RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP submission to Parliamentary Standing Committee on Health, Aged Care and Sport

Inquiry into Diabetes

August 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 21,000 physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) thanks the Parliamentary Standing Committee on Health, Aged Care and Sport for the opportunity to provide a submission for the Inquiry into Diabetes (the Inquiry).

Diabetes is a pressing issue for Australians, with almost 4.6% of the population living with type 2 diabetes, growing rates of preventable onset in young people, and 25% of children and 67% of adults living with overweight or obesity. There are even higher rates of these chronic diseases in rural, remote and regional areas, First Nations communities, culturally diverse communities and lower income households.[1]

This is clearly a widespread and impactful societal health problem.

Over the last ten years there have been several relevant national inquiries and strategies, including:

- Select Committee into the Obesity Epidemic in Australia
- National Obesity Strategy
- National Preventive Health Strategy
- Australian National Diabetes Strategy.

The Department of Health and Aged Care currently has 20 active strategies and four in development that relate to the current Inquiry. It is imperative to ensure that the recommendations of these documents are followed through and strategies are both funded and implemented.

The Inquiry must be a catalyst for urgent action on our national diabetes and obesity reduction targets, which clearly intersect with social equity and healthcare access targets. Without strengthened prevention and treatment arrangements for obesity and diabetes, inequities within socially disadvantaged priority groups will compound, resulting in higher rates of both disease and economic exclusion.

Key recommendations

The RACP's key recommendations include:

- Fully funding the effective implementation of key strategies - the National Preventive Health Strategy, the National Obesity Strategy and the Australian National Diabetes Strategy
- Comprehensive national regulations to restrict marketing of unhealthy diets to children
- Mandating the Health Star Rating System (HSR) for all packaged foods
- Implementing a tax on sugar-sweetened drinks
- Developing and funding an integrative model of care for the management of patients with obesity, comorbid chronic health conditions and associated disabilities, involving partnerships between physician specialists and primary care practitioners, and expanded multidisciplinary ambulatory care services
- Introducing MBS items for obesity management to support primary healthcare
- Funding the permanent reinstatement of longer telephone-based specialist consultations
- Subsidised pathways to effective pharmacotherapies
- Increased funding for bariatric surgeries in priority populations
- Developing consistent guidance to manage weight in clinical settings, supporting health professionals to understand and reduce weight bias.

The RACP would welcome the opportunity to engage further with the Inquiry on these recommendations.

Our submission responds to Terms of Reference (TOR) one to four and primarily relates to type 2 diabetes. However, our recommendations for improving healthcare responsiveness and equitable access to treatment are applicable to the clinical care of children and adults with type 1 diabetes.

[1] AIHW Diabetes: Australian facts, Diabetes: Australian facts, Type 2 diabetes - Australian Institute of Health and Welfare (aihw.gov.au)

TOR one: The causes of diabetes in Australia, including risk factors

The RACP's Position Statement on Obesity calls attention to the connection between escalating rates of type 2 diabetes and the rapid increase in obesity within our communities over recent decades. This is grounded in both poor diet patterns related to the consumption of foods high in fat, sugar and salt, and physical inactivity. The underlying macro drivers of obesity and type 2 diabetes are not individual in nature, but societal (political, commercial, economic, and socio-cultural). This creates the obesogenic food and activity environments which in turn interact with people's biological, psychological, social and economic susceptibilities to create unhealthy weight gain and related comorbidities.

Obesogenic environments encourage adults and children to consume more calories than are metabolically required. The rise in obesity and diabetes prevalence is mostly a biological response (mainly determined by genetic predisposition) to modern environments that promote unhealthier foods, stress, physical inactivity and weight gain.

The RACP believes that the interests of public health, social and economic inclusion and national productivity would be better served if the harmful impacts of obesogenic environments were reduced and ideally prevented.[2]

TOR two: The evidence base in the diagnosis, treatment and management of diabetes

Best practice in diabetes management requires delivery of optimal, joined-up care models. Improvements in glycosylated haemoglobin and total cholesterol have been achieved through integrated care models involving partnership between specialists and primary care practitioners working together on a shared care plan, engaging the patient, considering need for tests, assessing results and trialling healthcare interventions.

Beneficial health outcomes have extended to rural and remote First Nations communities with diabetes specific care needs where integrative innovative models involving routine communication between primary practitioners and specialists have been trialled.[3] Some evaluation data shows that the outcomes of such multidisciplinary integrative models in the community are comparable to tertiary diabetes clinics.[4]

The barrier to unlocking these benefits is the present lack of a funding source within our healthcare system to incentivise joined-up value led diabetes care. We expand on the need for improved integration in our response to TOR four.

TOR three: The broader impacts of diabetes on Australia's health system and economy

Obesity is a driver for over 22 high-cost diseases, including diabetes, musculoskeletal conditions (e.g. osteoarthritis and back pain), cardiovascular disease, kidney disease, asthma, dementia and various cancers. Diabetes is also a driver for many costly conditions including stroke, neuropathies, heart attack, and kidney disease.[5] [6]

For both obesity and diabetes, patients and carers bear the direct cost of lost income and disease, the economy faces the cost of lost productivity and governments experience lost revenue and higher costs for

[2] Alanna Weisman, Ghazal S. Fazli, Ashley Johns, Gillian L. Booth, Evolving Trends in the Epidemiology, Risk Factors, and Prevention of Type 2 Diabetes: A Review, Canadian Journal of Cardiology, Volume 34, Issue 5, 2018, Pages 552-564

[3] Hotu C, Rémond M, Maguire G, Ekinci E, Cohen N. Impact of an integrated diabetes service involving specialist outreach and primary health care on risk factors for micro- and macrovascular diabetes complications in remote Indigenous communities in Australia. Aust J Rural Health. 2018 Dec;26(6):394-399

[4] Russell AW, Baxter KA, Askew DA, Tsai J, Ware RS, Jackson CL. Model of care for the management of complex Type 2 diabetes managed in the community by primary care physicians with specialist support: an open controlled trial. Diabet Med. 2013 Sep;30(9):1112-21

[5] AIHW (2017) Impact of overweight and obesity as a risk factor for chronic conditions. Canberra, Australia

[6] AIHW (2023), Diabetes related complications in Diabetes Australian facts, June 2023

income support payments. These national costs are in addition to the Australian Government's direct healthcare costs.

In 2018, obesity cost the Australian community $11.8 billion, made up of $5.4 billion in direct health costs and $6.4 billion in indirect costs, including occupational time lost.[7] If nothing is done, overweight and obesity may cost an estimated $87.7 billion by 2032, according to the Australian Government's own estimates in the National Obesity Strategy.[8] Research links persistent obesity from childhood to adulthood with exclusionary outcomes and poorer overall social wellbeing. Particularly for women, poorer occupational outcomes and the risk of never being gainfully employed have been observed.[9]

At $3.1 billion, direct health costs for diabetes represented 2.2% of all healthcare costs in 2019-2020. Cost-benefit modelling has concluded that a 10% reduction in the rate of type 2 diabetes in Australia would result in a gain of GDP $532 million over the next 10 years.[10]

For decision makers, these figures are a call to action; without strengthened prevention and treatment arrangements for diabetes and obesity, social inequities will become further compounded within socially disadvantaged priority groups, in tandem with higher rates of both diseases and economic exclusion.

TOR four: interrelated health issues between diabetes and obesity in Australia, the causes of obesity and the evidence-base in the prevention, diagnosis and management of obesity

Evidence-base in the prevention of obesity and type 2 diabetes

Obesogenic environments encouraging unhealthy diets are of such concern that the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) have now called all countries to reduce their impacts in the interests of preventing a global public health crisis (i.e. undernutrition; micronutrient-related malnutrition; and overweight, obesity and diet-related noncommunicable diseases).[11] [12]

As a country, we are not doing enough; junk food, processed foods and sugary drinks are cheap, widely available, and frequently advertised. We now need swift implementation of the Australian Government's existing prevention commitments and other evidence-based policies to prevent further escalation of overweight, obesity and type 2 diabetes.

The Australian Government must:

- **Fully fund the effective implementation of the National Preventive Health Strategy, which commits 5% of health expenditure for prevention by 2030, specify how prevention will be funded over forward estimates, and appropriately fund the implementation of the National Obesity Strategy and Australian National Diabetes Strategy.**
    - We have urged successive Australian Governments to appropriately fund and implement these key national strategies. See RACP submissions to the National Obesity Strategy 2020-2030, draft National Preventive Health Strategy, and 2023-24 Federal Budget. Each of these strategies remain to be costed, funded and implemented. Full funding is required, going beyond ad-hoc projects and coupled with sound governance and accountability frameworks, including evaluation and reporting.

[7] Collective for Action on Obesity, 2019, Weighing in: Australia's growing obesity epidemic
[8] Australian Government, National Obesity Strategy 2022-2032
[9] Viner R M, Cole T J. Adult socioeconomic, educational, social, and psychological outcomes of childhood obesity: a national birth cohort study *BMJ* 2005; 330 :1354
[10] Kirthi Menon, Barbora de Courten, Danny Liew, Zanfina Ademi, Alice J. Owen, Dianna J. Magliano, Ella Zomer; Productivity Benefits of Preventing Type 2 Diabetes in Australia: A 10-Year Analysis. *Diabetes Care* 1 March 2021; 44 (3): 715–721
[11] WHO 2023, Policies to protect children from the harmful impact of food marketing- a WHO Guideline
[12] UNICEF 2023, Taking Action to Protect Children from the Harmful Impact of Food Marketing: A Child Rights-based Approach

- The National Preventive Health Strategy and National Obesity Strategy share the aims to reverse the trend in the prevalence of obesity in adults, and to reduce overweight and obesity in children and adolescents by at least 5% by 2030.[13] [14]
- The National Diabetes Strategy aims to reduce consumption on unhealthy foods and drinks, including their promotion, to decrease pre-diabetes and rates of type 2 diabetes.[15]

Effective implementation of these strategies is a prerequisite to meeting Australia's national obesity and chronicity reduction targets in the National Health Reform Agreement[16].

- **Introduce comprehensive national regulations to restrict marketing of unhealthy diets to children**.
  - Children in Australia see 168 junk food or sugary drink advertisements on the web or mobile devices per week, adding to the 800 promotions they see annually if they watch 80 minutes of television per day.[17] [18] Evidence shows that junk food and sugary drink advertisements influence the brand perceptions of children, their preferred products and dietary preferences. Emergent evidence also confirms a link with the obesity epidemic, as children in Australia have been found to eat more food after watching junk food promotions without decompensation at later meals.[19]
  - Reducing the harmful impact of this advertising is not supported by Australian Communications and Media Authority (ACMA) codes which only concern what can be shown during children's specific television programs on commercial television, with no regard to diet specifically. The existing codes are not aligned to the changing television viewing patterns of children and the rapid shifts toward internet viewing and subscription streaming platforms.
  - Beyond ACMA codes, industry self-regulation via the Australian Association of National Advertisers (AANA) is insufficient. Children are bombarded by junk food advertising despite the AANA encouraging advertisers to avoid depiction of material contrary to prevailing community standards on health.[20]
  - There is a growing groundswell for change - the WHO and UNICEF have recently urged countries to regulate junk food advertising and ACMA's community insights research indicates growing community support for national regulation, as do surveys of Australian adults.[21] [22] [23] [24]
  - Australia's physicians strongly support national regulation of food and drink advertising and promotions targeting children and has recently launched a call to community and medical professional action as part of the RACP's SwitchOffTheJunk Campaign.
  - We need a clear Australian Government commitment to support better, fit-for-purpose national regulation.

- **Mandate the Health Star Rating System (HSR) for all packaged foods to encourage consumers to choose healthier options and motivate food manufacturers to reformulate and develop healthier products.**

---

[13] Australian Government, National Preventive Health Strategy (2021-30)
[14] Australian Government, National Obesity Strategy (2022-32)
[15] Australian Government, National Diabetes Strategy (2021-30)
[16] Australian Health Ministers, National Health Reform Agreement- Long Term Health Reforms Roadmap
[17] Kelly B, Bosward R, Freeman B, Australian Children's Exposure to, and Engagement With, Web-Based Marketing of Food and Drink Brands: Cross-sectional Observational Study J Med Internet Res 2021;23(7): e28144
[18] Smithers LG, Haag DG, Agnew B, Lynch J, Sorell M. Food advertising on Australian television: Frequency, duration and monthly pattern of advertising from a commercial network (four channels) for the entire 2016. J Paediatr Child Health. 2018 Sep;54(9):962-967. doi: 10.1111/jpc.13929. Epub 2018 Apr 16. PMID: 29660198.
[19] Norman, J., Kelly, B., McMahon, AT. et al. Sustained impact of energy-dense TV and online food advertising on children's dietary intake: a within-subject, randomised, crossover, counter-balanced trial. Int J Behav Nutr Phys Act 15, 37 (2018). https://doi.org/10.1186/s12966-018-0672-6
[20] The AANA Code of Ethics sets the standard for advertising in any medium.
[21] Nuss T, Chen YJM, Scully M, Hickey K, Martin J, Morley B. Australian adults' attitudes towards government actions to protect children from digital marketing of unhealthy food and drink products. Health Promot J Austr. 2023 Jun 7. Epub ahead of print.
[22] WHO, Policies to Protect Children from the Harmful Impact of Food Marketing, 2023
[23] UNICEF, Taking Action to Protect Children from the Harmful Impact of Food Marketing, 2023
[24] Australian Government, ACMA, What Audiences Want- Audience Expectations for Content Safeguards, June 2022

- A review of the HSR by Food Standards Australia and New Zealand (FSANZ) in 2019 recommended making the system mandatory for all packaged foods, should uptake targets not be achieved under a voluntary model for the food industry.
- HSR uptake has been uneven between food suppliers and producers and certain products that should display an HSR to alert consumers to their harmful dietary contents are less likely to include an HSR rating.[25]
- Studies conclude recognition of the rating system is modest and patchy in some social demographics, but that consumers' ability to select healthier products is heightened when products display an HSR. [26] [27]
- This shows the clear limits to the voluntary model. Mandating the HSR should be a high priority.

- **Implement a tax on sugar-sweetened drinks to reduce consumption and use the revenue to fund initiatives that encourage healthy diets and physical activity.**
  - The RACP Obesity Position Statement identifies sugar sweetened drinks as a major source of added sugars in a diet. Reduced consumption of sugar sweetened drinks would potentially decrease obesity and related comorbidities.[28]
  - Many countries have now implemented a tax on sugar sweetened drinks and there is some emerging evidence that these taxes have been successful to reduce consumption and encourage industry reformulation. Australian modelling has identified that a 20% tax on sugar sweetened drinks would reduce the social costs associated with disability by $176.6 million and healthcare costs by $122.5 million overtime. Revenue from these taxes could go towards funding further prevention initiatives.[29]
- **Consistent with our submission to the National Obesity Strategy, not partner with the industries that have created the very problem we are now trying to address.**
  - The relationship between governments and the private sector needs to be transparent and grounded in governments' expectations of food and beverage industry actions that would lead to the creation of healthy and sustainable food environments.
  - There is a need for clear, publicly available industry policies and to give effect to these expectations and close government monitoring of industry actions.

These evidence-based prevention strategies must be coupled with a health-in-all policies framework that promotes health food sustainability in all policies and planning.

The evidence base in obesity and diabetes management

Appropriate prevention strategies and healthcare systems are needed in tandem to address our unsustainable rates of obesity, diabetes and related comorbidities. Better prevention would ease the strain of future chronic disease. Reform at all levels of our health system would improve our response to the high rates of need. We must remove the false dichotomy between prevention and treatment and realise the crucial and complementary roles of both.

- Our submission to the Draft National Obesity Prevention Strategy recommends that **MBS items for obesity management should be introduced to support primary health management**, covering appropriate weight assessment, examination for common complications as well as physical and psychological support.

[25] Shahid M, Neal B, Jones A. Uptake of Australia's Health Star Rating System 2014-2019. Nutrients. 2020 Jun 16;12(6):1791
[26] Jones A, Thow AM, Ni Mhurchu C, Sacks G, Neal B. The performance and potential of the Australasian Health Star Rating system: a four-year review using the RE-AIM framework. Aust N Z J Public Health. 2019 Aug;43(4):355-365
[27] Catherine L. Anderson, Erin L. O'Connor. The effect of the health star rating on consumer decision-making. Food Quality and Preference, Volume 73, 2019, Pages 215-225
[28] Malik, V.S., Hu, F.B. The role of sugar-sweetened beverages in the global epidemics of obesity and chronic diseases. Nat Rev Endocrinol 18, 205–218 (2022)
[29] Nguyen TM, Tonmukayakul U, Khanh-Dao Le L, Singh A, Lal A, Ananthapavan J, Calache H, Mihalopoulos C. Modeled health economic and equity impact on dental caries and health outcomes from a 20% sugar sweetened beverages tax in Australia. Health Econ. 2023 Jul 21. Epub ahead of print.

- Medicare's Chronic Disease Management (CDM) items are not used to their full capacity for obesity. When used, they do not allow for appropriate assessment of obesity, related comorbidities and suitable secondary prevention strategies.
- Inconsistent understandings of eligible conditions for CDM management and gaps in knowledge of services that can be subsidised for people with obesity are key barriers to CDM use.[30]
- Patients with obesity can only access a total of five allied health visits per year in contrast to patients on an eating disorder plan or mental health plan which allow a higher number of visits.
- Improving MBS primary care obesity management at an earlier point is expected to reduce high-cost hospital services at a later point in the patient journey.

- **Fund the permanent reinstatement of a full range of telephone-based specialist consultations**, **including complex consultations to support access and equity for people with obesity and comorbid health risks**.
  - Obesity consultations require additional time that is not available to rural, regional and remote patients beyond a video or in-person consultation, neither of which are viable for some patients.
  - An RACP rapid review of the evidence for telephone and video consultations has identified that technological gaps have limited the uptake of video consultations in rural, regional and remote communities, and that video technology is generally less accessible for each of First Nations, culturally diverse, and socioeconomically disadvantaged communities, each of which have higher rates of obesity and diabetes.[31] For these communities the risk is delayed, forgone and deferred care with an increased demand for acute services.
  - As outlined in our 2022 submission to the Australian National Audit Office (ANAO) Inquiry into Telehealth Expansion, a 'one size fits all' approach to telehealth should be avoided. The best option for consultation length and modality (face-to-face, telehealth by phone or video) should be decided by the patient and the doctor, based on what type of care is clinically appropriate.
  - The RACP also calls for funding for videoconferencing technology packages to support capacity building for patients with obesity, especially those in priority and under-serviced groups and to promote equitable access to remote consultations in rural and regional areas.[32]

- **Invest in expanded multidisciplinary ambulatory care services for obesity, integrated care services and outreach programs to ensure timely provision of complex whole-person care, including direct engagement of specialist care**.
  - For some people with obesity requiring multicomponent interventions, care may be more optimally delivered in a specialist obesity ambulatory care setting by a multidisciplinary team addressing relevant physical and mental health comorbidities.[33]
  - Poorly distributed networks of these services undercut their efficacy for patients outside major cities. For example, a recent Australian surveillance study of specialist paediatric weight management services identified only 16 in all of Australia and only two in a rural or remote area. No services were identified in Tasmania or the Northern Territory.[34] An absence of these services in the Northern Territory is especially problematic for First Nations communities and given Closing the Gap targets for health and wellbeing.

[30] Weight management conversations with general practitioners Obesity Collective Insights 2022
[31] RACP Rapid Review of telephone consultations versus video consultations (July 2023)
[32] RACP, Pathways to Wellbeing: Enhancing the health and wellbeing of all Australians Pre-Budget Submission to the Australian Treasury January 2023
[33] Gooey M, Bacus CA, Ramachandran D, Piya MK, Baur LA. Health service approaches to providing care for people who seek treatment for obesity: identifying challenges and ways forward. Public Health Res Pract. 2022;32(3):e3232228
[34] McMaster, C.M., Calleja, E., Cohen, J., Alexander, S., Denney-Wilson, E. and Baur, L.A. (2021), Current status of multi-disciplinary paediatric weight management services in Australia. J Paediatr Child Health, 57: 1259-1266

- **Develop and fund a model of care for the management of patients with obesity, comorbid chronic health conditions and associated disabilities that integrates specialist physician care (the RACP Model of Chronic Care Management or variation)**.
    - An innovative care pathway to connect physicians to team-based care for patients with obesity and related comorbidities at risk of hospitalisation is vital. This would avoid the need for lengthy delays between referral and consultation, overcome the divisions between primary, secondary and tertiary care, and give GPs convenient access to physician advice for more complex patients.
    - Patient outcomes in diabetes care may be augmented by integrated care models involving routine collaboration for supervision and case planning between an endocrinologist and primary practice.[35]
    - Innovation in the funding of medical care is needed. The fee-for-service model does not incentivise many elements of good chronic disease care in obesity or diabetes, such as supporting GPs and physicians to routinely work from the same care plan.[3]
    - The RACP's Model of Integrated Chronic Care Management is designed to enable seamless care for patients with intermediate level care needs at risk of hospital admission, noting obesity and diabetes drive a large share of avoidable admissions.
    - A blended value-based funding approach which breaks down siloes between primary, secondary and tertiary care would improve real-time responsive care for patients with obesity and related comorbidities. [36]

- **Subsidised pathways to effective pharmacotherapies should be established so that access is on equitable population health grounds, not individual affordability**.
    - The RACP acknowledges a role for pharmacotherapy in obesity where clinically indicated, and as an adjunct therapy in combination with nutrition and physical activity, given careful monitoring of interaction, contraindication, and potential for harm arising from use.[37]
    - There is emergent evidence supporting GLP-1 agonist use for obesity where clinically indicated.[38] [39] However, even where pharmacotherapy is clinically indicated, off-label GLP-1 agonists are difficult to access and are very costly, particularly for the many patients unable to pay several hundreds of dollars per month.[40] Again, the intersection of obesity and social disadvantage means that those most likely to benefit from pharmacotherapies are the least able to access them.

- **Increase funding for bariatric surgeries to support weight management in priority populations with barriers to treatment access and prevent further chronic disease.**
    - While bariatric surgery can improve health outcomes for patients with severe obesity and diabetes, backlogs make it inaccessible to many patients on public hospital waiting lists.[41] [42]
    - For instance, an RACP Fellow with extensive experience in tertiary obesity care has reported a number of First Nations patients have accessed their superannuation early to fund bariatric

[35] Zarora R, Immanuel J, Chivese T, MacMillan F, Simmons D. Effectiveness of Integrated Diabetes Care Interventions Involving Diabetes Specialists Working in Primary and Community Care Settings: A Systematic Review and Meta-Analysis. Int J Integr Care. 2022 May 12;22(2):11.
[36] RACP, Submission on the draft National Obesity Prevention Strategy, November 2021, page 5
[37] RACP, Action to prevent obesity and reduce its impact across the life course, Evidence Review, May 2018
[38] Wang JY, Wang QW, Yang XY, Yang W, Li DR, Jin JY, Zhang HC, Zhang XF. GLP-1 receptor agonists for the treatment of obesity: Role as a promising approach. Front Endocrinol (Lausanne). 2023 Feb 1;14:1085799. doi: 10.3389/fendo.2023.1085799. PMID: 36843578; PMCID: PMC9945324.
[39] Abbasi J. New Weight Loss Drugs Make Headlines at Diabetes Meeting. *JAMA.* 2023;330(5):399–400. doi:10.1001/jama.2023.12718
[40] Gooey M, Bacus CA, Ramachandran D, Piya MK, Baur LA. Health service approaches to providing care for people who seek treatment for obesity: identifying challenges and ways forward. Public Health Res Pract. October 2022; Vol. 32(3):e3232228
[41] Koliaki C, Liatis S, le Roux CW, Kokkinos A. The role of bariatric surgery to treat diabetes: current challenges and perspectives. BMC Endocr Disord. 2017 Aug 10;17(1):50. doi: 10.1186/s12902-017-0202-6. PMID: 28797248; PMCID: PMC5553790.
[42] Affinati AH, Esfandiari NH, Oral EA, Kraftson AT. Bariatric Surgery in the Treatment of Type 2 Diabetes. Curr Diab Rep. 2019 Dec 4;19(12):156. doi: 10.1007/s11892-019-1269-4. PMID: 31802258; PMCID: PMC7522929.

surgery privately and expedite the costly procedure.[43] [44] Priority patient groups should not have to choose between their health or financial standing, given a loss of either will reduce wellbeing and increase risk factors for disease.
    - Our Bariatric Rehabilitation Position Statement identifies that in addition to more public funding for this procedure, pre- and post-surgical rehabilitation services must be expanded to enhance the national capacity for bariatric surgeries in all geographical areas of the country.

- **Provide consistent guidance to manage weight in clinical settings, support health professionals to understand and reduce weight bias, and develop the skills needed to have sensitive conversations with patients**.
    - Weight stigma remains pervasive in Australia, grounded in the incorrect belief that obesity is an individual choice rather than a chronic disease driven by the interplay between biology and social environments. Discriminatory attitudes and weight stereotypes shape the way people with obesity are treated and perceived across many social contexts, including healthcare settings.[45] Stigma undermines the effectiveness of the health system, promotes self-isolation and reduces patient self-efficacy for health promotional behaviours.[46]
    - Doctors have reported feeling ill-equipped to enter sensitive conversations about weight and manage patients with obesity.[47] Health professionals require support to breakdown stigma-based barriers that serve to disconnect patients from healthcare services.
    - A review is now occurring of the National Health and Medical Research Council's Clinical Practice Guidelines for the Management of Overweight and Obesity for Adults, Adolescents and Children in Australia. In alignment with our Position Statement on Obesity, the revised guidelines should support health professionals to have sensitive conversations with patients about optimising their health and managing treatable risk factors at any weight. They should also strengthen understanding of the importance of physical environments in meeting the needs of patients with obesity and minimising the direct and indirect impacts of weight bias in the health system. Comprehensive and consistent diet, physical activity and weight management guidelines across the life course would support sensitive conversations and earlier intervention.

Concluding remarks

It is critical to acknowledge that the obesity and diabetes prevention agenda requires significant commitments and investment to reduce future demands on our health system, improve national productivity and maximise social participation. Reform is also needed for our health system so that diabetes and obesity can be managed in an interconnected and responsive fashion at the point of patient need. The status quo has not worked to date and considerable changes are needed.

This submission has outlined the key barriers to an effective national approach to reducing and managing the poorer health and social outcomes of diabetes and obesity. We thank the Parliamentary Standing Committee on Health Aged Care and Sport for its careful consideration of our recommendations.

The RACP welcomes further engagement with the work of the Parliamentary Standing Committee on Health Aged Care and Sport. Please contact the Policy and Advocacy Unit via policy@racp.edu.au for any additional information.

[43] *Ibid*
[44] RACP Fellow feedback.
[45] Lawrence BJ, de la Piedad Garcia X, Kite J, Hill B, Cooper K, Flint SW, Dixon JB. Weight stigma in Australia: a public health call to action. Public Health Res Pract. 2022;32(3): e3232224
[46] Westbury S, Oyebode O, van Rens T, Barber TM. Obesity Stigma: Causes, Consequences, and Potential Solutions. Curr Obes Rep. 2023 Mar;12(1):10-23. Epub 2023 Feb 14
[47] RACP, Action to prevent obesity and reduce its impact across the life course Evidence Review, May 2018 [online]; racp-obesity-evidence-review.pdf