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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 8500 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) program provides an assurance of safety and quality and is the foundation of self-regulation of the dietetic profession in Australia. Accredited Practising Dietitians have an important role in the health and wellbeing of all Australians.

This submission was prepared by Dietitians Australia staff in consultation with members, following the Conflict of Interest Management Policy and processes approved by the Board of Dietitians Australia. Contributors include Dietitians Australia members with wide ranging expertise in areas including clinical nutrition, food services, public health, food systems and academia.

Recommendations

Preventive health

Recommendation 1: Invest in national food and nutrition actions to reduce the exposure and intake of unhealthy foods, support healthy eating and protect all Australians from the risk of diet-related disease.

Recommendation 2: Fund ongoing nutrition monitoring

Community health services

Recommendation 3: Increase investments in Primary Health Network-funded community health services to deliver comprehensive multidisciplinary health care that includes access to Accredited Practising Dietitians

Medicare Benefits Schedule

Recommendation 4: Support access to and quality of care by increasing allied health service limits for chronic disease management from 5 to minimum 10 consultations per annum.

Recommendation 5: Support quality of care and optimal health outcomes for consumers by creating and funding Medicare items for dietetic consultations where duration is 50 minutes or longer.

Recommendation 6: Support quality of care and communication in the multidisciplinary team by creating and funding Medicare items for allied health professionals to prepare reports for the referring practitioner.

Recommendation 7: Create Medicare Benefit Scheme items relating to dietetic services for people experiencing depression, other mood disorders and severe mental illness, including standard and extended individual consultations, group sessions and telehealth.

Recommendation 8: Create unique 820** Medicare Benefits Schedule item numbers for children with autism, pervasive developmental disorder and disability to see an Accredited Practising Dietitian for dietary assessment, diagnosis and treatment, and create the associated multidisciplinary case conferencing item numbers.

National Disability Insurance Scheme

Recommendation 9: Increase price limits for dietetic therapy supports provided under NDIS in line with the Consumer Price Index.

Discussion

Preventive Health

Recommendation 1: Invest in national food and nutrition actions to reduce the exposure and intake of unhealthy foods, support healthy eating and protect all Australians from the risk of diet-related disease.

COST

- 5% total health spending*

*A target of 5% of total health spending dedicated to investments in preventive health, achieved by 2031 as stipulated in the National Preventive Health Strategy.[1]

BENEFITS

Progress to achieve the targets of the National Preventive Health Strategy and National Obesity Strategy:[1, 2]

- Adults and children (≥9 years) maintain or increase their fruit consumption to an average 2 serves per day and increase their vegetable consumption to an average 5 serves per day by 2030
- Reduce the proportion of children and adults' total energy intake from discretionary foods from >30% to <20% by 2030
- Reduce the average population sodium intake by at least 30% by 2030
- Increase the proportion of adults and children who are not exceeding the recommended intake of free sugars by 2030
- At least 50% of babies are exclusively breastfed until around 6 months of age by 2025

Cost saving and revenue generating:

- Reduce deaths, hospitalisations and burden of diet-related disease
- Reduce workplace absenteeism and increase workplace productivity and profitability
- Revenue generating policies

BACKGROUND

Diet-related disease, including malnutrition in all its forms is a leading cause of ill health and death. A nutritious diet is one of the most influential factors contributing to our overall health and well-being, as well as economic prosperity.[3, 4]

Australians are consuming a diet with a low intake of fruits, vegetables, wholegrains, nuts and seeds, and a high intake of salt, unhealthy fats and sugar.[4] Diet-related diseases, namely, cardiovascular disease, type 2 diabetes and cancer are leading causes of hospital expenditure and death in Australia.[5] Of the leading factors that have been identified as contributing to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, 5 of the 7 are related to poor dietary intake: low fruit and vegetable intake, obesity, alcohol consumption, high blood cholesterol and high blood pressure.[6]

Effective preventive health measures have the potential to have the greatest impact on the health of Australians, the health care system and the economy by preventing disease in the first place.

ACTIONS

An up-to-date National Nutrition Strategy is needed and would align with the National Preventive Health Strategy[8] where the need for food and nutrition action guided by a specific policy document is acknowledged. It would also be an essential component of the National Obesity Strategy[9] and the National Breastfeeding Strategy[10] and would deliver multiple complementary benefits in terms of health, the economy, equity and environmental sustainability.

A coordinated, multi-strategy approach to improve nutrition is needed to have the greatest impact on health.[7] There are multiple policy options available to improve nutrition in Australia. For example, they can impact on the way food is made, sold, labelled and advertised.

The World Health Organization recommends several food and nutrition policies which are evidence-based, cost-effective and practical. Many of these actions have been endorsed and adopted by the National Preventive Health Strategy and National Obesity Strategy. Below outlines several of these actions that can help to improve the nutritional health of Australians as part of a coordinated, multi-strategy approach.

Reformulation – government-led mandatory reformulation targets that set criteria for the maximum limits for sodium, saturated fats and sugars in pre-packaged/processed/manufactured foods. Reformulation is an effective way to reduce population intake of salt, fats and sugar. It creates a marketplace that preferences healthy food options regardless of where people shop or how much they understand (or have access to) information on labels. This type of policy requires no consumer action.

Front-of-pack labelling - government-led mandatory Health Star Labels. Front-of-pack labelling contributes to increasing consumer awareness and enables consumers to make healthier choices, change purchasing intentions and provide the food and beverage industry with incentive to reformulate and produce healthier products.[8, 9]

Policies to protect children from the impact of food marketing on diet - marketing impacts food preferences, purchase requests and consumption patterns. Implementing marketing restrictions limits exposure to unhealthy foods high in salt, fats and sugars, decreases demand and provides the food and beverage industry incentive to reformulate and market healthier products.[10-12]

Fiscal policies – a minimum 20% health levy on sugar sweetened beverages is publicly accepted,[13, 14] and will generate immediate revenue to subsidise healthy foods such as fruit and vegetables. Studies of levies on sugar-sweetened beverages have demonstrated both reductions in sugar-sweetened beverage purchases and reductions in healthcare costs for consumers over their lifetime.[15] Sugar-sweetened beverages are suitable for a health levy for several reasons:

- the product category is well-defined
- they provide minimal to no nutritional benefit
- consumption has been associated with chronic diseases, including dental decay leading to dental caries – conditions that are highly prevalent in Australia.[16-18]

Over one third of Australian adults and almost half of children consume sugar-sweetened beverages at least once a week. Adolescents and young adults are the highest consumers of sugar-sweetened beverages.[19]

In 2021, the Australian Medical Association estimated that the rise in annual revenue from levies on sugary beverages could be between $749 million to $814 million[20]

Education – investing in strong public health education campaigns has the potential for far-reaching impacts, including changing attitudes and behaviours across the community, reducing the incidence of disease and saving lives.[21, 22]

When the updated Australian Dietary Guidelines (ADGs) are released, comprehensive, well-considered public education campaigns will be needed to maximise their usefulness and uptake. While the ADGs review is underway, and to compliment it, there are other guidelines that also need to be updated to benefit high risk populations.

For example, the Australian Government's Get Up and Grow guidelines need to be updated. The Get Up and Grow guidelines[23] are now over 10 years old. Our understanding of the effect of different food environments on children's health has evolved significantly in that time.[24] Early childhood is a critical stage of development and an important time to ensure quality nutrition is accessible for all children.[25,26]

Nutrition during the early years is critical for development and for shaping lifelong nutrition, health outcomes and disease prevention. Poor nutrition and related outcomes are known to track from infancy through to childhood and adulthood.[27-29]

With two-thirds of children aged 1-4 years accessing childcare in some form in Australia, childcare settings represent a valuable opportunity to have significant impact through updated Get Up and Grow guidelines on children's and families' food intake, both in the short and long-term.[24]

Recommendation 2: Fund ongoing nutrition monitoring

COST

- Scoping needed

BENEFITS

- Regular food and nutrition monitoring will provide information on dietary behaviours and nutrition measures over time, which is critical to both informing effective policy and program development and evaluating their implementation
- Monitoring will support development of policy to protect public health and improve the health and wellbeing of Australians
- Implementing a food and nutrition monitoring and surveillance program would contribute towards achieving United Nations' Sustainable Development Goal 3: Good Health and Wellbeing. It is also an essential component of the wellbeing budget as it will support 'measuring what matters'.

BACKGROUND

Dietitians Australia calls on the Australian Government to fund a food and nutrition monitoring and surveillance program. This is in line with calls from other groups including the Public Health Association of Australia[30]

There have been previous food and nutrition surveys in Australia, and the National Nutrition and Physical Activity Study is a component of the Intergenerational Health and Mental Health Study. These surveys have not been conducted regularly and there is yet to be a clear ongoing commitment to a regular and comprehensive food and nutrition monitoring program in Australia.[31] Many other OECD nations have established programs for nutrition monitoring, and there is a need for Australia to become a world leader in implementing a food and nutrition monitoring and surveillance program.

According to the Australian Institute of Health and Welfare (AIHW), unhealthy eating was the third leading risk factor, contributing to 5.4% of the total disease burden in Australia in 2018. This was closely followed by high blood pressure for which unhealthy eating is a significant risk factor.[32] The AIHW reports that dietary risk factors contributed to:

- 50% of the total disease burden of coronary heart disease
- 26% of the total disease burden of bowel cancer
- 26% of the total disease burden of Type 2 Diabetes
- 26% of the total disease burden of stroke[33]

Australia is a food secure nation with enough food for its population, but many people do not have enough food and regularly rely on emergency food relief.[34] In 2011-2012, 4.0% of people lived in households that had run out of food in the previous 12 months and could not afford to buy more.[35] Food insecurity disproportionately affects Aboriginal or Torres Strait Islander people, with more than one in five (22%) reporting food insecurity at the same time.[36]

A comprehensive food and nutrition monitoring and surveillance program in Australia is critical for monitoring the healthiness of diets and access to, and affordability and availability of healthy foods in all communities and service settings across the country. Food and nutrition monitoring is imperative to inform the development of effective public health policy and programs, and regulation. It is also essential for monitoring the implementation of these policies, programs and regulations, including existing national health strategies.

There is a current commitment to develop a National Nutrition Policy framework, and work is underway to develop revised Australian Dietary Guidelines. To support the development and implementation of these, a commitment to an ongoing national food and nutrition monitoring and surveillance program is a priority.

Such a monitoring and surveillance program needs to measure more than just dietary intake. It should include at minimum a continual, comprehensive, population-based dietary survey program that measures trends over time including all measures outlined under the subheadings below:

Biometrics

- relevant anthropometry
- physical activity
- appropriate biological measures of nutritional status

Food supply

- food supply monitoring (including composition of contemporary Australian foods, soil quality, and biodiversity)
- food purchasing/acquisition (eg, food expenditure, food type, price and quantity of food purchased, place of food purchase)
- physical and online food environments (eg, availability, affordability, accessibility, advertising and promotion of healthy and discretionary foods)

Food literacy

- food literacy knowledge, skills and behaviours including planning and management, selection (eg, use and understanding of food labelling and promotion), preparation (eg, frequency and types of meals prepared, skills, distribution of work in households), and eating (eg, commensality, shared eating occasions, settings for eating)

Food consumption patterns

- food and nutrient intake behaviours including breastfeeding (eg, 24-hour recall and short questionnaire)[30, 37]
- food security (eg, using a validated screening tool such as the United States Department of Agriculture 18-item Household Food Security Survey Module (HFSSM)).[38]

Coverage

- Nutrition monitoring should be conducted for the entire population and also target different settings, such as early childhood education services, schools, aged care.

Community health services

Recommendation 3: Increase investments in Primary Health Network-funded community health services to deliver comprehensive multidisciplinary health care that includes access to Accredited Practising Dietitians

COST

- Needs scoping

BENEFITS

- Aligns with the Government's Strengthening Medicare Taskforce Report recommendations to increase access to primary care and encourage multidisciplinary team-based care[39]
- Addresses inequities in health outcomes and access to health care

BACKGROUND

Access to Accredited Practising Dietitians and other allied health practitioners under Medicare for the management of chronic disease is constrained under the Chronic Disease Management program.[40-45] The restrictions placed on consumers to access allied health through Medicare calls for consideration to be given to alternative funding models to ensure consumers can access comprehensive multidisciplinary care when they need it.

As the Government's Strengthening Medicare Taskforce Report (the Report) highlights, health professionals need to be enabled through strengthened and remodelled funding arrangements "to provide care that improves the quality of life for patients and reduces pressure on the health system."[39] Currently, the health system is geared towards providing episodic care. With ever-increasing rates of chronic disease in this country, the current system is no longer fit for purpose and it requires reforms to serve this growing need. The Report also identifies that "to improve access and achieve better health outcomes for all, we need systems and funding that support comprehensive continuity of care delivered by well connected teams working together to address people's health needs."[39] Coordinated multidisciplinary care teams that include dietitians are equipped to deliver accessible, comprehensive care, leading to better health outcomes and helping people better manage their own health.[39]

The Unleashing the Potential of our Health Workforce Scope of Practice Review Issues Paper 1[46] also supports calls for multidisciplinary team care arrangements to enhance outcomes for consumers. Among the mechanisms discussed are multiple funding avenues that the Government can explore, including block, bundled and blended funding, value based care and salaried workforce.

Revamping funding models to ensure people have access to multidisciplinary health care teams in their communities, including access to dietitians, will improve equity and health outcomes for all Australians.

Medicare Benefits Schedule

Recommendation 4: Support access to and quality of care by increasing allied health service limits for chronic disease management from 5 to minimum 10 consultations per annum.

COST

- $485 million, based on Medicare data[47] from 2022/23 financial year (Table 1)

Recommendation 5: Support quality of care and optimal health outcomes for consumers by creating and funding Medicare items for dietetic consultations where duration is 50 minutes or longer.

COST

- Additional benefit of $58.30 per 50-minute dietetics consultation
  (total $116.60 per consultation, ie, double the benefit for 20-minute consultation for dietetic items for chronic disease, eating disorders and Aboriginal and Torres Strait Islander health check follow-ups)

Recommendation 6: Support quality of care and communication in the multidisciplinary team by creating and funding Medicare items for allied health professionals to prepare reports for the referring practitioner.

COST

- $58.30 per report (equivalent to benefit for 20-minute consultation)

Recommendation 7: Create Medicare Benefit Scheme items relating to dietetic services for people experiencing depression, other mood disorders and severe mental illness, including standard and extended individual consultations, group sessions and telehealth.

COST

- Estimated $25 million, based on up to 7 sessions per individual, current referral rates to Accredited Practising Dietitians through Chronic Disease Management Plans and current prevalence of depressive disorders

Recommendation 8: Create unique 820 Medicare Benefits Schedule item numbers for children with autism, pervasive developmental disorder and disability to see an Accredited Practising Dietitian for dietary assessment, diagnosis and treatment, and create the associated multidisciplinary case conferencing item numbers.**

COST

- Scoping required

BENEFITS

- Increased utilisation of early-intervention and preventive allied health care to reduce future and ongoing health costs[48]
- Reduced preventable disability and deaths attributable to diet-related disease
- Better continuity and quality of care for consumers with complex needs, who require ongoing consultations and support to enable long-term changes[49]
- Improved cost-effectiveness of treatment,[50, 51] reduced cost to the economy[52-55] and reduced burden on the hospital system[56, 57]
- Improved health outcomes and quality of life for all Australians
- Increased social and economic participation of people with disability[58]
- Supported communication in the multidisciplinary team
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[59] ambitions 2 and 3 of the National Obesity Strategy,[60] streams 2 and 3 of the Primary Health Care 10 Year Plan[61] and goals 3, 5 and 6 of the National Diabetes Strategy[62]
- Address desired outcomes of the National Roadmap for Improving the Health of People with Intellectual Disability
- Adopt the Medicare Benefits Schedule Review Taskforce's recommendation to update the M10 items to include dietitians in the list of eligible professionals

BACKGROUND

Chronic disease

Outcomes for Australians with chronic health conditions can be improved by better access to allied health practitioners, including Accredited Practising Dietitians,[48] to support self-management under the Eating Disorder Treatment items (82350, 93074, 93108), the Medicare Chronic Disease Management items (10954, 93000, 93013) and Aboriginal and Torres Strait Islander allied health follow-up items (81320, 93048, 93061). This can be achieved by increasing the number of consultations attracting Medicare benefits, and introducing new items for longer consultations.[49]

Under the current system, patients with a Chronic Disease Management plan may access up to 5 sessions from their whole allied health team, including their dietitian.[40] This is 5 services each year, split across 13 allied health professions. Five sessions or fewer does not meet best practice guidelines for dietetic care,[41, 63] does not support building rapport and trust with clients,[43] and is insufficient to support sustainable long-term health behaviour changes necessary to improve health outcomes.[45, 49]

Previous changes in 2006 recognised that the allowance of 5 services across 12 allied health professions was insufficient to provide support and enable health behaviour change for patients requiring mental health services, and the Better Access Initiative was established.[64] Further, the 2019 implementation of the Treatment Cycle Initiative under the Department of Veteran Affairs allowed 12 consultations per allied health profession per year for eligible veterans.[65] Similar initiatives to support dietetics services for chronic disease management and prevention under Medicare should be implemented.

Increasing the limit to a minimum of 10 allied health consultations per year will enable patients to access the allied health care and support needed to manage their chronic health conditions, and prevent further complications and costs associated with ill health.[49, 66]

Dietetics in the ambulatory and community setting is largely a counselling-type therapy, backed by evidence. Effective counselling in a patient-centred approach requires time to build rapport[43] and develop an individualised nutrition care plan.[67] An Australian longitudinal study of 20 dietitians and 176 consultations under the Medicare Chronic Disease Management program found that the mean time spent on an initial consultation was 55 minutes and for a review, 36 minutes.[68] Other counselling professions (eg, psychologists, social workers, occupational therapists) have item numbers for consultations of 50 minutes or longer to reflect the time that is needed to support patients. The Department of Veterans' Affairs also recognises the need for longer consultations with a higher benefit for extended initial and subsequent consultations.[69] Increasing the benefit for longer consultations will help ensure that providers are able to undertake an effective assessment of the patient and provide a high-quality service.[45, 49, 70]

Effective multidisciplinary collaboration that leads to optimal outcomes for Australians must be underpinned by strong communication and appropriate resources.[71] With increasing rates of chronic disease in Australia and a greater demand for more complex care, it is imperative to support multidisciplinary health care teams to continue to deliver comprehensive, quality services through adequate remuneration for collaboration, including report writing. The Department of Veterans' Affairs recognises this and offers a benefit for reporting.[72] Renumerating dietitians for this time will promote strong communication across the multidisciplinary team and support a better health care experience for consumers.

Table 1. Benefits paid for chronic disease management services by allied health providers between July 2020 to June 2023

Service type	Item numbers			Benefits paid per financial year		
				2020/21	2021/22	2022/23
In-person	10950 10951 10952 10953 10954	10956 10958 10960 10962	10964 10966 10968 10970	$481,659,388	$443,202,000	$482,086,967
Telehealth	93000	93013		$ 6,621,992	$5,813,871	$3,695,125
			Total	$488,281,380	$449,015,871	$485,782,092

Mental Health

Half of all Australians will experience some form of mental illness in their lifetime.[73] Mental illness is a collective term that describes a wide array of conditions such as mood, anxiety, personality, psychotic, substance use and eating disorders.[74] Mental illness impacts all society and is associated with significant economic costs. The healthcare costs for individuals living with mental illness increases by at least 45% when they also have a long-term physical illness. These costs are largely avoidable.[53-55]

Dietary factors including poor dietary intake, poor hydration status, difficulty regulating food intake and food insecurity are all commonly associated with mental illness, yet nutrition is not part of

mental health care plans. Poor diet quality, often characterised by foods high in energy and salt, can contribute to physical illness and is prevalent in people across the spectrum of mental illness.[75] There is growing evidence of the direct impact that nutrients, food, dietary patterns and behaviours have on mental health showing they help support healthy brain structure and function in many ways. Factors that adversely affect physical health such as inflammation, glucose intolerance, impaired cerebral blood flow and oxidative stress, also impact on mental health.[76, 77] Further, several antipsychotic and other psychotropic medications used to manage mental health conditions have known metabolic side effects, such as affecting a person's weight.[78]

Early dietary intervention with referral to an Accredited Practising Dietitian provides people with the opportunity to make dietary changes that can help prevent, treat and/or manage both their mental and physical health, and manage the metabolic side effects of psychotropic medications. Evidence shows that individuals with depression attending 7 consultations with an Accredited Practising Dietitian and following a Mediterranean-style dietary intervention experience significant reduction in symptoms and over 30% remission rate.[79]

Early intervention, together with collaborative care, will mitigate costs to the economy, reduce the burden of disease and minimise the impact of physical illnesses.[52]

Disability

The prevalence of disability in Australia is estimated to be around 18% (4.4 million people) across all age groups, and 7.6% in children between 0 to 14 years of age.[80] Population studies show that people with disability have poorer self-reported general health and higher prevalence of modifiable risk factors, compared to people without disability. Modifiable risk factors include insufficient fruit and vegetable intake, higher consumption of sugar sweetened beverages, high blood pressure, insufficient physical activity, high Body Mass Index and high waist circumference.[80] The presence of these risk factors may contribute to the higher risk of diet-related health conditions, such as cardiometabolic disease, diabetes and cancer among people with disability, compared to people without disability.[81-83]

Disability may lead to unique food, fluid and nutrition requirements, further placing individuals at higher risk of nutritional problems.[84] For instance, children with disability are often at higher risk of growth alterations such as failure to thrive or obesity, metabolic disorders, poor feeding skills, drug-nutrient interactions and sometimes partial or total dependence on enteral or parenteral nutrition.

Accredited Practising Dietitians are the health professionals appropriately trained, qualified and credentialled to address nutrition problems in children with disability. Early dietetic intervention can improve the nutrition and food intake of children, leading to improved physical and mental health, and social outcomes of children with disability and their families.

However, there is a lack of investment in supported access to community based or outpatient dietetic services for people with disability. Standard Medicare allied health funding for chronic disease is insufficient to meet the needs of people with a disability for the same reasons as for all Australians indicated above.

Currently seven other allied health professions have access to M10 unique 820** numbers.[85] Expanding this to include Accredited Practising Dietitians will ensure people with disability can access affordable, preventive dietetic care and provide dietitians with parity to the other allied health professionals already included.[58]

The National Roadmap for Improving the Health of People with Intellectual Disability outlines key activities and outcomes to improve the lives of people with disability. Better use of MBS items is a key goal including "More comprehensive health plans for people with intellectual disability developed that include action on health promotion, disease prevention, and chronic disease

detection". One way to improve health outcomes and plans for children with disability is to fund the inclusion of dietitians in teams for children with autism, developmental delay and disability.

The Medicare Benefits Schedule Review Taskforce recommended updating the M10 items to include dietitians in the list of eligible professionals.[86]

National Disability Insurance Scheme (NDIS)

Recommendation 9: Increase price limits for dietetic therapy supports provided under NDIS in line with the Consumer Price Index (CPI).

COST

- Requires scoping

BENEFITS

- Enhanced outcomes by ensuring people with disability have access to high quality dietetic supports that build their function and independence
- Improved service equity by enabling the continued provision of dietetic therapy supports in rural, regional and remote areas
- Stabilised workforce through attracting and retaining skilled dietitians
- Maximised functional outcomes through dietetic support, reducing long-term healthcare and NDIS costs.

BACKGROUND

Dietitians play a pivotal role in supporting people with disability within the National Disability Insurance Scheme (NDIS). They address the unique and often complex dietary needs of people with disability, contributing to their overall health, wellbeing, independence, and quality of life.[87] However, the current NDIS pricing limits for dietetic therapy supports are not aligned with the increasing cost of living and service delivery. This misalignment may limit the sustainability of these essential services and impact outcomes of people with disability.

The current financial model under the NDIS does not adequately account for the diverse and escalating costs associated with running a dietetic service.[88] Financial pressures on dietetic practices can impact service delivery and their ability to provide care. As a result, consumers may face increasing challenges finding adequate services for their needs. Without a revision of the pricing limits, there is a risk of diminishing the amount, quality and safety of services offered to NDIS participants.

Furthermore, the potential impact on people living in rural, regional, and remote areas is particularly concerning. Financial pressures on practices in these regions can lead to service failings and thin markets, limiting the availability of comprehensive and accessible care. Consequently, this situation may contribute to widening health disparities among people with disability in these areas.

Providing for the sustainability of the system through raising price limits in line with CPI will ensure consumers can continue to find and receive the care that they need when they need it. Ensuring continued access to quality services will help people with disabilities actively participate in society and enjoy optimal health outcomes and good quality of life.

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