RACGP

RACGP Submission to the Department of Health on the Development of the Australian National Diabetes Strategy

25 May 2015

The Royal Australian College of General Practitioners

Overview

The new Australian National Diabetes Strategy seeks to prioritise Australia's response to diabetes, and to identify approaches to reduce the impact of diabetes in the community. The strategy is part of the Government's overall strategic framework for managing chronic diseases which recognises the shared health determinants, risk factors and multi-morbidities that exist across a broad range of chronic conditions.

The key goals addressed in the strategy are:

- Goal 1: Reduce the prevalence and incidence of people living with type 2 diabetes
- Goal 2: Promote earlier detection of diabetes
- Goal 3: Reduce the occurrence of diabetes-related complications and improve quality of life among people with diabetes
- Goal 4: Reduce the impact of diabetes in Aboriginal and Torres Strait Islander peoples and other high risk groups
- Goal 5: Strengthen prevention and care through research, evidence and data

Each goal is addressed by answering specific questions, with a 500 word limit for each response. As it is not compulsory to answer every question, the RACGP has only responded to questions relevant to general practice.

Goal 1: Reduce the prevalence and incidence of people living with type 2 diabetes

Question 1:

a) *Which of the areas for action described for this goal are most appropriate and why?*

Prediabetes

Patients at risk of developing diabetes should be assisted, however the RACGP has serious concerns with the use of the term 'prediabetes'. The term is contributing to a widening definition of diabetes capturing people with impaired fasting glucose (IFG) and impaired glucose tolerance (IGT). This has the potential to lead to over diagnosis resulting in unnecessary interventions, tests and treatment.

Gestational diabetes

Similarly, it is important that pregnant women receive the best care possible. However, we need to be aware that the recent lowering of the diagnostic thresholds for gestational diabetes by some groups has resulted in more than twice the number of women classified with gestational diabetes mellitus (GDM), for which the benefits are not proven.[1] This is also likely to lead to a further flow on effect for people being unnecessarily screened for type 2 diabetes after pregnancy. We recommend the position taken in the RACGP's type 2 diabetes guidelines,[4] which reflects current best practice, is formally adopted by the Government.

Lifestyle interventions

Specific support is required for lifestyle interventions for those at high risk of developing type 2 diabetes. Combined non-clinical and clinical approaches to modifiable risks need to be accessible through primary care, and the community. It's crucial that funding is targeted to support programs that have demonstrated their effectiveness and continued research and evaluation is required in this area.

Screening for risk

Similarly, research and evaluation into the effectiveness of tools and programs that identify people at risk of developing diabetes is needed. Such tools and programs must be linked to a national standard for accessible focussed prevention and risk management programs. Better incentives should be available for identifying people at high risk of type 2 diabetes. At present the general practitioner (GP) is only remunerated for screening for people at risk of diabetes if the result is positive. Funding options should be explored that encourage everyone in the 40-49 year old age group to be screened for risk of type 2 diabetes.

Bariatric surgery

Bariatric surgery should be supported for a narrowly defined population of individuals who have suboptimal blood glucose levels and are at increased cardiovascular risk.

b) Are there any additional actions you would you like to see the governments and/or other stakeholders take and why?

Gestational diabetes

As stated above, State Governments should withdraw the implementation of new diagnostic guidelines for gestational diabetes (diabetes in pregnant women) until evidence of benefit for this change is proven.

Question 2:

a) *Please describe any existing programmes, initiatives or activities relevant to this goal that you think are working well and why? (Please indicate if you are aware of an evaluation report, and how it may be obtained)*

b) Are there any existing activities, services or systems relevant to this goal that you think are not working well? (Please explain why, and discuss any barriers to their effectiveness)

Question 3:

The paper outlines some potential ways to measure Australia's progress towards this goal. What do you think would be the most appropriate ways to measure this goal and why?

Use of NDSS

Development of a national database similar to the National Diabetes Service Scheme (NDSS), but with improved functionality, would enable an accurate means to measure this goal. In addition, to improve functionality, increasing awareness of the NDSS role as not only a patient clinical support scheme but also as a national database, will be important. At present, membership of NDSS is incentivised by the subsidy of testing strips. Broader incentives should be examined to ensure all patients with type 2 diabetes enrol in this scheme.

Goal 2: Promote earlier detection of diabetes

Question 4:

a) *Which of the areas for action described for this goal are most appropriate and why?*

The consultation document suggests that to improve early detection of diabetes, primary healthcare practitioners should be educated about who should be screened. It is not a failure in general practitioner knowledge. The problems lie in the systems that are in place. Amending systems in which GPs work can support gaps in education to promote case finding of diabetes in primary care. With appropriate support and education, the RACGP has demonstrated that general practice teams can introduce better systems to identify those at risk and manage care, and also importantly, measure system change. The RACGP's *Standards for general practices (4th edition)*[2] and evidence based resources such as the *Guidelines for preventive activities in general practice* (Red book)[3] and our *General Practice Management of type 2 diabetes 2014-15*[4] should be nationally promoted to address and support systems and standards for the management of diabetes.

Whilst the current RACGP's *Guidelines for preventive activities in general practice*[3] do recommend screening for risk of type 2 diabetes, recent work from the US Preventive Services Taskforce is suggesting that the evidence for population improvement from screening for type 2 diabetes is not convincing.[5] Case finding in high risk populations is suggested as more appropriate (see the introduction section in the RACGP *Guidelines for preventive activities in general practice*[3] for an explanation of the difference between screening and case finding).

Before substantially funding large population screening protocols the Commonwealth should give careful consideration to these findings (as the RACGP is doing as we develop the next edition of our Guidelines for preventive activities in general practice for publication in late 2016).

b) Are there any additional actions you would you like to see the governments and/or other stakeholders take and why?

Question 5:

a) Please describe any existing programmes, initiatives or activities relevant to this goal that you think are working well and why? (Please indicate if you are aware of an evaluation report and how it may be obtained)

The RACGP, in partnership with Diabetes Australia, has produced our type 2 diabetes guidelines for over 18 years. The *General Practice Management of type 2 diabetes 2014-15*,[4] are the most up to date and evidence based guidelines for management of type 2 diabetes in general practice: http://www.racgp.org.au/your-practice/guidelines/diabetes/.

The RACGP remains committed to the ongoing review and development of these guidelines. The latest edition of these guidelines introduced new concepts and advice on managing co-morbidities, individualisation of approaches to differing patients, assessment for distress and depression in diabetes, and the role of clinical governance.

Somewhat alarmingly we note the absence of any reference to these guidelines in the consultation documentation. No doubt this is a reflection of the failure to include GP representation on the advisory group. The guidelines have been providing GPs with practical evidence based recommendations across the spectrum, from identifying those at risk, through to caring for patients at the end of life care. The RACGP's guideline should be referenced and referred to as the evidence base on which primary care achieves quality management of diabetes.

b) Are there any existing activities, services or systems relevant to this goal that you think are not working well? (Please explain why, and discuss any barriers to their effectiveness)

MBS rules

The MBS criteria for funding type 2 diabetes screening in general practice needs reform. Funding is allocated on a fee-for-service basis which does not direct resources where it is needed most or encourage a population health view. The MBS arrangements for completion of a type 2 diabetes cycle of care also need reform. This currently needs to be claimed at a separate attendance to care planning /other non-related presentation, leading to the low utilisation of the Medicare number. Unfortunately, this low utilisation is being misinterpreted as evidence of poor care, whereas it is administrative arrangements that are leading to lower claims. See answers to *Question 7* for further information.

Measurement

The consultation document references the low rate of GPs claiming an annual cycle of care. It is important to again clarify that this is a process measure rather than an indicator of what occurs in primary care. All it illustrates is that reimbursement processes currently in place are not best aligned to quality or quantity improvement nor reflection of care provided, and outcomes achieved.

It should be noted that overdiagnosis (such as of gestational diabetes mellitus in pregnant women) will artificially increase the overall numbers of patients with type 2 diabetes, making such measurements even more misleading.

Question 6:

The paper outlines some potential ways to measure Australia's progress towards this goal. What do you think would be the most appropriate ways to measure this goal and why?

Goal 3: Reduce the occurrence of diabetes-related complications and improve quality of life among people with diabetes

Question 7:

a) Which of the areas for action described for this goal are most appropriate and why?

General practice has the expertise and capacity needed for the identification and comprehensive management of type 2 diabetes. GPs are skilled at allocating levels of care to reflect the complexity of our patients. Our *General Practice Management of type 2 diabetes guidelines*[4] take a patient centred approach that promote the individualisation and prioritisation of care and treatment. For example, some patients on a GPMP do not need allied health support while other very complex patients need several visits (i.e. more than 5) to meet their needs. Work should be done to ensure care is targeted to those most in need.

Clinical guidelines

The RACGP supports the development and implementation of nationally agreed clinical guidelines that are accessible and usable in primary care. This should include involvement from all primary care professional groups. The current NHMRC guidelines were developed in 2009 and are not in a suitable format to achieve this.

Workforce

In regards to proposals on greater utilisation of diabetes educators, the number of diabetes educators is currently insufficient to suggest that expanding their role will free up the capacity of other health professionals. The RACGP suggests the creation of a national diabetes education and training program for existing practice nurses. Whilst education and training can be managed within general practice, current 'credentialing processes and requirements' prohibit general practice staff from attaining diabetes educator accreditation. This is particularly problematic in rural areas. If full 'diabetes educator' status cannot be achieved, then a modified educational standard should be developed to support appropriate multidisciplinary diabetes management into general practice.

Medicines and Devices

The RACGP notes the rapid advancements in the use of technology in management of diabetes (e.g. the progress of insulin pumps to artificial pancreas devices is complete) which are applicable to primary care. Consideration should be given for how such technologies can be appropriately integrated into primary care settings, which has the potential to deliver high quality care far more economically than other sectors of the health system.

Quality auditing at a national level

The consultation document references the low rate of GPs claiming an annual cycle of care. It is important to again clarify that this is a process measure rather than an indicator of what occurs in primary care. All it illustrates is that reimbursement processes currently in place are not best aligned to quality or quantity improvement nor reflection of care provided, and outcomes achieved.

b) Are there any additional actions you would you like to see the governments and/or other stakeholders take and why?

Collaborative care

The RACGP supports systems that promote the linkage of high quality secondary and tertiary diabetes care networks (e.g. National Association of Diabetes Centres) that support continual management in general practice through:

- expanded telemedicine services to regional and remote Australia – targeting local need, and supporting local service.
- expansion of education and training and incentives to support interventions such as retinal photography screening, that can be embedded into primary care settings and deliver enhanced quality and savings.
- promoting systems to enhance and embed education and skills of primary care services 'community based' specialist support rather than tertiary and secondary care support – allowing very complex patients to be seen within their own community setting. e.g. an endocrinology service rotating through primary care clinics instead of having to access hospital clinics or outpatient services.

Role for the NDSS

The NDSS should be further promoted to increase awareness for its role not only as a patient clinical support scheme but also as a national database.

Question 8:

a) *Please describe any existing programmes, initiatives or activities relevant to this goal that you think are working well and why? (Please indicate if you are aware of an evaluation report and how it may be obtained)*

Enhance existing chronic disease management (CDM) systems

MBS chronic disease management item numbers have supported general practice to introduce structured diabetes care programs which allow GPs to establish a cycle of care for people with diabetes. Existing CDM systems work well, and implementation of the CDM model has allowed the development of care models in general practice that are appropriate and are evidence based.[6] As already remarked above, further work needs to be performed to ensure care is targeted to those patients who are in highest need. Included in this should be targeted transfer of patients from hospital based clinics back into the primary care sector.

b) Are there any existing activities, services or systems relevant to this goal that you think are not working well? (Please explain why, and discuss any barriers to their effectiveness)

Question 9:

The paper outlines some potential ways to measure Australia's progress towards this goal. What do you think would be the most appropriate ways to measure this goal and why?

Goal 4: Reduce the impact of diabetes in Aboriginal and Torres Strait Islander peoples and other high risk groups

Question 10:

a) Which of the areas for action described for this goal are most appropriate and why?

Community ownership and leadership

While a focus on health education services is welcome, this should be led by the local community and their needs. It should not be assumed that the main problem in Aboriginal and Torres Strait Islander communities is a lack of knowledge or awareness about diabetes. Many Aboriginal and Torres Strait Islander people have a very good knowledge of diabetes and its consequences, because they live with it in themselves and their families every day.

It is good to see mention of health promoting environments and access to healthy food. This will require locally determined policy approaches that are affordable and culturally appropriate. In food security, this may include subsidised fruit and vegetable programmes (with evidence emerging that this has beneficial health effects), community gardens, changes to food (e.g. salt content) and food labelling regulations, and tax policy on food. Access to affordable areas for exercise, including safe, clean parks, and subsidised exercise groups may also be important.

The focus on maternal care is welcome and is likely to be highly effective in improving rates of diabetes in the future. This also reemphasises the need for accessible quality primary health care services for all Aboriginal and Torres Strait Islander people.

The goal relating to workforce will be crucial, and the focus on Aboriginal primary care services is the appropriate approach. While diabetes educators are important, thought should be given to research into which allied health team composition and skills most serve each local community need. Thought is also needed about increasing the number of Aboriginal and Torres Strait Islander health workers, nurses, podiatrists, dietitians, exercise physiotherapists, endocrinologists, and other groups working in Aboriginal health settings. There should also be scope for innovative models of self-managed care – such as peer-supported care, group work, telehealth, etc.

b) Are there any additional actions you would you like to see the governments and/or other stakeholders take and why?

The prevalence of diabetes is associated with socioeconomic status, but is worse in Aboriginal people at all levels of socioeconomic status. This is thought to be due to historical and current racism and trauma. This must be addressed as one of the social determinants of type 2 diabetes. Policies outside the health portfolio should be assessed for their effect on the health of Aboriginal and Torres Strait Islander people.

There should be a focus on person-centred care, not just disease-focussed. Many people with diabetes will also have other co-morbidities and disabilities, including a high prevalence of mental health/social and emotional wellbeing problems. Without addressing these, diabetes management will not succeed. Evidence from the Northern Territory shows that current services are underfunded to provide the full range of recommended care for diabetes in remote Northern Territory clinics.[7] It is likely that this is true in other services too. It will be impossible to achieve these improvements without adequate funding provision over the long term.

Question 11:

a) *Please describe any existing programmes, initiatives or activities relevant to this goal that you think are working well and why? (Please indicate if you are aware of an evaluation report and how it may be obtained)*

The Aboriginal community controlled health sector has consistently provided excellent care to their communities. They have a proven track record of providing accessible care to people who are often uncomfortable accessing other services in the health system. Other services that have performed well have done so with models that are similar to the Aboriginal community controlled health organisation (ACCHO) model, in being highly responsive to local Aboriginal community needs, and providing holistic care across a broad range, often seen as non-medical by other parts of the health sector.

b) Are there any existing activities, services or systems relevant to this goal that you think are not working well? (Please explain why, and discuss any barriers to their effectiveness)

Strategies and services to improve diabetes in Aboriginal and Torres Strait Islander communities must be led by, developed by, implemented by and evaluated by the Aboriginal communities they are servicing.[8,9] Funding should be provided over the long term. The evidence is clear that this is crucial for success.[10]

Question 12:

The paper outlines some potential ways to measure Australia's progress towards this goal. What do you think would be the most appropriate ways to measure this goal and why?

The suggested goals are reasonable. It might be useful to add socioeconomic measures, as poverty and inequality are clear drivers of diabetes rates. In addition, any measures of access to fresh food or rates of physical activity would also help assess the social causes of diabetes.
It may also be useful to measure ability to access primary health care, or satisfaction with primary health care, as these are going to be crucial in managing diabetes.

Question 13:

In relation to the impact of diabetes in Aboriginal and Torres Strait Islander peoples and high risk groups, please describe any barriers in accessing health services and/or education.

The barriers for Aboriginal and Torres Strait Islander people in accessing health care are well described in the literature.[11] Barriers include cost, transport, competing commitments, racism experienced in health systems and culturally inappropriate services or staff.

Goal 5: Strengthen prevention and care through research, evidence and data

Question 14:

a) Which of the areas for action described for this goal are most appropriate and why?

Health services research is important e.g. developing models of care which will optimise diabetes management in primary care. More support is needed for research into primary care needs, care models and outcome analysis. This includes support for research into the implementation of new technologies appropriate to assist in improving diabetes care in general practice. As such, it is important to incorporate and align primary care research into a national research agenda (to help bridge the gap between research/guidelines and practice) with integration across all health services. Ongoing funding for studies into the role for general practice in prevention through enhancement of general practice involvement in research, support for research to develop quality general practice databases so that there can be research into current diabetes care occurring in general practice and interventions developed as a result.

b) Are there any additional actions you would you like to see the governments and/or other stakeholders take and why?

Create a specific and separate general practice research fund

Recent studies demonstrate that patients with type 2 diabetes who receive multidisciplinary, community-based, integrated primary-secondary care diabetes service had reduced numbers of hospitalisations with no change in quality of care or outcomes of care.[12] Continued primary care research into diabetes and chronic disease prevention and management, through an independent merit based funding stream under the NHMRC and other federal funding systems should be supported.

Improved research and development of clinical governance in primary care

The RACGP supports ongoing support for, and research into, optimising and improving primary care clinical governance systems for chronic disease management and the linkage to improved diabetes management. The Government should recognise and reimburse high quality general practice for appropriate and targeted implementation of quality governance systems. Published research positively supports such initiatives, improving patient outcomes. Further development logically should be founded upon existing chronic disease management programmes, with proven track records. Elements identified include embedding the functional use of general practice diabetes database management, recall and reminder systems, linked to chronic disease management, combined with allied health referral support.

Question 15:

a) Please describe any existing programmes, initiatives or activities relevant to this goal that you think are working well and why? (Please indicate if you are aware of an evaluation report and how it may be obtained)

b) Are there any existing activities, services or systems relevant to this goal that you think are not working well? (Please explain why, and discuss any barriers to their effectiveness)

Question 16:

The paper outlines some potential ways to measure Australia's progress towards this goal. What do you think would be the most appropriate ways to measure this goal and why?

Whilst the number of publications are important, the impact of many primary care journals are lower than many science based journals. Translating published work into practice is no small task, and arguably more important, and increased focus needs to be placed on this.

Final comments

Question 17:

Please provide any further comments you may have.

General practice plays an integral role in type 2 diabetes prevention and management. General practice has embraced its responsibilities in this area and demonstrated its commitment and ability to deliver patient centred, high quality, and affordable care.

The consultation paper identifies key areas of action for a national diabetes strategy. These areas are closely aligned to core areas of general practice: prevention, care coordination, and management of multimorbidities.

Most people with type 2 diabetes have more than one chronic condition. Research suggests 95.6% of patients with type 2 diabetes have at least one other chronic condition and 38.6% have five or more.[13] These people need generalist care and their GP to play the central coordinating role for all their care needs.

To support the profession, the RACGP has produced its *General practice guidelines for type 2 diabetes*[4] for over 18 years. These guidelines provide GPs with practical evidence based advice on managing type 2 diabetes across the spectrum, from identification to end of life care. In addition, our *Guidelines for preventive activities in general practice* (Red book)[3] underpin the GPs role in prevention. Other resources such as our clinical indicators and continual education programs further support GPs in delivering high quality diabetes care.

In developing these resources, the RACGP has demonstrated its commitment, and the commitment of the profession, to tackling diabetes. A key part of a national strategy should be to recognise, support, and build on these existing resources and initiatives.

We believe general practice has the expertise and capacity to take an even larger role in diabetes management. Trials are demonstrating the opportunities that exist to devolve more care from hospitals.[12] There is also scope for GPs to play a greater role in the management of type 1 diabetes. The Government's strategy should invest in research and evaluation that explore these models of care.

It is crystal clear that if Australia is to tackle the growing burden of diabetes, the role of general practice must not only be properly recognised, but it must be strengthened. It is astonishing, therefore, that general practice was not represented on the National Diabetes Strategy Advisory Group. A specialist centric view of the problems and potential solutions will fail to meet the challenges we face.

Piece meal reforms and initiatives are likely to have a small impact. A more systematic reform agenda is required. The RACGP's recently released Vision for a sustainable health systems, http://www.racgp.org.au/support/advocacy/vision/ sets out the changes required to better look after the

health of Australians and tackle rising health costs as the population ages and chronic disease rates increase.

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