



Submission to the National Preventative Health Taskforce  
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Turning diabetes around

awareness | prevention | detection | management | cure

# **Diabetes Australia**

## **Submission to the National Preventative Health Taskforce**

### **1. Introduction**

Diabetes Australia is the national peak body for diabetes in Australia providing a single, powerful, collective voice for people living with diabetes, their families and carers. Diabetes Australia works in partnership with diabetes health professionals, educators and researchers to minimise the impact of diabetes on the Australian community. Diabetes Australia is committed to turning diabetes around through awareness, prevention, detection, management and a cure.

In collaboration with our member organisations and through the administration of the National Diabetes Services Scheme (NDSS), Diabetes Australia provides practical assistance, information and subsidised products to approximately 900,000 Australians diagnosed with diabetes.

Diabetes Australia works to raise awareness about the seriousness of diabetes, promoting prevention and early detection strategies and lobbying for better standards of care. Diabetes Australia is also a significant financial contributor to research into prevention, better treatments for diabetes and the search for a cure.

Diabetes is the world's fastest growing disease. It currently affects 246 million people worldwide and the number is expected to rise to 380 million by 2025. In Australia the prevalence of diagnosed diabetes in people aged 25 years and over was 3.7% in 2000. Including those with undiagnosed diabetes, the prevalence doubles to 7.4%.

Translated into numbers, approximately 1.5 million Australians are estimated to have diabetes, but only half are aware they do. By 2031 it is estimated that 3.3 million Australians will have type 2 diabetes. Around 275 adults in Australia develop diabetes every day. Internationally and in Australia, diabetes has become an epidemic. In 1996, Australia recognised diabetes as a national health priority. It remains a national health priority.

### **2. Impact of Diabetes.**

People with diabetes are 2 to 4 times more likely to develop cardiovascular disease than people who do not have diabetes and over twice as likely to have a heart attack or stroke. In fact, cardiovascular disease is the major cause of death for people with diabetes, accounting for some 50% of all diabetes fatalities.

Other disease complications resulting from undetected or poorly managed diabetes include diabetic retinopathy, diabetic foot and kidney failure.

People with diabetes report significant effects on health related quality of life, particularly related to mobility, pain and discomfort, and significantly higher levels of anxiety and depression.

On average, people with type 2 diabetes will die 5 to 10 years before people without diabetes, mostly due to diabetes being a risk for developing cardiovascular disease.

Diabetes is even more serious for Aboriginal and Torres Strait Islander communities. Rates of diabetes in Aboriginal and Torres Strait Islander communities are estimated to be at least 4 times higher than for other Australians. Aboriginal and Torres Strait Islander people in remote areas are twice as likely as other indigenous Australians to report having diabetes and in some Indigenous communities the prevalence of diabetes could be as high as 30%.

Indigenous people are diagnosed at younger ages with type 2 diabetes and have an excess of avoidable complications and die earlier, compared with other Australians. Aboriginal and Torres Strait Islander people over 35 years of age have a death rate from diabetes more than 20 times that of the non-indigenous population.

### **3. Diabetes Australia Policy Objectives**

Some of Diabetes Australia's policy objectives include:

- Diabetes to remain a high level initiative within the Council of Australian Governments (COAG), National Reform Agenda (NRA).
- Nationwide shift to prevention developed within a social determinants of health framework.
- Reduction in childhood obesity.
- Increased access to prevention and early intervention programs in workplaces, schools and other settings.
- Nationwide shift to active transport and a healthy built environment.
- Further research into and implementation of evidence based population interventions to create a healthy and active Australia.
- Detection of all high risk groups with specific focus on those with undiagnosed diabetes in Aboriginal and Torres Strait Islander communities, especially their children, with obesity and diabetes.
- Targeted intervention strategies for high risk groups.
- Increased access to health care services for all people with diabetes.
- Expansion of the National Primary Care Collaborative.

- Expansion of the national health workforce with a focus on training of Aboriginal and Torres Strait Islander health workers.

The National Preventative Health Taskforce (NPHTF) should be aware of Diabetes Australia's policy position and objectives. Most of them align with objectives proposed in the NPHTF discussion paper. However, the strategic approach to prevention proposed by Diabetes Australia in dealing with chronic diseases like diabetes differs from that of the NPHTF.

Diabetes Australia believes that in order to change behavioural risk factors for chronic disease like diabetes, a social determinants of health framework should inform national prevention strategies. Within this more contemporary framework, behavioural risk factor reduction strategies are more likely to be effective than through traditional approaches proffered by the NPHTF, which Diabetes Australia believes will have only marginal impact and effect.

#### **4. The Burden of Diabetes**

In 2008 there were 3.7 million obese Australians. This situation has been deemed an epidemic by many experts in public health in Australia. Obesity is a serious and complex health issue with type 2 diabetes one of its major complications. As a result of the obesity epidemic, in 2008, there were 242,033 Australians with type 2 diabetes caused by obesity. The health and economic burden for Australia is alarming. The total cost of obesity is \$58 billion which includes \$8.3 billion in financial costs and \$49.9 billion in the value of lost wellbeing, which accounts for years of healthy life lost through disability and /or premature death

The costs to the person with diabetes, to family members, to the health care system and society are significant. Although some types of diabetes are preventable, some are incurable and progressive.

Two thirds of the total costs of type 2 diabetes are incurred by individuals but there is also a significant impact on governments in terms of higher health services and welfare costs and lower tax revenues. Government health expenditure on type 2 diabetes in Australia is projected to increase by over 600 per cent between 2000–2001 and 2030–2031. Costs to state and territory governments are largely in the form of preventable hospital costs. Diabetes related complications are the major source of preventable hospital treatments. Even with successful prevention and management, costs in all areas will continue to grow.

In addition to hospital services, there are significant ambulatory costs in the ongoing management of diabetes including outpatient and allied health services such as diabetes education, podiatry and dietetics, and ancillary costs such as medications, blood glucose monitors and injecting equipment.

## 5. Need for a Preventative Health Strategy

Diabetes Australia commends the Australian Government for making prevention a priority and in establishing the NPHTF to develop a national prevention strategy.

Over 80% of diabetes is type 2. It is mainly preventable and commonly associated with unhealthy lifestyles including over nutrition and low levels of physical activity. It is more common in people over the age of 45 years. However, the incidence of type 2 diabetes is increasing in younger adults and children. Many people with type 2 diabetes have no symptoms consequently almost half of the people with type 2 diabetes are unaware that they have it. Diabetes Australia aims to turn around the type 2 diabetes epidemic by focusing upstream along the prevention continuum.

Diabetes Australia intends to address the rising incidence of type 2 diabetes and prevent its onset through strategies aimed at influencing healthy public policy supported by population based primary prevention initiatives and lifestyle interventions for people at increased risk of developing the disease. This also extends to achieving better management and reduced complications of all types of diabetes by effective early detection and intervention. Strategies will also include, increasing capacity in diabetes monitoring, surveillance, research and evaluation to inform effective policy and practice.

In order to achieve its aims, Diabetes Australia seeks collaboration with a range of key stakeholders including government, other non-government organisations, industry, academia, communities, families and individuals.

Diabetes Australia supports and encourages holistic and integrated approaches to the prevention and management of diabetes which requires concurrent behavioural and systems change. These are the basic challenges faced by all key stakeholders in chronic disease prevention and management and they must be met if Australia is to effectively reduce the scourge of chronic diseases like diabetes.

Diabetes Australia believes that the NPHTF needs to move towards advocating for holistic, integrated strategies within its overall plan. It must pursue these strategies as its lynchpin to an effective national prevention strategy. The NPHTF discussion paper rhetoric is about holism and integration, yet lifestyle issues and the risk factors for them are siloed into separate areas of tobacco, alcohol and obesity. In a real life context, these and other chronic disease risk factors interrelate and overlap. They should be addressed as a whole, not in isolation. Contemporary population health approaches in Australia need new ways of thinking and application, designed within frameworks that go to the heart of the genesis of chronic disease not just to its immediate risk factors like obesity, alcohol misuse and tobacco smoking. Contemporary approaches to chronic disease prevention need to centre on issues of equity and health inequalities, and these issue must drive the thinking and application of strategies.

The NPHTF discussion paper falls short in this respect. In the main, the NPHTF proposes behavioural risk factor change approaches of the past. Diabetes Australia believes that these are inappropriate and increasingly irrelevant to contemporary Australian lifestyle which is embedded in a more complex society than existed a few

decades ago. The NPHTF needs to move beyond simplistic social marketing and health education approaches as key strategies and core ways of addressing chronic disease, towards a systems and organisational change approach to prevention as its main strategic approach.

A national prevention strategy must build on a systems approach within a framework that clearly articulates real life causes of risk factors like obesity, tobacco smoking and alcohol misuse. It must be prepared to acknowledge and act on the underlying causes of these behavioural risk factors that are themselves the cause of most chronic diseases, and develop strategies that will effectively address them. A systems approach will inevitably take time; time well outside political electoral cycles of 3 and 4 years and their accompanying bureaucratic funding cycles with even narrower timelines.

The NHPTF must call on governments at all levels and of all political persuasions, to act in a non-partisan way to budget and plan for population health interventions of at least 5 years continuous duration with preferable reporting timelines allocated in 10 year blocks of time. This is particularly important in the case of reversing the obesity epidemic, which may prove to be a population health issue requiring a generational change timeline.

## **6. Risk Factors for Diabetes**

Diabetes shares risk factors with a range of other chronic diseases including obesity, cardiovascular disease and kidney disease. The development of type 2 diabetes can be significantly delayed and prevented by intervening early to reduce obesity and inactivity. Risk factors for type 2 diabetes are also risk factors for gestational diabetes. In general, the risk factors for type 2 diabetes include:

- Overweight and obesity;
- physical inactivity;
- increasing age;
- having pre-diabetes;
- having a history of gestational diabetes;
- being indigenous and in certain ethnic groups;
- psychosocial stress and prolonged exposure to stress;
- major depressive episodes; living in a rural environment;
- socioeconomic factors.

All of the above risk factors are important in predicting the development of diabetes, particularly type 2 diabetes. However, by far the most important factor in terms of

the leading cause of the more common risk factors for diabetes such as obesity, physical inactivity and unhealthy diet, are the socioeconomic factors. These factors characterise the social environment and are linked closely to population health.

Diabetes affects people of all socioeconomic and cultural backgrounds, but with an uneven distribution across society. Strong evidence is now emerging about the complex relationship between social inequalities and type 2 diabetes.

Social conditions associated with low income and lower levels of education have an impact on both people's risk of developing type 2 diabetes and their ability to manage the disease. Psychosocial issues are also extremely important considerations in any prevention strategy for diabetes. These issues need to be assessed and addressed concurrently with strategies aimed at physical risk factors such as unhealthy diets and physical inactivity.

There is a clear socioeconomic gradient in the prevalence of type 2 diabetes, with a rate almost twice as high in the lowest socioeconomic group compared with the highest. The gradient is even more accentuated in the Aboriginal and Torres Strait Islander population and some Culturally and Linguistically Diverse (CALD) populations.

The social, economic, political and cultural environment, collectively make up the social determinants of health which have been called the 'causes of the causes' of chronic disease. The social determinants underpin the risk factor of tobacco smoking, alcohol misuse and obesity which themselves contribute to a range of chronic diseases including diabetes.

The strong link between the social determinants of health, chronic disease and their risk factors suggest that a national prevention strategy needs a social determinants of health framework within which a systems approach can be developed. This would provide the necessary impetus for societal change through public policy and changes to organisational practices directed at reducing the social gradient and contributing to reducing health inequities. Behavioural risk factor reduction would occur naturally as an indirect consequence of applying a social determinants of health framework, reducing the amount of money required for risk factor reduction strategies.

## **7. Guiding Principles**

The following principles underpin Diabetes Australia's policy objectives and strategic approach to diabetes prevention.

- Equity focused approaches that recognise the social gradient of diabetes and its association with the social determinants of health. A focus on health inequalities should be maintained to ensure that equity of access to services and of health outcomes is achieved.
- Prevention aimed at the primary level to support the above equity focus approaches within a social determinants of health framework. People must be given the opportunity to lead a healthy lifestyle in settings where they live, work

and play. This must be a sustained effort over the long term so as to change social norms, community and environmental structures that will support healthy behaviours. A life course approach to chronic disease prevention is the most logical and systematic way to predict, assess, monitor and evaluate the needs of individuals and populations as they emerge and develop through the early years of life, grow, mature and age. The risk of chronic disease in adulthood is now understood to be associated with risk exposures across the life course. A comprehensive prevention strategy requires the systematic identification, prioritisation and application of evidence based, cost effective interventions for each stage of the life course. The life course approach incorporates important population health improvement strategies, all of which may be delivered through common settings such as schools, workplaces, neighbourhoods, communities, primary health care and so on. The importance and influence of the settings relevant to different life stages are therefore emphasised as key areas for population health action on chronic diseases like diabetes.

- Interdisciplinary models of care that recognise patients as active partners in life stage targeted strategies that promote prevention and self-management.
- Partnerships at all levels that recognise the intersectoral context for prevention, consumers as active partners and the interdisciplinary nature of disease management in different settings of care. The health sector must work with other sectors and services to influence the social determinants of health that determine the burden of diabetes and chronic disease.
- Accessible and culturally appropriate diabetes prevention and management initiatives, addressing individual and population needs.
- An evidence based approach for action promoting research and supporting information for program planning and evaluation. Surveillance, monitoring, research and evaluation underpin diabetes prevention, management of type 2 diabetes.

## **8. Strategic Approach**

The number of people with diabetes is expected to double by 2010. This makes prevention and management of diabetes a priority. The NRA has identified type 2 diabetes as a priority for action on chronic disease prevention and improvement in the health and wellbeing of all Australians.

Diabetes Australia believes that the following strategic directions which are in keeping with international and national approaches and enshrined in Australian Government strategies such as the *National Chronic Disease Strategy* and the *National Health Improvement Framework for Diabetes*, should be the basis for comprehensive, preventative action on diabetes in Australia:

### **8.1 Health Development in all Policies**

Population and individual health outcomes are largely determined by factors outside the health care system. The World Health Organisation (WHO) recommendations on

healthy public policy state that the main aim of healthy public policy is to create a supportive environment that makes health choices easier choices for people. There is a strong case for the health sector to engage and partner with other sectors to influence the social, economic, political, cultural and environmental factors, collectively known as the social determinants of health, that determine the burden of chronic disease.

Healthy public policy is characterised by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices easier for people. It makes social and physical environments health enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. Fundamental to this approach is an acknowledgement of the underlying social determinants of health as well as the individual's particular characteristics and behaviours. Factors such as poverty, poor education, social exclusion, unemployment and lack of or poor quality housing, all contribute to health inequalities. Even within an individual disease focus, a social gradient can be illustrated and for diabetes this is reflected in the increased risk for Aboriginal and Torres Strait Islander peoples and some CALD populations.

Many government policies have potential and actual impacts on health. The key to health in all policies is to ensure that, when public policies are developed, efforts to address those determinants of health that can be tackled within the scope of the specific policy do so with the aim of improving health outcomes for all people. Health Impact Assessment is a contemporary tool used in population health to determine policy and program impact on health and wellbeing. Such approaches and tools must be supported by any national prevention strategy and strongly advocated by the NPHTF.

The notion of an independently funded national preventative health agency, proffered by the NPHT, could fulfil the role of providing lead agency in invoking health in all policies.

## **8.2 Community Wide Primary Prevention Programs**

Community wide health promotion and diseases prevention programs are underpinned by a population health approach. This approach recognises the role of the social determinants of health and the importance of addressing the needs of the whole population, including the specific needs of those groups at highest risk. A population health approach aims to improve health in the whole population. The underlying aim is a healthy lifestyle supported and sustained by a healthy environment. An environment that promotes physical activity and good nutrition will help to develop and sustain healthy lifestyles as well as contributing to a reduction in the prevalence of risk factors associated with type 2 diabetes.

A population health approach is concerned with the underlying causes of ill health and the conditions that create health. Community wide prevention requires informed

people to act on the environments and conditions that influence lifestyle choices and their health outcomes.

Effective action to address environments and risk factors must be based on evidence and will require collaboration with other sectors of society. Important sectors that influence prevention of diabetes include the food industry, the recreation and fitness industry and sectors that provide education and child and family services. Key settings for engagement include the home, early childhood, education, workplace, neighbourhoods and the community and primary health care settings. Primary prevention aimed at children and young people will be especially important because of the long term nature of diabetes risk. It is also important to focus on the family setting so that the food and activity levels within the family environment are also enhanced. This has been found to lead to a sustainable healthy setting where family learn and change behaviours together.

### **8.3 Accessible Services for Prevention of Diabetes in Individuals at Increased Risk**

The onset of type 2 diabetes can be significantly delayed and possibly prevented in high risk populations by maintaining a healthy weight and being physically active. A systematic, ongoing approach is needed to identify high, medium and low risk people within the identified at risk population. COAG has agreed to a number of initiatives to reduce the incidence of type 2 diabetes. These include the development of a nationally agreed risk assessment tool, program standards and program/provider accreditation arrangements to provide evidence based interventions for eligible persons at risk of progressing to type 2 diabetes and for people newly diagnosed with type 2 diabetes. Health professionals need more flexible access to the Medicare Benefits Schedule (MBS), and additional opportunities for other types of incentives need to be considered. As part of its contribution to the diabetes reforms under the NRA, the Australian Government has introduced improved incentives for general practice to identify patients at high risk of type 2 diabetes.

A new MBS item will encourage the development of a Diabetes Risk Plan for those aged 40 to 49 years assessed as at high risk with an option for the general practitioner to refer these patients to accredited lifestyle modification programs. At present this item is not being highly utilised primarily as there is a lack of accredited programs. We need to support this initiative as there is a distinct need for a nationally consistent accreditation process and referral to lifestyle modification programs as an effective prevention strategy.

To work towards accessible services for the prevention of diabetes in individuals at increased risk, the needs of each high risk target group should be identified. Also, barriers to service access need to be identified and addressed. For example transport and the cost of getting to service delivery points are often barriers for some community groups, as are language and cultural issues.

## **8.4 Accessible Services for Optimal Early Detection and Management of Diabetes**

Early detection and effective management are critical to optimal health and quality of life outcomes for people with diabetes. Early detection and effective management of type 2 diabetes are important because they can be effective in avoiding or delaying complications. A large proportion of people with type 2 diabetes is undiagnosed and may be asymptomatic.

Detection of diabetes is primarily by medical practitioners both within community health services and by general practitioners, who can diagnose and start the management of diabetes, organise education and screen for complications. There is no systematic screening for diabetes in Australia. Detection of type 2 diabetes is opportunistic and primarily through general practitioners. A number of new initiatives are being introduced that can be expected to improve detection rates for type 2 diabetes. These include the Australian Government's health check for persons aged between 45 and 49 years with one or more risk factors for chronic disease and a risk assessment tool to support individuals to identify their risk status.

## **8.5 Integrated Care for People Living with Diabetes**

Diabetes treatment and management aim to optimise blood glucose levels, prevent acute and chronic complications and maintain optimal quality of life. The pathway of diabetes follows a continuum, requiring health service responses by health professionals.

Diabetes management strategies may require patients to learn a large amount of information, master skills and make life adjustments. Management can be a complex process. Coordination and communication among the many agencies that address the needs of those with diabetes is vital and need to be established and supported through locally based planning processes. Ongoing care for people with established diabetes generally involves multiple health care providers across multiple settings. These include general practice, community health, hospitals, private providers and community and non-government organisations. Community and disability support, as well as support from family and carers, may also be required.

People with diabetes have individual and constantly changing specialist care needs. They may require specialist attention, for a single complication, from an endocrinologist, ophthalmologist, renal physician, surgeon or other specialist medical practitioner. They may develop more complex conditions that require treatment by a multidisciplinary diabetes team at a tertiary service. They may have an episode that requires them to receive acute care in a hospital.

The mental health of people with diabetes is becoming an increasing issue in the management of diabetes. Elevated rates of psychiatric disorder in adolescents and young adults with type 1 diabetes have been reported. Psychological factors also impact on adherence to a person's ability to manage their diabetes. Accordingly,

integrated provision of diabetes care requires a flexible health system that can coordinate care across services, settings and sectors over time. This means commitment from a range of services and sectors and the ability to work together to achieve shared goals. In addition, as people age and move from one service system to another, especially from paediatric to adult services, transition of care is crucial to successful management of diabetes. Multidisciplinary coordination of services must be person centred, incorporate prevention, self-management and be responsive to changing patient needs.

## **8.6 Health Workforce**

A skilled and multidisciplinary health workforce is fundamental to the provision of effective diabetes management. Key health professionals include, but are not limited to, general practitioners, practice nurses, diabetes educators, nurse practitioners, endocrinologists, dieticians, podiatrists, nephrologists, obstetricians, midwives, psychologists, community health workers and Aboriginal and Torres Strait Islander health workers.

In addition to clinical skills, health service providers require a range of skills including communication, collaboration, advocacy, cultural awareness, health promotion, planning, management, research and evaluation.

There is an urgent and on-going need for more Aboriginal and Torres Strait Islander health workers with specific diabetes education skills.

In 2006 COAG recognised that health workforce policy will need to deal with the implications of changes in the nature and quantum of demand for health services. The nature of future health care demand is expected to change in line with the anticipated changes in the burden of disease facing the community. This affects the models of care employed in service delivery, the number and types of health care workers that will be required, and the development of multidisciplinary approaches to care.

Although most individual practitioners manage diabetes to a high standard, there are no agreed models for ongoing treatment. There is a need to promote clinical best practice as is being developed with the National Health and Medical Research Council (NHMRC) evidence based guidelines for the management of diabetes, to disseminate best practice guidelines relevant to all populations, and to keep practitioners up to date on new developments and support the provision of a range of continuing diabetes education opportunities.

## **8.7 Enhanced Surveillance Systems**

Surveillance is the ongoing systematic collection, analysis and interpretation of health population data, and the timely dissemination of this information to decision-makers. Public health surveillance of diabetes and its complications is critical

to increase the recognition of the disease, identify high risk groups, develop strategies to reduce the economic and human cost of this disease, formulate health care policy, and evaluate progress in disease prevention and control.

There is a need to build the evidence base for prevention interventions. A more integrated approach to collecting data would improve the ability to track progress and monitor performance. This needs to be agreed and coordinated across levels of government and undertaken in collaboration with services and organisations that need to collect information. It is widely agreed that outcomes can be improved by building on, harmonising and complementing existing activities.

The *Blueprint for chronic disease surveillance* in 2005 sets out the essential elements of a national surveillance system, describes an Australian Priority Setting Tool for agreeing information priorities and methods, and proposes immediate actions to establish the system. The diabetes monitoring system in Australia has developed over the last decade. The Australian Institute of Health and Welfare (AIHW) is the home for the National Centre for Monitoring Diabetes and the National Diabetes Register. The AIHW also holds data on the uptake of the NDSS. These datasets allow AIHW to analyse the characteristics and outcomes of people with diabetes. The data collected could be used to plan effective targeted prevention programs and also to determine the research needs of the population.

## **8.8 Research and Evaluation and Knowledge Exchange**

Research provides the basis for understanding the balance of approaches required to tackle diabetes, its causes, prevention, effective management, and its cure. The dissemination of research findings and supporting their use in community, clinical and policy settings will add to the effectiveness of cross sector prevention programs, community based prevention programs and clinical services. To this end, an emphasis on translational research will ensure optimal use of research knowledge.

To build the evidence base for effective community based primary prevention of chronic diseases like type 2 diabetes, research funding has to be long term and structured so that equal emphasis is applied to qualitative research as much as it is currently to quantitative research. Contextual information is as important in understanding why health behaviours occur in various populations and settings as is the need to know how many people smoke, drink to excess, eat unhealthy food and do not exercise sufficiently.

There is significant investment in medical research for diabetes, with funding from a variety of sources including Australian Government and State governments, industry, philanthropic organisations and research bodies such as the National Health and Medical Research Council. However, the current balance of research funding in diabetes is weighted heavily towards finding a cure for type 1 diabetes. This is an important endeavour and will remain so but with the burden of diabetes clearly in the area of type 2 diabetes, strides will need to be made to make the research dollar more equitably distributed.

## Conclusion

In August 2008, at the publication of the Access Economic report *The Growing Cost of Obesity in 2008: three years on*. Diabetes Australia national president Dr Gary Deed announced that:

*“The fight against obesity requires a new approach that considers the economic and social conditions under which we live and how this is impacting on our health. Long-term policy planning is needed on issues such as urban design, food labelling, workplace initiatives, lifestyle education, and making healthy choices easier for Australians and their families. Governments must act outside of concern for their current electoral cycle to address the explosion of obesity and diabetes.”*

This challenge to government is also a universal challenge to our society. Australia needs a new vision for prevention and different ways of thinking and acting on the determinants of health that we have failed to produce and do in the past. Without a new vision and different ways of thinking and working, inevitably we will be faced with a much larger, more serious problem with chronic diseases like diabetes in the very near future but with fewer resources and other means to address them. We must act decisively, now.

Diabetes Australia once again, thanks the NPHTF for the opportunity to comment on its discussion paper. Diabetes Australia welcomes any further opportunity to discuss with the NPHTF any of the above issues or points of view raised that may be of interest or assistance in the progression of the aims of the NPHTF.

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