

NATIONAL POLICY PRIORITIES 2010

*Better Management and Prevention of
Diabetes for all Australians*



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ABOUT DIABETES AUSTRALIA

Diabetes Australia is a national federated body comprised of state and territory organisations, supporting people with diabetes and those professional and research bodies concerned with the treatment and prevention of diabetes.

Diabetes Australia's purpose is to assist all people affected by diabetes and those at risk, and to contribute to the search for a cure.

The Diabetes Australia Federation embraces:

- Support and service to over 160,000 members by the various State and Territory bodies.
- Support and service to almost 1 million Australian Registrants of the National Diabetes Services Scheme (NDSS). The NDSS Scheme is an Australian government initiative administered by Diabetes Australia.
- Health professional members including endocrinologists, diabetes educators, scientists and researchers.

Diabetes Australia works to raise awareness about the seriousness of diabetes, promoting prevention and early detection and advocating for ways to improve care, support and management of diabetes. Diabetes Australia works with, and through its member organisations, with government, other Non-Government Organisations (NGO), health professionals and health service providers to promote the best possible, multidisciplinary approach to management and prevention of diabetes.

Diabetes Australia has a significant research funding program through its Diabetes Australia Research Trust (DART) and each year supports over 25 major diabetes research projects.

FACTS ABOUT DIABETES

- About 275 Australians develop diabetes every day.
- Diabetes is Australia's fastest growing chronic disease.
- About 970,000 Australians are currently diagnosed with diabetes. For every person diagnosed, it is estimated that there is another who is not yet diagnosed; a total of about 1.8 million people.
- The total number of Australians with diabetes and pre-diabetes is estimated to be 3.2 million.
- Diabetes is the sixth leading cause of death in Australia.
- Type 2 diabetes can be prevented through lifestyle behavioural changes, supported by changes to the social determinants of health.

BETTER SUPPORT FOR YOUNG PEOPLE TRANSITIONING TO ADULT SERVICES

KEY ISSUES:

- There are around 10,000 young people with type 1 diabetes in transition (age 15-25 years) in Australia and the incidence is rising.
- Between 30-40% of young people with type 1 diabetes are 'lost' from specialist care each year when transitioning to adult care and one third need additional mental health support.
- Those aged 16-25 often experience the most trying and difficult issues, have poorer diabetes control than at any other time in their lives and are at higher risk of developing preventable complications including eye, kidney, heart disease and psychosocial problems.
- There is an urgent need to improve services to young people to ensure successful transition to adult services. Current health care card benefits cut out at age 16 and then limitations apply but their diabetes does not become any less serious or costly.
- Young people with type 1 diabetes are unfairly burdened by the loss of access to the health care card particularly if they remain at school or continue with additional tertiary education that precludes them from accessing assistance. This places increased financial strain on many families.

POLICY:

1. Systematically identify each year all adolescents with type 1 diabetes who turn 15 years of age, and all those young people aged 15-24 years who are newly diagnosed in that period. All young people should have access to:
 - a. A comprehensive health assessment, including mental health screening using the HEADSS framework, commencing at age 15 and conducted annually until age 24.
 - b. A Transition Care Plan which should be developed to document the systematic and planned transition into adult services.
2. Medicare rebates for participating in the development of the Transition Care Plan should be accessible for endocrinologists, GPs and credentialed diabetes educators (currently limited to GP's).
3. Expand Medicare funded claims for allied health services for people with type 1 diabetes aged 15 to 24 from five to ten claims per year.
4. Endocrinologists should be able to refer to Medicare funded diabetes educators, allied health professionals and psychologists (currently limited to GP's).

POLICY:

5. A central coordination system should be established to identify and track young people with type 1 diabetes aged 15 to 24 years transferring from paediatric to adult services, using a variety of existing diabetes registers (NDSS, National Diabetes Register, health service level databases etc).
6. Transition Officers should be funded and employed to implement the transition model across Australia.
7. Additional support funding based on an annual per capita payment for each person with a Transition Care Plan should be provided for three years to support the development of innovative, multidisciplinary young adult programs within health regions (\$500pa for urban and \$1000pa for rural and remote). Submissions would be received from services that offer an appropriate model of care or service improvement for the type 1 adolescent / young adult population; meets specific criteria and critical elements for a transition program; and demonstrates effective partnerships and collaborates with key services within the region.
8. The model should be evaluated to monitor service improvement, health outcomes, hospitalisations and health care service use, engagement and loss to follow-up, and reviewed after three years.
9. Concession Card benefits should apply to age 18.

DIABETES IN PREGNANCY

KEY ISSUES:

- About 18,000 women each year develop Gestational Diabetes Mellitus (GDM) or around 5% of all births. In public hospitals the rate is as high as 10%.
- Women with existing type 1 and type 2 diabetes often need specialised care and services during pregnancy. Up to one third of women with type 1 diabetes may need insulin pump therapy and the hospital system is very under resourced to support diabetes in pregnancy.
- National standards for the management of GDM need updating and development.
- After GDM, women have a very high (one in two) chance of developing type 2 diabetes and their children have a higher risk of diabetes, obesity and hypertension.
- There is no systematic follow up, recall or prevention activities for women post GDM in Australia. A national recall system similar to cervical screening would improve prevention, early detection and early treatment of type 2 diabetes.
- Universal screening for GDM has been recommended by the Australasian Diabetes in Pregnancy Society, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. This has been identified as a priority area for action by the National Diabetes in Pregnancy Advisory Council (under the auspices of DOHA).
- Early diagnosis and treatment of GDM will improve pregnancy outcomes. Additionally, it will identify women who are at higher risk for future development of diabetes, facilitating targeted intervention to reduce diabetes risk.

POLICY:

1. Establish a national register of all women with GDM. The NDSS registrant database could be used with minimal additional cost.
2. Ensure a nationally consistent contact and follow up system for all women post GDM to provide information about type 2 diabetes risk for mothers and health risk for babies and integrate the system with prevention programs.
3. All women post GDM should be eligible for entry to type 2 diabetes prevention programs (lifestyle management programs) whether funded by the Commonwealth or States and Territories.
4. National standards for the management of GDM should be updated to ensure optimal pre and post natal support for women with GDM.

BETTER INSULIN PUMP ACCESS FOR ALL AGES

KEY ISSUES:

- There has been poor utilisation of the insulin pump subsidy program introduced in 2009. Australians have poor access to insulin pumps and currently rely on private health insurance.
- There is insufficient capacity in the health system to provide suitable access to safe and timely insulin pump commencement.
- The listing of insulin pumps on the prosthesis list for private health insurance has been at risk and limits availability of commencing insulin pump therapy.

POLICY:

1. Public funding of \$35 million over 3 years for the provision of 4,000 insulin pumps, fully funded and including specific new funding to designated centres to increase capacity for commencement of insulin pump therapy and reduce waiting times.
2. Eligibility should be expanded to include:
 - a. All children and adolescents with type 1 diabetes under 18 years.
 - b. Young adults with type 1 diabetes in transition aged 18-25 years.
 - c. Diabetes in pregnancy (type1, type 2 and GDM) based on clinical need.
 - d. People with type 1 diabetes at any age that experience 'hypo unawareness' or serious hypoglycaemic events.
3. Private health insurance funds must not be permitted to remove insulin pump subsidy from insurance products. The prostheses tables of private health insurance funders should be amended to allow for insulin pump therapy commencement outside of hospitals in designated centres.
4. The establishment of State and Territory based coordination services led by Diabetes Australia State and Territory organisations that integrate representatives of Juvenile Diabetes Research Fund, State and Territory health departments, the diabetes services (diabetes centres accredited under the National Accreditation of Diabetes Centres), and other relevant organisations.

DIABETES MANAGEMENT IN AGED CARE SERVICES

KEY ISSUES:

- People with diabetes requiring insulin therapy may be discriminated against for entry to aged care services due to unavailable or limited care and other health service resource issues. People in aged care settings may be discriminated against for access to the NDSS.
- Aged care workers receive little or no training in diabetes and there are no national standards for training aged care workers in diabetes management.
- There are currently over 170,000 residents 70 years and older in nursing homes with a significant percentage diagnosed with diabetes. This number will increase significantly over the next 10 to 20 years due to the ageing of the Australian population.
- Optimal management of older people with diabetes will have a significant impact on their wellbeing and quality of life.

POLICY:

1. A national survey should be conducted to assess the potential for discrimination against people with diabetes for entry to aged care services and to recommend solutions if necessary.
2. National standards for diabetes management (including insulin therapy) in aged care services should be developed and included in the Aged Care Standards Accreditation process. These standards should apply to home and community care and institutional care.
3. National standards for training of aged care workers (Div 1, Div 2 and PCA's) in diabetes should be established and a national training program developed for the existing aged care workforce.

DIABETES HEALTH LITERACY FOR PEOPLE WITH DIABETES

KEY ISSUES:

- Over 50% of people with diabetes in Australia have poor health literacy (defined as a person's ability to gain access to, understand and use information in ways that promote and maintain good health). This directly impacts on self management, long term outcomes and quality of life.
- The diabetes workforce is critical to improving health literacy and is insufficient in numbers for current and future demands. People with diabetes require access to care provided by a multidisciplinary team including, but not limited to, medical practitioners (general and specialists), diabetes educators, dietitians, podiatrists, exercise physiologists and physiotherapists, social workers and psychologists.
- Credentialed Diabetes Educators are the quality assured providers of diabetes self-management education recognised by the Health Insurance Commission and the Department of Veterans Affairs for rebatable diabetes education services. Credentialed Diabetes Educators play lead roles in coordinating diabetes care in general practice settings.
- Practice Nurses also play an important role in the organisation and delivery of diabetes management programs in general practice. Practice Nurses increasingly undertake further study in order to fulfil the role of diabetes educator in general practice settings.
- Access to multidisciplinary allied health care is limited in primary health care settings.
- Access to comprehensive diabetes self-management education provided to the quality standards of Credentialed Diabetes Educators in Australia is low due to:
 - a. Inconsistently targeted and/or dedicated funding at both Commonwealth and State and Territory levels. Currently there are more course graduates than available positions in health services including primary health care settings.
 - b. Limited consumer entitlement to Medicare Allied Health rebates.
 - c. Inconsistently available private health insurance rebates for diabetes self-management education services.
 - d. Low General Practitioner referral rates.
 - e. Lack of consumer awareness of the availability of diabetes self-management education and Credentialed Diabetes Educators.
 - f. No mechanism for diabetes specialists to refer for Medicare rebatable services.

POLICY:

1. National standards for diabetes self-management education should be developed which include assessment of health literacy.
2. A national plan for diabetes workforce development should be developed and implemented.

DIABETES IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

KEY ISSUES:

- The prevalence of diabetes among Indigenous people is estimated to be over 3 times the rate of non-Indigenous people.
- Indigenous people have a higher prevalence of overweight or obesity and related chronic diseases.
- Diabetes hospitalisations for Indigenous peoples are nearly 11 times higher than other Australians. Hospitalisations for kidney disease, a common complication of diabetes in Indigenous people, are 29 times higher than other Australians.
- The death rate from diabetes among Indigenous people is almost 12 times that experienced by non-Indigenous Australians.
- Death rates from kidney disease complications among Indigenous people are 19 times higher than for other Australians.
- Indigenous people are diagnosed at younger ages with type 2 diabetes and have an excess of avoidable complications and earlier death, compared with other Australians.
- Indigenous people over 35 years of age have a death rate from diabetes more than 20 times that of the non-Indigenous population.
- The value of Indigenous health workers within the Australian primary health care and allied health care setting has been underestimated for many years.

POLICY:

1. Increase the number of Indigenous health workers trained in diabetes management, early detection and prevention and increase the capacity for more training programs.
2. Advance the role and status of Indigenous health workers.
3. Increase the number of allied health visits available under the MBS for Indigenous people.
4. Support Indigenous people to undertake professional training in medicine, nursing and allied health disciplines.
5. Engage Indigenous communities in the development and implementation of culturally appropriate diabetes prevention and management strategies.

PREVENTION OF TYPE 2 DIABETES

KEY ISSUES:

- Type 2 diabetes is the fastest growing chronic disease in Australia and a major contributor to increased hospitalisations and health system costs and is a major threat to workforce productivity in Australia.
- 275 Australians develop diabetes every day and about 85% is type 2 diabetes.
- Type 2 diabetes can be prevented in high risk people through lifestyle behaviour change programs supported by changes to the social determinants of health.
- Prevention of type 2 diabetes must include national obesity prevention initiatives for all Australians concurrent with targeted prevention programs for the estimated 2 million Australians at high risk of developing the disease.
- Recommendations of the National Preventative Health Taskforce and National Primary Health Care Strategy need to be implemented.
- Lifestyle risk factors like physical inactivity, unhealthy diet, smoking and alcohol misuse, contribute to the development of type 2 diabetes but are modifiable by a combination of behaviour and systems changes.

POLICY:

1. Ensure that a national strategy for targeted prevention of type 2 diabetes in high risk people runs in concert to a national strategy for primary prevention of type 2 diabetes in the general community through obesity prevention and related strategies.
2. Establish the National Preventative Health Agency and appoint a Diabetes Australia nominee to its proposed 'Advisory Council' or governance body.
3. Implement the National Preventative Health Taskforce recommendations.
4. Ensure that a national strategy for primary prevention of type 2 diabetes focuses on the underlying social determinants of health concurrently with addressing behavioural risk factors for the disease.

ADVERTISING AND MARKETING OF JUNK FOOD AND SUGARY BEVERAGES TO CHILDREN

KEY ISSUES:

- The current self-regulation framework is not effective in protecting Australian children from advertising and marketing of junk foods (defined as energy rich, nutrient poor food high in levels of trans fats, total fat, sugar and salt), and sugary beverages.
- The Australian government has national and international responsibilities to protect the rights of children and our children have a right not to be targeted by junk food and beverage advertising and marketing.
- Inappropriate marketing practices are far more widespread than television advertising.
- There is evidence that Australians support government action to limit and control junk food and beverage advertising and marketing.
- Many other countries have established policies to limit children's exposure to marketing and promotion of junk food.
- In 2006, WHO called for national action to protect children from marketing by substantially reducing the volume and impact of the commercial promotion of junk food.

POLICY:

1. Ban junk food and sugary beverage advertising on television during children's viewing hours, review and extend the banned hours over time.
2. Abandon the current, failed self-regulatory framework and establish a national regulatory role to monitor and control junk food and sugary beverage advertising and marketing.
3. Empower the new National Preventative Health Agency to make recommendations for further national regulatory and legislative measures to protect Australian children from junk food and sugary beverage marketing.
4. Establish annual, national reporting of the marketing budgets and actual spend on junk food and sugary beverage marketing and advertising in Australia and make this accessible to the public.

FRONT OF PACK FOOD LABELLING

KEY ISSUES:

- Current nutrition information on food packaging is of very limited use to consumers.
- Consumers support a simple 'traffic light' approach providing useful information on trans fats, sugar, total fat and sodium.
- Traffic light labelling allows consumers to more easily identify healthy food and make healthy choices.
- The provision of nutrition information at the point of sale potentially provides a direct vehicle for assisting consumers to identify healthier food choices and in doing so may improve health outcomes.

POLICY:

1. Introduce national front of pack food labelling (FOPL) requirements incorporating a traffic light system that clearly delineates nutritional content of food products.
2. In parallel with the development of a FOPL scheme, there must be supporting consumer education initiatives including improving standardisation of serving sizes.

KIDS AND SCHOOLS AND PREVENTION

KEY ISSUES:

- There is currently no national framework that ensures access to healthy environments including healthy food choices and physical activity in all Australian primary and secondary schools and all licensed child care facilities.
- Some state-wide, award based frameworks have been established (Victoria and Tasmania) and could be developed into a national award based framework.
- There is insufficient information available to parents to enable them to choose a healthy school for their children.
- There needs to be a national focus and program developed on 'Health Promoting Schools' based on the WHO framework and principles.

POLICY:

1. Introduce a voluntary national, award based framework for all primary and secondary schools and all child care facilities to develop, maintain and report on healthy eating and healthy activity for all children. This should incorporate the WHO Health Promoting Schools framework and principles.
2. Introduce a nationally consistent framework that incorporates preferred drinking water policies, increased fruit and vegetable consumption, decreased unhealthy food consumption, increased active play, and increased safe, active transport (walking and cycling) to and from school.
3. Establish a national 'Healthy Schools' website to provide information to parents on all Australian schools, the award framework and status of schools, and the healthy eating and healthy activity programs.
4. Establish a national 'Health Promoting Schools' program based on the WHO framework and principles.

TARGETED PREVENTION FOR THE HIGH RISK

KEY ISSUES:

- Type 2 diabetes prevention in people at high risk using lifestyle behaviour change is proven and powerful with a strong evidence base.
- Current type 2 diabetes prevention activities in Australia are poorly coordinated and the national prevention program for 40-49 age group disadvantages other age groups and does not support some of the State and Territory funded prevention programs.
- The development of evidence based lifestyle management programs (LMP) across Australia has been slow.
- The current subsidy/payment level for LMPs is insufficient to ensure development and delivery of high quality, evidence based programs across Australia.
- Workplaces need to be a focus for type 2 diabetes risk assessment and integrated referral to prevention services both inside and outside the workplace.

POLICY:

1. The current 40-49 age limitation for the Commonwealth funded risk assessment by GP's should cease and be replaced by a scheme that is accessible to all adult Australians.
2. The current Commonwealth subsidy level for LMP's should be increased to \$500 per person. This subsidy should be delivered as a 'voucher' system whereby any adult identified as high risk should receive a voucher to the value of \$500 to enable them to purchase diabetes prevention services.
3. Prevention service coordination should be enhanced by merging the current (disconnected) AGPN Commonwealth service coordination with the various State and Territory coordination structures.
4. Categories of high risk individuals should be extended to include all women who have had GDM and any adult who has existing cardiovascular disease including a prior history of heart attack or stroke.
5. Targeted social marketing campaigns (modelled on the Quit campaign) should be integrated with prevention service development to facilitate recruitment to programs.

DIABETES PREVENTION IN THE WORKPLACE

KEY ISSUES:

- The COAG National Reform Agenda in 2006 identified human capital as a focus and the risk posed to productivity in Australia related to type 2 diabetes and other chronic diseases.
- There is no national focus on identifying workers at high risk of type 2 diabetes and maximising the potential for prevention.
- There is insufficient focus on the balance of incentives and regulations to ensure every workplace in Australia is a healthy workplace.
- A positive workplace culture specifically designed to promote healthy lifestyle choices is essential to improving the health, wellbeing and productivity of the Australian workforce.

POLICY:

1. There should be a national policy commitment that every Australian worker will be eligible for and will have access to a workplace based risk assessment for type 2 diabetes and other preventable health problems, over the next 5 years.
2. COAG should ensure that all States and Territories develop suitable workplace screening programs for type 2 diabetes and other preventable health problems.
3. The existing type 2 diabetes risk assessment tool (Ausdrisk) should be systematically used in workplace based screening programs.
4. Every Australian worker identified as high risk (based on the Ausdrisk score) should be offered, encouraged and systematically referred to an accredited LMP.
5. A 'Healthy Workplace' assessment tool should be developed and provided to every registered employer in Australia employing more than 10 people.
6. Establish a national 'Health Promoting Workplace' program based on the WHO framework and principles.

DIABETES PREVENTION THROUGH HEALTHY CITIES AND HEALTHY INFRASTRUCTURE

KEY ISSUES:

- Australia is highly urbanised and our cities and their planning, development and infrastructure represent a critical focus for prevention of chronic diseases like diabetes and cardiovascular disease.
- There is insufficient focus on building healthy infrastructure.
- Planning the built environment on the basis of providing a healthy infrastructure is critical to supporting and enhancing physical activity and healthy eating.
- The achievement of healthy, sustainable cities and towns relies on positive behavioural change by households and businesses, support from government and other decision makers, development of healthy public policy, and effective, cooperative, working partnerships between different individuals and agencies.

POLICY:

1. Establish a national 'Healthy Cities' program based on the WHO framework and principles and incorporate an award framework to create competitive pressures for cities to plan for and invest in healthy environments and policies.
2. Develop a national active transport policy incorporating alternative, sustainable means of transport to encourage walking, cycling, use of affordable public transport and less reliance on cars.
3. COAG should ensure that every road and rail investment project in Australia in the next 10 years has 5% of its budget allocated to walking and cycling infrastructure.
4. COAG should ensure that all local government planning approvals for multi-dwelling developments for more than 10 dwellings, incorporate investment in walking and cycling infrastructure and ready access to affordable public transport and recreational/sporting facilities.
5. Government at all levels should incorporate 'Health Impact Assessment' in urban planning as mandatory processes in the design and development of new and revitalised areas of cities and towns.

STATE & TERRITORY ORGANISATIONS AND DIABETES HEALTH PROFESSIONAL BODIES

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Tasmania

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Northern Territory

Healthy Living NT
Shop 1 and 2 Tiwi Place
Tiwi NT 0810
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Australian Capital Territory

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