Australian government targets diabetes sufferers to cut health costs

John Mackay
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Nearly three months ago, as part of its cost-cutting health "reform" agenda, the Australian government announced a plan to shift diabetes patients onto a "managed care" system. There are concerns among doctors that diabetes sufferers are being made a test case for a new scheme to ration access to medical care.

In effect, Prime Minister Kevin Rudd's diabetes plan is a trial for broader steps to erode the 35-year-old Medicare public insurance system, under which patients are meant to be able to see General Practitioners (GPs) without charge, and with no limit on the number of visits. By signing up to "personalised care plans" with GPs, however, diabetes patients will only receive care within a capped annual budget.

This "primary care" model dovetails with the Rudd government's hospital plan, which seeks to curtail long-term health spending by funding for public hospitals according to benchmark prices for the number of specific procedures they perform. Known as "casemix," the funding mechanism places pressure on hospitals to push patients through their wards as quickly as possible.

Likewise, under the diabetes scheme, GPs will be paid pre-determined annual amounts for each patient who enrols with them: $950 to handle all their consultations, and $250 to be spent on care by allied health workers, such as physiotherapists and dieticians. These amounts will be inadequate to cover complex diabetes conditions. Diabetes is a leading cause of blindness and a common cause of serious kidney failure, as well as an important contributor to cardiovascular complications, feet damage, lack of mobility, pain and discomfort, and higher levels of anxiety and depression.

GP clinics will also receive bonuses for meeting various performance indicators, with the aim of keeping patients out of hospitals. Thus doctors will have a financial incentive to help cut spending on costly hospital beds, equipment and procedures. Both aspects of the diabetes plan—capped payments and performance bonuses—are likely to lead to treatment being determined by cost considerations rather than clinical need.

A concerned GP told the WSWS that diabetes was a complex, chronic and socially-rooted condition that meant it could not be approached by using crude "key performance indicators". He expressed fears that he would be forced abandon his "difficult" patients to public hospital clinics "as then I won't have 'treatment failures' on my books and hence be financially penalised".

The GP explained that the main proposed performance measure that will determine doctors' bonuses is called the HbA1c—a blood test that reflects the average blood glucose level over a period of three months or more. There is controversy over requiring doctors to lower that reading to a set level. "A large international clinical trial showed that there was actually an increase in deaths when people were actively treated with medications (tablets and or insulin) to achieve a low level."

The doctor added: "I don't have the ability to control the HbA1c in individual patients. I can recommend changes in diet and increases in physical exercise and prescribe tablets/insulin but I have no control as to what the individual patient actually does outside of my consulting room." He emphasised that diabetes "is a social disease and hence the approach is an economic one and a whole of society one".

Diabetes is the fastest growing disease in the developed countries. Its three primary social determinants are rooted in contemporary capitalism: poverty, food industry profits and unequal access to decent health care. It is also a disease of social inequality. While prevalence rates are generally higher in wealthier countries, they are associated with low socio-economic status within those countries.

The World Health Organisation (WHO) has estimated that the number of people worldwide with diabetes increased from 30 million to 171 million between 1985 and 2000. By 2030 the number is expected to double to 366 million, with the prevalence rate among adults reaching 6.4 percent. There is evidence that rates of diabetes are rising more quickly. A study

published in the *Lancet* medical journal in 2007 demonstrated that the prevalence in Ontario, Canada was expected to reach the predicted 2030 levels by this year.

The increase is mainly attributed to Type 2 diabetes, which is strongly linked to rising rates of obesity and an overall increase in life expectancy in wealthy countries. Around 90 percent of diabetes cases are estimated to be Type 2, rather than Type 1, which mostly begins in childhood, or gestational diabetes, which typically manifests itself during pregnancy.

Over the past 20 years, there have been sharp rises in obesity rates. According to the WHO, more than 1 billion adults are overweight and at least 300 million of them are clinically obese. Both obesity and Type 2 diabetes can be delayed or prevented in the majority of cases by adopting a healthy and active lifestyle, which includes regular exercise and a healthy diet. But they follow similar socio-economic patterns, with the highest rates among groups with the lowest levels of income and education. One authority, Dr Adam Drewnowski of the University of Washington, stated in a 2002 paper that "obesity is the toxic consequence of economic insecurity and a failing economic environment".

Inequitable access to healthy foods is one factor. As income decreases, energy-dense but nutrient-poor foods (rich in fat and sugar) are more easily affordable sources of daily calories. Refined grains, added sugars and added fats are among the lowest-cost sources of dietary energy, whereas the more nutrient-dense lean meats, fish, fresh vegetables and fruit generally cost more. Energy-dense diets may also result in passive overeating because they are less effective in providing a feeling of "fullness" following eating.

While the standard dietary advice is to replace fats and sugars with fruit, vegetables, whole grains, poultry and fish, this is difficult to achieve for low-income families. If a family of four has only $100 per week to spend on food, that amounts to less than $4 per person per day. A study of Food Stamp Program users in the United States reported that price was the most important consideration in making food choices, along with ensuring that no one would complain they were still hungry. Currently in the US, one in nine people rely on food stamps, while one in 50—some six million—have no income other than $100 or $200 a month in food stamps.

The lowering of prices for foods containing added sugars and fats has been bound up with technological advances in production. A 2006 US study estimated that the energy costs of fresh produce were 10 times higher than foods containing processed vegetable oils and sugars. The decreases in production costs of the latter have led to greater profitability.

In 2004 the WHO recommended tighter regulation of advertising for fast foods and soft drinks, particularly for children. The US and other sugar-producing countries opposed the release of the report. Any serious attempt to constrain global food marketing has been met with opposition from forces supported by multinational food corporations.

Adding to the impact of diabetes are income-based inequalities in access to health care. A recent Canadian study observed an overall decrease in mortality due to diabetes from 1994 to 2005 among those with higher incomes. Poorer sections of the community, however, did benefit from the advances in diabetic care. The study showed that income-related differences were less in those aged over 65, for whom drug costs are subsidised, compared to younger age groups who do not have the same subsidies.

Over recent years, more intensive diabetes treatments are thought to be responsible for better survival rates. There have been improvements also in treating the chronic aspects of diabetes such as cardiovascular disease. However, the complexity and cost of the treatments has markedly increased, along with the proportion of diabetes patients who cannot afford their medications. In addition, preventative screening for diabetes is not widely implemented due to cost, even though people with initial symptoms can be identified and offered early treatment.

The Rudd government's scheme is not designed to address these underlying causes of the diabetes epidemic. Instead, like other governments internationally, the Labor government is moving to implement the demands of business and the financial markets to cut social spending, including through the rationing of health care.