Delivering quality care more efficiently inquiry

Questionnaire response 45

Name: Diabetes Australia

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an industry or advocacy organisation, professional association or peak body

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   The participant did not respond to this question.

2. What are the benefits of pursuing greater collaborative commissioning?

   The participant did not respond to this question.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

   The participant did not respond to this question.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Summary

With it long being recognised that the wellbeing of communities and sustainability of the health system lies in prevention, low public health spending together with the distribution of decision-making in our federated system continue to be key barriers to investments in evidence-based prevention programs across the care economy.
Governments have progressed some key structures and agreements to enable better decision-making. However, investment in operationalisation of prevention programs for chronic conditions is needed in a way that brings together national campaigns and programs with place-based initiatives; and occurs within a common framework for monitoring and evaluation.

In responding to the recommendations to the Parliamentary Inquiry into Diabetes, investing in a national diabetes prevention approach would provide governments with a unifying goal to demonstrate a shared framework that connects data and decision-making in a way that drives evidence-based prevention programs.

To address significant health inequities, access to tailored prevention programs, support and services for First Nations people and communities and CALD populations must be prioritised.

Health spending towards public health spending on prevention

The National Preventive Health Strategy 2021-20301 committed to an increase in investment in preventive health to 5% of total health expenditure across Commonwealth, state and territory governments by 2030.

At the time the strategy was published, less than 2% of overall health spending was allocated to public health spending towards infectious and chronic disease protection, prevention and health promotion.2 The need for more visibility and accountability of the spending was also raised.

Prevention in a federated system

Health and wellbeing are closely linked with the communities and settings in which people live, work, play and age.3 These environments are influenced by all levels of government which, within our federated political model, are each responsible for different areas of health and social care. And historically, governments, health and community organisations and other key stakeholders have attempted to address complex health issues through linear and/or siloed solutions.

At a community level, this distribution of decision-making presents as fragmentation – in data, service planning, priority setting, funding streams, workforce development and monitoring and evaluation. Government investments are then challenged to reflect a collective and coordinated approach, demonstrate value for money or return on investment and identify successful approaches for sustaining and scaling.

However, a range of structural enablers have been identified or established federally that overcome fragmentation and provide opportunities for investment in evidence-based prevention programs.

Within the health system, this includes: [edited version; see full submission]
a. National Health Reform Agreement
The mid-term review of the NHRA 2020-20254 recommended that the health system performance framework be accompanied by a shared commitment to indicators that focus not only on the quantitative and qualitative performance of public hospitals, but also the outcomes achieved at the interface with the broader health system such as prevention/health promotion.
b. Health System Performance Assessment (SPA) Framework
The draft for consultation, prepared by the Australian Institute for Health and Welfare (AIHW) and Australian Commission on Safety and Quality in Health Care in April 2025, brought a specific focus in assessing health system performance for a 'learning health system approach'. Being primarily a tool to support policy action, its main audience is health leaders who are responsible for and have influence over system-level decision making.
The draft recognised that 'the world today is awash with data and the sheer volume of data can be a barrier to its effective use. Contemporary performance reporting needs to go beyond producing regular static reports to embrace new data capabilities that allow it to be dynamic and responsive to the needs of varied audiences', with a primary purpose to 'support shared stewardship, mutual understanding, continuous improvement and innovation'.
c. Commitment to place-based approaches
Place-based initiatives continue to be advocated by leaders across the health system,3 with cross-sectoral support demonstrated by the Australian Government in their support for PLACE.5 The maturing of Primary Health Networks (PHNs) and their performance and outcome monitoring by the Department of Health, Disability and Ageing; the formalisation of governance arrangements between PHNs and Local Health Networks (or equivalent, e.g. the Queensland-Commonwealth Partnership6); and requirements for joint regional needs assessments can be important enablers for preventive action.
d. Data linkage and utilisation for impact

However, with it generally accepted10 that only 20% of the variation in health outcomes being explained by health care, with physical environments, social and economic support, and health-related behaviours contributing to up to 80%, a broader approach to the integration of government investment in prevention is needed. Progress towards a holistic approach to health and wellbeing has been promoted, and can be enabled, by: [edited version; see full submission]
e. Measuring what matters, Australia's first national wellbeing framework
Refining the framework was identified at the outset as an iterative process. This will be important for prioritising prevention for health and wellbeing, noting the lack of indicators for important contributing factors such as food security and physical activity environments when it comes to health.
f. Australian Centre for Evaluation
The Centre12 was established within the Treasury to help put evaluation evidence at the heart of policy design and decision-making.

However, despite these developments, the system is still challenged in the operationalisation of prevention programs for chronic conditions in a way that brings together national campaigns and programs with place-based initiatives; and within a common framework where data and evidence support shared stewardship, mutual understanding and priority setting, continuous improvement and innovation.
Health service and system leaders have advocated8 driving progress for system reform through common frameworks for chronic conditions, risk factors or determinants. This would be the natural next step for governments.

A strategic direction for self-care

Self-care has been defined as 'the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider'.13 It is a concept complementary and central to the concept of prevention in health14, and challenges many longstanding notions about the role of doctor and patient in maintaining the health of individuals and families, recognising that people must be active participants in, rather than passive recipients of, their care.15

While the term 'self-care' implies a focus on the actions of individuals, the underlying drivers of self-care and health-supporting behaviour are complex and include environmental, economic and social factors that sit beyond the individual. Successful policy initiatives have targeted risk factors, with national approaches driving public health campaigns to provision of direct and indirect self-care support for individuals. Evidence promotes similar policy attention be directed to the prevention of chronic disease.15 As such, self-care must be recognised, supported and enabled as an integral component of prevention.

Operationalising through investment in a national priority

The Australian National Diabetes Strategy 2021-203016 and the Parliamentary Inquiry into Diabetes17 both recognise the overwhelming evidence for the increasing prevalence of diabetes, its impacts on individual wellbeing and health system sustainability, the need to prioritise primary and secondary prevention and the opportunities to enable self-care (including through technologies).

The federal government has not yet responded to the Parliamentary Inquiry and the Australian National Diabetes Strategy does not have an implementation plan and associated funding, and this needs to be addressed. Investment in a national diabetes prevention approach, introducing national programs together with place-based initiatives within a common framework for monitoring and evaluation, is a necessary action to be taken.

Tailored programs for First Nations and other priority groups

Aboriginal and Torres Strait Islander Australians are three times more likely to develop type 2 diabetes than non-Indigenous Australian, 4.3 times more likely to be hospitalised with type 2 diabetes, and four times as likely to die from it.18

The prevalence of diabetes is higher in some CALD communities in Australia compared

to the Australian-born population, particularly for people originating from the Pacific Islands, Middle East, South Asia and Africa. People from these communities are also at higher risk of hospitalisation for certain diabetes-related complications when compared to Australian-born people, such as lower limb amputations.19

Improved access to tailored, culturally sensitive and appropriate prevention programs, support and services must be a priority.

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2. What are some examples of successful prevention programs (this could include discontinued programs)?

Summary

Diabetes Australia is a trusted provider of self-management, education and support programs, locally and nationally, partnering with governments, healthcare providers and local organisations across the country. This includes:
1. Behaviour change programs, such as the Get Healthy Service in NSW, My health for life in Queensland and the COACH program in Tasmania
2. Alert and reminder services, such as KeepSight
3. Administration of the National Diabetes Services Scheme, an initiative of the Australian Government. It enhances the capacity of people with diabetes to understand and self-manage their life with diabetes; provides access to services, support and subsidised diabetes products; and is a national data asset.

The evidence demonstrates that scaling these programs could significantly reduce health care utilisation from chronic conditions, leading to a more efficient and responsive health care system.

The breadth of service delivery and the commitment to listing to, connecting and empowering people living with or at risk of diabetes, provides Diabetes Australia with unique insight into the system enablers for implementing successful prevention programs.

Behaviour change programs

Diabetes Australia develops and delivers behaviour change programs locally and nationally, partnering with governments, healthcare providers and local organisations across the country to provide coaching programs to help people living with diabetes make lifestyle changes.

Behaviour change programs aim to lower individual risk factors and either prevent chronic conditions or improve their management through:
• Personalised coaching & education. Trained health coaches identify participant's behaviour gaps, set goals and provide skill-building, self-monitoring tools and regular feedback.

• Behaviour-science techniques. Programs blend motivational interviewing, problem-solving, social support and environmental cues (texts, emails, peer groups) to keep people on track between sessions.
• Maintenance follow-ups. The programs also include low-intensity follow-ups (emails/app portals or booster calls) for 6-12 months to support participants to maintain habits.

Program evaluations demonstrate sustained behavioural changes, including:
• Reduced smoking
• Reduced alcohol consumption
• Improved exercise habits
• Improve healthy eating habits
• Healthy weight reduction.

Examples of Diabetes Australia behaviour change programs include:
a. The Get Healthy Service operating in NSW delivers free telephone coaching (6-10 tailored calls over approximately six months) by university-qualified coaches. The service aims to improve lifestyle behaviours for all adults statewide, with dedicated streams for diabetes prevention, pregnancy and Aboriginal and Torres Strait Islander participants.

There is strong evidence of behaviour change at program end post completion:20
• Physical activity – mean activity rose +43.5 min/week
• Healthy eating – mean improvement in consumption with +11% fruit serves per day; +30% vegetable serves per day; -44% sugary drinks serves per day; -31% takeaway meals serves per day.
• Weight – mean improvement 0.51 kg/m² BMI; and 2.74cm waist circumference.
• Evidence of sustained behaviour change 12 months from program completion.

b. My health for life operating in Queensland provides six coaching sessions over six months offered as small group (face-to-face/video call), telephone, or digital modules. The program targets adults at high-risk of developing chronic conditions.

There is strong evidence of behaviour change at 6 months post completion:21
• Physical activity - median activity rose +70min/week
• Weight – mean weight loss of 2.8 kg (3% body weight) and 5cm from waist circumference (5%).
• Goal maintenance – 68% report still achieving their primary SMART goal.
• Smoking – one in four smokers at baseline had quit; smoking prevalence in entire group fell from 6% to 5%
• Diabetes risk – 12.5% moved out of the high-risk AUSDRISK category.

c. The COACH program which operates in Tasmania provides structured 6-month one-to-one telephone coaching led by health professionals to reduce risk factors for adults with a diagnosed chronic condition or are at high risk of developing one.

Ten-year evaluation showed:
• Improved survival (34% reduction in mortality at 10 years).
• Reduction in hospitalisations-(8% reduction in 10 years).
• Evidence of sustained behaviour change >10 years (biomarkers and medication

adherence).
• Saving on healthcare costs (mean AUD 1,499 pp/year).

Further, a clinical research study published in the American Journal of Medicine Open22 found the COACH Program to be associated with significant long-term improvement in participants' survivorship and an overall reduction in healthcare costs to the health funder and participants.

The Program participation was associated with a 34% reduction in mortality over 10 years. On average program participants experienced 8% (95% CI: 0.85, 0.98) fewer hospital episodes per year (a reduction of 0.24; 95% CI: 0.04, 0.44 hospital episodes per year) and a 12% (95% CI: 0.83, 0.94) reduction in length of hospital stay (0.30; 95% CI: 0.15, 0.45 fewer bed days per year). This contributed to an average annual reduction in healthcare costs for the insurer of A$1,499 (95% CI: $1,909, $1,087) per participant per year alive. This resulted in an accumulated 10-year savings of A$4,852 (95% CI: $5,872, $3,833) per participant, exceeding the average program cost per participant of $800. Furthermore, contingent on being hospitalized in a year, the accumulated 10-year saving was A$11,342 (95% CI: A$19,657, A$3,031) suggesting potential for greater savings among those with higher frequency of hospitalization. Participants also gained financial benefit with a 10-year saving of AUD$415 in out-of-pocket costs and were associated with increased likelihood of achieving target risk factor levels for LDL-cholesterol, triglycerides, blood pressure, waist circumference, BMI, alcohol consumption, and physical activity.

The evidence demonstrates that scaling these programs could significantly reduce health care utilisation from chronic conditions, leading to a more efficient and responsive health care system.

(Note permission can be sought from program funders for sharing evaluation reports, should the Productivity Commission request.)

Alert and reminder services

Automated alert and reminders directed to patients may reliably assist patients to adhere to their health regimen, increase attendance rates, supplement discharge instructions, decrease readmission rates, and potentially reduce clinic costs.23

In Australia, close to 2 million people live with diabetes with 100,000 at risk of diabetes-related blindness. Identifying that 50% of people living with diabetes were not having regular eye checks, KeepSight24 was established to increase the number of people with diabetes undergoing regular comprehensive eye examinations.

The experience involves:
• Easy enrolment: People join KeepSight through targeted diabetes education campaigns or during optometry consultations.
• Safety net: Diabetes eye-check reminder sends messages outside of standard optometry recall.
• Seamless care: Ensures continuity of care, directing people back to their previous optometrist.
• Smart tracking: Automatically resets the reminder schedule following an eye check,

ensuring timely future care.
• Adaptive engagement: Keeps track of recent appointments to avoid sending unnecessary reminders

Since 2019, KeepSight has sent 1.6million reminders and documented 1.4 million eye tests. The program has:25
• reached over a third of people living with diabetes, approximately 6% who were recently diagnosed and 65% who were considered high risk
• increased the return-rate for eye checks of people with diabetes by 20%.
• Increased attendance for eye checks within the recommended RANZCO guidelines by 30%.

Administration of the National Diabetes Service Scheme

The National Diabetes Services Scheme (NDSS)26 is an initiative of the Australian Government that commenced in 1987 and is administered by Diabetes Australia. It aims to enhance the capacity of people with diabetes to understand and self-manage their life with diabetes and prevent complications; and to provide access to services, support and subsidised diabetes products.

NDSS supports all aspects of diabetes self-management, much broader than food, nutrition and physical activity, including prevention of diabetes-related complications, for example FootForward, for people to learn about their risk level, how to make foot care part of everyday routine and prevent foot problems, and find high-risk services for the right support. Information and support are tailored for different population groups, including Aboriginal and Torres Strait Islander Peoples (e.g. covering topics such as yarning about diabetes, addressing stigma and brief interventions for diabetes educators).

Diabetes Australia also supports the NDSS database as a national asset that may be used for research, policy development, or service planning and delivery to provide improved health outcomes for people with diabetes and wide-ranging benefits for the community. Access to NDSS data supports Goal 7 in the Australian National Diabetes Strategy to strengthen prevention and care through research, evidence and data. Population data about people in Australia who are diagnosed with diabetes and registered with the NDSS, including prevalence rates, is available at the Australian Diabetes Map27.

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3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Governments have established a number of key structures and agreements to enable better decision-making across our federated system, including for prevention. However, investment in operationalisation of prevention programs for chronic conditions is needed in a way that brings together national campaigns and programs with place-based initiatives, and within a common framework for monitoring and evaluation.

In responding to the recommendations to the Parliamentary Inquiry into Diabetes, investing in a national diabetes prevention approach would provide governments with a unifying goal to demonstrate a shared framework that connects data and decision-making in a way that drives evidence-based prevention programs.

Within this national framework, a systems lens to prevention can be used to sustain, scale, spread or adapt programs that have been demonstrated to be effective, including behavioural and alert programs. These investments in prevention activities should be underpinned by investments that demonstrate:

- Genuine and ongoing engagement with people with a lived experience, advocating for their needs, amplifying their voices and empowering them to manage their health.
- Access to information and referral systems that promote prevention and early intervention for diabetes and other chronic conditions, and integrate with the health system to support, e.g., advanced education, personalised health plans, navigation to relevant services and integration with innovative technologies.
- Data linkage and utilisation across the system that drives specific outcomes.
- Tailored prevention programs, support and services for First Nations people and communities and other priority populations, recognising the significant health inequities that exist.