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Tēnā koe Alexandra

RNZCGP Submission on the Ministry of Health - Diabetes Action Plan 2022-2027

Thank you for providing the opportunity to comment on the Draft Diabetes Action Plan 2022-2027.

The Royal New Zealand College of General Practitioners (RNZCGP) is the largest medical college in New Zealand. Our membership of 5,500 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

Our Submission

Diabetes is responsible for significant and increasing health losses and diabetes also accounts for a significant and increasing amount of general practice activity. We note that Specialist General Practitioners and General practice teams are the leading providers of community medical services to people living with diabetes. General Practice conducts 80,000 consultations with patients a day throughout New Zealand, and part of that work relates to chronic disease conditions of which diabetes is a major part. Most diabetes care is provided in community based general practice settings by General Practice Teams.

The College recommends the following changes would improve the effectiveness of the Diabetes Action Plan.

1. Provide context for the plan

The previous diabetes action plan 'Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020'[1] is not mentioned in the draft plan. The College considers that an analysis of progress against the 2015 plan to identify barriers to achievement would be useful for informing the proposed draft plan and indicate where to focus action.

We are aware that there were areas of innovation that resulted from implementation of the 2015 plan and that reporting these improvements would have been useful lessons in the framing of the proposed plan. Learning from a quality pathway helps to give context and meaning in moving forward.

2. The scale of the impact of diabetes in Aotearoa New Zealand needs stronger emphasis

There needs to be a sense of urgency to address the significant health impacts of diabetes in Aotearoa, and the scale of the problem needs greater emphasis at the outset of the document. Diabetes is one of the greatest contributors to heath inequity and the impact of diabetes on patients and whānau needs should be highlighted up front along with a focus on resourcing and action, for example, the statement that one in every

[1] https://www.health.govt.nz/system/files/documents/publications/living-well-with-diabetes-oct15.pdf Accessed 3/5/22

eighteen people have been diagnosed with diabetes should be an upfront statement rather than in an appendix.

3. Specialist General Practitioners are well placed to manage diabetes

Comorbidities are frequent among patients with diabetes and generalist services are essential for these patients. The importance of comorbidities in the management of diabetes is well illustrated by the statement on page 35 which shows that among 15 - 64-year-olds with diabetes, 68% have at least one other comorbidity compared to only 19% of those without diabetes. Rates of depression amongst people living with diabetes are twice as high as the general population.

The Action Plan does not acknowledge the role of diabetes care by Specialist GPs and general practice teams working in general practices to integrate generalist care to reduce risks that result from increased fragmentation.

Specialist general practitioners are trained to address the holistic concerns of the patient, referring only when necessary to the most appropriate care provider and following up as required.They:

- See the person as a whole and in the context of their family and wider social environment.
- Are accessible and available to deal with undifferentiated illness and the widest range of patients and conditions.
- Demonstrate concern not only for the needs of the presenting patient, but also for the wider group of patients or population.
- Engage in effective multi-professional working and co-learning.
- Communicate freely and clearly with patients and professionals across health and social care.
- Care is in the context of general practice, taking continuity of responsibility across many disease episodes and over time.
- Within a general practice setting they also co-ordinate care across organisations, to integrate care in health and social care. [2]

4. Collaboration between general practice and secondary care

To support Specialist GPs to integrate between general practice care, it would be helpful to be able to access to specialist expertise when it is needed to support care of patients living with diabetes. The right skill mix at the right time should be central to providing comprehensive diabetic care. Integration between community services and hospital based secondary services is a key enabler to improving diabetic care.

Collaboration between primary and secondary care is noted as one of the successful enablers to implementing the Diabetes Action Plan (p 29). The plan would benefit from expand how collaboration will be improved. In addition, there is no reference to some of the successful interventions and where specialist and generalist teams in the community have worked together in innovative ways.

We also suggest that the regional Health Pathways[3] are a useful aid to collaboration and are widely used, and note that collaboration may operate differently in each region. To facilitate successful health pathways, we support actions that integrate patient records across the health system to support improved patient care, quality improvement, monitoring, and accountability (p. 22).

[2] http://www.health.org.uk/sites/default/files/GuidingPatientsThroughComplexityModernMedicalGeneralism.pdf Accessed 3/5/22

[3] https://www.healthnavigator.org.nz/clinicians/r/regional-pathways/ Accessed 3/5/22

5. General practice care for people with diabetes is overlooked in the action plan

The document would be strengthened by acknowledging that diabetes care provided in general practice is a key element for improving equity and access in the community. For example, on page 8 there is emphasis on "equitable access to high quality emergency and specialist care". Despite the high public and media visibility of these hospital-based services they comprise a small minority of all healthcare provided by comparison with general practice. With over 17 million patient consultations in 2021, it is a recognised point of entry for patients accessing the health system.[4]

Secondly, the statement on page 20 states, "Most people with type 1 diabetes are managed in secondary care". While most people with type 1 diabetes would have seen a diabetes specialist in secondary care at some stage following their diagnosis, routine management usually takes place in general practice. There needs to be open acknowledgement of that general practice is the place that people access most often, and where care is delivered in the community.

6. Capacity in general practice

The College does not agree with the statement on page 37 of the document which states, "primary care services have limited capacity to be able to provide the comprehensive support whanau need to effectively manage their condition and associated complications" and refers to the pressures resulting from the increasing burden of diabetes and the impact of COVID-19. Throughout the Covid -19 pandemic general practice has continued to deliver care to patients with diabetes, shifting to a virtual mode of delivery wherever possible to limit the spread of COVID-19. Early in the pandemic Dr Samantha Murton, College President issued a call for practices to aim to deliver 70 percent of all care virtually.

The expansion of general practice teams that has occurred in recent years through initiatives like the Health Care Home programme, has enhanced the ability of general practices to deliver care. This is not acknowledged in the document. An exceptional improvement in general practices, due to advances in technology, is the increased capacity and capability to record and sort data to enhance patient care. The potential to leverage off this existing resource is significant. In order to maximise care we also need to continue to build capacity and expertise within the general practices to work more effectively in the community space.

7. The system needs to enable proactive care

We consider that a less reactive health system would enable care to be delivered to patients when they are symptomatic or needing specific interventions. More emphasis on proactive care such as screening, preventative care and education, addressing access barriers including financial, and encouraging patients to engage with community-based care and programmes, would be more beneficial. We support proposed actions to "Reduce the financial barriers that prevent priority groups from accessing healthcare" (p 22).

8. Measures

Diabetes is a disease that progresses over time. This means performance measures designed to focus on limiting progression would be more beneficial than curing diabetes. We note that measures are still in development and the College would be interested in contributing to this work.

We also question the demarcation between high level performance measures and local improvement measures. For example, the percentage of women with gestational diabetes screened at three-months post-partum and then yearly would be a better high-level measure, rather than a local improvement measure, and this should be reported on by region.

[4] https://www.graham-center.org/publications-reports/publications/one-pagers/contemporary-ecology-2001.htmlAccessed 3/5/22

In summary

The College looks forward to the release of the final Diabetes Action Plan.

Please contact Maureen Gillon, Manager, Policy, Advocacy, Insights - maureen.gillon@rnzcgp.org.nz, if you have any questions, or seek additional information about our submission.

Nāku noa, nā

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