Medical Services Advisory Committee (MSAC)

STAKEHOLDER MEETING OUTCOME STATEMENT

Continuous glucose monitoring for people with insulin dependent type 2 diabetes, gestational diabetes, and other types of diabetes similar to type 1 (such as type 3c diabetes)

Wednesday, 20 May 2026

T2D subpopulations and eligibility

Stakeholders broadly supported prioritising access for people with type 2 diabetes at highest clinical risk, particularly those using intensive insulin therapy such as basal-bolus regimens or multiple daily injections. Participants also noted that access may be particularly relevant when people are commencing basal-bolus or other multiple daily injection regimens or have highly unstable glucose levels. Frequently identified priority groups were:

- younger people with youth-onset type 2 diabetes (i.e. diagnosed before age 25);
- Aboriginal and Torres Strait Islander people, noting the disproportionate burden of diabetes, complications and barriers to specialist care in this population;
- women with pre-existing diabetes who are planning pregnancy;
- people with asymptomatic hypoglycaemia (i.e. people are unaware that they are hypoglycaemic due to lack of usual warning signs);
- people with marked variability in glucose levels;
- those with advanced diabetes-related complications (e.g. diabetic foot disease) or in high-risk clinical situations such as renal disease requiring dialysis.

One participant also emphasised that people with diabetes-related foot disease are established high users of hospital care and carry a substantial healthcare burden. Therefore, this group would benefit from funded access to CGM. It was also noted that some vulnerable groups may be relatively disengaged from managing their diabetes, and that CGM may improve engagement in these groups. Examples included people from refugee backgrounds and people from lower socioeconomic backgrounds. For vulnerable people experiencing food insecurity, who are more likely to experience unstable blood glucose levels, participants considered that CGM may make optimisation of diabetes management safer. At least one participant also argued that anybody who is using insulin should get access to CGM. However, another participant stated that some populations may not benefit from CGM, including older adults who have a limited life expectancy, who are residing in nursing homes, and/or are in palliative care, where international evidence suggests de-intensification of diabetes management is preferable, and CGM may cause unnecessary distress and burdensome care. Similarly, people who do not engage with core healthcare providers (such as endocrinologists, diabetes educators, or GPs) were proposed as unlikely to benefit from CGM.

Stakeholders expressed mixed views on the use of an HbA1c threshold to determine eligibility for CGM. Several participants considered that a higher HbA1c threshold may identify people more likely to derive measurable glycaemic benefit, with one participant noting evidence that CGM use in people with higher baseline HbA1c was associated with larger reductions in HbA1c, compared to people with a lower baseline HbA1c.Another participant referred to the Australian Diabetes Society perioperative guidance which suggested HbA1c levels below 9% should ideally be achieved prior to elective surgery. People with known diabetes and HbA1c levels greater or equal to 9% should have elective surgery delayed due to evidence of poorer outcomes. For youth-onset type 2 diabetes, one participant considered that any young person above the HbA1C target of 6.5% should be eligible, in line with

HbA1c targets outlined in NICE and ISPAD guidelines. However, the predominant view was that the use of a fixed HbA1c threshold to determine eligibility was not appropriate, and that clinical discretion should be used. This involves considering the broader clinical context including factors such as treatment intensity, clinical risk, vulnerability and safety considerations. Participants also argued that HbA1c alone is an inadequate basis for access because it does not necessarily capture those experiencing hypoglycaemia (who may have lower baseline HbA1c), glycaemic variability, or other circumstances in which CGM could improve safety and treatment adjustment, such as patients with renal impairment. Some participants suggested that better measures of glycaemic control, other than HbA1c, may include 'time in range' and 'coefficient of variation'. However, it was noted that the evidence base for diabetes control used HbA1c as the eligibility criteria and the outcome measure of interest and so remains the predominant biomarker at present. There was also consistent opposition to removing funded access to CGM once glycaemic targets are achieved, on the basis that improved control may itself depend on continued CGM use.

One participant considered that framing of eligibility criteria should refer to people *requiring* insulin or intensive insulin therapy, rather than strictly limiting to people who are *prescribed* or *on* a specified insulin regimen. It was argued that some people, including those affected by food insecurity, disability, or other social and practical barriers, may clinically require basal-bolus or other intensive insulin therapy but may not in practice be prescribed or able to use that regimen. Participants therefore considered that if wording is limited to current prescribing, it could exclude vulnerable groups who may have substantial clinical need for CGM. However, stakeholders noted that this may be difficult to implement, where current treatment or prescribing status is more definitive and easier to verify than who may or may not "require" insulin. Overall, participants emphasised that wording should avoid unintended exclusion of people whose clinical need for insulin therapy is not fully reflected by their prescribed regimen, while noting the importance of clear and workable eligibility criteria.

Gestational diabetes and type 3c and other types of diabetes

Stakeholders distinguished between gestational diabetes and pre-existing type 2 diabetes in pregnancy. There was strong support for CGM access for women with pre-existing type 2 diabetes, who are planning pregnancy, are pregnant, or are in the early postnatal period, with participants emphasising potential benefits for maternal and fetal outcomes and noting the precedent of currently available CGM access in type 1 diabetes for preconception, pregnant and postnatal women.

Views on funded access to CGM for women with gestational diabetes were mixed. Some participants supported access to CGM for this population, particularly given the short window for intervention during pregnancy, the potential to use CGM as a temporary or pregnancy-limited intervention, and the possible benefits for maternal and fetal outcomes. Others considered the evidence base is still emerging for this population, with current evidence demonstrating minimal benefit for pregnancy outcomes, and therefore did not support routine publicly funded CGM access for women with gestational diabetes alone. One participant specifically highlighted that there may be potential for increased risk of small for gestational age in babies born to mothers using CGM, which may result from increased restriction of carbohydrate intake and overtreatment.

There was stronger agreement on extending access for people with type 3c and other insulin-requiring conditions similar to type 1 diabetes, including cystic fibrosis-related diabetes, diabetes after pancreatectomy, mitochondrial-related diabetes and similar conditions. Participants described these groups as highly vulnerable to glycaemic instability and hypoglycaemia. It was noted that some people with these conditions currently lose funded access to CGM after age 21 despite ongoing need, and argued that the eligibility wording should be broad enough to capture all people with insulin-requiring conditions similar to type 1 diabetes rather than narrowly restricting access to people with type 3c only.

One stakeholder also raised glycogen storage diseases (GSD) as a rare but relevant group in whom CGM may have value. It was noted that some people with these conditions have very short fasting tolerance and are managed with regular feeding, uncooked cornstarch, or overnight continuous feeds

via a nasogastric tube (tube feeds) to avoid acute hypoglycaemia. In this context, participants suggested that intermittent CGM may be useful in milder forms, such as types 3, 6 and 9 GSD, to profile glucose patterns and fasting tolerance a few times each year, while more continuous monitoring may be valuable in people with frequent and unpredictable changes in blood glucose levels, such as type Ia or Ib GSD, to improve overnight safety and detect feed interruption or hypoglycaemia.

Short-term or intermittent use of CGM

Stakeholders considered intermittent or time-limited CGM a potentially useful option, particularly where continuous access for all eligible groups may not be feasible. Suggested uses included:

- at diagnosis;
- during treatment initiation or intensification (such as when a person is newly commencing insulin therapy and requires support with education and dose adjustment);
- when there are suspected hypoglycaemic episodes or unstable glucose patterns;
- before major surgical procedures;
- during periods of clinical destabilisation such as steroid treatment, cancer therapy or other major changes in health status.

Some participants also considered intermittent use may be helpful in pregnancy-related contexts. A stepwise model was also proposed, in which short-term CGM could be used initially for eligible populations and ongoing access considered if clinically important hypoglycaemia, high glucose variability or other indicators of need are identified. This approach would also avoid the need to rely on a HbA1c threshold to determine eligibility which many participants had argued could be problematic. Indicative examples raised of intermittent use included funded access to one sensor every three months, coinciding with the routine frequency of HBA1C monitoring, which would equate to 10-14 days of usage (depending upon the sensor). At the same time, some participants emphasised that continuous use is associated with better outcomes, particularly for people requiring intensive insulin therapy, and cautioned that intermittent access should not become a substitute for continuous CGM in groups with sustained safety needs.

Equity issues

Equity concerns were a major theme throughout the discussion. Participants repeatedly noted that restrictive rules around which healthcare professionals could authorise funded CGM access could increase inequity for people in rural, regional and remote areas, Aboriginal and Torres Strait Islander communities, younger people, and others with limited access to endocrinology services, which can currently authorise funded CGM access for people with type 1 diabetes. Many supported allowing general practitioners (GPs), and in some cases nurse practitioners, to authorise CGM access, provided there are clear referral pathways to specialist endocrinology services, training and support. One participant supported GP certification of eligibility only in the case of intermittent use. It was emphasised that successful implementation of GP authorisation of funded CGM access would require adequate education, and support for troubleshooting and sensor data interpretation for both clinicians and consumers, including support from manufacturers and diabetes services, so that access is meaningful in practice rather than nominal. At the same time, some participants cautioned that highly specialised rare conditions may still require specialist oversight. More broadly, stakeholders stressed that restrictive eligibility criteria and specialist-only access could unintentionally exclude the populations most likely to benefit.