EDITORIAL

Can we afford intensive management of diabetes?

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The Commonwealth budget for 2001–02 included financial incentives for general practitioners to provide systematic care to their patients with diabetes. This initiative is likely to increase the number of consultations with general practitioners, specialists and allied health professionals, and the number of drugs used and tests ordered. The annual cost to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme of treating patients with diabetes will increase. This expenditure will be in addition to the funds allocated through the budget initiative. Furthermore, the number of patients being treated will continue to increase as the prevalence rises and we become better at detecting previously unrecognised cases. In Australia, in 2000, 770 000 people had diabetes. The direct annual healthcare costs of diabetes in 1995 were $1.4 billion[1] (approximately $1800 per patient).

With both the number of cases and the costs of care increasing, there will be increased pressure in the health system and on individual general practitioners to provide more intensive care to more diabetic patients. What is not clear is how this change in competing priorities for limited resources will unfold. For example, will there be more patients on waiting lists for specialists and allied health services, will other patients be displaced, or will more funds be put into these areas?

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Medical advances will continue to increase expenditure on health care, but will we be able to afford 'best practice'? Brita Pekarsky and Ben Ewald say that the intensive treatment of diabetes may require the diversion of resources from other areas. Should we therefore limit the funding for Robyn Guymer's treatment of macular degeneration, or Stephen Clarke and Laurent Rivory's chemotherapy for colorectal cancer?

Information about how the funding for drugs is decided is currently secret. However, Lloyd Sansom is hoping to increase the transparency of the decision-making process of the Pharmaceutical Benefits Advisory Committee.

Transparency is also needed when informing patients about the risks of treatment. In the first of a series of articles on risk John McPhee focuses on the legal view of risk.

Some idea of the costs of treating a patient with diabetes can be gleaned from the Australian Co-ordinated Care Trials (1997–2000). These trials included a total of 1654 patients with diabetes recorded as the primary diagnosis. Although these patients represented 15% of the intervention group there was no analysis of the effect of co-ordinated care on their health. Using the data from 10 of these trials, the annual costs per patient for Medicare and PBS services varied across trials from $1900 to $3200.[2] These costs are indicative of those associated with best practice care for older patients with diabetes. More intensive monitoring has significant cost implications, as it will often lead to more intensive treatment of blood glucose, lipids and blood pressure.

The National Diabetes Strategy states that the UK Prospective Diabetes Study (UKPDS) provides evidence that intensive treatment significantly improves clinical outcomes and reduces diabetes-related complications. However, UKPDS showed that the benefits of intensive treatment of blood pressure are at least as great as the benefits of intensive treatment of blood glucose. Approximately six patients need to be treated intensively for blood pressure over 10 years to prevent one patient developing any complication, and 15 need treatment to prevent one diabetes-related death.[3] In contrast, only one case of microvascular disease (mostly retinopathy) was prevented for every 196 patients treated with intensive glucose control for 10 years. Reductions in macrovascular complications or death did not reach statistical significance.[4]

Increased intensive management of diabetes will increase the workload of general practice in differing ways across the country. In a region where there is a high ratio of general practitioners to patients, the additional work may be easily absorbed. However, in an area where there is a low ratio of general practitioners to patients, the increased demands will only be accommodated by displacement of other care provided by the general practitioner, or diversion of this workload to other staff. If a general practitioner sees fewer patients with coughs and colds, this may in fact be a desirable outcome, however if it is at the expense of other important services then any health gain in diabetes may be offset by losses in other areas.

There are opportunities to reduce both the impact on the general practitioner's workload and the costs to the practice of providing systematic care. These include using diabetes educators and practice nurses, and better information

management and decision support software. The budget initiative has the potential to improve the flexibility of funding, allowing practices greater scope in deciding how diabetes care is provided.

The additional costs of more intensive monitoring may be justified by future savings from a reduced need for hospitalisations to treat the complications of diabetes. The UKPDS included cost-effectiveness analyses for intensive blood glucose and blood pressure management. In both cases, more intensive management was found to be cost saving in the trial setting. It was expected to have additional costs, but still to be cost-effective in a community setting.[5,6] Whether the additional costs of more intensive management for a number of conditions would be considered to be cost-effective is unclear. The pharmaceutical and diagnostic test costs of each condition managed intensively are clearly additive, but the health benefits may not be. Furthermore, the UK results may not be generalisable to Australia.

The Australian example most frequently cited in the co-ordinated care trials was the patient who could not access cheap podiatry services, but then required an expensive hospital admission for the treatment of 'diabetic foot'.[2] The fund-holding model in the trials was intended to provide funding for the additional podiatry services which would be offset by the savings from reduced hospitalisation for complications. The evidence of either reduced hospital admissions or the subsequent savings was not apparent from the trials, partly because of their short duration and partly because improved care was more expensive. Despite up to 60% of all patients in some trials having diabetes, any impact on their health within the two-year period was not sufficient to generate the intended savings.

The only certain and immediate consequence of more intensive management of diabetes is increased pressure on the resources of both general practitioners and the broader healthcare system. Any health benefits for patients may not be for some years. General practitioners may be consistently referring patients to podiatrists, diabetes educators and ophthalmologists, but are these services available in all regions to low income patients? Will preventive advice on lifestyle changes be provided to patients at risk? Will other patients with other needs find themselves less able to access care? If there are insufficient resources to provide intensive management to all patients with diabetes, there will be some patients who will miss out on some or all aspects of this care. It may be that these are the very patients who would benefit most from improved management, better access to allied health services and preventive advice.

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Transparency and the Pharmaceutical Benefits Advisory Committee

Professor Emeritus Lloyd Sansom AO, University of South Australia, Adelaide, and Chair, Pharmaceutical Benefits Advisory Committee

Comment on Professor M.J. Eadie's editorial 'The secrecy of drug regulatory information' (Aust Prescr 2002;25:78–9)

Recent debate about the sustainability of the Pharmaceutical Benefits Scheme (PBS) has again raised the issue of transparency of the decision-making processes of the Pharmaceutical Benefits Advisory Committee (PBAC). The excellent editorial by Professor Eadie entitled 'The secrecy of drug regulatory information' widens the debate about the release of information about drugs into the public domain.[1]

There is no question that the public has a right to know the basis on which decisions are made for the approval or rejection of a drug for marketing and subsidy. In order for those decisions to be able to be debated and discussed, full disclosure of information at the time the decisions are made is needed. Professor Eadie raises a number of critical issues which may be seen by some as barriers to such action. However, they should not be seen as insurmountable, but simply as issues which need to be addressed in the development of a strategy towards the timely disclosure of relevant information.

The PBAC is committed to the release of information regarding its decisions. This includes the reasons for both positive and negative recommendations and in addition the reasons why a