



Value and affordability of private health insurance and out-of-pocket medical costs

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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 respond to the Senate Standing Committee on Community Affairs regarding the value and affordability of private health insurance and out-of-pocket medical costs.

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DAA interest in this consultation

As the leading nutrition and dietetic organisation in Australia, the Dietitians Association of Australia considers it important that people with physical or mental health issues have access to health services to achieve and maintain good health and wellbeing. Nutrition is a key factor in the prevention and treatment of a wide range of illnesses which affect Australians.

The Accredited Practising Dietitian (APD) credential is a trademark of DAA. APDs are food and nutrition experts who translate the science of nutrition into practical solutions for healthy living. APDs assist people with special dietary needs to make positive lifestyle changes tailored to their unique needs.

The APD program is the platform for self-regulation of the dietetic profession, and provides a public assurance of safety and quality. The APD credential is required by Medicare, the Department of Veterans Affairs and private health insurance funds.

Response to Terms of Reference

Chronic diseases contribute to nine out of every ten deaths in Australia. Four disease groups – cardiovascular disease, cancer, chronic obstructive pulmonary disease and diabetes (three of which have strong links to dietary behaviour) – account for three-quarters of all deaths due to chronic diseases. The compelling evidence is that many chronic diseases share common causes – a set of behavioural risk factors, biomedical factors and social determinants that increase the likelihood of developing chronic diseases¹. A conservative estimate is that potential cost savings of about \$2.3 billion could be realised, based on achievable reductions in six behavioural risk factors (smoking, high risk alcohol use, physical inactivity, intimate partner violence, obesity and inadequate diet). This includes savings generated in the health sector and as a result of improved workforce participation and productivity¹. This creates enormous potential to transform health care models in Australia to better prevent and manage the root causes of chronic disease.

It is well established that primary health care leads to better health outcomes, lower costs and greater equity in health². As such, an important part of any country's development should be the strengthening of primary health-care services, such that the health care provided is comprehensive and people-centred, for all ages and stages of life, and it incorporates and coordinates health promotion, prevention, acute and chronic care management activities to deliver equitable access and safe, high-quality care.

With regards to the U.S. Institute of Medicine 'six dimensions of quality care'³, DAA considers that Australian consumers do not have equity, nor timeliness and accessibility,

with respect to dietetic services in the context of private health insurance or government funded insurance through Medicare.

The effect of co-payments and medical gaps on financial and health outcomes

Inadequate number of permitted consultations for allied health: APDs have an important role in preventing and managing chronic disease (e.g. cardiovascular disease, diabetes, cancer, renal disease etc.), in treating malnutrition (especially among the elderly and those with eating disorders), in supporting people with disability and mental illness and more. Gaps in payment by Medicare and private health insurance limit access of everyday Australians to support for self-management of physical and mental health issues. This has long term implications for the quality of life for Australian citizens and government spending on healthcare, as chronic health conditions result in acute episodes treated in hospital.

Better outcomes for Australians with chronic disease and complex healthcare needs could be achieved by better overall access to allied health practitioners, including APDs, to support self-management under the Medicare Chronic Disease Management items. The current limit of five services per annum in total for allied health is considered inadequate to achieve adequate health outcomes. An evaluation of the Diabetes Care Project⁴ demonstrated that the limit of five allied health services is not adequate to meet the needs of people. Greater investment in allied health resulted in better outcomes measured by HbA1c, systolic blood pressure, total cholesterol, LDL cholesterol, waist circumference and depression.

The small number of allied health consultations currently allowed (5 per annum) poses a barrier to change in lifestyle management of many other chronic diseases. A 2014 report on osteoarthritis by Arthritis Australia⁵ estimated that osteoarthritis affects 1.9 million, or one in 12 Australians and it costs the Australian health system \$3.75 billion and the economy around \$22 billion annually. Excess weight is the most important modifiable risk factor associated with the development and progression osteoarthritis. It has been estimated that supporting people to lose weight would halve the number of knee replacements, resulting in an annual saving to the health system (at 2012 rates) of nearly \$600 million.

Arthritis Australia stated in their report⁵ that *'The cost of accessing private allied health services, which are inadequately covered by Medicare and private health insurance, creates a significant barrier to optimal access.'* The organisation called for an increase in allied health services to provide optimal care of people with osteoarthritis.

Inadequate consultation times for APDs: In addition to the inadequate number of permitted consultations for dietitians, the Medicare return figure doesn't adequately compensate for the time needed to see complex dietetic clients. Dietetic consultations are of a counselling nature and sufficient time is needed to work with clients to build their self-management capacity. DAA considers that introducing a long consultation would assist, and in support of this draws the Committee's attention to the statistics on the Medicare website which show that 90% or more of the items accessed by eligible allied health practitioners under the Better Access to Mental Health Care are of one hour duration. Longer consultations for private sector APDs would facilitate counselling to empower clients to achieve positive health outcomes through sustainable healthy behaviour change.

Having higher Medicare rebates, more consults and longer consultation options for private sector APDs will help to reduce the gap that is currently experienced by people with chronic disease in achieving long-term healthy behaviour change and positive health outcomes. **As such, DAA considers it well justified to:**

- **raise the level of subsidy for individual dietetic consultations (MBS item 10954) so that it more closely reflects the cost of accessing services;**
- **increase the limit from 5 to 10 services per annum in total for allied health under the Medicare Chronic Disease Management items;**
- **provide APDs with options for longer consultations (i.e. 1 hour consultations) under the Better Access to Mental Health Care; and**
- **lift the freeze on indexation for Medicare.**

Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements

Cases of 'Dietitians' and 'Nutritionists' falling within the same category: A 'dietitian' is a tertiary qualified allied health professional who has completed a Bachelor or Masters degree in nutrition dietetics. The term 'Accredited Practising Dietitian' is given to those dietitians who are further credentialed and qualified by the professions governing body, the Dietitians Association of Australia. The term 'nutritionist' is much broader. A nutritionist may have qualifications in nutrition, but not necessarily the qualifications to provide evidence-based, medical nutrition therapy to clients.

APD is the only national credential recognised by Medicare and the Department of Veterans Affairs, as the quality standard for nutrition and dietetic services in Australia. While private health funds generally only recognise APDs registered with Medicare as providers of dietetic services, we know from surveys done and recent interaction with a

major private health insurance fund that differences in services offered by ‘dietitians’ and a ‘nutritionists’ are not always clearly conveyed by private health funds to consumers.

A survey of 29 private health insurance funds (survey carried out by DAA in 2016, with all funds registered under the Private Health Insurance Act 2007), revealed all funds provide coverage for individual initial and subsequent consultations with a ‘dietitian’ with ‘top-range extras’ cover, yet just one-third (n=9) of funds offer benefits for services by a dietitian on the ‘basic extras’ level of cover. One-third (n=10) of funds offer benefits for members to access services from a ‘nutritionist’, with six of these funds considering nutritionists and dietitians to be in the same category (i.e. members could claim the same benefit for services from a dietitian or nutritionist). **DAA believes consumers have a right to know the difference between a dietitian and nutritionist, so that those needing medical nutrition therapy know to access the services of an APD, not a nutritionist.**

Inadequate rebates for dietetic services: Many private health funds only offer a \$20-25 rebate for clients per dietetic consultation, which equates to only 15-20% of the cost for an average consultation with a dietitian. In comparison, rebates for other allied health professionals is close to 25-40% (or more). This difference is due to dietitians in the private sector not being recognised for their requirement for much longer consultation times (e.g. 1 hour) compared to many other allied health services (e.g. typically 20-35 min).

Having higher private health insurance rebates for private sector APDs would reduce the gap for longer consultations needed to achieve sustainable dietary behaviour change and positive health outcomes. As such, **DAA would like to see increased and extended private health insurance rebates for dietetic services, with more meaningful definitions created for the dietetic HICAPS item numbers.**

Health & wellbeing services with a weak evidence base: Another issue of concern is the offering by some private health insurers of health and wellbeing services with a weak evidence base. The evidence for some natural therapies (e.g. homeopathy) is questionable, yet despite a review of the Australian Government rebate on natural therapies for private health insurance, some insurers pay members benefits for natural therapies as part of their product. **DAA suggests that private health insurers have an important role to play in primary health care by covering services for which there is a strong evidence base.**

Allied health services for people with mental illness: Physical illness is a leading cause for shorter lives and greater morbidity among those with mental illness, yet at present, many

people with mental illness are unable to access dietetic services to improve their physical health. Better Mental Health items enable access to some allied health providers, but not APDs. This is a major oversight, especially given food is relevant to mental health (i.e. diet impacts the risk and progression of some common mental disorders) and many people with mental illness suffer physical ill health (e.g. obesity, cardiovascular disease, diabetes, metabolic syndrome).

In the mental health sector, APDs are skilled in coaching strategies to improve diet quality through lifestyle change, so as to⁶:

- Improve concurrent and comorbid conditions (e.g. diabetes, cardiovascular disease, obesity, metabolic syndrome) and reduce all-cause mortality risk;
- Mitigate weight gain commonly seen in patients taking psychotropic medications;
- Reduce the risk and progression of common mental disorders (e.g. depression and anxiety);
- Identify and improve disordered eating patterns and eating behaviours; and
- Enhance food security (i.e. food access, supply and utilisation) through improved meal planning, budgeting, shopping, food preparation and cooking skills.

DAA would like to see APDs funded to work alongside psychologists, social workers and occupational therapists under the Better Access Initiative mental health items, to support early dietary interventions for people with depression and for those prescribed psychotropic medications, to minimise risk of adverse metabolic consequences of the medication. DAA has submitted an application to the Medical Services Advisory Committee for an item for APDs to treat depression through diet (to complement other treatments, not as a substitute to other treatments), but more general access is required. Consumer and carer groups have indicated to DAA that they support greater access to dietetic services for people with mental illness.

Allied health services for people with eating disorders: An Australian study⁷, which empirically and quantitatively examined the household economic burden of eating disorders from the patient perspective, supports the need to minimise the economic impact of treatment on families. Results showed current models of funding for the treatment of eating disorders do not encourage management of patients in the community or in outpatient settings because the public system offers limited treatment options beyond admission for severe, acute episodes. Private health insurance tends to provide only limited reimbursement outside private hospital admission. This pattern of funding discourages upstream management of illness, does little to prevent exacerbation

of illnesses and leads to a model of care based on high cost acute management. This inevitably creates inequities in access to treatment based on socioeconomic status, access to health insurance and type of condition. **This research underscores the need for more sustainable and affordable treatment models within the public and private systems to not only improve health outcomes, but to mitigate the substantial household economic burden experienced by patients with an eating disorder who are undergoing care.**

Medical services delivery methods, including health care in homes and other models

Telehealth for allied health practitioners: People living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities. They also have less access to health care. In recognition of this the Australian Government has permitted medical specialists, general practitioners, midwives and nurse practitioners to deliver specialist video consultations without the time and expense for individuals to travel to major cities.

To improve accessibility, DAA supports the harnessing of technology, telehealth and digital technology to provide flexible, accessible health services that are responsive to individual needs. 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 change⁸⁻¹¹ and improves metabolic parameters in individuals with metabolic syndrome¹¹. **DAA would like to see provisions for telehealth services extended to Accredited Practising Dietitians (under MBS Dietetics Item 10954) and other allied health practitioners, as an alternative to face-to-face services, so as to help improve:**

- **chronic disease management in rural and remote areas;**
- **management of people (urban, rural or remote based) with health conditions requiring input from a specialist dietitian (e.g. an APD who specialises in eating disorders, gastrointestinal disorders, endocrine disorders, mental health or disability etc.).**

With regards to private health insurance, a survey of 29 private health insurance funds (carried out by DAA in 2016) revealed just 8 (27.6%) of the funds provide rebates for telehealth services provided by a dietitian. This issue means many privately insured Australians living in rural and remote locations, or even those living in urban areas needing assistance from a dietitian working in a specialist field (e.g. eating disorders, gastrointestinal disorders, Cystic Fibrosis) are being denied the right to adequately access dietetic services to achieve their health goals. **DAA strongly encourages**

expanding private health insurance coverage of dietetic services to include telehealth and home visits as options for initial and subsequent individual consultations.

Case conferencing for allied health practitioners: Individuals with chronic disease experience better outcomes when they have access to primary health care provided by a multidisciplinary team, including a GP and one or more allied health practitioners¹². Multidisciplinary case conferencing has the potential to improve the effectiveness of health care and reduce hospital admissions. Although GPs have incentives through Medicare items 735 - 758 to participate, they do not do so because others in the health care team cannot afford to attend a conference, which compromises the quality of patient care. **An additional item for allied health professionals under the MBS, as an incentive for participation in multidisciplinary case conferencing, would improve the quality of care for Australians with chronic disease.**

Health Care Homes Model: The current ‘Health Care Homes’ model, where a GP practice or an Aboriginal Community Controlled Health Service (ACCHS) coordinates care for patients with chronic and complex conditions, provides no incentive for the involvement of allied health, and no incentive for case conferencing, which is another major barrier to having expert dietary input from an APD. **The quality of care for Australians with chronic and complex conditions could be improved with incentives for allied health involvement in Health Care Home services and incentives for allied health to be part of multidisciplinary case conferencing.**

New products to support self-management: DAA would like to see new products developed which provide consumers with value for money and support them to consult health professionals to increase their capacity in self-management. Examples include: group education programs and access to a package of care (single profession or multidisciplinary).

Other related matters

Allied health services for people with disability: DAA is concerned about the interface between the health and disability sectors as NDIS rolls out and state/territory governments withdraw from disability services delivered by government funded disability or health services. Some NDIA planners are recommending that NDIS participants seek services under Medicare Chronic Disease Items for allied health. This is inappropriate as the maximum of five services per annum for allied health (under the

Medicare Chronic Disease Management items) is generally insufficient in time and number to support NDIS participants experiencing complex health and social situations. **APDs experienced in the area of disability suggest a minimum of 20 hours are required in initial NDIS plans to meet client goals.**

Medicare data to inform program improvements: DAA has discussed telehealth with several advisers to Health Ministers, and we are told that despite the merits of improved access to telehealth, increasing access to allied health will only drive demand and government spending. On the other hand we are told that on average only 2.5 allied health visits are used per person per year. So there is still room for greater service provision to meet the needs of those with the poorest health outcomes and the least access to services.

This underlines the importance of understanding Medicare data to see which groups in the community are accessing services through Medicare Chronic Disease Management items and which ones are missing out. **As such, DAA welcomes better use of Medicare data to inform program improvements. Interrogating the Medicare data to understand patterns of use by allied health disciplines in geographical and socio-economic regions would better inform policy decisions on program development.**

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