Priorities for the 2019-20 Budget

February 2019

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6500 members. As a leader in nutrition DAA advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide a submission in response to the call by the Assistant Minister for Treasury and Finance seeking views on priorities for the 2019-20 Budget.

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DAA interest in the priorities for the 2019-20 Budget

As the professional body for dietitians in Australia, DAA wants to see that Australian Government programs support food security and the opportunity to access high quality professional services for all Australians to experience physical health, mental health and well-being.

DAA manages the Accredited Practising Dietitian program as the foundation for self-regulation of the dietetic profession in Australia. The Accredited Practising Dietitian program provides an assurance of quality and safety to the Australian public.

Accredited Practising Dietitians are the food and nutrition professionals uniquely qualified and credentialed to work in diverse settings including aged care, hospitals, disability, mental health, private practice, public health, community health, food service, food industry, research and teaching.

Recommendations

1. Recognise the need to nourish all Australians by funding an updated Scoping Report and consultation for a National Nutrition Policy.

2. Fund the vital work of the National Alliance of Self Regulating Health Professions to promote national consistency in professional regulation alongside the Australian Health Practitioner Regulation Agency.

3. Introduce new Medicare items for people with mental illness to address the physical illness which shortens their lives. Consumers experiencing depression, anxiety, schizophrenia and other conditions want access to Accredited Practising Dietitians to help them make dietary changes to enjoy better physical and mental health.

4. Permit telehealth services as an alternative to face to face services by allied health practitioners, such as Accredited Practising Dietitians. Rural Australians with chronic medical conditions such as diabetes, cardiovascular disease, stroke, cancer or musculoskeletal conditions would have better quality of life and cost the health system less if provisions under the Medical Benefit Schedule were extended.

5. Include pre-diabetes in the conditions which can be treated under Medicare Chronic Disease Management items. Early intervention by Accredited Practising Dietitians and Accredited Exercise Physiologists for people with pre-diabetes markers identified by a general practitioner can delay or stop progression of disease and avoid the costs associated with treating Type 2 diabetes.

6. Reintroduce scholarships for allied health students studying in accredited education programs to take up placements in rural and remote areas. The evidence tells us that students with exposure to rural and remote practice are more likely to take up positions outside urban areas after graduation.

Background to recommendations

1. *National Nutrition Policy*

DAA calls on the Australian Government to develop a new National Nutrition Policy. The old 1992 policy urgently needs updating and expanding so it aligns with recommendations from the World Health Organization, the United Nations Steering Committee on Nutrition and the Food and Agriculture Organization. Poor diet and excess weight costs Australia dearly, not just the obvious medical costs, but also in reduced productivity and lower levels of well-being among the population. Poor diet is a leading risk factor for deaths in Australia. In 2015, the Global Burden of Disease study determined poor diet contributed to almost 18% of deaths (over 29,000 deaths)[1].

A contemporary and comprehensive nutrition policy would

- Ensure population health strategies are in place to address chronic disease
- Assure vulnerable Australians of food and nutrition security
- Improve access by individuals with special dietary needs to dietitians as the professionals uniquely qualified to provide medical nutrition therapy
- Support regular monitoring and surveillance of the food supply and nutrition markers in the population.

The budget initiative would require funding of an update to the Scoping Framework which was completed in 2013 and a national consultation.

2. *National Alliance of Self Regulating Health Professions*

The National Alliance of Self Regulating Health Professions (the Alliance) was established in 2008 to support functions of public safety and quality assurance for the self regulating health professions. Over 45,000 self regulated health professionals, including dietetics, audiology, and diabetes educators, work across all care settings in public, private and not for profit settings to deliver over 65 million health services[2] some of which are funded by Medicare and Department of Veterans Affairs.

In 2017 the Australian Government provided seed funding to facilitate national consistency in professional regulation to satisfy national and jurisdictional regulation requirements. Ongoing funding would continue this work alongside that of the Australian Health Practitioner Regulation Agency and facilitate regular data reporting to inform national workforce planning and development. It would also promote greater understanding of health regulation to address the unintended consequences arising from exclusion from regulation under the Australian Health Practitioner Regulation Agency.

3. *Medicare item for dietitians to treat mental illness*

New MBS items are needed for APDs to treat physical and mental health as an adjunct to medical interventions for mental illness. People with serious mental illness experience

considerable morbidity, loss of quality of life and a lower life expectancy of 20 or more years[3]. They also have far greater incidence of chronic disease, with 90% experiencing physical illness[4]. This costs individuals and their families, and impacts on the government bottom line.

Recent Australian studies show that diet is a highly effective treatment when sufficient consultations are available to establish relationships between patient and professional and reinforce complex concepts for ongoing self-management. Outcomes include symptom reduction and remission of mental illness, as well as improvement in physical health parameters[5-9].

Funded positions for dietitians in public hospitals and community services are not sufficient to meet community needs. Medicare Chronic Disease Management items offer limited access because the five items available per year are shared across all eligible allied health providers. This is not enough to meet the complex needs of people with mental illness who require more and longer consultations with Accredited Practising Dietitians to be clinically effective.

Introducing MBS items for Accredited Practising Dietitians for individual and group consultations would improve equity of access to nutrition services for people with mental illness who are most at risk of poor diet and mental illness but may have the least capacity to pay for private services.

4. Telehealth

Australians living in rural and remote areas have poorer health outcomes than their metropolitan counterparts[10] and yet they have less access to allied health services to support self-management of their chronic medical conditions[11] such as diabetes, kidney disease, gastrointestinal disease or food intolerance.

DAA records indicate 20% of Accredited Practising Dietitians practice in regional, rural or remote areas, but not all geographical areas are covered. Even where Accredited Practising Dietitians do offer a service, patients may not be able to afford private practice fees. There is evidence that out-of-pocket-costs can influence patient decisions about when they access health care[12]. In some cases, the patient may have specialised needs for complex nutrition care which is not within scope of the local generalist Accredited Practising Dietitian.

The Australian Department of Health states that specialist video consultations under Medicare 'provide many patients with easier access to specialists, without the time and expense involved in travelling to major cities'. 47,883 patients benefited from 120,005 services claimed by 8,823 medical specialist, general practitioners, midwives and nurse practitioners between July 2011 and December 2013[13]. Allowing telehealth consultations for allied health consultations would be consistent with a human rights approach and more equitable than the status quo.

Dietetic services are well suited to the medium of telehealth, as demonstrated by the inclusion of telehealth in the pilot of the Coordinated Care for Diabetes reform. There is evidence that telephone counselling by a dietitian achieves dietary behaviour change[14,15] and improves metabolic parameters in individuals with metabolic syndrome[16].

An Australian review of allied health video consultation services found clinical outcomes have generally been similar to outcomes of face-to-face consultations, with relatively high levels of patient satisfaction[17]. A US study found programs delivered by telephone had a lower cost but similar outcomes compared with face to face format[18].

The utility of telehealth is recognised by private health funds offering telephone and online health services to members[19].

The 2010 Telehealth for Aged Care report[20] concluded that older Australians participating in telehealth may delay entry to residential aged care.

5. Pre-diabetes interventions

Current eligibility for Medicare Allied Health assessment items and group service items requires a diagnosis of Type 2 Diabetes. DAA proposes extending eligibility for these items to include pre-diabetes to slow the increasing prevalence of Type 2 Diabetes with its associated co-morbidities and healthcare spending as outlined in a previous submission advocating for this initiative.

There are established criteria published by authoritative bodies in Australia and internationally[21] for determining pre-diabetes, a recognised risk factor for diabetes and cancer. Peer reviewed evidence supports the efficacy of lifestyle intervention on delaying disease progression from pre-diabetes to diabetes, with benefits persisting long-term. Improvements in quality of life and significant direct and indirect cost savings could be realised by slowing disease progression.

6. Reintroduce scholarships for rural allied health placements

Services for Rural and Remote Allied Health Australia administered scholarships under contract to the Australian Government Department of Health for a number of years. This was a welcome measure to enable student dietitians and other allied health students to undertake clinical placements in rural and remote areas.

This initiative was important as there is evidence to show that students undertaking such placements were more likely to return to rural and remote practice after graduation[22]. Scholarships mitigate some of the financial barriers to moving away from metropolitan areas, including loss of income from usual employment, additional rent for the period of placement, and travel to distant locations.

However, a change in government policy has seen a winding down of support for clinical placements. In the 2016-17 Annual Report of Services for Rural and Remote Allied Health

it was noted that under the new Health Workforce Scholarship Program clinical placements would no longer be available for allied health. This is at odds with efforts to increase the health professional workforce in rural and remote areas in response to high levels of chronic illness and few resources. There appear to be opportunities for medical students from various programs but DAA has been unable to identify national programs offering opportunities for student dietitians.

DAA calls on the Australian Government to address inequities in access to health services in rural and remote areas and build the workforce in those areas by reintroducing a scholarship program for rural clinical placements.

Cost of recommendations

New MBS item for dietitians to treat mental illness

As an example using depressive disorders, improving symptoms has the potential to reduce admissions to hospital and shorten length of stay, and to reduce absenteeism and presenteeism. The benefits in financial terms in the context of the estimated cost of medical nutrition therapy of a mean seven sessions of $1318.05 could be exceeded by possible cost savings under plausible assumptions, given the high cost to the health sector and the economy of major depression.

Depressive episode is the most commonly reported principal diagnosis for separations with specialised psychiatric care (17.4%) in Australian public hospitals[23]. The median cost per bed day is $1424[24]. In 2014-15 the average length of stay for mental health related patients in public acute hospitals was 15.7 days[25].

In terms of productivity, it is estimated that an additional six days of absenteeism can be related to a moderate severity mental health condition, i.e. more than one working week. In May 2016 the Full-Time Adult Average Weekly Ordinary Time Earnings were $1,516.0026[26,27].

Telehealth

Substituting telehealth services for standard consultations covered by Medicare Item 10950 would be cost neutral for the consultation. Advice from the Department of Health is that patients accessing Chronic Disease Management items attend an average 2.5 allied health items per year. Demand from people wishing to access services by telehealth is likely to be modest, and very unlikely to approach the current limit of five items per year.

Improved outcomes would reduce expenditure on medications and decrease hospital costs as demonstrated by the pilot of the Diabetes Care Project.

There would be a requirement to update Department of Health and Department of Human Services processes and information related to Medicare.

Pre-diabetes

Studies by Diabetes Australia and other agencies demonstrate that effective funding of lifestyle interventions has the potential to mitigate rapidly increasing government expenditure attributed to Type 2 Diabetes. A systematic review identified a median incremental cost effectiveness return for diet and physical activity promotion programs of $13,761 per Quality Adjusted Life Year (QALY) saved[28]. Group-based diabetes programs were more cost-effective (median $1,819 per QALY) than those that used individual sessions (median, $15,846 per QALY)[28].

Relationship to government policy

These recommendations are consistent with the Coalition government commitment to delivering a 'fair go' for regional Australia to ensure that they receive their 'fair share' of support from government on a wide range of policy programmes[29].

The recommendations are also consistent with the funding of a Centre for Research Excellence in Telehealth[30], and the objectives of the National Diabetes Strategy[31].

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