Development of the Australian National Diabetes Strategy

Online Public Consultation

Questionnaire

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

500 word limit for each response

Question 1:

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

The consultation paper identifies 3 areas for action including: reduce the prevalence of modifiable risk factors in the general population; identify and provide prevention programmes to people with diabetes; and ensure pregnant women and children get optimal care. While they are all important areas for action, the AMA believes that identifying and providing prevention programmes to people with prediabetes should be the priority for this goal.

With 20% of the population at high risk for developing diabetes Type 2 and 50% of new diagnoses over the next decade expected from this cohort, preventing their diabetes will generate significant savings on medium term health care expenditure. However, this area for action must be supported with action to reduce the prevalence of modifiable risk factors and to keep people healthy including increasing the health literacy and physical activity of the general population.

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

General practitioners must be supported with incentives, MBS items for Point of Care Testing (POCT) and more flexible MBS Health Assessment items to encourage pro-active identification of at-risk patients and enable preventative action to be taken. Health Assessment items are currently restricted to people aged 40-49 with a high risk of developing diabetes Type 2. With the rate of overweightness and obesity increasing across the age ranges, many people at risk of diabetes fall outside the qualifying age ranges for MBS funded health assessments.

In addition, funding needs to be made available to support standard capability across clinical software platforms used in general practice to enhance GPs' capacity to capture, store and utilise patient data to identify those patients at risk of developing diabetes Type 2.

Additional support with regard to patient education resources and enhanced access to allied health services to support patients with lifestyle modification will be essential if modifiable risks are to be reduced, and the development of diabetes Type 2 prevented.

The AMA position statement on Obesity -2009 identifies a number of actions that Governments can take to reduce obesity and the diseases associated with it. These include:

- Encouraging and supporting all Australian mothers to solely breastfeed their babies for the first six months of life (unless there are medical contraindications);
- Whole of school-curriculum programs around nutrition;
- Requiring school canteens to provide only healthy food choices;
- Prohibiting the marketing and promotion of energy-dense/nutrient poor food to children;
- Introduction of simple and uniform 'front of pack' nutritional labelling for packaged food;
- Higher taxes applied to energy-dense/nutrient poor foods;
- Subsidising healthy food, especially in remote areas;

- Encouraging food industry and retail food outlets to adopt measures to reduce the production, sale and consumption of energy dense and nutrient poor products applying penalties for non-compliance;
- Ensuring all new housing developments provide local access to retail outlets for fruit, vegetables and other fresh food; and
- Town planning regulations governing house, urban development and transport infrastructure that mandate the incorporation of measures to promote and facilitate physical activity.

Public health campaign health campaigns should make it clear that Type 2 diabetes is preventable and that the best way for Australians to protect themselves against it is have a healthy diet and be physically active.

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)

Students as Lifestyle Activists (SALSA) – This programme is based on peer education models in which volunteer Year 10 students are trained to be peer leaders who then go on to teach Year 8 students about the value of nutrition and physical activity. It is a collaborative project between Rooty Hill High School, Western Sydney Local Health District and Mt Druitt and Blacktown Medical Practitioners' Associations. SALSA has been running for over 10 years and is currently run in 13 high schools in Sydney. More information is available from: http://sydney.edu.au/medicine/public-health/salsa-triple-a/salsa/index.php

Nurse Family Partnership Programme – This programme involves a series of programmed visits during pregnancy and following birth, delivering around 50 visits by the time the child is aged two years. This program has demonstrated acceptability when implemented in Aboriginal and Torres Strait Islander communities.

Life! – This program provides lifestyle modification coaching and support from trained health professionals to support people at high risk of Type 2 Diabetes, health disease or stroke in preventing the onset of disease and to reach their goals for a healthier life. More information is available at http://www.lifeprogram.org.au/.

The AMA, however, is not aware of any evaluation conducted or report published on these programs.

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)

The AMA does not have any information about existing activities, services or systems relevant to this goal that are not working well. This is partly because many of these programs are being funded on a short term basis and few are being evaluated.

The AMA believes there must be a mechanism for evaluating the success of the existing programs/activities, in particular from the perspective of patients. Without a proper evaluation, it would be difficult to determine the impact of these programs/activities in reducing the prevalence and incidence of people developing type 2 diabetes.

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?

Measuring the percentage of the population developing, or with, diabetes is the most appropriate way to measure Australia's progress towards this goal, as it reflects the burden, prevalence and incidence of people developing type 2 diabetes within the community. However, the AMA notes that it would be difficult to accurately estimate the percentage of the population with diabetes other than via a periodic survey of the population.

Goal 2: Promote earlier detection of diabetes

500 word limit for each response

Question 4:

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

Actions to improve the detection of Type 2 diabetes in primary care should be a priority, given early detection and management can reverse the condition. Targeted screening of those patients identified as at risk of developing Type 2 diabetes should facilitate not only prevention but early diagnosis in those who have unknowingly developed the condition.

The AMA notes that the consultation paper at 3.2.1 implies that primary healthcare practitioners need education regarding whom to screen. Greater clarity is required here as to whether practitioners other than GPs are being referred to. GPs are the highest trained general health professional with a minimum of 10 to 15 years training. A GP's skills encompass: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling. GPs are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom or health concern. The AMA would argue that GPs are better equipped than any other primary health care provider to identify a patient's risk factors for diabetes and to appropriately screen those identified as at risk.

Further to the comments above about GPs skills and diagnostic role, the AMA would query, unless there is evidence to suggest that GPs are missing presentations of Type 1 Diabetes, the value in directing resources to educating those already educated to recognise the symptoms. Any awareness campaign of the signs of Type 1 Diabetes should be targeted at those members of the community involved in caring for children and should emphasise the importance of raising any concerns with a GP, preferably the child's usual GP.

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

It is most important that the community understand the risk factors for Type 2 Diabetes, the potential consequences of ignoring them, and that the "cure" is in their hands. Campaigns to educate the community on this score and what help is available to mitigate the risks and thus avoid developing Type 2 Diabetes should be a high priority.

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)

Diabetes Queensland delivers a number of services (for health professionals) in the community to increase early detection of people who have diabetes including:

Are you at risk? Is an online risk assessment for type 2 diabetes. If a person is at a high risk, the relevant tests will need to be done by the health professional to assist in the diagnosis of type 2 diabetes, or pre-diabetes.

Know your number? Is a Pharmacy based risk detection, aims to increase the awareness about blood pressure and the impact of type 2 diabetes in the community. Screening is carried out by trained individuals at community screening stations using the AUSDRISK tool.

The AMA, however, is not aware of any evaluation conducted or report published on these programs.

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)

The AMA does not have any information about existing activities, services or systems relevant to this goal that are not working well.

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?

The number of people screened for risk of diabetes annually would be the most appropriate way to measure Australia's progress towards this goal. While this is likely to be difficult to measure, the AMA notes that one potential way is to count the number of people who use the AUSDRISK screening tool, or to count Medicare claims data for tests in people who do not have diabetes, including oral glucose tests, fasting plasma glucose and diagnostic HbA1c.

Alternatively, the University of Sydney Bettering Evaluation and Care of Health (BEACH) data currently records the problems managed when a patient visits a GP. Screening for diabetes could be specifically added to this data collection to provide a valid indication of the rate of screening. The 'new conditions managed' data would then provide an indication of the rate of diagnosis comparative to the rate of diabetes screening. Over time this data would also provide an indication of success rates in reducing modifiable risks, as the rate of those at high risk for diabetes decline or increase it would be expected the rate of screening and diagnosis would also decline or increase.

Further, the MBS Health Assessment items for a type 2 diabetes evaluation require the completion of the AUSDRISK tool. Removing the age restriction for this item would provide a ready mechanism for counting the level of screening done for at risk groups.

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

500 word limit for each response

Question 7:

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

There are a number of areas for action identified in the consultation paper that would be most appropriate for this goal, including nationally agreed clinical guidelines, quality improvement processes and improved funding arrangements and incentives.

While a single set of national guidelines would provide greater clarity for medical practitioners in screening, managing and treating diabetes, care must be exercised in their application. Given that many people with diabetes suffer multi-morbidities strict adherence to single disease guidelines may not provide the best care for the individual patient. This may well account in part for why clinical guidelines are not followed in 37 per cent of diabetes clinical encounters. Guidelines are just that, and doctors take the whole patient into account when providing health and medical care.

Additionally care will need to be exercised when refining the guidelines given the variations in recommendations. For example the RACGP *General practice management of type 2 diabetes 2014-15* states on page 95 that 'the Australian diabetes in Pregnancy Society (ADIPS) recommendations are considered controversial both nationally and internationally (Ref 166) and have not been endorsed by the RACGP. There is a lack of clinical evidence that intervention is beneficial in the additional women identified by the new screening criteria. Until further evidence is forthcoming, existing recommendations remain the basis of RACGP support.' Furthermore, while the RACGP recommends a two-step diagnostic process for women between 26 and 28 weeks gestation, the Royal Australian and New Zealand College of Gynaecologists recommends a single step process for women at 24-28 weeks gestation.

Programs and initiatives that support patients with diabetes taking responsibility for and actively managing their condition should be encouraged and appropriately funded. The AMA Chronic Disease plan: Improving care for patients with chronic and complex care needs provides a framework for GP-led, coordinated and multidisciplinary care that recognises and responds to the reality that some patients need greater support then others in managing their condition/s.

High quality care across the health sector must be underpinned with appropriate and effective transfer of care arrangements. The AMA would expect that Primary Health Networks will have a significant role to play in streamlining care pathways as diabetic patients' transition across and between medical and health care providers, health sectors and community care.

GP-led coordinated care such as that outlined in the AMA Chronic Disease Plan and which is a fundamental element of the Department of Veterans' Affairs Coordinated Veterans' Care program is essential in delivering patient centred and holistic care.

Funding evidence-based preventative and quality care must be viewed as an investment in the nation's health. General practice has consistently demonstrated it is the most efficient and cost effective part of the health system. Recent BEACH reports show that the same service provided by GPs for around $50 would cost $396 and $599 if performed in a hospital emergency department. We know from the Queensland

Coordinated Care Trials that coordinated care reduced hospital admissions by up to 25%, reduced inpatient costs by 26%, reduced patients rate of depression and improved their quality of life. When all costs are included service provision costs can be reduced by 8%. The trials also demonstrated that patients connected to community models of care were more active in their own health maintenance.

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

The AMA strongly supports team based care within the medical model, with appropriate delegation to other health care providers who have the relevant skills and expertise. GPs are the highest trained generalist practitioner in primary health care with the skills to diagnose, treat, manage and appropriately refer where additional support or specialist care is required. The involvement of other health providers has the potential to fragment patient care and lead to poor health outcomes, unless it is well coordinated. Recognising that there is scope to better utilise the skills of other health practitioners in the medical model, to enhance workforce capacity the Government should concentrate on:

1. ensuring that adequate numbers of GPs, practice nurses, diabetes educators, psychologists, podiatrists, dieticians, exercise physiologists, Aboriginal Health Workers and other allied professionals relevant to the care of diabetic patients are trained and encouraged to work in areas of need to enhance workforce capacity; and
2. ensuring funding is available to support patients with additional care needs to access the care they need.

The AMA has been in discussions for some time with the Department of Health about chronic disease reform. The AMA recognises that there is scope to improve the current structure of MBS items to strengthen the role of a patients usual GP as well as better recognise longitudinal care. Consideration also needs to be given to how patients with higher care needs could be better supported, with the DVA CVC program offering a good model that could be applied more broadly.

To maximise the benefits to patients of available funding new arrangements need to be put in place to better support GPs in providing patients with chronic and complex disease with access to multidisciplinary care and essential support services.

Furthermore, in light of strong evidence that disadvantaged communities, whether due to economic disadvantage or remoteness, are at a higher risk of developing diabetes, additional resources are required to ensure these communities have access to preventative and coordinated health care. Outreach services that align with communities needs and are developed collaboratively with the community may be beneficial in ensuring coverage of care.

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)

HARP: Hospital Admission Risk Program – This Victorian program provides integrated and coordinated care to diabetics (among others with chronic and complex health care needs) frequently presenting to hospital or a risk of doing so. More information is at http://www.health.vic.gov.au/harp/index.htm. The AMA, however, is not aware of evaluation conducted on this program.

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)

The AMA does not have any information about existing activities, services or systems relevant to this goal that are not working well.

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?

The percentage of people with diabetes with high HbA1c, cholesterol or blood pressure would be the most appropriate way to measure Australia's progress towards this goal. As the paper highlighted, these metabolic indicators are good predictors of a person's long-term likelihood of developing diabetes-related complications. However, the AMA notes that there is currently no nationally standardised way to collect this data and the Government should strive to identify and implement a mechanism for doing so.

Relevant to the collection of HbA1c, cholesterol or blood pressure data, the paper highlights that a significant proportion of diabetics are not receiving the recommended checks but this assumption is primarily based on the MBS claims made by GPs for a completed annual cycle of care. Completion of the annual cycle of care item may not be the best measure. For many GPs, a large proportion of the required elements of the diabetes cycle of care item are business as usual, although the claiming of the cycle of care item is not, and the red tape involved in claiming the additional item may also act as a barrier. Much clinical information on patients is recorded free hand and is thus difficult to readily extract from practice clinical systems. The item for some practitioners may not justify the time required in determining if all the requirements have been fulfilled. In addition, we know from the National Health Performance Authority *Healthy communities: Frequent GP attenders and their use of health services in 2012-13* report that some patients are seeing multiple practitioners. For these patients, it would be unlikely that any one practitioner could claim the item. Furthermore, claiming the item is only relevant for those participating in the Practice Incentives Program Diabetes Incentive.

Measuring patient's progress towards recommended targets rather than the achievement of the target per se would better demonstrate the effect of preventative health initiatives in reducing the risks of diabetes related complications. A Quality Improvement incentive through the Practice Incentive Program would help facilitate the record of such progress. In addition, a Quality Improvement incentive could be used to track the HbA1c, cholesterol, blood pressure and any number of diabetes related complications of a diabetic population. The incentive, however would be limited to practices participating in the Practice Incentives Program.

Practice software systems that unilaterally enabled practitioners to quickly and easily record that recommended screening activities for complexities had been undertaken would help facilitate the measurement of such activity. This would not only help facilitate the completion of cycles of care, but the collection of data that could be utilised to demonstrate improved patient outcomes under any Quality Improvement incentive. Funding would need to be made available to software providers to support the introduction of such capability across the clinical software sector.

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

500 word limit for each response

Question 10:

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

The AMA believes an area for action targeting Aboriginal and Torres Strait Islander peoples should be a priority for this goal though other groups at high risk, including culturally and linguistically diverse people, older Australians and Australians living in rural and remote areas, should not be neglected.

The AMA would agree that culturally relevant awareness education initiatives provided in school; before and during pregnancy; and to diabetics and their families should be provided. Educational resources and their application, along with any initiatives to create a health promoting environment should be developed in consultation with Aboriginal and Torres Strait Islander (ATSI) communities to ensure they are culturally sensitive and appropriate for each community. Partnering with the community will help enhance their involvement, help foster peer support mechanisms and success of any initiative.

As per the AMA Position Statement on Nutrition 2005 access to affordable fresh fruits and vegetables for every Australian should be a priority for Government. Providing such access for Aboriginal and Torres Strait Islander peoples in particular should be a priority given 20% over the age of 25 have Type 2 Diabetes and the rapid progression of its severity and complications within this group.

Any initiatives to create a health promoting environment must be developed in partnership and in a culturally sensitive way with ATSI communities.

In line with the AMA position statement Aboriginal and Torres Strait Islander Health 2005, the AMA supports initiatives to increase the number of health practitioners, including diabetes educators and Aboriginal Health Workers, working with and within Aboriginal primary care settings. The government needs to provide additional fully funded training to address the total shortfall of health professionals providing services to Aboriginal peoples and Torres Strait Islanders.

In addition, in consultation with NACCHO, it is proposed that enhancing the capacity of the Aboriginal Health Worker workforce to assist medical providers with patient care coordination should help facilitate access to culturally sensitive health and support services.

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

With access to health services an issue for Aboriginal and Torres Strait Islander communities, resources to facilitate preventative in-the-home health education from Aboriginal Health Services would be beneficial.

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)

Australian Indigenous HealthInfoNet provides an extensive listing of programs and projects that address diabetes among Aboriginal and Torres Strait Islander peoples. This can be accessed at: http://www.healthinfonet.ecu.edu.au/chronic-conditions/diabetes/programs-projects.

The Aboriginal Life! program is a type 2 diabetes prevention program funded by the Victorian Government, for Aboriginal people and their families. It is coordinated by Diabetes Australia Victoria as part of the *Life!* program. The program aims to identify people at high risk of developing type 2 diabetes using the Diabetes Risk Test (Type 2 Diabetes Risk Assessment Tool for Aboriginal Victorians), and to deliver a healthy lifestyle program (Road to Good Health course) to reduce the risk of progression to diabetes. Studies have shown that interventions that support lifestyle change can prevent up to 58% of the expected progression to diabetes.

The Road to Good Health course is a group-based healthy lifestyle program for Aboriginal people and their families. It helps Aboriginal people identified at high risk to get off the road to type 2 diabetes and on the road to good health. The course is about helping people make sustainable lifestyle changes, like choosing healthier food and drink and being more physically active, which helps reduce the risk of developing type 2 diabetes and other problems such as heart disease and high blood pressure. The course is free and run in local communities by Aboriginal Health Workers and health professionals who have been trained to deliver the course.

The 2012-13 Report Card "*The Healthy Early Years – Getting the Right Start in Life*" collates the most up to date research and evidence on the factors in the early life of Aboriginal and Torres Strait Islander children that determine their later life health outcomes. On the basis of that evidence, the 2012-13 Report Card makes a range of recommendations to Governments to improve health and wellbeing in the early years, in the following areas:

- Development of a comprehensive plan for maternal and child services;
- Support for families at risk;
- Measures to keep children at school;
- Strengthening community capacity;
- Improving the living environment, and
- Ensuring better data, research and evaluation.

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)

The AMA does not have the information about any existing activities, services or systems relevant to this goal that are not working well.

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?

Measuring the percentage of people with diabetes in groups at higher risk with high HbA1c, cholesterol or blood pressure would be the most appropriate way to measure Australia's progress towards this goal. The AMA would agree that these metabolic indicators are good predictors of a person's long-term likelihood of developing diabetes-related complications and would require the government to develop a nationally standardised way to collect these data.

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 Closing the Gap Report "Improving the accessibility of health services in urban and regional settings for indigenous people" identified a number of barriers and facilitators to adequate health service access for ATSI peoples. The report is available at: http://www.aihw.gov.au/uploadedfiles/closingthegap/content/publications/2013/ctgc-rs27.pdf

The report indicates accessible health services are those that are physically available, affordable (economic accessibility), appropriate and acceptable. Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical barriers and economic barriers, or if the community is not aware of available services. Differing concepts of health and treatment of illness, reluctance to engage due to colonial history and past injustices and language and communication barriers also contributed to this problem.

The report also provides strategies for improving Indigenous access to urban and regional health services including:

- Addressing physical and economic barriers through strategies such as:
  - providing services locally;
  - providing transport to health services;
  - having flexibility in setting appointments;
  - using home visitation as part of a multi-faceted engagement strategy;
  - increasing services that do not require co-payment; and
  - improving access to private health insurance and private health services.
- Addressing cultural competence, acceptability and appropriateness through strategies such as:
  - developing services around the holistic model of health and wellbeing;
  - building therapeutic and clinical relationships based on trust and mutual respect;
  - employing Indigenous health professionals and health workers to promote culturally safe service delivery;
  - where feasible, providing a choice between Indigenous-specific and non-Indigenous–specific health professionals and services
  - adopting strategies that support cultural competency and safety at the systemic, organisational and individual levels, including appropriate communication styles, and working through community Elders and kinship networks; and
  - providing services in non-traditional settings.

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

500 word limit for each response

Question 14:

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

A priority in determining areas for future research into diabetes is to ensure access to comprehensive and relevant data on a national level. Quality data will provide indicators for what action is needed and where it is needed. It will help identify what interventions are effective and which ones are not. Data sharing not only between providers but across health sectors will be essential in the compilation of robust data that will drive any national research agenda.

Research should be prioritised around preventing or finding a cure for Type 1 Diabetes as opposed to Type 2 Diabetes, as the latter is lifestyle disease which evidence informs us can be prevented, better managed, and

in some cases reversed. While Type 1 Diabetes may affect fewer people and not have the same overall cost impact as Type 2 Diabetes it is a lifelong autoimmune disease with complex origin, dramatic onset and a strong association with serious long term health complications. It incurs substantial costs to the Australian health system due to the cost of ongoing medication and hospitalisation for ongoing health complications.

With regard to Type 2 Diabetes there is already a significant body of evidence as to its risk factors, prevention and better management. For example, the Coordinated Care Trials and Primary Care Collaboratives have shown the benefits of GP-led coordinated care in the better management of chronic disease (such as Type 2 diabetes) increased best practice, reduce hospital admissions and in-patient costs; as well as overall service provision costs. Through the Primary Care Collaboratives the data collected on biomedical indicators has improved. What is needed now are the development and implementation of models of care compatible with the Australian health system to support integrated care pathways with care coordinated and led by the usual GP.

The AMA is supportive of initiatives that align and target diabetes research. Funding this research, however must not be at the expense of existing frontline services and programs. The indexation freeze on MBS items, for example, devalues patient rebates in the face of rising service delivery costs. It will reduce the viability of some services, and over time force a rise in patient out of pocket expenses. Those with limited incomes and existing service access issues, may be discouraged from seeking medical care and adhering to planned care and referred allied health care, exacerbating the advancement of their condition and risk of complications. Delayed diagnosis, managing avoidable complexities, and failing to prevent avoidable hospitalisation will only shift the cost of health expenditure from the most efficient and cost effective end of the care continuum (i.e. General Practice) to the most expensive end (i.e. Hospital care). The Government must reverse its freeze on MBS indexation immediately.

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

General practice is the central point around which a patient's health is monitored, treatment provided, and care transitioned. It will be essential that any research initiatives involve general practice.

As previously mentioned, GPs capacity to capture, store and utilise patient data must be enhanced, but without interfering or intruding on clinical practice. Practice clinical systems across the board must facilitate the routine collection of key biomedical indicators for their patient population that can be aggregated and shared to direct continuous quality improvement initiatives.

Funding must be provided to support software development that enables seamless data collection, sharing and transfer, and its implementation, including for system upgrades and provider training.

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)

The Improvement Foundation supports general practices with information to facilitate and encourage quality improvement practices. The Foundation also provides access to IT systems, such as the Pen Clinical Audit Tool which enables robust measurement of improvement efforts. Practices are able to assess their own data against best practice standards and benchmark improvements against the Medicare Local, State or Territory and national averages. This ability for practices to compare their outcomes provides an effective tool for driving continuous quality improvement and for directing their future quality improvement activities.

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)

The AMA does not have the information about any existing activities, services or systems relevant to this goal that are not working well.

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?

Progress towards key milestones in developing national diabetes datasets will be fundamental to the Diabetes Strategy in providing the basis for assessment, action and measure of improvement.

Final comments

Question 17:

1,000–2,000 word limit

Please provide any further comments you may have.

- The AMA is disappointed that there is not a practising general practitioner on the National Diabetes Strategy Advisory Group. General practice is well placed to provide preventative advice, screen for risk factors, diagnose, treat and manage diabetes. In the last year GPs provided 128 million consultations and they are the only practitioner who see 80% of the population at least once a year and most patients an average of five times per year. The perspective of a practising GP, in developing the National Diabetes Strategy and the strategic framework that will underpin it, would have helped the group to better understand and acknowledge the fundamental role of general practice in diabetes prevention and care and the challenges faced at the coalface. Nevertheless, the AMA hopes that its response will assist the Group in this regard.
- The National Diabetes Strategy must not promote models of care that would lead to fragmentation of patients' care. Service delivery must be appropriately funded, co-ordinated and provided by those best qualified. Care pathways must be integrated and seamless to the patient. Clear communication protocols and mechanisms must be developed and supported to facilitate this seamless care from GP to allied health provider to hospital/aged care facility and back again. The AMA would expect PHNs to have a role in facilitating streamlined care pathways. Where pathways involve the transition from one health care sector to another or shared care in a multidisciplinary team the flow of quality information is essential, and patient care must be seamless. Mechanisms, such as an effective eHealth record and timely discharge summaries, must be adequately funded to support the transfer of appropriate and relevant information between care providers.
- The majority of seamless care can be provided by the patient's usual GP. However, that care must be adequately funded to ensure GPs can spend the time required on liaison and care coordination, and prevention activities.
- Given the breadth of the problem and specific challenges when it comes to the Aboriginal peoples and Torres Strait Islanders, as well as other disadvantaged groups such as CALD, older Australians and rural and remote communities, there will be no one-size-fits-all solution. Strategic priorities and initiatives for action must be developed in partnership with those communities most at risk.
- Where possible, models of care should be trialled particularly in those areas that would most benefit especially in those communities demonstrating high level risk for diabetes. The AMA would expect that the Primary Health Networks would be well placed to assist with the identification of such areas.
- PHNs would also have a role in facilitating streamlined care pathways. Where pathways involve the transition from one health care sector to another or shared care in a multidisciplinary team patient care must be seamless. Mechanisms, such as an effective eHealth record, must be funded that will support the transfer of appropriate and relevant information between care providers. The majority of seamless care can be provided by the patient's usual GP. However, it must be adequately funded to ensure GPs can spend the time required on liaison and care coordination, and prevention activities.