NZMA
New Zealand Medical Association

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Living Well with Diabetes: a draft plan for health services for people with diabetes 2015–2020

Dear Sam

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above consultation. The NZMA is the medical profession's leading pan-professional body, and includes over 5000 members from all disciplines within medicine as well as medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders. Our submission has been informed by feedback by our advisory councils as well as the Board.

General Comments

1. The rising prevalence of type 2 diabetes in New Zealand is a serious health challenge, and we welcome the work the Ministry is doing in this area. While aspects of the draft plan are welcome (eg, the attention to mental health needs), we believe a number of areas could be improved. It is particularly unsatisfactory that the draft plan is more or less predicated on the assumption that the prevalence of type 2 diabetes will inevitably continue to rise, with the resulting emphasis on secondary prevention. In our view, the overwhelming emphasis, priority and resourcing should be on the **primary** prevention of type 2 diabetes because it results in better health outcomes and is almost always far more cost effective. This makes particular sense when taking into account the "growing fiscal sustainability challenge" and the "constrained funding environment for the foreseeable future" described in the document.

2. Our main concern with the draft plan is the explicit exclusion of "wider system changes for tackling obesity". The draft plan's own Case for Change very clearly sets out the link between obesity and type 2 diabetes. Excluding the most effective upstream measures to prevent and reduce obesity is at odds with the plan's own commentary around primary prevention. For

example, on page 11, the draft plan states that: "The rising prevalence of type 2 diabetes requires greater attention to preventing diabetes in the first place…this will reduce both the personal costs of the disease and protect the long-term sustainability of health services".

3. It is our view that the draft plan **must** give much greater emphasis on measures to tackle obesity as the basis for the primary prevention of type 2 diabetes. While the draft identifies supporting people with pre-diabetes to make healthy lifestyle choices as a priority, tackling obesity requires an integrated suite of measures to counter the obesogenic environment and improve health literacy. We believe a combination of legislative, regulatory and policy levers are necessary to complement community-based approaches such as the Healthy Families programme and initiatives by health professionals to provide advice around healthy living. A key aim of these measures should be to support individuals to make the healthy choice the easy choice.

4. We draw attention to the substantive NZMA policy briefing *Tackling Obesity*[1] (attached) and its 10 key evidence-informed recommendations. We ask that the Ministry broaden the scope of the draft plan to include the most effective measures to tackle obesity. Such measures include, for example, the use of fiscal instruments to influence food consumption (with priority given to a tax for sugar-sweetened beverages), protecting children from the marketing of unhealthy food, and mandatory front-of-pack food labelling that is consistent and easy-to-understand. Other important measures include reducing the density of unhealthy food outlets near schools, ensuring that health impact assessments guide urban planning, and incorporating healthy living advice as a health target. We also suggest the Ministry refer to the recent paper 'Government action on diabetes prevention: time to try something new'[2] published in the Medical Journal of Australia that we believe is of direct relevance to policy makers in New Zealand.

5. There is a general sense that–while some areas of the plan require further detail (we elaborate on where we think this is necessary in our specific comments below)–the document overall is too wordy and would benefit from being simplified and shortened. We believe the draft also undervalues the importance of interventions at the level of whānau. For example, it repeatedly refers to "optimal self-management", while whānau and family involvement are relegated to "when appropriate". We believe that engagement with whānau is crucial for any services for all people with diabetes. A terminological issue also needs addressing. The draft plan avoids use of the term 'patient', instead referring to 'consumers', 'individuals' or 'people' with diabetes. Our preference is for the draft to use the term 'patient' rather than 'consumer' when referring to services and interventions for people that have been diagnosed with diabetes, while using the term 'people' in the context of primary prevention.

6. We are pleased to note that the draft plan gives priority to reducing disparities in health outcomes by geography, ethnicity and socioeconomic status. There are, however, many other social determinants of health (eg, education, employment status, housing, etc). Accordingly, we would like the document to expand on equity considerations, and we suggest the Ministry refers to the NZMA position paper on health equity[3] (attached). We are also pleased to note that the plan identifies providing integrated and coordinated care as a priority. However, we suggest that the plan refer to the importance of the medical home as well as to the patient's GP. In most cases, the GP will be the key clinician responsible for co-ordinating multidisciplinary patient-centred care for patients with diabetes. Where non-medical professionals assume this co-ordinating role, it is

[1] Available from http://www.nzma.org.nz/__data/assets/pdf_file/0015/32082/NZMA-Policy-Briefing-2014_Tackling-Obesity.pdf
[2] Kaldor JC, et al. Government action on diabetes prevention: time to try something new. Med J Aust. 2015 Jun 15;202(11):578–80. Available from https://www.mja.com.au/system/files/issues/202_11/kal01611.pdf
[3] Available from http://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf

our view that they should do so under a delegated rather than an independent model to ensure collaborative care and prevent fragmentation.

7. We are concerned that the draft plan devotes minimal attention to Haemoglobin A1C (HbA1c). As HbA1C is the key blood test for monitoring the progress of patients with pre or confirmed diabetes, it should be highlighted in the plan as the key measureable indicator of diabetes control. We elaborate on this in our responses to the questions below. We agree that the use of financial incentives may play a role in facilitating weight loss (and therefore lowering the risk of type 2 diabetes). However, this must be subject to rigorous evaluation to ensure that short-term gains are durable,[4] and that it does not lead to unintended negative consequences (including on equity).

Specific comments

8. On page 23, the addition of further detail would be useful for the following action: "Develop and promulgate a toolbox of self-management approaches to address the needs of all individuals:

- including behaviour change and effective weight management tools and programmes
- incorporating behavioural economic approaches as appropriate
- including approaches relevant and appropriate for high risk population groups
- with appropriate evaluation."

We also suggest that exercise be included in this list. The importance of exercise throughout the document appears to be underplayed. Exercise has an important role in the primary prevention of obesity (and therefore of type 2 diabetes). Exercise is also beneficial in reducing the progression of patients with pre-diabetes to type 2 diabetes. In patients with diagnosed type 2 diabetes, exercise reduces the risk of developing complications.

9. While the draft plan identifies better screening as a priority, the actions relating to screening could be made more specific. For example, we submit that screening for diabetes / pre-diabetes should be provided to all people that smoke, as well as to patients with hypertension, dyslipidaemia, a family history of diabetes, or a family history of cardiovascular disease. It should also be provided to people from lower socioeconomic groups, and to persons of Indian, Pacific and Māori ethnicity. We also suggest that the age for opportunistic screening be brought down to 25 years to cover the surge in cases of new diabetes in the 25–44 year age group.

10. Regarding workforce issues, page 11 of the draft plan deals states that: "an anticipated shortage of doctors in general practice may mean that nurses and other healthcare workers will need to carry out a wider range of functions". While it is true that New Zealand faces increased pressure in primary health care with an ageing GP workforce, good progress is being made to address this issue, with more doctors being trained in general practice than in recent years. For example, in 2007, 69 new trainees entered the GP training programme, while the 2014/15 intake had 172 new trainees,[5] with the expectation that even more will enter the programme in coming years. The largest future shortage in the healthcare workforce will be nurses. An analysis of the nursing workforce, taking into account predicted changes in population size and structure,

[4] Mantzari E, Vogt F, Shemilt I, et al. Personal financial incentives for changing habitual health-related behaviors: A systematic review and meta-analysis. Prev Med 2015 Jun;75:75–85. Available from http://www.sciencedirect.com/science/article/pii/S0091743515000729; Marteau TM, Ashcroft RE, Oliver A. Using financial incentives to achieve healthy behaviour. BMJ. 2009 Apr 9;338:b1415. Available from http://www.bmj.com/content/338/bmj.b1415.full; Paul-Ebhohimhen V & Avenell A. Systematic review of the use of financial incentives in treatments for obesity and overweight. Obes Rev. 2008 Jul;9(4):355–67. Available from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0026010/

[5] RNZCGP. 2014 RNZCGP Workforce Survey released. 10 December 2014. Available from http://rnzcgp.org.nz/assets/documents/Publications/RNZCGP-workforce-survey-media-release-FINAL.pdf

suggests that there will be a shortage of 15,000 nurses in New Zealand by 2035.[6] The assertion that "nurses will need to carry out a wider range of functions" does not take into account this predicted nursing shortage. The NZMA is supportive of appropriately trained non-medical professionals (eg, nurse practitioners, physician associates) working collaboratively using a delegated model, with GPs and other members of the healthcare team, to provide care to patients with diabetes. We are opposed to independent practice and believe this would fragment patient care.

11. We believe that outcome targets should be used rather than risk assessments per se, which may not lead to informed patient care. We elaborate on these targets in our responses to the questions below.

12. It is our view that the importance of research is not reflected in the draft plan. We recommend that research to improve knowledge of diabetes as well as patient care be added to the vision statement. We also recommend that research be included as a priority in the 'Priorities and actions for 2015–2020' section. On page 21, we suggest expanding the 5th bullet point to read "testing promising interventions to build our knowledge of what works with properly designed randomised clinical trials where possible".

13. We also suggest that all relevant sections of the draft plan give greater emphasis to reducing obesity, reducing smoking and increasing exercise. For example, we believe that the draft actions on page 18 for people with pre-diabetes should include smoking cessation, appropriate diet and increased exercise. Similarly, the section on page 22 on enabling effective self-management should include discussion about exercise (in the fifth paragraph or as a standalone paragraph). We also suggest that the prevention of cardiovascular disease, including stroke, be explicitly incorporated into the priorities for actions.

14. While we have concerns about the lack of access to certain drugs to treat patients with type 2 diabetes, we acknowledge that this issue is probably beyond the remit of a draft plan for health services for people with diabetes. However, we do consider that the plan should at least acknowledge the issue of limitations in treatment availability. With respect to Appendix 1: Understanding Diabetes, we suggest that statin therapy and long-term steroid therapy be added to the section on other classes of diabetes. We also recommend that the following conditions be added to the list of complications: impotence, dementia (Alzheimer's, vascular dementia) and cognitive impairment.

Responses to questions

Question 1. Can you see your own work or role in this Plan?
Yes. The NZMA aims to provide leadership of the medical profession, and promote the health of New Zealanders. Tackling obesity (and its consequences, particularly type 2 diabetes) is a major issue for New Zealand and is a high priority public health issue for our association.

Question 2. Do you agree with the "case for change" set out on pages 8 to 13, and guiding criteria for choosing priorities and actions set out on page 13?
Yes. However, we would suggest changing the following sentence on page 11: "Increasingly, health practitioners are recognising that the effective treatment of chronic disease requires attention to the needs of the whole person" to read "Most health practitioners recognise that the effective treatment of chronic disease requires attention to the needs of the whole person". The

[6] Dr Ganesh Nana, Fiona Stokes, Wilma Molano and Hugh Dixon (June 2013), NEW ZEALAND NURSES: workforce planning 2010-2035, BERL, Wellington. Available from http://www.nursingcouncil.org.nz/News/The-Future-Nursing-Workforce

current terminology could be considered insulting to many health practitioners who have practised this way for many years.

Question 3. Do you think the key messages in the Plan, for example, around integrated and coordinated care, and flexible funding models, are consistent with other messages you are receiving from Ministry?
Yes

Question 4. Do you agree with the choice of priorities for the next five years, and if not, what is missing or needs to be different?
We believe that outcome targets should be used rather than risk assessment, which may not lead to improved patient care. For example, how many patients are controlled according to their HbA1c (eg, <50 or <60), how many patients are on statins, how many patients have good blood pressure control, etc. Other targets could relate to how many people 25–44 years have been screened, and how many people in high-risk ethnic groups have been screened.

Question 5. Does the plan set out the right draft actions – can you suggest alternatives? What are the practical implications of the actions from your organisation's point of view, including affordability, feasibility and timing?
As stated above, we believe that there should be more detail for some of the actions. We strongly support patient self-management as well as increased health literacy. We suggest that the document identify the important role of the GP as the leader of the medical home and in the best position to co-ordinate the multi-disciplinary team in providing patient-centred care.

Question 6. If you had to prioritise the actions in the plan what would be your top 5 for implementing in the next 5 years?
We consider that **all** actions listed in the draft plan are important and should be implemented. In addition, we suggest the addition of the following: increasing health literacy, and stopping smoking in 95% of patients with diabetes. Our caveat regarding specific drug treatments notwithstanding, we have received feedback suggesting that fenfibrate should be made available and funded to prevent retinopathy (it is approved in Australia for this and there is no evidence for bezafibrate). We have also received feedback suggesting that the DPPIV inhibitors should be funded.

Question 7. How ambitious should our targets be for measuring our progress (see page 36) - and can you suggest specific percentage increases or decreases for the proposed target measures? Do you have any suggestions for refining the proposed target measures?
The targets are ambitious. To halt the increase in diabetes would be a huge achievement. We consider that it would be useful for a large group of diabetes experts to define targets including, for example, HbA1c, blood pressure, LDL, and smoking rates. The suggested 5 levels for HbA1c should not be assessed just for decreases. It should be a decrease in higher levels and an increase in lower levels, with targets of perhaps <60 and <50.

We hope that our comments on this draft plan are helpful. We would welcome the opportunity to engage further with the Ministry on this important area and look forward to the next iteration of the draft plan.

Yours sincerely

Dr Stephen Child
NZMA Chair

Attachments

NZMA. Tackling Obesity Policy Briefing. May 2014.

NZMA. Health Equity Position Statement. January 2011