EDUCATION AND HEALTH STANDING COMMITTEE

FOLLOW-UP HEARING ON THE INQUIRY INTO THE ROLE OF DIET IN TYPE 2 DIABETES PREVENTION AND MANAGEMENT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 24 JUNE 2020

SESSION ONE

Members

Ms J.M. Freeman (Chair)
Ms J. Farrer
Mr Z.R.F. Kirkup
Mr R.S. Love
Ms S.E. Winton

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Hearing commenced at 10.14 am

Mrs SOPHIE ELIZABETH McGOUGH
Senior Manager, Business Development and Strategy, Diabetes WA, 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 suitability of the "Australian Dietary Guidelines" for type 2 diabetics. My name is Janine Freeman. I am the Chair of the Education and Health Standing Committee. This is Zak Kirkup. You would not have met Zak before; he was not on the committee.

Mrs McGOUGH: I have met Zak before.

Mr Z.R.F. KIRKUP: We have met. I am a diligent shadow Minister for Health.

The CHAIR: There you go. That is on record. He is also the deputy chair. This is Mr Shane Love. Ms Sabine Winton sends her apologies, and Josie Farrer is on my left.

Mrs McGOUGH: It is nice to meet you, Josie.

The CHAIR: It is on *Hansard*. It is important that you understand that any deliberate misleading of this committee may be regarded as contempt of Parliament. I am sure that is not an issue. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. Can you introduce yourself for the record?

Mrs McGOUGH: Hello, I am Sophie McGough. I must clarify that I am now the senior manager of business development and strategy at Diabetes WA and not the health services operations manager anymore. I work for Diabetes WA.

The CHAIR: Do you have any questions about your attendance here today?

Mrs McGOUGH: No, but I do need to also bring to your attention that since the last time I appeared, I applied for and was offered the co-lead position for the diabetes and endocrine network for the Department of Health. I am not appearing for the Department of Health, but I just wanted to declare that straight up.

The CHAIR: Does that mean that you will leave Diabetes WA?

Mrs McGOUGH: No. The co-lead positions sit under the health networks branch at the Department of Health and they basically employ people for half a day a fortnight to act as clinical engagement to the department.

The CHAIR: Thank you. Did you want to make an opening statement? If you wanted to, you could give us a bit of an overview on Diabetes WA's response to "The burden and cost of excess body mass in Western Australian adults and children", if you have anything to say about that, because that is one of the things that probably prompted us to want to have a chat with you further.

Mrs McGOUGH: I have not actually prepared on opening statement at all, but, yes, certainly when you read that report, it has diabetes all over it; has it not? Obviously, chronic kidney disease comes up as one of the major issues from an obesity perspective, but I am sure that everyone in this room is aware that diabetes is one of the leading causes of chronic kidney disease. I note some of the other areas for hospitalisation such as ischemic heart disease, stroke, are all related to diabetes as well. So, when I read that report, I certainly see a huge problem for people with diabetes and certainly a huge need for our consumers.

The CHAIR: One of our confusions around this—and we have discussed this before—and I understand that the "Australian Dietary Guidelines" are a broad document, but they promote the Australian Guide to Healthy Eating, which is the plate, and then the plate has, from our perspective, the six slices of bread, the carbs and how many you should have in the day, and that all of the indications that we were getting from input into our "The Food Fix" report was that a diet based on the Australian Guide to Healthy Eating, or the equivalent plate in the UK, is not appropriate for people with type 2 diabetes, based on the high carb load, and yet, it seems to be still there. Do you want to first take us through the difference between the "Australian Dietary Guidelines" promotion and what the Australian Guide to Healthy Eating promotes, and then I will probably drill down into that a bit more in terms of questioning?

[10.20 am]

Mrs McGOUGH: The "Australian Dietary Guidelines" is the starting point, obviously aimed at healthy Australians. It demonstrates the most evidence-based advice around general nutrition for people in Australia. Those guidelines are developed by the commonwealth Department of Health, and they look at over 200 000[1] studies to come up with those guidelines. The guidelines themselves, if you think about them from a diabetes perspective, if we were to say that they are not appropriate for someone with diabetes, we would be saying, "It's not appropriate for somebody with diabetes, for example, to prepare their food safely. It's not appropriate for someone with diabetes to breastfeed their children." The dietary guidelines are appropriate for people with diabetes, but they do not prescribe the medical nutrition therapy associated with diabetes. Then you have the Australian Guide to Healthy Eating, which is, I suppose, a consumer resource to try to interpret the dietary guidelines and put those into practice, again for healthy Australians. Again, as a starting point, most accredited practising dietitians would use those as a starting point because we do not want people with anything—whether it is diabetes or any chronic disease—to develop other chronic disease problems. We do not want them to develop constipation; we do not want them to have problems with bone health down the track. It is very much about giving people, I suppose, a starting point or an overview to say, "This is general healthy eating and nutrition." That is how we start. Then, the next step around medical nutrition therapy is to look at those serving sizes.

The Australian Guide to Healthy Eating, like you say, it has carbohydrate in the grains group, it has carbohydrate in the fruit group, it has carbohydrate in the milk group, so carbohydrates are everywhere, and we know that diabetes obviously is a condition where people struggle to metabolise glucose. Some people will start to eat according to the Australian Guide to Healthy Eating and when they eat that portion size of carbohydrate contained in that guide, if they do a test before and postprandial, they may find a rise in their glucose level. That is part of my job as a credentialed diabetes educator and a dietitian to see what happens when someone has two slices of bread, for example, which would be two serves out of the grains group. If someone was having their six serves and they were having two slices in the morning, two slices for lunch, two slices for dinner, that is about 30 grams of carbohydrate at each of those points in time. Most people with diabetes could probably handle that. But then, if they decided for lunch to have two rounds—a ham and cheese toastie would be a classic one—"All right; I'm going to have two ham and cheese toasties." Then we have four slices of bread. Suddenly we have a little bit more, but that is four serves of the Australian Guide to Healthy Eating all at once. Then they might say, "I'm going to have an apple as well with that." That is another 12 grams of carbohydrate. "I'm going to have a yogurt as well", and suddenly, even though they are still eating within the Australian Guide to Healthy Eating serving sizes, they are eating too much at once, and it is too much carbohydrate at once. As a dietitian, what I would do is help them to spread that out over the day or look at their portion sizing and testing their

[1] The witness has subsequently indicated the correct figure is 55 000.

glucose levels before and two hours after they have had that carbohydrate to enable them to work out what works for them, remembering that every single person with type 2 diabetes will have different responses with their insulin. Because diabetes changes over time and we have different levels of insulin being produced over time, how one person responds and the amount of insulin they are able to produce themselves to cover that amount of carbohydrate will be different to another person. That is why it has to be very, very tailored.

The CHAIR: It all sounds so very well planned and so logical, but the fact that we have increasing diabetes and an increasing burden on weight and stuff like that would indicate to me that the theory and the policy framework is wrong. It sounds nice and you can justify it and you can see where that is, but, you know, firstly, it does not have a preventative mechanism in it; secondly, it relies on people being able to interpret it properly or have, you know, professional assistance to interpret it properly, which is always limited, because they go to their GP and the GP says to just eat according to that. We know that access to dietitians when they have got type 2 diabetes—they have to access a podiatrist, a dietitian, an exercise person and usually a psychologist, and that has used up all of their six people, so they are not having that intense look at diabetes. For me, one of the things that came out clearly in "The Food Fix" report was that people who were pre-diabetic or had type 2 diabetes wanted really simple instructions. The simple instructions, such that Dr Unwin gives, which is, "Just stop eating carbs or really lower your carbs", are so much better than, "Here's your plate, and, you know, if you want to eat this, you can eat this at this time and that time and whatever." Clearly, people are not interpreting the guidelines properly, the general nutrition for healthy Australians properly; otherwise we would not have a major report telling us that we are all getting obese; not even fat—obese. I get that they are different, I get that they are well thought out in theory, I get that they are a nice theory, but how do we make it simpler? It is the job of Diabetes WA to be able to, hopefully, prevent and reduce diabetes. How do we make that simpler for people, instead of having to come and see you, Sophie, as a dietitian, to tell them, "Okay; well, you had those two toasties and an apple. Now you really should have water and lettuce for dinner", you know?

Mrs McGOUGH: I probably stopped there, but you take the next level—and maybe I am going off track a bit. But there are two different conversations going on here. There is one around managing diabetes—there are probably three—there is one around losing weight, and then what that takes to lose weight, and then there is another one around preventing diabetes as well. I guess the concern of the profession and the medical professions out there will be that if we promote one message, you'll hit the same problem as well. If you went out with, "Just don't eat carbs", then there will be cultural groups in Australia that that is not possible for either. There is not a one-size-fits-all message. That is what we keep saying.

The CHAIR: The problem is that you are giving a one-size-fits-all message. You are telling me, "There's not a one-size-fits-all message, but go to the Australian Guide to Healthy Eating because that's the one-size-fits-all message." You are telling me two different things.

Mrs McGOUGH: Again, you are taking one website. As soon as you talk to Diabetes WA, there is not a one-size-fits-all message, or if you rang our helpline or if you come to any of our courses, that is not a one size fits all; it is just on one website that you are looking at. Certainly, it is not a one size fits all on the website either.

The CHAIR: The "Australian Dietary Guidelines" are still promoted on the website, and therefore the Australian Guide to Healthy Eating is still promoted on the Diabetes WA website. If it creates confusion for me, and I am someone who now has looked into this issue—you know, you came to see me because you said "You are confused about this." I am a reasonably highly educated, well-

paid person, and you had to come and tell me why I was confused about it. If it creates confusion for me, I cannot imagine what it creates for people who have a diagnosis of type 2 diabetes and who go on to your website and it says, "Follow the 'Australian Dietary Guidelines', try the phone call line", but they cannot get through. "My doctor is really not telling me too much. They have just put me on insulin, and this seems like the way to go." My concern is that we are also getting mixed messages about you, because we have gone back to the minister and said that you should tell Diabetes WA that this parliamentary committee thinks that you should not be promoting this on your website, and they have said, "No, no; they're an independent body; they have to make that decision themselves." Partially we have gone, okay, we are going to come to you and tell you that we do not think, as someone who has looked at this from a lay perspective and a perspective of policy and a perspective of representing people, that that is helpful on your website, because it is confusing.

[10.30 am]

Mrs McGOUGH: We can review the website, and we are more than happy to do that. We have already talked to the Department of Health. The Department of Health has been in touch with us. We have already said to them that we will work with them to review our website. So, the website is not the problem here. It is one website; that is easy to change. It is the whole system. The interpretation of that website, we can work with consumers and we can find out how they interpret that website. We have no issue at all with that. But it is not just the website, it is the whole system.

The CHAIR: I do not doubt that it is, but it is the tip of the iceberg that indicates what is under it, for us. There is this massive thing under it. We cannot drill through the health department. I got interviewed—you would have heard—on 6PR, and Gareth Parker was basically saying, "Aren't you appalled at the government's response to your report on type 2 diabetes? Aren't you really angry?" It was, like, no, I understand the measured response and they are going to set up this committee. Meanwhile, you had a doctor who gets on and says, "This is stupid that they would not even consider the low-carb diet." When we went to Britain, what we knew, before we got to see Diabetes UK, is they did not have the low-carb diet on their website as a suggestion, not as a prescription. But, by the time we met with them, they had put it on the website. In between the time, that movement had gone. Now, what we also know, because reports from Professor Taylor have come out, is that when we are talking about those three factors, that the losing-weight factor is primacy. I completely agree with that. The prime issue when you get a diagnosis is: yes, you can go low-carb; yes, you can manage, but if you can do this, then you have much more control.

Mrs McGOUGH: I think it is really important not to forget there tends to be—I understand it—a focus in on food groups, and the carbohydrate in the food groups, but it is the discretionary foods. They have nothing to do with the Australian Guide to Healthy Eating, they have nothing to do with Australian health guidelines. Both of those documents say, "Don't eat so much discretionary food." That is the big issue that we have in all of our communities, regardless of where you live in Australia. That is the problem. You could pick on a slice of bread or you could pick on a Tim Tam. Which one are you going to pick on in terms of carbohydrates? That is the message that we need to get out there. If we spend too much time focusing on healthy foods and trying to get people to stop eating healthy foods, we are missing the point of being able to focus on the discretionary foods, and focusing on reducing discretionary food intake, because that is how we should be going.

The CHAIR: I do not doubt that, but for someone who has got a diagnosis of type 2 diabetes focusing on those food groups, whether it is discretionary or your piece of wholemeal bread—if you are told to reduce your carbs, but choose the wholemeal bread over the Tim Tam, reducing from six slices of bread seems to assist.

Mr Z.R.F. KIRKUP: All reports suggest there is such a high level of confusion about what should and should not be eaten. Governments, at various stages, have intervened on different things. Often there is different prevailing dietary recommendations that might exist for periods of time, so you go from low fats and you replace them with carbohydrate-rich foods and sugars, and we have better facts now. The evolution of diet, if you follow it through from the 1960s and 1970s, continues to take place significantly. Do you think that is still so? Because of the amount of times that things have changed—and I guess those discretionary food items that you talk about are coming over the top of that—is that one of the reasons why there is so much confusion? I am trying to understand why it is so confusing? I know that sounds absurd, but we eat every day. It is a conscious decision that all of us make. Evidently many of us are eating too much, but it is not just how much we are consuming in terms of caloric intake but it is the types of food. Why is there such confusion? Is it because of the change of advice from governments over time, because of the nature of foods that come along, different iterations of complex carbohydrates? What is it that makes this such a confusing argument? Because, from my perspective, it should be a relative easy conversation to talk about something that you eat; we have been doing it since we have been alive.

Mrs McGOUGH: I guess, because of that, we do not see it as a medical scientific process that we are going through. If you look at the evolution of antibodies or the evolution of surgical changes in that time period, you would see the science has changed over that period of time. Of course, science is a quality improvement process. Every time we are doing a new scientific study we are finding out more about nutrition, but people tend not to put nutrition in the scientific bucket. So, there is that side of it. I think the other thing that drives it is this never-ending quest to find out how to help people lose weight easily. We are constantly trying to find that out. I do not think anyone has the solution for that. There is going to be a whole range of different ways that people are going to be able to lose weight. Anyone who says, "I've got the solution"—next week there will be another study that comes out to show there is another one. It is driven by a diet industry that has got a lot of money behind it. There is a lot more media attention that goes to the non-scientific approaches versus the scientific approaches. For example, you will get people like chefs come out and write books and talk about, "This is the new panacea and this is what we should be doing." Now, there was no scientific evidence behind that, yet it is talked about, it is promoted, and people think that the Department of Health is changing its mind; it is not. It is the media changing their minds, and they are reporting a new story about nutrition, not necessarily the nutrition and scientific professionals. I think, yes, there are two different things going on. But the discretionary foods, the need to reduce discretionary food, in all of that time has not changed. Yet every single nutrition report that is done, the discretionary foods that are off the plate, outside of food groups, keep coming up. That has not changed.

The CHAIR: Sugary drinks.

Mr Z.R.F. KIRKUP: Yes.

Mrs McGOUGH: Cakes and biscuits, hot chips. I am a parent. I go to netball and football and instead of giving a kid an apple, which has 12 grams of carbohydrate, it is, "Oh, here, have a hot chips and the sauce on top," which will get 50 grams of carbohydrate. Yet we are worried about bread. We are not focusing on things—not just high-carb —

The CHAIR: We are not worrying about bread. What we are saying is that it is confusing for people. It is easier to say, "Just eat low-carb" instead of saying, "Here, eat these six low-carbs". Half the people do not even know that if you eat a banana you have additional carbs coming in, or an apple you have additional carbs coming in, but they do know if you eat less chips or you eat less potatoes

or less bread then you are low-carbing, so it might mean that they do not choose the chips, or whatever.

Mrs McGOUGH: But, then, it is like what are you giving up from a nutrition perspective? So, which one is the message for people to give up is more nutritious. With my children, yes, they could eat a Tim Tam or an apple, but I want them to give up the Tim Tam because the apple has fibre, vitamins and minerals in it.

The CHAIR: We are not saying no carbs. We never said no carb; that is not the thing. It was a low-carb diet, and the difficulty with that is that we had submitters that said the suitability of the Australian Dietary Guidelines, in particular now we have ascertained the Guide to Healthy Eating, they basically said it is not suitable for the general population as well as not for diabetics and the issue is that that plate, telling people how to eat, is confusing people. That is what that was saying. It is not a workable guideline. It clearly is not a workable guideline. How long have the guidelines been in place?

Mrs McGOUGH: I have been in nutrition for 20 years and they have been in place since then.

[10.40 am]

The CHAIR: And in that 20 years we have not seen a reduction. Yes, I get it. It is the chips and it is the coke, but those guidelines are not assisting. They are not doing anything about preventing it. Everyone keeps saying that if they ate the Australian guidelines, they would be okay, but they are not. We are also saying that it is also not helpful, it appears to us from the evidence we have heard, for people with type 2 diabetes, and that they need specifics; they need you sitting down and a doctor saying to them, "Well, what you really should be doing is having a low-cal diet. That means that if you have to have carbs, you are going to have to make your choice that you want your toast in the morning, not your cake in the afternoon."

Mrs McGOUGH: Again, why should people with diabetes not be able to access health professionals to support them? Why should we be saying, as with every other disease process —

The CHAIR: Well, they do. They access their GP, a health professional. But GPs are scared of dietitians—because that is what they tell us—because of what happened to Dr Fettke and a whole bunch of other people who have gone and given dietary advice. I know that may have been an overreaction on behalf of GPs because Dr Fettke may have—or it is clear now that he did overstep the mark; he went to court and went through a whole legal process. I am told by GPs often, "We don't give dietary advice", yet they go and see a primary healthcare operator and say, "You have type 2 diabetes" or "You have got prediabetes; let's just put you on insulin." They do not say to them, "Here's the dietary guidelines; follow the dietary guidelines." Basically, they medicate. They do not do that.

Mrs McGOUGH: Obviously, at Diabetes WA, we know that what we promote is access to diabetes self-management education support. Every single person with type 2 diabetes should have access to that, but they do not. I am working up in the Kimberley at the moment on a foot initiative. We are working down the other end of the scale, where people are having legs chopped off. I have just done a service mapping, and I can tell you that people just do not get access. They do not get access to culturally appropriate —

The CHAIR: Do they get access to doctors?

Mrs McGOUGH: Limited—but it is a bit like saying a GP has to deal with everything to do with heart disease; when someone has a heart attack, the GP has to do everything. Diabetes is not seen seriously enough. People with diabetes need to have access to everything, not just a GP. It is not

good enough just for someone to see a GP. They must get access to diabetes self-management education support, and if they do not, we are doing a disservice to our community.

The CHAIR: Josie, did you have any questions?

Ms J. FARRER: That is basically some of the things I was talking about right from the beginning in regard to all these health issues that are mainly diagnosed by GPs. A lot of our GPs who come to the Kimberley are on locum, so whatever that doctor prescribes for that patient in particular, he leaves, then somebody else comes in and the next GP, I guess, prolongs that by saying, "Well, we have a dietitian in the Kimberley." But that one dietitian has to do a service to a lot of those areas.

Mrs McGOUGH: Imagine, though, if we had Aboriginal health workers delivering diabetes self-management education support. I have put in grant after grant after grant application. I have just put in another. I cannot get funding for it. That is the solution: it is having people delivering culturally appropriate diabetes education self-management and support—Aboriginal health workers who are capacity-built to be able to give that advice. We cannot get funding for it.

Ms J. FARRER: That is right. A lot of these Indigenous health workers that work wherever—in KAMS or OVAHS or wherever—they are only limited as to what they can do because they are not considered through the Medical Board of Australia as people in their profession. That is the problem we have right across.

Mrs McGOUGH: And we have the training program. You know, it is —

The CHAIR: Frustrating; I can see that. Our report says "fund more training of those things", but it does not take away from the issue that, for us, that is still: we are not suggesting that there is not still a huge iceberg underneath the pointy end, but we are trying to change the thinking about the pointy end just so we can get into the iceberg; because, you know, we cannot even chip away at the top of the iceberg at the moment.

Mrs McGOUGH: But, again—and, Josie, I hope you back me up on this—there is no-one in the Kimberley going to our website and hoping that they are going to solve their diabetes by looking at our website. That is not what the issue is. It is food security. It is access to services. That is not why —

The CHAIR: But there is a whole philosophy of thought around the guidelines that does not mean we take diabetes seriously because we have got the guidelines, and if they just ate the guidelines, they would be fine.

Mr R.S. LOVE: On the issue of the Kimberley and Aboriginal health, from memory—I am just going by memory—one of the facts that came out of the discussion we had was that although the idea is that remoteness, lack of food et cetera leads to these issues, there actually is not a significant difference in diabetic outcomes for Aboriginal people in the Kimberley and Aboriginal people in the south west, who have much greater access to those types of things.

Mrs McGOUGH: That is not true at all.

Mr R.S. LOVE: That is not true?

Mrs McGOUGH: No.

Mr R.S. LOVE: Okay.

Mrs McGOUGH: I would highly recommend that you read David Wyatt's report on foot-related complications and hospitalisations from the Kimberley. Certainly, there are other diabetes hotspots—Balga–Mirrabooka is another one.

Mr R.S. LOVE: I am not talking about the whole population of the south west. I am talking about Aboriginal people specifically in the south west land division.

Mrs McGOUGH: No. The prevalence rates of diabetes—again, speak to the Kimberley Aboriginal Medical Service; they have just done some prevalence work, and you are talking about very, very high rates of diabetes in those communities. I do not want to talk on their behalf, and they have not published those results, so I am not going to say those, but I would highly recommend you speak to Lorraine Anderson.

Mr R.S. LOVE: Does your organisation—Diabetes WA I am talking about, not the health department that you are now mixed up with—and that comes back to the response we got, where the minister would not direct Diabetes WA, but actually you do seem to be very closely aligned to the health department as an organisation. I cannot quite see why the government does not think it does not have an influence over what you do and say. Do you as an organisation accept that there are some circumstances where a person with diabetes can go into remission through changes to their diet, and is that something which you actively seek to achieve?

Mrs McGOUGH: I will give you a situation. We run the DESMOND program, and the DESMOND curriculum comes from the United Kingdom —

The CHAIR: We went to see that.

Mrs McGOUGH: — the Leicester Diabetes Centre. We have just received the updated changes to that curriculum, which talk about remission. Obviously, there is a huge evidence base and there is a position statement in the UK around the use of the term "remission of diabetes". I have been to the Australian Diabetes Society, the Australian Diabetes Educators Association and the RACGP to ask if we are able to use the word "remission", and they said no. Diabetes WA, as part of a bigger system, cannot be seen to be undermining the body that talks to GPs because we do not want to be inconsistent with what those bodies are telling their health professionals to do. It is the same with the dietary guidelines. We do not come up with the dietary guidelines; it is the commonwealth Department of Health. We cannot be seen to be being inconsistent because we do not want to add additional confusion. You are saying it is confusing, but we do not want to be adding more confusion by not aligning ourselves with the national bodies.

A lot of what you are asking at a state level is not within the state government's control either. These are commonwealth decisions. If you want the "Australian Dietary Guidelines" to be reviewed and changed, that has to happen at a commonwealth level. The Department of Health and Diabetes WA are completely on the same page with this. But, like you say, it is our consumers who are confused. Some of the work that we are trying to do is—this is more from a weight-loss perspective, because I think that is the main area of confusion—we are looking at bringing in new programs and services that provide all the different options. We have got things like the position statement on low-carb. We are reviewing the curriculum at the moment and we are reviewing some of our other programs and services to ensure that they represent that low-carb position statement so that is included in all our things. But that position statement came at a national level, not at a state-based level.

[10.50 am]

The other area we are looking at at the moment is around offering and piloting a proof of concept around very low energy diets, or I call them total meal replacements. We are going to be piloting that and we have received —

The CHAIR: Do you have funding?

Mrs McGOUGH: — some funding to do that, through the state Department of Health and the WA Primary Health Alliance.

The CHAIR: When does the pilot start?

Mrs McGOUGH: That starts, hopefully, in July.

The CHAIR: And where are you doing it, or is it just all around?

Mrs McGOUGH: We have only got 50 participants in that one and we will be using three GP practices to trial whether or not we can, within the WA health system, actually run a total meal replacement initiative. That will include training of GPs to increase their confidence in the use of total meal replacements.

The CHAIR: Is that based on the NHS or based on —

Mrs McGOUGH: Roy Taylor's, but it is broad-based consumers, not people with type 2 diabetes, but if people with type 2 diabetes are obese, they will be able to access that program.

The CHAIR: Sorry, I cut you off. There are a couple of questions that come up for me. Do you want to continue? You have the dietary stuff, the very low-carb diet?

Mrs McGOUGH: We have Let's Prevent as well.

The CHAIR: Yes, DESMOND.

Mrs McGOUGH: So for some people we have got DESMOND, which is for people diagnosed with type 2, and then we have Let's Prevent for those who are at risk of not just diabetes but all chronic conditions. For example, we have been running that as a pilot in the south west. We have been doing self-reported weight loss—but about five kilos of weight loss in four months, self-reported, for those who chose to set their goal as being weight loss in that program; other people might have decided to do other things. Again, we are seeing weight loss happen. Now, that is not being prescriptive. That is not telling people a one-size-fits-all approach. When people come in to the Let's Prevent program, we encourage them to work out what is actually going to work for them, particularly if weight loss is on the agenda. And it has got a very strong focus towards physical activity. That one is going to roll out into the midwest as well.

The CHAIR: Can I just come back to the statement you made in answer to Shane, which was you have the DESMOND program; they have sent you new guidelines and it has got remission in the new guidelines. You have gone to all of the professional bodies and the organisations and they have said, "No, you can't bring that program that you use and use the term remission." Why not?

Mrs McGOUGH: As in why are they saying that?

The CHAIR: Why are they saying that?

Mrs McGOUGH: I think because a lot of the research that has been done in that space is UK based. There has not been any —

The CHAIR: We believe that Australians are different that they will not go into remission in the same way that —

Mrs McGOUGH: Again, it is about following the scientific process and having scientific rigour around everything that we do, otherwise we are criticised for not having —

The CHAIR: And is there not scientific rigour in the UK?

Mrs McGOUGH: It is small, though. I am definitely very positive about it, but 147 people in one study is not the same as 200 000[2] studies that have been reviewed by the "Australian Dietary Guidelines". They are very inequitable in terms of the evidence base behind them. We have just got to build up that evidence base, but along the way we do need to keep looking at that evidence and making sure we are providing opportunities for people to do that research in Australia. Again, Fiona Stanley and

[2] The witness has subsequently indicated the correct figure is 55 000.

Diabetes WA put in a research submission to do the DiRECT trial here in WA. We wanted to do it. Everyone got together. There was Curtin, Fiona Stanley and Diabetes WA who all got together, put in the research submission. Do you think we could get any money for it? No.

The CHAIR: When did you do that?

Mrs McGOUGH: That was over 12 months ago.

The CHAIR: Before our report came out?

Mrs McGOUGH: No, after your report came out.

The CHAIR: You are right; they do not take it seriously. They did not take our report seriously. That is quite clear. There is an argument that much of the research that the dietary guidelines are established on is contaminated because it is driven by vested interests in food marketing, food companies and stuff like that. That is a predominant argument through the US that one of the reason —

Mr Z.R.F. KIRKUP: Industry groups.

The CHAIR: The industry groups influenced the outcome of, if not the dietary guidelines in a modern form, at least the genesis of that, and that historical bias and contamination has continued through to now. Do you have any view on that?

Mrs McGOUGH: I would not have a clue. I was not involved in doing the review of all the 200 000[3] studies, so without having a look at all the studies I could not comment.

The CHAIR: Do you have any view that the guidelines have made any contribution at all to the rise in type 2 diabetes?

Mrs McGOUGH: I actually believe that it is just that people have not been able to implement those guidelines. It is consumers' ability to take those guidelines and put them into practice. It is not necessarily the guidelines.

The CHAIR: Is that not a fault of the guidelines?

Mrs McGOUGH: Well, yes. Again, that is a marketing and coms issue: it is not the guidelines, it is the marketing and coms that come out around them. That, again, is a commonwealth Department of Health issue if they cannot communicate those messages that are within those guidelines, they are not necessarily culturally appropriate—all of those things.

The CHAIR: I know the guidelines are not culturally appropriate. You are talking about communities—when you say you want to cut out carbs, it is not necessarily a realistic proposition for many of the communities in the areas of Balga and Mirrabooka. Yet you go to all of those people who are handing out COVID food packages and they were full of food that is based on western diets.

Mrs McGOUGH: Yes, exactly.

The CHAIR: This is not very useful. Did anyone have any other questions? We are going to lose Zak. He has got to go off and be the shadow for health and all of those very important things.

Mr Z.R.F. KIRKUP: I appreciate your time, thank you. Thank you, Chair.

The CHAIR: Does anyone else have any questions?

Mr R.S. LOVE: I guess this is probably an observation and maybe you have a comment, but from my point of view one of the things I found through that whole committee process was that I started with a view that diabetes was an inevitably degenerative condition which would lead to a person's

[3] The witness has subsequently indicated the correct figure is 55 000.

gradually worsening health and finally their succumbing to some disorder on an outcome based on that. What we found was that in fact there is some body of evidence that that might not necessarily be the case. But given the negative prognosis, and if you do not accept that remission is possible, that only leaves one outcome and that is managing an ongoing deterioration in your health.

The CHAIR: That is right—that death is inevitable.

Mr R.S. LOVE: What I have observed in it is that then leads to people losing any sense of agency because they feel that their health is now in the doctor's hands or the dietitian's hands. What you are talking about is that they cannot keep to the guidelines. I would put it that perhaps they do not feel that they have control over their lives and that is leading them to feeling somewhat negative about their potential health and leads to depression, and all of that is bound up with obesity and all sorts of other things, as you know. To me, accepting that maybe there might be a way out of that for some people will at least give some glimmer of hope. I put that to you, otherwise you are just dealing with a terrible negative outcome. A long-term friend of mine, an Aboriginal person up at Kalbarri, a week or so was hobbling along with two toes on one foot and four on the other now; it is just a progressive loss of mobility, which then leads to more weight, which then leads to further diabetes. You see where this all goes. We need to break that cycle and I do not see the current impasse between—you are saying it is the patient's fault. I know you are not entirely saying that but to paraphrase it, it is the patient's fault for not following the guidelines.

[11.00 am]

Mrs McGOUGH: No, I am not saying that at all.

Mr R.S. LOVE: Something needs to change, because at the moment it is a circular downward spiral for so many people. That is what we are trying to see—what can be done to address it.

Mrs McGOUGH: I would say two things: it is definitely not the patient's fault; it is access to services and supports. That is the biggest one. I agree 100 per cent that we need to give people hope. Certainly, in our revised curriculum, we may not be using the word "remission" but we will be using progression terminology and giving people the whole story of diabetes, looking across a continuum and where people are at on that continuum. If they have just been newly diagnosed with diabetes and they lose significant amounts of weight, remembering that it is the weight that has the biggest impact on where people are at with their diabetes, or what they can do to change where they are at in terms of the diabetes. Our messaging will be: what could you do with your weight, if you are able to lose weight in whatever way is the most sustainable way for you? We will not be saying to people they have to lose weight using the Australian Guide to Healthy Eating; it will be a range of different options that people can choose. We see ourselves as a repository of what are the pros and cons of each of those different approaches to give people the hope that they can move backwards and forwards on the continuum, but we cannot use the word "remission".

Mr R.S. LOVE: When you are doing this study that you have outlined into non-remission, or whatever term you want to use —

The CHAIR: Very low-calorie diet.

Mr R.S. LOVE: — very low-calorie diet et cetera, are you also monitoring the situation, because when we did the inquiry we visited some bariatric surgeons and we also had some come here and give evidence? Are you following up any—perhaps not necessarily funding those—but following those on their journey to see whether or not they are —

Mrs McGOUGH: As bariatric patients?

Mr R.S. LOVE: Yes.

Mrs McGOUGH: Not within this project, but again one of the options within our advice is that bariatric surgery is one of those options for people should they choose to have it. When people used to see me as a dietitian—I worked clinically for a while—I would sit down and say, "Look, there is a whole different way of losing weight. I can support you to lose weight in all of these different ways. Here's the pros and cons for each of them." Bariatric surgery is a viable one. If someone is sitting in front of you, they have tried the healthy eating approach and that did not work, they have tried VLCD or they have tried low carb—people do not often come to you as a dietitian having tried nothing—people have tried. If they are at that point where they can afford bariatric surgery, then certainly that is a viable option as well. They are all options, but there is not just one single option; that is what I am saying. I think that is something our website needs to do better at. It needs to show there are a range of different options. But that is more in the weight loss perspective, which is part of the management of type 2 diabetes; it is not the only management option.

The CHAIR: It is one of the most important management issues in type 2 diabetes, is it not? If the reality is they have given you this funding for the very low-calorie diet, not for type 2 diabetes but for obesity because they want people to lose weight.

Mrs McGOUGH: Again, remember our website; there are lots of different types of diabetes. You know, we are Diabetes WA—we are not type 2 Diabetes WA, so our diabetes advice —

The CHAIR: And that is part of the problem, is it not? One of the interesting things—and I am interested in your comment—is that the people who are in decision-making positions or seem to have influence, their experience is mostly about type 1 diabetes and not type 2 diabetes, so their experience is quite different in how they look at the experience and the life aspect of diabetes. Would you say that that —

Mrs McGOUGH: Well, no, because 85 per cent of diabetes is type 2, so anyone working in diabetes, what they are going to see is 85 per cent type 2; however, of course, in the tertiary hospitals they are more skewed towards type 1 because they tend to see more people.

The CHAIR: We built a whole centre next to Osborne Park Hospital based on type 1 diabetes. Have we built a whole sector based on trying to deal with type 2 diabetes?

Mrs McGOUGH: No.

The CHAIR: Yet 85 per cent of them are diabetics type 2. Is that because we think it is their fault?

Mrs McGOUGH: Well, there is certainly a considerable stigma around type 2 diabetes. As an organisation, if we tried to fundraise for type 2 diabetes, we would not get the empathy in the community that something like cancer or heart has. Certainly, there has been a lot of work done around stigma and type 2. We also know from some of our researchers that people do not access services because of the stigma associated with type 2 diabetes. Then we have Live Lighter campaigns that, yes, are now related to just cancer; they are not even related to diabetes or heart disease any more. It is just talking about Live Lighter to prevent cancer. If you look at that obesity report, what was the big thing? It was diabetes and kidney disease, yet we are not talking about Live Lighter to prevent diabetes anymore at all. Then, when we do those campaigns, certainly in talking to consumers, does it make them feel less stigmatised, does it make them feel like they want to go and do something and access services? Then, when they do want to access services, they are living in a remote community that a dietitian visits once every three months.

The CHAIR: The issues that you confront in the Kimberley, you are suggesting they are of a similar nature in Balga–Mirrabooka. Do they get more visits from dietitians in Balga–Mirrabooka because they are —

Mrs McGOUGH: Not necessarily; they probably have more access to services because there are more dietitians. But, as a publicly funded service, there is not a huge amount of access. That is certainly what David Wyatt's report was— that the Balga–Mirrabooka area, particularly, had very few podiatry services, for example, versus some of the western suburbs and other areas because business is not as viable in some areas versus others.

The CHAIR: It is a very interesting thing, because when you look at the ICSA index, which is the index of community social advantage, the Mirrabooka electorate sits only just marginally above the Kimberley. Because we are in the inner city, the expectation is that we do not have the same social disadvantage. We clearly do have the same social disadvantage.

Mrs McGOUGH: Yes, most definitely. What we have done as an organisation is to target programs and services in those, what we call the "diabetes hotspots". What we have tried to do is work with local government to promote those services, but also run as many as possible in those areas.

The CHAIR: Are you doing that through their local health plans? Because they have to do local health plans now.

Mrs McGOUGH: No, we just contact the local government and say we are going to run what we call a "Connect with your diabetes", so it is just a big community event. That is the way we get people along to come and talk about diabetes and then we try and funnel all those people into our programs and services from there. You know, there are cultural issues. We need to adapt the DESMOND program for culturally and linguistically diverse communities. We are doing that. We have an Arabic version. A South Pacific–Maori version is being trialled in Queensland at the moment. Again, it comes down to funding.

The CHAIR: We are going to wrap it up, but I have a bit of a controversial question to ask you. I have read quite extensively now, and if you look at the epidemiology reports in Australia and the UK—I have not seen the American ones—there is a high comorbidity between COVID-19 and type 2 diabetes. That and hypertension are the two leading comorbidities in that aspect. Is Diabetes WA doing anything on that or talking to the health department about that or saying in this case that if we are preventing it in other ways, clearly physical ways, but in the long term if we do not end up with viable treatments, if we want to be able to assist actual good treatment on people who are going, not into remission but going back in their journey, would actually make them fitter and more capable of recovery if we did have COVID-19 community cases?

[11.10 am]

Mrs McGOUGH: I mean, certainly, immediately the Department of Health brought together a diabetes and COVID-19 response group that had all the heads of endocrinology from each of the major tertiary hospitals—Diabetes WA was on that—so a range of different health professionals came together. Those studies were discussed and certainly had the risk here escalated, I am sure they would have been used to inform.

The CHAIR: That is to inform patients. That was not to do a preventive health aspect of it, was it? Really, we gave ourselves time to get more ventilators. We gave ourselves time to beef up our hospitals and to do that sort of stuff, but in no aspect of that did we use any of that time to think about preventive health measures that would lead to people having less adverse consequences. Are you aware of any innovative way—like, if someone said, "Oh, yes, we are going to need ventilators; yes, we're going to need this"? But if you look at the comorbidities, if we actually did some preventive health work around type 2 diabetes, hypertension and all of those, but particularly type 2 diabetes from my perspective, the health outcomes of people would also be improved.

Mrs McGOUGH: We obviously doubled the staff on our helpline. We have funding for telehealth for country WA. We reoriented that whole service and started running telehealth for the metropolitan region. We did things like the gestational diabetes ladies who were attending Midland hospital could not go face to face, so we started seeing those virtually because we had the telehealth system set up. There was certainly a lot of action around diabetes, but it did not turn into the pandemic here that we thought it might. But everyone was ready and waiting with telehealth services.

The CHAIR: It is still not my question, but yes.

Mrs McGOUGH: In terms of the evidence base, we have read the studies. Tim Davis and I, through Diabetes WA and RACGP, did an update for GPs around COVID-19 and diabetes, and we included some of those studies and that information. But there was not a response, I suppose, in terms of now: let us try and prevent diabetes because we think it might be a problem in COVID-19. No, that has not been a response.

Mr R.S. LOVE: I would like to ask, on the telehealth matter, you mentioned before about the Kimberley and other remote areas. But it is not only the Kimberley; people in my electorate do not have access to health services either. Is telehealth something you would see as being a way of being able to overcome some of those issues?

Mrs McGOUGH: Most definitely, yes.

Mr R.S. LOVE: What actions are being taken to expand that now?

Mrs McGOUGH: Again, it comes down to funding. We are funded, again, for another year for our diabetes telehealth service. We have been doing some work to look at the cultural security of telehealth as well. What we want to make sure—what we know is the telehealth technology is not the barrier in some of the remote communities, it is actually feeling culturally secure. Like with any service, it is feeling culturally secure to access that service. Things like having Aboriginal health workers involved in the telehealth consultations who are in community and can help people to feel comfortable using those services is one of the things I would like to see happen. But in terms of expanding our telehealth, again, we could expand it tomorrow—if I was given the money—to help with access.

The CHAIR: Do you think part of the problem is because you are a separate organisation to the health department, because you are not a department having to service from the department that they can almost divorce themselves from it and just say, "Well, you are a separate organisation, you have to get grant funding for this. Yes, we will give you grant funding, but there are competing demands." If they actually had to own the problem inside the organisation, as a unit inside the organisation, then they would have to own some of the outcomes because they are not putting in the resources. I mean, the health department has massive resources and it depends where it wants to put those resources. The "Sustainable Health Review" has told them to find and reallocate some of those resources to preventive health. If they owned it within the department, instead of being able to push it off to a not-for-profit and say, "It is your problem how you deal with that", do you think that there would be more response?

Mrs McGOUGH: Definitely. If we had a state diabetes strategy, like we have a national diabetes strategy, that would certainly put diabetes on the agenda. It is not on the agenda in WA at the moment. Diabetes is not in any document being prioritised.

The CHAIR: No. It is all throughout this document, yet it is not in this document.

Mrs McGOUGH: Yes.

The CHAIR: For the purposes of Hansard, it is throughout "The burden and cost of excess body mass in Western Australian adults and children". It really is quite a broad overview of what happens in terms of some of the aspects of diabetes.

Mrs McGOUGH: Yes; and the classic one with that is that it probably will end up with a focus on kidney disease, because as soon as that report came out, everybody started talking about kidney disease. But the reality is, within that report, it is diabetes that is the issue. They keep talking about increased cataracts could be another association with obesity. That is because people with diabetes have an increased risk of cataracts as well. They are related. Gout was in there. Well, diabetes and gout go together. Diabetes is such a multisystem problem that it impacts on everything—cognitive function. Now we are looking at people with diabetes having 20 times greater risk of dementia. It is related to everything. When I look at that report, to me, it screams having a strong focus on diabetes in our state. But we have a strong focus on obesity, so I am hoping that through the work in obesity that we can also help diabetes as well. But let us not think that everybody with type 2 diabetes is obese, because they are not, and we forget that a lot.

The CHAIR: Even those people with type 2 diabetes who are not obese, if they lose weight, have the investigations, the reports, the studies shown that if they also lose weight that they can take their journey back—if we are not using the word "remission"?

Mrs McGOUGH: They have not been included in those studies. And it is unlikely because the other reasons you develop diabetes are genetics, weight, your mother having gestational diabetes. Some development of diabetes—this is part of the stigma problem—is that some of it is within your control, not all of it. So, maybe 60 per cent of it is in your control and the other 40 per cent is not. People develop type 2 diabetes all the time who are not obese. Again, that is why messages of "you can reverse it or put it into remission" are not true for everybody, which is probably why the medical profession gets concerned when we start saying things like that. But it needs to be there for some people.

The CHAIR: They probably should not give chemotherapy to people either because it does not work for everybody! So, some measures work. The idea is that some things work and some do not.

Mrs McGOUGH: Yes. It keeps coming back to that. I know we talk a lot about the guidelines; it is the same thing. Those guidelines do work for some people and do put some people into remission for diabetes because they followed the guidelines and they got rid of all their discretionary foods. That does work for some people.

The CHAIR: The reality is they got rid of their discretionary foods. The guidelines were not the issue. They got rid of their discretionary foods.

Mrs McGOUGH: The guidelines say, "Don't eat your discretionary foods."

The CHAIR: Yes, well, just say that! Just say, "Don't eat your discretionary foods." And eat a healthy diet.

Mr R.S. LOVE: Well, I do not know what you are saying, so you just have to be clear—what are you talking about?

Mrs McGOUGH: If I was to have —

The CHAIR: No cokes, no Maccas!

Mrs McGOUGH: If I was to have a message, it would not be low carb, it would not be all of the other messages, it would be: eat within your food groups; do not eat discretionary foods.

Mr R.S. LOVE: So, where do salt and vinegar chips fit in?

Mrs McGOUGH: In the discretionary foods. Your Tiny Teddy biscuits, your lamingtons, your Tim Tams—all of those things.

Mr R.S. LOVE: I do not want to live without my salt and vinegar chips!

Mrs McGOUGH: But then we would become very unpopular, so then the guidelines go —

The CHAIR: Yes, that is right, then we end up on the front page of the newspaper like the Cockburn council did saying, "Oh, you're the fun police."

Mrs McGOUGH: Exactly.

The CHAIR: So, that is why the low-carb message is easier than "Don't eat discretionary foods"? The reality is saying "Don't have a low-carb diet" means do not have your salt and vinegar chips.

Mrs McGOUGH: But does it also mean do not lather everything with butter, which would also be —

The CHAIR: We are not talking keto; we are talking low carb. This is David Unwin, very simple—I do not know if you have seen his little outline. I think we had it in our report. It is a very simple prescriptive way that when people enter his surgery he can say, "Here are the things you need to cut out of your diet or lessen". He does not say "Take them out of your diet"—just lessen them.

Mrs McGOUGH: It is the same as what a dietitian would say.

The CHAIR: Yes, yes. But he is a GP and they are the people who see people who are at risk of diabetes in the first instance or are diabetic, and his message is really simple. What we have now is his prescriptive low-carb stuff has been taken up by GPs all through the state. That is how we found out about him, because he has been used. GPs are confronted with this; they are the primary health carers. As much as we can debate whether we should have more dietitian services, we have got what we have got, and people see GPs and we have got to get GPs away from being frightened when talking to people about diet. An easy way for them to have that—I mean the other way is to say eat Mediterranean, which is exactly the same as saying eat low carb. It is the same message.

[11.20 am]

Mrs McGOUGH: No, not really.

The CHAIR: Well, similar.

Mrs McGOUGH: No, because it is high carb. It has beans, rice and pasta.

The CHAIR: No, not the one —

Mrs McGOUGH: The traditional Mediterranean-style diet?

The CHAIR: Not the one that Michael Mosley says.

Mrs McGOUGH: Yes, but that is not —

The CHAIR: And not the one that the CSIRO says.

Mrs McGOUGH: The Mediterranean diet was done in Spain, so it is a Spanish way of eating with added nuts and olive oil. Again, you have to be careful not to take —

The CHAIR: Let us just go back to the simple David Unwin one, which is low carb, which gets rid of these tiffs! Thank you very much, people. We have to get to Parliament.

Thank you. We know your frustration, but we share your frustration. With our report we thought, "Hey, whoa! Come on, guys." I mean, I took someone into this report who thought this was a waste of time and he came out the other side and said, "Whoa, okay, yes, there is an issue here." But the pushback we are getting is from the health department. It is the health department saying, "Yes,

these are the guidelines. This is how it is." We do not think they are helpful but we are told, "No, no. You've got to go and talk to Diabetes WA." So we are talking to you.

Mrs McGOUGH: We can change the website. That is the easy bit. What I would love you to do is, once we have changed the website, then actually do something about the real issues.

The CHAIR: Well, we are trying. We are a parliamentary committee. We do not do the funds. You have to use your influence in the health department as the lobbying organisation in the community. We are still doing stuff on the report. We are still on it. Thank you.

Mrs McGOUGH: Thank you so much.

Hearing concluded at 11.22 am