2017 Price Controls Review

April 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the 2017 Price Controls Review by the National Disability Insurance Scheme.

Contact Person:
Position: Senior Policy Officer
Organisation: Dietitians Association of Australia
Address: 1/8 Phipps Close, Deakin ACT 2600
Telephone: 02 6189 1202
Facsimile: 02 6282 9888
Email: policy@daa.asn.au

DAA interest in this consultation

The NDIS is providing new opportunities for people with disability to access the support they need to realise personal goals. DAA considers it is important that people with disability are able to access nutrition products and the services of Accredited Practising Dietitians (APDs) needed for health and wellbeing. Pricing arrangements are a key factor in participants being able to access services and products.

The APD program is the basis of self-regulation of the dietetic profession by DAA. APDs are dietitians who are qualified and credentialed to provide nutrition services to people with disability. They also support families, care workers and other health professionals in multidisciplinary care and education.

Key Recommendations

1. Training should be included in the assumptions for setting price limits for attendant care
2. Pricing is important but adequate hours are needed to meet the needs of clients. Minimum hours should be set for APDs and other allied health professionals in participant plans. Complex care deserves individual consideration of hours.
3. Travel should be negotiated between provider and participant. If this is not possible, the cap of $1000 should be increased for travel to participants in rural and remote areas; an alternate time-based approach to travel should be considered in urban and rural settings; and the allocation of travel costs across participants should be clarified.
4. Prices be reviewed regularly using accepted benchmarks such as the CPI.
5. APDs be included in the Behaviour Support Registration Group. Also APDs should be included in the Early Intervention Supports for Early Childhood Registration group to enable inclusion of APD services in Early Childhood Early Intervention.

Discussion

Price limits for attendant care

The assumptions described in Table 2 on page 10 of the Discussion Paper make no mention of training. The workforce is increasing rapidly to meet the demands of NDIS registrants and there will be a requirement for workers to be adequately trained at entry to meet the general needs of participants and for specific complex needs. Ongoing training of support workers will also be required due to turnover in the sector, with assignment to participants with various care profiles and with changing evidence for quality care. DAA recommends that the assumptions include a percentage for training costs of support workers.

Hours and pricing are connected

APDs report difficulties in getting sufficient hours included in initial plans to assess and provide appropriate person centred nutrition therapy for people with disability. It is not helpful to talk about the price per hour, without also accounting for the hours needed to provide safe and competent care to enable the participant to meet their goals and for the practitioner to be adequately compensated for their work. DAA would like to see minimum hours allocated to dietitian consultation and nutrition care plan development, and recognition of client complexity with the allocation of hours needed to meet client goals. APDs experienced in the area suggest a minimum of 20 hours in initial plans but DAA would be pleased to discuss this further with the NDIA.

Updates being considered based on market feedback - travel

Providers can claim travel time at the hourly rate for the relevant support item for travel in excess of 10km, up to a maximum annual limit of $1000. APDs report this annual limit presents problems in rural and remote locations where participants have complex needs and have few or no therapy options nearby. Even if there is a practitioner nearby we argue that participant choice and control should be exercised such that the participant is able to choose the practitioner who will best meet their needs and to negotiate travel. Travel for some participants is very difficult and there are recognised advantages of providing care in the participant's home surroundings.

Another aspect which is not clear in the current price guide in relation to travel is how to allocate travel in a trip in which the distances are significant and the practitioner is attempting to be efficient by covering more than one client in a trip.

At present travel is framed in terms of distance travelled and appropriately considers the needs of participants in rural and remote areas. However another way to consider travel is in the time expended in providing services to participants in their home in the city. In larger cities with heavier traffic the time spent travelling between participants can be significant.

DAA would like to see travel negotiated between provider and participant, but if that is not acceptable to the NDIS then the current travel cap of $1000 should be increased for residents in rural and remote regions. We also suggest consideration of alternate means of considering compensation for travel i.e. a time-based approach which addresses needs of urban, rural and remote dwelling participants.

Updates being considered based on market feedback – cancellation policies

We have not had the opportunity to canvas APDs widely but limited feedback indicates that cancellation policies do not appear to be problematic. It seems where cancellations occur, they are by the client more often than the practitioner.

Practitioners negotiate with participants at the beginning of their relationship and document their agreed position in the service agreement. One APD indicated that their terms and conditions of service delivery are that a cancellation fee will apply if the participant cancels an appointment, whereas another said in her experience very few participants cancel and consequently she does not charge a cancellation fee. We suggest the critical issue is agreement and documentation of the arrangement between participant and practitioner.

Approach to shared care

While we agree that overlap in support definitions may be confusing, in some cases flexibility and efficiency may arise from cross over in support categories. For example, where an APD can claim from improved daily living skills hours. The disadvantage which may arise for participants is that at the time of reviewing a plan, therapy hours may be seen 'generically' rather than specifically identifying the 'dietitian consultation' hours. 'Hiding' the APD hours in this way leads to insufficient APD hours being allocated in the participant's new plan. DAA would appreciate the opportunity to discuss this further with the NDIA.

Other updates

The Discussion Paper focus is described on page 2. There is mention also of minor adjustments being made and DAA would like to know what these might be.

Price banding – efficient costs

Feedback from APDs is that the administrative burden of providing services to NDIS participants is considerable and reduces efficiency in practice. The frequent changes which have occurred in NDIS administrative processes to date have also been difficult for practitioners. DAA encourages improvements in NDIS processes in a measured fashion with good communication over time to reduce the burden of administration to enable practitioners to be efficient and meet the needs of more participants. Alternatively, administration time required by the NDIA should be a factor in allocating hours needed to support participants.

Price banding – incentives to develop services

At present the single hourly rate is sufficient for one practitioner to service the needs of participants. However, there is no incentive through the current hourly pricing approach to charge for higher skill level, employ other workers, or to provide training and/or supervision of lesser experienced APDs or allied health assistants.

Price banding – higher and lower levels

Implementation of pricing with two or more levels would present opportunities e.g. to employ others and build long term efficiencies. However it may present perverse incentives. For example, there may be a preference by practitioners to

service participants who are prepared to pay more, with participants who choose to pay less finding it hard to access services in thin markets.

Benchmarking

APDs represent a relatively small number of practitioners amongst NDIS providers and the market is still immature. Consequently DAA considers that benchmarking of APDs is inappropriate at this time.

Increasing the rate by CPI

DAA supports regular review of prices in line with relevant benchmarks, such as CPI.

Items not within scope – Registration Groups

DAA considers that participants are being disadvantaged through lack of access to APDs in several areas because they are not listed in some registration groups despite established professional practice. In these cases, price is not the issue but rather the inability of participants to purchase these items. DAA would like to see APDs included in the following registration groups as listed in the 'Provider Toolkit Module 4: Guide to Suitability'

- Behaviour support – APDs can provide significant support to participants with regard to eating behaviours. APDs also work with mental health clients and have the skills to provide behaviour support.
- Early interventions Supports for Early Childhood – APDs have a long history of contributing to team care for infants and children. Children who experience nutrition impairments without appropriate support are less able to participate in social and school activities and are less able to respond to other therapies provided by other health professionals.