

EDUCATION AND HEALTH STANDING COMMITTEE

**INQUIRY INTO THE ROLE OF DIET IN
TYPE 2 DIABETES PREVENTION AND MANAGEMENT**



**TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 10 OCTOBER 2018**

Members

**Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton**

Hearing commenced at 10.11 am**Mrs SOPHIE ELIZABETH McGOUGH****Health Services Operations Manager, Diabetes WA, examined:**

The CHAIR: On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence on the committee's inquiry into the role of diet in type 2 diabetes prevention and management. My name is Janine Freeman and I am the Chair of the committee. The other members of the committee are Bill Marmion, Deputy Chair; Shane Love; Sabine Winton; and Josie Farrer, who unfortunately is an apology today. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside today's proceedings. Before we begin, do you have any questions about your attendance here today?

Mrs McGough: No, I do not.

The CHAIR: Would you like to make a brief opening statement?

Mrs McGough: Yes, if you do not mind. Thank you for inviting me to represent Diabetes WA here today. I would like to give an opening statement to give you the context of Diabetes WA as an organisation so that you understand the context in which I will answer your questions today. Diabetes WA is the peak body for people living with diabetes in Western Australia. There are currently 126 000 of those people living with diabetes, with 28 Western Australians diagnosed every day. Diabetes WA is a not-for-profit organisation and a company limited by a guarantee. We were formed about 50 years ago by some consumers, and we have an active database of around 200 000 people, including 10 000 members and about 120 000 people with or at risk of diabetes on that database. It is an understatement to say that diabetes is a complex and multifaceted disease. There are different types of diabetes with multiple causes and treatments and multiple organs and systems in the body that are impacted by the condition. The pharmaceutical and technology advances in type 1 and type 2 diabetes alone are advancing so quickly. If you look at classes of medications, things like pumps and continuum blood glucose monitoring, these things are all part of everyday life for people with diabetes now—and not just them, but their healthcare professionals and carers as well.

Parallel to this is the increasing rise of psychosocial complexity of people in general. Diabetes and its prevention has to fit within family, finances, housing, work, food security and those other social determinants of health that impact on a person's ability to self-manage their diabetes or try to prevent it. To address this clinical and social complexity, Diabetes WA employs a large group of credentialed diabetes educators with different primary disciplines: nursing, dietetics, exercise physiology and pharmacy. The quality of the programs and services we provide is led by our in-house research and evaluation team and we are backed by our strong relationship with the Leicester Diabetes Centre. I notice that you are going to go to the UK and I would highly recommend that you meet with them. They are one of the largest diabetes research centres in Europe.

We have customer service, corporate finance and marketing communications teams, which are integral to our mission to support people living with diabetes. It is important that you understand that Diabetes WA also manages the commonwealth Department of Health's National Diabetes Services Scheme, the NDSS—as opposed to the NDIS. This enables us to bring free quality structured diabetes education programs to people with diabetes, together with community education and awareness events, peer support, camps, health professional training, schools training, childcare

centre training and aged-care worker training. We have our annual Aboriginal health forum and we supply diabetes products to rural and remote consumers and Aboriginal medical services across the state.

Diabetes WA does not approach advocacy in its traditional sense. We see ourselves as part of the WA health system, not sitting outside of it. We try to engage in solutions to break down those silos and add value to the system as it exists. We lead through collaboration and believe that all solutions start with putting the person with diabetes at the centre of their care and seeing the whole person with diabetes not just their diagnosis or their risk. We believe that with continued investment and support in the work we do that we could be instrumental in significantly reducing diabetes-related hospitalisations and, where possible, the prevention or delay of type 2 diabetes.

I would like to thank you for the opportunity to come along today. As you will see in the submission, we made some recommendations and I encourage you to ask any questions you have about those as well as your own.

The CHAIR: You are the health services operation manager. When you came up to Parliament recently I met a gentleman who is the director; is that right?

Mrs McGough: He is the chief executive officer, yes—Andrew Wagstaff.

The CHAIR: Okay. In terms of you coming and not him—you are welcome to come—what was the decision-making process in that?

Mrs McGough: Because my background is a credentialed diabetes educator and an accredited practising dietitian, and because you are particularly looking at the dietary interventions, it made more sense for me to come and talk in that space.

The CHAIR: You said that you have dietitians and nurse practitioners. How many people are employed at Diabetes WA?

Mrs McGough: There are 64 in total, but we have 16 health professionals in that staff.

The CHAIR: You said that you put the patient at the centre of what you look at. If you were going to think about it as a systemic issue, which it appears now to be when we consider that 28 people are diagnosed every day, what do you think the systemic issues are around diabetes—we are looking at just type 2 diabetes, not type 1—in terms of being prediabetes or being diagnosed as a diabetic?

Mrs McGough: To me, as we read it at the moment, the current health system is largely fragmented. I do not believe that there are not necessarily all the services available for people with diabetes. It is more about whether or not those services are interlinking together. In terms of systemic issues with the health system, that is a significant problem that we are seeing at the moment. Some of the work that we have been doing to integrate some of the NDSS services into the system, a lot of people do not even know that the NDSS is part of the health system in Western Australia. I am spending a lot of time and effort going into the primary care sector, for example, and encouraging the primary care sector to interlink with that system. In terms of services, that is a huge area for us in terms of integrated pathways between different funding arrangements. People are often funded in silos without encouraging integration to other services that may be providing exactly the same service and trying to achieve exactly the same outcome. There is not often a quality framework that sits around some of the services that are provided. Often outcomes are not necessarily reported or expected—it may be expected but not given the opportunity to be measured. In terms of the quality loop and the continuous quality improvement cycle, that does not tend to happen. It tends to be: “We have done a program, we have ticked it off, and let’s hope we all did something for diabetes.”

[10.20 am]

The CHAIR: Is that because there is a feeling out there that there is no cure or that it is an individual problem instead of seeing it as something that everyone could have? This organisation has been around for 53 years, yet in that period you have watched type 2 diabetes increase in the community. Would that be accurate to say?

Mrs McGough: No, that is not accurate to say. Our current statistics are that WA at the moment has reduced the number of people with type 2 diabetes.

The CHAIR: Okay. How have they managed that?

Mrs McGough: It is hard to prove that, because we have not necessarily got the outcome-based evidence to say exactly what thing actually worked. We would look at a range of things that have helped that to happen.

Mr W.R. MARMION: While we are on the funding, you are probably the best person placed to explain how someone with diabetes might access funding and how your organisation even accesses funding. I do not know. Can you explain in words—or do you need a flow chart—how the funding is organised? Where do you get the money from, and is it enough?

Mrs McGough: Do you want to talk about the personal level or the organisational level?

Mr W.R. MARMION: The organisation first and then you can address the person.

Mrs McGough: As I said, as an organisation we manage the commonwealth Department of Health's NDSS contract. The money comes in through Diabetes Australia nationally and we get a portion of that based on our needs in WA. That is a significant amount of money. Then we have state-based contracts through the state Department of Health. One of the contracts is for the Let's Prevent program that is happening as a pilot in the south west at the moment. That would be another source of funding. We are part-funded by the WA Primary Health Alliance and the WA Country Health Service for the Diabetes Telehealth program. The money for that is really only viable for the rest of this financial year. Then we have our fundraising. Obviously a big part of our income is coming from fundraising as well, and our membership base. So we have 10 000 financial members and we also have money coming from them.

Mr W.R. MARMION: Do you have bequeaths? I know some people on the board.

Mrs McGough: Yes.

Mr W.R. MARMION: So you have trust money set up and you get income from that?

Mrs McGough: Yes, you would probably need to talk to Andrew for more detail in that space.

Mr W.R. MARMION: Would you believe that I thought of Andrew for the first time in 20 years in a dream this morning, and you mentioned him! He worked at Main Roads with me. He was a very good young operator.

Ms S.E. WINTON: Just following up with the question about funding: in the review you say that the funding has been reduced. Are we able to get some quantifiable figures in terms of what the funding has been? I do not know whether you have that with you. Is it possible to get that?

Mrs McGough: Yes.

Ms S.E. WINTON: What kind of reduction has there been percentage-wise from 2016–17 to now? What funding cuts have you seen?

Mrs McGough: It is not so much that we have had them cut yet, it is that things post-2019 are not going to be funded—the self-management grant that I have been using. Just to give you an example of how hard it is sometimes to reach out, we have NDSS, which provides me with the opportunity to do some of the DESMOND programs, but that NDSS money does not provide me any travel or

expenses cover to then be able to go out to Looma in the Kimberley in two weeks' time, which is rural and remote, to provide that to the community who would really like the DESMOND program. I am using the money from the state Department of Health that it has given us to support the Aboriginal DESMOND component to be able to marry that up so I can get staff up there. The consultation required for that Looma program to go ahead has been phenomenal. For us to fly up to Broome, meet all the players, meet the community, work with local providers, and obviously work with the community to make sure that they want the service that we are providing and that it meets their needs, takes a long time and a lot of effort. The money we have had from the Department of Health has really helped to supplement the NDSS and we have been able to go up there. That money will finish at the end of this calendar year, so I will no longer have that to do the regional and remote side of things.

Mr W.R. MARMION: What will happen if you do not have that money?

Mrs McGough: We will try to keep it going to the end of the 2018–19 financial year, but then I do not know. We will have to look at trying to reorient some of the money we do have, but it will mean less services for less people with diabetes.

The CHAIR: All of the services that you deliver, and they are multiple, but there are major areas that you do in terms of the services, is there anyone in government that is doing that, or are you the only service that offer programs such as DESMOND, Let's Prevent, My Healthy Balance or Get on Track? Does the health department provide any services around diabetes prevention and management?

Mrs McGough: In terms of management, in some regions some of the diabetes educators, say in WACHS, have been able to provide DESMOND, but they cannot do the marketing and administration. They are clinicians. They have not got time and they are not paid to get people into programs that are not being used or to pay for the participant booklets that go with it. In South Hedland, for example, through another pot of money that we received through WAPHA in the Pilbara, we worked with the South Hedland WACHS staff. They said that they would allocate their time to deliver DESMOND if we could do all of the wraparound to help to get people there. It is very difficult when there is an apathetic population who do not even realise that diabetes is on the agenda to try to then get them along to a program. But you can do it with good support. On Monday night they won the Rotary Allied Health Award for their South Hedland DESMOND team. We have shown a 17 per cent reduction in risk of hospitalisations just in that Pilbara area. It can happen in collaboration. It is not about providing one organisation with one pot of money; it is about getting people to work together and bringing funds together to be able to say, "This is what we can bring to the table. This is what you have already got." And in other areas: "There is not a diabetes educator—that is where Diabetes Telehealth can come in and support you." Or if your diabetes educator goes on leave or your diabetes educator leaves and you have not filled that position for three months or six months, or in some cases for 18 months because nobody wants to go and work in the Pilbara, then we can be there with Diabetes Telehealth to support that service while they are trying to find somebody to do a face-to-face as well.

The CHAIR: That is the fragmentation that you are talking about: that there is no consistent capacity to deliver ongoing services. It is always bits are here, bits are there. The other aspects you were talking about in terms of the fragmentation was with the primary health carers; that is, GPs. Do they have a good knowledge of what is available through Diabetes WA? If a patient comes in who is pre-diabetic or who has just recently become diabetic, what is the normal course in terms of a system? I am not talking about individual aspects, but the majority of what you think happens out there.

Mrs McGough: I will talk about it in two levels—the prevention side, because it is quite different to the diagnosed. I will start with the diagnosed. We have done a huge amount of consultation with

GPs. We have a primary care advisory group and we have done focus groups with GPs to see exactly that: what do they know about the current system? Most GPs would not be aware that the NDSS provides anything beyond products.

[10.30 am]

The CHAIR: When you say “products”, what is that?

Mrs McGough: That is diabetes supplies, so insulin pump consumables and testing strips. That has been well known across the system, but what has not been well known is the availability of the structured diabetes education. We have been doing all the work to try to change that, but I have one FTE under the NDSS to do that. I have to try to get across 400 GP practices across the whole state. The current system is that they would not know what is there. At the moment, most GPs will do a GP management plan, which is item 721, and then a team care arrangement, which is item 723 under the MBS. They create a care plan, which is generally electronically developed, not really done with the patient, and that is given to the patient and they are told, “You have five visits; these are the ones I am going to refer you to.”

The CHAIR: Five visits, and that is to a podiatrist, a dietitian —

Mrs McGough: Exercise physiologist.

The CHAIR: Psychologist?

Mrs McGough: The psychologist tends to go through the mental health care plans, but can be part of that as well. The other one is the diabetes educator.

In a previous life I worked in private practice as a diabetes educator and a dietitian, and you get one visit. Now, the complexity of the dietary change alone, never mind the diabetes on top of that, in one visit? I have said in my submission that what was required in the trials to prevent and manage diabetes is not going to be done in one visit. We have been going out and saying, “You can do structured diabetes education as part of this as well. The randomised control trials of DESMOND in the UK are very impressive and reduced cardiovascular risk outcomes considerably compared with usual care. It is really important that people do attend DESMOND as well as do those five visits.

The CHAIR: DESMOND is possible without any additional cost; it is just that GPs need to be aware of it?

Mrs McGough: Yes, we have done a lot of awareness raising but it does not necessarily result in referrals.

The CHAIR: Why?

Mrs McGough: People get busy in their practice. You need to change the system. When the EPC, enhanced primary care, system came in—the 721s and the 723s; the GP management plans and team care arrangements—it took five or six years for that to start to embed within GP practice. It takes time to change behaviours, and that is clinician behaviours and patient behaviours as well. We are looking at a primary care support service at the moment that we would like to trial with practices themselves, and look at the roles and responsibilities within the practice and the systems at the moment: can they access the referrals points? It is really simple stuff. Can they access the referral form? Is it electronically on their system? How do they know about their cohort of people with diabetes or at risk of diabetes? WAPHA is working quite a lot with practices to improve their data quality. And then: What is the role of your practice nurse? What does she currently do? How can she fit within the system and how can she start referring into this system as well? The feedback loop is particularly important. To see the NDSS and the products under it as part of the multidisciplinary team, GPs need that feedback loop, certainly from the Medicare perspective. We are writing back

to every single GP when their patient has attended. We are doing as much as we can to try to help the system. For example, we are doing work in the south west at the moment. There is a great group down there, the diabetes steering group, led up by WACHS, WAPHA and GP Down South.¹ We all came together and said that there are lots of these different programs that are happening. There are care coordination programs that are also happening, and that is more for that social complexity I was describing earlier. We have come up with a pathway that integrates all of those things together. We have NDSS in it; we have the people who are trying to do the care coordination; and then we have the local hospital and the WACHS staff into the tertiary hospital as well.

The CHAIR: Where are you doing that—in Bunbury?

Mrs McGough: Just in the south west, yes.

The CHAIR: Everywhere in the south west or in particular places?

Mrs McGough: Yes, we are trying to extend it to everywhere in the south west. But again, that just came from Diabetes WA sitting on the committee and I just said that we have to do this, we need to look at this across an integrated space.

The CHAIR: Yes, as a systemic issue, not just as an individual issue.

Mrs McGough: Yes. I suppose the other thing to point out is that there is HealthPathways WA, which again is a project in which the Department of Health and WAPHA are involved in. HealthPathways is there, and the information is on that system, but no-one can find it.

The CHAIR: Why can people not find it?

Mrs McGough: Because it is too buried and it is all over the place. If you try to work out the pathway, it is a clinical pathway, not a services pathway. You will go into it and go, “That bit’s there.” There might be a bit about diabetes education in the type 2 space, and in the chronic care management there is another bit, and in the healthy living bit there is another bit. We have tried to bring that altogether and have an interactive PDF that links into that pathway, so then that gives you all the information you need once you get there. That has been done with no funding.

The CHAIR: That is the people with diabetes. You were going to talk about the preventive aspect.

Mrs McGough: Yes, on the prevention side, I was talking with a GP just recently about the Let’s Prevent program. That has been a new program for us to implement into the south west.

Mr W.R. MARMION: What is his name?

Mrs McGough: Sorry—Chris. You have got me now!²

Mr W.R. MARMION: Which town was he from?

Mrs McGough: He was from Forrest Road medical in Bunbury. I asked where he currently sent his people at risk of diabetes. He said that there was no service for people. WACHS had tried to do some impaired glucose tolerance, IGT, groups for people with diabetes, but other than that, you cannot access a dietitian under the EPC system because it is not a chronic disease yet, so those people at risk cannot access any of those five visits. Apart from that, if you are a dietitian in a hospital, because so many people are overweight and obese, I am sure the health system would be overrun if they tried to open up the doors and say, “All right—those 70 per cent of people in WA can access their dietitians.”

Mr W.R. MARMION: Seventy per cent?

¹ The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).

² The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).

The CHAIR: Who are at risk?

Mrs McGough: Yes, who are at risk. Seventy per cent of people who are overweight or obese—Western Australians.

Ms S.E. WINTON: Can I just get some clarification because I know that Janine suggested previously that diabetes is on the increase and you said no. From the literature, I thought it was on the increase. Can you go a little more into that?

Mrs McGough: I can provide you with the statistics as well. It may be on the increase in all of Australia, but just in WA alone —

The CHAIR: That is a per capita thing, is it not? So a percentage of the population has not increased, but there is an increase because we have a greater population.

Ms S.E. WINTON: I just wanted to clarify it, because you said by 2023 type 2 diabetes is projected to become a leading cause of disease burden, and I guess your comment earlier seems to suggest that it is on the decline.

Mrs McGough: It is hard to say because that is NDSS registration and that assumes that every single person with diabetes is on the NDSS register. It is 5.1 per cent in the Australian population, and our figure is 4.3 per cent, and that has dipped.

The CHAIR: But not significantly,

Mrs McGough: Not significantly, but it is not going up at this point in time. I can provide you with that data if you like.

Ms S.E. WINTON: Is that not contrary to what we are talking about with the levels of obesity going up?

Mrs McGough: Yes. Again, no prevalent study has been done since the AusDiab study in Busselton, so it is hard to say. Like I said, we do not know.

The CHAIR: Assume that we do not know many things. When was the AusDiab study done in Busselton?

[10.40 am]

Mrs McGough: You would probably have to ask the researchers. It was a while ago—it would be something like 15 years ago. I do not have that to hand. They tested people who did not necessarily think they had diabetes. They tested an entire cohort of people and they found that for every one person diagnosed with diabetes, another person did not know they had it. That was that study that was done. We do not know with the NDSS and the slight dip we have seen whether it is fewer GPs registering people on the NDSS. Is it fewer people being registered in general?

The CHAIR: If you are not registered on the NDSS, can you still get your medication and the testing kit?

Mrs McGough: The medications you can get.

The CHAIR: And if you are not registered on the NDSS?

Mrs McGough: No, medications are not on the NDSS; that is a PBS. But those with type 1 diabetes can always access products if they are on the NDSS; if you are not, obviously you would not be able to. People with type 2 diabetes on the NDSS can only access the testing strips for up to six months, because a change was made to that about 18 months ago now.

The CHAIR: What do you do for the other six months? Do you pay for them?

Mrs McGough: After that, yes, unless your GP or diabetes educator decides that you clinically need to keep doing the testing, otherwise you will not be able to access that anymore.

The CHAIR: So you just do not test yourself after that? You just assume that you are diabetic and you either need insulin or not?

Mrs McGough: No, blood glucose monitoring is about self-management. It is about people knowing what is going on with their blood glucose level, but they can go back to their doctor and have an HbA1c, which is another three-month test. It gives you a look at your red blood cells over the past three months and how much glucose was attached to them, to put it simply, so it is another measure of control of diabetes.

The CHAIR: Let us just go back to the prevention, which they say is always better than a cure. You are saying that you have the Let's Prevent program, which is an early program, and that is predominantly down south. How long has that been going for?

Mrs McGough: The actual program itself has only just started in June. In terms of the intervention period, we started training facilitators in June and we have started recruiting for that now.

The CHAIR: And that is being done through a GP service?

Mrs McGough: It is being done across all of the south west, so that is including WACHS people, GP Down South—all the providers I mentioned before.

The CHAIR: When I go to a pharmacy these days, I walk in and they have big signs: Diabetes Help Here; Diabetes Prevention. Is that another illustration of the fragmented aspect of the service and some people's need to have some way of controlling their diabetes? What is the integration or dialogue that is happening with the pharmacies?

Mrs McGough: Under the NDSS we have what we call "agents". That changed a little and now the Pharmacy Guild of Australia has the contract for the supply of the products under the NDSS. We do have a relationship with the pharmacists. We go out and visit the pharmacies and they do understand about the NDSS and what is available under the NDSS. My issue is: why are they not promoting all of the products and services?

The CHAIR: When you say "all of the products", do you mean why are they not promoting the dietary and education side of it?

Mrs McGough: Yes, all the services.

The CHAIR: And that is not happening?

Mrs McGough: Not that we have seen so far, no.

The CHAIR: And that is because if they promote that, they are going to come into your system of Diabetes WA, whereas if they promote their own dietitian at the pharmacy —

Mrs McGough: There are not really many dietitians at pharmacies. I do not think I have ever seen that.

The CHAIR: Okay. There is one where I go.

Mrs McGough: Is it a dietitian or a nutritionist?

The CHAIR: Good question.

Mrs McGough: Or a naturopath?

The CHAIR: No, it was not a naturopath.

One of the things that is going to change over the next couple of years is local health plans by local government where it will be much more on the ground. If diabetes is such a huge issue in terms of a latent disease and an issue around chronic disease, has Diabetes WA had any input into some of those local governments, or have you had any involvement with local government in Let's Prevent or the other education programs?

Mrs McGough: Yes, I will start with Let's Prevent. Our immediate thought around Let's Prevent was to work directly with the City of Bunbury and the Shire of Capel—there is another city down there as well—so we approached them. Similar to another program called Your Move, with the City of Wanneroo and the City of Cockburn, we based Let's Prevent on their recruitment model and asked the city if we could work with them and access their ratepayers' database, which they did with Your Move, and help us to recruit people to Let's Prevent. Unfortunately, that has not happened to this point, so we are now having to take another tack. Now we are going through GP practices to try to help GPs recruit into programs as well. We do see local governments working closely with us to try to tackle the prevention issue.

The other area in which we have been working with local governments is under the NDSS we have run community awareness and education events. One of those events is called Connect, which is about connecting with diabetes. It is encouraging people to come. It is really just about awareness raising, about the NDSS, a little about diabetes education and what you can do in terms of the NDSS to help it. We work specifically with every local government to do that, so we combine with them. They help us with venues and with advertising. If they want to promote one of their healthy living programs in their local government, we give them time within that session to come and promote that as well. We try to work in collaboration with local government where possible, but not every local government is committed to their public health plan and having one that includes what we are trying to do.

The CHAIR: Was Let's Move more to do with exercise and diet?

Mrs McGough: Yes. I think it started with the Department of Transport, from memory.

The CHAIR: We spoke to Tim Davis, who is an endocrinologist and part of the diabetes health network. My understanding is that when it gets to the point that you have diabetes and you need insulin, there is some role—can you take me through the process of what happens? Do you have to see an endocrinologist to determine what your treatment will be?

Mrs McGough: When you start insulin?

The CHAIR: Yes.

Mrs McGough: Yes, obviously when someone is ready to start they can also be started by their general practitioner. It does depend on the GP's confidence to start somebody on insulin and the support services that they have around them. Having worked as a diabetes educator in general practice, I did see GPs starting people on insulin because they had me there as a support system to be able to help them with teaching somebody how to start injecting insulin. It is quite a big deal for someone with diabetes to start insulin, or any injectable. In fact, people tend to focus on insulin as injectables but there are other injectables that we now use before insulin.

The CHAIR: What are the other injectable you use before insulin?

Mrs McGough: They are called GLP-1 agonists. We have done a lot of work with Roebourne and the Mawarnkarra Health Service. There is one that is a long-acting GLP-1 agonist—I will not talk product names.

Mr W.R. MARMION: What do they do? What is in them?

Mrs McGough: Without going into a huge amount of physiology, a hormone called incretin is produced by the stomach. Think about it like a little megaphone man in your stomach which says, “Pancreas, put out insulin. Liver, store the glucose. Brain, stop wanting to eat so much. Gastric system, slow down, don’t put so much glucose in.” What they have found is that people with type 2 diabetes may be deficient in this incretin, and so not just insulin is a problem but incretin as well. The GLP-1 agonist is actually giving them incretin. It has a side effect of weight loss.

The CHAIR: That is handy!

[10.50 am]

Mr W.R. MARMION: Have you got evidence of when people are on that that stops and they recover and they do not have to go on insulin?

Mrs McGough: I have not got the evidence here but I am sure there have been some clinical trials done.

Mr W.R. MARMION: Anecdotally?

Mrs McGough: Certainly from what we have seen, particularly because it only requires a once-a-week injection in some of the therapies, we find that the ability to do that, particularly, for example, in Mawarnkarra, some of their clients just come in once a week and have that injection done. I know Lockridge Medical Centre has had some great success in that as well. Some of the diabetes medications require that you take them three times a day. Just that behaviour alone, if you have ever tried to take a medication, can be difficult for some people.

The CHAIR: Is that well known in terms of diabetes treatment?

Mrs McGough: Yes, it is part of the algorithm that endocrinologists would use.

The CHAIR: But what about doctors?

Mrs McGough: Yes, doctors are using it as well.

Mr R.S. LOVE: If these persons are taking this drug, why are you referring to them as “diabetic” if their pancreas is still functioning? I thought the definition of diabetes was that the pancreas was unable to function properly. It sounds more like pre-diabetic and some sort of a preliminary condition rather than diabetes. What is your definition of diabetes?

Mrs McGough: Type 1 diabetes is an autoimmune disease which stops the pancreas from producing completely. There is no insulin happening in type 1. In type 2 diabetes, there is actually enough insulin to start with. There are different levels. We have the “pooped-out pancreas” that happens, the “rusty locks”, a “leaky liver” and the “quiet megaphone man”. If you think about all the things that happen in terms of type 2, the first is that the rusty locks start to happen. The ability of insulin to come to the muscle cells, open up that lock and let the glucose inside the cell to get it out of the blood stream is inhibited. There is what is called “insulin resistance”. We call them rusty locks to make it easy for people to understand. That is starting to happen probably 10 years before someone develops diabetes. The other thing that is often going on as well, is that if you have a lot of fat infiltration into your liver—if you picture the liver as a big storage shed, there is only so much you can store in your storage shed. If you put a heap of fat into that storage shed and then you try to put some glucose in there as well, because there is extra glucose floating around the blood stream that needs to go somewhere because the muscles do not need it. It has to go somewhere, it does not go into the liver if there is too much fat already stored in there, hence fatty livers and the relationship between weight and diabetes. That is the leaky liver. Those two things are happening again for a period of time before someone gets diagnosed. All that the pancreas knows is that the glucose level is high and it needs to do its job, which is to put out insulin when the glucose level is

high. It just puts out more and more insulin. Eventually, like with any worker, if you are telling them to produce more and more, eventually that insulin is going to be reduced and at that point, someone develops type 2 diabetes. It is not that they do not produce any insulin at all anymore; they just do not produce enough to overcome the rusty locks and the leaky liver, and now we know about the little megaphone man and his role.

The CHAIR: What is the little megaphone man?

Mrs McGough: He is the incretin. It has quietened down, there is not enough of it, so they are also not putting out insulin at the most appropriate time. They are not storing the insulin properly at the most appropriate time as well.³

The CHAIR: Do you introduce the incretin prior if they are pre-diabetic or do you introduce it once they have just become type 2 diabetic?

Mrs McGough: It is not PBS listed for anything beyond the diagnosis of diabetes.

Mr R.S. LOVE: If you have a GP who is treating a person and they do not appreciate the things you just spoke about, would there be incidents where people are diagnosed as being diabetic and put on insulin prior to these other stages being addressed, so they are not actually exhibiting the symptoms of diabetes at that point?

Mrs McGough: It is all based on your blood glucose levels. We know that your HbA1c, so this three-month test that you have done, needs to be less than seven per cent or less than 53 millimoles per mole for you to reduce your risk of the cardiovascular complications of diabetes. At the end of day, that is really what we care about. People can walk around with diabetes and high glucose levels and be very tired and go to the toilet a lot and feel quite thirsty, but that is not going to impact on their mortality down the track. It is about being able to avoid those cardiovascular risks and microvascular risks—the kidneys, eyes and feet. There is a cut-off point that we know of that will prevent that. If someone with diabetes has a HbA1c that is higher than the target and they have tried the lifestyle changes and all the other medications, they have been doing all the exercise that they can, they are trying everything and they have tried the incretin, then at that point they will be put on insulin but only at that point.

Mr W.R. MARMION: What is that level again? Was it seven per cent?

Mrs McGough: Above seven per cent or above 53 millimoles per mole. It is all based on your glucose level and other factors like how old you are and what your blood pressure is because the cardiovascular aspect of diabetes is important and just as important as the glycaemic aspect of diabetes. It is not to be ignored. If somebody has a high cholesterol level, a high family history of heart disease and high blood pressure, then even if their glycaemic control is quite good the doctors still might choose to do some different things because of their profile and if they are only 30 years of age versus 90 years of age.

The CHAIR: Do you believe you can reverse type 2 diabetes?

Mrs McGough: Recent studies have been done. Roy Taylor in the UK has been doing some really interesting work using very low calorie diets. He has shown that if you can pull some of that fat out of the liver—you know how we talked before about the fatty liver and the pancreas—and lose around 10 kilos of weight on average, then he was able to show levels coming back to the non-diabetese range and he was able to hold that for a significant period of time. For some people, if weight and weight loss is the reason why they have developed type 2 diabetes, they will have the ability to—I prefer the word—“halt” it. With all the genetics that a person could potentially have—

³ The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).

because remembering that if 70 per cent of people are overweight and obese but only five per cent are developing diabetes, it is not just weight that is causing this because otherwise you would have 70 per cent of people with diabetes. There is obviously a genetic aspect to all of this. If you are unlucky enough to have one of the 40 or 50 genes associated with development of type 2 diabetes, we do not know which gene it is for you. That is why I said in my submission that Grant Morahan is doing a lot of work to look at the five different types of type 2 diabetes. For those set of people where it is just purely about their weight being one of the main reasons why they have developed type 2 diabetes, they will be able to halt or reverse it. Other people will lose weight and they will still go on to progress because they have unfortunately got the other set of genes. That is why there cannot be a one-size-fits-all message: “Yes, everybody can reverse diabetes”, because not everybody will be able to reverse diabetes, but some people might be able to at least halt it. Some of the studies that we have seen, again, the ones I have talked about in the submission—the Finnish study, the DPP—that was only five to seven per cent weight loss. It was not extreme and did not use one dietary approach. It used a range of different dietary approaches and people were able to prevent diabetes—60 per cent of them. The other 30 per cent were not able to. Not everybody will be able to and I guess the message is that yes, we do not want to be negative and say you cannot reverse it completely, but I think we also have to be honest with people in terms of their risk and say, “Yes, you could halt it.” If you can halt it for 10 or 20 years—I have had people diagnosed with type 2 diabetes with a very strong family history or a very strong genetic risk and I will see them at 80 years of age. Someone developing type 2 diabetes at 80 years of age has prevented diabetes potentially for 40 years, and that is the message that you tell that person.

[11.00 am]

Mr W.R. MARMION: How have they done that, through diet?

Mrs McGough: Generally, yes, that is part of it—good medical management. Yes, lots of different ways.

The CHAIR: In terms of any sort of gastric sleeve and all of those aspects, that is pretty radical. Is that in any way a part of treatment for diabetes 2 or does that have more to do with obesity and the 70 per cent of people who are overweight and obese, and that has a different set of chronic disease aspects to it as well?

Mrs McGough: No, it should be part of the mix.

The CHAIR: When should it become part of the mix?

Mrs McGough: Again, we would have to look at the defined criteria as to how you pick that person, but certainly having seen—when I worked in private practice for eight years, I would have seen 5 000 or 6 000 people who needed to try to lose weight. So many people sat in front of me and there are lots of people who are trying really hard to lose weight but it is just not working for them, for a variety of reasons. I cannot count on my hand the number of times that people have talked about sexual abuse being a big part of their weight-gain story and every time they try to lose weight, it is a protective mechanism. They eat again to protect themselves because they do not want to appear attractive to men. We have to provide different services for different people, but I have had people with polycystic ovarian syndrome who have tried everything to lose weight and it is just not happening. Maybe gastric banding or gastric sleeve probably would be the answer for someone like that.

The CHAIR: How does that proceed in terms of someone like that if they have tried everything else? Can they then get access in the public health system or they always have to do it as a private patient?

Mrs McGough: The majority of it is done as a private patient. Most people are accessing their superannuation. You can access it through Joondalup hospital at the moment —

The CHAIR: As a public patient?

Mrs McGough: As a public, but I am not sure of the criteria for that.

The CHAIR: From a public health point of view, the chronic disease aspect of diabetes will be a major drain on the public health system.

Mrs McGough: Yes.

The CHAIR: Looking at it as a system again, if you go through all of these stages and you cannot assist, is there a stage where the public health system says, “Look, at this stage you can get access to this quite extreme surgery because we think keeping you at a level that is a manageable diabetes level of lifestyle will benefit us in terms of the long-term cost”? Has anyone looked at that in terms of cost-benefit analysis?

Mrs McGough: Not that I am aware of, but certainly you would be looking at your high-risk groups. Like I said, that psychosocial complexity, that is where that really comes in. When the ability to eat well and exercise is not within the control of the individual as much as somebody else, I think those individuals should be able to access it more than somebody who is able to make those choices.

The CHAIR: Are those the things, for instance, such as if they are in certain areas where they do not have access to fresh food? Can you give the committee some of the —

Mrs McGough: Mental health is a massive one. The relationship between mental health and diabetes is very strong, and the development of type 2 diabetes. We are not sure, it could be the chicken or the egg, but there is a big link between the two —

The CHAIR: In depression or anxiety —

Mrs McGough: In both.

The CHAIR: — or schizophrenia?

Mrs McGough: Depression and anxiety particularly, and I have not got them with me today but I can provide you with some stats on those rates. We have a mental health professional network that we have just started at Fiona Stanley Hospital to try to address this issue. But certainly mental health, addiction and food security definitely comes into it in some of the rural and remote areas and that is why we see increased rates, particularly in Aboriginal communities, particularly as you go out into those rural and remote areas we see higher rates of diabetes that we know of anyway. It is hard to track.

The CHAIR: Do you want to talk about addiction?

Ms S.E. WINTON: Obviously, you are a dietitian, but this thing with addiction—we talk a lot about people being overweight and not being able to lose weight et cetera. Is addiction a part of it? I know we talk about it as a behavioural thing but is it that people are just addicted?

Mrs McGough: It is not addiction in the same sense of the word as we know it from pleasure centres being, I suppose, increased in some of the other drug-related addictions. There is some really interesting work by Amanda Sainsbury–Salis. She is over at —

The CHAIR: Deakin?

Mrs McGough: No, over east.⁴ She is a neuroscientist and she was looking at this NPY 9 peptide that is very close to the pleasure centre of the brain, and for some people who try to calorie restrict, that

⁴ The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).

kicks in and it makes them eat more. It is because they almost need the ability to eat again. Sorry, I am not explaining myself very well. There is definitely a relationship between psychology and food intake, but I would not call it an addiction. Of all behaviours, you have to make something like 200 food decisions every day. Some great work has been done by Brian Wansink in the US. They did an experiment and found that if you give people larger bowls, they will eat more. If you give people more choices in different bowls, they will eat more. He did an interesting experiment where he gave a bunch of students a lecture on food and psychology. Then he gave them free passes to go and watch a movie. One of the boxes of popcorn they got for free was a big one but it contained week-old stale popcorn versus another smaller box of popcorn that was fresh. The people who had the week-old stale popcorn still ate more than those who had the smaller box, even though they knew about the psychology as well. It is about helping people to work out their triggers and working out what works for them, because that is going to be very different for every person. That is why we spend a lot of time in the DESMOND program, and Let's Prevent will be the same. There is all this information out there. Knowledge is very rarely the reason why people do not change their behaviours. It is more about: okay, you know the knowledge, so what is it about your world right now that makes it difficult for you to do it? They need to then acknowledge that and start action planning around how to change that bit rather than just pretend that if you know all the knowledge that it will change by itself. Yes, we spend a long time doing that.

The CHAIR: So availability and accessibility would feed into that, yes?

Mrs McGough: Yes. It is very much about—the diets that you see are classic scenarios of people going: everybody should just do the 2 and 5 or the fasting diet, and everybody should do the Mediterranean or everybody should do—as soon as you say that, when you sit with the person who is trying to do that, you go, “Okay, so how about you look at trying to change your intake.” Then they say, “My husband doesn't like that and I need to cook for my kids in this way.” That is just at a personal level, and then they also say, “I can't really afford to go down and buy those products”, or, “My culture tells me that these products are part of my—that is what we eat for breakfast, lunch and dinner.” My Indian clients, for example, to sit there and say have —

The CHAIR: Less rice.

Mrs McGough: Yes, it is the conversation you have to have within culture, within country. It is more complex than just “Here's the one-size-fits-all approach.”

Mr W.R. MARMION: Are we talking about the people who are at risk or the people who actually have diabetes 2 or —

Mrs McGough: Both.

Mr W.R. MARMION: That means you have no chance, have you. If you gain weight before you are at risk of adopting—if you are having a hard time having a conversation with people who obviously are at risk along the lines of, “You've got to do something mate, you're having trouble”, how would you get the message across? We have had a positive comment about the 2 and 5—fruit and veg—being a strong thing. In Western Australia the book has been very successful. I know that kids seemed to have picked it up, so can you comment about the education side? I know you say it is hard, but should we be doing a bit more in education early on?

Mrs McGough: Yes, I have kids myself. It is about helping parents to make those healthy decisions. You can educate the kids but the kids do not have a choice about their intake. You certainly see it within schools with the Crunch&Sip program, for example. That is something that I would say has the biggest cut through in most of what I have seen. The physical activity programs that are trying

to be done—Cockburn Integrated Health is doing a lot of work with the City of Cockburn in trying to work with schoolchildren. There is always more that could be done.

[11.10 am]

Mr W.R. MARMION: Whose responsibility is that? You talk about the funding, so is it Diabetes WA or is it the health department that is responsible? Does it need to be better coordinated and who is responsible?

Mrs McGough: Yes, I think it is everybody, in short. The education department obviously has a role in that as well if you want education to happen in schools, but teachers get more and more added to their role every week so we cannot expect teachers to solve nutrition. Yes, Diabetes WA could have a role in that but unfortunately we do not receive money for prevention interventions outside the Let's Prevent program.

The CHAIR: You were talking about the Indian community. What other communities—I note that you had a list of communities that you dealt with, but how do you interplay with the culturally and linguistically diverse communities?

Mrs McGough: We have the structured diabetes education program. We have one for mainstream and one that we call Aboriginal DESMOND. We do not have a product in that space for the CALD community. At this point in time, we are using a tool called "Feltman", which is literally a felt man. We walk through what I was describing before which was the rusty locks, the pooped out pancreas and the leaky liver and we do that with an interpreter and very visual tools. We go out to a multicultural access centre or the English-as-a-second-language schools. We do about 20 a year with different groups such as church groups and people who will get in contact with us. We do not do general community education but we prioritise the CALD community.

The CHAIR: In some parts of the world—I think it was Texas—they do programs with churches where they train different people in churches to have conversations with their parish around diabetes, but your stuff is going and delivering to churches. You are not doing anything in terms of upskilling anyone who is in that church?

Mrs McGough: Yes, it is probably the same model that we will end up rolling out, hopefully, eventually with Aboriginal DESMOND. We want Aboriginal health workers to be able to deliver Aboriginal DESMOND. That is the goal and we are on that pathway. We currently have an Aboriginal health coordinator running DESMOND and she is about to go to Looma. She is going to be giving us a lot of feedback in terms of the training pathway that we will be using hopefully in the future to be able to roll it out. A similar thing would be done for the cultural health workers. We did things many years ago—again, funding was probably lost—around training cultural health workers and some work has been done over in Victoria where bilingual health workers have been trained to deliver diabetes education programs.

The CHAIR: Do you know if there are any real hotspots in any particular CALD community for diabetes? Has there been any research in terms of that?

Mrs McGough: Do you mean in Perth?

The CHAIR: Yes, Perth, Australia-wide or even internationally.

Mrs McGough: Certainly, there are the at-risk groups, which are Asian communities and South-East Asia being pretty much anyone from South-East Asia. You have your Italian communities, your Middle Eastern communities and some of the African communities as well in general. In terms of hotspots in Perth in the metropolitan area, we can see the hotspots through some of the reports that WAPHA have done combined with our NDSS data that are in Balga, Mirrabooka and around

there—no surprises. Some of the southern suburbs have a high number of pockets of people at risk, but that is with diagnosed diabetes, not those at risk because we do not have a register for those people.

The CHAIR: Do we have access to those hotspots?

Mrs McGough: It is called the “Lessons of Location” report by WAPHA, which looked at hotspots for a lot of things but diabetes was one of those. If you access the diabetes maps as well, you can look at the NDSS registrations.

The CHAIR: Are the diabetes maps on your website?

Mrs McGough: It is on the NDSS website.

Mr R.S. LOVE: You mentioned earlier on about the role of WACHS in your work. Do you find them to be embracing of the work that you do, and have you got any suggestions about improving how country health services might embrace the diabetes message?

Mrs McGough: It probably varies across different regions. Certainly in the south west, WACHS is very much involved in helping us to co-deliver the DESMOND program in the Pilbara and, like I said, in the South Hedland group. In other areas we work with the ICDC providers, so it might be the WAPHA-funded commissioning in those areas, so we do not always need to work with WACHS staff. But yes, certainly in terms of our Diabetes Telehealth we would very much like WA Country Health Service to find more funds to support us to keep rolling out that program.

Mr R.S. LOVE: And the funding deficiency is because of what? The WACHS centres have the telehealth facilities, so is it because they do not have staff to operate the facilities or they do not have the budget to interact with you? What is the hold up?

Mrs McGough: Diabetes Telehealth is not within the WACHS telehealth system; it is outside of it. It is situated at Diabetes WA rather than in the tertiary hospitals or the WACHS centre itself. We trialled it that way because it needed to be diabetes educator led, so we started that process. One of the issues with telehealth, and I was talking to the endocrinologist from Royal Perth Hospital recently, is that when telehealth gets done sometimes in tertiary hospitals, the technology is a bit ad hoc. The doctor was describing a specialist running around with his laptop and hopefully getting the connection right to allow that person to connect with the telehealth service, and it is not as integrated as we would like it to be. We pulled it out of that system and trialled it with a community-based approach and they are also doing it at the Asthma Foundation as well, so it sits out of that system. In terms of why it is not being funded, again, the outcomes we were achieving: we saved one million kilometres’ worth of travel for people to access diabetes education. We added the endocrinologist ourselves on top of it so we are using the MBS to fund the endocrinology. We won the director general’s award. Certainly everybody is happy with it. You would have to ask WACHS why there is no funding there for it to continue. They believe it is a WAPHA funding issue and WAPHA have been supporting us as well, but being that it does cover rural and remote, it is a WACHS issue as well. We have written to all of them to bring them all together and say, “Look, can we get you all in a room to sit down and have a conversation? Rather than coming to you all individually and begging and pleading for this to keep going, can we look at a joint service agreement to enable this to happen?” Because it is across everybody’s brief to deal with diabetes in the rural and remote areas.

Mr R.S. LOVE: If we sought some further information from you about that background would you be happy to provide that?

Mrs McGough: Yes, sure.

Ms S.E. WINTON: You mentioned before about the five different type 2 diabetes and the work of Professor Morahan. When people are diagnosed with diabetes now, are there any statistics about where that is coming from in terms of these different type —

Mrs McGough: No, it is very early stages. That is world-first research that he has done. He has identified the different five and now it is like: what do we do with that information next? But there is no test that you can have done to identify your type of type 2 diabetes.

Ms S.E. WINTON: I imagine that would be important work.

Mrs McGough: What we do not know is what that means. I know that Grant would be able to tell you about some of the work that he is interested in doing. But then it is intervention trials, identifying the different type that you have and does diet make a difference, does physical activity make a difference or does medication make a difference. I know that that work has not been done yet.

[11.20 am]

Ms S.E. WINTON: It seems to me that that would be an important part because otherwise we feel like we are stabbing around in the dark a bit. The other question is around your recommendations about Medicare and being on the scheme with dietitians et cetera. Would you like to elaborate on that, and do we have the dietitians in WA? Do we have the capacity to handle that increased work if that were to come about?

Mrs McGough: Like I said, I do not think it is a WACHS funding or Department of Health funding issue. A change to the MBS would help with that and therefore, yes, we do have a workforce that could help with that. I do not know of the number of dietitians that we have in WA but it is significant, and we have lots of dietitians in private practice who would then be able to access those item numbers and be able to help with some of those patients.

The CHAIR: Diabetes WA used to run Living with Diabetes and that consisted of six sessions on different topics. Now there is an online course: Life with Diabetes. We understand, or I am told, that it is not run by Diabetes WA. Has Living with Diabetes been replaced by other programs such as the SmartSession and how did it end up being delivered —

Mrs McGough: I was a co-author on Living with Diabetes many years ago. What happened with Living with Diabetes is that, first of all, it was a six-week program. You were asking people to come for six weeks in a row and the attrition rate was terrible. People would come for the first couple of sessions and then it would all just drop off. Nobody was getting a standard dose. The other thing we found is that we did not really have any evidence that it was doing anything. Yes, it all sounded nice and everybody felt good delivering it, but did it actually do anything? Our general manager at the time did an international scan and said, "Right, I want an evidence-based program. If we are going to have one, let's know that it is actually does something." That is when she came across the DESMOND program and because it had a randomised control trial around it—it was the only one in the world at that stage. The big thing about translating research into practice is the facilitator effect. If you take a great program and then you get untrained people who are not quality assured to deliver that program, you will not get the same results as the original research. DESMOND is the only program that ensures that what is delivered—it is a bit like the Macca's effect—has fidelity and consistency. Every single facilitator who is trained in DESMOND then goes on, delivers three programs and is videotaped, so recorded. The assessor then looks at that and there is what is called a "dot test". They put the headphones on and every 10 seconds a beep goes off: who is talking? Is it the facilitator or is it the people with diabetes? You have to meet a certain percentage of talk time and there are 35 core behaviours that they have to meet that are around group facilitation being

person-centred using the psychology theories that DESMOND was built on—the social learning theory, Leventhal’s common sense model and dual-processing theory—to ensure that that looks exactly like it looked in the trial. Then they are mentored and they do another three. They get videotaped again and at that point, if they meet all those requirements, they become an accredited DESMOND facilitator. The quality of DESMOND and the reproducibility of DESMOND is its strength. Yes, we have a great randomised control trial that sits behind it, but facilitators are delivering it both here and across Australia—it is now under the NDSS across Australia—plus we have trained people in New Zealand and it is in the South and North Island of New Zealand as well, and it has gone to Malawi, I believe. Myanmar was looking at it, Singapore was interested and, of course, it is in the UK. To us that was a much better product than Living with Diabetes.

Mr W.R. MARMION: How many DESMOND facilitators have we got in WA, roughly?

Mrs McGough: I would say we have trained about 300 across Australia, but we probably have about 60.⁵

Mr W.R. MARMION: Are they full time or do they just have those skills to be brought in when you need them and they spread out in a number of professions?

Mrs McGough: Some of them work for WACHS, and that is where WACHS has invested in DESMOND training. That is when we use WACHS staff. Some of them might work for Amity Health down in Albany. Some of them are working for other private organisations such as 360, Boab Health Services in the Kimberley and Karratha Central Healthcare. They fund the DESMOND training and then we help them to fund the DESMOND programs. What we are very careful of is that we do not train people and then they are not able to deliver the DESMOND program. We probably were not so great at that in the past and we trained more people than were actually going to deliver. So we have been very careful in the last 18 months to two years to make sure that people are trained and have the ability to deliver. Our last group that we just trained is in the Gascoyne region.

The CHAIR: Who delivers Life with Diabetes now?

Mrs McGough: Are you talking about life —

The CHAIR: Now there is a MOOC called “Life with Diabetes”—sorry, that is the Curtin one.

Mrs McGough: I do know about it. That is different. That is just an online program. The good news that I can tell you is that we have been funded by the commonwealth government for MyDESMOND online. The Leicester Diabetes Centre has taken DESMOND and turned it into an online version as well and we will be rolling that out over the next couple of years.

The CHAIR: What does DESMOND stand for?

Mrs McGough: Diabetes Education and Self Management for Ongoing and Newly Diagnosed—it is a horrible name. It is a very hard name to market, but, interestingly, we get really good rates of men turning up to DESMOND. I wonder is it something to do with the name?

Mr W.R. MARMION: I reckon it probably is, psychologically.

Mrs McGough: And we have DAFNE for type 1, which is Dose Adjustment for Normal Eating.

The CHAIR: This is absolutely my last question. Online and health programs such as My Healthy Balance presumably only reach a limited section of the community—My Healthy Balance is yours. Do you have any demographic details of the participants, and what are the options for people do not have internet access?

⁵ The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).

Mrs McGough: Again, My Healthy Balance has not been funded for a few years. It would be limited at the moment. We have not got funds to actively promote it. We have some for a few years as they come in.⁶ Our issue is being able to activate people through the program. Get on Track seems to work a bit better because it is in workplaces and people are a bit more motivated, but again we are not doing it actively because we have no staff to actively help and promote those programs and to make sure that people are engaging with them and support them through that process. In terms of those people who cannot access the internet, I would say that our Diabetes Telehealth option is their best option, but of course that is only for diagnosed people with diabetes and not those at risk. We would love to see the ability of those in rural and remote areas who cannot access a dietitian, to be able to access Diabetes Telehealth.

The CHAIR: Excellent. Thank you very much. We have kept you for a good hour and bit. Thank you, it was really great. If we have any more questions are you happy for us to come back and ask you?

Mrs McGough: Please do, yes.

The CHAIR: We are at the beginning stages of learning about all of this. There is a mountain of stuff to get across so we really appreciate your assistance.

Mrs McGough: Thanks for taking the time to look at it. It is an interesting topic.

Hearing concluded at 11.30 am

⁶ The witness has made a correction or provided further information here. See link on webpage (underneath link to transcript).