

Wednesday, 26 May 2010

Ms Christine McDonald  
Committee Secretary  
Senate Standing Committee on Finance and Public Administration  
Email: fpa.sen@aph.gov.au

Dear Ms McDonald,

**National Primary Health Care Partnership submission to the Senate Committee  
Inquiry into the Council of Australian Governments reforms relating to health and  
hospitals**

The Australian population over 25 years of age have a diabetes prevalence of 7.6%. An estimated 275 Australian adults are diagnosed with diabetes each day. The incidence of diabetes continues to increase. In 2005, an estimated 700,000 Australians (3.6% of the population) had been diagnosed with diabetes. This was more than double the Australians diagnosed with diabetes in 1990 (1.3% of the population). Diabetes is a chronic lifelong condition. Poorly managed diabetes leads to debilitating complications such as blindness, renal failure, cardiovascular disease and lower limb amputation. The annual cost of care for type 2 diabetes alone exceeds \$3 billion. In recognition of the high personal cost of diabetes, its cost to the health care system and the potential to intervene, diabetes was included as Australia's fifth National Health Priority area in 1997. Therefore, the Australian Diabetes Educators Association (ADEA) welcomes any initiative that commits funding to providing best practice care and management for people living with diabetes.

ADEA is the peak diabetes health professional body in Australia representing a national perspective on diabetes self-management education and care. ADEA welcomes to opportunity to elaborate on the impact of current health funding arrangements on clinical service delivery for people living with diabetes, and how the lack of clarity around national funding and regional coordination arrangements may perpetuate long standing access problems rather than provide the intended improvement.

Funding arrangements and responsibility and authority for primary health care services [Terms of reference (a), (b) and (e)]

Currently diabetes self-management education and associated clinical care is provided by diabetes educators in tertiary and primary care settings. Credentialed Diabetes Educators work across this continuum of care providing services in the inpatient acute care setting, in the ambulatory care setting (for example at hospital outpatient clinics), in community health services, and elsewhere in the community (for example Super Clinics, GP+ Clinics). This can occur as employees of these services or as independent practitioners.

ADEA is aware of cost-shifting between acute and community sectors for the provision of diabetes self-management education services in the present environment. For example, in New South Wales (NSW) there has been a decrease in the hours and positions for Credentialed Diabetes Educators employed to provide services to inpatient and outpatients in some public sector hospitals. The rationale for this change consistently provided by hospital managers to staff, who have been retrenched or re-deployed into other roles, is that Medicare will fund access to diabetes self-management education in the community

through the Chronic Disease Management (CDM) items and therefore continuing access in the tertiary sector is “duplicating” service delivery. This is clearly an erroneous assumption as rebate for individual’s accessing CDM items is limited to a total five allied health consultations per year, not five consultations with the Credentialed Diabetes Educator.

Firstly, hospital inpatients require diabetes self-management education and care as part of a safe discharge plan to return home. Not providing this support to diabetes inpatients risks increased readmission rates. Errors in self-care are far more likely following discharge due to the patient not understanding the medication and diabetes management changes made during hospitalisation.

Secondly, diabetes education individual and group programs at Community Health Centres frequently have extensive waiting lists due to growing community demands. In addition, Medicare group services items for credentialed diabetes educators, dietitians and exercise physiologists are frequently not an appropriate consultation method when providing diabetes services due to the often sensitive and delicate nature of addressing common problems experience by people with diabetes, for example female sexual dysfunction and male impotence. Furthermore, group services disadvantage access to services for people with diabetes from culturally and linguistically diverse (CALD) backgrounds and are not available at all for people with type 1 diabetes.

Thirdly, Medicare will currently support only five consultations with allied health care professionals in total per year for those people who meet the Chronic Disease Management framework criteria. People with diabetes need access to multidisciplinary care, including podiatry, dietetics and frequently physiotherapy, leaving limited or no access to diabetes self-management education provided by a credentialed diabetes educator under the CDM framework.

Diabetes education and management support must be tailored to the individual person’s needs and be accessible and available across the continuum of life and diabetes stage in both the acute and primary care setting, not potentially further diminished. This is an especially flawed approach in the face of the current diabetes epidemic. Research supports a multilayered approach to diabetes service delivery that promotes better service access in all settings, and the ability to engage all people living with chronic conditions. To do otherwise, results in more people falling through “the cracks” between services, leading to increased presentations to tertiary services once diabetes complications are well established, which adds to, not reduces the long term costs of managing the condition.

The lack of clarity, regarding accountability for services between Primary Health Care Organisations and state governments, and how services will be planned and coordinated across a region, leaves the door open to exacerbating the current problems of cost-shifting and decreasing access to diabetes care.

ADEA appreciates the opportunity to provide this response and looks forward to providing further input into decision-making processes.

Sincerely,

Clair Matthews

Executive Director

Australian Diabetes Educators Association