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Diabetes in Australia Inquiry

ASLM submission for diabetes inquiry – type 2 diabetes

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Executive summary

- Lifestyle medicine is a whole of person approach, not only to prevent, treat and reverse disease, but to lead to biopsychosocial-cultural wellbeing.
- Lifestyle and social determinants are the leading causes of type 2 diabetes and common comorbidities.
- Lifestyle medicine approaches to diabetes attend to the causes of diabetes (insulin resistance, chronic inflammation, progressive pancreatic failure, and excess visceral adiposity) and hence contribute to disease treatment and often remission.
- The evidence and implementation-base for the role of lifestyle medicine has grown rapidly over the past 10 years, specifically in the prevention and treatment of common chronic diseases such as type 2 diabetes mellitus, cardiovascular disease, and mental health conditions such as stress, depression, and anxiety disorders.
- The Australasian Society of Lifestyle Medicine (ASLM), James Cook University, Southern Cross University and Avondale University are established global leaders in the field of lifestyle medicine.
- New models of primary, tertiary and community care are urgently needed to address the lifestyle and social determinants, including health coaching, social prescribing, multi-disciplinary care and shared medical appointments.
- Culturally partnered models of care, such as Medical Yarn Ups, are effective and have high levels of satisfaction and engagement for whole-of-person whole-of-community chronic disease management.
- Several policy recommendations are available to improve the prevention and treatment of type 2 diabetes.
- The writers of this report welcome an opportunity to meet and discuss our submission.

The Australasian Society of Lifestyle Medicine

adding years to life and life to years

The Australasian Society of Lifestyle Medicine (ASLM) is a not-for-profit organisation working towards improved prevention, management, and treatment of chronic, complex, and lifestyle-related conditions. 'Lifestyle-related' includes environmental, societal, behavioural, and other factors, including but not limited to type 2 diabetes mellitus, obesity, mental illness, and cardiovascular disease.

ASLM has four primary goals:

1. Train and promote an extensive and professional lifestyle medicine workforce.
2. Develop and promote innovative models of care to the healthcare system and to health policy to ensure greater inclusion of lifestyle medicine.
3. Champion change through strong advocacy and collaboration with government, industry, and the public to remove systemic barriers and inspire innovation in the healthcare system.
4. Improve the health and wellbeing of all health professionals.

Not one health discipline or profession alone can meet our health needs. Instead, we must work together, embracing practitioners from all fields for the value of their expertise and input. ASLM is a leading member of a global network of ~50 multidisciplinary societies and medical colleges, all working to establish lifestyle medicine as central to health and wellbeing, medicine, healthcare, and health policy.

ASLM members support and utilise lifestyle medicine approaches in practice, and include GPs, medical specialists, allied health practitioners, public health physicians, educators, scientists, researchers, and healthcare executives.

Lifestyle Medicine and whole of person health

Lifestyle medicine has been defined by Egger et al. (2017) as the "application of environmental, behavioural, medical and motivational principles to the management (including self-care and self-management) of lifestyle-related health problems in a clinical and/or public health setting." Put in other words, lifestyle medicine is the formal evidence-based application of nutrition, fasting, movement, sleep, mind-body practices (such as mindfulness, relaxation therapies and stress management), reduced substance use and pathological screen use, social connectedness, connection with the natural world (such as green and blue prescriptions), clinical approaches to address the social determinants, combined with enhanced behaviour change and health coaching, new models of care and digital health to prevent and treat disease and lead to whole-of-person wellbeing.

The evidence and implementation-base for the role of lifestyle medicine has grown rapidly over the past 10 years, specifically in the prevention and treatment of common chronic diseases such as type 2 diabetes mellitus, cardiovascular disease, and mental health conditions such as depression and anxiety disorders. Lifestyle interventions have a strong safety profile. As a result lifestyle medicine has grown as a field to provide health professionals with the knowledge and skills to assess, address and improve the lifestyle and social determinants of disease and wellbeing as well as develop innovative models of care to address these causal determinants.

A lifestyle medicine approach strongly aligns with the quintuple aim of healthcare: better health outcomes, lower cost, improved patient satisfaction, improved provider well-being and advancement of health equity.

Type 2 Diabetes Mellitus and Lifestyle Medicine in Australia

Type 2 diabetes mellitus (T2DM) is a chronic, metabolic disease characterized by elevated levels of blood glucose and insulin resistance. It accounts for 90% of diabetes mellitus cases. Over time hyperglycaemia and insulin resistance leads to endothelial dysfunction, atherosclerosis and metabolic inflammation to the heart, vasculature, eyes, kidneys, and nerves. It is associated with a spectrum of metabolic diseases and emerging evidence on a range of other disease states including cancers, hormonal and neurological diseases (Galicia-Garcia et al., 2020).

In Australia, ~5% of Australians have T2DM and ~16% have pre-diabetes, with a 2-2.8-fold increase between the years 2000-2020, with some studies reporting that the true disease burden of T2DM is likely an underrepresentation as 1 in 3 diabetic people are underdiagnosed (Galicia-Garcia et al., 2020) . In 2018-19, 17% of Indigenous adults reported having diabetes or high blood sugar levels and are four times as likely to be hospitalized (AIHW 2023).

The increasing prevalence of T2DM has increased in line with BMI, with 2 in 3 (67%) of Australians overweight or obese (AIHW 2023). These are alarming trends that require urgent action and are well overdue for immediate action at various tiers of society, from policy change to health service provision.

In 2022, type 2 diabetes contributed 2.3% of the total disease burden in Australia and was the 12th leading contributor. In 2019–20, an estimated $3.1 billion of expenditure in the Australian health system was attributed to diabetes, representing 2.2% of total disease expenditure. Of the $3.1 billion in expenditure type 2 diabetes represented 63% (AIHW 2023).

Role of lifestyle in causation of type 2 diabetes mellitus

The European Prospective Investigation into Cancer and Nutrition (EPIC) study found that improvements in lifestyle could prevent 93% of type 2 diabetes cases (Ford et al., 2009). A recent global analysis of the association between type 2 diabetes risk and diet in 184 countries found that 11 dietary factors predicted over 70% of diabetes, including: insufficient intake of wholegrains, yoghurt, fruit, nuts and seeds, non-starchy vegetables, and excess intakes of highly processed rice and wheat, processed meat, red meat, sugar sweetened beverages, potatoes, and fruit juice. This paper reports *"Poor carbohydrate quality (excess refined rice and wheat, insufficient whole grains) as a leading driver of diet attributable T2D globally"* (O'Hearn et al., 2023).

In addition to poor diet, lifestyle factors and related diseases such as obesity, inactivity, prolonged sitting, poor sleep, stress, phenotypic variations due to early childhood nutrition, depression and low socioeconomic status are all associated with increased risk of type 2 diabetes (Galicia-Garcia et al., 2020).

The prevalence of obesity and diabetes continue to rapidly rise in parallel worldwide as these diseases share powerful genetic and environmental determinants. Although both diabetes and obesity have genetic links, diabetes risk is increased in the presence of obesity.

Excessive adiposity, particularly surrounding the viscera, muscle, and intrahepatic lipid, is a key driver to the development of diabetes (notably T2DM) along with low grade inflammation (from lifestyle and social factors) which induce loss of b-cell insulin secretion in the pancreas and insulin resistance across multiple tissues, and an imbalance in the microbiome-gut-brain axis (Ruze et al., 2023).

Role of lifestyle approaches in management and reversal of type 2 diabetes mellitus

T2DM is managed largely by pharmaceutical means, with 2016 primary care BEACH data indicating 85% of people with T2DM are on pharmaceutical medication (Britt et al 2015-16). However, in the past ~5 years, multiple high quality lifestyle intervention trials have demonstrated that T2DM is both treatable and even able to be put into remission (defined as HbA1c of less than 48 mmol/mol (< 6.5%) for at least 3 months after discontinuing all antidiabetic medications). The mechanisms by which a healthy diet, such as a

Mediterranean-style diet, and other lifestyle factors such as physical activity, adequate sleep and mind-body practice can protect against type 2 diabetes and cardiovascular disease and lead to their treatment and potential remission are multifactorial.

A 2022 meta-analyses and systematic review of trials of diets for diabetes remission showed that using dietary approaches alone can lead to 11-54% remission rate at 12 months (Churuangsuk et al., 2022). The American Diabetes Association 2019 Nutrition Therapy (Evert et al., 2019) for Adults with Diabetes or Prediabetes: A Consensus Report states that *"strong evidence supports the efficacy and cost-effectiveness of nutrition therapy as a component of quality diabetes care, including its integration into the medical management of diabetes."* The protective and healing effects of healthy diets are also multifactorial, including but not limited to; nutrient repletion, reduction in oxidative stress, and chronic inflammation, improved gut microbiome, epigenetic modulation and more through the rich sources of bioactive nutrients (Itsiopoulos et al., 2022). A variety of eating patterns are acceptable for the management of diabetes, and health professionals require training in various medical nutrition therapies (MNTs) to be competent and safe in their prescription. Further detail can be provided upon request.

Physical activity programs (aerobic and resistance training) show reductions in HbA1c of 0.6-1.2%, and greater whole-body insulin sensitivity is seen immediately after exercise and persists for 96 hours) Kirwan et al., 2017). Furthermore, a 2023 meta-analysis demonstrated that mind-body approaches, such as yoga and mindfulness-based stress reduction, lead to a mean reduction in HbA1c of -0.84% (Sanogo et al., 2023) likely due to reduced inflammation (reducing insulin resistance), decrease in bio-psychological distress and increased treatment compliance.

By using lifestyle approaches for diabetes, we are treating and reversing the causes of diabetes (insulin resistance, chronic inflammation, progressive pancreatic failure, and excess visceral adiposity) and hence contributing to disease remission, thereby avoiding pharmaceutical medications which are both expensive and have potential side effects. A wide range of other lifestyle and social prescription approaches can be detail upon request.

Despite the evidence and impressive outcomes achieved by lifestyle medicine trained health professionals, the current practice of lifestyle medicine in health professionals more broadly is poor. Studies indicate that 22% of GPs usually assess nutrition, and 28% of GPs usually assess physical activity, with 38% rating their motivational skills as low and 52% as moderate. The 2015-2016 primary care BEACH data indicate that nutrition, weight, exercise, smoking, lifestyle, prevention, alcohol, were together given at a rate of 8 per 100 encounters (8%), (Britt et al., 2015-16) well below the average 85.5 medication prescriptions per 100 encounters. Sadly, community surveys indicate that health users *"rated their general practitioners as poor at delivering prevention"* (Mazza et al., 2011). Cited barriers to assessment include time limitations, knowledge, confidence, and funding. Training of GPs in lifestyle programs, such as the Australian Government's 'smoking, nutrition, alcohol and physical activity' (SNAP) program, can lead to a significant increase in assessment and management of lifestyle factors and increased behaviour change skills (Denney-Wilson et al 2010; Harris et al., 2005).

Training of health professionals to address the determinants and causes of T2DM is urgently needed.

Beneficial effects of lifestyle approaches beyond Type 2 diabetes

It is imperative that we see lifestyle medicine as a foundational part of care to directly address the mental and physical health of those with chronic mental and physical diseases. The European Prospective Investigation into Cancer and Nutrition (EPIC) (Ford et al., 2009) study found that improvements in lifestyle could prevent 93% of diabetes, 81% of heart attacks, 50% of strokes and 36% of all cancers. In addition to the remission of T2DM using lifestyle medicine approaches, remission of multiple leading chronic diseases such as coronary artery disease has been shown possible in prospective trials (Ornish et al., 1998).

Furthermore, lifestyle interventions have demonstrated significant benefit for common mental illnesses directly, such as depression and anxiety. 50% of people with diabetes are thought to also have a mental illness such as depression or anxiety (Diabetes Australia, 2023). In 2021 the Royal Australian and New Zealand College of Psychiatrists (RANZCP) published its clinical practice guidelines for mood disorders (Malhi et al., 2021). The guidelines highlighted the important role of lifestyle approaches in mental health, citing them as **first-line, foundational and "essentially non-negotiable" for all patients**. Furthermore, in 2022 a collaborative taskforce from the World Federation of Societies for Biological Psychiatry (WFSBP) and the Australasian Society of Lifestyle Medicine (ASLM) produced the clinical guidelines for the use of lifestyle-based mental health care in major depressive disorder (Marx et al., 2022). The document provides extensive discussion on the current evidence and explores implementation considerations.

Furthermore, on average people with mental illness have a 10–20-year shorter life expectancy, largely due to the presence of cardiovascular, metabolic (type 2 diabetes) and respiratory diseases. The prevalence of comorbid chronic physical health conditions in people with mental illness is ~80% (Roberts et al., 2022).The major determinants of preventable deaths are lifestyle and social factors, medication, and poor access to healthcare.

> *Lifestyle medicine is a whole of person approach, not only to prevent, treat and reverse disease, but to lead to genuine whole of person biopsychosocial-cultural and spiritual wellbeing.*

T2DM in Aboriginal and Torres Strait Islander communities

Diabetes in Aboriginal and Torres Strait Islander communities is the single most important chronic condition. In 2018-19, 17% of Indigenous adults reported having diabetes or high blood sugar levels and are four times as likely to be hospitalised. It is a major risk factor for cardiovascular diseases, kidney disease, eye conditions and dementia. The burden of these disease on people quality of life is high (Health Infonet, 2016).

Diabetes in Aboriginal and Torres Strait Islander communities needs to be tackled from the prenatal period. The concept of first 1000 days is extremely important. We know the stresses, both physical and emotional, place on mothers and child has an impact on chronic disease trajectory including early onset type 2 diabetes. To tackle diabetes holistically will require investment in the prenatal, antenatal, and postnatal programs. The Indigenous Child Health Checks need further promotion and investment in terms of training for health care providers to address lifestyle and social determinants (GPs, AHW/P, maternal child health nurses and so on). (Hoy and Nicol, 2019 and Bianchi ME, Restrepo, 2022).

In Aboriginal and Torres Strait Islander health we often say that social wellbeing needs to occur before better health outcomes is realised. With this principle in mind, we promote a community development approach. It is well known that community development is long-term strategy, increases social capital, empowers community members, and creates stronger and more connected communities. Community

engagement in lifestyle and health literacy programs rarely occur in community-based projects that is led by external providers and programs. True community engagement required Elders and community members to design, plan and implement these programs (Thornton et al., 2016 and Erku, 2023).

Access to allied health and lifestyle medicine professionals who take a whole-of-person and whole-of-community approach can prevent and treat diabetes in Aboriginal communities and reduce the need for further escalation of medication. We have found that innovative culturally partnered models of care championed by ASLM and currently funded by multiple PHNs, such as group-based Medical Yarn Ups, are both effective for health outcomes and rated very highly by Aboriginal participants, with increasing attendance over time (Stevens et al., 2016).

Models of care

Australia's current model of care must change from a reactive, treatment-based model, where one size fits all, to a preventive and integrative model, as recognised by the National Preventive Health Strategy 2021-2030 (DoH, 2021). A shift from an overburdened primary care system to an interdisciplinary care team approach, with a focus on prevention, health promotion and disease remission will require government attention and policy action; not only in the field of health, but in a systemic 'Health in All Policies' (HiAP) synergistic approach. These solutions take into consideration preventing and better managing chronic disease, adopting innovation in the primary care, tertiary care, and community care models, and supporting the health workforce to enable delivery of the new models. These are bold yet achievable solutions to influence innovative, sustainable, and collaborative change. They support the government to achieve key strategies including the Long Term National Health Plan, the National Preventive Heath Strategy, Primary Health Care Ten-Year Plan, the 2030 Mental Health Vision, and the National Obesity Strategy.

Greater emphasis needs to be placed on enhanced primary care teams that are trained and funded to address the lifestyle and social determinants, including diverse workforce input (interdisciplinary), self-management support programs (e.g., digital therapies, health coaching support), increased integration with community organisations (e.g., effective social prescribing), and enhanced collaboration across sectors.

It is worth nothing that health professionals who provide lifestyle medicine approaches to chronic diseases report higher levels of workplace satisfaction (Pollard et al., 2023). Rates of burnout (O'Connor et al., 2018), psychological distress, chronic disease and substance use are concerningly high in the health profession indicating that the evolution of our services must also include the focus on the wellbeing of its providers. Evidence indicate that low levels of physicians' well-being can lead to suboptimal performing health care systems whereas physicians with higher levels of well-being tend to provide better patient care (e.g., satisfaction, adherence to treatment, and interpersonal aspects of patient care) (Scheepers et al., 2015). The benefits of improving our own wellbeing can lead to improvements in these priority areas such as well professionals, higher satisfaction, and better service outcomes.

Health coaching and behavioural support

Behavioural science can be defined as "an interdisciplinary approach to the study of human behaviour encompassing disciplines including psychology, sociology, anthropology and economics and the interaction between these" (Curtis et al., 2018). What influences human behaviour is a complex theme, however, several developed frameworks can be used to answer the fundamental question: "What conditions internal to individuals and in their social and physical environment need to be in place for a specified behavioural goal to be achieved?"

In a health setting, behaviour change approaches will be split into three broad categories:

1. The behaviour change approaches a health professional may use in an individual or group based clinical setting, for example health coaching skills. Health and wellness coaching (HWC) is an emerging discipline championing healthy behavior change as a means of averting or mitigating chronic lifestyle-related diseases. A number of skills and models can be integrated into practice to

adopt a health coaching approach, including motivational interviewing, positive psychology coaching and goal setting.

2. The use of digital health technology (apps, online programs, wearables etc.) to support behaviour change: knowledge, motivation, self-efficacy, and access.
3. The use of behaviour change principles that inform the modification of built environments.

There is significant evidence that health coaching can improve people's confidence and ability to self-manage their health conditions and adopting healthier lifestyle choices such as reducing smoking, eating more healthily, and physical activity.

In the Compendium of Health and Wellness Coaching (Sforzo et al., 2017) and its 2019 Addendum, diabetes articles present an overwhelmingly positive group of outcomes for the effects of HWC with a large majority of studies (85%) measuring glycosylated hemoglobin (A1C) provided positive findings for improvement. A 2018 meta-analysis (Pirbaglou et al., 2018) of 22 RCTs found that HWC intervention significantly improved A1C. Other outcomes (e.g., disease management, weight management, quality of life, medication adherence, healthy eating, smoking, physical activity), including psychological variables (e.g., self-efficacy, stage of change, satisfaction) are also often improved.

Digital technologies, including websites, mobile health apps, and wearable devices can improve the delivery of care. There are a variety of options available here, including continuous glucose monitors which can provide real-time data on blood sugar levels and hence personalized lifestyle plans and have shown to be effective in type 1 and 2 diabetes (Lin et al., 2021), and various online programs such as "Beat It" from Diabetes Australia (2023), and emerging machine learning algorithms for chronic disease management such as Nellie/Flo (SEMPHN 2023). For people in rural locations or those who have other mobility barriers, programs such as telehealth can be an effective tool. Telehealth interventions produce positive outcomes when used for common chronic conditions, dietary interventions, and behaviour change, with improvements in lifestyle factors, mortality and quality of life, and reductions in hospital admissions (Hanlon et al 2017). State based health coaching services are becoming increasingly common, such as My Health For Life in Queensland, and are showing high volume access and outcomes. Social media is another tool that can be harnessed for improved T2DM care. The "Reverse Diabetes 2 Netherlands holistic programme" (Pot et al., 2019) is a lifestyle medicine program including multidisciplinary team (dietitian, personal coach, nurse practitioner, GP), group-based appointments, practical application/events (e.g. cooking classes) and social media support to build community. At 6 months, 49% of patients had reduced their glucose-lowering medication or 13% eliminated it completely and the number of patients with "to-target" HbA1c levels increased from 36% to 60%.

Shared medical appointments and Medical Yarn Ups

Shared Medical Appointments (SMAs) are also known in the medical literature as Group Consultations, Group Medical Appointments, and when applied to the care of Aboriginal and Torres Strait Islander people, Medical Yarn Ups (MYUs). A typical SMA may take up to 90 minutes with 8-12 patients attending with similar concerns, managed, and supported by a trained facilitator, in which the General Practitioner (GP) consults with each patient individually and consecutively, according to the requirements of their scope of practice and the Health Insurance Regulations (2021).

The SMA process is predicated on a personal attendance, by a single medical practitioner, being provided to a single patient, on a single occasion – this is an important consideration if an Australian provider is intending to claim MBS item numbers.

The requirements of a consultation are met in a SMA as the GP evaluates the patient's health-related issue/s; formulates a management plan in relation to the health issues; provides advice to the patient and/or their relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient.

The main difference that the SMA process offers is that other patients with similar concerns are listening and, when appropriate, are asked to contribute their knowledge and lived experience to a conversation that might follow the consultation.

Evidence for Shared Medical Appointments

There is a large and growing body of evidence showing that this difference in the consultation process is making significant improvements to: patient outcomes, practice efficiencies and cost effectiveness [1 2 3 4 5 6 7]; reduced waiting times [5 7 8]; reduced presentations to emergency departments and hospital admission rates [2 8 9 10]. The literature also strongly and consistently reports that SMAs improve patients' knowledge and self-management competency [3 11 12].

SMA consultations are a rare example of a model that meets healthcare's quintuple aim of better cost-effective care and outcomes, better education, high patient, and clinician satisfaction. [6 13 14 15]

Shared Medical Appointments and Type 2 Diabetes

There is also a growing body of evidence about the utility of SMAs, specifically, in the overall improved management of patients with type 2 diabetes mellitus as well as specific measures in knowledge and self-management skill development and overall provider and patients' satisfaction [12 17-27]. A few recent studies have emerged showing patients using SMAs having equal and or improved management of specific determinants of T2DM such as blood glucose measurements (HbA1c) [28 29] and weight [3 30 31 32 33].

SMAs As A Strategy for First Nations people In Closing The Gap

Shared Medical Appointments provide a model of care that is of great interest to Aboriginal Controlled Community Health Organisations (ACCHOs) as it also offers improved accessibility while being culturally safe and responsive [3 33 34]. The model has been named Medical Yarn Up by the ACCHOs and their clients using it. Medical Yarn Ups have been reported in the literature and through roundtable discussions facilitated by ASLM, to being an important strategy in closing the Gap [33 34]. Studies with other First nations people are also showing positive engagement and outcomes when using SMAs [35 36 37 38 39].

SMAs, Current Practice, And Collaborations With Primary Health Networks

ASLM is currently working with a number of PHNs to develop SMAs as an adjunct to General Practice. The PHNs are engaging SMAs as a strategy to enhance primary care's capacity to manage the rise in lifestyle-related chronic disease presentations and workforce issues.

ASLM has trained over 1400 clinicians in the last five years in the SMA process and conducted a number of trials showing its effectiveness and acceptance by patients and providers in practice [3]. ASLM has worked with UK and NZ health Services to help develop equivalent SMA processes that are now integrated into services in those countries [5]. The UK is now routinely using Group Consultation (SMAS) in over 1000 medical centres. Group Consultations, as SMAs are referred to in the UK, have been identified by the NHS as the most important strategy for reducing ~8 million patient waiting list in the aftermath of the Covid 19 pandemic [40 41].

Multi-disciplinary care

Lifestyle approaches to T2DM and its co-morbidities are both warranted and evidence-based at the clinical level. A multidisciplinary team may be required to comprehensively meet the medical and psychosocial needs of a patient living with mental illness, particularly when addressing lifestyle-related factors. The roots of many lifestyle, psychological and physical chronic diseases also lie in social risk factors such as isolation, lack of accommodation, financial distress, lack of education and occupation. Therefore, a multidisciplinary team is recommended and may consist of a GP, social worker, peer support person, health coach, link worker, case worker, psychologist, dietitian, exercise physiologist, addiction specialist, psychiatrist, diabetes educator and nurse (Manger 2019).

In line with the findings from the Productivity Commission 2021, Innovations in Care for Chronic Health Conditions; the current healthcare system is overly reliant on General Practitioners to deliver care, whilst other primary care workers have latent or under-utilised capacity. For example, nurses, diabetes educators, Aboriginal Health workers, health coaches, link workers and various allied health practitioners have knowledge and capabilities that expand beyond their current roles in the Australian system. In practice, this may look like nurse practitioners delivering health coaching, allied health professionals taking more responsibility of client overall health, community leaders providing coaching and support services facilitating SMAs, and all healthcare practitioners working together in a teams-based approach.

Multiple leaders in the lifestyle medicine field, including contributors to this report, are working with international teams, such as Altogether Better (UK) and Te Tumu Waiora (NZ), to develop Australian based pilots that are inter-disciplinary, community engaged, whole of person and evidence based to support positive behaviour change, improve health outcomes, improve the use of health care services, and decrease hospital admissions.

Policy change

Policy change is urgently required to influence the focus on lifestyle medicine in health care provision that is in keeping with the strengthening medicare recommendations, the Productivity Commission 2021, Innovations in Care for Chronic Health Conditions, and more broadly across society to address the lifestyle and social determinants of T2DM and other chronic diseases.

The recommended policy initiatives are:

1. Increase the prevention budget by 1% each year for the next three years to fast-track arrival at the 5% expenditure of the health budget on prevention.
2. Australian National Diabetes and Lifestyle Medicine Guidelines for children and young people, for adults (18 to 64) and for older adults should be commissioned and implemented in alignment with national health and wellbeing policy aims and objectives. The Australasian Society of Lifestyle Medicine (ASLM), James Cook University, Southern Cross University and Avondale University are established global leaders in the field of lifestyle medicine, and we recommend their involvement.
3. Combined National Guidelines on lifestyle and social determinants in health and wellbeing.
4. A comprehensive and multi-focal diabetes and wellbeing public awareness campaign should be undertaken in alignment with national health and wellbeing objectives. The campaign should be evidence-based, and consumer informed for both the general public and for priority and high-risk population groups.
5. Consistent biometric measures of diabetes should be developed and validated in the Australian context and regularly collected and monitored through National Health Measures Surveys and National Primary Health Care Data Collections
6. Policy and funding to urgently support the provision of new models of care in primary and tertiary care settings that address the lifestyle and social determinants, such as: shared medical appointments and medical yarn ups, social prescribing, multidisciplinary care in general practice, antenatal/prenatal/postnatal lifestyle programs, longer appointments and improved health

professional undergraduate and postgraduate training in lifestyle domains e.g. via existing University programs at James Cook University and/or Southern Cross University

7. Recognition of the influence of public policy on health and wellbeing, particularly of industry and workforce specific policies; education policies and town and community planning policies. For example, but not limited to:
    i. Local/nationwide healthy food school lunch program
    ii. Local/nationwide program for workplace wellbeing programs
    iii. Subsidise healthy food and community food programs for people and communities with high type 2 diabetes prevalence, especially in lower socio-economic areas.
    iv. Regulation of sales and marketing strategies of the ultra-processed 'food' and fast-food industries, especially those aimed at children on TV and social media.
    v. Remove the subsidies and tax breaks for ultra-processed food industries.

A Final Word

The Australasian Society of Lifestyle Medicine welcomes the opportunity to speak to this submission or provide any further information at any time. Please contact Roni Beauchamp, CEO on 0448 810 660 or at roni@lifestylemedicine.org.au.

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