



Regarding 'Preventing diabetes—time is running out'

Congratulations on the 17 December 2004 issue of the *Journal*—devoted to the important issues of diabetes, obesity, nutrition, and physical activity. The papers contribute to our understanding of these conditions, provide evidence to support the planning and funding of both public and personal health services, and identify important issues for further research.

Unfortunately, the negative tone of Robert Scragg's editorial¹ did not do justice to either the accompanying papers or the current policy environment, and some of the statements were truly puzzling. The assertion that "a degree of apathy and indifference appears to prevail among influential circles in the Ministry of Health and District Health Boards [DHBs]" regarding diabetes could not be further from the truth, and at the Ministry we are unable to understand how this conclusion was reached.

The effort to tackle chronic disease is spread across several different parts of the Ministry and across DHBs, PHOs, and other health providers. Thus, it is not as easy to quantify as work on more specific issues such as immunisation or cancer screening. However, this should not lead to the impression that this work is not being done.

The prevention and management of chronic disease has been a top priority for both the Ministry and DHBs for several years. Diabetes and cardiovascular disease are top priorities in *The New Zealand Health Strategy*²—as are reducing obesity, improving nutrition, and increasing physical activity.

*The Primary Health Care Strategy*³ aims to build capability in primary care to address chronic diseases (specifically diabetes and cardiovascular disease). Considerable additional funding—NZ\$1.7 billion by July 2007—is going into this. Primary health organisations (PHOs) are expected to address chronic diseases through improved access, taking a population health approach, closer links with communities, developing multi disciplinary team approaches and more ongoing (rather than episodic) patient care.

Health Eating: Healthy Action (HEHA)^{4,5} provides a clear framework for preventative action both across and beyond the health sector. As important causes of diabetes and other chronic diseases are outside the health sector, it is arguable that the most important interventions are there also. Government funding for the Sport and Recreation Council (SPARC), and elements of transport, education, and conservation, inter alia, are all highly relevant. The Ministry has a role in coordinating and leading this activity, and is doing this through HEHA. The Ministry is also leading intergovernmental work to promote healthy eating and healthy activity as one of five "critical social issues for sustained interagency action" identified in the recent Government report entitled *Opportunity for All New Zealanders*.⁶

This high priority in policy work is also reflected in the funding and delivery of services. Professor Scragg himself points to (and commends) the "Get checked" programme, now in its third year. The Ministry continues to require all DHBs to provide "Get checked" as part of their funding arrangements with the Crown, and to

report on diabetes and cardiovascular disease in their annual plans. Existing public health funding to improve nutrition and increase physical activity totals NZ\$12 million, and new initiatives under HEHA are likely to boost this.

Likewise, chronic disease prevention is demonstrably a priority for DHBs. Work in Waikato (Te Wai O Rona), Counties Manukau (Let's Beat Diabetes), and Tairāwhiti (Ngāti and Healthy) are just a few examples of many great DHB and PHO initiatives in this area.

Finally, we concur with the conclusion by Mann et al in the companion editorial, that perhaps the greatest issue remaining to be solved is how to persuade at-risk individuals and populations to make the necessary changes.⁷ This is a huge challenge, and we need to work cooperatively with each other as health sector practitioners, providers and policy makers, and with other sectors, to achieve the goal of reducing the impact and incidence of diabetes and cardiovascular disease.

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Response

The response by Don Matheson and Colin Feek to my comments¹ about the study showing a high prevalence of insulin resistance among East Coast Maori,² confirms my statement that apathy towards diabetes prevention appears to prevail among influential circles in the Ministry of Health. I am surprised they have focused on the 'negative tone' of my statements instead of being concerned about the very high prevalence of insulin resistance found among East Coast Maori. How can a report of an insulin resistance prevalence of 37%, on top of a diabetes and impaired glucose prevalence of 16%, have a 'positive tone' when we know only too well the smoke of insulin resistance precedes the fire of diabetes?

It is misleading to mention additional funding of NZ\$1.7 billion by July for primary healthcare when most of this funding will go towards the provision of health services, for the treatment of a range of diseases besides diabetes, rather than specifically for diabetes prevention.

I agree with both doctors that the Ministry of Health has put considerable effort into preparing reports about obesity. But a closer look at the ones cited in their letter,^{3,4} including the 2001 to 2003 reports implementing the NZ Health Strategy, contain only summary statements about the extent of the obesity epidemic, not the solutions. A few case examples are cited of individual initiatives by a small number of DHBs trying to do something about the obesity epidemic, but overall this creates the impression of an uncoordinated and ad-hoc approach to try and quell a mounting epidemic of national importance. It does not show the coordinated effort, lead by central Government, that is so urgently needed.

Dr Matheson and Dr Feek state the Ministry of Health plans to use *Healthy Eating: Health Action* (HEHA)⁵ as a framework for preventive action, and further, that the Ministry of Health will lead and coordinate the HEHA implementation plan with other Government agencies. This will be great if it happens. I agree that the *2004-2010 Implementation Plan* contains many options related to obesity prevention.⁶ But it also includes many unrelated to obesity prevention, and my worry is that so many options are listed, often in very general terms, that I can't see how the Ministry will start implementing concrete initiatives without a dedicated group focused on obesity prevention.

I am concerned by their statement that the 'greatest issue remaining to be solved is how to persuade at-risk individuals and populations to make necessary changes.' It suggests that senior Ministry officials believe the focus of obesity prevention should remain on getting individuals to change their behaviour, rather than also considering legislation and policy which will change our 'obesogenic' environment. A dedicated committee working on obesity prevention within the Ministry of Health needs to look seriously at all options. Legislation is likely to be very cost-effective. For example, the evidence linking increased consumption of soft drinks with childhood obesity is so compelling a case can be made for taxing soft drinks by their level of sugar concentration, to decrease purchasing, since soft drinks are price elastic.⁷ (Mechanisms are already in place for alcoholic drinks to do this).

In addition, the evidence linking TV watching with childhood obesity is very convincing, and a case can also be made for banning advertising of unhealthy foods on TV, especially during after-school viewing hours. The latter action may appear

radical to some readers and to the Ministry, but the example of tobacco shows how public opinion will change on important health issues—it was only 30 years ago that smoking was allowed in airplanes and tobacco advertising on TV.

Ultimately, the commitment of the Ministry towards obesity prevention will be measured by the scale of its funding. Given that the Ministry of Health estimates that obesity costs NZ\$303 million per annum (based on World Health Organization estimates of 2%–7% of the annual health budget), it would be reasonable initially to spend 5% of that amount on research and development to prevent diabetes—about NZ\$15 million per annum.

Drs Matheson and Feek do not mention the amount of funding available for the current obesity and diabetes prevention activities by DHBs, such as those they cite in Waikato, Counties Manukau, and Tairāwhiti, but I would guess it is nowhere near NZ\$12 million of public health money already being spent on all nutrition and physical activity programmes related to HEHA. Not all of these relate to obesity prevention, but I am very happy to be proved wrong on this.

Hopefully, my concerns are unfounded, and that the Ministry of Health will provide leadership and funds towards preventing an epidemic that currently causes the deaths of over 3000 New Zealanders each year.⁸ Otherwise the grand statements of intent in the latest implementation plan⁶ will continue to be viewed as a public relations gesture.

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