Australian Meals on Wheels Association Inc.

SUBMISSION

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Australian Meals on Wheels Association (AMOWA)

From its inception 60 years ago, Meals on Wheels has grown to become a driving force of care in the community. In the course of a year, over 14 million meals are delivered by some 80,000 volunteers to more than 75,000 recipients Australia wide in cities, regional and rural areas.

Meals on Wheels is all about people in the community joining forces to help others. While age, ill health or disability may reduce some people's capacity to get out and about, Meals on Wheels helps make it possible for them to stay in their homes, where they are happiest, and maintain some independence. Delivery of nourishing meals offers social interaction and ensures a clients' wellbeing, helping people live the lives they choose.

Our Members are the peak State and Territory organisations for Meals on Wheels in NSW, Queensland, Tasmania, South Australia and Victoria, with subscriber representatives from Western Australia and the ACT.

AMOWA provides proactive and strategic national leadership and a clear coherent voice on matters that affect our clients, volunteers and staff and the local communities in which they are placed. It enables a single point of contact between Meals on Wheels services and policy-makers, funders, regulators, sponsors and other key stakeholders.

AMOWA provides an avenue for developing and sharing best practice between the 680 services that the State and Territory Associations represent, along with promoting and raising awareness of Meals on Wheels in Australia.

INTRODUCTION

Meals on Wheels may be viewed merely as an organisation that produces and distributes relatively cheap food. But our clients and our volunteers know that Meals on Wheels is so much more than that.

We're ***more than just a meal.*** We're **3 services in one**.

1. We **nourish**: delicious and nutritious ready-to-eat meals delivered to the door.
2. We **care** for: physical and psychological well-being of vulnerable people is monitored, with family members or doctors notified if we notice anything amiss.
3. We **strengthen communities**: important social contact is provided to people who may be isolated and lonely, and relationships are built with clients and volunteer teams.

Nutritional need is often confused with the 'capability' of the individual. Phrases like, "if someone only needs meals three times a week, they don't really need them", or, "she's quite capable of shopping and cooking" seem sensible, but sometimes fail to see the big picture. For example, a client may be able to cook, but after years of cooking casseroles or roast dinners for a partner who has recently deceased, they are almost repelled by the idea of doing it for themselves. They simply won't. Their interest in food wanes, they lose weight, and their health suffers. A supply of frozen TV dinners will not resolve this problem. Meals on Wheels meals are incredibly important for both psychological *and* nutritional reasons.

The 'meal' aspect of the service we provide cannot be simply defined as nutritional refuelling. Emotional well-being is nourished by the desire and pleasure in eating.

Monitoring of a person's health and well-being through telephone contact can be effective in some circumstances. However, the last thing *most* older people want to do is complain or ask for help. And phones miss those critical visual cues that indicate levels of wellness. We believe services like ours take the best possible approach to monitoring.

Through regular, frequent contact our volunteers develop trust, listen and observe, almost like a family member would. They then take follow-up action as required, often preventing hospitalisation and even saving lives when a client fails to respond to a scheduled visit.

The term monitoring is the professionalisation of notions such as 'looking out for' and 'caring' and is often considered by clients and their families as more important than the actual meal.

Socialisation aspects of the service enhance the well-being of the client and give peace of mind to their families. Clients feel cared about, because someone was willing to give up some of their time to cook and/or deliver a meal, and have a 'bit of a natter'. The benefits to volunteers cannot be overlooked. Each year nearly 80,000 registered volunteers, as well as thousands of secondary students and corporate volunteers, have a way of connecting, contributing positively and helping others in their community. Reaching out and making a difference in somebody else's day, makes their day too. In some instances the act of volunteering has assisted people to

cope with bereavement or depression. Making a meaningful contribution not only increases their sense of worth, but benefits both clients and the wider community.

The socialisation networks built and enhanced by our service benefit the client, the volunteer, and strengthen communities.

We get funded for delivering meals.

SUMMARY OF RECOMMENDATIONS

Recommendation 1:
That the Commonwealth government recognises the benefits of Meals on Wheels as an essential health service in the prevention and treatment of poor nutrition in older Australians, and ensures that it is funded and supported accordingly.

Recommendation 2:
That a primary health funding mechanism, separate from the Commonwealth Home Support Programme, is found to subsidise Meals on Wheels services for people who are at risk of malnutrition, at risk of hospitalisation or in need of nutritional support following a hospital stay.

Recommendation 3:
That older people at risk of malnutrition can directly access Commonwealth government-subsidised Meals on Wheels services, without the requirement for a preliminary eligibility and need assessment to be completed by My Aged Care.

Recommendation 4:
That an evidence-based intervention pathway is established to support nutrition outcomes for older consumers identified as at risk of malnutrition by My Aged Care.

Recommendation 5:
That the impact of competitive tendering on Meals on Wheels, particularly on small and rural and remote services, is evaluated prior to any changes to the allocation of funds under the Commonwealth Home Support Programme.

Recommendation 6:
That the implementation of a wellness approach within the Commonwealth Home Support Programme incorporates improved access to dietitian support for Meals on Wheels services and their clients.

THE IMPACT OF REDUCED COMMONWEALTH FUNDING FOR HEALTH PROMOTION, PREVENTION AND EARLY INTERVENTION

Meals on Wheels contributes significantly to prevention and early intervention of malnutrition in older Australians residing within the community. This directly benefits the health system by preventing hospitalisation, reducing the length of hospital stays, and promoting early discharge[4]. Yet Meals on Wheels is characterised as a long-term, community aged care service, rather than as a preventive health measure, and

receives no Commonwealth funding specifically in support of this critical public health objective.

Poor nutritional health is a silent public health issue affecting many older Australians. Australian research has identified that when body weight and nutritional status are accurately measured, the risk of malnutrition in the elderly population can be 30 to 43%[1,3,5]. That is, around 1 million older Australians may not be receiving adequate nutrition.

The University of Wollongong has identified that this is rarely due to "a lack of foods in the home, but rather an inability or desire to prepare meals for themselves"[2]. Furthermore, those older people who are most at risk are unlikely to recognise their need for more nourishing meals[2], with only about 60% of those people classified as under-nourished seeking services from Meals on Wheels[3].

Poorly nourished older Australians do not enjoy active, healthy and independent lives that enable them to participate fully in our society. Malnutrition in older people leads to poor outcomes including reduced quality of life, poorer health, increased general practitioner visits, more frequent Emergency Department presentations, frequent and longer hospital admissions (particularly due to falls injuries), increased risk of infection and greater antibiotic use, longer recovery time from surgery and illness, greater likelihood of premature admission to residential aged care and a 30% increase in the incidence of mortality within 1 year[1-3,5,7,8].

These identified poor outcomes are associated with high public health costs[1]. The cost of treating a poorly nourished older patient is 20% higher than the average for the respective diagnostic-related group[2]. In Australia, in 2010, Access Economics estimated the annual cost to the health system of under-nutrition in 40,000 community dwelling people aged 70 years and above at $158.2 million[1]. This comprised the costs of hospitalisation and bed days in excess of a 14 day admission, along with the costs of treating fractures resulting from falls. Assuming 8% per annum increase in health care costs, this figure would be around $200 million in 2014. In addition, the estimated cost of residential aged care admission attributed to weight loss resulting from poor nutrition in the above population was estimated at $1.6 billion in 2010[1]. Studies from the UK present a similar picture, where malnutrition in the elderly costs £5 billion for direct health care costs and £13 billion for associated health and social care expenditure[8], more than the cost of treating obesity-related conditions[2].

Malnutrition in the elderly is both preventable and treatable.

It is not a natural consequence of older age[8]. Effective interventions to improve nutrition have significant potential to save costs to the healthcare system[1]. Australian analyses indicate that every $1 spent on improving nutrition in the elderly can save $5 in health care costs[5].

Meals on Wheels plays a crucial role in supporting healthy ageing and independence of older Australians. It is estimated that around 5% of the community residing population aged 70 years and above receives support from Meals on Wheels[1], increasing to around 14% of people aged 85 years and over[7].

Besides providing nutrition and food security for people unable to prepare or shop for meals, and valuable brief social interactions[9], Meals on Wheels services are an essential component of the health system, contributing significant cost savings[4].

A review of Commonwealth Home and Community Care (HACC) meal services in 2013 established that there was an evidence base supporting the impact of home delivered meals on preventing nutritional deficiencies[7]. Australian Meals on Wheels services generally aim to provide at least one third of the daily nutritional requirements of older people in each meal supplied. Analysis of Meals on Wheels menus across Queensland and South Australia showed that most meals contain around 40% of daily energy and protein requirements.

A pilot study in South Australia found that under-nourished individuals who received Meals on Wheels had better health outcomes after 12 months than those who did not receive Meals on Wheels. In particular, they were less likely to be admitted and spent fewer days in hospital, and there was a trend towards having less falls[3].

Access Economics estimated that providing a meal that contained 60% of the daily energy and protein requirements to existing Meals on Wheels clients who were identified as poorly nourished on commencement of services, would create a net present value of savings to the Australian health system of more than $463 million over 10 years. This figure considered only the benefit to the proportion of the current Meals on Wheels client population who are estimated to be at risk of malnutrition on entry to services[1].

In the UK, hospital admissions through malnutrition increased by 217% when provision of community meals decreased over the 5-year period 2003-2008[4]. Social return on investment (SROI) evaluations of community meals services demonstrated a positive impact on preventing malnutrition, maintaining independence and preventing isolation. Analysis showed that every £1 invested leads to a SROI of between £3.00 and £5.30[8]. Higher SROI results occurred for regular delivery of hot, compared with frozen, meal services as the former model of service incorporates regular social interaction between volunteers and clients, along with monitoring of the clients' wellbeing. It has been estimated that in the UK an increase in government funding of just over £5 million per annum for Meals on Wheels services would support 10% of the older population to remain in their own homes and by 2020 would save £1.7 billion each year, even taking into account the projected cost of domiciliary care in 2020[8].

In the United States, it has been found that for every $25 per year per older adult above the national average that states spend on home-delivered meals, they could reduce their percentage of low-care nursing home residents compared to the national average by 1 percentage point, after adjusting for several other factors[6].

The impact of Meals on Wheels services on reducing social isolation and providing low level monitoring of clients' wellbeing is well recognised[7-9], though there is limited data to support the financial benefits to the health system of these outcomes. There is a link between social isolation and poor nutritional status, with loneliness contributing to poor nutrient intake[7]. It is estimated that more than 750,000 older Australians are socially isolated.

Up to 75% of Meals on Wheels recipients live alone, with a significant proportion of clients reporting that the social contact and monitoring function offered by Meals on Wheels is equally or more important than the meal itself[7]. The engagement of volunteers to undertake much of the work of Meals on Wheels provides further social benefits by supporting the health and wellbeing of those volunteers, who are generally around 65 years of age.

Australian and international evidence clearly demonstrates the benefits of Meals on Wheels services in reducing health expenditures. Yet, in Australia, the service is considered part of the aged and community care system, rather than the health system. This definition of Meals on Wheels, for policy and funding purposes, is short sighted, particularly in light of reforms to the aged care system and the potential impact on Meals on Wheels discussed below.

Recommendation 1:
That the Commonwealth government recognises the benefits of Meals on Wheels as an essential health service in the prevention and treatment of poor nutrition in older Australians, and ensures that it is funded and supported accordingly.

THE INTERACTION BETWEEN ELEMENTS OF THE HEALTH SYSTEM, INCLUDING BETWEEN AGED CARE AND HEALTH CARE

In Australia, Meals on Wheels services receive a low level of Commonwealth Government funding via the Home and Community Care (HACC) Program, now administered by the Department of Social Services (DSS). The level of funding varies within and across jurisdictions[7], from as little as $2 per meal to as much as $10 per meal. Australian Meals on Wheels Association data suggests that the majority of providers receive less than $3 per meal in Commonwealth government subsidies, which is less than 25% of the full cost of delivering the service. The remainder of operating costs are recovered via client fee payments, modest fundraising efforts and, in some states, local government contributions.

The positioning of Meals on Wheels services within the Commonwealth aged care system is problematic.

It has led to a lower than CPI level of indexation on the level of subsidy, year on year, for decades and does not keep pace with the increasing cost of food, utilities and fuel. The current funding model constrains development of more nutritionally dense products for poorly nourished clients and neglects to address the significant variation in costs arising from providing culturally specific meal services and services to indigenous communities or in rural and remote locations[7].

From July 2015, Commonwealth funding support for Meals on Wheels will be via the Commonwealth Home Support Programme (CHSP). This new Programme is currently being designed and the Australian Meals on Wheels Association has expressed several concerns to the DSS. In particular, a significant change in the way older people can access and be deemed eligible to receive Meals on Wheels services may compromise the role of Meals on Wheels in preventive health, hospital avoidance and early discharge services.

It has been proposed that access to and assessment for Commonwealth-subsidised CHSP services from July 2015 will only occur via the My Aged Care ‘gateway’. The Australian Meals on Wheels Association is concerned that this process may increase the likelihood of hospital admission for conditions related to poor nutrition and prolong the recovery of poorly nourished older people following hospitalisation.

There is a need for maintaining and improving referral systems between general practice, hospitals and Meals on Wheels services that avoid the delays frequently

experienced by patients awaiting assessment for Home Care Packages, residential or transition care. My Aged Care will retain responsibility for assessing clients for these services, with the added responsibility of determining eligibility for the CHSP. Waiting times for eligibility assessments may delay access to delivered meal services during the critical period of recovery.

Currently, Meals on Wheels typically starts delivering meals to new clients within 1 – 2 business days of referral and, very often, well-established processes enable meal delivery on the day of discharge from hospital. When a similar aged care 'gateway' model commenced operation in Western Australia in 2011, waiting times of more than 2 weeks for an eligibility assessment were the norm, and significant numbers of poorly nourished older people were directed away from inexpensive and evidence-based Meals on Wheels services to unregulated, private frozen meal suppliers.

The ability of telephone call centre operators to identify people at risk of malnutrition is also of concern. Identifying risk of malnutrition at the earliest opportunity is vital to supporting clients with specific strategies to improve their health status and maintain independence at home[5]. The Dietitians Association of Australia and the Australian Association of Gerontology have advocated for incorporation of a short, validated nutrition screen within the MBS-funded 75+ Health Assessment[2]. The DSS has indicated that the My Aged Care eligibility screening process will include questions that identify nutritional risk, however the exact nature and content of this assessment is not yet known.

Research shows[2] and Australian Meals on Wheels Association members know from experience, that clients' self-reported nutritional status is frequently over-stated, and only becomes apparent following the development of relationships and regular monitoring by Meals on Wheels volunteers. There is the potential that a great many of the 40% poorly nourished older Australians will not be identified by My Aged Care. A general practice referral to Meals on Wheels following identification of poor nutritional status is not guaranteed to be deemed eligible by My Aged Care, or referred to Meals on Wheels if eligibility criteria are met.

Consumers who are concerned about their own health, particularly nutrition, may not identify that the pathway to delivered meal services is via the aged care system, and some may actively reject support that is framed as aged care rather than health care.

For those whose needs are identified by My Aged Care, there is a need for an evidence-based intervention pathway to assist to improve the nutrition outcomes for these people. If client needs are conceptualised and assessed within an aged care paradigm, rather than a health paradigm, and assessors lack understanding about the benefits of evidence-based and nutritionally balanced Meals on Wheels services, when compared to private, non-subsidised options, older people who are identified as at risk of malnutrition may be deflected to inappropriate and ineffective treatment options. This will only be compounded by the limitations of a My Aged Care service database that relies on search optimisation to ensure that Meals on Wheels is even suggested as a support option to consumers.

Recommendation 2:
That a primary health funding mechanism, separate from the Commonwealth Home Support Programme, is found to subsidise Meals on Wheels services for people who are at risk of malnutrition, at risk of hospitalisation or in need of nutritional support following a hospital stay.

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The inclusion of Meals on Wheels within the aged care system, with its current policy focus on applying market economics and competitive tendering processes, may lead to some highly undesirable health outcomes.

Meal services in the United Kingdom were subject to tendering processes in the early 2000's. The largely voluntary management committees were ill prepared to respond to complex tendering processes. The subsequent allocation of contracts to large, multinational corporations resulted in many unintended and regrettable social and economic consequences, including an increase in hospitalisations linked to poor nutrition and an increase in the number of socially isolated and chronically lonely older people in the UK[4]. Those regions that have sought to reinstate the Meals on Wheels model of service have been challenged to do so as the pre-existing volunteer workforce was disenfranchised through the tendering process.

Recommendation 5:
That the impact of competitive tendering on Meals on Wheels, particularly on small and rural and remote services, is evaluated prior to any changes to the allocation of funds under the Commonwealth Home Support Programme.

IMPROVEMENTS IN THE PROVISION OF HEALTH SERVICES, INCLUDING INDIGENOUS HEALTH AND RURAL HEALTH

Meals on Wheels services work closely with dietitians to ensure the highest possible nutritional values in meals supplied to our clients. Dietitians assist with food service and menu development and review, however this is inadequately resourced within current HACC subsidy payments. The Review of HACC Meal Services[7] identified that, across all jurisdictions, there is extremely limited access to HACC-funded dietitians for menu development or assessment of clients at risk of malnutrition.

Recommendation 6:
That the implementation of a wellness approach within the Commonwealth Home Support Programme incorporates improved access to dietitian support for Meals on Wheels services and their clients.

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