Youth Diabetes Action
兒童糖尿協會

Empowering Progress: Achieving Equitable Access to Diabetes Technology in Hong Kong

Youth Diabetes Action (YDA) and The Chinese University of Hong Kong (CUHK)
Diabetes Technology Discussion Forum

7 June 2025

Summary of Presentations

Key Insights

- **Challenges in Diabetes Care**: Dr. Hon David Lam emphasised the challenges in diabetes care, highlighting 3 key areas: accessibility, affordability, and sustainability especially in terms of funding. Acknowledging that a more structured subsidy system would make subsiding CGM funding easier for the Government.

- **Clinical Benefits of CGMs**: Professor Elaine Chow highlighted that continuous glucose monitors (CGM) can reduce HbA1c levels by 0.5-1%, significantly decreasing diabetes complications and improving the quality of life for people with diabetes, yet only 10% of young people with Type 1 diabetes (T1D) in Hong Kong currently use them.

- **Results from the YDA Survey:** Revealed that, of 526 respondents, 92% have used CGM, with 80% being continuous users. However, 94.7% would stop if costs remain high.

- **Global Insights and Best Practices**: International speakers, including Professor Partha Kar and Dr. Daphne Gardner, shared successful models from the UK and Singapore, where improved access to CGMs has led to higher uptake and better health outcomes.
    - "Without CGMs, you cannot bring the HbA1C level down at a population level and/or reduce complications"
    - "Engaging various stakeholders are important in raising awareness, with people with diabetes being their own advocates"

- **Community Engagement and Advocacy**: Professor Alicia Jenkins discussed the importance of stakeholder collaboration and advocacy was underscored, with calls for united efforts to ensure the voices of people living with diabetes are heard in policymaking and funding decisions.

- **Economic Justification for Subsidies**: Dr. Juliana Lui presented cost-effectiveness analyses showing that CGMs are economically viable, with significant long-term savings from reduced complications, supporting the case for government subsidies.

Dr Hon David Lam Tzit-yuen

LEGCO MEMBER FOR MEDICAL AND HEALTH SERVICES FUNCTIONAL CONSTITUENCY

Dr Lam discussed the challenges and advancements in diabetes care, highlighting 3 key areas: accessibility, affordability, and sustainability of the healthcare system especially in terms of funding. He expressed his limited experience with people with diabetes and mentioned his role as a surgeon.

He shared his first encounter with a CGM system through a friend with T1D and highlighted the positive impact on his friend's life.

Dr Lam stressed the need for competition to drive down costs and mentioned the availability of more affordable brands globally. He also discussed the recent public healthcare reform in Hong Kong, which aims to broaden subsidies and make healthcare more affordable. He suggested that a means-tested subsidy system, similar to Singapore's, could improve healthcare funding and planning.

Outline

Accessibility of Diabetes Devices

- Are we giving CGMs to everyone with diabetes?
- From a policy point of view – What are the clinical benefits? How much is it going to improve the glycaemic control of people with diabetes in the short term? How is it going to change the treatment for people with diabetes in the long term and how is it going to affect long term complications? How much does it affect or improve lifestyle?

Affordability

- It is still quite costly for families
- A few things that can drive costs down: if the price universally drives down due to competition, and the availability of more economically priced brands globally
- As new tech becomes available – how will that affect the future management of diseases including diabetes? This will have a huge impact on driving the cost down

Sustainability and Public Health Care Reform in HK

- Sustainability is a big issue, especially when the government is having a deficit budget and the need for subsidies to support patients
- Discussed the recent public healthcare fee reform in HK, including the broadening of fee waivers to make healthcare more affordable for those who need it most
- Many people who are not eligible for a waiver today will become eligible for a full/partial waiver at the turn of the year, and that is important. The purpose is to make those people who can afford more to pay more, so funds can be channelled to those who really need the funds

Challenges in Subsidy Allocation and Data Accessibility

- The Singaporean health care system provides subsidies based on income and property value – could be potential for a similar system in HK. However, there are challenges in HK due to the lack of accessible data on tax and property information
- Dr Lam is open to the idea of having subsidy levels – patients should be able to apply for subsidies ahead of time to have peace of mind and better plan their healthcare expenses, eg people on higher subsidy levels could receive subsidies for CGM, vaccines, cancer screening, whereas for those on lower levels co-payment would be needed
- Dr Lam acknowledged the hope that all children with T1D will have sufficient subsidies for their devices, but said there is a need for a more structured subsidy system to make funding easier and more prudent.

Professor Elaine YK Chow

ASSOCIATE PROFESSOR (CLINICAL), DEPARTMENT OF MEDICINE AND THERAPEUTICS, CUHK/PWH

Prof Chow discussed the clinical evidence and benefits of CGMs for diabetes management. Studies have shown that CGM reduces HbA1c by 0.5-1%, cutting diabetes complications by 30% and hypoglycaemic episodes by 50%. In HK, only 10% of children and young people with T1D use CGM, compared to nearly 25% in developed nations. A survey of 526 respondents found 85% had T1D, with 92% using CGM. Cost (78%) and skin irritation (26%) were major challenges. Subsidies could increase CGM usage; 95% would use it if fully subsidised, 70% with a 75% subsidy.

Outline

Usage and Clinical Benefits of CGM in people with T1D

- Prof Chow presented data from the HK T1D Paediatric Registry (funded by YDA), showing low CGM usage in children and young people with T1D[1]
- Clinical benefits of CGM, including reducing HbA1c by 0.5 to 1%, reducing[2] hypoglycaemic episodes by 50%, and decreasing diabetic ketoacidosis (DKA)
- Improvement in mental well-being and quality of life due to CGM usage
- Example from Australia, where universal subsidised CGM funding for people with T1D <21 years increased CGM uptake (from 5% to 79%) and improved HbA1c target attainment by two-fold[3]. Decreased severe hypoglycaemic episodes and hospitalisations by 50%

[1] HK J Paediatr (New Series) 2022;27:145-151

[2] *Diabetes Care* 2020;43(3):e40-e42 / *JAMA 2017;317:371-378* - These studies also included adults

[3] *Diabetes Care* 2022;45(2):391-397

Guidelines and Recommendations for CGM Usage

- American Diabetes Association guidelines recommend CGM for T1D management[4] with highest level of evidence
- HK Reference Framework for Diabetes Care for Adults in Primary Care Settings suggest CGM is important for assessing treatment effectiveness and preventing hypoglycaemia in T1D
- Limited clinical evidence for CGM in Type 2 diabetes (T2D) but may be beneficial for intensive insulin users

YDA Survey Results on CGM Usage and Challenges

- Survey collected responses from 526 people, with 85% T1D, 10% T2D, and 5% other forms of diabetes
- Majority of respondents (92%) have used CGM, with 88% being continuous CGM users
- Nearly 90% stated CGM positively impacts their diabetes management
- Real-time glucose readings and alerts for high or low levels, and the need for fewer finger-pricks being highly useful
- Cost-related issues (78%), skin irritation (55%), and sensor accuracy (43%) are the main challenges for CGM users

Factors Influencing CGM Continuation and Alternatives

- Majority of respondents (94.7%) would have to stop using CGM if cost-related issues persist
- For non-CGM users – the main factors that would make them consider CGM in the future include government subsidies and lower costs; some would be influenced by better insurance coverage, and healthcare provider recommendations
- Respondents showed willingness to use CGM with different co-payment options, with higher subsidies leading to higher usage
- Alternative solutions suggested by respondents include government full subsidy, bulk purchase discounts, and partial subsidies/support from other NGOs

Comments and Concerns from CGM Users

- Respondents expressed concerns about the financial burden of CGM, especially if subsidies end. Negative impact on the children's wellbeing if already using a CGM and funding ends
- CGM is compared to a critical tool for managing diabetes, including analogies "without the CGM it is like going blind" and "if insulin is the vehicle, CGM is the driver"
- Emphasis on the need for government support to fund devices and other equipment for T1D management
- If the government is able to support CGM and other diabetes tech, people can better self-manage their diabetes and therefore can reduce long-term diabetes-related expenditures.

[4] *Diabetes Care* 2024;47(Supplement_1):S126-S144

Professor Partha Kar

TYPE 1 DIABETES & TECHNOLOGY LEAD, NHS ENGLAND

Prof Kar discussed the evolution of T1D management in the UK, emphasising the shift from limited CGM access in 2017 to nearly 97% uptake by March 2025. He highlighted the importance of CGM and hybrid closed-loop systems, noting that 67% of children in the UK now have access to these technologies. The goal is to reduce HbA1c levels below 7.5% and extend healthy years without complications. Prof Kar stressed the cost-effectiveness of these technologies and their critical role in improving self-management and quality of life for people with diabetes.

Outline

Challenges and Solutions in T1D Management

- There are not enough trained professionals. Therefore, individuals are living with the condition 99.9% of the time on their own. By giving people better self-management tools, along with peer support, things can improve
- In 2017, the uptake of CGM in the UK was very low, with only 1% of the population having access. Disparities in access to tech based on socio-economic factors were significant
- The goal was to provide CGM for everyone; however, it took time

Impact of CGM on Population Health

- Prof Kar discussed the concept of "healthy years of life" and how CGM can extend these years
- It's important to realise that at a population level, you will fundamentally struggle to drop the HbA1c below 7.5% without CGM. You can get individual results, but not at a population level
- International data support the idea that CGM is essential for achieving population-level HbA1c targets below 7.5%
- CGM reduces complications across the board and therefore improves health outcomes
- Data also show a positive impact of CGM on pregnancy outcomes for women with T1D

Hybrid Closed-Loop Systems and Future Plans

- Prof Kar talked about the current use of hybrid closed-loop systems for children with T1D. Data coming out next week (Diabetes Week in the UK) shows children aged 0 to 18 with access to hyper closed loop system is about 67% so 2/3 of all children are on it. Everybody is on a CGM
- The goal is to shift the median HbA1c level below 7% for the entire T1D population
- 5-year plan includes expanding access to CGM and hybrid closed-loop systems for adults
- Cost-effectiveness and the role of international bodies in supporting these initiatives are important to the success
- The role of self-management tools in achieving better health outcomes is underscored
- Must share data and information on the cost-effectiveness of the CGM and insulin pump initiatives with policymakers and governments.

Dr Daphne Gardner

SENIOR CONSULTANT, SINGAPORE GENERAL HOSPITAL

Dr Gardner discussed the integration of technology for T1D in Singapore, highlighting the country's diabetes prevalence is 7.3% – around 1,200 listed people with T1D. Initiatives included adopting the UK diabetes curriculum, introducing Medtronic pumps in 2014, and securing reimbursement for insulin pumps and flash glucose monitoring. Dexcom G6 sensors' retail price dropped after reimbursement policies. Engaging stakeholders, peer support communities, and advocacy efforts were emphasised to improve diabetes management and awareness.

Outline

Healthcare System Overview and Diabetes Prevalence in Singapore

- Singapore has an estimated diabetes prevalence of 7.3%, with a population of 6 million, including 4 million residents
- Of the 420,000 individuals with diabetes, less than 5% have T1D
- SingHealth has listed 130,000 unique individuals with diabetes listed in their registry, with about 1,200 having T1D

Early Challenges and Implementation of Diabetes Management Programs

- Dr Gardner recounted the lack of T1D knowledge in self-management and education in Singapore in 2007. A severe hypoglycaemia case highlighted the neglected needs of people with T1D in the region
- A work plan was developed to bring the UK DAFNE curriculum to Singapore. This is a 5-day group education programme in advanced carbohydrate counting and self-management for individuals with T1D
- The DAFNE curriculum enabled the T1D healthcare providers to provide consistent educational messages to people with diabetes and permitted the onboarding of diabetes technology. This was in the form of retrospective continuous glucose monitoring (Medtronic IPro reporting service) in 2014
- The establishment of the Agency for Care Effectiveness in Singapore in 2015 and a call for health technology appraisal in 2016 were key milestones

Reimbursement and Cost-Effectiveness of Diabetes Technologies

- In 2016, an application for insulin pumps to be considered for reimbursement in T1D was submitted
- Flash glucose monitoring was launched in Singapore in 2017, and in 2020, pumps were approved for reimbursement for T1D individuals with an HbA1c above 8.5% or disabling hypoglycaemia
- The approval of reimbursements led to a significant reduction in the pricing of insulin pumps, making them more affordable for subsidised people with diabetes. Eligible people with T1D pay 50% with government co-paying 50%
- Dexcom G6 rt-cgm was approved for reimbursement in 2024, with a means-tested policy for reimbursement, that lowered the sensor's price by nearly 45-75% compared to retail pricing

- In 2025, current real-time CGM uptake is around 50% of people with T1D in SingHealth

Engaging Stakeholders and Advocacy Efforts

- Engaging various stakeholders, including peer support communities and industry providers are also important in raising awareness, with people with diabetes being their own advocates
- Examples included organising events with industry partners like Medtronic to raise awareness about T1D, collaboration with the Minister of Health in Singapore to highlight the needs of T1D individuals
- Collaborating with other T1D individuals which culminated in the publication of a children's book on T1D to inform the next generation and distribution of the book in primary schools and children with T1D to share in their school

Educational Materials and Future Plans

- Production of educational materials and animation videos on insulin dosing and self-management for T1D. Provide tools for people to raise awareness
- Plans to speak to funders about reimbursing advanced hybrid closed-loop systems, such as the MiniMed 780G
- Cost-effectiveness analysis (CEA) of the MiniMed 780G system, showing a significant reduction in HbA1c levels with favourable ICER values
- Ongoing communication with funders to secure positive outcomes for the reimbursement of advanced diabetes technologies

T1D Care and Access to Technology

- Setting the stage was as important as building it up
- Education: T1D self-management and carb counting – everyone speaking the same language (people with T1D and healthcare professionals)
- Implementation of technology
- Awareness and advocacy
- Evidence building
- Engaging funders.

Q&A Session and Additional Insights from Speakers

Q: *How can we help to ensure the voices of people living with diabetes are heard in communicating this need?*

- **Dr Gardner** suggests forming peer support communities and organising events to bring more people together to provide a louder platform. (Often people will speak one on one but reluctant to speak in public as an individual)
- In Singapore, published a book – invited a panel discussion to talk about access. Bringing funders and people with diabetes together to engage in conversation. Co-incidentally ACE

(Agency for Care Effectiveness) was also thinking more about engaging people with diabetes in their patient empowerment arm.

- **Prof Kar** emphasised often healthcare professionals when going into larger meetings it is important to remember to collaborate without collusion (and forget the reason for being there) and sharing the stage with individuals living with T1D
- Being open and transparent

Both highlighted the need for continuous awareness and communication with funders to secure necessary resources and support

Q: *What will it take for the HK Government to support this?*

Dr Lam:

- Need advocates – diabetes is a major health threat to the population. If the new devices can improve long-term health outcomes, and the professors from universities suggest this is the way to go – there is a moral obligation to push forward
- However, it's impractical to ask governments to subsidise everyone for everything – diabetes, cancer, stroke, etc. There are many areas to take care of
- How to make good use of the healthcare fund? Need to ensure that those who cannot afford it get subsidies first
- There is also an issue of over-subsidisation, with an example of the HPV vaccine where full funding led to a decrease in vaccination rates and people not valuing the service

Q: *What is the first step to connect to the authorities? We are far behind compared to everybody else*.

Dr Lam:

- The first step is data
- Second step – put it into a reference framework. Important for Primary Healthcare Commission – they are aware of the changing trend of diabetes care
- Third step – how to implement the reference framework. This really goes to the Primary Healthcare policies. They have done pre-screening for diabetes and hypertension, plus others such as enhancing treatment for stroke victims. There are others on the list and improving overall treatment of diabetes is one of them
- Work with the professors at the universities to send a proposal to government – evidence based, supported by universal/ international guidelines and local guidelines. Define what types of subsidies?

Dr Gardner:

- For every funding authority, there is a finite budget with competing interests from different groups. However, there is a finite number of individuals with T1D (well-defined population). And clinical thresholds will be applied so subsidies reach those who benefit. The budget will not be stretched beyond this to T2D which is a wider population. Even if co-payments

go down to a minimum sum, still not everyone will be willing to wear sensors continuously – personal choice, having the alarms on, wearing a device 24/7, and for some, even 21 SGD will still be more than what they are willing to pay (prioritisation of expenses). So, you are not going to get 100% uptake. Nevertheless, as a healthcare provider, these reimbursements will enable people to have the choice of harnessing technology to improve self-care and reduce the burden of diabetes care.

Prof Kar:

- All global data will show the same result
- If you are in a policy role and dedicated to want to reduce complication costs, CGM is the prevention method at its finest
- In the UK, they do a lot of prevention work for T2D but struggle to see gains as the impact is dependent on environmental factors, deprivation, ability to have healthy food, etc
- Without CGM, you cannot bring the T1D population's HbA1c down. They are about to get a major uplift in T1D as the data collected in the last seven years have shown there is a reduction in complications
- Investing in CGMs for people with T1D is a return on investment; without it you cannot bring the HbA1C level down at a population level and/or reduce complications

Q: *Is there any data related to savings from reduced complications?*

Prof Kar:

- UK data shows that the complications spend has been reduced. For example, if spending GBP100 there has been a shift:
    - Previous spend was GBP80 on complications, GBP20 treatment
    - Spend is now GBP60 on complications, GBP40 treatment
- See the T1D Global Index – how many "healthy life years"? The data is not 100% accurate but it gives a good idea. It combines real-life data and study data to do the calculations

Q: *How can we reduce the cost from venders – making it more competitive?*

Prof Kar:

- All countries will have deals at a local level. If government decides it's the way to go – it will need to be commercially confidential – each country will have their negotiable pricing.

Professor Alicia Jenkins

ST VINCENT'S HOSPITAL, MELBOURNE,
DIABETES AND VASCULAR MEDICINE LAB HEAD, BAKER HEART AND DIABETES INSTITUTE

Outline

Benefits of CGM

- Improves glucose management – clearer understanding of glucose levels, better decision making re glucose treatment / insulin dosing, improves quality of life, less anxiety
- Reduced risk of hypoglycaemia, DKI and long-term complications
- Fewer hospital visits, can be cost saving for healthcare providers
- Best way to improve glucose control is combined insulin pump and CGM. However, that's two devices. Strong data show that if you can only afford one device – CGM is the most useful

Availability and Subsidies for CGM in the Western Pacific Region

- Six different CGM devices are available in the Western Pacific region, with three in Australia
- Competition among CGM device companies helps drive down costs, but affordability remains a major issue in many countries
- Australia, New Zealand, Japan, and some other countries subsidise CGM, while others still rely on user-pay scenarios
- In Australia, out of 27m, 135,000 people with T1D. Good the numbers are low – makes it more affordable to subsidise

Historical and Current Subsidy Policies in Australia

- CGM was initially user-pay but became subsidised by the Australian government in mid-2022 for all Australians with T1D. In 2025 about 80% CGM uptake with most abstainers being from the older 70 yr old group.
- 2017-2019: Subsidies started with people under 21 yours and pregnant women, later expanding to concession card holders, eg pensioners, disabled, veterans
- 2022: A co-payment of AUS$32 per month was implemented for all other T1D not listed above, reducing the cost by 10% of the system's total. For pensioners and concession card holders the CGM is free.
- No subsidy yet for people with T2D and other forms – full payment about AUS$4,000 per annum

Advocacy and Data Supporting CGM Subsidies

- It was achieved through years of persistent advocacy and having a united front with various stakeholders
- Emotional, clinical, and economic cases were central to advocating for CGM subsidies
- Personal stories and testimonials from people with diabetes and their families were crucial in highlighting the benefits of CGM
- Multi-channel public engagement through community meetings, social media, and online petitions mobilised community support, and community forums

- Subsidised CGM is not just a healthcare issue but also about social justice and equity.
- Language used is important. Materials are available to help ensure consistency in how we talk about and advocate for people with diabetes, including for young people to use

Impact of CGM Subsidies on Diabetes Management

- Direct lobbying with policymakers – not just with data but personal stories (See *Equitable Access to Diabetes Technology* booklet)
- Economic framing included immediate health benefits and long-term cost savings from reduced complications
- CGM would cost government AUS$14K per person over a lifetime and reduce complications: eyes (17%), kidney (21.1%), nerves (8.7), and cardiovascular (2.5%)
- CGM subsidies led to increased use among youth with T1D, improving glucose control, reducing hypoglycaemia, and significant improvements in HbA1c levels
- Continued use of CGM is essential for achieving better glucose control and emotional well-being
- Community-led surveys showed high importance of CGM for achieving better glucose control and reducing hypoglycaemia
- Before subsidy for T1D youth, only 5% uptake, but with subsidy 79% uptake after only 2 years. Those using CGM for >75% of the time lowered Hb1Ac levels and kept it down.

Summary

- Learn from other countries' successes
- Engage multiple stakeholders
- Important to include the emotional, clinical, and economic cases, as well as social justice
- Starting with support for children first is wise, then pregnant woman, and then to all who may benefit
- Be persistent.

Dr Juliana Lui

RESEARCH ASSISTANT PROFESSOR, HEALTH ECONOMICS, CUHK/PWH

Outline

Dr Lui discussed cost-effectiveness analysis (CEA) of CGM for T1D and T2D. The incremental cost-effectiveness ratio (ICER) compares costs and outcomes, with thresholds varying by region:

- UK is £20,000-£30,000 per QALY (quality-adjusted life years)
- USA is $50,000-$100,000 per QALY
- Hong Kong is 1-3 times GDP per capita

Studies show CGM is cost-effective, with ICERs below thresholds in multiple regions. In the USA, Medicare fully covers CGM, while Medicaid varies by state. In Canada, CGM is reimbursable, and in

Australia, it's partially covered. Reimbursement is also available in Taiwan, South Korea, Singapore, and Japan.

Cost-Effectiveness Analysis of CGM

- Summarised 34 studies on CGM cost-effectiveness for T1D, most from Western countries. Only 1 study from China
- CEA comparing CGM to standard care (self-monitoring blood glucose (SMBG)) or intermittent CGM
- ICER compares the cost of CGM to the standard of care over the effect
- Most results show that CGM is cost-effective in both T1D and T2D, with significant improvements in QALYs
- Cost savings are primarily from reduced complications, particularly renal
- UK studies find CGMs for T1D and T2D are very cost-effective. Willingness to pay (WTP) threshold = £20,000 to £30,000. But T1D cohort only around 9,000 still within the WTP threshold
- In US, $98,000 per QALY gained for CGM compared to SMBG, Increase of 0.54 QALY. WTP threshold of $100K per QALY
- Canada, WTP is CAD$50K. CAD$33K per QALY still within threshold

Reimbursement and Subsidy Policies in Different Countries

- In the US, Medicare fully covers CGM for T1D and some T2D, while Medicaid coverage varies by state
- In the UK, all people with T1D are eligible for CGM, while people with T2D need to meet specific criteria
- Canada has a federal and provincial funding model, with tax payment credits for CGM users
- Australia provides full subsidies for people with T1D under 21 and pregnant women, with a co-payment for others (but changed to all in mid-2022)

Asian Reimbursement and Subsidy Policies

- Taiwan and South Korea have government-funded universal health coverage, with subsidies for CGM
- Taiwan provides full subsidies for pregnant women and people under 21, with co-payments for others
- South Korea offers reimbursement for CGM users, with varying subsidies based on age and condition
- Singapore has an 80% subsidy for CGM, making it more affordable for users.

Discussion Groups (mixed stakeholders)

Discussion 1: *Who would benefit and should have priority to enable equitable access to CGM in HK (T1D, T2D, age group, clinical criteria, socio-economic factors)*?

Yellow group

Divide people with diabetes into different groups and prioritise as follows:

1. T1D
2. GDM (Gestational diabetes mellitus)
3. T2D on insulin treatment

Green group

Individuals with diabetes requiring insulin, who are full-time students under 25 (similar to what the government is doing already)

- Only 400 people within this group so this is only a small number. Economically this makes sense

Orange group

Prioritise:

1. Children with T1D – fully subsidise
2. Pregnant women with T1D – fully subsidise – only short-term issue
3. Young adults with T1D – can accept partial subsidy (payment similar to cost of finger-pricking)
4. Newly diagnosed adults with T1D – no longer children but could benefit while learning how to manage diabetes. Start with full subsidy but go down to co-payment after time
5. T2D on insulin treatment

Discussion 2: *What options should there be for different funding models in HK: fully funded via HA/government, co-pay, tiered subsidy, etc?*

Purple group

- Thinking 50% is the minimum subsidy – but we should aim for 70% at least if not full
- Community pharmacies – maybe we can get the CGM from there. Dr Benjamin can provide some tips
- CGM vouchers is an option
- Make HbA1C level as a criterion. If level is still more than 10% for over a year of using CGM – reassign the resource if they are not making progress on improving levels

- Insurance companies – get them involved in helping and providing cover. If we present the information directly to the companies, we (people with diabetes) may have better bargaining power

Blue group

- Promote HK as a good place to live – if government wants to promote this, then they should help families with diabetes
- Protect the family to help raise children
- Pilot programme – get the foot in the door and expand gradually to more people
- Ideal is to have full subsidy but willing to have partial modest subsidy
- Start with small group – T1D children – and once that is successful expand to other groups.

Q: *Dr Jenkins went to Australian Congress to ask for support – how did you do that?*

Dr Jenkins:

- It was a united front – Diabetes Association, healthcare providers, people with diabetes – all coming together to support and lobby and using the pillars of emotional, clinical and economic need.
- Data is important, showing that it could be achieved for a relatively low cost – we were not asking for everyone with diabetes (just all with T1D). It was also a social justice case.
- What government likes to hear in Australia, and likely other places, is a united voice and a reasonable ask – It should be achievable, especially with the data to prove it.