



Eating Disorders & the Medicare Benefits Schedule (MBS) Review

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DAA interest in the MBS Review

As the peak body for the dietetic profession, the Dietitians Association of Australia (DAA) has an interest in the health and wellbeing of all Australians, including those with eating disorders. Access to Accredited Practising Dietitians (APDs) is paramount in the mental and physical health management of people with eating disorders. Correspondence to DAA from mental health consumer advocates supports better access to medical nutrition therapy provided by APDs.

The Accredited Practising Dietitian (APD) program is the basis for self-regulation of the dietetic profession in Australia. APDs have an important role in providing medical nutrition therapy to individuals with eating disorders.

DAA highlights that practice guidelines support the inclusion of dietitians in the multidisciplinary treatment of eating disorders¹⁻³. Nutrition intervention, including nutritional counselling by an APD, is an essential component of team treatment for all patients with eating disorders during assessment and treatment across the continuum of care¹⁻⁴. APDs have supported people with eating disorders for many years in public hospitals and community services, but funded positions are not enough to meet community needs.

At present, people receiving eating disorder treatment from an APD are able to access a maximum of 5 dietitian sessions under the Enhanced Primary Care Place – Item 10954. For the majority of these people, the dose of treatment represented by these sessions is not adequate. Due to the limited resources within public health tertiary services, many individuals with eating disorders must self-fund or use their private health insurance to consult APDs in private practice. Private health insurance cover (if available) will cover up to about 3 sessions of outpatient medical nutrition therapy, far less than is required by most individuals with eating disorders to achieve an improvement in their eating behaviour.

The Medicare Benefits Schedule (MBS) Chronic Disease Management items offer limited access because the five items available per year are shared across all eligible allied health providers. This is not enough to meet the complex needs of people with eating disorders who, in order to be clinically effective, require a greater number and longer duration of consultations with APDs to develop trust, rapport and a therapeutic alliance.

APD services are not available at present under the [MBS Better Access initiative](#). Introducing a greater number of MBS supported consultations for allied health to manage individuals, and new MBS consultation items for APDs working with groups and telehealth would improve equity of access to nutrition services. This is important for people with eating disorders who are most at risk, but in many cases have the least capacity to pay for private services.

Households experience a substantial burden associated with the treatment and management of an eating disorder in Australia. Research by Gatt et al⁵ revealed high rates of hardship, high out-of-pocket expenditure and high out-of-pocket cost burden associated with having an eating disorder, with 97% of Australian study participants reporting at least one incident of hardship in the previous 12 months and 17.8% reporting cost-related non-adherence. Over 40% of participants spent greater than 10% of their household income on illness-related costs, a level of expenditure that has been defined as ‘catastrophic’ in other studies.

DAA supports the work of the taskforce in proposing an increase in rebatable dietitian sessions, however we have a number of broader concerns with the recommendations of the proposal.

DAA feedback on the EDWG Report for Consultation

Recommendation 1.1 *Create a new MBS consultation item for the treatment and management of a patient with severe anorexia nervosa, as diagnosed by a psychiatrist or paediatrician. In accordance with the evidence and with clinical best practice, this new ‘trigger’ item will:*

- *Require the development of a treatment and management plan;*
- *Allow eligibility for up to 40 psychological sessions per year; and*
- *Up to 20 dietitian sessions per year*

DAA Key Messages:

- **DAA supports the creation of a new MBS item supporting patients to access up to 20 dietitian sessions for the purpose of eating disorder treatment.**
- **DAA does not support this access being limited to severe anorexia nervosa as diagnosed by a psychiatrist or paediatrician, nor the definition of access being limited to BMI measures.**
- **DAA strongly believes that limiting diagnosis made by psychiatrists or paediatricians will impede access to the new MBS item due to issues regarding limited access to these practitioners in rural & remote areas, extended wait times to see such practitioners, and cost barriers to see these practitioners (as many charge a substantial out-of-pocket fee).**
- **DAA recommends extending this new MBS item to be accessible to all patients diagnosed with an eating disorder, by allowing diagnosis to be made by a medical practitioner under the supervision of a psychiatrist or paediatrician.**

Telehealth could offer a means to allow a GP to make an eating disorder diagnosis in the presence of a psychiatrist or paediatrician.

- **DAA recommends extending the new MBS consultation items to allow allied health professionals to provide individual and group consultations to patients with an eating disorder by means of telecommunications technology (telehealth).**

Given the Eating Disorders MBS review is intended to deliver on affordable and universal access, best practice health services, value for the individual patient and value for the health system, DAA is concerned that the proposed new MBS consultation item solely focuses on patients with severe anorexia nervosa. As stated on page 20 of the Eating Disorders Working Group (EDWG) Report for Consultation, the number of people in Australia with an eating disorder is estimated to be 913,986 at any given time. Of these people, 47 per cent have Binge Eating Disorder (BED), 12 per cent have Bulimia Nervosa (BN), three per cent have Anorexia Nervosa (AN) with 0.3 per cent diagnosed as experiencing 'severe' AN and 38 per cent experience Other Specified Feeding or Eating Disorders (OSFED). So whilst 0.3 per cent percent of the population with an eating disorder have 'severe' AN, 99.7 per cent are affected by another debilitating eating disorder (e.g. Mild-Mod AB, BED, BN or OSFED). DAA does not support the proposed new MBS consultation item, which leaves 99.7 per cent of people with an eating disorder without adequate clinical best practice treatment.

DAA considers it vital to improve access to services for all people with an eating disorder, regardless of DSM diagnosis or Body Mass Index (BMI). DAA supports early intervention and early recovery as a focus for the treatment of any patient with an eating disorder, especially in the private sector, as early intervention in the first 3 years of illness provides a critical window for full recovery⁶.

DAA advocates a principle of consistency in allied health items available under Medicare which ensure patients are able to access the right practitioner, at the right time in the right place with sufficient number of services to meet the complexity of their unique situation.

The model put forward to the Medicare EDWG by The Butterfly Foundation⁷ for community-based treatment of eating disorders is supportive of treatment for all people with an eating disorder and includes integrated medical, psychological, nutritional and functional treatment with an evidence-based tiered number of sessions of therapeutic intervention. DAA supports this tiered model in that it recognises that people present with varying levels of severity of illness. Other reasons for supporting the Butterfly Foundation model⁷ include:

- At present, many GPs do not use the items for five allied health MBS Chronic Disease Management items for patients with eating disorders and even if they do, the number is inadequate for effective treatment. APDs are unable to access the MBS Allied Health Better Health items. Removing barriers to the combination of

psychotherapy and dietetic care under these schemes is essential for early intervention of eating disorders.

- Nutrition is critical to medical stability and to the patient's capacity to engage successfully with psychotherapy. Nutritional therapy is therefore integral to eating disorder specific treatment and this is recognised in various practice guidelines¹⁻³.
- Patients require access to nutritional therapy as part of integrated care which addresses the complexity of their individual situation. Individually tailored integrated nutrition care may require bi-weekly services over a 12 months course of treatment. The proposed model provides for up to 20 sessions with a dietitian in a 12-month period.

DAA also considers it essential that the number of dietetic interventions available to a person is sufficient to address the severity of their eating disorder and other factors which determine the overall complexity of their situation. For example, other comorbidities such as depression, diabetes or food intolerance would increase the time needed to support a patient. Social and cultural factors would also add complexity which may increase the time needed to treat. A limitation of the tiered model is that it assumes that the referring medical practitioner can reasonably predict the number of sessions required by the dietitian. DAA therefore favours a trial of the proposed model to test if it is superior to a simple model which allows access of up to 20 sessions for any patient with an eating disorder.

DAA supports the eligibility criteria for 'Early Intervention', 'Integrated Care for Eating Disorders' and 'Integrated Care for Complex Eating Disorders' as outlined on pg: 30 of The Butterfly Foundation model⁷. DAA disagrees that the application of eligibility criteria should be based on BMI, as body mass index has been shown to be an insufficient indicator of severity^{8,9}. The taskforce document (section 5.1.1, pg: 25) states "The Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM 5) provides a scale of severity for people with eating disorders. Body Mass Index (BMI) is used as the major indicator, however, **best practice** also suggests that the rapidity of weight loss, medical stability, psychological distress, suicide risk, and response to previous treatment be incorporated into the clinical assessment of a patient with an eating disorder. Combining these factors allows for a more comprehensive assessment of the individual, their circumstances and care needs".

DAA strongly believes that limiting diagnosis made by psychiatrists or paediatricians will impede access to the new MBS item due to issues regarding limited access to these practitioners in rural & remote areas, extended wait times to see such practitioners, and cost barriers to see these practitioners (as many charge a substantial out of pocket fee). It is the position of the DAA that this new MBS item should be accessible to all patients diagnosed with an eating disorder, by allowing diagnosis to be made by a medical practitioner under the supervision of a psychiatrist or paediatrician. Telehealth could

offer a means to allow a GP to make an eating disorder diagnosis in the presence of a psychiatrist or paediatrician.

Access to care is a major issue for patients with eating disorders living in rural and remote locations. Findings suggest that while the prevalence of disordered eating is evening out across demographics, the rate of increase and its impact on perceived functioning remains highest for marginalized groups with less access to specialized care, such as those who are poorer and live outside of the major cities¹⁰. DAA recommends extending the new MBS consultation items to allow allied health professionals to provide individual and group consultations to patients with an eating disorder by means of telecommunications technology (telehealth). Providing allied health professionals with access to telehealth would vastly improve patient equity of access to dietetic services, especially for people with eating disorders living in rural and remote areas of Australia.

Recommendation 1.2 *The Working Group requests that any future work on the MBS items for mental health services consider the needs of patients with moderate cases of eating disorders with a view of increasing access to appropriate evidence based care.*

DAA Key Messages:

- **DAA recommends that current work on a new MBS model for disordered eating services addresses the needs of all patients with an eating disorder, including those with low, moderate and high levels of severity of illness across a range of diagnoses.**

As outlined in the points raised above, DAA considers it vital that all patients with an eating disorder are given timely access to evidence-based treatment through the creation of a new MBS consultation item for eating disorders. Early intervention is key to the success of treatment for eating disorders, therefore it is important that patients with ‘low to moderate’ cases of eating disorders are given equal access to the best evidence-based care as patients with more complex presentations. As such, DAA recommends that current work on a new MBS model for disordered eating services addresses the needs of all patients with an eating disorder, including those with low, moderate and high levels of severity of illness across a range of diagnoses. The model put forward by The Butterfly Foundation⁷, with input from an Expert Advisory Council, is supportive of this notion.

As previously noted, DAA supports the model forwarded to the Medicare EDWG by the Butterfly Foundation, and strongly believes that this item warrants the support of the taskforce immediately. While item 1.1 provides access to MBS rebates for people with anorexia nervosa, there is an absence of increased access for people with other eating disorder diagnoses who may also require access to care. For this reason, DAA supports inclusion of the diagnoses of Bulimia Nervosa, Binge Eating Disorder, and Other Specified

and Feeding Disorders eating disorder diagnoses. DAA also acknowledges that limiting access to the current allied health MBS rebates for these additional eating disorder diagnoses of up to 10 psychological sessions and up to 5 dietitian session is inadequate and associated with people not receiving a suitable dosage of treatment.

Recommendation 2.1 *The Working Group requests that the Allied Health Reference Group investigate and consider expanding access to provide multidisciplinary team (MDT) case conference MBS items 735, 739, 743 and to item 729 (contribution to a MDT care plan prepared by another practitioner) to allied health professionals who are trained in the treatment of eating disorders.¹ This would enable these practitioners to be remunerated for their involvement in MDT care plan development and case conferences.*

DAA Key Messages:

- **DAA proposes that recommendation 2.1 is expanded to include ‘... allied health professionals who are trained and supervised/mentored in the treatment of...’.**
- **DAA strongly supports the expansion of access to MDT care plan development and case conferencing (through the listed MBS items) to allied health professionals trained in the treatment of eating disorders.**
- **DAA suggests that equal rates of reimbursement for MDT should apply to allied health professionals trained and supervised/mentored in the treatment of eating disorders.**

Supervision/mentorship is vital for all clinicians who treat those with eating disorders and especially for those in the early stages of training for the treatment of eating disorders. Therefore, DAA proposes that recommendation 2.1 is expanded to include ‘... allied health professionals who are trained and supervised/mentored in the treatment of...’.

DAA strongly supports the expansion of access to MDT care plan development and case conferencing (through the listed MBS items) to allied health professionals trained in the treatment of eating disorders. Remuneration for allied health professional involvement in MDT care plan development and case conferences will help to address current inadequacies in this area. DAA suggests that equal rates of reimbursement for MDT should apply to allied health professionals trained and supervised/mentored in the treatment of eating disorders, such that APDs receive the same reimbursement for MDT as a psychologist or any other allied health professional.

Recommendation 2.2 *Allow appropriately trained practitioners (for example those registered with the Australian Association of Family Therapy) to provide family-based therapy (FBT) under the items for focussed psychological strategy services (items 80100-*

80171). Family-based therapy should be for patients referred under the new MBS items, less than 18 years of age who reside with family. Family based therapy services will count towards the patient's allocation of psychological services provided through the new MBS item.

DAA Key Messages:

- **This recommendation encourages registration to a specific professional body, which should be reworded to be more impartial.**
- **DAA supports appropriately trained practitioners, including APDs who are trained and supervised/mentored in FBT and who work within their scope of practice, to provide Family Based Therapy (FBT) under the items 80100 – 80171.**
- **DAA suggests that funding for FBT should be commensurate with the professional skills and knowledge required to deliver safe and competent care, and that it should not preference one discipline over another.**
- **DAA cautions placing an age limit on patients of less than 18 years of age for FBT.**

DAA proposes that this recommendation, which encourages registration to a specific professional body, should be reworded to be more impartial.

APDs working in the field of eating disorders are well placed to provide Maudsley Family Based Treatment (FBT)¹¹ given that FBT has an integral weight restoration component and refeeding component. As such, DAA proposes that APDs trained and supervised/mentored in FBT be permitted to provide nutrition therapy for FBT under the items for focussed psychological strategy services (items 80100-80171). Furthermore, DAA suggests that funding should be commensurate with the professional skills and knowledge required to deliver safe and competent care, and that it should not preference one discipline over another.

DAA cautions placing an age limit on patients of less than 18 years of age for FBT, given that preliminary research indicates that an adaptation of FBT (called FBT-TAY, meaning FBT for transition-age youth) may have benefits for older adolescents and young adults (aged 16 to 24 years) with anorexia nervosa¹². DAA therefore recommends removing the age restriction on FBT until further research comes to light on the ages to which it is useful.

Recommendation 3.1 *Further support and education should be provided to GPs about locally available services for patients with eating disorders and their families.*

DAA Key Messages:

- **DAA suggests that GPs (and their professional organisations) are best placed to provide feedback on the type of support and education that GPs need about locally available services for patients with eating disorders and their families.**

Recommendation 3.2 *Professional associations and other relevant training organisations should develop specific training, education and clinical guidance for working with people who have eating disorders. This training should be included in continuing professional development programs for disciplines involved in the treatment and management of patients with eating disorders, in particular, any health professionals providing eating disorder services under the new MBS item recommendations made in this report.*

DAA Key Messages:

- **DAA supports training, education and clinical guidance, specifically for those practitioners providing treatment under the additional MBS items proposed.**

DAA supports the development of training, education and clinical guidance for professionals working with people who have eating disorders. Under National Alliance of Self-Regulated Health Professions (NASRHP) Standards, the Dietetic Credentialing Council govern the Accredited Practising Dietitian (APD) program, the credential for the dietetic profession providing an assurance of public safety and quality.

DAA also supports training, education and clinical guidance to support professional competency. The DAA APD program fosters competent and ethical practice to allow APDs to practice at the highest level. In order to achieve and maintain the APD status, annual goals need to be established and reflected upon, while a minimum of 30 hours of continuing professional development (CPD) needs to be logged every year. Members of DAA are offered training, education and clinical guidance to support their field of work, including eating disorders.

Whilst all APDs are deemed competent at entry level to see all clinical conditions, obtaining and maintaining APD status assists in ensuring clinical competence in the area of practice. It is a requirement that some of the annual hours must be in the area of work to maintain clinical competence. So APDs providing clinical care in eating disorders must undertake ongoing and regular professional development in this space – this includes self-directed training, supervision and professional education options.

The financial and geographic barriers to training and education requires thorough consideration. The cost of training, time away from work and the rural/remote location of some dietitians can be a major barrier to this process. DAA is working to provide accessible professional development options.

Recommendation 3.3 *A credentialing process should be established, specific to practitioners that provide treatment for patients with eating disorders. Once established, these credentials should be used to determine practitioner eligibility to provide eating disorder services under the new MBS item that is recommended within this report.*

DAA Key Messages:

- **APDs are the professionals uniquely qualified and credentialed to provide medical nutrition therapy. APDs working in eating disorders have a professional responsibility to work within their scope of practice, as per the DAA code of conduct and role statement for APDs practising in the area of eating disorders. So existing requirements for professional practice are already in place for dietitians.**
- **The requirement for further credentialing (beyond that of the APD credential) may pose as a barrier for some clinicians to work in this area and therefore a barrier to service access by patients.**
- **If credentialing was to go ahead, it is DAAs preference that credentialing is provided by an overarching professional body (e.g. ANZAED) so as to ensure consistent training, education and support is provided to all professionals working in the field of eating disorders.**

DAA sees risks and benefits in requiring credentialing for professionals working in the area of eating disorders who provide services under the new MBS consultation items. Additional credentialing would be expected to be based on achievement of education and experience milestones. DAA suggests this is where limited government and professional resources should be directed rather than into further credentialing structures and processes. Additional credentialing may reduce access to services by limiting the supply of practitioners, particularly in areas in which thin markets are prevalent (e.g. rural areas or poorer socioeconomic areas). This is not in the interest of people experiencing eating disorders.

In the case of dietetics, existing frameworks already address competency with the APD credential. APDs are the most qualified nutrition health professionals to provide medical nutrition therapy. APDs working in eating disorders have a professional responsibility to work within their scope of practice, as per the DAA code of conduct and role statement for APDs practising in the area of eating disorders⁴. Therefore existing requirements for professional practice are already in place for dietitians.

DAA supports equitable access to competent professionals for individuals with eating disorders, and highlights that the requirement for further credentialing (beyond that of the APD credential) may pose as a barrier for some clinicians to work in this area, and ultimately impact those individuals with eating disorders the most. Credentialing may also incur a membership fee, providing a further potential barrier to become an APD working with eating disorder clients, especially if eating disorder clients are not the only

ones managed within their practice. The additional training requirements may also be a barrier to those APDs who not only see patients with eating disorders, but also a diverse range of conditions in their practice. These barriers may mean some APDs with knowledge and experience in eating disorders may choose to not be credentialed, leaving patients without access to an APD close to where they live.

Credentialing is not required for allied health MBS Chronic Disease Items requiring dietetic input (e.g. diabetes, renal disease). APDs work under a statement of ethical practice and code of conduct that allows them to conduct their work in a professional, evidence-based manner. Over 3 million chronic disease services have been delivered without issue and without the requirement for additional credentialing.

If credentialing was to go ahead, it is DAAs preference that credentialing is provided by an overarching professional body (e.g. ANZAED) so as to ensure consistent training, education and support is provided to all professionals working in the field of eating disorders.

Recommendation 3.4 *The Department of Health to write to the 31 Primary Health Networks (PHNs) on behalf of the Working Group to increase awareness about evidence-based clinical pathways for the treatment of people with eating disorders, and to provide an example clinical pathway which could be adapted and implemented for use in their local area.*

DAA is supportive of this recommendation. However, DAA recommends that in the first instance the Department of Health investigates what PHNs are already doing in the area of eating disorder clinical pathways, and then review PHN capacity for further work in this area.

Other feedback

DAA considers it important to ensure the recommendations for the MBS are in line with state plans.

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