Dietitians Australia
The Leading Voice of Nutrition

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Recipient

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 8000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for food and nutrition for healthier people and healthier communities.

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 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 process approved by the Board of Dietitians Australia. Dietitians Australia members have wide ranging expertise in areas including clinical nutrition, food services, public health, food systems, food industry, digital health and academia.

Summary

National health policy

Recommendation 1: Provide funding to update the 1992 National Food and Nutrition Policy into an up-to-date National Nutrition Strategy with a well-resourced, co-ordinated, evidence-based and strategic action plan.

Aged care

Recommendation 2: Fund the implementation and evaluation of routine malnutrition screening and food-first management in residential aged care facilities.

Recommendation 3: Maintain the Basic Daily Fee supplement under the condition that every residential aged care home undergoes an annual on-site Menu and Mealtime Quality Assessment' performed by an Accredited Practising Dietitian.

Medicare Benefits Schedule

Recommendation 4: 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 5: Include Accredited Practising Dietitians in teams for autism, pervasive developmental disorder and disability (M10), including providing a unique 820** Medicare item number for dietetic services, and inclusion in the 820** case conferencing item number rules.

Recommendation 6: Support access to and quality of care by increasing allied health service limits for chronic disease management from 5 to 10 consultations per annum.

Recommendation 7: Acknowledge the complexity of dietary intervention and support quality of care by creating and funding Medicare items for dietetic consultations where duration is 50 minutes or longer.

Recommendation 8: 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 9: Ongoing commitment to telehealth dietetics as a permanent fixture of Medicare for all Australians.

Food-based dietary guidelines

Recommendation 10: Additional funding to develop Dietary Guidelines for Older Australians within scope of the Australian Dietary Guidelines review.

Recommendation 11: Fund successful public education, implementation and evaluation of the reviewed Australian Dietary Guidelines.

Regional, rural and remote health care

Recommendation 12: Ensure regional communications infrastructure can support telehealth for greater healthcare access.

Recommendation 13: Reintroduce scholarships for allied health students studying in accredited education programs to complete placements in regional, rural and remote areas.

Recommendations

National health policy

Recommendation 1: Provide funding to update the 1992 National Food and Nutrition Policy into an up-to-date National Nutrition Strategy with a well-resourced, co-ordinated, evidence-based and strategic action plan.

COST

- Scoping required

BENEFITS

- Reduced healthcare expenditure related to unhealthy eating patterns – estimated $1.4 billion of health spend in 2015-16 was attributable to insufficient vegetable intake[1]
- Reduced health care costs and lost productivity attributable to overweight and obesity – recently estimated to be $8.6 billion per annum[2]
- Reduced burden of disease from heart disease, stroke, diabetes and several cancers[3-5]
- Reduced preventable deaths attributable to unhealthy eating – currently 28,000 per year[6, 7]
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 1, 2 and 3 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goal 1 of the National Diabetes Strategy[11]

BACKGROUND

Australia last updated its national nutrition policy in 1992. Since that time, the diet-related health of Australians has become worse. Many diseases are caused or exacerbated by a poor diet, including heart disease, stroke, type 2 diabetes, bowel cancer and lung cancer. Food insecurity is also on the rise in Australia, affecting 1 in 6 adults and 1.2 million children in 2021.[12] The COVID-19 pandemic has exacerbated food access issues for many Australians.[13] Demand for emergency food relief has risen as people experience reduced income from loss of work,[12, 14] and our supermarket shelves are going bare due to supply issues.[15, 16]

Nationally, less than 1% of the population report eating patterns consistent with the Australian Dietary Guidelines.[17] In 2017-2018, around 90% of Australians weren't eating enough vegetables and more than 35% of energy intake was from unhealthy foods and drinks high in added sugar, saturated fat, salt or alcohol.[3, 4, 17]

Eating patterns are influenced by factors including affordability,[18-21] composition of the food supply[22-24] and promotion of unhealthy food for commercial profit.[25-27] These vary greatly across Australia, presenting issues of inequality. Groups who experience greater social disadvantage through relative lack of opportunity in education, employment, and income suffer increased risk of malnutrition, food insecurity and diet-related chronic disease.[28, 29]

If it was easier for Australians to enjoy healthy foods and drinks consistent with the Australian Dietary Guidelines[17] the disease burden amongst the community would be reduced by 62% for coronary heart disease, 34-38% for stroke, 41% for type 2 diabetes, 37% for mouth, pharyngeal and laryngeal cancer, 22-29% for bowel cancer, 20% for oesophageal cancer, 12% for prostate cancer, 8% for lung cancer and 2% for stomach cancer.[3-5]

Contemporary food and nutrition strategies should be underscored by four pillars: health, equity, environmental sustainability, and monitoring and evaluation. The most effective national food and nutrition strategies internationally are centrally coordinated, multisectoral, adequately resourced, championed within and outside government, free from vested interests and regularly monitored, reviewed, revised and evaluated.[30] For more detail, see our National Nutrition Strategy position paper.[31]

Aged care

Recommendation 2: Fund the implementation and evaluation of routine malnutrition screening and food-first management in residential aged care facilities.

COST

- Implementation and evaluation of routine malnutrition screening would be equivalent in cost to the implementation and evaluation of Aged Care Quality Indicator 3 (unplanned weight loss)

BENEFITS

- Addresses Aged Care Royal Commission recommendations 13, 19 and 22[32]
- Savings from reduced oral nutrition supplements, wound care and hospital admissions[33]
- Reducing the added costs of malnutrition in the hospital system – previously estimated to be $10.7 million per year in Victoria alone[34]
- Further savings in quality of life for residents

BACKGROUND

The delivery of high-quality aged care for older Australians is a priority.[35] With more older adults using home care[36] and residential aged care services,[37] identifying those who are malnourished and in need of enhanced nutritional care remains a challenge. 22% to 50% of Australians in residential aged care are malnourished,[33] and 43% of older adults receiving home care in Victoria have been identified as malnourished or at risk of malnutrition.[38]

Malnutrition increases the risk of falls, pressure injuries, hospital admissions and mortality. As a result, costs increase across the aged care sector and the broader healthcare system. Barriers to identifying and treating malnutrition in aged care include lack of knowledge and awareness, the inability of care staff to identify malnutrition, and eating environments that are rushed and task focused.[39]

Multiple nutrition screening tools have been validated to indicate the nutritional status of adults in aged care settings. Screening tools are broadly considered to identify residents who are at high nutritional risk, whilst not requiring calculations, blood tests or measurement of anthropometric variables[40] and are widely adopted in the acute care sector.

It is vital for malnutrition screening to become embedded in aged care services, and for this to be supported by adequate funding. Malnutrition needs to be included in the National Aged Care Mandatory Quality Indicator Program for both residential and in-home aged care. Results of quarterly malnutrition screening must be reported as part of the Quality Indicators. The framework for screening of malnutrition risk must include, staff training, prompt referral of all identified as being malnourished to an Accredited Practising Dietitian (APD) for nutrition intervention, and minimum standards for the documentation of screening results and follow up. Mandatory malnutrition screening with nutrition management by Accredited Practising Dietitians using a food-first approach (ie food before nutrition supplement powders and liquids) will improve the quality of life for aged care consumers and provide significant healthcare savings.[33, 41]

Recommendation 3: Maintain the Basic Daily Fee supplement under the condition that every residential aged care home undergoes an annual on-site Menu and Mealtime Quality Assessment' performed by an Accredited Practising Dietitian.

COST

- As per current implementation costs

BENEFITS

- Addresses Aged Care Royal Commission recommendations 13, 19, 22 and 112[32]
- Significant savings in oral nutrition supplements, wound care and hospital admissions[33]
- Further savings in quality of life for residents

BACKGROUND

There are a number of contributing factors that lead to malnutrition in older people. Individual factors include social isolation, poor dentition, multiple medications, difficulty swallowing and an overall poor appetite. The organisation may provide a menu with limited nutritious options, offer foods that are unfamiliar or have poor delivery systems. There may be a staff culture that views weight loss a normal part of ageing, which it is not.

In many aged care organisations, the menu is not designed by APDs and will often be deficient in protein and other key nutrients across the day. As the menu is the sole source of nutrition in an aged care home, it must provide adequate nutrition for all residents across the whole day, including meals, mid-meals and fluids.

Dietitians Australia welcomed the $10 per day increase in the Basic Daily Fee for aged care homes, announced in the 2021-22 Federal Budget. The increased payment should be maintained in the 2022-2023 Federal Budget, with the condition that that every residential aged care home undergoes an annual on-site Menu and Mealtime Quality Assessment' performed by an Accredited Practising Dietitian. Providers must prepare a written report annually, in consultation with an Accredited Practising Dietitian, on how food and nutritional requirements have been met.

Medicare Benefits Schedule

Recommendation 4: 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

- Scoping required

BENEFITS

- Improved quality of life for people experiencing depression, other mood disorders and severe mental illness[42]
- Improved cost-effectiveness of treatment, when compared to medication alone[42, 43]
- Reduced cost to economy[42, 44-46]
    - Current macroeconomic flow-on effect is $70 billion annually[47]
    - Additional, avoidable economic burden of disability and early mortality of people with mental illness is approximately $150 billion annually[48]
- Reduced burden of disease[42] – currently affects over 1.1 million (4.6% of) Australians[46]
- Reduced impact of comorbid physical illnesses[42] – current cost $15 billion annually[44, 47]
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 2 and 3 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goal 1 of the National Diabetes Strategy[11]

BACKGROUND

Half of all Australians will experience some form of mental illness in their lifetime.[49] Mental illness is a collective term that describes a wide array of conditions such as mood, anxiety, personality, psychotic, substance use and eating disorders.[50] Mental illness impacts all society and is associated with significant economic costs. Mental illness impacts the capacity of those affected in the workplace and results in more frequent absences and lower performance. 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.[44-46]

People living with mental illness often have poor dietary intakes, poor hydration status, difficulty regulating food intake and food insecurity, yet nutrition is not part of care plans. Poor diet quality, often characterised by foods high in energy and sodium, can contribute to physical illness and is prevalent in people across the spectrum of mental illness, but particularly in those living with severe mental illness.[51] 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.[52, 53] Further, several antipsychotic and other psychotropic medications used to manage mental health conditions have known metabolic side effects, affecting a person's weight.[54]

Early dietary intervention with referral to an APD will help prevent, treat and manage common mental health conditions, including eating disorders, and manage the metabolic side effects of some

psychotropic medications. Early intervention, together with collaborative care, will mitigate costs to the economy, reduce the burden of disease and minimise the impact of physical illnesses. Early intervention is particularly important in vulnerable groups such as young people. Current available evidence points strongly to the cost effectiveness of dietary interventions for prevention, treatment and management of mental illnesses.[42]

Recommendation 5: Include Accredited Practising Dietitians in teams for autism, pervasive developmental disorder and disability (M10), including providing a unique 820 Medicare item number for dietetic services, and inclusion in the 820** case conferencing item number rules.**

COST

- Scoping required

BENEFITS

- Improved health and wellbeing of people with disability
- Increased social and economic participation of people with disability[55]
- Reduced preventable deaths attributable to diet-related disease
- Reduced impact of comorbid physical illnesses

BACKGROUND

The prevalence of disability in Australia is estimated to be around 18% (4.4 million), across all age groups, and 13% (2.9 million) of people under the age of 65 years.[56] Population studies show that people with disability have poorer self-reported general health and higher prevalence of health and behavioural risk factors, compared to people without disability, including insufficient fruit and vegetable intake, higher consumption of sugar sweetened beverages, high blood pressure, insufficient physical activity, high BMI and waist circumference.[56] The presence of modifiable risk factors, such as poor diet and lower levels of physical activity, may contribute to the higher prevalence of diet-related health conditions, such as cardiometabolic disease, diabetes and cancer among people with disability, compared to people without disability.[57-59]

Not only are individuals with a disability more likely to experience diet-related health conditions, their disability, be that physical, intellectual, sensory or psychosocial, may lead to unique food, fluid and nutrition requirements, further placing individuals at higher risk of nutritional problems.[60] For instance, untreated dysphagia may lead to malnutrition, dehydration, aspiration pneumonia and choking.[61] Access to healthy food, fluids and person-centred nutrition care are significant factors in promoting both the mental and physical health of people with disability.[62-64]

There is a lack of specific funding to support 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 a number of reasons:

- Limited to 5 consultations per calendar year across all allied health services
- Funding provides for a short consultation (20 minutes) or results in often large out-of-pocket fees (rebate is $55.10, dietitian fees are often above $150 per hour)

Currently seven other allied health professions have access to M10 unique 820** number.[65] Expanding this to include Accredited Practising Dietitians will ensure clients with a disability can access affordable, preventative dietetic care and provide dietitians with parity to the other allied health professionals already included.[55]

Recommendation 6: Support access to and quality of care by increasing allied health service limits for chronic disease management from 5 to 10 consultations per annum.

COST

- $490 million, based on Medicare data[66] from 2020/21 financial year (Table 1)

BENEFITS

- Increased utilisation of early-intervention and preventive allied health care to reduce future and ongoing health costs[67]
- Better continuity and quality of care for patients with complex needs, who require ongoing consultations and support to enable long-term changes[68]
- Cost-effective for managing chronic illness and reducing burden on hospital system[69, 70]
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 2 and 3 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goals 3, 5 and 6 of the National Diabetes Strategy[11]

BACKGROUND

Outcomes for Australians with chronic health conditions can be improved by better access to allied health practitioners, including Accredited Practising Dietitians,[67] to support self-management under the Medicare Chronic Disease Management items (10954, 93000, 93013) and Aboriginal and Torres Strait Islander allied health follow-up items (81230, 93048, 93061). This can be achieved by increasing the number of consultations attracting Medicare benefits, and introducing new items for longer consultations.[68]

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.[71] This is 5 services each year, split across 12 allied health professions. Five sessions or fewer does not meet best practice guidelines for dietetic care,[72, 73] does not support building rapport and trust with clients,[74] and is insufficient to support sustainable long-term health behaviour changes necessary to improve health outcomes.[68, 75]

Changes under the Howard Government 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 established the Better Access Initiative.[76] Further, the 2019 implementation of the Treatment Cycle Initiative allows 12 or more consultations per allied health profession per year for eligible veterans.[77] Similar initiatives to support dietetics services under Medicare should be implemented.

Increasing the limit to 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.[68, 78]

Table 1. Benefits paid for chronic disease management services by allied health providers between July 2018 to June 2021

Service type	Item numbers			Benefits paid per financial year		
				2018/19	2019/20	2020/21
In-person	10950 10951 10952 10953 10954	10956 10958 10960 10962	10964 10966 10968 10970	$432,369,422	$428,699,814	$481,659,388
Telehealth	93000	93013		Not applicable	$3,658,609	$ 6,621,992
			Total	$432,369,422	$432,358,423	$488,281,380

Recommendation 7: Acknowledge the complexity of dietary intervention and support quality of care by creating and funding Medicare items for dietetic consultations where duration is 50 minutes or longer.

COST

- Additional benefit of $55.10 per 50-minute dietetics consultation
  (total $110.20 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)

BENEFITS

- Improved incentive for dietitians to provide bulk-billed and low-gap services[68]
- Increased utilisation of early-intervention and preventive allied health care to reduce future and ongoing health costs
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 2 and 3 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goals 3, 5 and 6 of the National Diabetes Strategy[11]

BACKGROUND

Outcomes for Australians with chronic health conditions can be improved by better access to allied health practitioners, including Accredited Practising Dietitians, to support self-management under the Eating Disorder Treatment items (82350, 93074, 93108), Medicare Chronic Disease Management items (10954, 93000, 93013) and Aboriginal and Torres Strait Islander allied health follow-up items (81230, 93048, 93061). This can be achieved by increasing the number of consultations attracting Medicare rebates and introducing new rebates for longer consultations.

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[74] and develop and individualised nutrition care plan.[79] 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.[80] 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.[81] 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.[68, 75, 82]

Recommendation 8: 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

- $55.10 per report (equivalent to benefit for 20-minute consultation)

BENEFITS

- Support communication in the multidisciplinary team
- Improved incentive for dietitians to provide bulk-billed and low-gap services[68]
- Support achievement of streams 2 and 3 of the draft Primary Health Care 10 Year Plan[10]

BACKGROUND

Nutrition and dietetics services provided under a Medicare rebated plan (Chronic Disease Management Plan, Team Care Arrangements, Eating Disorders Management Plan, Aboriginal and Torres Strait Islander follow-up) attract a high administrative workload. Requirements for dietitians providing services under these plans include ensuring the referral form is valid and accurate, providing a consultation for at least 20 minutes, and providing a written report to the referring GP after the first and last consultation.[68, 83] Checking referrals and providing reports takes dietitians as long as 45 minutes on top on patient-facing time, depending on the presentation of the referral and complexity of care the patient requires.[68] Many dietitians complete these reports in their own time, without renumeration, or charge a gap to cover the time required. The Department of Veterans' Affairs recognises this and offers a benefit for reporting.[84] Renumerating dietitians for this time will improve incentives for dietitians to provide bulk-billed and low-gap services, and support communication in the multidisciplinary team.

Recommendation 9: Ongoing commitment to telehealth dietetics as a permanent fixture of Medicare for all Australians.

COST

- No extra cost per telehealth service as these attract same Medicare benefit as in-person services
- $8 million per year, based on increased use of services

BENEFITS

- Telehealth dietetics services are highly cost effective, with cost per Quality Adjusted Life Years (QALY) gained ranging from 0.4% to 62.5% of GDP per capita[85]
- Increased access to allied health services will reduce expenditure on medications and decrease hospital costs, as demonstrated by pilot projects[86]
- Reduced long-term health spend due to uptake in preventive and early-intervention care
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 2 and 3 of the draft National Obesity Prevention Strategy,[9] streams 1 and 2 of the draft Primary Health Care 10 Year Plan[10] and goals 1, 3, 5 and 7 of the National Diabetes Strategy[11]

BACKGROUND

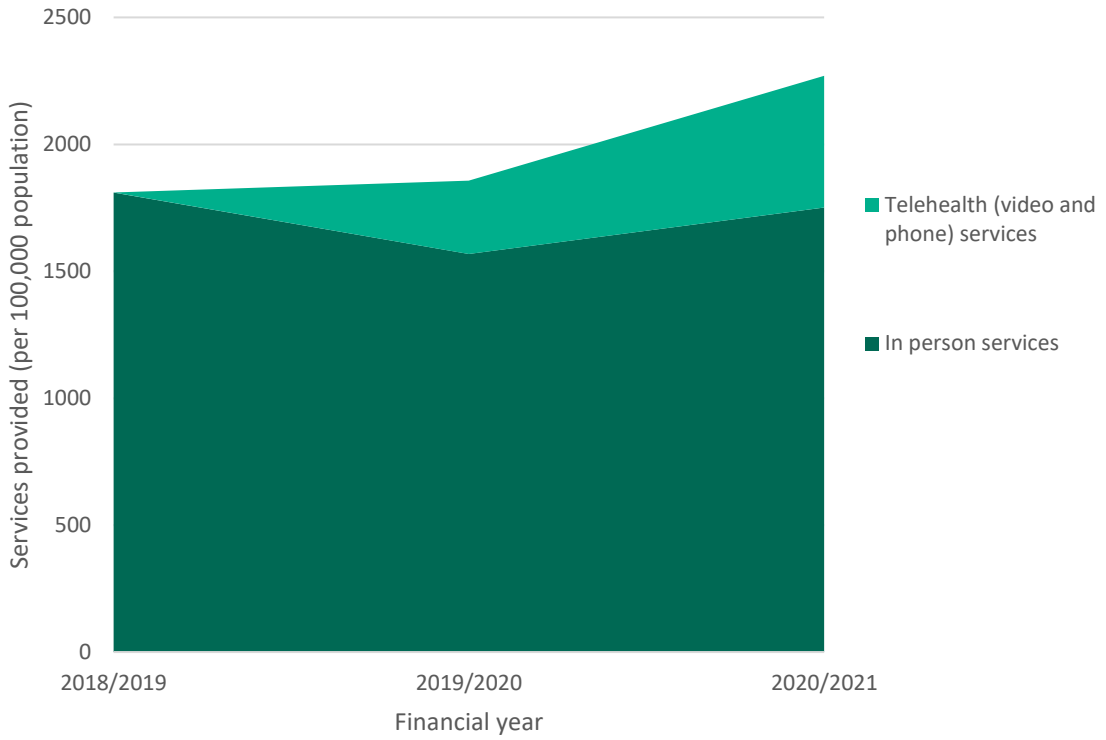
Dietitians Australia welcomed Minister Greg Hunt's announcement[87] on 13 December 2021 that telehealth would be made a permanent feature of Medicare.

Telehealth dietetics services are highly cost effective, with cost per Quality Adjusted Life Years (QALY) gained ranging from 0.4% to 62.5% of GDP per capita.[85] Increased access to allied health services will reduce expenditure on medications and decrease hospital costs, as demonstrated by pilot projects.[86]

Patients can receive high quality and effective dietetic services via telehealth. Outcomes of telehealth dietetics are as effective as in-person services and do not require training beyond graduate level. Telehealth services improve access to effective nutrition services, help to address health inequalities and support Australians to optimise their health and well-being, regardless of location, income or literacy level.[88]

Medicare data[66] from the last three financial years shows that use of dietetic services under Medicare has increased each year. This increase is attributable to significant usage of telehealth services after their introduction in March 2020, on top of similar use of in-person services (Figure 1). This suggests increased access of services, enabling a greater proportion of the population, half (47%) of whom have a chronic disease,[89] to access support from dietitians and other health professionals.

Figure 1. Dietetic services funded by Medicare provided between July 2018 to June 2021



Food-based dietary guidelines

Recommendation 10: Additional funding to develop Dietary Guidelines for Older Australians within scope of the Australian Dietary Guidelines review.

COST

- $2.5 million

BENEFITS

- Clear evidence-based information to inform food systems and menu planning in aged care
- Support residential aged care providers to meet the Aged Care Quality Standards, all of which relate to food, nutrition and the mealtime experience in aged care
- Support healthy ageing for older adults in the community, delaying entry into residential aged care facilities, reducing preventable hospital admissions, improving quality of life and reducing long-term health spending
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 1 and 2 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goal 6 of the National Diabetes Strategy[11]

BACKGROUND

The Morrison Government's 2019 announcement of $2.5 million in funding for the review of the Australian Dietary Guidelines was welcomed by Dietitians Australia as an important step in promoting the health of all Australians. Along with this funding of the Guideline development, funding is needed to provide advice specific to older adults (70+ years), who have different nutrition needs to the rest of the population.

Nutrition needs change as people enter different stages of life. On a physiological level, older adults need more protein to maintain protective muscle mass, calcium to maintain bone strength and adequate energy (calories/kilojoules) to prevent unintentional weight loss when a person has a reduced appetite. On a social level, loneliness and lack of the social aspects of eating can reduce the amount of food an older adult eats, leading to poor health.[90, 91] Failure to meet these needs leads to the serious consequences of malnutrition and associated poor health, as demonstrated by the preliminary findings of the Royal Commission into Aged Care Quality and Safety.[92]

The current Australian Dietary Guidelines and the planned review do not account for the unique needs of older adults, instead providing guidelines for the generally well adult population.[93] Older adults who follow the Australian Dietary Guidelines are at risk of becoming malnourished and impacting their quality of life. A clear, consistent evidence-based document at a national level would provide aged care facilities, hospitals, respite centres, rehabilitation facilities and carers the information they need to help older Australians to age well and maintain their quality of life.

Recommendation 11: Fund successful public education, implementation and evaluation of the reviewed Australian Dietary Guidelines.

COST

- $2.5 million per year for public health campaigns, community support programs and systems level initiatives promoting healthy eating and other health behaviours
- $2 million for evaluation of the Australian Dietary Guidelines, including dietary guidelines for older adults

BENEFITS

- Adherence to dietary guidelines may reduce prevalence and impact of diseases such as cancer, type 2 diabetes, obesity and other diet-related diseases, thus reducing overall health spending and additional indirect costs of these diseases
- Evaluation of nutrition programs, initiatives and other actions supports cost effectiveness and efficacy of future programs
- Support achievement of targets in focus area 2 of the National Preventive Health Strategy,[8] ambitions 1 and 2 of the draft National Obesity Prevention Strategy,[9] stream 2 of the draft Primary Health Care 10 Year Plan[10] and goals 1 and 7 of the National Diabetes Strategy[11]

BACKGROUND

The Morrison Government's announcement of $2.5 million in funding for the review of the Australian Dietary Guidelines was welcomed by Dietitians Australia as an important step in promoting the health of all Australians. Along with this funding of the Guideline development, funding is needed to provide advice specific to older adults, who have different nutrition needs to the rest of the population, and to support the implementation and evaluation of the Guidelines.

With less than 4% of the population eating a diet consistent with the Australian Dietary Guidelines,[93, 94] it is crucial that the time and effort put into the reviewed Guidelines is translated into real action to support healthy diets. A comprehensive implementation plan may include effective strategies such as mass media campaigns,[95-97] community support programs and systems level actions.[98, 99] Campaigns, programs, initiatives and other actions must be evaluated to indicate the returns of Government investments in terms of population health, community wellbeing and financial implications.[100-102]

Regional, rural and remote health care

Recommendation 12: Ensure regional communications infrastructure can support telehealth for greater healthcare access.

COST

- Scoping needed

BENEFITS

- Improved access to health services via telehealth, for people living in regional, rural and remote Australia[103, 104]
- Increased utilisation of early-intervention and preventive allied health care to reduce future and ongoing health costs
- Better health outcomes for people living in regional, rural and remote Australia[105, 106]

BACKGROUND

Tenuous access to healthcare in regional, rural and remote Australia has been a sore reality given a spotlight during the COVID-19 pandemic. Restrictions on movement of health professionals and people seeking care has placed great strains on regional health care and impacted the wellbeing of thousands of Australians. Telehealth has been a crucial lifeline in these times, giving Australians access to health care that is lacking in their region. However, rural and remote Australians face barriers to even telehealth access, that city-dwellers often do not.[105]

Rural and remote Australians face barriers related to service suitability, reliability and affordability,[105] and are more reliant on out-dated telecommunications technology such as landline services delivered through the copper wire network.[107] This can negatively impact telehealth services like video calls (eg Zoom, Coviu, WebEx) and secure voice calls (eg WhatsApp, Telegram). Initiatives in the United States and United Kingdom demonstrate that investment in telecommunications infrastructure in rural and remote areas improves access to health care.[103, 104] Rural and remote Australians face barriers related to service suitability, reliability and affordability,[105] and are more reliant on out-dated telecommunications technology such as landline services delivered through the copper wire network.[107] This can negatively impact telehealth services like video calls (eg Zoom, Coviu, WebEx) and secure voice calls (eg WhatsApp, Telegram). Initiatives in the United States and United Kingdom demonstrate that investment in telecommunications infrastructure in rural and remote areas improves access to health care.[103, 104]

Recommendation 13: Reintroduce scholarships for allied health students studying in accredited education programs to complete placements in regional, rural and remote areas.

COST

- $4 million per year[108]

BENEFITS

- Address Recommendations 1, 2 and 3 of the National Rural Health Commissioner's Allied Health Report[109]
- Greater workforce in regional, rural and remote Australia
- Increased access to services and better health outcomes for people living in regional, rural and remote Australia

BACKGROUND

The evidence shows that students with exposure to rural and remote practice are more likely to take up positions outside urban areas after graduation. However, many students struggle to undertake placements in regional areas due to financial burden of paying for accommodation, travel, and lost income from place of usual work. This has the implication of fewer students undertaking placements in these areas, and in turn fewer graduates providing services to these communities. This was identified as a key workforce issue in the National Rural Health Commissioner's Allied Health Report.[109]

The Australian Government supports students to undertake education and training in the Indo-Pacific through the New Colombo Plan.[110] This initiative builds Australia's relationships with international communities, establish study in these regions as a rite of passage, and increase the number of work-ready Australian graduates with regional experience.[110] Until 2017, a similar scholarship program was available for allied health students undertaking undergraduate education and training in regional, rural and remote Australia. This program was administered by Services for Australian Rural and Remote Allied Health (SARRAH), allocated approximately $4 million per year for undergraduate and clinical placement scholarships.[108] The program was highly successful, with 60% of scholarship recipients practising in regional, rural or remote areas after graduation.[111] Reviving a similar program for undergraduate scholarships would increase student engagement in rural Australia and develop a stronger health workforce for Australia's future.

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