

**A portrait of occupational therapy in Ontario: Results of a 2003 survey**

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*As the recent report of the Commission on the Future of Health Care in Canada (the Romanow Report) emphasized, Canada's health-care system is in a period of change and transition. Driven by technological advances, changing social values and growing concerns about the sustainability of publicly funded health care (Medicare) in the face of rising costs and an aging and increasingly diverse population, governments across the country have engaged in wide-ranging health-care reform and restructuring initiatives.*

In Ontario, as in other provinces, rehabilitation has been at the centre of reform and restructuring. Until the early 1990s, most rehabilitation was provided in hospitals. By the late 1990s, however, a series of policy initiatives, legislative acts and provincial regulations had resulted in a substantial shift of rehabilitation to the community. The availability of inpatient rehabilitation eroded as hospitals responded to budget cuts by protecting "core" inpatient acute care services at the expense of presumably less "core" rehabilitation; some hospital rehabilitation departments were closed, rehabilitation services were contracted out and patients requiring rehabilitation care were discharged to home and community. Because the *Canada Health Act*, the legislative basis of Canadian Medicare, requires public coverage only for services provided in hospitals or by doctors, an increasing proportion of the costs of rehabilitation was transferred to clients and private insurers. This was complicated by new automobile insurance legislation that pushed greater responsibility for rehabilitation onto private insurers and accident victims, and by changes to the provincial workers' compensation plan which put greater responsibility for rehabilitation on private employers and pushed the provision of such services increasingly toward community-based for-profit providers. In home and community care, growing service demands from people discharged earlier from hospitals were met by capped home care budgets and a new system of managed competition for purchasing services resulting in lower priority for rehabilitation care, the contracting out of rehabilitation therapists and reductions in rehabilitation home care service volumes.

**What do such changes mean for occupational therapists and their clients? How do occupational therapists organize and conduct their practices in an increasingly fragmented and commercialized field?**

This article, the first in a series of three, outlines initial findings from a three-year study of rehabilitation services in Ontario conducted by a multidisciplinary team of researchers at the University of Toronto and Ryerson University. Because there was little available evidence of the extent or consequences of health-system change in the rehabilitation sector, the team, in collaboration with professional colleges and associations, conducted large-scale mail surveys of Ontario's occupational and physical therapists during the spring and summer of 2003. The survey of occupational therapists included 1,022 practitioners (about one in three of all occupational therapists in the province) randomly selected from the registrant database of the College of Occupational Therapists of Ontario. Just over 64% (657) completed and returned the questionnaires. This strong response rate ensures that the survey results provide an accurate and up-to-date portrait of occupational therapists in the province. It also reveals a high level of interest among occupational therapists on the front lines of change in issues affecting the future of their profession.

In subsequent articles in this series, we will report occupational therapists' views on professional working conditions, and professional autonomy, and describe the ways they respond to an increasingly diverse client base. In this article we begin by describing key characteristics of occupational therapy employment and levels of satisfaction with different aspects of their work; we then present occupational therapy views on health-system performance and key health policy issues.

## **Findings**

### **Employment characteristics**

Table 1 shows that a large majority (79.9%) of Ontario's occupational therapists work for only one employer during a typical working week; 17.9% work for two employers and 2.2% work for three or more employers. The majority of occupational therapists work in the publicly financed sector: 53.3% are employed by not-for-profit hospitals and an additional 15.4% work in public sector agencies such as boards of education and Community Care Access Centres (CCAC). CCACs provide publicly funded home care services including occupational therapy, physiotherapy and nursing. Private independent businesses are the next largest source of employment (26.4%) while large for-profit corporations account for just 4.9%. Even though a majority of therapists are employed by hospitals, most provide services in the community: only 40% provide services in hospitals, 29% list the client's home as their main work setting, with 11.1% and 8.5% providing services mainly in schools and community clinics. The remaining 11.4% provide services in other settings such as specialized treatment centres. Payment for these services remains heavily public: respondents estimate that government funding through hospital global budgets and CCAC home care contracts account for the largest part of employer revenues (76.5% and 5% respectively), while private insurance, out-of-pocket payments and other fees account for almost a fifth (18.8%). Just under seven in 10 occupational therapists (69.5%) report that they are employed on a permanent basis and 7.5% indicate that they are owners or partners in their own businesses; however, 17% are contract or casual employees and 6% indicate that their employment status is mixed.

**Table 1**  
**Employment Characteristics**

Variable	Category	Percent (%)
Number of employers	One	79.9
	Two	17.9
	More than two	2.2
Primary employer	Independent business	26.4
	Large for-profit corporation	4.9
	Hospital or publicly funded facility	53.3
	Other public sector (e.g. board of education)	15.4
Main work setting	Hospital	40.0
	Client's home	29.0
	School	11.1
	Community based clinic	8.5
	Other (e.g. treatment centre, nursing home, workplace/ industry)	11.4
Employer's main source of revenue	Government funding	76.5
	Private insurance	13.8
	Community Care Access Centre (CCAC)	5.0
	Other (e.g. worker' compensation, client, out-of-pocket)	4.7
Employment status (primary employer)	Owner/partner	7.5
	Permanent employee	69.5
	Contract/casual employee	17.0
	Mixed	6.0

### Hours and incomes

Table 2 shows that a majority (77.8%) of Ontario's occupational therapists work full-time (30 hours or more per week) while over a fifth (22.2%) work part-time. Direct patient care (e.g., assessment, treatment, education of client and/or family) remains a central element of occupational therapy practice, taking up just over half (51.8%) of paid working hours during a typical working week, with indirect patient care (e.g., supervising

support personnel, treatment planning) accounting for an additional 20%. Administration (14%) and travel (6.5%) together take up just over a fifth of paid working hours, with research and teaching accounting for 4.8%. Note that in addition to these paid hours, occupational therapists say they average a further three hours of work per week in professional activities for which they are not paid. Net, before-tax incomes for all practising occupational therapists (including those working less than 30 hours per week) average just over \$49,000 annually; the corresponding figure for occupational therapists working full-time (30 hours or more per week) is just under \$54,000.

<b>Variable</b>	<b>Category</b>	<b>Percent (%)</b>
Number of paid hours worked/week		
	Less than 30	22.2
	30 or more hours	77.8
Percent paid hours/week providing:		
	Direct patient care	51.8
	Indirect patient care	20.0
	Administration	14.0
	Travel	6.5
	Research/teaching	4.8
	Other	2.9
Average number of unpaid hours/week		3.3
Net average annual income (after expenses, before tax) 2002		
	Occupational Therapists (including part-time and full-time)	\$49,592
Net average annual income (after expenses, before tax) 2002		
	Occupational Therapists (full-time only)	\$53,693

### **Satisfaction and health system performance**

Table 3 reveals varying levels of satisfaction among occupational therapists with key aspects of their work. Just over half of the survey respondents (50.3%) say they are satisfied with their professional incomes; however, about the same proportion say they are only somewhat satisfied (29.1%) or dissatisfied (20.6%). Levels of satisfaction are higher for employment security (61.2%) but lower for employment benefits (44.9%). By far, the most positive responses relate to occupational therapists' professional relationships with clients: 87.7% say they are satisfied, while only 2.2% say they are

dissatisfied. By comparison, occupational therapists are more critical of the health-care system. Only 15.1% rate the performance of Ontario's health-care system as "excellent," while almost a third (32.1%) rate it as "poor." Asked specifically about the rehabilitation sector, 38% rate the performance of independent businesses/clinics as "excellent"; fewer (20.4% and 23.1% respectively) rate the performance of large for-profit corporations and

hospital inpatient rehabilitation services in the same way.

**Table 3**  
**Satisfaction and Health System Performance**

Variable	Response	Percent (%)
Satisfaction: income	Dissatisfied	20.6
	Somewhat satisfied	29.1
	Satisfied	50.3
Satisfaction: employment security	Dissatisfied	18.5
	Somewhat satisfied	20.3
	Satisfied	61.2
Satisfaction: employment benefits	Dissatisfied	30.1
	Somewhat satisfied	25.0
	Satisfied	44.9
Satisfaction: professional relationship with clients	Dissatisfied	2.2
	Somewhat satisfied	10.1
	Satisfied	87.7
Performance rating: Ontario's health-care system	Poor	32.1
	Neutral	52.8
	Excellent	15.1
Performance rating: independent businesses/ clinics, rehabilitation	Poor	13.7
	Neutral	48.3
	Excellent	38.0
Performance rating: large for-profit corporations, rehabilitation	Poor	28.4
	Neutral	51.2
	Excellent	20.4
Performance rating: hospital inpatient, rehabilitation	Poor	29.2
	Neutral	47.7
	Excellent	23.1

### **Health policy options**

The survey asked occupational therapists for their views on a range of current health policy options. Table 4 reveals limited support for a two-tier health-care system. Only 24% of the survey respondents agree that “individuals should be allowed to pay extra to get quicker access to health-care services”; 62.1% explicitly disagree. Support for private sector health care and for the profit motive is also limited: only a minority (23.5%) agree that the private sector is more efficient than the government, or that the profit motive has a place in health care (22.7%). By comparison, support for a publicly funded universal health-care system is stronger: 56.2% agree that government spending on health care should increase even if it means higher income taxes, and almost two thirds (65.7%) agree that universal government health insurance (Medicare) should be expanded to cover all home care services within three months of discharge from hospital. On the other hand, occupational therapists strongly oppose the possible “Americanization” of Canadian health care: more than two thirds (67.8%) disagree with the proposition that “American corporations bring useful competition and choice to health care” while only

10.6% would permit American health-care corporations to enter Canada.

**Table 4**  
**Health Policy Options**

<b>Variable</b>	<b>Response</b>	<b>Percent</b>
Individuals should be allowed to pay extra to get quicker access to health-care services	Disagree	62.1
	Neutral	13.9
	Agree	24.0
The private sector is more efficient at managing health care than the government	Disagree	43.5
	Neutral	33.0
	Agree	23.5
The profit motive has a place in health care	Disagree	53.1
	Neutral	24.2
	Agree	22.7
Government spending on health care should be increased even if it means higher income taxes	Disagree	16.5
	Neutral	27.3
	Agree	56.2
Medicare should be expanded to cover all home care services for up to three months following hospital discharge	Disagree	11.4
	Neutral	22.9
	Agree	65.7
American corporations bring useful competition and choice to health care	Disagree	67.8
	Neutral	23.8
	Agree	8.4
American health-care corporations should be permitted in Canada	Disagree	72.6
	Neutral	16.8
	Agree	10.6

## **Discussion**

Although these survey results cannot tell us how individual therapists have been affected by health-system change or how their practices may have changed over time as a result, they paint a portrait of a profession in an increasingly complex and commercialized field.

Over half of Ontario's occupational therapists are still employed by not-for-profit hospitals and public funding remains a major source of employer income. However, many occupational therapists are now found in a mix of different funding and employment arrangements, in public and private sectors, and a majority provide services outside of hospital walls in a range of settings including schools, homes, community clinics and workplaces. Of particular interest is the fact that over a fifth of occupational therapists now work for multiple employers, while about the same proportions are employed part-time and on a contract/casual basis. These findings pose important questions for the future. Are we seeing, as some would suggest, an increasing fragmentation and casualization of occupational therapy as a whole? What challenges do occupational therapists in different employment arrangements and work settings face as they attempt to provide client-centred care according to professional norms and standards?

A related point addresses the content of professional work. In this connection, concerns have been raised that because of budget constraints and a general restructuring of professional employment, occupational therapists may be drawn away from patient care to non-clinical tasks such as administration and travel. While our survey data cannot demonstrate a trend, they show that non-clinical tasks now account for about a quarter of all paid occupational therapy hours, and that occupational therapists average an additional three hours of unpaid work during a typical week. Is there a connection here? In written comments, some respondents suggested that the only way they feel they can provide adequate patient care, given an increasing burden of administrative duties, is to work extra patient care hours "for free." How true is this for the profession as a whole? Do occupational therapists working in community clinics or home care spend more hours in administration and unpaid work than their counterparts in hospitals? What are the implications for the ability of occupational therapists to provide client-centred care? As shown in their overwhelmingly high satisfaction ratings, professional relationships with clients remain a defining point of occupational therapy practice.

Finally, occupational therapists have strong views on important health-care issues. In this connection, many are critical of the performance of Ontario's health-care system, including its rehabilitation sectors. Nevertheless, a majority still support the principle of single-tier publicly funded, universal health care even though, as we have seen, rehabilitation in Ontario is already multi-tier – clients will have different access to care depending on whether they fall under hospital, home care, private insurance, or workers' compensation. In fact, a large majority approve of the extension of Medicare coverage to home care (including rehabilitation) and are willing to see tax increases to pay for it. Many occupational therapists also strongly resist the introduction of "American-style" corporate health care. Thus, as a group, Ontario's occupational therapists are substantially in agreement with the recommendations of the recent Romanow Report which affirmed

the continuation of a strong and expanded Medicare system, while also opposing a greater role for private, for-profit health care. Further analysis will allow us to explore how such views vary within the profession. Are occupational therapists working in not-for-profit publicly funded hospitals more likely than those working in private practice to support the extension of Medicare coverage? Are they less likely to support the entry of global health-care corporations into Canada?

What is already clear is that occupational therapists face challenges in a period of change and transition, and that they have important contributions to make to the ongoing debate about the future of Canada's health-care system. In the next two articles in this series we examine occupational therapists' perspectives on their clinical autonomy and their capacity to provide services to an increasingly diverse client population.

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