Questions for Medical, Health and Other Organisations (non-consumer)

Please answer the survey questions in as much detail as you can. You do not need to complete the survey all at once. You can save it and come back later. But you must submit the survey before the consultation closing date.

Reviewing the Application Form and PICO set for the proposed health service or technology will help you to answer the questions. A link to these documents is provided under 'Related' at the bottom of the Overview page. You can access this link by using the back arrow on your browser until you reach the Overview page. Using the 'back' option at the bottom of the survey page will **not** take you to the required page. If the MSAC PICO Advisory Subcommittee has considered the application, the most recent version of the PICO will be called a **PICO confirmation.**

Towards the end of the survey, you can upload a file (up to 25 MB in size). You can use this to give MSAC other information that you think it may find helpful. If the information is available on a website, you do not need to upload it, just link to the information in your answers.

1. **What is the organisation's experience with the proposed health service or technology, or with the related health condition?**

   The Royal Australian College of General Practitioners (RACGP) is the national peak body representing over 50,000 members working in or towards a career in general practice. Our core commitment is to support GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population.

   According to the [2019–20 Medicine Insight General Practice Insights report](#), patients recorded with type 2 diabetes accounted for 11.8% of encounters of the 13.3 million clinical encounters with general practitioners (GPs). Patients with type 1 diabetes represented 0.9% of clinical encounters, and patients with gestational diabetes represented 0.8% of encounters.

   As specialist generalists, GPs play a fundamental role in the prevention, diagnosis, and management of diabetes across the life spectrum of this disease, working with patients at every stage of their healthcare. The holistic, patient-centred, and relationship-based approach of general practice ensures the effective delivery of care and treatment.

   GPs are the anchor within a multidisciplinary team of health professionals delivering high-quality healthcare for diabetes patients. GPs and their teams play a key role in coordinating health care for patients across sectors. General practice is, therefore, central to a health system supporting people with diabetes.

2. **Is the proposed population(s) for the health service or technology appropriate?**

   Examples of information MSAC may find helpful.

   - Are the proposed eligibility criteria appropriate?

   - Are there groups who could benefit from the proposed health service or technology, but who are not included in the eligible population?

   - Is the proposed population too broad? That is, does it include groups who would not benefit from the proposed health service or technology?

   - Are there key differences between the proposed eligible Australian population and the participants in studies or other evidence relied on in the application?

   - Will the proposed eligibility criteria impact (positively or negatively) people who are known to face health inequalities. For example, First Nations people or people with a disability?

   The proposed population(s) / eligibility criteria are described in the 'population' section of the PICO.

The evidence supports individuals with type 2 diabetes on insulin, either basal or basal-plus (with added mealtime insulin), or those using formulated and co-formulated insulin as a defined sub-group for consideration of this technology.

Patient numbers in the high-quality trials were generally low. Additionally, there are concerns about the lack of long-term efficiency data. It is essential to assess whether the benefits can be sustained in real-world settings outside of defined clinical trials, especially given the request for permanent ongoing funding.

We propose this technology would be best utilised in newly initiated users whilst titrating insulin and stabilising glycaemia or when there is a clinical need such as managing recurrent hypoglycaemia. This is in line with National Diabetes Service Scheme (NDSS) guidelines for Self-Monitoring of Blood Glucose (SMBG). For additional details, please refer to the [NDSS 6 month access form](#).

---

3. **Is the proposed approach to delivery of the health service or technology appropriate?**

   Examples of information MSAC may find helpful.

   - Is the proposed delivery of the health service or technology feasible and consistent with Australian clinical practice?

   - Are any proposed limitations appropriate? For example, limitations on:

     ➢ who can deliver the service

     ➢ the number of times a patient may use the proposed health service or technology in a defined period.

   - Does the proposed delivery of the health service or technology raise any access and equity issues? If so:

     ➢ How do these compare to current management?

     ➢ How might these issues be resolved?

   - Are there services not mentioned in the application that need to be used before, with, or after the proposed health service or technology? For example, counselling, dietician, pathology etc.?

     ➢ If yes, what type of services and why are they required? Are these services readily available?

   - Does the proposed approach to delivery create any other barriers? For example, barriers to access for people who are known to face health inequalities, such as First Nations people or people with a disability.

   The proposed approach to delivery is set out in the 'intervention' section of the PICO.

There has been an acceleration in the uptake of technology for managing diabetes, as an adjunct to conventional therapy, to improve self-management and to provide education. This presents both challenges and opportunities for GPs and people with diabetes.

In clinical practice, SMBG is utilised in the management of diabetes. It is used during insulin initiation and titration, as well as for intermittent structured monitoring on a longer-term basis. Additionally, SMBG is utilised in sick day management even if people are not utilising insulin.

Technological innovations for monitoring of glycaemia – such as continuous glucose monitoring (CGM) and flash glucose monitoring, provide greater insights into glycaemic patterns for patients and reduce the need for fingerpick glucose testing. For some patients CGM provides less painful and more discreet methods of monitoring. Presently, these services are restricted to specialised diabetes services that not all patients can access due to costs or lack of access creating unequal health care delivery.

GPs are usually the most accessible health service, but barriers have been unnecessarily created to inhibit GPs from supporting their patients' access and use of CGM systems. GPs are currently excluded from the authorised certifier group to certify patient access to subsidised CGM and flash glucose monitoring products for patients with Type 1 Diabetes Mellitus (T1DM). Managing patients with T1DM within a specialist team is within the scope of specialist GPs. People with T1DM are managed by a healthcare team in which GPs are central. It is therefore essential that GPs be allowed to provide access to this technology for people with T1DM and for people with type 2 diabetes mellitus when this is introduced.

As expert generalists, GPs are professionals who work within their scope of practice and seek relevant education to gain the knowledge and skills they need to serve the needs of their patient population. It is important that GP education and resources are available to enable more GPs to support their patients in CGM. However, the RACGP does not support any mandate for GPs to complete additional educational requirements as this will only increase barriers to patients accessing appropriate diabetes services.

Additional comments regarding implementation of new diabetes technologies have been included in our response to question 8.

4. **Does the comparator(s) set out in the application accurately reflect Australian clinical practice?**

Examples of information MSAC may find helpful.

- Does the comparator(s) in the PICO accurately reflect how the health condition is currently managed in Australia?

- Does the clinical management pathway for the comparator(s) capture current practice?

- Is the comparator applicable in all areas and for all populations? For example, rural and remote areas, First Nations people?

- Is the comparator(s) more, less, or as effective in practice to how the applicant has described it?

- Does the current management of the health condition in Australia raise access or equity issues?

  ➢ If yes, how do these affect individuals with the health condition, their families, and carers?

A description of the comparator(s) for the application is available in the 'comparator' section of the PICO.

Compared to well-structured SMBG, this technology offers more comprehensive insights into glycaemic variables, such as time in range (TIR), usually set between 3.9-10 mmol/L, as well as time below range and hyperglycaemia. By providing minute to hourly visual assessment of glucose levels over the day or weeks, it offers a more detailed view of glycaemic pattern. However, these are not truly real-time due to interstitial glucose lags behind capillary and venous levels by 10-15 minutes. This limitation is mitigated by software that includes alarms for key variables such as real or imminent hypoglycaemia. Additionally, the technology

can offer valuable insights into the effects of food and exercise on glucose levels.

However, the technology does not fully eliminate the need for SMBG, which may be needed to validate hypoglycaemic events. Unfortunately, the technology has a greater Mean Absolute Relative Difference (MARD) when blood glucose level is at higher and lower ranges compared to TIR levels.

As this technology is to be used for people requiring insulin, monitoring of usage should be linked to the insulin prescribed in the recipient. The technology could easily be overutilised if it is accessed by individuals who are not using insulin. There is evidence that for some patients, the technology has the unintended consequences of increasing self-management burden.

5. **Does the organisation agree with the outcomes as set out in the PICO?**

Examples of information MSAC may find helpful.

- Is there a reasonable level of certainty around the proposed outcomes?

- Does the organisation have any concerns about whether the proposed outcomes will be maintained over time?

- Are there other potential outcomes that are not mentioned in the application? For example, patient or system level outcomes.

Comments have been included in our response to questions 2 and 4.

6. **Where the application is for an item on the Medicare Benefits Schedule, does the organisation want to comment on the proposed item descriptor(s)?**

Examples of information MSAC may find helpful.

- Does the proposed descriptor(s) capture any limitations on access or use? For example:

  ➢ types of practitioners or training requirements

  ➢ patient access criteria

  ➢ limitations on the number of times a patient can access the item in a defined period.

- Does the proposed item descriptor(s) cross-reference all relevant MBS item numbers?

The proposed MBS item descriptor is generally set out in the MSAC application form, which is available on the MSAC website.

N/A

7. **Where the application is for an item on the Medicare Benefits Schedule (MBS), does the organisation support the proposed fee for the health service or technology?**

Examples of information MSAC may find helpful.

- Is the proposed fee in line with any similar health services or technologies?

- Does the organisation have a view on other potential costs, such as patient out-of-pocket costs or health system costs?

The proposed MBS fee for service is generally set out in the application form, which is available on the MSAC website.

N/A

8. **If MSAC supported the proposed health service or technology, would the organisation want to see it implemented? If yes, what would have to happen for this to occur? If no, why not?**

   Examples of information MSAC may find helpful.

   ● Does the organisation see any barriers to the successful implementation of the proposed health service or technology? For example, high up-front costs.

   ➢ How might any barriers be addressed?

   ● Are there factors that would facilitate implementation? If yes, what are they?

   ● Are there things that would need to be put in place to support the implementation of the proposed health service or technology? For example, training programs.

   ● Would there be a need to monitor the use of the health service or technology? For example, data capture through a clinical registry or other means?

   > For the successful implementation of new diabetes technologies, changes in healthcare delivery will be necessary. GPs are central to the process as insulin initiation and management of type 2 diabetes falls well within scope of general practice. It is essential that GPs be allowed to provide access to this technology without requiring endocrinologist approval. There should be appropriate educational support for GPs – particularly on the clinical utility of the proposed technologies. Removing patients from the GP setting would increase costs, fragment care, burden patients and carers and defeats quality of life benefits
   >
   > While there may be additional short-term costs in developing educational resources for GPs, the alternative of requiring patients to visit endocrinologist and credentialled diabetes educators (CDEs), could negatively impact healthcare economics, patient satisfaction and accessibility, particularly in regional and rural areas with more limited access to these professionals.

9. **Does the organisation support public funding for the health service or technology, as it is proposed to be delivered?**

   Please choose the most appropriate answer and tell us your reasons for choosing it below.

   ☐ Do not support

   ☒ Support

   ☐ Unsure/Other

   > The RACGP supports application 1785 and achieving equitable access to diabetes technology. We recommend that GPs and primary care workers be allowed to support access to this technology for people living with diabetes in the defined populations.

Next Steps

Thank you for providing input for an organisation, you are almost done. Click 'continue' to finalise and submit the survey.