Canadian Diabetes Association

2015 Pre-Budget Submission

to the House of Common Standing Committee on Finance

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The Canadian Diabetes Association (the Association) is a registered charitable organization that leads the fight against diabetes by helping those affected by diabetes to live healthy lives, and preventing the onset and consequences of diabetes while we work to find a cure. Our staff and more than 20,000 volunteers provide education and services to help people in their daily fight against the disease, advocate on behalf of people with diabetes for the opportunity to achieve their highest quality of life, and break ground towards a cure.

The Association believes that Canadians with diabetes have the right to be treated with dignity and respect, and have equitable access to high quality diabetes care and supports. Such are the guiding principles within Association's Diabetes Charter for Canada.[1] Our vision through the Charter is a country where all people with diabetes can live to their full potential.

Executive Summary

Today, one in four Canadians lives with diabetes or prediabetes. If nothing is done to stem the tsunami of diabetes, by 2020, it will be one in three.[2]

The increasing rate of diabetes and its complications pose a serious burden on Canada's publicly funded health care system and our economy. In 2015, diabetes will cost Canada almost $14 billion, and by 2020, diabetes will cost our health care system and our economy almost $16 billion.[3]

To alleviate cost pressures on our publicly funded health care system, and address one of the federal government's identified priorities – supporting vulnerable populations by improving their health – the Canadian Diabetes Association recommends the following:

1. Renew and make the Aboriginal Diabetes Initiative permanent by committing annual funding at current levels of $55 million indexed to inflation;
2. Expand the disability tax credit for people dependent on insulin as a life-sustaining therapy by extending the credit to all Canadians living with type 1 diabetes;
3. Focus current investment of the Canadian Diabetes Strategy to support diabetes prevention, early screening and management for immigrant populations at higher risk of type 2 diabetes.

I. Introduction

From 2000 to 2010, the prevalence of diabetes doubled from 1.3 million to 2.5 million.[4] Today, one in four Canadians — or over nine million people —lives with diabetes or prediabetes[5]; if nothing is done, by 2020, it will be one in three.[6]

Diabetes is a leading cause of blindness, end stage renal disease and non-traumatic amputation in Canadian adults.[7] One of ten deaths in Canadian adults was attributable to diabetes in 2008/09.[8] Management is complicated by the fact that nearly a million people living with it remain undiagnosed. The Canadian economy and all Canadians are paying the cost of treating diabetes-related complications.

II. Recommendations

1. Diabetes in Aboriginal People in Canada: Addressing the unique needs and disparities in care and health status of Aboriginal communities.

Background

Aboriginal people in Canada bear a disproportionate burden of diabetes. Diabetes prevalence rate is three to five times higher among First Nations than the non-First Nations population. Aboriginal women have over twice the risk of gestational diabetes than non-Aboriginal women, which exposes both mothers and children to a higher risk of developing type 2 diabetes. Diabetes prevalence rates have more than tripled from 1980-2005 among First Nations children, and the age of diagnosis is younger in First Nations people.[9]

If poorly managed, diabetes can cause serious and potentially life-threatening complications, and Aboriginal people experience higher rates of these complications and mortality. For example, studies in Manitoba have shown that:

- In a remote northern Aboriginal community in that province, in 82% of the population, there is an average of three foot complications per individual, including foot deformities, neuropathy, foot ulcer and amputation.[10]
- The prevalence of diabetes-related lower-extremity amputation are 16 times greater among Aboriginal people than non-Aboriginal people.[11]

Barriers to care contribute to the poor health outcomes in Aboriginal people with diabetes, including fragmented healthcare, poor chronic disease management, high healthcare staff turnover, and limited or non-existent surveillance. Factors concerning the social determinants of health, including low income, lack of education, high unemployment, poor living conditions, lack of social support, negative stereotyping and stigmatization, and poor access to health services also compound the problem.[12] In addition, participants at the 2013 National Aboriginal Diabetes Association (NADA) Conference also identified lack of accessible and affordable healthy food, mental and

emotional health concerns and the effects of trauma as challenges to living well with diabetes.[13]

The Aboriginal Diabetes Initiative

The Aboriginal Diabetes Initiative (ADI) supports over 600 programs for Aboriginal people with diabetes in Canada. The current funding of the ADI at approximately $55 million per year is scheduled to sunset in 2015. We urge the federal government to renew funding for this essential program.

Since its creation, the ADI has demonstrated incredible success in supporting prevention, health promotion, screening and care management initiatives that are community-based and culturally appropriate.[14] Continuation of the ADI will both support important services for these populations at disproportionately higher risk of diabetes and related complications, as well as reduce the costs associated with complications which account for 80% of total diabetes costs.[15]

RECOMMENDATION 1:

The Canadian Diabetes Association recommends that the federal government commit to permanent funding for the ADI at the current funding level ($55 million annually) indexed to inflation to preserve the real value of the program.

2. Diabetes and the disability tax credit: Ensuring fairness in supporting Canadians with type 1 diabetes by expanding the disability tax credit.

Background

When a person is diagnosed with type 1 diabetes, usually at a young age, the lifelong management regimen begins, including activities directly related to determining each dosage of insulin as a life-sustaining therapy, including frequent blood testing, dose calculation and insulin injection. Research shows that the complexity and effort required to perform diabetes self-management activities are often underestimated, and that the number of tasks for managing type 1 diabetes can involve as many as 600 steps every day, with the insulin injection process alone involving approximately 40 steps.[16]

In addition, depending on individual circumstances, the estimated financial burden assumed by people with type 1 diabetes can be as high as almost $4,700 per year (or over 10% of individual income).[17]

The Disability Tax Credit

The inclusion of insulin as a life-sustaining therapy within the eligibility criterial for the disability tax credit (DTC) is intended to provide financial relief to insulin-dependent

individuals. However, inequities exist in accessing the DTC among people with type 1 diabetes.

The current eligibility criteria for the DTC state that individuals on insulin therapy may be eligible if a physician certifies that the patient requires therapy for at least 3 times a week, with an average of at least 14 hours per week spent on activities related to this therapy. Examples of these activities are provided within the Disability Tax Credit Certificate form (T2201E), including:

- Monitoring blood glucose levels;
- Preparing and administering the insulin;
- Calibrating necessary equipment; and
- Maintaining a logbook of blood glucose levels.

Currently, most adults with type 1 diabetes do not qualify for the DTC because conducting additional activities related to managing their insulin therapy are not permitted in this calculation. For children with type 1 diabetes, the Income Tax Act permits the time that parents, or other primary caregivers, spend on these activities to be counted toward accumulated hours, thus, children up to age 18 may qualify for the DTC, as well as the registered disability savings plan (RDSP).

However, examples of activities related to insulin therapy within the eligibility criteria for the DTC do not adequately capture the range of activities or the amount of time required to determine dosage and administer multiple daily injections of insulin. People with type 1 diabetes spend well over 14 hours a week on activities related to their insulin therapy beyond those activities specified by the examples. Current permitted activities related to insulin therapy result in inequitable access to the DTC.

Inclusion of all actual activities related to insulin therapy within the DTC criteria would be consistent with the spirit and intent of the program, which is to relieve some of the burden required to receive life sustaining therapy. The cost of expanding the permitted activities is estimated at $100-150 million for 2015.[18] However, this pales compared to the cost of the diabetes in Canada of almost $14 billion in 2015. This tax credit will also provide financial relief and fairness for people with diabetes to optimally self-manage their disease. Families who have invested in an RDSP to save for their children's future would also be able to maintain their financial commitment.

Recommendation 2:

The Canadian Diabetes Association recommends that the government create equity for Canadians with diabetes by amending Section 118.3 of the Income Tax Act to include additional activities undertaken by people with type 1 diabetes to determine insulin dosages and thereby permitting all Canadians living with type 1 diabetes to claim the DTC.

3. Canadian Diabetes Strategy: A renewed focus to help high-risk immigrant groups both prevent type 2 diabetes and also live well with the disease

Background

No one is immune to diabetes; however, people of certain ethnocultural origins, such as Asians, South Asians, Africans, and Hispanics, are at higher risk of type 2 diabetes and complications. In 2011, people of South Asian, Chinese and African descent made up 61.3% of the total visible minority population in Canada and represented 19% of the Canadian population. In addition to their genetic predisposition to type 2 diabetes, certain subgroups such as recent immigrants and people on low incomes also have more difficulty obtaining needed care.

All Canadians, either at risk of or diagnosed with diabetes, have the right to affordable and timely diabetes supports that are culturally and linguistically appropriate. As outlined in the Diabetes Charter for Canada,[19] governments have the responsibility to respond to the needs of vulnerable populations who experience both higher rates of diabetes and complications and barriers to care.

The Canadian Diabetes Strategy

Since its creation, the Canadian Diabetes Strategy (CDS, now part of the Integrated Strategy on Healthy Living and Chronic Disease) supports a well-established surveillance system and data collecting mechanism, partnerships to address childhood obesity and other risk factors associated with chronic diseases, and development of self-management tools. Work has also been initiated to target funding to high-risk populations, such as translating the CANRISK questionnaire to facilitate diabetes risk screening among high-risk populations, in partnership with pharmacies, provinces and local public health units.

The Canadian Diabetes Association urges the government to build on this work for populations at high risk of type 2 diabetes. Additional measures may include funding for community-based diabetes prevention or management programs for high-risk populations, culturally and linguistically appropriate diabetes education and wellness programs, and partnering with community organizations with network within respective communities. The Canadian Diabetes Association would welcome the opportunity to work with the government to launch CANRISK screening programs through our 14 Diabetes Chapters in the Greater Toronto Area such as the South Asian, Chinese and Caribbean Chapters.

Recommendation 3:

The Canadian Diabetes Association recommends that federal government, using the current funding under the Canadian Diabetes Strategy, commit to a renewed focus in populations at high risk of type 2 diabetes and associated complications.

III. Conclusion

Positive interventions such as measures to promote healthy eating and physical activity have been shown to reduce the onset of diabetes by over 50%.[20] We commend the government for initiatives directed to support these measures.

We urge the government to build upon these initiatives by adopting recommendations afford and building upon its commitment to promoting healthy public policy. The Canadian Diabetes Association looks forward to continuing to work the government and other stakeholders in the diabetes community towards optimal health outcomes by helping people at higher risk of diabetes to prevent the disease, and supporting those with diabetes to avoid serious complications and live a healthy life. These strategic investments will, in turn, reduce cost pressures on our health care system and economy.

We thank the committee for the opportunity to provide these recommendations.

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[1] Canadian Diabetes Association. (2014). The Diabetes Charter of Canada. Available at: http://www.diabetes.ca/diabetes-and-you/know-your-rights/support-the-diabetes-charter-for-canada/diabetes-charter-for-canada
[2] See Diabetes: Canada at the Tipping Point – Charting a New Path, 2011. Available at: http://www.diabetes.ca/CDA/media/documents/publications-and-newsletters/advocacy-reports/canada-at-the-tipping-point-english.pdf. Figures concerning prevalence and cost estimated through the diabetes cost model are updated on an annual basis.
[3] Ibid.
[4] See note 2.
[5] Prediabetes exists when blood glucose is elevated, but not as high as type 2 diabetes. About 50% of Canadians with prediabetes develop type 2 diabetes in their lifetime. See Diabetes: Canada at the Tipping Point – Charting a New Path, p. 8.
[6] See note 2.
[7] Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. Can J Diabetes 2013.
[8] Public Health Agency of Canada. (2011). *Diabetes in Canada: Facts and figures from a public health perspective*. Ottawa, Ont.: Public Health Agency of Canada. Retrieved from http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/index-eng.php
[9]See note 7.
[10] Reid, K.S., Martin, B.D., Duerksen, F., Nicolle, L.E., Garrett, M., Simonsen, J.N., ...&Embil, J.M. (2006). Diabetic foot complications in a northern Canadian Aboriginal community. *Foot & Ankle International*, 27(12), 1065-1073.
[11] Green, C., Blanchard, J., Young, T. K., & Griffith, J. (2003). The epidemiology of diabetes in the Manitoba-Registered First Nation population: Current patterns and comparative trends. *Diabetes Care*, 26(7), 1993-1998.
[12] See note 7.
[13] National Aboriginal Diabetes Association. 7th National Aboriginal Diabetes Conference and Strategic Planning Engagement - Celebrating Success: Building Healthier Pathways. Diabetes Strategic Planning Session Report, March 2014.
[14] Ibid.
[15] See note 2.
[16] Coffen, R. D. (2009). The 600-step program for type 1 diabetes self-management in youth: The magnitude of the self-management task. *Postgraduate Medicine*, *121*(5), 119-139.
[17] Canadian Diabetes Association. The Burden of Out-of-pocket Costs for Canadians with Diabetes. 2011. Available at: http://www.diabetes.ca/publications-newsletters/advocacy-reports/out-of-pocket-costs-for-canadians-with-diabetes.
[18] A detailed analysis of this estimated cost is available upon request.
[19] See note 1. The Diabetes Charter for Canada has been endorsed by governments as well as not-for-profit organizations, and over 9,000 Canadians across Canada at time of writing.
[20] See note 2.