

Health Services and Diabetes Policy Statement

As the state's peak consumer body for people affected by diabetes, Diabetes Victoria is committed to working with the Victorian Department of Health and public health services to make diabetes a priority in health system design and planning, including as part of the Local Health Service Network (LHSN) reform.

We support the ambitions of the LHSN reform to deliver a system that is easier to navigate, with more consistent pathways between hospitals, as well as better and more consistent support for the health workforce. The introduction of LHSNs creates both opportunities and risks. There are opportunities to continue to innovate and provide better care, but there are risks of deterioration of services if diabetes is not prioritised as a strategic area for planning.

Collaboration is key, and we know it is possible to create lasting improvements in the system when the right partners work together.

An example of success in system design is the Victorian Virtual Emergency Department (VVED) Diabetes Service, which has been recognised for its innovation, collaboration and impact. The service was developed through a partnership of Northern Health, the Australian Centre for Accelerating Diabetes Innovations, Ambulance Victoria, the Royal Flying Doctors Service and Diabetes Victoria to address the high volume of diabetes-related emergency department presentations. The service recently won both the Designing Services for People Award and the People's Choice Award at the 2025 IPAA Victoria Leadership Awards.

We see many opportunities where further innovation can occur in other parts of the health system. Victoria is fortunate to have very passionate diabetes specialists - many of whom are also national and international leaders, and we have consulted with them in preparing this statement.

Diabetes in the health system

Almost 400,000 Victorians live with diabetes and a further 125,000 Victorians are estimated to be living with undiagnosed type 2 diabetes.¹ This makes diabetes one of the most prevalent chronic conditions in the community and rates are rising. Significant inequities exist across geographic areas, with rates of type 2 diabetes in some local government areas as high as 10-12.7% of the adult population.²

Living with diabetes puts people at greater risk for many other conditions, including cancer, cardiovascular disease and circulatory complications, kidney disease, ophthalmic conditions and neurological illnesses. Furthermore, people living with diabetes experience an emotional and cognitive burden of living with this condition. This means diabetes is an underlying factor driving service needs across Victoria's health system, with significant impacts for renal, heart, and stroke care, amputations, and dementia and mental health care, among others.

People with diabetes are more likely than the general population to use the hospital system and to be hospitalised. Research indicates that 25 to 30 per cent of people admitted to Victoria's hospitals have diabetes.³⁴

Diabetes can be viewed as a barometer. How well diabetes is monitored and managed in a health system can influence many other outcomes. Prioritising diabetes care not only improves patient safety and outcomes but also has flow-on improvements across a range of conditions and services.

It is well established that people with diabetes are at increased risk of developing infections and adverse outcomes.^{5 6 7} This means that whether or not diabetes is the principal diagnosis, living with diabetes can affect almost every interaction with healthcare services, including emergency care, surgical services, general and specialist acute medicine, and Hospital in the Home.

Paediatric and adult diabetes services provide different models of care, reflecting the different care needs across the lifespan. Paediatric diabetes clinics are reporting increasing numbers of children and young people diagnosed, and increasing complexity of care, however with no standard data system across health systems there is no way to track this service demand, or the outcomes of care provided.

Diabetes is a major factor leading to potentially preventable hospitalisations. A key indicator monitored by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and included in the Report on Government Services (ROGS) shows that Victoria has the highest rate of potentially preventable hospitalisations for type 2 diabetes, outside the Northern Territory.⁸ This reflects the importance of communication and processes needed both pre and post hospital, as well as connections from diabetes specialists through to primary care and other providers.⁹

What do we hear from the community?

When people living with diabetes in Victoria tell us about their experiences, it is evident that there is significant variation in how care is managed.

Victoria's health workforce is highly regarded, and we know that they do their best every day to deliver care for community members. The experiences and recommendations we convey in this position paper are focused on system changes to improve care and health outcomes.

The following examples represent experiences that we hear from the community. Addressing these issues is critical to improving patient outcomes, enhancing the efficiency of health services, and ensuring equitable, person-centred care for people living with diabetes.

Failure to identify whether a person has diabetes on hospital admission. Without recognising diabetes at admission, patients may receive care that overlooks critical blood glucose management, increasing risks of complications, such as infections or delayed healing and for people with type 1 diabetes, increased risk of diabetes emergencies, in particular diabetic ketoacidosis.

A tendency to de-emphasise diabetes care when people attend a health service for another health issue, leading to missed monitoring or management opportunities.

Limited understanding of contemporary diabetes care by the general health workforce, outside of specialists, resulting in outdated practices or insufficient patient support, and patients feeling less able to engage in their care.

Confusion by general hospital staff between type 1 and type 2 diabetes, leading to difficulties with medication timing, glucose monitoring and nutrition requirements.

Inability to integrate modern wearable diabetes technologies in inpatient care, with people frustrated at having to remove devices while in hospital. This interrupts real-time data flow, and results in patients having suboptimal diabetes management in an environment where optimal diabetes care is vital.

Limited or no access to paediatric diabetes services closer to home, which puts a travel impost on families and can result in delayed care and increased reliance on emergency or hospital services. This affects both metropolitan and regional areas, but regional areas are especially impacted by limited specialist staffing to care for children.

Difficulty in transition from paediatric to the adult system, with care interruptions and lack of communication.

Long waiting lists for outpatient care, especially in rural and regional areas, delaying access to essential care. Every day that people go without treatment puts them at greater risk of complications.

Lack of mental health support, even for significant complications, or for young people who are newly diagnosed and coming to terms with a condition that requires daily monitoring and management. This leads to unmet psychological needs and increased risk of anxiety, depression and/or, most commonly, diabetes-related distress. These experiences highlight systemic gaps that contribute to fragmented and inconsistent diabetes care. Addressing these issues is critical to improving patient outcomes, enhancing the efficiency of health services, and ensuring equitable, person-centred care for people living with diabetes.

Diabetes and mental health

People living with diabetes have an increased risk of depressive symptoms or anxiety, which can be supported by general practitioners and psychologists. In addition, approximately 30-60 percent of all people living with diabetes experience diabetes-related distress. This is because diabetes is a challenging and relentless condition to manage.

On average, a person with diabetes thinks about their condition every 12 minutes.¹⁰ , There is an increased mental load associated with the constant vigilance of managing self-care to avoid

hypoglycaemia and hyperglycaemia, as well as reducing the risk of long term, serious complications such as heart attacks, kidney disease, vision loss and amputations.

Around 4 in 5 people with diabetes have experienced some form of stigma due to diabetes, and up to 1 in 3 have experienced discrimination due to diabetes.¹¹ Importantly, one of the key settings where people with diabetes experience diabetes stigma is the healthcare system, which can lead to low quality healthcare, higher HbA1c, and delayed or missed appointments to avoid being blamed and judged by health professionals.

Children and young people living with diabetes are similarly at increased risk of experiencing challenges to their emotional and mental health issues, which can be influenced by the reactions and level of support through school environments and their peers, as well as the physical, emotional and social implications of their stage of development.

Technology and diabetes

Diabetes care has evolved rapidly in the last decade due to advances in technologies. These technologies offer dramatic improvements to the experiences of self-care and health outcomes for people with diabetes.¹²¹³

However, systems of care in health services have not kept pace. Health services have not integrated people's individual technology into systems of care, and people with diabetes are often asked to remove their technology when admitted to hospital. Hospital systems of care need to be able to support individuals who are actively using insulin pumps, continuous glucose monitors (CGM) and automated insulin delivery (AID) systems as part of their routine, everyday diabetes self-management.

There is policy advocacy to the Federal government to expand access to CGM for people living with all types of diabetes as well as to increase access to insulin pumps and AID systems for people with type 1 diabetes. Currently the National Diabetes Services Scheme (NDSS) provides subsidised access to CGM only for people with type 1 diabetes and insulin pumps to children and young adults with type 1 diabetes who meet eligibility requirements.

With strong community demand and increased evidence of the benefits of technology for health outcomes, it is anticipated that there will be new federal policy commitments to expand diabetes technology use in the next 1-2 years. When this occurs, the health care system needs to be ready to support individuals initiating and using the technology.

Diabetes and Local Public Health Units

Health services are an important part of the system for primary prevention of chronic disease, including diabetes. Several Local Public Health Units are involved in reducing the risk factors for disease, such as increasing healthy eating, as well as engaging with the community to promote referrals to the state-funded *Life!* program for preventing type 2 diabetes, cardiovascular disease and stroke. These are important functions which should be standardised across the state so that all people



who are at higher risk of type 2 diabetes and cardiovascular disease are aware of and can access proven programs to support them to reduce their modifiable risk factors. This can be further embedded as core prevention provided by Local Health Service Networks.

Diabetes improvement initiatives

There is currently no Victorian mechanism for health services to share best practice and drive consistency in diabetes care. As a result, healthcare quality varies significantly between services, leading to inequitable patient experiences and outcomes across the state. This lack of coordination also represents a missed opportunity to strengthen care through system-wide learning and continuous improvement.

Examples of Victorian service improvements that could be further developed are outlined below:

Proactive model of diabetes care using electronic alerts for specialist consults

A pioneering trial at the **Royal Melbourne Hospital** (RMH) has shown that a proactive, technology-enabled model of diabetes care—using electronic alerts—can significantly reduce hospital-acquired infections among surgical patients. The study builds on a trial that not only reduced infection rates and hyperglycaemia events but also demonstrated sustained improvements in glucose management post-discharge. The model has since been refined and adopted by Northern Health to help prevent dangerous blood glucose fluctuations in hospitalised patients. Despite its proven success, there is currently no system-wide mechanism to support the broader adoption of this effective model across other health services—representing a missed opportunity to improve outcomes, enhance safety, and reduce costs across the Victorian health system.

Healthy pregnancy interventions

Antenatal lifestyle interventions being implemented at **Monash Health** as part of maternity care have been shown to reduce the development of gestational diabetes, with direct maternal and neonatal health benefits, and associated cost savings. Modelling indicates for every dollar spent on implementation, there is a return on investment of A\$3.00 generated within 6 months. This is a standard of care that should be available to all Victorian women at high risk of gestational diabetes.

Western Health paediatric diabetes clinic

Western Health initiated a paediatric diabetes clinic in March 2024 to enable children with diabetes to access care closer to home. The clinic has quickly approached capacity, supporting close to 50 children with type 1 and type 2 diabetes. However, data from the National Diabetes Services Scheme indicates that over 600 children in the catchment could benefit from this service. Families that cannot access a local paediatric diabetes clinic need to travel outside the catchment to another health service that has paediatric diabetes care, usually to one of the children's hospitals. The high demand underscores the urgent need to expand local, community-based paediatric diabetes services to ensure timely, equitable care for all children living with diabetes.

Beacon model of care

Alfred Health is implementing the Beacon model of integrated care. This model transfers care of patients with complex Type 2 diabetes out into the community where they are managed by GPs with special interests under the supervision of an Endocrinologist working with a multidisciplinary team. Evaluation has shown this to be noninferior to specialist clinics in terms of clinical outcomes but better patient satisfaction, more cost effective and it reduced preventable diabetes related hospitalisation.

Health service screening for diabetes

As part of a Diabetes Discovery program, **Austin Health** established an early identification program for diabetes. This innovation uses electronic medical records to order HbA1c tests in anyone admitted to hospital above the age of 54. The diabetes and endocrinology service automatically sees patients who have HbA1c above 8.3%. The program leads to more people receiving review and changes in their medications and greater long-term improvement in glycaemic control post-hospital discharge. The initiative also found that one-third of admitted patients over the age of 54 have diabetes and a further one-third have pre-diabetes. This program initiated at Austin Health led to the American Diabetes Association (ADA) changing guidelines to recommend HbA1c being ordered in all inpatients, referencing the Austin Health Diabetes Discovery Program.

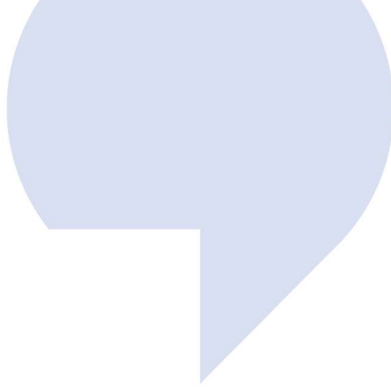
Victorian Virtual Emergency Department (VVED) Diabetes Service

The Australian Centre for Accelerating Diabetes Innovations (ACADI) approached the newly formed VVED at **Northern Health** to develop a specific program for people with diabetes. The VVED had identified diabetes as a priority due to the high volume of diabetes-related emergency department presentations. ACADI developed clinical guidelines in partnership with the VVED and Ambulance Victoria. Through its partnership with Abbott, ACADI secured funding for ketone strips for Ambulance Victoria to enable ketone testing so that patients with or at risk of diabetic ketoacidosis are rapidly identified. Staffed by diabetes nurse practitioners who are experienced in managing people with diabetes, the VVED diabetes service has been described as a lifeline for people living with diabetes, providing a helping hand at time of need. In less than a year, the service has achieved a diversion rate of over 80%, helping people with diabetes receive the care they need at home and avoid unnecessary travel to emergency departments. The VVED Diabetes Service won both the **Designing Services for People Award** and the **People's Choice Award** at the 2025 IPAA Victoria Leadership Awards.

Recommendations

Diabetes Victoria makes the following recommendations to enable Victoria’s health system to deliver better care for people affected by diabetes.

<p>1 Establish a Diabetes Learning Health Network</p>	<p>The Victorian Department of Health should support the establishment of a Diabetes Learning Health Network. This could be modelled on networks in other states, such as the Queensland Diabetes Clinical Network. The network would involve health professionals and people with lived experience to improve the quality, safety and effectiveness of care. The network would enable the examples of innovation and improvement outlined in the previous section to be shared across health services and scaled up where appropriate. The network is a low-cost, practical solution with strong support among healthcare professionals, who recognise its potential to drive consistent, evidence-based improvements across the system.</p>
<p>2 Prioritise diabetes in service planning</p>	<p>Prioritise diabetes in system planning led by the Department of Health and in service planning by public health services. A high proportion of people receiving care through our hospital system have diabetes, and the condition impacts on many other aspects of care delivery.</p>
<p>3 Develop consistent diabetes protocols and guidelines</p>	<p>Optimise and harmonise protocols and guidelines for diabetes care across a range of service types including subacute, paediatrics, maternity and newborn, cancer services and hospital in the home. Currently, protocols tend to be developed individually by larger health services, with ad hoc sharing on request with other health services, rather than a standardised, shared approach to system improvement. Consistent protocols and guidelines will reduce medication errors and increase patient safety.</p>
<p>4 Ensure families can access diabetes care closer to home</p>	<p>Conduct a focused review and develop a universal model of care for paediatric diabetes care and transition to adult services across metro and regional areas, enabling all children to access care close to home, providing clear pathways for children after diagnosis, appropriate program support for transitioning into adult services, and leveraging the new VVED diabetes service for after hours care where appropriate.</p>
<p>5 Increase access to specialist advice</p>	<p>Extend the VVED diabetes service to home-based hospital care and scale up other models that provide specialist support to general practice. The success of the VVED diabetes service can be extended to support home-based care delivery through health services. In addition, the Beacon model of integrated care alongside telehealth through the Victorian Virtual Specialist Consults service can help reduce specialist waiting times in outpatient clinics.¹⁴ Involve people with lived experience, specialists from across the state and primary care professionals to scale up these models .</p>



6	Integrate diabetes technology into inpatient care	Develop policies for in-patient use of diabetes technology to better integrate diabetes technology into care. Prioritise funding for diabetes technology nurse educators and provide support for commencement and review of use of diabetes related technology. Progressively train all hospital medical staff in diabetes technology.
7	Make it easier for people to access mental health support	Build in referrals and linkages to mental health support , particularly for children and young people, but also for significant events such as the development of diabetes complications. There should be expanded rollout of diabetes distress health professional training , which was funded in Diabetes Connect sites in Victoria in 2024-25, including for psychologists/counsellors so that they understand the barriers associated with diabetes. Endorse the Pledge to End Diabetes Stigma to provide a public commitment by health services to end diabetes stigma and discrimination in healthcare settings, and their harmful impacts on health, self-care and wellbeing.
8	Make early intervention the emphasis in care	Make early intervention the emphasis in care , recognising it will reduce risks of complications and future costs. Develop pathways supporting access to specialist care soon after a diabetes diagnosis.
9	Embed prevention into service models	Scale up proven prevention models that improve outcomes and result in cost savings in maternity and neonatal care. Leverage the role of Local Public Health Units in chronic disease prevention to raise the visibility of diabetes prevention and expand the reach of the state-funded Life! prevention program . This requires a coordinated and locally driven approach that strengthens the interface between health services, community health and primary care, and other community-based services.
10	Establish consistent data collection to inform clinical service planning and monitoring	Establish systems to collect and report on data on the clinical care and diabetes outcomes of children, young people and adults. Bring together data on population prevalence, service capacity and outcomes. Adult data collection can draw from indicators established through the Australian Diabetes Clinical Quality Registry (ADCQR) as well as a new Australian National Diabetes Inpatient Audit launched in August 2025. Paediatric diabetes can leverage work done in other jurisdictions, such as the UK National Paediatric Diabetes Audit ¹⁵ .

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