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, 21 November 2018

SESSION TWO

Members

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

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Hearing commenced at 11.08 am

Mrs CHRISTINE KANE
General Manager, Strategy and Health Planning, WA Primary Health Alliance, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's inquiry into the role of diet in type 2 diabetes prevention and management. My name is Janine Freeman. I am the Chair of the Education and Health Standing Committee. This is Bill Marmion, the Deputy Chair; Josie Farrer; Sabine Winton; and Shane Love in the corner. It is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside of today's proceedings. You also know Sarah and Jovita, who are our are research assistants, and we have Hansard here. Before we begin today, do you have any questions about your attendance here today?

Mrs Kane: No, I do not. I am standing in for our CEO, who unfortunately had to go east so could not attend.

The CHAIR: Would you like to make a brief opening statement? You might want to explain WA Primary Health's —

Mrs Kane: Yes. I thought that would be wise because we are still a young organisation. Thanks very much for the opportunity to speak to the committee today. WA Primary Health Alliance—WAPHA is our acronym—is the organisation that oversights the strategic commissioning functions of Western Australia's three primary health networks—Perth South, Perth North and Country WA primary health networks. WAPHA's primary objective is to improve health outcomes and patient experiences through our commissioning activities of appropriate primary healthcare services in areas where they are most needed for the people for whom they are most needed. Our principal source of funding is from the commonwealth Department of Health, and key to our work is partnerships that we develop at the local and state level. The focus of WA Primary Health Alliance and the PHNs is on potentially preventable hospitalisation and commissioning for better interventions and management in primary care that keep people well in the community and out of hospital. Primary health care has an important role in assessing, preventing and managing the most prevalent, modifiable risk factors for chronic disease—like type 2 diabetes—namely poor diet, physical inactivity, tobacco use, harmful alcohol consumption and obesity.

Despite evidence of how to prevent chronic disease in primary health care as well as documentation on best practice, there remain gaps in preventive care in primary care practice and inequities in access to preventive care in the primary settings by disadvantaged population groups. Primary health networks have an important role in commissioning and improving quality of primary health care but the commonwealth guidance that is developed for primary health networks do not explicitly frame our commissioning role through our preventive health lens. The key role for PHNs in areas like lifestyle management in respect to type 2 diabetes is to facilitate practice change within the primary care setting as well as to develop partnerships with state health services, local governments and NGOs across the state to commission and coordinate new preventive services and programs and to integrate clinical and population health approaches to chronic disease prevention.

I am aware that the range of submissions and evidence to this inquiry have focused specifically on treatment of type 2 diabetes and specific dietary interventions but I understand that the reason for requesting WAPHA to attend the inquiry hearing is to give evidence to better understand the intersection of state and commonwealth-funded services for people dealing with type 2 diabetes and weight issues, and to hear our perspective on what else is needed. I have some detail on some of the commissioning activities that we are undertaking in relation to type 2 diabetes, which I am happy to go through if that is helpful, and also some of the information that has come through the primary health network needs assessments that we have just completed and submitted to the commonwealth last week.

The CHAIR: That would be great. All of us need to get up and go at about 10 minutes to 12 because we are due back in Parliament. In the interests of not trying to curtail you, if, at about 20 minutes to, you do not feel like you have covered those in our questions—I will ask you to go through some of that stuff but why do not we just do a bit of questioning at this point in time and then it may come out in questioning. You can also make stuff available to us.

Mrs Kane: I did request a set of very specific information on type 2 diabetes from the needs assessment, so that is in a format that I can provide to you.

The CHAIR: That is excellent. That would be great. Do you want to ask your question that you asked previously?

Mr W.R. MARMION: You heard the question, did you not?

Mrs Kane: Was this the system question?

Mr W.R. MARMION: Yes. I think that is an important question.

Mr R.S. LOVE: I did not hear the question, so maybe ask it again.

Mr W.R. MARMION: I added a bit of value to the question by suggesting that I was sexually abused as a child and that actually filled in with the thing, but I am a client, so what do I do? I go to the GP and how do I know I am getting the right course of interventions? Do I go to a psychiatrist or a clinical psychiatrist or other types of psychiatrists that I could see? Does Medicare fund that or do they not fund it? Then someone says that I should see a psychiatrist, and Roger Paterson I know some years ago charged $1 200 an hour. Then it gets to the worst situation where you might have bariatric surgery. There is that whole continuum. Who guides you through and how does it work?

Mrs Kane: I think it was Carol, the previous speaker, who pointed out that general practitioners are the gatekeepers in this respect. But we do know that care for a person that you are outlining can be very fragmented. It can be very hard to access. It can be very variable across the state. In some of our rural and remote regions, there are a whole range of issues. But essentially in the primary care setting we see the GP as being the health professional with whom the person will have the relationship and who will be able to see the person in their entirety. They would be able to consider the whole range of factors that interplay in the person's diabetes and weight management issues. One of the problems that GPs will identify is that it is often a very difficult conversation to start with a patient about their weight issues. They may be presenting with some heart issues or arthritis issues and to get to the nub of the problem, which might be around their weight management issues, can be really hard for general practitioners, firstly, because of the amount of the time that they often have available with the general MBS-funded appointment, but also we have the data from general practice that shows that there is a very low rate in general practice of recording BMI for patients. Recording the height, the weight and the waist circumference can, for a whole range of reasons, be quite a challenging process for GPs.

The CHAIR: Because they do not want to approach it or they just do not have time or what?

Mrs Kane: Some of it is difficult to approach. We have heard that patients will, on occasions, see that as also being very confronting. It is difficult with the GP–patient relationship to be able to really effectively manage those conversations. The primary health networks are looking at how we can support general practice by looking at the data that we get from general practice about the recording of BMIs, having a look at what that looks like in individual general practices and seeing how we can support general practitioners to start having those conversations. There is some really good best practice around the country around providing some scripting for general practitioners and other health professionals—practice nurses and others—around those weight management conversations.

The CHAIR: Where is that best practice from?

Mrs Kane: The Hunter New England primary health network has a healthy weight initiative underway and they have developed some scripting from behavioural psychologists, which has been really helpful in this space. The Cancer Council has also developed some resources for GPs and the RACGP provides a lot of clinical support and guidance in this area. It is an important area within general practice that does require a lot of focus because the GPs are really, really well placed to be starting the process of helping to navigate the person through the system. Bill, in the event that the person requires a bariatric surgery intervention, there is still a lot of work that can be happening in the general practice of support and weight management for that patient because, as you will have found from the inquiry, there is a significant wait time on the public list to have the bariatric surgery.

Mr W.R. MARMION: Is it five years?

Mrs Kane: Yes. So for that patient who is on that wait list, that management with the general practitioner is really important and that is where the primary health network is looking at how we can better support general practices to be able to do that.

[11.20 am]

Mr R.S. LOVE: Just on the idea of GPs finding it confronting to talk to a patient about weight, I can give you a few names of GPs, the ones that I visit, who all tell me I am fat, so that is not necessarily a problem with every GP. But it would seem to me that we had evidence from another practitioner here about surgery and not just in terms of diabetes 2 but in terms of knee replacements and all those other bits where people basically just carry too much weight around. Surely the duty is on the GP to actually confront that issue up-front. It seems to me that if people are being paid $300 000 or $400 000 a year to work, that should be inculcated in the basic training of a GP that this is an issue that needs to be addressed, as brutally as it needs to be to actually get the message across.

Mrs Kane: Yes, and GPs are seeking the support in this area to really work with their patients on these issues. The GPs will see this as being part of the two-way process with patients. GPs are really well placed to work proactively on an ongoing basis with their patients. The GPs will seek out a lot of this education and training and are very open to looking at the data in their practices, around capturing the BMIs and having the conversations with their patients to look at how, within a quality improvement cycle in general practice, they can use—there are a number of techniques. The Plan, Do, Study, Act cycle —

The CHAIR: What was that?

Mrs Kane: The Plan, Do, Study, Act cycle. These are the cycles of quality improvement that GPs undertake to be able to, for instance, really drive up their rates of recording BMIs and having the conversations with patients. GPs are really amenable to looking at some of those initiatives around scripting and those mechanisms that will support them to have the conversations with their patients

because the GPs will be very keen to have the conversations. They see themselves as being at the forefront of care, and I think the AMA submission to the inquiry really pointed this out.

The CHAIR: Absolutely at the forefront of care, but we have had evidence too that GPs, when they are training to become a GP in the university system, are not trained in how to assist. They can do a BMI and they can tell Shane that he is overweight —

Mr W.R. MARMION: Slightly overweight.

The CHAIR: Slightly; he said it himself. They can tell someone else that their BMI is risky and they have these risks because of that, but they do not have a capacity then to prescribe anything. If you go in there and you see a general practitioner and you are a menopausal woman and you need to go on hormone treatment for something, they will prescribe that. That is the issue around prescription. What sort of work are the primary health networks doing to assist them, given that there is that lack of nutritional training in their degrees, basically?

Mrs Kane: One of the tools that we have at our disposal is the HealthPathways system. HealthPathways is a clinical decision support tool for general practice. It is a New Zealand–based model but we are localising the HealthPathways for a number of conditions that present in general practice. There is a pathway for weight management. HealthPathways provides evidence-based pathways for GPs to be able to access to provide that care for their patients. That is one tool that we have available.

The CHAIR: So when they go into the HealthPathways for that tool, do you know what sort of dietary advice they are given?

Mrs Kane: I do not know specifically on that pathway, but I can get the information for you on the particular HealthPathways that are relevant.

Mr R.S. LOVE: Before you go on, because I am interested in what you are about to say so I do not want to stop you, but if you look at the Medicare schedule, which funds a lot of the work that is done, I know that there are plans written for various chronic conditions. Are there plans written for patients with obesity so that a GP can actually be funded for writing and helping to implement?

Mrs Kane: Not specifically that I am aware of, but I can get some further information on that part of the care plan, but as far as I am aware, not specifically.

Mr R.S. LOVE: It is not on the Medicare schedule so it is funded just out of the general consultation?

Mrs Kane: And as part of the development of the care plan, to my knowledge.

Mr R.S. LOVE: But the care plan itself is not funded though to be provided.

Mrs Kane: There is MBS funding for the care plans.

Mr R.S. LOVE: Okay.

The CHAIR: We have also had evidence that the HealthPathways are hard to navigate for actual services. Is it a clinical pathway?

Mrs Kane: Yes.

The CHAIR: But it is not a nutritional pathway as such?

Mrs Kane: No.

The CHAIR: So it is a referral to other clinical —

Mrs Kane: It is a tool that the GP has on the desktop that enables them to consider for the particular patient who is sitting in front of them what options are available.

The CHAIR: So they might then refer them to a nutritionist as part of their six visits, and the nutritionist may see them once. Let us say that they have gone to the doctor and they are prediabetes and, really, in most instances you would want to prevent or more than prevent that. If you send them off to a nutritionist, you are sending them off to someone else and then there is all that stuff—you may have a busy lifestyle, and clearly you have all those issues around that. Is there any tool that the doctor can use to assist in them making choices around diet that is presently available for GPs?

Mrs Kane: There are some and there are some that are being trialled in various PHNs in other jurisdictions. There is a counterweight program. Another program is being trialled in one of the Melbourne PHNs that provides quite a comprehensive set of resources both for the clinician and for the patient around diet management, and I can again give you some more detail on this.

The CHAIR: That would be great.

Mrs Kane: That particular program has now been taken up, I believe, by nine primary health networks.

The CHAIR: But not in Western Australia?

Mrs Kane: We are working on that at the moment. It is a university developed evidence-based program and it has been made available without charge to the primary health networks to provide the resources into the general practices that they support. We would provide funding from our commonwealth funding for the printing and the publication of those resources.

The CHAIR: Do you do the training as well for the general practitioners?

Mrs Kane: Not through the PHN ourselves, but we would outsource. We would commission the training that would support those resources.

Ms J. FARRER: I just want to throw a question in there. A couple of people have been hounding me in regard to bariatric surgery. I come from the Kimberley and you may be aware that we have a huge turnover of GPs who come into the Kimberley on locum and different ones have gone in for health reasons. One of the ladies has been constantly going backwards and forwards. She is a huge lady and she asked me the question: how do we get help and support if I want to lose weight because I am having lots of problems? I have been to the various GPs that have come into the area and have asked them these questions. The question that the GP puts back on the person is: is this for cosmetic reasons or is this for health reasons? This lady said to me, "I have spoken to the different ones and I have said I am having all these health issues but I don't seem to be getting any support or advice anywhere." There is a big need for some of these people to have that sort of issue treated.

[11.30 am]

Mrs Kane: Yes, and that is very interesting for us to know. Those sorts of patient stories are really interesting to know. We are doing a lot of work in the area of telehealth for the remote areas. In country WA, the country primary health network is developing a range of telehealth services to support people in terms of self-management strategies, how to prevent the exacerbation of symptoms and new symptoms, provide triage assessment, one-to-one and group support, linking with local social services where they exist, assisting GPs also to manage patients, so some of that specialist in-reach by telehealth. For a lot of the remote areas, that is a viable solution, given the workforce issues that you are referring to. That is an area that we are able to influence.

Ms J. FARRER: Are the GPs obligated to give that advice to some of those people? We are in the dark about a lot of these things and people say there does not seem to be much support. I just imagine if I was that big and I asked not only once but maybe several times that we have had new

GPs come into the area and all they say is, "I can't help you but if it's for cosmetic reasons, you need to find the money." A lot of these people live on welfare. How would they get that support or how does the health system give them that support? This is not only just Indigenous people; there are a lot of white people up there as well.

Mrs Kane: Yes, and that is a really interesting topic certainly. One of the opening statements I made was that the primary health networks have a significant role in our partnerships with other agencies and the WA Country Health Service in some of these rural and remote regions is a provider-of-last-resort mechanism to address some of the workforce issues in the Kimberley region, for instance. That is a particular topic I would really like to progress from the PHN perspective with WACHS in terms of what sort of solutions we could look at in partnership for these people because you are right, they are not having a good experience of care in terms of a very fragmented relationship with a general practitioner where there are different locums at different points in time and so the person is not developing a relationship with the GP. There is no specialist information that is being communicated to the patient to help them through that journey. I would be really interested in talking to you further about this particular topic because I think there is some work that we can do with the WA Country Health Service in this regard.

Ms J. FARRER: I think so because constant consultation with the patients is another thing. If there is no continuation of seeing a GP, then you do not get a referral. That is one of the things communicated to me that is lacking via the GP to the customer.

The CHAIR: Shane, do you have a question?

Mr R.S. LOVE: It is actually similar to Josie's. In fact, it is the same. I am a regional member and in many of my areas, we have a churn of locums. It seems that reading through the material prior to your arrival that you do have relationships with individual practices in some areas. I am wondering how that then leaves out other practices in a town—maybe in, say, Geraldton, you have a relationship with the Panaceum, for instance. What happens to other GPs and how do you interact with them. In the case of what Josie is talking about there, you mentioned telehealth, but telehealth generally is provided at the WACHS centre, not at the GP clinic, so there is that disconnect between what is happening in the GP's surgery and what is happening across the road at the WACHS facility often times, and not just in the Kimberley. I think similar things would happen right throughout country WA where you have a doctor who—because they are a health centre, not a hospital, so they are not actually treating patients in there. There is not that close relationship that there might be if you were a doctor servicing a hospital as such. I am just wondering structurally if you recognise that as being an issue and if you have in place some sort of strategies for those country areas to engage directly with the many different GPs who might be there.

Mrs Kane: Our approach to the general practice support is that we provide support to all general practices. We have a smaller group of general practices in areas of highest need where we run our comprehensive primary care program, and that involves some really intensive practice support for general practices. In those particular areas, the ability for general practices to participate in the comprehensive primary care program was an open invitation, so practices chose to work with us for more intensive support. But we have range of support options for general practice that does not disadvantage any particular practice.

The CHAIR: But not all GPs have to do that, do they?

Mrs Kane: No, they do not.

The CHAIR: If a GP does not want to interact with the primary health network, they do not have to.

Mrs Kane: Absolutely.

The CHAIR: So you can have a GP in a remote and regional area who says, "I'm good. My business is good. I'm dealing with people. I don't want anyone poking around in my business."

Mrs Kane: Yes. Absolutely right.

The CHAIR: Because they are small businesses, are they not?

Mrs Kane: They are, yes. They are essentially small businesses.

Mr R.S. LOVE: I can give you another scenario and this does happen in a town that I am aware of where there is a medical practice, which is supported by the country —

Mrs Kane: WACHS service.

Mr R.S. LOVE: They are provided support to provide services across a region in one particular town where there is a country hospital where they do not even have a practice. So that locks out the existing GP practice from providing services in those streams from your organisation. It has actually set up a very negative situation where there is this conflict between a practice that does not exist in the town and a practice that does for those funds. The third complicating factor is that WACHS seems to provide similar services without much clear idea of working with your organisation in the provision of those services. There are actually three competing health providers in this one town, none of whom are talking to each other, and money being provided for programs which are duplicating each other without anybody actually being aware that they are even there from the point of view of governance. It is not very helpful.

Mrs Kane: We do work closely with WACHS and we are improving in that area. Without more knowledge of the particular instance that you are talking about with the practices that are precluded from involvement in commissioning activities—so this is in the Geraldton region?

Mr R.S. LOVE: No.

Mrs Kane: Again, it would be good to have further information so that we can have a look at it.

Mr R.S. LOVE: I am happy to provide that offline.

The CHAIR: Do you think part of the issue is that general practitioners do not have enough information about the cohort of people with diabetes or prediabetes? Do you think that there is a real issue around that? Is there any plan from the primary health networks to work given that it is one of the major chronic diseases and it is preventable?

Mrs Kane: Yes. Type 2 diabetes and the complications associated with type 2 diabetes is a priority for us. It is a priority to work with general practice but also to consider how a multidisciplinary health team approach can support people better. It is one of our key focus areas; so chronic heart failure and type 2 diabetes and the associated complications are probably our two —

The CHAIR: And both of those are diet related, are they not?

[11.40 am]

Mrs Kane: That is right. Yes. We are working at the moment not only with general practices, but we have also partnered with WA Health. I think James Williamson might be giving evidence also. But we have partnered with the state Department of Health to develop the obesity strategy for WA, so Health Consumers' Council WA, the Primary Health Alliance and the Department of Health.

The CHAIR: That has not come out yet.

Mrs Kane: No. We just recently had the obesity summit and the strategy will develop from that. So the primary health networks are keeping funding available for developing the strategy, and our focus, obviously, is going to be very much on supporting general practice and supporting other

primary health care professionals to be able to better manage the weight issues and the obesity issues. But in terms of type 2 diabetes sort of exclusively, that has been identified through our needs assessments and also through a collaborative project that we did with the Department of Health called "Lessons of Location". I am not sure if anyone is familiar with the report, but it identifies the hotspot areas across the state for the top potentially preventable hospitalisations. We have a lot of really good information about type 2 diabetes, for instance, from our needs assessment and "Lessons of Location" about where we really need to target our interventions because, of course, we have limited funding so we very much focus on those really high need areas.

The CHAIR: I am going to wrap this up in a little bit. Did you want to add anything more that you do not feel that you have touched on? You are always welcome to send us an email if you go back and read your notes and say—

Mrs Kane: Sure.

The CHAIR: Is there anything in particular that you wanted to raise that you thought would be worthwhile for us in terms of our recommendations?

Mrs Kane: Probably the only other thing that I would recommend, so WA Primary Health Alliance was invited to partner with the Department of Health or to provide primary care input to the Sustainable Health Review. I would certainly recommend consideration of the recommendations that talk about integration of care across the primary and tertiary sectors and also the specific recommendations around obesity because I think that provides a really good platform for how some of those partnership approaches are going to take us forward.

Ms J. FARRER: I have one question and I do not know whether it fits into all this because sometimes you talk about it and people do not seem to want to answer. It is about genetics. Now with type 2 diabetes, would genetics have a role in that? Also, a lot of the diagnoses that has been done in the past with families and that, and now it has been revealed that some families have things like Parkinson's or Huntington's disease and that has never been talked about. I know back in the 1960s, someone was collecting blood samples from various locations of mostly Aboriginal people in the Kimberley and they had a whole compilation of data. That was in the 60s. What is happening now is that someone is coming back out; they have been sent out through the commonwealth health department and they have gone around the Kimberley trying to find the people or family descendants who are connected to try to trace back when they are looking at those samples because they have discovered all sorts of things. Whose responsibility is that because we do not seem to know where it is going to?

The CHAIR: The commonwealth department, I should think. Do you have any understanding of that?

Mrs Kane: No. And also not being a clinician, but I think somewhere within the commonwealth Department of Health.

The CHAIR: Obviously you are funded by the commonwealth department and in terms of those chronic diseases areas, do you have any contacts in the commonwealth Department of Health that would be worthwhile us talking to?

Mrs Kane: Yes, absolutely.

The CHAIR: I do not think we have anyone presenting to us from the commonwealth department and that would be worthwhile, so if you can give us a contact, that would be really worthwhile.

Mrs Kane: Yes. There is the chronic diseases area and the prevention branch.

Ms J. FARRER: There were two questions in there. The first one I asked in regard to genetics. Is that all commonwealth?

Mrs Kane: Yes.

The CHAIR: Thank you very much. We really appreciate your assistance. You will get sent out *Hansard*—have a look at it. If there is any other things you want to send to us, that would be good, and those contracts in the commonwealth department will be really worthwhile. If there is anything else, we might have a chat to you as well. Thank you.

Mrs Kane: Also, Josie and Shane, if there are particular issues that I can take forward.

Hearing concluded at 11.45 am

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