Is Australia ready to use glycated haemoglobin for the diagnosis of diabetes?

To the Editor: I would like to add some detail to the article by Shaw and colleagues[1] on the costs of screening for diabetes and glycated haemoglobin (HbA_{1c}) testing. At face value, using the 85% Medicare Benefits Schedule (MBS) rebate, the item for HbA_{1c} testing costs $1.85 less than the item for a glucose tolerance test (more than 10% cheaper), but it is a little more complicated than these simple figures suggest. In 2010, 295 023 glucose tolerance tests (item number 66542) were claimed on the MBS — up 61% on the number ordered in 2004 (183 090)[2] — which reflects the increase in ordering by general practitioners, who I believe are more aware of the increased incidence and prevalence of one of the most common chronic diseases in Australia. I also believe that it reflects the use of the glucose tolerance test as the definitive test for diabetes (rather than relying on a single fasting glucose level) in private practice.

In contrast, 1 021 247 HbA_{1c} tests (item number 66551) were claimed in 2010, versus 911 623 in 2004 — up by only 12% over the same 7-year period.[2] This reflects "coning" of pathology items in the MBS. There are two types of cone that affect billing of HbA_{1c} tests: the "grand cone", which restricts billing to the three most expensive items ordered by a GP on a single occasion (regardless of the number of tests ordered), and the "temporal cone", where only four HbA_{1c} tests can be billed in any 1 year. The glucose tolerance test has no temporal restrictions and is usually performed on its own, so it avoids the grand cone, but the HbA_{1c} test is often ordered with a bank of other tests (eg, as part of diabetes monitoring) and is thus not usually billed to Medicare. In my practice, only 30% of reported HbA_{1c} tests can be billed to Medicare, hence the cost to Medicare per reportable test is about a third of the listed rebate of $14.40. Furthermore, as Shaw et al point out, HbA_{1c} testing cannot currently be billed for the diagnosis of diabetes, although my personal observation is that many doctors are already using this as a screening test.

There are essentially three powerful drivers for HbA_{1c} testing: the increased prevalence of diabetes, the (honest) push to test HbA_{1c} levels every 4 months (through care plans etc) and the use of HbA_{1c} tests to diagnose diabetes. I believe that Medicare currently pays for less than 40% of these tests and that this proportion will fall as more HbA_{1c} tests are requested.

The majority of the costs for HbA_{1c} testing are subsidised by pathology practices — which, philosophically, I find quite odd. These points need to be taken into account when undertaking a cost–benefit analysis of screening for diabetes in Australia.

Len D Moaven Director
Moaven and Partners Pathology, Sydney, NSW.

moa6747@bigpond.net.au

Competing interests: I am a pathologist in private practice.

doi: 10.5694/mja11.10920

1 Shaw JE, d'Emden MC, Goodall I. Is Australia ready to use glycated haemoglobin for the diagnosis of diabetes [editorial]? *Med J Aust* 2011; 195: 7-8.
2 Medicare Australia. Medicare item reports. https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml (accessed Sep 2011). ❑

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