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**Submission from the Dietitians Association of Australia
to the Department of Health and Ageing, Medical benefits Reviews Task Group**

MBS Quality Framework

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 4200 members. DAA is the leader in nutrition and advocates for better food, better health, and better living for all.

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DAA thanks the Medical Benefits Reviews Task Group for the opportunity to provide a written submission as a key stakeholder as part of the consultation period on the MBS Quality Framework. DAA is pleased to see the Department of Health and Ageing undertake a review of the MBS and is supportive of the aim to make the schedule evidence based.

DAA is pleased to see that the review process includes an allied health representative on the MBS Quality Framework Reference Committee and will consult with each profession on relevant items as they are reviewed.

Dietetics and Medicare

The number of DAA members working in private practice has increased by 45% since 2005. DAA currently has around 950 members (~22% membership) working in private practice. This is significant growth since the introduction of Medicare items for individual dietetic services in 2004.

Medicare-Plus Chronic Disease Management program referrals are becoming increasingly important for dietetic business as they provide more than 60% of work for one third of practices, 40-60% of work in another 14% and 22-40% in almost one fifth of practices, (Cant, 2010).

Dietetics was the third most used allied health profession after podiatry/chiropractic and physiotherapy providing 184,028 individual services Jan 2009-Dec 2009, (Medicare Australia).

Dietetic Medicare item number usage: Jan 2009-Dec 2009

Item description	Item number	Total Services
Individual service	10954	184,028
Group assessment service	81120	1,253
Group session service	81125	3,464
ATSI service	81320	145
		Total: 188,890

Source: Medicare Australia

DAA recommends that the quality framework defines eligible allied health service providers as those who are either registered health professionals or accredited by the relevant health professional association where those professionals participate in continuing professional development, have recognised qualifications, commit to a code of professional conduct and are subject to complaints and disciplinary procedures. DAA encourages the definition that currently exists with Medicare, for dietetic services this means dietitians 'must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).'

Allied health associations, such as DAA, could assist the Department with benchmarking data regarding actual fees charged by registered and accredited practitioners for various services.

General issues

- One size does not fit all. Chronic disease is complex and patients can have multiple co-morbidities. The framework needs to consider this in terms of different conditions, the different roles of health professionals, different settings and different patient's capacities. For example, a patient with multiple chronic conditions, from a non-English speaking background with an interpreter who sees a dietitian for education will require a longer appointment time than a patient with less co-morbidities.
- Funding must be based on evidence for treatment. Current chronic disease items are not. Current consultation time is inadequate to complete initial patient education (Cant, 2010). There is also low availability of follow up consultations, (Cant, 2010). For example, the existing items for dietetic services are limited and are not consistent with evidence based practice. For example, it is recommended that individuals with type 2 diabetes see an Accredited Practising Dietitian for an initial visit for 1-1.5 hours and then three follow up appointments of 30-45 minutes each in the first three months, (DAA, 2006).
- Patients have limited access to low cost dietetic services, (Cant, 2010).
- There is low acceptance of current Medicare CDM program by dietitians (Cant, 2010).
- GPs do not use the allied health items as effectively as they could.
- Current fees are not reflective of actual costs for allied health professionals to provide high quality evidence based services.

Responses to the discussion paper

- Key principles to guide MBS reviews outlined on p26. These reviews should be conducted in consultation with allied health practitioners as well as medical practitioners and consumers.

Q (p30) Asks what other strategies are useful in facilitating evidence based changes in practice?

DAA has endorsed eight evidence based practice nutrition management guidelines and published four of these in the journal *Nutrition & Dietetics*. There is evidence that developing and publishing practice guidelines does not necessarily change practice. Developing and revising evidence based clinical practice guidelines is useful to clinicians but only when the evidence based practice changes are implemented in practice. Resourcing should be directed to comprehensive implementation strategies to support the communication and uptake of existing guidelines. Evaluation of practice change and patient outcomes is also currently lacking. Funding to resource the regular revision of evidence based practice guidelines and implementation strategies would be welcome. Financial incentive to change practice must also be considered. Fee for service or other funding models should support, not impede, evidence based practice.

Q (p31) What other ways could stakeholders provide input or participate in process to review existing items?

As well as the methods listed in the paper, DAA suggests that an email newsletter is created to keep interested stakeholders up to date with reviews and changes to the website. This could be via subscription to interested individuals or via health professional associations. DAA would be happy to communicate such information to DAA members.

Q (p35) Does an approach in which a base of time which may be modified for additional complexity, coupled with a conversion factor which is specific to the specialty providing the service, provide an adequate measure of the professional component of the service?

This approach sounds reasonable. However the complexity co-morbidities need to be considered when reviewing allied health items. For example, a patient with type 2 diabetes who also has a diagnosis of coeliac disease presents as a more complex case for a dietitian though the same patient may not be considered complex for another profession, for example, a physiotherapist.

Dietitians often travel to visit clients in their homes. This time of the professional is not accounted for by existing items.

Are there other factors you would wish to be taken into account?(p35)

Current fees are not reflective of actual costs for professionals to provide high quality services. The time required to provide a consultation to patients includes assessment and education and may also include multi-disciplinary team case conferencing. DAA would like to see future items take account of the total time of service providers involved in managing patients with complex conditions such as chronic disease.

Support must also be provided for incentives equitably across professions. Evidence based care involves health professionals to work together in teams. Incentives must exist for all health practitioners involved in team care of patients. For example, if a health team meet to discuss patient care via case conferencing, all health professionals involved should be eligible for incentives to participate.

Dietitians are providing professional consulting services to patients by telephone, videoconferencing and via email. This tends to occur where patients are located in isolated rural or remote areas but may well occur where this is the preference of the patient and provider. DAA calls for these types of service delivery to be considered for support if the evidence shows that these methods are as effective as face to face consultations.

References

1. Cant, R.P. (2010). Today's profession: Views and practices of private practice dietitians re Medicare Chronic Disease Management program. *Nutrition & Dietetics*. **67**:77-83.
2. Medicare Australia. Statistics: Medicare allied health 2007-08 and 2008-2009 financial year. (Available from: http://www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 21 June 2010).
3. Dietitians Association of Australia. (2006) Evidence Based Practice Guidelines for the Nutritional Management of Type 2 Diabetes Mellitus for Adults. (Available from: www.daa.asn.au, accessed 24 June 2010).