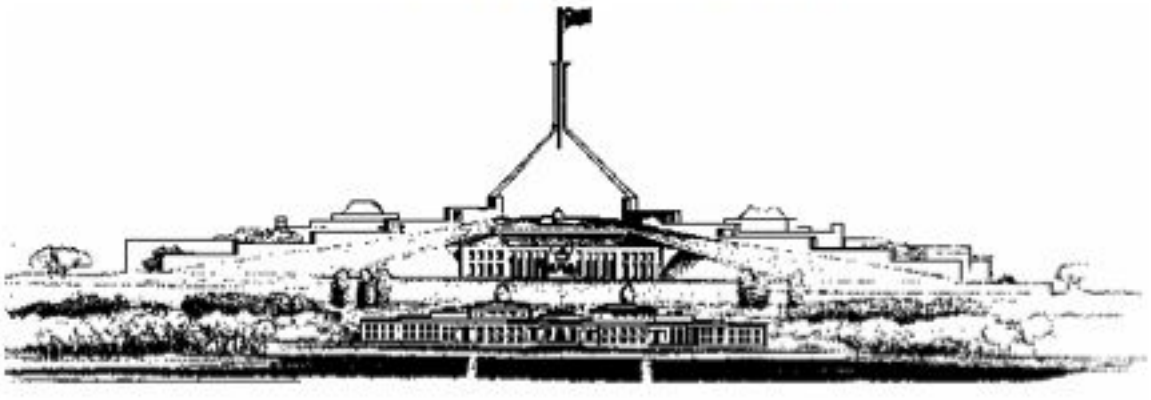
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



THE SENATE

PROOF

BILLS

Social Security Amendment (Diabetes Support) Bill 2016

Second Reading

SPEECH

Thursday, 17 March 2016

BY AUTHORITY OF THE SENATE

SPEECH

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Questioner		**Responder**	
Speaker	Fawcett, Sen David	**Question No.**	

Senator FAWCETT (South Australia—Deputy Government Whip in the Senate) (10:12): I rise to make a contribution on Senator Muir's bill on diabetes—the Social Security Amendment (Diabetes Support) Bill 2016—and the topic of concession cards. I would like to talk a little bit about diabetes up-front—particularly for South Australia because it is a significant burden for individuals there. We actually have the highest rate of diabetes in Australia. I would also like to talk a little bit about the current process of how the government provides support to people who are suffering with diabetes. Lastly, I will talk a little about concession cards.

The framework of my points on this is that concession cards are something that the government targets to people on the basis of means and not on the basis of a condition. We have traditionally provided support for people with a medical condition to make those treatments affordable and sustainable. There are areas in that where I concur with Senator Muir that there are perhaps improvements to be made, but I would argue that it is within the established system that we need to extend those improvements, rather than crossing purposes, if you like, with a system that is designed to support people on the basis of income as opposed to their condition.

As I said, South Australia has the highest prevalence of diabetes of all Australian states and territories. The last quantitative report, of 30 June 2015, showed that 1.17 million Australians, some 4.9 per cent of the population, suffer with diabetes. In South Australia that rate is at 5.8 per cent, which means that over 98,000 people in South Australia are suffering with diabetes. The rate of diagnosis is estimated to be around 600 people every month in South Australia. That is approximately 20 people every day in South Australia who are diagnosed with diabetes.

It is Australia's fastest-growing chronic condition and it leads to quite serious complications, the consequences of which can include heart attacks, stroke, blindness, kidney damage and foot ulcers that in far too many cases lead to amputation. So it is a serious issue that we need to understand and manage and then, where we cannot manage pre-emptively and help people to avoid it—as Senator Muir has pointed out, type 1 is not necessarily something that you can avoid—then we need to make sure that people can adequately obtain the services, medications and items they need to live with the condition.

Part of managing and understanding is actually monitoring and looking at trends. According to the Australian Institute of Health and Welfare there is actually no measurement data for monitoring trends in diabetes prevalence at the moment. There is a great deal based on self report, but even the self-reporting has doubled from around 1½ per cent in the early 1990s to around 4.2 per cent in 2011-12. As I said, now the national rate is some 4.9 per cent.

There are a few reasons for that. One is that with an increased awareness of diabetes, people are seeking diagnosis and then reporting for that. Also, with increased and improved management people are living longer and therefore there is a greater period where people who have diabetes are part of the population. But that does not mask the fact that this is, across both type 1 and type 2 diabetes, a growing problem in Australia that we do need to manage.

We need to manage it from two perspectives. Clearly, one is the impact on the individual and their family. As Senator Muir has pointed out—particularly from the letters from constituents that he has received—it does have a significant impact on the individual's lifestyle and on their family or carers. This is particularly where we see the incidence of things like overnight monitoring. We have had a young lady, tragically, pass away in Australia just recently because of the fact that her blood sugars dropped dramatically overnight and that was not picked up. So it does have a significant impact on people's lifestyles.

The other aspect that we need to address, though, is that the consequential costs to Australian society and to our economy are large in terms of the treatment that is required. In some cases—for example, post-amputation, if people lose a foot or more due to diabetes—the ongoing rehabilitation and care, prostheses and other services for those people are dramatic costs that our country can ill afford. So there are a couple of significant reasons why we should seek to manage and provide support for diabetes in the best possible way.

The other point I just want to raise on this is that if we look at diabetes as a whole, our Indigenous population actually has a substantially higher rate of diabetes than other Australians. If you look at the hospitalisation rates for both diabetes and renal diseases, it is some eight times higher for Indigenous people than for other Australians. And so this is something that we need to be very proactive about in our preventative and management work for people in those communities.

In South Australia, for example, one of the measures that the South Australian health department reports is that over a five-year period there were some 63,300 hospitalisations as a result of diabetes. Type 2 was the principal secondary diagnosis in many, but there were also 12,671 hospitalisations with type 1 diabetes being listed as the principal secondary diagnosis. Mortality attributed to diabetes has not changed significantly but it is a significant number, with an average of 280 deaths reported—106 of these over a five-year period attributed directly to type 2 diabetes and another 31 attributed to type 1 diabetes. A further 144 deaths were attributed to diabetes, but the records did not show whether it was for type 1 or type 2. Clearly, there is a significant impact on people and their families through this disease.

So what does the government do at the moment? I come here specifically to type 1 diabetes. Under the Pharmaceutical Benefits Scheme we supply and support subsidised medicines. We also supply diabetes products through the National Diabetes Services Scheme, or the NDSS. Over the past five years there has been $1 billion supplied by the government into the NDSS to meet these support needs.

In 2014-15, expenditure on medicines for diabetes through the PBS was $526 million. That was for things such as insulin. Expenditure on products supplied through the NDSS was $185 million. That is on top of the $35 million that was provided to the Juvenile Diabetes Research Foundation—the Australian Type 1 Diabetes Clinical Research Network—to help find a cure and to provide support and education for people suffering from this.

So the current agreement for the National Diabetes Services Scheme has been running since 1987. As I said, over the last five years that has had approximately $1 billion. That agreement is coming to an end during this year. That does not mean the funding is coming to an end; it means the agreement for the current service provision is. One of the changes that we are looking at there, which I think needs to be accelerated, is just like under the PBS, where providers can come to the government and say, 'We have a product that we wish to see listed,' and there is an independent body which assesses the efficacy of that product and the difference it will make in people's lives. I think we need the same kind of system in the diabetes space so that where we see, particularly, young people who have that very intensive daily routine, and there are certain technologies that can help them to manage that more proactively, that people could put forward their case to an independent body and say, 'This is why an investment in this technology, subsidised and provided to sufferers of type 1 diabetes, will be a saving to the government in the long run'. We could see that kind of support provided.

I come back again, Senator Muir, to the point that the way our system works is that we provide support through these kinds of schemes to people with a condition, as opposed to giving them a card for the condition. As we look at renewing the agreement the funding will continue; it is an uncapped scheme. I think it is important to note that it is uncapped funding for the NDSS. But as we change the agreement we need to look at that opportunity and ask, 'What are the other measures, technologies, services or support that would deliver long-term savings that we can bring into this scheme?'

The scheme is available to anyone who is a resident of Australia and has been diagnosed with diabetes. It is free and the products that are subsidised currently includes syringes and needles, blood glucose test strips, urine ketone test strips, insulin pump consumables et cetera. All of these are designed to help people to self-manage their condition in an affordable manner. There are also new services being developed through the National Development Programs which are targeted priority areas such as Indigenous health. I would like to see that independent body associated with the NDSS so that we can see the specific programs and products provided to people who need them.

The other program that is funded by the federal government is the Insulin Pump Program. That provides a means tested subsidy for insulin pumps and associated consumables for people under the age of 18 with type 1 diabetes. Again, the means testing in these programs is a way to address the concerns raised by Senator Muir, where those who can afford to pay for the service with some subsidy do so, but for those who do not have the means, the means testing is there so that this enhanced subsidy is available for them. The program is designed to increase the affordability of the insulin pumps for families, who do not have access to other means for reimbursement

such as private health insurance. Subsidies are available for families with an annual income of up to $101,000 and that is indexed each year. There is an attempt there to address the point Senator Muir was talking about in terms of making sure those on a lower incomes do have access to subsidised services.

It is an area where, again, if you look at the cost of not managing diabetes, perhaps that program and those subsidies should be enhanced and I would certainly support consideration of that. But I think that is the mechanism to do it rather than a concession card, which is not something we do in our current system. Concession cards are provided to people on the basis of their income not on the basis of a condition.

The framework within which we can take some of these conversations forward is the Australian National Diabetes Strategy, which is over the period of 2016 to 2020. That was launched in November last year. It is a strategy that aims to have goals and areas for actions that cross different levels of government. It is important to realise that this does cross levels of government. It also includes private practice, it includes research and it includes not-for-profit groups who provide training and support for people with diabetes. All of those efforts need to be keyed up for this to work well.

The Australian Health Ministers' Advisory Council has undertaken to develop an implementation plan for the strategy and, as always, strategies are not worth the paper they are written on if they just sit on a shelf. There needs to be an effective implementation plan that crosses all of those areas.

The Department of Health is also looking beyond diabetes to develop a National Strategic Framework for Chronic Conditions to update how we approach support for people suffering from chronic conditions in Australia. That was to provide an overarching policy framework for national and state based strategies. That will include disease specific strategies such as the Australian National Diabetes Strategy.

It is important that we do get alignment in terms of our approach to all chronic diseases because as bad as diabetes is it is only one of a number of diseases that are chronic and affect people long-term. We owe it to the people of Australia to provide the level of good governance that can see us working collaboratively not only on a bipartisan basis here but also across state and federal boundaries to make sure we have a coherent approach to providing affordable and effective care to people. To do that the cross-jurisdictional working group has been established, and that is officials from each state and territory and federal department. The key deliverable they have set for this year is the final implementation plan, which will identify short, medium and long-term goals.

Prevention is also important. Again, for type I diabetes specifically this is perhaps not as applicable, but the prevention and management of chronic conditions is important. The Primary Health Care Advisory Group is looking at ways to get better prevention and connection between primary health care and hospital care. The Medicare Schedule Benefits Review Taskforce is looking to consider how services can be aligned with contemporary clinical practice to improve health outcomes for patients. The National Strategic Framework For Chronic Conditions is being developed to give an overarching framework.

The kinds of areas where these reviews could be of benefit are, for example, the Podiatry Association have come to me in the past seeking support for some of the work that they are doing where they have looked at the fact that there are some 10,000 hospital admissions nationally due to diabetes related foot ulcerations and in excess of 4,300 amputations every year due to diabetes. Each of the amputations alone costs the Australian healthcare system some $26,700, not to mention the after-care costs in terms of rehabilitation, prostheses and support for the person who has lost one or more feet.

Best practice research by the podiatrists indicates that improving access to podiatry services for patients with foot complications from diabetes can prevent future hospitalisations and amputations, which would well and truly recoup the cost of the services of the diabetes compared to the costs of the amputation and the follow-up support. Cost savings in the implementation of best practice research were estimated in 2012 of being in the order of $397 million annually. Whilst the Medicare Benefits Schedule Review sounds like something that is just another process, one of the letters that Senator Muir referred to referred to a lady who said there are only five services available—one visit to the podiatrist a year. However, it is this kind of review that has the potential to look at the cost burden of not providing these services and to put in place affordable access for people for those allied health services they need to better manage their health condition so that not only does the individual stay healthier but the economy overall has a better outcome in terms of a lower cost of providing the preventive care.

Even with type 1 diabetes, there are consequential effects so that, if we are more proactive and effective in our preventative measures—whilst we cannot change the fact that people have type 1 diabetes—we can pre-emptively put in place measures that will improve the quality of life for the individual, improve the quality of life for those who are caring for them as well has having long-term positive outcomes for our economy.

The contribution I have made to this bill, Senator Muir, through you, Mr Acting Deputy President Williams, recognises the significant burden, as I say, in South Australia, where we are particularly affected in terms of not only our total population but also our Indigenous population. I support your call for affordable services for people to make sure they get the care that the need.

My contention is that the concession cards that the Commonwealth government gives out—such as the pensioner concession card, the health care concession card and the Commonwealth seniors health card—are more around people's financial positions as opposed to a specific condition. We already have schemes in place—whether it is the Medicare scheme and specific strategies such as the NDSS—to provide support to people with particular conditions. My advocacy has been in the past and continues to be that it is through those schemes and processes such as the Medicare Benefits Schedule Review that we need to be pushing for enhancements to see sufficient access to the right services that will make a difference to people—whether they are affected type 1, type 2 diabetes or other chronic conditions—that will not only improve their quality of life but from the taxpayers' and community's perspective deliver longer-term savings to the government.