Attention: Dr Mike Freelander MP
Chair of the Standing Committee on Health, Aged Care and Sport

Health.Reps@aph.gov.au

Question taken on notice from Committee hearing on 22 March 2024

Extract from Hansard:

Ms WARE: The health committee in the previous parliament completed an inquiry into the approval processes and published a report called *The New Frontier* in November 2021, which was subsequently tabled. Are you familiar with that report? I just want to ask a couple of questions about it.

Mr Ozenc: I'm not familiar with that.

Ms WARE: Are you, Doctor?

Dr Svensson: No.

CHAIR: I'll give you a copy, if you want.

Ms WARE: Yes. Dr Freelander was the deputy chair of that committee. I was just interested. The government has responded to that report and my question is: do you think that, on the back of the government's response and on the back of the report overall, enough is being done to support access to new drugs and medical technologies for Australians with prediabetic conditions? That was where my question was going.

Response

Novo Nordisk welcomed the Albanese Government's response to the New Frontier report and the commitment to implement 26 of the 31 recommendations. We believe that the HTA review is critical to the implementation of many aspects of the New Frontiers report and to improving access to new drugs for all conditions including prediabetic conditions.

Novo Nordisk is aligned with our industry peers and peak body, Medicines Australia regarding the issues and solutions for improved access to medicines on the Pharmaceutical Benefits Scheme (PBS) The Medicines Australia contribution to the HTA Review can be found here.

Australians must have equitable access to both medicines and high-quality clinical services, ensuring the right patient receives the right care at the right time. In the case of pre-diabetes, this would include a greater focus on prevention by recognising pre-diabetes as a chronic disease state within the scope of Medicare Benefits Schedule chronic disease management item numbers.

Novo Nordisk is also aligned with other stakeholder submissions such as Diabetes Australia and the Australian Diabetes Educators Association (ADEA), recognising the number of associated allied health professional contacts should increase from the five currently subsidised.

Additional Information

Health Technology Assessment (HTA) in the United Kingdom

Health is a devolved responsibility within the UK. The National Institute for Health and Care Excellence (NICE) is responsible for HTA in England and its decisions are routinely adopted by Wales and Northern Ireland.

The HTA body in Scotland is the Scottish Medicines Consortium (SMC). The SMC is independent of NICE and has its appraisal processes and methods. It also has a narrower remit than NICE as it is only responsible for the HTA review of new medicines.

Patient pathways and service designation in the UK NHS

As a centrally managed system with strong strategic and operational levers throughout the system the NHS in the UK can define service provision and patient pathways at a local level. At a national level, the Department of Health or NHS England would publish service specification guidance to guide local service development and implementation. For example:

- *Developing a specification for lifestyle weight management services Best practice guidance for tier 2 services*.
- Guidance for Clinical Commissioning Groups (CCGs): Service Specification Guidance for Obesity Surgery

Priority service developments attract targets and performance that are monitored at the designated levels within the system.

If a service falls under the remit of NHS specialised services commissioning, the appropriate *programme of care* will collaborate with clinical experts in that area to draft a service specification included in contracts for designated hospitals running that service.

Hospitals not designated and contracted to provide this care could theoretically choose to do so but would not be paid to do so. Moreover, they would be working against the established system. An Australian equivalent of this is the supra LHD services in New South Wales, however, the NHS system is more mature, transparent and open.

This system might work efficiently for combining patients with rare conditions needing specialised care, such as complex paediatric and adult diabetes or weight management. However, it

wouldn't apply to the services we typically expect at most hospitals, like specialist outpatient care for type 2 diabetes.

NHS General Practice can receive guidance through the standard contract or for strategic priorities beyond the scope of agreed standard service delivery via national direct enhanced services (DES).This would be the NHS example of '*blended funding*'. For example , there is a national DES for weight management .

At a local level access and service delivery is managed through commissioning policies . These can be lengthy and complex such as this example from Bristol or relatively straightforward such as this example from Essex. These local policies would be influenced by national -level policy guidance as referred to above.

First Nations Communities in Canada and Diabetes

The experience of Australian First Nation's communities is unique as it sits in the context of their cultural heritage and experience . Internationally other First Nations communities also suffer higher rates of diabetes and there is dialogue between global First Nations communities to share experiences and approaches to solutions.

The Novo Nordisk Canadian affiliate works in partnership with Canadian First Nations communities and stakeholders to address inequities in outcomes and access to care . They have shared the following information and insights .

Canadian context :

- If you are First Nations and 25 years of age and younger in Canada, you have an 80% chance of a type 2 diabetes diagnosis in your lifetime[i].
- Within the worldwide diabetes epidemic, the rates of type 2 diabetes In Canada are 17.2% among First Nations individuals living on-reserve, 10.3% among First Nations individuals living off-reserve, and 7.3% among Métis people, compared to 5.0% in the general population.
- Indigenous individuals are diagnosed at an increasingly younger age, have greater severity at diagnosis, develop higher rates of complications, and experience poorer treatment outcomes. The rising incidence among youth and young adults has been shown to be accompanied by 2.6 times higher rates of end-stage renal disease (ESRD) and death in First Nations compared to non-First Nations persons diagnosed under 20 years of age[ii].
- As elders die from NCDs, the younger generation loses access to their culture, heritage and language, resulting in an overall loss of identity[iii].
- A lack of resources in the community including poor housing and food security contribute to poorer health outcomes[iv v vi].

Information resources on diabetes rates, care and initiatives:

- An article from Raven and the Lawson Foundation looking at community driven solutions to the type 2 diabetes epidemic in Indigenous communities in Canada: diabetes-in-indigenous-communities.pdf (lawson.ca)
- Statistics from Diabetes Canada on Indigenous Peoples living with diabetes including prevalence rates, and barriers to care: Indigenous communities and diabetes - Diabetes Canada
- Diabetes Canada clinical practice guidelines for type 2 diabetes and indigenous peoples: Diabetes Canada | Clinical Practice Guidelines
- A link to the National Indigenous Diabetes Association website which includes a lot of health resources: National Indigenous Diabetes Association – The National Indigenous Diabetes Association envisions diabetes-free healthy communities (nada.ca)
- An article on social determinants of health and Indigenous Peoples in the Canadian context which includes an analysis of the effects of colonization: "The root causes of contemporary SDOH stem directly from intersecting and intergenerational factors, including, but not limited to, systemic racism, trauma, displacement from lands, destruction of food systems, imposition of federal and provincial jurisdictions and fragmented health-care provision": Determinants of Wellness: A Perspective on Diabetes and Indigenous Health - Canadian Journal of Diabetes

Whilst every community's experience is unique to its cultural and historical context, there are parallels in the experience of Canadian and Australian First Nations people that would support international collaboration and sharing.

Example of a Novo Nordisk Canada (NNCI) collaboration with First Nations communities

REACH (Dr. Stewart Harris, Western University): Advancement of a National Indigenous Quality Improvement Health Network[vii].

- Since 2018, NNCI has funded work toward a novel National Indigenous Quality Improvement (QI) Network using a virtual platform to improve the status of diabetes in Indigenous people in Canada.
- The QI Network builds capacity and provides impact to multiple stakeholders with the primary goals of increased awareness of prevention measures and programs, along with improved care services directly related to diabetes in Indigenous communities.
- The National Indigenous QI Health Network is the **first community-centered, community-owned, and community-driven network** created to improve diabetes care in Indigenous communities.
- The QI approach and tools implemented within the REACH program have shown potential in improving diabetes clinical outcomes:

- significant decreases in **HbA1c, BP, LDL** with individuals not meeting T2DM clinical targets at baseline
- significant increases in frequency of measurement of **HbA1c, BP, LDL, ACR, eGFR**
- community members were **51% more likely** to have received at least **75% of guideline recommended services**

This funding led to the development of **CEDAR**

- Started as a First Nations Diabetes Surveillance System, deployed in 17 First Nations communities, but rather than involving continuous data entry, CEDAR uses 'snapshots' of where the community is at a point in time, in order to;
  - assess the quality of health care received by patients in line with best practice guidelines
  - identify and prioritize areas of service delivery that can be improved as part of a quality improvement process
  - track changes over time in the quality of health care provided, showing whether planned improvements to health care systems have resulted in better care

This allows communities to;

- list all people in the communities with type 2 diabetes
- centrally store clinical information entered for each patient encounter
- access data presented in tables and graphs
- identify gaps (e.g., patients not receiving recommended foot exams)

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[i] Turin TC, Saad N, Jun M, et al. Lifetime risk of diabetes among first nations and non-first nations people. CMAJ 2016;188:1147–53.

[ii] Diabetes Canada | Clinical Practice Guidelines. Accessed 17 April 2024

[iii] Importance of Indigenous elders' contributions to individual and community wellness: results from a scoping review on social participation and intergenerational solidarity - PMC (nih.gov). Accessed 17 April 2024

[iv] Housing conditions among First Nations people, Métis and Inuit in Canada from the 2021 Census (statcan.gc.ca). Accessed 17 April 2024

[v] Food Security Status of Indigenous Peoples in Canada According to the 4 Pillars of Food Security: A Scoping Review - PMC (nih.gov). Accessed 17 April 2024

[vi] Understanding the social determinants of health among Indigenous Canadians: priorities for health promotion policies and actions - PMC (nih.gov). Accessed 17 April 2024

[vii] REACH Program (reachcommunity.ca). Accessed 17 April 2024