RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SUBMISSION TO THE HOUSE STANDING COMMITTEE ON HEALTH, AGED CARE AND SPORT

Inquiry into diabetes

About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.

RDAA believes that all Australians have the right to excellent medical care regardless of their postcode.

The health needs of people living and working in rural and remote communities, and the provision of healthcare services, varies considerably from community to community. However, access to all health professionals and healthcare services is generally worse than in cities. This is a significant factor contributing to poorer health outcomes in rural and remote areas, including life expectancy.

It is essential that healthcare services be provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their own communities to redress rural and remote health inequities.

RDAA uses the term 'rural' to encompass all locations described by Modified Monash Model (MMM) levels 3-7 [1], acknowledging that this includes remote and very remote places where the health needs are often greater and healthcare service delivery challenges most difficult.

Introduction

Diabetes[2] has been called the "silent pandemic"[3] and is one of the leading causes of death and disability globally[4]. It has a continuing and extensive impact on the health and welfare of Australians, significantly impacting on the demands for appropriate health services and on the provision, delivery and cost of those services. This submission focuses mainly on Type 2 and gestational diabetes as they are largely avoidable conditions. Investing in diabetes prevention and management is critical to redressing poorer health outcomes, including mortality rates, in rural Australia where there is an increased prevalence of diabetes and a high demand for appropriate services[5].

Any discussion of diabetes within the rural context must consider food security and other prevention issues as a key focus, in particular for Type 2 and gestational diabetes. Poorer access to the social determinants of health contribute to worse health outcomes and mortality due to diabetes complications in rural communities. Policy and program initiatives – including to increase the availability of quality fresh, frozen and canned/bottled fruit, vegetables, whole grain products,

[1] The Modified Monash Model (MMM) is a scaled classification system measuring geographical remoteness and population size with MMM 1 being a major city and MMM 7 being very remote.
[2] Throughout this submission the term "diabetes" is refers to diabetes mellitus (Type 1, Type 2 and gestational).
[3] https://www.diabetesaustralia.com.au/wp-content/uploads/Diabetes-the-silent-pandemic-and-its-impact-on-Australia.pdf Viewed 30 August 2023.
[4] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)01301-6/fulltext Viewed 30 August 2023.
[5] After controlling for differences in the age structures of the population, diabetes prevalence increased with increasing remoteness and socioeconomic disadvantage with people living in remote and very remote areas being 1.3 times as likely to have diabetes than those living in metropolitan areas. https://www.aihw.gov.au/reports/diabetes/diabetes-australian-facts/contents/how-common-is-diabetes/all-diabetes Viewed 30 August 2023.

proteins and potable water at an affordable price – must be developed and implemented to break the cycles of inequity being experienced by rural Australians that contribute significantly to worse health outcomes, including mortality from diabetes complications. This is particularly pertinent to the health and wellbeing of people living in remote communities. These cycles of inequity can have multi-generational impacts.

Aboriginal and Torres Strait Islander people are at significant risk. With over 60 per cent of Indigenous people living outside major cities[6], the degree of rurality and resulting inequities can exacerbate this risk.

While the overall increasing prevalence of diabetes trend in Australia appears to have flattened there is a significant caveat in that there is an unknown level of undiagnosed Type 2 diabetes[7]. Rural Australians are at particular risk of developing gestational and Type 2 diabetes because of the impact of the social determinants of health and lifestyle factors, and a lack of access to appropriate health professionals and services to diagnose and treat chronic conditions. Management of their diabetes, including compliance with treatment (sometimes for reasons outside the patient's control), can be difficult.

In these areas, the well-recognised maldistribution and shortages of medical and other health workforces contribute to the stresses being experienced by rural Australians in accessing timely and ongoing care (including to prevent diabetes) and support.

The development of the *Australian National Diabetes Strategy 2021-2030* [8](the Diabetes Strategy) and the funding initiatives announced in the 2023-24 federal budget, particularly in relation to chronic disease management, multi-disciplinary care, First Nations Health, My Health Record, aged care and the bulk-billing incentive, are positive steps. However, as with any high level strategies, success in redressing inequities of access and patient outcomes in rural areas will be dependent on the details governing how measures are developed, implemented, monitored and assessed.

There is a need for timely, coordinated and connected care to improve the poorer diabetes-related health outcomes being experienced by people in rural Australia. Targeted initiatives that focus on preventing diabetes and supporting primary care multi-disciplinary teams to provide seamless and ongoing care throughout a patient's health journey should be developed to redress the inequities of access to health services and unacceptably worse health outcomes in rural areas.

Almost 90 per cent of Australians visit a general practitioner (GP) at least once annually[9] and rural GPs, Rural Generalists and their teams are often the point of referral to other health professionals who assess, treat and help patients to manage their diabetes. Rural GPs and Rural Generalists are a key part of the health response to diabetes and are best placed to help their patients manage their diabetes. They must be supported to undertake this work.

---

[6] https://www.aihw.gov.au/reports/australias-health/profile-of-indigenous-australians# Viewed 30 August 2023.
[7] https://www.aihw.gov.au/reports/diabetes/diabetes-australian-facts/contents/how-common-is-diabetes/all-diabetes Viewed 30 August 2023.
[8] https://www.health.gov.au/sites/default/files/documents/2021/11/australian-national-diabetes-strategy-2021-2030_0.pdf Viewed 30 August 2023.
[9] https://www.racgp.org.au/getmedia/80c8bdc9-8886-4055-8a8d-ea793b088e5a/Health-of-the-Nation.pdf.aspx p13. Viewed 30 August 2023.

During the development of this submission, rural consultant physicians who know and understand the scope of practice, skill level and relationships with their patients that rural GPs and Rural Generalists have – and know that they will seek advice and refer to other clinicians as needed – have advised RDAA that they support this position, recognising that making patients wait or travel to see an endocrinologist unnecessarily is not conducive to best practice diabetes care.

Barriers to primary care management of diabetes and imposition of lifestyle restrictions that require rural patients to travel to consultations with endocrinologists (and often pay for accommodation) when a rural GP or Rural Generalist could provide the assessment must be eliminated.

Initiatives to attract, educate, train, recruit and retain health professionals to address the workforce constraints that underlie poorer access to health services in rural areas, including for diabetes management, will be essential.

Recommendations

Invest in prevention and primary care management of diabetes in rural Australia, including in shorter term, achievable actions to mitigate against diabetes and diabetes-related complications, hospitalisations and mortality:

- Identify, establish and fund flexible models of care to provide timely, coordinated and connected diabetes care by multi-disciplinary teams of medical and other health professionals located as close as possible to patients' homes, including by:
    - Developing and implementing strategies that encourage more GPs to work in rural areas and providing specific training in team-based care and diabetes treatment and management.
    - Providing funding and support for group consultations[10,11] and the use of telehealth that is complementary to in-person care and where it is clinically appropriate.
    - Providing greater access to allied health care, by increasing funded allied health visits under Medicare Chronic Disease Management (CDM) plans to 20 visits.
    - Facilitating more secure income streams and employment arrangements for allied health professionals in rural areas by reducing fragmentation due to different arrangements,

[10] Group consultations (shared medical appointments) are 'a series of individual office visits sequentially attending to each patient's unique medical needs individually, but in a supportive group setting where all can listen, interact and learn'… [They] were developed in the US to improve access to care, utilise peer support, reduce costs and improve patient and provider satisfaction in the management of chronic disease. https://www.racgp.org.au/afp/2014/march/shared-medical-appointments#:~:text=Shared%20medical%20appointments%20(SMAs)%20or,listen%2C%20interact%20and%20learn%27. Viewed 30 August 2023..

[11] [Group consultations] are a way for primary care practices to bring patients with chronic conditions together with a clinician/s to help them with better self-management and share experiences and learning, fostering a sense of community between patients and staff, allowing everyone to learn from each other in a safe and secure setting, making a real difference to day-to-day life. https://www.england.nhs.uk/gp/case-studies/group-consultations-together-patients-are-stronger/#:~:text=Group%20consultations%20are%20a%20way,share%20their%20experiences%20and%20learning. Viewed 30 August 2023.

and enabling state-employed allied health professionals to provide services in private practices to rural and remote communities.

- Continue existing efforts to address workforce constraints ensuring that policies and programs that have proven to be ineffective are discontinued, with funding reinvested in those that are successful, and in new, innovative initiatives. Care must be taken to mitigate against unintended detrimental consequences[12].
- Develop and implement new initiatives to attract, educate, train, recruit and retain medical, nursing, Aboriginal Health Workers and other allied health professionals in rural areas that allow the potential of all members to the team to be effectively utilised.

Response to Terms of Reference

1. The causes of Diabetes Mellitus (type 1, type 2 and gestational) in Australia, including risk factors such as genetics, family history, age, physical inactivity, other medical conditions and medications used

A key concern of rural doctors is that many of the underlying causes of diabetes, particularly of gestational and Type 2 diabetes, have not been adequately tackled in rural areas.

While the prevalence of diabetes overall increased by 80 per cent from 2000 to 2012 it has remained largely unchanged since then. The incidence of Type 1 diabetes has remained relatively stable for two decades. However, in 2021-22 the incidence of gestational diabetes was more than twice that in 2012–13, and although there appears to have been a fall in the incidence of Type 2 diabetes between 2000 and 2021, the prevalence of undiagnosed Type 2 not known[13] but has been estimated at 500,000 people[14].

Rural Australians are at particular risk of developing gestational and Type 2 diabetes because of factors such as: poor dietary balance because of a lack of access to affordable food and drink options; poorer access to preventive measures such as education initiatives and online support; the impact of the social determinants of health; and other lifestyle factors (including higher rates of risky health behaviours). These underlying issues, as well as health workforce constraints must be addressed, and mechanisms to support diabetes care be improved, if the rates of diabetes and diabetes-related complications and hospitalisations are to be lowered.

Specific, culturally safe policies and programs targeting the more than 60 per cent of Aboriginal and Torres Strait Islander people living outside major cities are urgently needed to reduce the very high prevalence of diabetes within the Aboriginal and Torres Strait Islander population.

---

[12] For example, changes to the Distribution Priority Area mechanism to include areas classified as MMM 2 https://www.health.gov.au/topics/rural-health workforce/classifications/dpa#:~:text=The%20Distribution%20Priority%20Area%20(DPA,to%20be%20eligible%20for%20Medicare
have led to resignations from rural general practices and to changes in area preference by overseas-trained doctors entering the country, compromising primary and hospital care in those areas.

[13] https://www.aihw.gov.au/reports/diabetes/diabetes/contents/summary Viewed 30 August 2023.

[14] https://www1.racgp.org.au/ajgp/2019/may/the-pervasive-impact-of-diabetes Viewed 30 August 2023.

Self-management of their diabetes (and co-morbidities), including compliance with treatment protocols, can be problematic for rural people and can lead to a worsening of their condition[15]. Non-compliance may be due to factors such as lack of diabetes education and understanding about the importance of managing the disease, and the impact of social determinants of health and lifestyle factors. Sometimes non-compliance is for reasons outside the patient's control. For example, lack of refrigerators to store food and medicines/insulin in some of the hottest regions of Australia makes it almost impossible for people to manage their diabetes through diet or to adhere to a treatment regimen that requires medication.

The COVID-19 pandemic interrupted chronic disease screening and management (including for diabetes) with many people not seeking or delaying needed care. The repercussions continue in rural Australia. The Royal Flying Doctor Service (RFDS) has indicated to RDAA that there had been a significant increase in the number of priority one aero-medical retrievals since the pandemic, likely because of the reduced access to comprehensive primary care services.

The worsening provision of maternity care in rural Australia is also a serious concern. The ongoing closures of maternity services in rural areas means that rural women are unable to receive this care (including diagnosing, treating and monitoring gestational diabetes) close to home increasing the likelihood of adverse health consequences for mothers and babies. Aboriginal and Torres Strait Islander women are at particular risk. They are 1.5 times more likely to have gestational diabetes mellitus (GDM) and 10 times more likely to have pre-existing type 2 diabetes mellitus (T2DM) compared to the general population[16] .

If left untreated, gestational diabetes "*can have devastating consequences for mother and baby alike. There are proven links, for example, between [gestational diabetes mellitus] GDM and the risk factors that contribute to maternal mortality, like postpartum hemorrhage, obstructed labor and pre-eclampsia. Children born to mothers with untreated GDM face increased risk of neonatal death and long term disability. Furthermore, children born to mothers with GDM are four to eight times more likely to develop type 2 diabetes in later life, while daughters of affected mothers are more likely to be similarly affected during any future pregnancy of their own*."[17]

Effective policy and programs to prevent the onset of diabetes, to screen for and diagnose diabetes early, to slow disease progression, and to provide ongoing, coordinated care for those with diabetes are critically needed in rural Australia.

2. New evidence-based advances in the prevention, diagnosis and management of diabetes, in Australia and internationally

In Australia, some relatively recent initiatives have made access to diabetes medication and technologies more affordable and are welcome (e.g. expanded access to insulin pumps for children

[15] https://www.publish.csiro.au/py/Fulltext/PY20110 Viewed 30 August 2023.
[16] Australian Institute of Health and Welfare. Diabetes in pregnancy: its impact on Australian women and their babies. Canberra: Australian Institute of Health and Welfare; 2010. Diabetes series no. 14. Cat. no. CVD 52 cited in https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2562-6 Viewed 30 August 2023.
[17] https://www.mhtf.org/2017/05/10/diabetes-in-pregnancy-a-neglected-cause-of-maternal-mortality/#:~:text=Left%20untreated%2C%20GDM%20can%20have,obstructed%20labor%20and%20pre%2Declampsia Viewed 30 August 2023.

and young adults with Type 1 diabetes[18]). However, there can be inequities in the availability and timeliness of introduction of new treatment options in rural areas. For example, "*there are considerable and persistent differences in receipt of newer diabetes medications between major cities and remote areas of Australia*"[19, 20]. There appears to be no single clear reason for this, suggesting that there may be a number of contributing factors. These may include: affordability for people without concession status if the cost of the newer medication is more than an older one; poorer access to consultant specialists who are more like likely to prescribe newer medications; and lack of rural GPs and Rural Generalists education and training on new medications. A patient cohort with lower literacy (including health literacy and digital literacy), lack of access to diabetes education contributing to poorer understanding of their chronic disease or co-morbidities and what they should be asking their health professionals, and lesser access to technology that allows them to keep up to date with advances in diabetes medication and care may also be a factor.

Any barriers to rural people receiving equitable access to new evidence-based advances in technology and treatment to manage their diabetes must be investigated and addressed, including by making treatment and necessary equipment and consumables more affordable (possibly by providing subsidies for rural people diagnosed with diabetes) to contribute to the driving down of diabetes prevalence in rural communities. Existing Close the Gap prescription arrangements must also be maintained to assist Aboriginal and Torres Strait Islander people access diabetes medications.

Poorer digital inclusion[21] in rural areas is a barrier to care which has increased in importance as the use of telehealth is becoming more frequent. Virtual care that complements in-person care and is part of a multi-disciplinary approach to diabetes care has the potential to improve the timeliness, coordination and connectedness of care. Developing trusting relationships with health professionals who provide regular and ongoing access to support has proven positive results[22].

Maintaining the funded telehealth access for mental health, initially instituted as part of the COVID-19 pandemic response, has been a positive action that supports the overall health of rural Australians. The availability of this mental health support for people diagnosed with life-changing chronic conditions such as diabetes should be better promoted.

3. The broader impacts of diabetes on Australia's health system and economy

Diabetes has a significant impact on Australia's economy through health system expenditure on types of diabetes that are largely avoidable with appropriate screening and early intervention at the pre-diabetes stage.

Diabetes also impacts on the broader economy through the loss of productivity that occurs when rural people are debilitated by their diabetes and/or have to travel to more distant appointments (and often find and pay for accommodation nearby). Out-of-pocket expenditure together with lost

[18] https://jdrf.org.au/insulin-pump-program-extended-to-21-years-of-age/ Viewed 30 August 2023.
[19] https://www.diabetesaustralia.com.au/news/access-to-diabetes-treatment/ Viewed 30 August 2023.
[20] https://link.springer.com/article/10.1007/s00125-020-05304-3 Viewed 30 August 2023.
[21] "Digital inclusion declines with remoteness, with particularly strong declines in Access and Digital Ability." https://www.digitalinclusionindex.org.au/wp-content/uploads/2023/07/ADII-2023-Summary_FINAL-Remediated.pdf Viewed 30 August 2023.
[22] https://www.flyingdoctor.org.au/sant/news/april-better-results-diabetes-during-covid-19-shutdown/ Viewed 30 August 2023.

income and social impost adds to the financial and emotional burden on individuals, carers and families that can significantly impact their physical and mental health.

The contribution of people living with diabetes to the wellbeing and prosperity of the nation may also be reduced as they may not be able to fully participate in economic and social activity, particularly as they age.

The incidence of diabetes increases with age[23] adding to the significant challenges for Australia's health system presented by an ageing population. For rural health professionals providing diabetes care for the local people as well as coping with the demands of transient populations such as 'grey nomads', can be extremely challenging especially when travellers have unrealistic expectations of rural health services and are ill-prepared to manage their diabetes in isolated places[24, 25, 26]. This can place increased demands on already stretched rural doctors, hospitals and pharmacists if complications arise and has cost implications for the health system.

Of the estimated $3.1 billion health expenditure attributed to diabetes in Australia, well over $2 billion is attributed to Type 2 and gestational diabetes[27]. This expenditure could be significantly reduced through the prevention and delayed onset of these types of diabetes.

The return on investment that can be achieved through prevention is evidenced by the Western Sydney (described as a 'hotspot' for diabetes in Australia) Diabetes primary prevention program which aimed "*to reduce the development of type 2 diabetes in the community and limit the progression of people at 'high risk' or with pre-diabetes to a formal diagnosis of type 2 diabetes shows that type 2 diabetes can be prevented through lifestyle intervention, weight reduction and changes to diet and exercise. Robust economic modelling demonstrated a net economic benefit of $4.65 for every $1 invested in diabetes prevention*"[28].

4. Any interrelated health issues between diabetes and obesity in Australia, including the relationship between type 2 and gestational diabetes and obesity, the causes of obesity and the evidence-base in the prevention, diagnosis and management of obesity

Biomedical risk factors that can develop as a result of obesity increase the risk that a person will develop chronic diseases, including Type 2 diabetes[29].

People who are identified as obese may experience negative attitudes based on stereotypes and discriminatory behaviours even from health care professionals. The stigma of obesity makes its

[23] https://www.aihw.gov.au/reports/diabetes/diabetes-australian-facts/contents/how-common-is-diabetes/all-diabetes# Viewed 30 August 2023.
[24] https://www.thegreynomads.com.au/health-5/ Viewed 30 August 2023.
[25] https://ro.uow.edu.au/cgi/viewcontent.cgi?article=6312&context=smhpapers Viewed 30 August 2023.
[26] https://www.publish.csiro.au/py/PY19164 Viewed 30 August 2023.

[27] https://www.aihw.gov.au/reports/diabetes/diabetes-australian-facts/contents/impact-of-diabetes/health-system-expenditure Viewed 30 August 2023.
[28] https://www.pwc.com.au/health/health-matters/investment-approach-in-health.html#:~:text=The%20evidence%20shows%20that%20type,%241%20invested%20in%20diabetes%20prevention Viewed 30 August 2023.
[29] https://www.aihw.gov.au/reports/diabetes/diabetes-australian-facts/contents/diabetes-risk-factors/overweight-and-obesity Viewed 30 August 2023.

management a sensitive topic best addressed by trusted health professionals working with the patient (and where necessary with families and carers) to focus on lifestyle changes such as diet, physical activity, sleep and stress reduction[30].

This type of weight management is often part of Type 2 diabetes management. However, improved dietary balance becomes infinitely more difficult in places where there is limited access to fresh healthy foods and potable water at affordable prices. Specific initiatives to improve food security and availability of affordable food and drink options in rural areas must be developed to address a key underlying cause of Type 2 and gestational diabetes in rural areas. Investment in educational activities to reduce stigma, raise awareness of the link between diabetes and excess body fat, provide budgeting and food preparation guidance and in other activities to mitigate individual risk such as school breakfast programs, and community sport and physical activity programs would also be beneficial in these areas.

In 2018, RDAA identified specific measures to address the persistent inequities that contribute to the health risks and harms (including diabetes) from overweight and obesity in rural Australia (see Appendix A). While there has been some action to address issues since then, including through the development of the Diabetes Strategy, many of the recommendations remain pertinent to a public health approach to the management of diabetes risk within the general population and should be progressed.

5. The effectiveness of current Australian Government policies and programs to prevent, diagnose and manage diabetes

The high prevalence of diabetes and significantly higher number of deaths and hospitalisations related to diabetes in rural Australia[31] indicates that Australian Government policies and programs have not been very successful in preventing and managing diabetes these areas.

Rural people comprise all the demographic groups in the broader Australian population. The degree of geographical isolation and poorer access to health services that impacts on all rural Australians can exacerbate specific issues impacting on these groups (for example, language difficulties and lack of access to translated information and/or translators) can make accessing diabetes care even more difficult.

As previously noted, the development of the Diabetes Strategy is a positive step with a number of high level goals and areas for action for Australians living in rural and remote areas, but it must be supported by robust implementation plans and adequate funding.

While there is acknowledgement that national strategies do not sit in isolation from other strategies, policies and programs that impact on the underlying issues contributing to the current diabetes situation (including workforce initiatives) unless these issues are remedied, many of the Diabetes Strategy areas of action cannot be effectively progressed. For example, "*Support[ing] and upskill[ing] the specialist diabetes workforce with relevant education, knowledge transfer and training to support*

[30] https://www.ncbi.nlm.nih.gov/books/NBK568511/ Viewed 30 August 2023.
[31] Figure 3: Variation in the impact of diabetes between selected population groups. https://www.aihw.gov.au/reports/diabetes/diabetes/contents/summary#Impact%20of%20diabetes. Viewed 30 August 2023

implementing and maintaining diabetes management best practice in primary care"[32] will not be an effective mechanism unless there is a sufficient specialist diabetes workforce to educate and train. Poor access to appropriate primary care clinicians and other health professionals and services (largely due to workforce constraints) will continue to be a major barrier to rural people being able to get the diabetes care they need at the time they need it.

Lack of access to medical professionals can result in a late initial diagnosis and consequent complications for people with diabetes. Workforce maldistribution and shortages can also mean that the care is fragmented by time between appointments with rural GPs, rural generalists, consultant specialists, dieticians, diabetes educators and other health professionals, which also impacts on the flow of information between health professionals and services.

For rural people weeks, and sometimes months, can go by between seeing their GP or rural generalist for initial diagnosis, and appointments with every other diabetes health professional they need to see for diabetes education, nutrition information and dietary planning, podiatry assessments, endocrinology assessments and so on. Rural people can also incur a significant financial burden for travel and accommodation if these appointments are not locally available.

Barriers to seamless, coordinated care can also relate to inefficient requirements and protocols. For example, the National Diabetes Service Scheme (NDSS) Insulin Pump Consumable Access Form[33] excludes GPs as certifiers but includes nurse practitioners. This is a real concern in rural areas where this type of requirement can have a significant impact on patients in relation to delayed care (as they have to be referred to another clinician) and the financial and other costs associated with travel and accommodation to see these other clinicians. These types of barriers must be identified and eliminated.

While the severity of the problem of health workforce shortages in Australia is recognised and significant work is being undertaken on aspects of the issue, it will take time. Shorter term, achievable actions are needed to mitigate against diabetes and diabetes-related complications, hospitalisations and mortality.

It is imperative that measures to improve the timeliness, coordination and connectedness of diabetes care be identified and implemented to better support rural people with diabetes and reduce the unacceptably high prevalence of diabetes, diabetes-related complications and mortality in rural areas.

They should include:

- Investment to develop flexible models of care provided by multi-disciplinary teams of medical and other health professionals, within the local area where possible, including:
    - Support for group consultations and the use of telehealth (where clinically appropriate).

[32] https://www.health.gov.au/sites/default/files/documents/2021/11/australian-national-diabetes-strategy-2021-2030_0.pdf p 30. Viewed 30 August 2023.
[33] https://www.ndss.com.au/wp-content/uploads/forms/insulin-pump-consumables-access-form.pdf. Viewed 30 August 2023.

    - Increased funding for allied health visits under Medicare Chronic Disease Management (CDM) plans to support 20 visits to provide greater access to allied health care, including for mental health.
    - Facilitation of secure income stream and employment arrangements for allied health professionals in rural areas by reducing load fragmentation. Collaboration with rural allied health professionals to identify and develop appropriate mechanisms for this to be achieved is needed. Expansion of COAG Section 19(2) Exemptions Initiative arrangements[34] could be considered, as could a single employer model (SEM)[35] suited to allied health professions training and employment arrangements. This would enable state-employed allied health professionals to provide services in private practices to rural and remote communities.

- Continuation of workforce initiatives to improve shortages and maldistribution of all health professionals in rural areas:
    - Discontinue ineffective policies and programs.
    - Redirect released funding into successful and new innovative rural health workforce initiatives, with mitigation strategies to prevent unintended negative consequences.
- Development and implementation of new initiatives to attract, educate, train, recruit and retain medical, nursing, Aboriginal Health Workers and other allied health professionals in rural areas.

Other measures could include:

- Providing education to improve awareness of diabetes and risks to health, nutrition and financial budgeting advice and education/training to prevent or delay onset of diabetes.
- Investing in screening to:
    - Identify people who are pre-diabetic who would benefit from early intervention strategies to prevent or delay onset of diabetes and provide this care.
    - Ensure early diagnosis so that progression of the diabetes can be slowed down.
    - Identify people who are at risk of developing or who have diabetes-related kidney disease[36].

[34] The COAG Section 19(2) Exemptions Initiative allows states and the Northern Territory to bulk bill primary care services through the Medicare Benefits Schedule (MBS) in eligible health facilities in rural and remote areas. https://www.health.gov.au/our-work/coag-section-192-exemptions-initiative/about Viewed 30 August 2023.

[35] The Rural Generalist Single Employer Model (SEM) provides a coordinated pathway for doctors who want to become Rural Generalists by offering single employer arrangements for trainees that support a seamless transition between general practices and public health facilities. The model was originally trialled in the Murrumbidgee, NSW https://www.mlhd.health.nsw.gov.au/careers/medical-services-careers/murrumbidgee-rural-generalist-training-pathway-(mr with trials now being undertaken in other parts of Australia. Viewed 30 August 2023.

[36] https://www.diabetesaustralia.com.au/wp-content/uploads/2023-Diabetes-Related-Kidney-Disease-Report-1.4-DIGITAL.pdf Viewed 30 August 2023.

- Identifying and facilitating clinically appropriate digital/technological interventions to help health professionals manage their workload and their patients to effectively self-manage their diabetes.

Conclusion

Unless these diabetes prevention, detection, treatment and support activities are adequately funded, implemented, monitored and evaluated with appropriate lines of accountability and performance measures in place, rural Australians will continue to experience the inequities that contribute to the higher prevalence of diabetes in rural communities and to poorer health outcomes.