Commonwealth Home Support Programme

National Fees Policy

April 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for better food, better health, and wellbeing for all. DAA appreciates the opportunity to provide feedback on the Commonwealth Home Support Programme – National Fees Policy by the Australian Government Department of Social Services.

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DAA interest in this consultation

As the leading organisation of nutrition professionals in Australia, DAA is concerned about the high prevalence of malnutrition in older Australians living in the community.

Accredited Practising Dietitians (APDs) are the health professionals whose primary interests are the food, nutrition, and the wellbeing of older Australians. APDs apply their training and experience in clinical nutrition, community health and food service to direct the efforts of carers, providers, health professionals, volunteers and the Australian Government to improve the nutrition and quality of life of consumers.

Key messages

DAA agrees in principle that consumers should contribute to the cost of benefits received under the CHSP but this must be managed to ensure that wellness and reablement is achieved, and hardship avoided. If clients refuse services and their nutritional status is negatively impacted this will result in increased use of state funded health services, or earlier admission to residential aged care at a higher cost.

The Commonwealth Home Support Programme has the potential to improve the nutritional status of older Australians, provided a number of risks can be successfully managed. These risks relate to consistency and coherence of fees across programmes, and clients with special needs or in rural and remote regions.

Discussion

Consistency and coherence of fees across programmes

One important risk in the implementation of the National Fees Policy is the lack of consistency across Commonwealth programmes. Consumers will not take up programmes if they are financially disadvantaged by shifting from one Commonwealth programme to another, or from a State funded programme to a Commonwealth programme. DAA members report that this is happening at present, where members have historically never been charged (e.g. by NSW Health or Medicare Locals) and that this presents a barrier to consumers accessing nutrition products or services.

Consumers generally do not discriminate between different levels of government and whether it is State or Commonwealth Government delivering the service to the consumer. Understandably consumers question why they must pay to obtain a product or service which they have previously received at lesser or no cost.

Risk management should include

- Clear explanations of the costs and benefits to consumers about programmes
- Detailed monitoring to identify untoward effects on wellness and reablement outcomes of consumers
- Development of coherence with respect to cost across programmes.

Hardship provisions

A rationale is given in the policy for not capping fees, and that hardship provisions are proposed as an alternative. This appears reasonable but DAA is concerned about the wide variation in fees which might be charged. For example, a DAA member reported recently that a consumer was charged a higher fee for meals than that available through a neighbouring service, and was not informed that another service was available (which also happened to be less costly). How are consumers to exercise choice in such circumstances if they are not fully informed? And how are consumers to exercise choice where they live in areas serviced by only one provider?

Food costs are considered to be a personal responsibility of the client, but there is no statement about what the total cost of food (say per week) is considered to be for the purpose of assessing hardship under the CHSP. Where consumers live in rural and remote areas, or where they have special needs e.g. diet for impaired renal function, or nutrient dense texture modified foods and fluids, the costs are expected to be greater than in other circumstances.

The Policy is silent on how providers will determine a consumer's ability to pay fees. DAA would like to see more guidance on this question to promote consistency in interpretation across services.

DAA considers it will be important to monitor the frequency with which hardship is experienced and whether this has adverse effects on clients taking up services to the detriment of their wellbeing and reablement.

Consumers with special needs

The Proposed Fee Schedule includes fees for *Allied Health and therapy services*, *Other food services* and *Meals* to be applied equally across Australia. However the cost of delivering food, transport costs and the cost of other goods and services in rural and remote areas has been shown to be considerably more than the cost in urban areas[1]. DAA would like to see measures to address this issue.

Consumers requiring home enteral nutrition consumables and enteral formula may face higher costs than consumers eating and drinking ordinary foods and fluids. The combined value of these items should be considered when setting fees.

Cost of meals

Fees are suggested per meal. DAA would like to see clarification about what constitutes a meal, whether the same fee is to apply if more than one meal is required per day, and whether snacks are costed at the same rate as meals.

The consultation documents make no mention of quality of meals. Consumers should expect that meals are nutritious and represent value for money. The development of national nutrition guidelines for home delivered meals and other food services would address this point.

Block funding model for allied health reablement programs

DAA would also like to see alternative models of allied health reablement programmes considered on a block funding basis. The delivery of multiple services per week in the short term may be unaffordable for some clients. It is not unusual for a client to need nursing, dietetics and occupational therapy for example whilst also paying for domestic assistance, meals and other medical expenses.

DAA suggests block funding with modest cost to consumers with strong reablement potential for a limited time according to agreed consumer goals be considered. Accessing multidisciplinary care in a timely fashion can avert deterioration of consumers and early more expensive admission to residential care or hospital admission.

References

1. Harrison MS, Coyne T, Lee AJ, Leonard D, Lowson S, Groos A, Ashton BA. The increasing cost of the basic foods required to promote health in Queensland. Med J Aust 2007; 186: 9-14