therapists are opting for part time work, or work for employers willing to offer more flexible working environments. Research by OT AUSTRALIA has shown that the bulk of such employment opportunities are in the private sector, where occupational therapists can work as contractors or providers in their own right. Successful private practitioners have also developed their business skills alongside their clinical skills and move into consultancy based businesses where they are remunerated at appropriate market rates.

Case Study 3

Diane has two children aged 5 and 3. She worked as an occupational therapist for 5 years before resigning to give birth to her first child and has been out of the workforce since. Both children are now at her local child care centre 2 days a week and Diane decided to re-enter the workforce and work for 2 days a week. After looking through the papers, Diane realised that the only occupational therapy jobs on offer in her local hospitals are full time positions. She eventually secured a 2 day a week occupational therapy position in the local community health centre. After the first three months of work, Diane calculated that she earned only $80 for her two days' work, or just over $5 per hour, after tax, child care costs and car payments. She has since quit her job and has taken on bookkeeping for her husband's business.

The Occupational Therapy Labour Force study found that 44% of the 79% of occupational therapists aged over 30 were not employed as occupational therapists due to child rearing reasons. More importantly, 88% of the 79% had plans to return to work at some stage. The above case study illustrates the frustration experienced by occupational therapists seeking to return to part time employment after a period of absence. These difficulties contribute directly to the low workforce participation rate by occupational therapists, especially in the public health sector.

The Commission made reference to the "feminisation" of the health workforce and its increasing trend towards part time employment to achieve greater work-life balance (2005, p15). With females composing of over 90% of its workforce, the profession of occupational therapy has experienced these issues first hand and has developed several innovative programs in response. Two recent and successful programs include the MentorLink and workforce re-entry programs undertaken by OT AUSTRALIA Victoria.

As its name suggests, MentorLink-Allied Health is a facilitated mentoring program for allied health professionals in Victoria. The program started as a pilot involving occupational therapists in rural and remote practice between 1999 and 2001. As part of its funding agreement in 2002, the program was expanded to include physiotherapy, podiatry, social work and speech pathology. The program provides mutual support for practitioners, especially in isolated locations. It assists career development and is a practical and useful tool in aiding workforce re-entry. The limitation of this program is that it only allows for Victorian participants due to funding agreement with the Victorian Department of Human Services (DHS).

The Victorian DHS also funded OT AUSTRALIA Victoria's workforce re-entry pilot in 2003. Under this pilot, occupational therapists wishing to re-enter the workforce after a period of absence were enrolled in a "refresher" course, followed by placements in healthcare facilities. The pilot met all its agreed targets, but was

discontinued as the DHS did not provide further funding to the project and the cost for the project and its administration was beyond the financial means of OT AUSTRALIA Victoria.

Similar projects to the two described above have been run successfully overseas and in professions such as nursing in Australia. Professional associations such as OT AUSTRALIA have limited capacity to initiate and sustain such industry reform programs without financial partners from government, education institutions and other stakeholders. The current crisis in health workforce recruitment, retention and re-entry demands urgent and cooperative action from government, consumers and industry stakeholders.

RECOMMENDATION: 7

Restrictive areas of professional practice as a legacy of the outdated medical model of health

Despite their high levels of training, education and abilities to practice as independent clinicians, allied health professionals including occupational therapists are still being subject to practice restrictions as a legacy of the outdated medical model of health. This is most evident in Commonwealth initiatives such as the Enhance Primary Care (EPC) program, where medical practitioner referrals are required for clients to access occupational therapy services.

OT AUSTRALIA acknowledges that general practitioners (GPs) remain the most appropriate primary contact for clients in the majority of primary care cases. However, for people living in the community with carefully controlled and regularly monitored medical conditions, occupational therapists can assist clients with overcoming decreased functional independence and increased safety without GPs playing referrer or "gate keeper" roles.

Clients wishing to access occupational therapy services under the current EPC program must first visit their GP and obtain appropriate referrals, even if they have no medical reasons to do so. As a result, many occupational therapists in private practice have advanced into non-clinical areas such as consultancy services in occupational rehabilitation and injury management.

Research by OT AUSTRALIA has shown that the current rate of remuneration for occupational therapy services under the EPC's Medicare Benefit Schedule (MBS) and the DVA's Occupational Therapy Fee Schedule is some 40% below the market rate for occupational therapy services in other areas. The MBS fees also assume a "waiting room" scenario for allied health. In reality, it is not uncommon for occupational therapists to complete a four hour return journey to see clients in rural and remote areas. The mobility of the profession, the relative poor rate of pay as clinicians and ever increasing level of debt of graduates as mentioned earlier have all contributed to the exacerbation of the current workforce supply to the health system, as noted by the Commission (2005, p31).

Despite the Commonwealth's efforts in attracting health professionals to practice in rural and remote Australia, structural barriers mentioned above means that initiatives such as the More Allied Health Services (MAHS) program has very little effect in addressing the allied health workforce shortage.

RECOMMENDATIONS: 8 & 9

The way forward

This submission is titled “Partnership, Vision and Commitment” for specific reasons. A whole-of-government approach is required in order the tackle the growing problem of health workforce shortages. Partnerships must be formed between government and stakeholder organisations such as OT AUSTRALIA. That partnership must be articulated in a clear vision for the healthcare workforce and underpinned by political courage and commitment.

The profession of occupational therapy has undergone enormous growth and associated changes over the last ten years. The profession needs to, but more importantly, ***wants*** to change and evolve in response to the increasing demands placed upon it by the health system and its consumers. However, structural barriers such as the fragmented structure of the healthcare system, partial regulation of the profession and continued dominance of the outdated medical model of health result in many practitioners becoming discontent with the healthcare system and choosing to leave in pursuit of better recognition, remuneration and increased work flexibility.

OT AUSTRALIA acknowledges that it is beyond the scope of this study to address all the issues outlined in this submission. However, these issues must be acknowledged as contributing factors to the current workforce crisis, for no solutions can be found if the problems are not identified first.

OT AUSTRALIA was appreciative for the roundtable discussion with the Commissioners along with other members of the Health Professions Council of Australia (HPCA) in May 2005 and will be more than pleased to further contribute to the Commission’s study upon the release of the Draft Report in November/December 2005.

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OT AUSTRALIA Victoria

(Australian Association of Occupational Therapists – Victoria Inc).

Submission to the Department of Human Services discussion paper "Regulation of Health Professions in Victoria"

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Australian Association of Occupational Therapists - Victoria Inc.
ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068.
Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au
Web: www.otausvic.com.au

Executive Summary

OT AUSTRALIA Victoria (Australian Association of Occupational Therapists – Victoria Inc) strongly supports statutory regulation of occupational therapists in the state of Victoria as it would provide the optimal form of protection to health consumers.

Occupational therapy is a dynamic and growing profession, as evident by the continued growth in the membership of OT AUSTRALIA Victoria and the rapidly expanding areas of practice by occupational therapists. This growth combined with expansion in specialty practice areas has resulted in a corresponding increase in complaints received by OT AUSTRALIA Victoria against members and non-members from the public. Complaints against non-members cannot be followed up by OT AUSTRALIA Victoria and are always referred to the Health Services Commissioner. However the Health Services Commissioner has limited powers to sanction unregistered health professionals. OT AUSTRALIA Victoria can act on complaints against members with the ultimate penalty of de-listing a member. However, this does not prevent a de-listed member from practicing in Victoria as there is no statutory body overseeing the regulation of occupational therapists. This situation also provides a potential loophole for de-registered occupational therapists from other states and territories to practice in Victoria unchallenged.

Negative licensing as outlined in the discussion paper, while offering some improvements to the status quo, provides an inadequate solution to the issue of regulation of unregistered health professionals in Victoria. It does not prevent health consumers from exposure to possible harm as it does not set entry requirements and offers no protection of title to the unregistered professions. It therefore represents a less than ideal form of risk management.

OT AUSTRALIA Victoria supports the introduction of an umbrella act of parliament similar to acts recently introduced in the Canadian provinces of British Columbia and Albert that cover a range of allied health professionals. The benefits of statutory regulation are recognised worldwide with mandatory statutory regulation of occupational therapists in the USA, Canada, Britain, New Zealand and South Africa. Australian State and Territory governments with registration have all recently reviewed and maintained registration for occupational therapists.

Statutory regulation, once established would be self funding and cost neutral to operate. It will provide effective maintenance of professional and practice standards for the benefit of all health consumers. Workforce competencies can also be maintained by restricted or limited registration for overseas trained occupational therapists or those seeking to return to the workforce after a period of absence, further preventing possible harm to the public. Statutory regulation for occupational therapists will ensure equity and consistency of standards for the full benefit of the public; it will also ensure a vibrant and responsive occupational therapy workforce able to deal with the challenges of the ageing population.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Self regulation in Victoria of is ineffective and poses unacceptable risks to the community

Occupational therapy is a self regulated profession in the state of Victoria. This is overseen via OT AUSTRALIA Victoria (Australian Association of Occupational Therapists, Victoria Inc.), the peak body representing occupational therapists. OT AUSTRALIA Victoria represents and promotes the profession and its members. It is also responsible for setting standards of practice of the profession as well as following up complaints against members from the public.

To be admitted as a member of OT AUSTRALIA Victoria, a potential member must produce copies of appropriate degrees or academic transcripts demonstrating that he/she has completed the required studies to be an occupational therapist. Members also abide by a code of ethics which sets out acceptable standards of professional behaviour. However, membership to OT AUSTRALIA Victoria is voluntary. It has no legislative powers to enforce mandatory membership. This form of self regulation poses several problems:

a. Complaints cannot be followed up by OT AUSTRALIA Victoria if the complaint is against a non-member; non members have no implied standards of behaviour or performance.
b. Complaints against non members are referred to the Health Services Commissioner, who has limited power to prosecute against unregistered health professionals and to prevent unethical/unprofessional conduct;
c. The Health Services Commissioner can only follow up complaints made by the clients directly. Peer complaints and from those from family or carers of clients cannot be followed up.
d. De-registered occupational therapists from other states can move and work in Victoria unchallenged as a non member. Similarly, a member de-listed by OT AUSTRALIA Victoria for serious offences can practice unchallenged as a non-member in Victoria.
e. Occupational therapy graduates from overseas can work in Victoria as non-members without obligations to have their qualifications appropriately assessed and their practice regulated.
f. There is no protection of title; an unqualified person can claim to undertake work as an occupational therapist.
g. There is an underlying conflict of interest as the role of the professional association is to promote and serve the interest of its members and has limited disciplinary options for handling complaints from consumers against members.

These problems pose unacceptable risks to health consumers. Serious breaches of professional conduct by non-members or former members cannot be followed up by OT AUSTRALIA Victoria, and unless complaints are made by clients directly, the Health Services Commissioner has little power to act. Health consumers are often disempowered individuals in vulnerable situations unwilling to make such complaints in fear of retribution or are unable to do so due to their disabilities.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

If a member of OT AUSTRALIA Victoria was found to be in serious breach of professional conduct or behaviour, the strongest sanction available to OT AUSTRALIA Victoria is to de-list that member. However, this does not prevent that member from practising occupational therapy as a non-member, either in Victoria or in other self regulated states. Furthermore, the title of occupational therapist has no protection. This means that health consumers cannot readily identify qualified, competent therapists from those who claim to be occupational therapists but without appropriate qualifications.

The regulation of occupational therapists varies greatly across Australia. South Australia, Western Australia, Queensland and the Northern Territory have statutory regulation for occupational therapists with the rest of the states and the Australian Capital Territory relying on self regulation. De-registered occupational therapists are barred from practising in other states with statutory regulation. However, there are no mechanisms in place to prevent such therapists from practising in the self-regulated states. This potential loophole poses serious risks of harm to the community. In addition, those Australian State and Territory governments with statutory regulation have all recently reviewed and maintained registration for occupational therapists.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

These risks will increase as the profession of occupational therapy is dynamic and growing

Occupational therapy is a highly skilled profession. Australian occupational therapists are required to undergo a minimum of four years of university education covering a range of specialised topics. In Victoria, undergraduate occupational therapy course are currently taught at La Trobe University (Bundoora Campus, with over 130 undergraduates and about 20 masters graduates in 2004) and Charles Sturt University (Albury-Wodonga Campus, 50 graduates/ year). Deakin University Geelong Waterfront Campus began its undergraduate training of occupational therapists in 2002 and expects all of its 55 undergraduates to finish at the end of 2005. OT AUSTRALIA Victoria is currently is discussion with Monash University regarding an undergraduate occupational therapy course in 2005. OT AUSTRALIA Victoria expects that by December 2006 the number of new graduate occupational therapists entering the workforce in Victoria will have almost doubled in the last 5 years.

All Victorian universities have increased their intake of undergraduate occupational therapy student in recent years. Several major changes have also been made in the undergraduate curricula to accommodate the increase in specialised areas of practice of occupational therapists. For example, La Trobe University has introduced new modules in risk assessment and case management for mental health; and Deakin University has introduced modules in biometric testing and worksite assessments for vocational rehabilitation.

The practice of occupational therapy poses a number of potential risks to the community. Potential risks include, but limited to: serious injuries due to incorrect manual handling and/or treatment of clients; exposure of clients to possible emotional, physical and financial abuse by therapists and failure of adequate home/work safety assessments by therapists. Please refer to Appendix 1 for full information.

The number of practising occupational therapists in Victoria has also been on the increase. Data from the membership database of OT AUSTRALIA Victoria showed an average growth in membership in excess of 7% over the last eight years with a membership count in excess of 1400 members in 2003. Occupational therapists, like many health professionals, are in demand due to a combination of factors such as the ageing population and the integration of health care provision between acute, subacute and community settings.

Occupational therapists are increasingly being sought after in the private sector, often in sole or isolated positions to carry out a variety of services. These include

a. Vocational rehabilitation, such as work site assessments determining a worker's capacity to work or to resume work after a work related accident or injury;
b. Home based care with elderly and disabled, such as assessment, treatment and coordination of therapy services to maximise a person's safety and independence at home;
c. Working with children with intellectual/developmental disabilities and people with mental illness to maximise their independence in the community; and

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Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

d. Driver assessments where an occupational therapist assesses a person's ability to safely operate a motor vehicle after a medical event such as stroke or part of a disease progression such as Alzheimer's.

The growth of the profession and its areas of practice have led to a proportional increase in complaints received by OT AUSTRALIA Victoria. Both the Association and the Health Services Commissioner rely on cooperation from an occupational therapist in trying to investigate complaints. If the occupational therapist is unwilling to cooperate, complaint investigation is difficult. Data analysis of the complaints received indicated that complaints have increased both in the frequency and in the areas of specialty. There has been a sharp increase in the number of complaints from 0.08% to 0.63% of the overall membership in the last three years alone.

While it is difficult o assess the individual impact these complaints had on clients, the majority of earlier complaints centred on professional behaviour and conduct; while recent complaints included serious breaches in patient confidentiality and the Health Records Act. A summary of the complaints received by OT AUSTRALIA Victoria from 1998 to 2003 is listed under Appendix 2.

It has been fortunate that none of the complaints received to date led to or directly contributed toward any death in Victoria to date. However, the increased specialty areas will increase the likelihood of such an event occurring in the near future, as outlined in Appendix 1. Urgent action in the form of statutory regulation of the profession must be undertaken to protect the public from these increasing risks.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Safety of the public is compromised by the differential statutory regulation between health professionals

The ageing population of Victoria has put increased pressures on the health care system. In response to these demands, many health services are restructuring the provision and delivery of their services. Occupational therapists are now vital members of multidisciplinary teams at all levels of health care delivery to the public. However, they are not subject to statutory regulation, despite performing tasks similar or virtually identical in complexity as their colleagues who are subject to statutory regulation.

For example, both an occupational therapist and a registered nurse may prescribe pressure care seating and mattresses to clients. Failure to adequately assess a client's pressure sore may lead to exacerbation of the wound, leading to infection, unplanned hospital admission or even death. Repeated occurrence of this issue from a registered nurse may result in professional misconduct charges with the risk of being de-registered from practising. While de-registered the nurse may be required to undergo mandatory professional education on wound care assessment as a condition of regaining registration. These measures protect the public from further harm. An occupational therapist facing the same issues however, would be deemed as "incompetent" but sanctions would be very limited. Moreover, with no statutory regulation of the profession, the public will continue to be exposed to the same risks of harm.

The above example is one of many scenarios where the safety of the public is compromised by the differential statutory regulation between health professionals. Both occupational therapists and physiotherapists are able to prescribe graded activities to clients following a heart attack as part of their rehabilitation. Inappropriate assessment of the clients' capacity and subsequent activity prescription could have serious consequences. Physiotherapists are subject to statutory regulation, whereas occupational therapists once again have no such implied standard of behaviour or performance.

The expansion of occupational therapy practice areas has further exacerbated this situation. This is particularly evident when occupational therapists interact with clients outside of the traditional health care setting, such as in workers' compensation or driving assessment. Occupational therapists meet with clients in workplaces, in homes and cars, schools and other settings to provide services where their work is not under the direct scrutiny of other health professionals.

The following is from a recent telephone conversation with a senior policy officer within VicRoads:

> *"VicRoads refer complaints to a variety of sources currently. Comment has been made that a single point of contact for the referral of complaints would be invaluable. This point of contact needs to have sufficient power and resources to take action to limit scope of practice or de-register if warranted. The National accreditation program set up by OT AUSTRALIA should continue to develop and maintain competencies required for occupational therapy practice."*

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Similarly, a senior manager within the Victorian WorkCover Authority commented

> *"The issue for the Victorian WorkCover Authority (VWA) is who to recognise and pay for work with VWA clients. It is much easier if there is registration for a profession. WorkCover at times needs to undertake work that a registration board would normally do when a significant health profession such as occupational therapy is not registered in relation to title and qualifications. The VWA requests that occupational therapy providers are eligible for membership to OT AUSTRALIA, but in competition terms this is less desirable than evidence of registration and qualifications then need to be checked by the VWA. In addition, referral of complaints is difficult. Currently with an increased emphasis on use of occupational therapists for reviewing and conducting assessments of daily living, there is an increasing number of complaints from clients, particularly when the reports are used to terminate benefits. There is not one port of call for referral of complaints."*

The lack of a statutory regulatory body coupled with the expanding practice areas of occupational therapy will increase the potential risks to the public; while public confidence in statutory bodies such as the VWA and the profession are being eroded by incompetent and unethical therapists due to the differential statutory relation between the health professionals.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Negative licensing is not the answer

Negative licensing, as described in the discussion paper, presents an improvement to the *status quo* for regulation of occupational therapists. However, it is an inadequate and short term solution to the issue of regulation of occupational therapists and represents a less-than-ideal model for the management of risks to the public.

The optimal level of protection for the public is for statutory regulation of the profession as it has the potential to prevent or eliminate the majority of risks. Negative licensing does not modify or minimise the risks to the public as it is only a mechanism for dealing with complaints after the events have occurred.

OT AUSTRALIA Victoria welcomes new powers for the Health Services Commissioner under the proposed negative licensing arrangements. However, these arrangements do not prevent or limit potential harm to the public as it sets no entry requirements and offers no protection of title. Health consumers will continue be exposed to increasing risks as outlined previously.

If negative licensing is to be introduced, the Health Services Commissioner should have access to specialist advisors in all relevant allied health professions including occupational therapy. This will require significant resources to assess, follow up and if necessary, prosecute those found to be in breach of their duties.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Statutory regulation provides optimal form of protection to the public

Statutory regulation of occupational therapists in Victoria will provide the optimal form of protection to the public. Registration boards are self funding via registration fees and are therefore cost neutral to the public. With the appropriate legislative powers, registration boards will ensure that health consumers are protected from incompetent and unethical therapists with appropriate sanctions and restrictions.

While the form in which statutory regulation of occupational therapists is a matter for the government to decide upon, OT AUSTRALIA Victoria believes that one possibility is via the establishment of an Allied Health Registration Act. Under this proposal, an Act of Parliament (e.g. Allied Health Registrations Act) could be established covering a range of allied health professionals, especially those who work in the public health areas. The act should establish an Allied Health Registration Board with powers to sanction and de-register professionals found to be in serious breaches of the Act. Existing allied health registration boards can be merged or incorporated into the Allied Health Registration Board, thus reducing the overall cost for the board and for the health professionals. Sessional board members can be elected for hearings of discipline specific complaints. The board should have links with other state and territory's registration boards to prevent "border hopping" of de-registered professionals. The board will be responsible for setting and enforcing workforce entry requirements including practice audits for all registered professions.

This mechanism will achieve the most comprehensive protection for the Victorian public as it will achieve in full the principles of accountability, transparency, fairness effectiveness, efficiency, flexibility and consistency for registered allied health professionals.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Statutory regulation of occupational therapists is a feature of other OECD countries

The benefits of statutory regulation of occupational therapists are recognised in many OECD countries; including the United States, Canada, United Kingdom, South Africa and New Zealand.

Occupational therapists practicing in the US are subject to licensure or other forms of statutory regulation in all states except Colorado, where trademark law offers title protection of occupational therapy and its practitioners. The trend in the US is for increased regulation of occupational therapists with state licensure for occupational therapists introduced as recently as 2000 in California, Minnesota and Wisconsin and 2002 for Kansas and Vermont (National Board for Certification in Occupational Therapy, 2004).

Occupational therapists are also subject to statutory regulation in all 10 provinces of Canada. Of particular note are the provinces of British Columbia and Alberta. In British Columbia, the government approved an umbrella Health Professions Act in 1990 and introduced the Occupational Therapists Regulation in 1998 to further protect the public (College of Occupational Therapists of British Columbia, 2004). In a similar move, the government of Alberta introduced its own Health Professions Act in May 1999 to regulate all 30 self governing health professions in the province (Alberta Association of Registered Occupational Therapists, 2004). The act *"comes into force on a profession-by-profession basis as each profession's regulations are approved and its schedule under the act comes into effect"* (Alberta Association of Registered Occupational Therapists, 2004). The proposed regulation of occupational therapists in Victoria by OT AUSTRALIA Victoria would be similar to the approaches taken by the governments of British Columbia and Alberta.

In the United Kingdom, the government introduced the Health Professionals Order in 2001, which established the Health Professions Council as the umbrella regulator for various health professionals including occupational therapists (Health Professions Council, 2004). Similar government regulator bodies exist in other Commonwealth countries such as South African and New Zealand.

It is clear that there is a trend among OECD countries towards the statutory regulation of occupational therapy and its practitioners. Victoria should follow this trend in the interest of protection to the public by introducing statutory regulation for occupational therapists.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Statutory regulation will enhance the responsiveness of the occupational therapy workforce

The allied health workforce has been the subject of several recent studies to profile its characteristics. The Queensland Auditor General found in a study in 2000 that the workforce was "predominately young and female, with 86% being female and 65% aged less than 40 years" (Queensland Health, 2000). The same report pointed out the lack of recognition for advanced clinical skills and lack of career structure as significant factors influencing avoidable loss of experienced staff. Lack of adequate management and supervision combined with high demand and workload were cited as major factors of workforce attrition by the latest review conducted in Western Australia (Western Australian Allied Health Taskforce on Workforce Issues 2002). These same factors attributed to a staff turnover of 45 percent within 3 years within the Northern Territory Health Services (1999).

Occupation therapy is one of several health professions with a very strong female dominance. Women account for 93% of the current OT AUSTRALIA Victoria membership. 2001 workforce data from the Australian Institute of Health and Welfare (AIHW) on occupational and physiotherapist found that these two professions' workforce is gradually ageing and increasingly turning towards post graduate studies and mainly concentrated around capital cities (AIHW, 2001a., AIHW 2001b). In particular, 44% of the 79% of occupational therapists aged over 30 were not employed as occupational therapists due to child rearing reasons. However, 88% of these do plan to return to the field at some stage (AIHW, 2001a).

Occupational therapists are also migrating out of Australia at an alarming rate. Data from the AIHW showed that in between 1999 and 2000, there was a net migration loss of 12% for occupational therapists, in direct contrast with net migration gains of 8% for podiatrists, 9% for physiotherapists and 68% for optometrists (AIHW, 2002).

These workforce characteristics of occupational therapists and previous data show that occupational therapy is a female dominated profession that is a dynamic and growing. Occupational therapists are also very mobile due to reasons of child rearing, higher education and overseas migration. These characteristics can have detrimental effects on the competencies of practitioners. Statutory regulation for the profession will ensure that the public is protected from possible harm by limiting or restricting the entry of practitioners in accordance with their competencies. This will ensure a vibrant and competent profession that is able to respond to the demands of the ageing population.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

Conclusion

The case for statutory regulation of occupational therapists in the state of Victoria is strong. The profession is dynamic and its workforce growing with corresponding expansion of clinical specialties. These changes have unfortunately brought a proportional increase in the number of complaints against occupational therapists in Victoria. The current situation of self regulation for occupational therapists is ineffective and poses unacceptable and growing risks of harm to the public. These risks are further exacerbated by the fact that occupational therapists are often performing virtually identical tasks to their colleagues who are subject to statutory regulation. Negative licensing as proposed in the discussion paper presents an improvement on the *status quo*, but is a short term and inadequate solution to the risks of harm to the public. The occupational therapy workforce has one of the highest female representations in all of the health professions. It is also a very mobile workforce with high rates of attrition from the profession. Statutory regulation of occupational therapists in Victoria will not only protect the public from risks of harm by incompetent and unethical therapists, it will also ensure a vibrant and responsive occupational therapy workforce able to deal with the challenges of the ageing population.

Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

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Australian Association of Occupational Therapists - Victoria Inc. ABN 59 282 667 269
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Email – info@otausvic.com.au

APPENDIX 1
THE CASE FOR FULL REGISTRATION OF OCCUPATIONAL THERAPISTS THROUGHOUT AUSTRALIA
(Council of Occupational Therapy Registration Boards Australia and New Zealand – Inc.)

1. NO COST TO PUBLIC

- Registration Boards are self-funding.
- There is a minimal cost to occupational therapists
- There is no cost to the public or government.

2. EFFECTIVE MAINTENANCE OF STANDARDS

- Registration provides effective maintenance of professional and practice standards.
- It ensures that the public can identify practitioners who are trained and competent to provide occupational therapy services
- It prevents unqualified persons practising thus protecting the public.
- Limited registration provides an incentive and process for retraining/return to work and enables supervision of overseas trained persons.

3. HARM TO PUBLIC

- Occupational therapy is a highly skilled and diverse health profession. As such in the hands of unskilled or unethical practitioners the public is at risk of harm. Many examples of such risk to clients are provided in the attached sheet
- The vulnerability and limited knowledge of clients must be taken into account.
- Registration Boards provide the public with effective and inexpensive complaint and monitoring mechanism.

4. SELF REGULATION – NO ANSWER

- Association membership is optional.
- There is no power by the Association to prevent incompetent, negligent or unprofessional therapists form working.
- Around 50% of occupational therapists work in private practice or organisations with their own referral rights and health fund rebates for clients.

5. NATIONAL FOCUS: MUTUAL RECOGNITION

- Mutual recognition exists and works well between the States and Territories with registration (SA, WA, Qld & NT). It leaves Victorian therapists with no automatic right to have their qualifications recognised.
- The respective boards work on National issues as a coordinated council and have been given responsibility from the Commonwealth for the assessment of the qualifications of overseas trained therapist's seeking to work in Australia
- The national process for assessing overseas qualifications which requires competency demonstration in the first six months of work is hampered because there is no registration authority in Victoria to enforce this. As such therapists working in Victoria cannot be mandated to demonstrate competence.

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Suite 4, 430 Rae Street (PO Box 1286) North Fitzroy Vic 3068. Ph 03 9481 6866. Fax 03 9481 6844
Email – info@otausvic.com.au

6. SUPPORT FOR REGISTRATION

- The profession clearly supports registration.
- The medical and allied health professions support registration – they work with the same clients as occupational therapists and have the same responsibilities to clients.
- Governments in States and Territories with registration have all recently reviewed and maintained registration for occupational therapists meaning any past considerations by AHMAC are obsolete

7 REGISTRATION DOES NOT MEAN PROFESSIONAL MONOPOLY

- The registration of occupational therapists has not prevented the development of other professions such as rehabilitation coordinators/ counsellors, developmental educators, music/art therapists and diversional therapists.

8. RELATIONSHIP WITH THE REST OF THE WORLD

- Registration is mandatory in USA, Canada, Britain, New Zealand, South Africa etc.
- In order to register and hence to practice in those countries, an occupational therapist must show proof of registration and good standing in their own country.
- Unregulated states in Australia potentially disadvantage those occupational therapists and are out of step with the rest of the world.

Potential risks to consumers of Occupational Therapy services

The following table sets forth examples of potential risk to the public in certain areas of occupational therapy practice:

Occupational Therapy Area or Intervention	Nature of Potential Risk
Functional capacity evaluation - taking clients through increasing lifting and other physical demands to identify maximum functional capacity. The therapist needs to identify safe lifting limits and have knowledge of the pathology to avoid serious damage.	Injury – serious damage to vertebral discs and consequent pain Loss of earning capacity
Upper limb rehabilitation following stroke - correct handling and techniques need to be applied	Damage to a paralysed shoulder can lead to subluxation which, once it occurs, is mostly untreatable. Subluxation is caused by poor handling of the upper limb post-stroke. The condition causes considerable pain on movement and consequently leads to reduced function of the upper limb.

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Email – info@otausvic.com.au

Hand therapy - splinting (dynamic and static) (after surgical repair eg. nerve or tendon repair) - prescription of program to mobilise using passive or active techniques to avoid tissue damage - identification of infection and appropriate infection control	Causing damage to the surgical repair either by mobilising too early, not protecting the graft by adequate positioning, inadequate mobilisation, not dealing with the scarring or deformity. There is a fine line between mobilisation and splinting with a fine margin for error. Damage to the nerve repair can lead to permanent loss of sensation, reduced function and/or increased risk of further injury Hand infection is generally regarded as a serious risk, often with hospitalisation required. Inadequate identification of signs of infection can lead to serious consequences including restricted movement, scarring and eve, potentially, amputation.
Equipment prescription - assessment of needs/limitations - selection of appropriate equipment - training and assessment of safety	Injury (eg. falls) or injury to carer A less than optimal outcome may occur Increased need for assistance/ services Excessive cost for inappropriate equipment recommended and then abandoned
Environmental modifications/ergonomics - design, placement and prescription of ramps, rails etc. - house modifications eg bathroom, kitchen to enhance safety and function - assessment of needs, recommendation of appropriate and cost effective options - worksite modifications or work redesign	Restriction of function/risk of injury resulting from poor choice of equipment Cost of ineffective or overly expensive modifications Damage to plant/equipment/homes Exacerbation of work injury or occurrence of overuse injury by inadequate modification
Manual handling - training and undertaking manual handling of clients, and training of clients	Poor technique may cause falls and/or injury to client and/or carer

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Mental health - increasingly services are provided to clients at home or in community. A large number of people with mental illness are emotionally and financially vulnerable with diminished capacity - monitoring medication compliance - monitoring status and early signs of need for changed management (including medication review) - monitoring, and reporting of abuse - managing clients and public in acute crisis (eg. suicidal) and in volatile living circumstances - supervision of untrained/unregulated support staff to ensure accountability of practise - critical incident de-briefing	High risk of harm to client (eg. suicide, overdose, exploitation) Potential for emotional, physical or financial abuse Failure to obtain timely and appropriate management of changing health status – exacerbation of illness Risk of harm to workers/carers/public
Working with children (developmental delay) - appropriate application of specialised techniques (eg. sensory integration) - preventative programs eg. literacy, developmental programs, social skills training, school programs - feeding programs – recommendations for techniques to assist children who have significant difficulties with normal feeding patterns, involving positioning, food texture, facilitation of oro-motor function	Hyperexcitability, deterioration of behaviour/function, seizures Poor outcomes in education, functional areas Poor behavioural and learning outcomes Poor nutrition, aspiration and choking
Acute post-surgical management - supervised resumption of daily activities - discharge planning – establishing equipment and level of support required on discharge - equipment prescription - education on precautions post-surgery and positioning - splinting - wound protection/management	- damage to surgical repair resulting in extended hospitalisation - return to hospital due to inappropriate discharge plans - falls - contracture - less than optimal functional outcomes - damaged wound site/infection

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Cardiac rehabilitation - prescription of graded activities - education about self-monitoring and precautions - early mobilisation following heart attack testing the cardiovascular response and tolerance to activity	- further cardiac event (eg. heart attack, angina) if inappropriate mobilisation program or precautions are given - alternatively, inadequate early mobilisation can lead to deterioration of the heart muscle and invalidism
Driving assessment & rehabilitation - assessing capacity to drive on and off the road - prescription of vehicle modifications - prescribing training programs	- inappropriate assessment leading to unsafe drivers on the road or safe drivers taken off the road. Significant cost to community in either situation. Risk to drivers and other road users.
Use of physical modalities - modalities including electro-myography, functional electrical stimulation, biofeedback, thermal agents such as ultrasound, contrast baths, paraffin wax, ice	Burns – electrical or thermal Pain from misuse of the techniques Operation of cardiac pacemakers can be affected by inappropriate use of electrical modalities Circulatory problems
Burns Prescription and fitting of pressure garments and splints to healing or burned skin	Poorly fitted or fabricated splints or pressure garments can result in scarring or contractures which can cause permanent deformity and limited function
Brain injury Assessment and management of reduced cognitive capacity. Accurately determining and responding to the safety risks a client may encounter in his or her environment Management of unconscious clients Positioning and treatment of consequent motor damage and spasticity	Failure to anticipate likely safety risks may result in client sustaining an injury eg. burns, accidents at home, crossing roads unsafely Risk of physical, sexual and financial abuse Inappropriate management can result in long term deformity and pain

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APPENDIX 2
Summary of complaints received by OT AUSTRALIA Victoria 1998-2003

Year	Nature of Complaint	Areas of Practice
1998 (4 complaints) • 3 against the same member; • 1 against a non-member	• Poor professional conduct, and communication • Disrespect shown for client • High fees • 1 complaint received via member of parliament	Driver assessment (all complaints)
1999 (5 complaints) • 2 against 2 members • 3 against 2 non-members	• Poor professional conduct and competency • Lack of professional communication • Lack of suitable consent obtained from client	Driver assessment (all complaints)
2000 (1 complaint) • 1 against a member	• Poor professional conduct and communication • Disrespect shown for client • High fees and unprofessional invoice for fees	Driver assessment
2001 (5 complaints) • 1 against a member with a previous complaint • 4 against 3 non-members	• Poor professional conduct and communication.	Driver assessment (all complaints)
2002 (8 complaints) • 4 against members • 4 against non-members	• Poor professional conduct • Breach of Health Records Act, • OT calling himself a physiotherapist • Unsatisfactory home modifications with hospitalisation following 9 falls • Failure to recognize safety issues • Breaches in client confidentiality • Poor professional judgment (2)	• Driver assessment (3) • Home assessment (2) • Occupational rehabilitation (1) • Hand therapy (1) • TAC review decision (1)
2003 (9 complaints) • 4 against members • 5 against non-members	• Poor professional conduct and judgement • Fees charged unprofessional • Poor invoice with no ABN number or identifying details • Breach of Privacy Act • Sexual innuendo and harassment	• Driver assessment (5) • Occupational rehabilitation (2) • Home assessment (1) • Paediatrics (1)
Repeated complaints for this period • 6 against a member • 6 against a non-member		• Driving

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