Diabetes education

We are all aware that diabetes mellitus prevalence is rising, affecting around half a billion people worldwide (International Diabetes Federation, 2015) and approximately 5% of Australians (917 000 people; Australian Institute of Health and Welfare, 2012). Unfortunately, almost half of people with type 2 diabetes have glycaemic levels out of target range (Si et al, 2010), leading to increased rates of macro- and microvascular complications and early mortality (Holman et al, 2008), as well as increasing healthcare costs (Lee et al, 2013).

Diabetes education is pivotal in supporting effective diabetes self-management, and structured diabetes education supports self-management, having been shown to improve blood glucose levels, blood pressure, weight and lipid levels, as well as having a positive effect on blood glucose self-monitoring (Norris et al, 2001; 2002; Ellis et al, 2004; Minet et al, 2010). Despite the advantages of structured education, over 40% of Australians with diabetes do not have access to such programs (Deloittes Access Economics, 2014).

To provide an independent analysis of the cost effectiveness of diabetes education, the Australian Diabetes Educator Association (ADEA) commissioned Deloittes Access Economics (2014) to produce the report *Benefits of Credentialled Diabetes Educators to people with diabetes and Australia*. The report identified that for every $173 investment in diabetes education, there would be a return of $2827 per patient, per annum in healthcare cost savings. These cost savings were due to a reduction in frequency of hospital admission, emergency presentation, GP visits and treatment of related comorbidities. If diabetes education was made available to all Australians with diabetes, the total healthcare cost savings in 2014 would have been $3.9 billion and the lives of thousands of people with diabetes would have been improved.

Unfortunately, many private health insurance companies do not fund diabetes education services, and current Medicare funding includes diabetes education as part of the five annual team care arrangement visits, alongside podiatry, dietetics and other associated healthcare providers. This means that many Australians with diabetes either have to pay for sessions with a diabetes educator themselves or miss out entirely. Out-of-pocket costs for people with diabetes is one of the main barriers to accessing diabetes education (Deloittes Access Economics, 2014).

More is needed to support all Australians with diabetes accessing diabetes education. One way to do this is through private health insurers funding diabetes education. This would be feasible given that diabetes education is a relatively inexpensive cost compared to the healthcare costs incurred later on from sub-optimally managed diabetes (Deloittes Access Economics, 2014), such as the management of blindness, amputation, kidney failure and early mortality. Some therapies, which have less evidence for effectiveness compared to diabetes education, are currently reimbursed by private health insurance companies. Effective support of optimal diabetes management would lead to significant gains in the health of many people, as well as reduced health costs. Of course, private health insurance-funded diabetes education will only increase access to those who have private health insurance. Many people with the poorest diabetes outcomes are those of low socio-economic status and marginalised groups who are likely to not have private health insurance. In this issue, Mark Kennedy and Trisha Dunning provide the evidence for structured education and helpful guidance to encourage uptake (page 10). They highlight the importance of diabetes education in supporting people with diabetes to achieve optimal management of their diabetes while also highlighting the

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funding constraints that limit access for some people.

Also in this issue

This issue also includes a CPD module on peripheral arterial disease screening. Read the article on page 16 and then go to www.pcdsa.com.au/cpd to complete the 10-question module. After completing the module you will receive a certificate that can go towards your continued professional development. There is an additional article on page 25 on antimicrobial infection of foot ulcers in people with diabetes by Roy Rasalam, Caroline McIntosh and Aonghus O'Loughlin.

Ralph Audehm and Laura Dean provide a practical guidance on using and initiating glucagon-like peptide-1 analogues in people with type 2 diabetes (page 35), and there is an interesting, practical article on the role of a readily available, but under-used medication, fenofibrate, a cholesterol-lowering drug. This issue's From the Desktop is by Gary Kilov, who provides the practitioner, and patient, perspective on flash glucose monitoring on page 7. ■

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