Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Submission No: 17

Submitted by: Occupational Therapy Australia

Publication: Making the submission and your name public

Attachments: See attachment

Submitter Comments:

Queensland Parliament
Health and Environment Committee

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Occupational Therapy Australia submission

December 2021

Occupational Therapy Australia Limited ABN 27 025 075 008 | ACN 127 396 945
5 / 340 Gore St. Fitzroy VIC 3065
Phone 1300 682 878 | Email info@otaus.com.au | Website www.otaus.com.au

Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a submission to the Queensland Parliament's Health and Environment Committee's *Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of September 2021, there were more than 25,300 registered occupational therapists working across the government, private and community sectors in Australia. Queensland represents 20% of the Australian occupational therapy workforce (AHPRA, 2021).

Occupational therapy is a person-centred health profession concerned with promoting health and wellbeing through participation in occupation. Occupational therapists achieve this by working with participants to enhance their ability to engage in the occupations they want, need, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement. Occupational therapists provide services across the lifespan and have a valuable role in supporting participants affected by developmental disorders; physical, intellectual, chronic and/or progressive disability; and mental health issues. Occupational therapists work in a diverse range of practice settings including, but not limited to, acute hospitals, rehabilitation settings, private practice, aged care facilities, community, primary health and in the home.

Primary, allied, and private healthcare

Focus on prevention

As the Australian population grows and ages, our already overstretched health care system will come under increasing pressure. It is imperative, therefore, that government policy focus on the preservation of wellness, as well as the treatment of illness and rehabilitation.

The World Health Organisation defines health as *a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*. Occupational therapists are uniquely skilled in taking a whole of person approach to health, focusing on a person's physical and mental health as well as their environment. This skillset positions occupational therapists to provide vital services that reduce hospital admission and readmissions and improve transitional outcomes. In a hospital setting, occupational therapists provide care coordination, case management, transition services including discharge planning, and onward referral to relevant services. Occupational therapists also provide essential rehabilitation and community care services that are vital to reduce strain on hospital resources. Given their dynamic skillset, many occupational therapists were redeployed during the COVID-19 pandemic to assist across various hospital departments.

Currently, the full scope and value of occupational therapy is underutilised and is too often inaccessible to clients in the primary health care setting. This results in an undue burden on other health services and a failure to utilise all available resources in an already understaffed field.

It is vital that the Queensland Government adopt a systems level approach to public health service delivery, that focuses on coordination of funding models, a seamlessness of budgets and that champions a collaborative approach to healthcare provision. An increased awareness of the skills of occupational therapists will also ease pressure on other health services by enabling the referral of patients to more appropriate care in the most appropriate setting.

The value of the multi-disciplinary approach

The value of the multi-disciplinary team is particularly apparent in the care of those clients with whom primary health is most readily associated – those with chronic diseases and conditions, early developmental needs, progressive health conditions or mental health conditions. When such a model is not in place, it is ultimately the client who misses out – on choice, on person-centred care and, in the most severe or complex cases, on recovery and/or wellness.

While OTA acknowledges that there must be a “gatekeeper” to assess the client and coordinate the work of the multi-disciplinary team, experience to date suggests that our already overstretched GPs struggle on occasion to perform this role. In addition, not enough GPs understand exactly what it is that some allied health professions do, and the nature of the contribution they make to a client’s wellbeing. This is particularly true of the role of the occupational therapist in primary health care and in mental health service provision. Moreover, there are indications of a looming GP workforce shortage. Any primary health care model that imposes an additional burden on GPs, in the face of a developing workforce shortage is at best unreasonably optimistic, at worst irresponsible.

To adequately service communities who require allied health services, the workforce must be supported beyond traditional primary health services such as general practice referrals. This requires a primary health workforce that is fully informed of the role of allied health professionals, including occupational therapy, and can therefore ensure that people are able to acess the right care, in the right setting. A coordinated system where GPs fully utilise the allied health workforce would help remove barriers for clients to access allied health services. Currently, by inefficiently funneling allied health through an already overstretched GP workforce, an unnecessary hurdle is added to accessing multidisciplinary care. In addition to referrals from GPs, access to allied health professionals should be available and encouraged through other primary health programs.

It is imperative that creative solutions to this dilemma be proposed and piloted. It is vital that Government understands the importance of a well-run multi-disciplinary team, in which all professions can make an informed and timely contribution to the client’s care.

Commonwealth funding for primary and allied health

There is a pressing need for appropriate funding models to support allied health professionals working across primary health services. OTA members have noted that funding for primary health has become fragmented, and the system has become difficult for consumers to navigate,

particularly in rural areas. It is important that direct pathways to multidisciplinary care in the primary care setting are accessible, and that clients have the necessary support to navigate these pathways, in order to get the allied health care they need and want, in a timely manner and without unnecessary overreliance on GPs.

Primary Health Networks

Committee members would be aware that a network of 31 Primary Health Networks (PHNs) has been established across Australia by the Commonwealth Government, with a view to increasing the efficiency and effectiveness of medical services for patients and improving coordination of care. If PHNs are to achieve these outcomes, there needs to be a properly resourced commitment by governments at all levels to preventative care and the principle of wellness. And in the case of those with chronic disease, it is imperative this be managed in a more effective, evidence-based way.

The Medicare Benefits Scheme (MBS)

It is extremely disappointing that the Commonwealth Government's recent review of allied health items on the Medicare Benefits Schedule (MBS) disregarded recommendations made by Allied Health Professions Australia (AHPA) without offering an alternative vision of how allied health would be funded into the future. This is particularly relevant to Community Health Services in outer metropolitan, regional and rural sectors, where they are less likely to have the economy of scale required to sustain the range of services clients need within the current model of individualised funding.

Furthermore, individualised funding that is available through the MBS is often inadequate for clients with complex health needs and/or chronic and progressive conditions. OTA is concerned that the cost of care not funded by the MBS falls back on clients, many of whom do not have capacity to independently fund the healthcare they need. A focus on individualised funding alone most often results in further silos that exacerbate health care inequity and the further fragmentation of the health care system. OTA would recommend that the PHNs consider what partnerships could be created with core providers and funding agencies to ensure core services are accessible to clients who need them.

Given the absence of an alternative funding model, there must be greater access to allied health through MBS items, with Chronic Disease Management (CDM) and other allied health MBS items enhanced to meet the varying needs of clients, particularly those with complex and chronic needs. While a fee for service model is appropriate for some forms of care, other mechanisms are sometimes preferable. Accordingly, innovative models of care and funding (block/blended/pooled etc.) must be introduced to support wider access to allied health services.

Moreover, any genuine commitment to multi-disciplinary care should involve a funding model that remunerates members of the care team for all case conferencing, not just case conferences

convened by the GP. This is of relevance to occupational therapists, who often find themselves performing the time consuming but unremunerated role of de facto case manager.

The increasing demand for mental health services

Mental health service provision is a longstanding and core area of practice in occupational therapy. Occupational therapists work across the full spectrum of mental health, treating relatively common conditions, such as anxiety and mood disorders, as well as those which require more targeted interventions, such as psychosis, eating disorders and trauma-related conditions. A key strength of occupational therapists is their ability to focus on both physical and mental health, and this is highly relevant in areas such as chronic pain or where a person might have a dual diagnosis. This expertise is nationally recognised and well-established.

While occupational therapists utilise many of the same psychological therapies as other mental health professions, they are uniquely skilled in using 'occupations' to improve and maintain wellbeing. Suitably experienced occupational therapists are endorsed to provide Focussed Psychological Strategies (FPS) through the Commonwealth Government's Better Access initiative and have been since its inception in 2006. Eligible occupational therapists also deliver psychological treatments for eating disorders under the MBS.

OTA members working in private practice report they are experiencing an overwhelming demand for mental health occupational therapy services, with many practitioners forced to stop taking on new referrals. This has been compounded since the introduction of the NDIS and will continue to be an issue as new reforms and budget increases for clients amplify demand. The Queensland Government has made significant investments in mental health and suicide prevention, yet this has not been directed towards training or supporting the mental health workforce. To ensure the Government can deliver on these investments, it is critical that significant funding is directed to support front line mental health professionals

Regrettably, from a primary healthcare perspective, several therapists have reported that it is simply not financially viable to work in this space due to inequities within the system. There is currently a sizeable disparity between the MBS rebates for services provided by psychologists and those provided by occupational therapists and social workers. For example, a clinical psychologist who sees a client between 30 and 50 minutes will receive a higher rebate than an occupational therapist who sees a client for 1 hour. This lack of consistency can lead to significant out-of-pocket expenses for consumers. Moreover, lower rebates devalue the important work of occupational therapists and other professionals such as social workers, and make it harder for consumers to access their services. OTA is concerned that the lack of occupational therapy services in the primary care sector results in undue burden on clients, their families and carers, and the health care system as a whole.

Below are examples of feedback provided by OTA members working in private practice in Brisbane:

"I am a Brisbane mental health OT and I have closed my books to taking new clients as my waiting list became too long. I have a message on my voicemail and website stating this, but I still would receive about 5 messages a week asking if I can recommend someone else who can do mental health ot work that I do. Some clients have been on my waiting list and waited to see me for 36 weeks so far. That is why I decided to close my books. But there are also many people who did not find an alternative OT in that time and waited that full length if time to see me."

"I know many other mental heath OTs who are not taking on new referrals. There seems to be great demand for experienced OTs who can work with people with psychosocial disabilities and neurodevelopmental involving suicidality, self harm, pain, dissociation, anxiety and behaviours of concern. I have taken my name off Find an OT and I know quite a few other mental health mental health OTs who have done this in order to reduce the number of phone call enquires."

Aged Care

Occupational therapists work with older people with age-related conditions such as poor balance and coordination, memory loss and confusion, and vision and hearing loss, which lead to changes in their ability to participate in the meaningful activities of everyday life. Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology, and the assessment of environment and safety risks. Thus, occupational therapists can enable meaningful engagement in the residential aged care environment, and provide residents with an enhanced sense of identity, greater purpose and improved wellbeing.

Ageing at home

Over the next 40 years, the number of Australians with a mobility limitation due to disability is estimated to increase from 3 million to around 5.75 million (BBH, 2021). 80% of older Australians aged over 55 want to live in their own home as they age, and with accessible housing only representing only 5% of new builds (BBH, 2021) clearly something needs to change to prevent millions of older Australians being forced into residential care.

When an otherwise capable person is forced into residential care it is not only a personal tragedy for them and their loved ones, it is an unnecessary burden on the public purse. The average annual cost of care for older Australians who require assistance at home is $15,525, while it is $66,512 for those in residential care (AHURI, 2019). Home care represents savings of up to 77%. Now is the time to take proactive steps to enable people to age where they most want to – at home.

Importantly, accessible housing saves health expenditure by preventing falls. In 2009 and 2010, one in every 10 days spent in hospital by a person 65 years or older was directly attributable to an injurious fall (AIHW, 2013). The average total length of stay per injurious fall incident was estimated to be 15.5 days (AIHW, 2013). According to one study, these hospitalisations typically incur costs of between $6,000 and $18,600 per incident (Watson et al., 2010).

Serious falls can cause death. Neck of femur (NOF) fractures – the most common kind of hip fracture – are associated with particularly high rates of premature death (AIHW, 2018). According to an Australian study, the mortality rate for patients admitted to hospital with a NOF fracture is 8.1 percent after 30 days and 21.6 percent within one year (Chia et al., 2013).

Even in less severe cases, a fall can impair an older person's long-term mobility and independence, often irreversibly. In such instances, they will require higher levels of assistance to continue living at home and may be forced to enter residential care. This situation is not only detrimental to the individual's quality of life, it also imposes a financial burden on our health care system.

OTA has welcomed the introduction of minimum accessibility provisions for residential housing and apartments in the National Construction Code (NCC) 2022 and commends Queensland on its commitment to implement the new national code. Mandatory accessibility standards will ensure greater access to appropriate housing, support choices for older Australians, and will result in substantial savings to the Queensland health sector from reduced injuries and homecare, as well as reducing the cost of aged-care.

The National Disability Scheme (NDIS)

The interface between NDIS and public health

There is lack of clarity at the interface between NDIS and public health service provision. OTA members report that public sector occupational therapists are spending considerable amounts of time completing functional capacity reports to get people out of hospitals and onto the NDIS. Anecdotal feedback from members suggests there is a lack of recognition of the huge burden falling on hospitals, primarily occupational therapists, to meet NDIS reporting requirements. Delays in NDIS processes and lack of availability of providers are impacting hospital discharge, and inpatient settings are being inappropriately used as a "holding bay" for NDIS applicants.

Members report that there is a lack of clarity between what is considered a disability-related need (funded by the NDIA) and what is considered a mainstream health need (funded through the public health system). In practice, this is resulting in duplication of supports in some instances, and no supports in others.

It is imperative that Governments prioritise enhancing the coordination of health care services, through co-designed, integrated models of care.

The Queensland Occupational Therapy Workforce

The provision of high-quality health care in any sector or practice setting relies first and foremost on a skilled, well-supported health workforce. The priority should be to focus on ensuring

Queensland's allied health workforce reflects the diversity and future needs of the Queensland people.

The Department of Health (2021) has identified occupational therapy as the fastest growing registered health profession in Australia. Between 2015 and 2019, the occupational therapy workforce experienced an annual growth rate of 7.0 per cent, followed closely by osteopathy at 6.9 per cent (Department of Health, 2021). In Queensland, the number of registered, practicing occupational therapists increased in Queensland by 49 per cent from September 2016 to 2021 (AHPRA, 2021).

The roll out of the NDIS in 2016 has undoubtably changed the landscape for allied health service providers across the country. Most employers reported a strong increase in the demand for occupational therapy services in Queensland between 2016 and 2019, and attributed this to the implementation of the National Disability Scheme (DESE, 2019). The Queensland Productivity Commission's 2020 Inquiry into the NDIS market in Queensland highlighted significant demand for occupational therapists under the NDIS, with more than 80% of Queensland providers reporting difficulty recruiting an occupational therapist between 2018-2019 (QPC, 2020).

The 2020 Health Workforce Needs Assessment completed by Health Workforce Queensland also highlighted that recruitment and retention of the allied health workforce in remote, rural and even regional areas was a common challenge. Occupational therapy rated in the highest workforce gap rating, with a mean gap rating of 58.8 (Health Workforce Queensland, 2020).

Despite new university courses being established nearly every year, those graduating from occupational therapy programs often do so with multiple job offers awaiting them. OTA members operating larger practices routinely report that they cannot fill job vacancies, despite the often very generous packages on offer.

This workforce shortage will become more pronounced as the NDIS continues its rollout and more Australians with disability are deemed eligible to join it. The NDIS has already drawn significant numbers of allied health professionals from other areas of practice. One OTA member provides the following comment:

"there needs to be enhanced coordination and collaboration between services in rural and remote areas. The link between public and private health needs to be strong, particularly for NDIS practitioners as they are more likely to be able to practice remotely if they have access to public facilities or local hospitals for service provision."

Demand for occupational therapists is also expected to boom as our population ages. Whether opting to age in place or move into residential care, Australia's rapidly growing number of elderly people will require the expertise of an occupational therapist to ensure not just their physical safety, but their health, their mental wellbeing and their quality of life.

In this context, Australian governments must explore ways to fast-track the registration of more occupational therapists, without compromising the quality of occupational therapy services in

Australia. They must also consider how to retain occupational therapists in the profession for longer, at a time when multiple careers are considered the norm in a person's working life.

Conclusion

OTA thanks members of the Health and Environment Committee for the opportunity to contribute to its Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system. We would be pleased to meet with committee members to expand on our submission if this were deemed to be helpful.

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