My name is Martin Cominotto; I own a pharmacy, Martin's Chemist, in the outer western suburbs of Sydney. My primary catchment is St Marys which has a high incidence of type 2 diabetics (T2D). My secondary catchment area includes suburbs of Mt Druitt that has some of the highest incidents of T2D

My experience with T2D has been very close over the past 18 months with the following activities:

1. Over one thousand blood glucose monitors (BGM) sold, 90% of which to T2D. Every monitor is sold with a 15 minute demonstration of correct use of the monitor, correct lanceting techniques and counselling. We are often complimented with the extensive information provided with comments such as: "this is the most information I have been given ever" Every member of my team is trained to do these demonstrations. In the sales process we differentiate between T1D and T2D. With the high volume of strips we provide for the BGM recommended for T2D, anecdotally our monitor demonstrations are engaging T2Ds to test regularly.
2. Twice monthly 90 minute supermarket tours with a dietitian specialising in diabetes management. This involves about 6 customers at a time and Martin's Chemist covers the cost of the dietitian
3. Monthly information evenings attended by 40 to 120 people
4. Worked with the Australian Diabetes Council to re-establish a local diabetes support group.
5. Established a credentialed diabetes educator in store to provide free to the public diabetes consultations

Through this involvement I have observed:

1. Bias of diabetes services toward T1D
2. Stereotyping of T2D as disinterested and resistant
3. In the majority of cases, an absence of education and support

As a consequence, I am enrolling in the UTS Diabetes Management post graduate course with a mandate to provide from my pharmacy the support and education that is missing

The access to strips is a vital tool in this process of awareness, education and empowerment. As T2D is asymptomatic and drug therapies provide little positive feedback to the patient. The use of a BGM can provide tangible and quantitative feedback. Studies such as 2001-075 conducted for the Third Agreement; will engage the T2D to achieve better outcomes and reduce the risk of complications.

The current system with NDSS provides access for the patient, but if the patient is not engaged, the system fails. Involvement with the NDSS is a cost to the pharmacy and therefore during busy times, little professional engagement occurs. This can lead to reduced engagement by the patient. NDSS provides access to the strips but in the process creates a commodity. A model incorporating professional services is necessary to achieve any health outcomes.

A service, such as Diabetes Medscheck, has shortcomings because it can only be conducted annually. All programs conducted over 6 months with 3 to 4 visits show marked improvement in BGL and HbA1c results. Whilst follow-on visits can be recorded as a Clinical Intervention (CI), there is a disjoint in the records and payment amounts for CI fluctuate greatly.

Currently, my motivation is to continue the value I provide to my community. Whilst leads to greater customer loyalty, the current commercial reality are it is not immediately financially viable. I will develop more services, but my colleagues do not match my enthusiasm.

In this regard, I am developing a more structured approach to the supply of strips that will include regular visits by the patient and comparison with their HbA1c results. The current educational and support programs will be restructured to be less clinical and more social. The theory will be to engage the patient more through enjoyable lifestyle modifications and professional support that is non-confrontational.

In my experience, the financial subsidy of strips to T2D is essential. I believe supply should be linked to a structured and incentivised professional services component incorporating:

1. Empowerment of the patient so that:
    a. They test in a structured and meaningful manner. My experience is they test haphazardly with no relationship with food. This habit has come from their doctor!
    b. They understand the value of knowing their BGL and that HbA1c is just a 3 month average
    c. They understand the dynamics of their BGL with different foods and activity
    d. They develop better habits to reduce risks of complication
2. Engagement of the patient in a non-confronting manner. Patients are as accustomed to 30 minute consultations with a pharmacist as they are accustomed to buying their groceries at the local petrol station. Monthly quick consultations when they collect their prescriptions not only are non-confronting, but are more inline with current therapy habits. Studies show regular intervention result in better BGL and health outcomes.
3. A fixed financial component based on information reported so that a continual monitoring and education process is achieved within the dynamics of the pharmacy environment.

This submission is just a brief summary of my position on this matter. I would be pleased to be involved in any advisory groups in the future