**Australian Government**

**The Treasury**

***2019-20 Pre-Budget Submission***

Occupational Therapy Australia submission

February 2019

**Introduction**

Occupational Therapy Australia (OTA) welcomes the opportunity to make a pre-budget submission to the federal government ahead of the release of the 2019-20 budget on Tuesday 2 April.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of September 2018, there were more than 21,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

**Recommendations**

**NDIS**

* OTA reiterates its call for a flat rate for therapy supports that reflects the true costs of providing services under the NDIS. The processes and systems underpinning the NDIS place a considerable unpaid administrative burden on service providers that other schemes do not.
* The NDIS Quality and Safeguards Commission should ensure that audits are proportionate to the size of an organisation and the types of supports it provides. Funding should also be provided for educational programs with flexible attendance options (in person and online) for providers required to undergo certification, as well as more comprehensive resources outlining the certification process.
* The federal government should clearly outline how it intends to fund the NDIS in the coming years and the likely impact of scheme costs on other areas of spending.

**DVA**

* The DVA Schedule of Fees for Occupational Therapists should be reviewed as a matter of urgency to ensure that occupational therapists are fairly reimbursed for their work with veterans. This must involve a significant increase in fees that is well above and beyond the mere reintroduction of indexation.

**Mental health**

* There should be a flat rate in respect to rebates across the professions included in the Better Access to Mental Health initiative, along with recognition of the need for loading for work undertaken in rural and remote areas.

**Primary health care**

* The federal government should implement an interdisciplinary, preventative model of health care that encourages active dialogue between all members of a patient’s care team, and removes the possibility of a single profession adopting a ‘gatekeeper’ role.

**Aged care**

* Interventions and modalities funded under the Aged Care Funding Instrument (ACFI) should be expanded to take into account the broad scope of occupational therapy practice.
* The federal government should undertake a comprehensive analysis of how home care package recipients are utilising their allocated funds. A higher level of governance is needed to ensure that there is greater consistency across the country with regard to the allocation of level 4 home care packages, while consumers who have been allocated a higher level package should be able to move easily to a lower level package if their needs change.

**The maldistribution of the health, aged care and disability workforce**

* The federal government should commit to addressing workforce shortages, and consequently reduced access to essential services, in rural, regional and remote parts of Australia. The government should work with state and territory governments to develop training networks that link major metropolitan hospitals with smaller regional and rural hospitals, and increase the provision of rural-based scholarships and fellowships to attract students and recent graduates to locations outside our major cities.
* The office of National Rural Health Commissioner should be made a permanent entity, with funding and resources being provided to support the functions of the Commissioner.

**Private health insurance**

* The federal government should encourage the private health insurance industry to play a more proactive role in the delivery of preventative health care and, in particular, falls prevention among elderly policy holders. Private health insurers should be required to consult with key stakeholders, including relevant peak bodies and professional associations, with regard to decisions concerning product design and the exclusion of particular services from available extras.

**National Disability Insurance Scheme (NDIS)**

**Reforms to therapy pricing arrangements**

Consulting firm McKinsey & Company provided its final report from the NDIS Independent Pricing Review (IPR) to the National Disability Insurance Agency (NDIA) in February 2018. The report was made public in March.

OTA and other peak bodies expressed concern around the lack of meaningful consultation with key stakeholders undertaken by McKinsey & Company, and the fact that several of the report’s recommendations were not supported by evidence. None of the major allied health professions were approached for input, and it also transpired that there was no concerted data collection or modelling to inform the proposed reforms.

Of particular concern to occupational therapists and other allied health providers were recommendations 17-21, which pertain to therapy supports. Recommendation 17 – the introduction of a tiered pricing system for therapy supports based on the complexity of a case – has generated alarm amongst service providers and prompted many to consider revoking their NDIS registration. OTA’s members have reported that it would not be financially viable to provide services to Level 1 participants, or those who are deemed least complex, who require physical therapy.

OTA welcomes the recent announcement by the NDIA that it will undertake a separate pricing review of therapy services, which commenced in December 2018. OTA, along with other peak bodies, is being consulted as part of the review. We understand that the implementation of a tiered pricing structure based on complexity has been abandoned, with the Agency instead considering an alternative model based on factors such as therapy type, service type and geography. Understandably, the allied health sector remains concerned that ‘differentiation’, as it is being referred to by the Agency, could pave the way for the introduction of different prices for different professions.

***Recommendation 1:*** ***OTA reiterates its call for a flat rate for therapy supports that reflects the true costs of providing services under the NDIS. The processes and systems underpinning the NDIS place a considerable unpaid administrative burden on service providers that other schemes do not.***

**Certification of NDIS providers**

OTA has received extensive feedback from members, particularly sole providers and small business owners, who are concerned about the administrative and financial cost of seeking certification to provide early childhood supports. The NDIS Quality and Safeguards Commission has commenced operation in New South Wales and South Australia, and will progressively begin operating in other jurisdictions between now and 2020.

Many providers are seriously considering walking away from the scheme due to the requirement that they undergo a prohibitively expensive audit. Furthermore, providers are required to select from a list of approved auditors, which clearly limits their capacity to choose an auditor that can best meet the needs of their business.

It remains unclear to our members why one arm of government – the Australian Health Practitioner Regulation Agency (AHPRA) – can deem an occupational therapist fit to practice, while another – the NDIS Quality and Safeguards Commission – can suggest they are not. An additional concern is that states and territories may seek to duplicate or even override the national framework by implementing their own verification/certification schemes, which will result in more red tape and added costs for providers.

***Recommendation 2:*** ***The NDIS Quality and Safeguards Commission should ensure that audits are proportionate to the size of an organisation and the types of supports it provides. Funding should also be provided for educational programs with flexible attendance options (in person and online) for providers required to undergo certification, as well as more comprehensive resources outlining the certification process.***

**Ensuring funding certainty for NDIS participants**

Despite assurances by the government that the NDIS is fully funded, its decision to abandon a planned increase in the Medicare levy to pay for the scheme has created uneasiness within the disability sector. The proposed increase of 0.5 per cent, announced in the 2017-18 budget, would have raised $8 billion over four years from July 2019.

With the scheme estimated to cost around $22 billion in the first year of full operation, it is imperative that any lingering uncertainty around funding be resolved.

***Recommendation 3:*** ***The federal government should clearly outline how it intends to fund the NDIS in the coming years and the likely impact of scheme costs on other areas of spending.***

**Department of Veterans’ Affairs**

Given the demands of military service, both physical and mental, a sizeable proportion of veterans require the services of occupational therapists.

While occupational therapists derive enormous professional satisfaction from working with veterans and war widows, it has become increasingly difficult work to sustain. This is because remuneration for such work has, in effect, been frozen by the Department of Veterans’ Affairs (DVA) for more than a decade. There has been no increase in the rebate, beyond adjustment in line with the CPI, since 2007. That increase was modest and applied to only one item on the schedule of fees. And, moreover, there was no adjustment in line with the CPI between 2013 and 1 July 2018.

Those occupational therapists still working with veterans do so at a loss; they only keep doing it out of loyalty to longstanding clients and by relying on cross subsidies from other work.

The fee schedule is outdated, no longer reflecting the increased complexity of the work done by occupational therapists and the assistive technology they prescribe. Our members often identify mental health issues while doing assessments and are subsequently expected to perform a case management role which is not remunerated. An updated fee schedule should reflect the changing landscape in which occupational therapists work. It should remunerate them for the time it actually takes to perform increasingly complex consultations.

The most recent DVA Schedule of Fees for Occupational Therapists, effective 1 July 2018, pays $88.30 for initial and subsequent consultations undertaken at a therapist’s rooms or the client’s home. This fee is not time-based, meaning occupational therapists will be paid a flat rate regardless of how long the consultation actually takes.

Proposed technical adjustments to fee codes will streamline some administrative functions but will not result in any significant increase in fees paid. DVA has made it clear that there will be no increase in fees until 2021 at the earliest.

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

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

***Recommendation 4:*** ***The DVA Schedule of Fees for Occupational Therapists should be reviewed as a matter of urgency to ensure that occupational therapists are fairly reimbursed for their work with veterans. This must involve a significant increase in fees that is well above and beyond the mere reintroduction of indexation.***

**Mental health**

Mental health service provision is a core area of practice for occupational therapists dating back to the beginning of the profession. Occupational therapists work across the spectrum of mental illness, providing services to people with mild, moderate and severe mental health conditions. They deliver services to people with relatively common conditions such as anxiety disorders, as well as more severe conditions that require targeted interventions, such as psychosis and trauma-related disorders.

Despite this, there is currently a sizeable disparity between the rebates for services provided by psychologists, and those provided by occupational therapists and social workers through the Better Access to Mental Health initiative. This lack of consistency can lead to significant out-of-pocket expenses for consumers who are often not made aware of the differences in rebates prior to commencing treatment.

A number of therapists have reported that it is simply not financially viable to work in this space due to inequities within the system. Moreover, lower rebates devalue the important work of occupational therapists and social workers and make it harder for consumers to access their services.

Practice owners, irrespective of their profession, must cover operating costs, including rent, equipment, utilities, computers and insurance. Unless occupational therapists and social workers receive the same rebate as other health professionals, private providers may be squeezed out of the market.

Co-payments can prove prohibitive for many clients, some of whom decide to cancel appointments or delay their next appointment. This is particularly true of rural and remote consumers, whose income is, on average, lower than that of people living in metropolitan areas.

The work of occupational therapists often requires significant travel, and consultation and liaison with relevant others, in order to secure effective outcomes for clients. This is inadequately subsidised under the program.

***Recommendation 5:*** ***There should be a flat rate in respect to rebates across the professions included in the Better Access to Mental Health initiative, along with recognition of the need for loading for work undertaken in rural and remote areas.***

**Primary health care**

Targeted spending on primary health care is a means of addressing the health needs of individuals

before they become more acute. A proactive investment in ‘wellness’, rather than reactive

spending on the treatment of illness, represents a longer-term investment in the health of the

community.

While the creation of Primary Health Networks (PHNs) tasked with addressing local population health needs is a positive initiative for local communities, OTA believes there should be greater investment in raising community and GP awareness of the vital ‘value add’ provided by allied health professionals. This will enhance the holistic nature, and therefore the effectiveness, of primary health care.

While OTA acknowledges the evidence base underpinning the Health Care Homes model, whereby patients with chronic and complex conditions receive ‘wraparound’ care from a team of health professionals, our members have also raised concerns. The centralised role of GPs in Health Care Homes will potentially limit the role and influence of allied health professionals in chronic disease management. Furthermore, we understand that the number of patient enrolments during the trial period has fallen well short of the target, suggesting that the model has not been appropriately designed or promoted.

By enabling people to participate in daily activities, occupational therapists are key to illness prevention. By assisting the injured to return to work as soon as possible, occupational therapists enhance economic productivity. And by promoting wellness, occupational therapists help minimise avoidable hospitalisations, thereby relieving pressure on the health system.

OTA notes that the 2018-19 MYEFO included funding of $512 million to strengthen Australia’s primary care system. This included a suite of initiatives to support doctors and specialists, with very little investment in the allied health sector.

***Recommendation 6:*** ***The federal government should implement an interdisciplinary, preventative model of health care that encourages active dialogue between all members of a patient’s care team, and removes the possibility of a single profession adopting a ‘gatekeeper’ role.***

**Aged care**

Occupational therapists play a key role in providing aged care services to older people, both in the community and in residential aged care facilities (RACFs).

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.

**Aged Care Funding Instrument**

Occupational therapists have reported that the Aged Care Funding Instrument (ACFI), the resource allocation instrument used to assign funding to RACFs, does not take into account the full breadth of services that occupational therapists are able to provide. The interpretation and application of the ACFI is not holistic enough and does not support therapeutic engagement.

The ACFI is interpreted by the team of staff at each RACF, which is often led by a registered nurse. Multidisciplinary care teams are needed in all facilities to provide a range of treatment options for residents who may be suffering from a multitude of conditions. Ongoing dialogue between members of a client’s care team is needed to better manage their condition and identify the most appropriate interventions.

Pain management is not the totality of occupational therapists’ skills and experience in chronic disease management. Occupational therapy is not about simply managing pain; rather, occupational therapists are able to assess changes in a person’s functional capacity and promote reablement. Concerns have been raised that the ACFI is not aimed at improved or sustained quality of life, and residents are therefore missing out on goal or function-directed therapy.

***Recommendation 7:*** ***Interventions and modalities funded under the ACFI should be expanded to take into account the broad scope of occupational therapy practice.***

**Home care packages**

Despite the addition of 10,000 new high level home care packages in the 2018-19 MYEFO, tens of thousands of consumers remain on the waiting list for a package. OTA believes that consideration should be given to rebalancing the distribution of home care packages, as proposed in the Aged Care Legislated Review led by David Tune.

We believe that a higher level of governance is needed to ensure that only those with the most

complex care needs are being allocated level 4 packages. There have been cases of consumers being allocated a level 4 package when they do not actually require this level of support, as their needs have decreased from when they were first assessed. There have also been reports of consumers who are allocated higher level packages exhausting all of their funding through the purchase of a large item of equipment. OTA understands that steps are being taken to address this problem, with only 15 per cent of the total number of clients assessed now being assigned level 4 packages. In practice, this means that each full time ACAT assessor can only assign one client per week to a level 4 package.

Another issue is the spending of allocated funds on items and services that do not appear to be covered under home care package guidelines, but have been approved for purchase by the Australian Competition and Consumer Commission (ACCC). The Department of Health needs to address the inconsistent decision-making that is currently occurring, as it may result in the purchase of unnecessary items that do little to improve a client’s quality of life.

In many remote areas, consumers do not have a choice of provider as only one option exists. In some instances, providers are using a computer-generated system as a quick and easy way to bill for services against certain core line items, however the system is not necessarily updated if a particular client does not receive certain core services as part of their package (i.e. daily meals). As a result, providers are approaching government services for items such as equipment, stating that clients have exhausted all of their package funding. However, the client believes they are receiving minimal services from the provider. With no other providers to choose from, the client is often not in a position to leave or complain about this.

***Recommendation 8:*** ***The federal government should undertake a comprehensive analysis of how home care package recipients are utilising their allocated funds. A higher level of governance is needed to ensure that there is greater consistency across the country with regard to the allocation of level 4 home care packages, while consumers who have been allocated a higher level package should be able to move easily to a lower level package if their needs change.***

**The maldistribution of the health, aged care and disability workforce**

In a land as vast as Australia, and with a population as urbanised as Australia’s, it is unsurprising that our health, aged care and disability workforce is stretched so thinly between our major cities. But while the problem comes as no surprise, it nonetheless remains a problem.

Key issues behind these workforce shortages include the difficulty of recruiting and retaining workers, high turnover rates, inadequate availability of senior/experienced staff, and an oversupply of part-time and casual workers.

The federal government should work to address this maldistribution as a matter of urgency, ensuring those Australians living outside our major cities and regional centres enjoy reasonable access to health services befitting one of the world’s most advanced countries. The stated determination of all governments to ‘close the gap’ of Indigenous disadvantage is another compelling reason to ensure such access.

Education must play a key role in any long-term solution to this problem. Regular and meaningful rotations through regional and remote locations during the training of medical and allied health professionals heighten the possibility that the student will eventually settle and practice in such a location. This is most easily achieved by way of training networks that link major metropolitan hospitals with smaller regional and rural hospitals. While this is largely the responsibility of state and territory governments, the federal government should work with, and encourage, these governments to implement such arrangements.

The provision of rural-based scholarships and fellowships is another means of attracting students and recent graduates to locations outside our major cities.

OTA strongly supports the development of an Allied Health Rural Generalist Pathway, which is key to the provision of multidisciplinary care in rural and remote areas. We also join with other organisations in calling for the development and implementation of a comprehensive rural and remote health strategy.

***Recommendation 9: The federal government should commit to addressing workforce shortages, and consequently reduced access to essential services, in rural, regional and remote parts of Australia. The government should work with state and territory governments to develop training networks that link major metropolitan hospitals with smaller regional and rural hospitals, and increase the provision of rural-based scholarships and fellowships to attract students and recent graduates to locations outside our major cities.***

***Recommendation 10: The office of National Rural Health Commissioner should be made a permanent entity, with funding and resources being provided to support the functions of the Commissioner.***

**Private health insurance**

An ongoing concern to members of OTA is the lack of recognition of occupational therapy

by Australian private health insurance funds. Some cheaper packages offered by private health

insurers exclude occupational therapy altogether, while including other therapies with little evidence in support of their benefits. Many of the more expensive packages relegate occupational therapy to the status of an optional extra.

While OTA understands there is no overarching or mandated framework that determines which services are included in private health insurance packages, we believe it is critical that private health insurers are made aware of the efficacy of occupational therapy and are encouraged to incorporate its services in their basic packages. This would enable policy holders to access therapeutic services of proven value if and when the need arises.

At a time when government is focusing on the public health and economic benefits that flow from preventative medicine, OTA believes private health insurers should be encouraged to devote more energy and resources to preventative care when undertaking product design. While we recognise that many insurers offer customers benefits, such as discounted gym membership, that encourage healthy lifestyles, it is fair to say that there still exists a general belief that health insurance only ‘kicks in’ once someone is sick or injured.

In the case of elderly customers, for example, the health system and the private health funds would generate substantial savings by making even a modest investment in assistive technology and home modifications as prescribed by an appropriate allied health professional. There is also ample evidence to support the assertion that every dollar invested in falls prevention by a private health fund will save that fund multiple dollars.

***Recommendation 11:*** ***The federal government should encourage the private health insurance industry to play a more proactive role in the delivery of preventative health care and, in particular, falls prevention among elderly policy holders. Private health insurers should be required to consult with key stakeholders, including relevant peak bodies and professional associations, with regard to decisions concerning product design and the exclusion of particular services from available extras.***