National Diabetes Roadmap 2026

Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora

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Foreword

Diabetes is one of the greatest and most-persistent health challenges we face in New Zealand. It affects hundreds of thousands of people and impacts significantly on health outcomes. Without meaningful change, both the human and economic cost of diabetes will continue to rise.

Health New Zealand | Te Whatu Ora's recent baseline review revealed that while numbers of families affected and economic costs are scaling rapidly, so too is the impact on people's lives. Māori and Pacific peoples experience earlier onset, higher complication rates and poorer outcomes from diabetes.

The National Diabetes Roadmap (NDR) sets out clear directions for addressing these challenges. It recognises that diabetes cannot be managed through individual effort alone. Responding to these challenges requires system-level leadership, ongoing commitment and a shift in how we work together across the health system and beyond, into our homes and communities.

This NDR was built on extensive engagement with people and their whānau living with diabetes, clinicians, health providers and subject matter experts. It is based on lived experience coupled with evidence. It reinforces our growing understanding that earlier intervention and strong community partnerships are essential if we are to improve outcomes.

With the announcement of this Roadmap, I note the progress that has already been made. We have clinical leadership structures in place, a baseline review was held to better-inform our investment process and several pilots and programmes are already underway within our communities to help build our capabilities against diabetes. The NDR brings this work together, providing clear direction, prioritisation and accountability.

The NDR is also honest about the scale of the task ahead. Diabetes is a complex, chronic condition that requires a long-term response. Success will depend on continuous efforts from clinicians, communities, Māori and Pacific partners and the wider health and social sectors.

I see the NDR as a commitment – to act earlier, to work differently and to place the wellbeing of our people and whānau at the centre of our motivation to change the trajectory of diabetes. Our responsibility is not only to manage the growing demand for care but to address the conditions that lead to these illnesses in order that we might achieve a healthier future.

Dr Dale Bramley

Chief Executive

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Executive summary

Intent

The National Diabetes Roadmap (NDR) sets out a direction that will address the growing health needs of people living with diabetes in New Zealand. Central to the plan is a strong commitment to an equity-focused approach. The Roadmap will guide the development of a detailed implementation action plan that has prioritised actions, costings and timelines.

The NDR is based on consultation with patients and families living with diabetes, specialists, clinicians and health providers. Six working groups identified the key most impactful, evidence-based action areas and initiatives to address the growing incidence of diabetes in New Zealand.

A significant milestone was the establishment of the Mahitahi Matehuka National Diabetes Network (MM.DN) to provide strong diabetes leadership and clinical expertise. The MM.DN represents lived experience, multidisciplinary clinical expertise and diabetes organisations to provide diabetes leadership for Health NZ | Te Whatu Ora.

A key recommendation to emerge was the need for a Diabetes Baseline Review. The analysis, which collated the 2024 diabetes related expenditure under Vote Health (totalling $2.1 billion) has been completed. There were limitations by current data architecture and management, therefore, the total spend exceeds what has been accounted for in the Review. The forecast of increasing expenditure highlights the need for a planned response to the growing incidence of diabetes in Aotearoa New Zealand.

To ensure the delivery of the NDR, an Oversight Group has been established to lead the development of an implementation plan, oversee milestones and outcomes, and provide challenge and assurance to Health New Zealand of delivery. This group will work alongside the MM.DN who will identify and progress clinically focused priorities and collectively support the initiatives and emerging clinical priorities.

The current landscape of diabetes in New Zealand

Diabetes is one of the leading contributors to health loss in New Zealand. Māori, Pacific and Indian populations consistently experience higher rates of hospital admissions. Additionally, mortality rates related to diabetes are higher, particularly type 2 diabetes, than non-Māori, non-Pacific and non-Indian populations.[1] It is the leading cause for people developing blindness and renal failure, and results in preventable lower limb

[1] Yu, D. etal. (2021). Ethnic differences in mortality and hospital admission rates between Māori, Pacific, and European New Zealanders with type 2 diabetes between 1994 and 2018: a retrospective population-based, longitudinal cohort study. *Lancet Global Health*, 9(e209-17).

amputations and has a significant impact on the mental and physical wellbeing of families.

In New Zealand, this harm is felt most acutely and inequitably in our Māori[2], Pacific, and Indian communities. The prevalence of diabetes among Pacific peoples is approximately four times the rate of European people. Māori[3], Pacific, and Indian communities experience a higher prevalence of diabetes, earlier onset, higher mortality and complication rates, and greater health loss compared with other population groups.

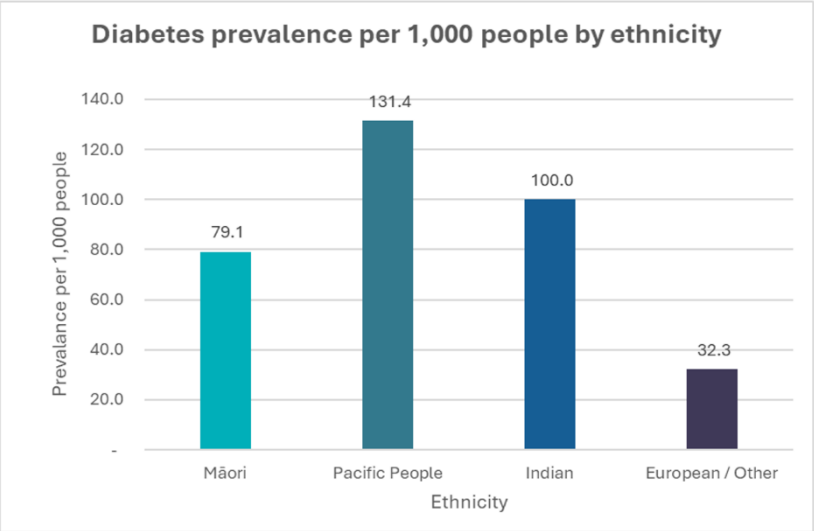


Figure 1: Estimated prevalence of diabetes per 1000 people, by ethnicity group in New Zealand. VDR 2024[4]

There are an estimated 348,527 people in New Zealand living with diabetes in 2024 (age standardized prevalence of 4.7%). The estimated cost to Health New Zealand is around ~$2.1 billion (8.15% of Vote Health Funding). The prevalence of type 2 diabetes is projected to increase to ~509,000 (8.4% of the population) and the economic cost for Vote Health is expected to double by 2040.

The causes for diabetes-related inequities experienced by Māori, Pacific and Indian populations are complex, intersectional, intergenerational, and compounding. Barriers to access to healthcare and differences in the quality of care are recognised as perpetuating inequities for priority populations [2].

Diabetes is a complex metabolic condition that touches all parts of society. The NDR requires systemic, multilevel solutions (including outside of health) to effectively

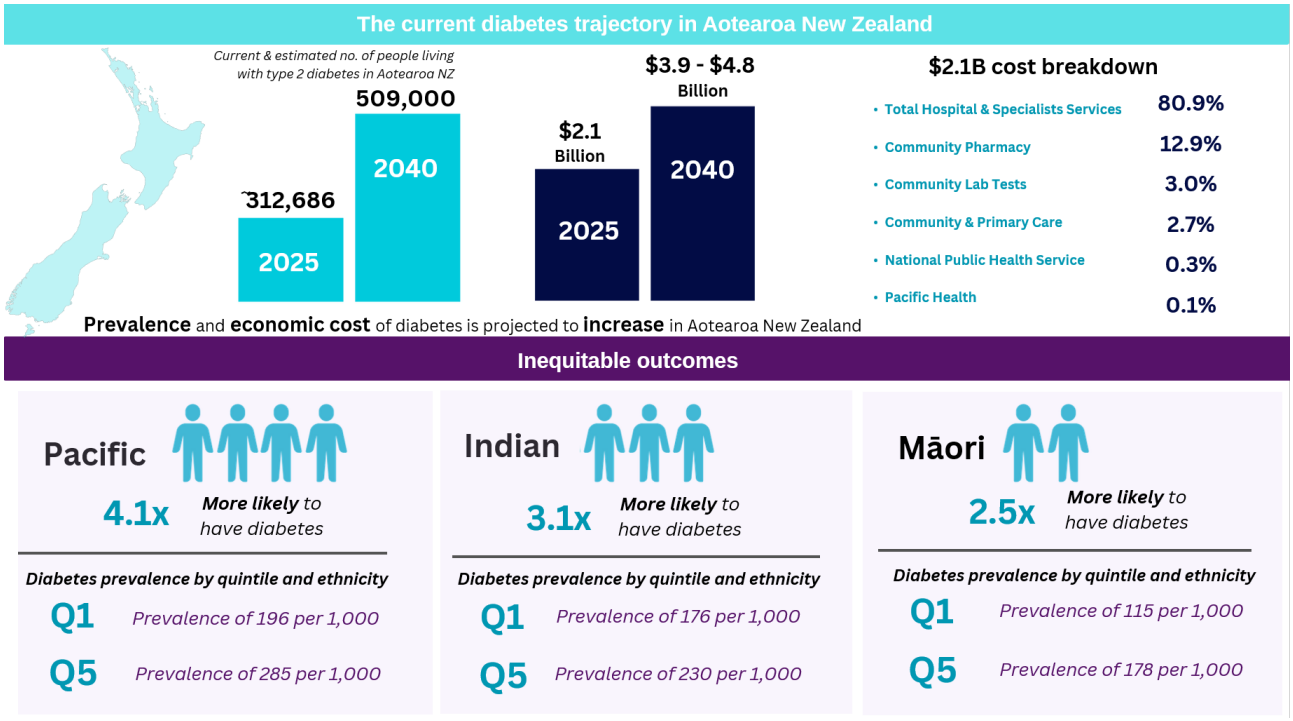
[2] Curtis E, Loring B, Harris R, McLeod M, Mills C, Scott N, & Reid P. (2022). Māori health priorities. A report commissioned by the interim Māori Health Authority to inform development of the interim New Zealand Health Plan. Te Aka Whai Ora.

[3] Curtis E, Loring B, Harris R, McLeod M, Mills C, Scott N, & Reid P. (2022). Māori health priorities. A report commissioned by the interim Māori Health Authority to inform development of the interim New Zealand Health Plan. Te Aka Whai Ora.

[4] Te Whatu Ora. (2024). Virtual Diabetes Register web tool (Data file). URL: **https://tewhatuora.shinyapps.io/virtual-diabetes-register-web-tool/**

address the distribution of, and access to, the socio-economic and cultural determinants of health.

Without significant and urgent change, the diabetes trajectory will continue to create a significant burden on both the health system, wider economy and the quality of life of our communities.



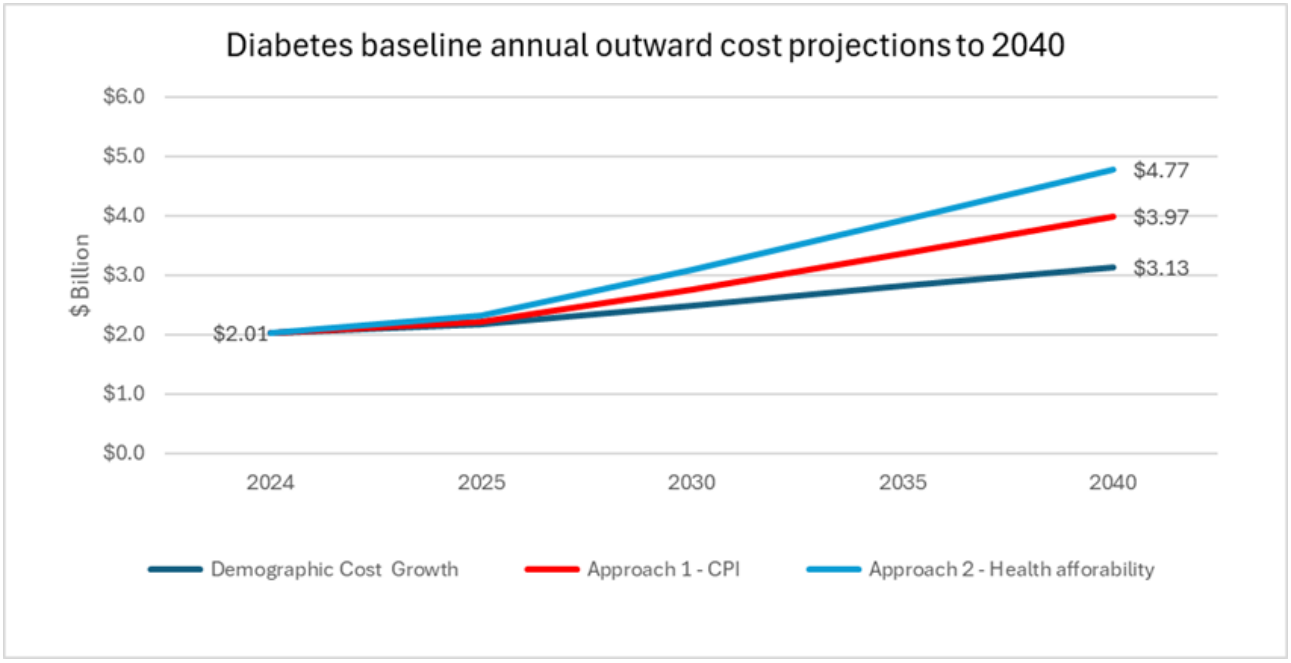
The benefits

The NDR aims to significantly reduce the forecasted social and economic costs of diabetes. While there is no single conclusive estimate of these costs, various reports over the past few decades have consistently identified diabetes as one of the greatest disease burdens to New Zealand. A crucial part of NDR will be to establish the models and measurement capabilities required to better estimate costs and understand benefits.

The actions in the NDR require prioritisation, planning and costing as national and service planning occurs, and funding is available. Various actions may be implementable immediately within baseline funding, while others require additional scoping and case development.

Connection into local planning and community delivery will be essential to improve diabetes outcomes for all families in New Zealand with priority groups requiring targeted interventions, including Māori, Pacific and Indian families; rural communities; youth; people who experience gestational diabetes; people living with type 1 diabetes; and people with consistently high glucose levels.

Health New Zealand's spend for diabetes care is projected to increase from $2.1 billion in 2024/25 to between $3.9 billion and $4.8 billion in 2040, assuming no changes to models of care or service delivery models. This is an average increase of ~$172 million per year.



Source: Health NZ Diabetes Review November 2025

It is important to note that New Zealand currently has a different diagnostic cut-off to the rest of the world which results in the number of people with diabetes being under diagnosed by approximately 10%. Changing the HBA1c diagnostic threshold of diabetes and prediabetes has been identified as an important step forward. This will shift the focus from low-risk prediabetes to early intervention in high-risk groups to reduce complications, costs and disparities in care and align with international standards.

The NDR will therefore provide broader economic benefits as well as significant wellness benefits to people and families, including additional benefits related to type 1 diabetes that have not yet been estimated.

Key action areas

There are five key actions areas with initiatives of highest impact:

A. Strong leadership to transform diabetes in New Zealand.

B. Slowing the progression of diabetes through proactive interventions.

C. Improving access and quality of care for families experiencing diabetes.

D. Strengthening the diabetes workforce and leveraging modern technologies.

E. Confronting the drivers of diabetes.

A. Strong leadership to transform diabetes in New Zealand

Establish and provide strong leadership to transform diabetes in New Zealand

i. Establish National Diabetes Clinical Network to provide diabetes leadership and clinical expertise.

ii. Active partnership and collaboration with Pharmac to ensure an optimal range of technologies and medicines is funded for diabetes-related care.

Baseline review and cost of diabetes

iii. Scope and deliver a baseline review of diabetes services across Health New Zealand.
This will provide an in-depth view of expenditure on diabetes care and management on our health system, informing future investment planning.

Develop a National Diabetes Register to enable responsible clinicians to access and update actionable information at multiple points of care, thereby supporting diabetes-related services such as retinal screening and the management of diabetes.

iv. Investigate the costs of extending work on the Health Data Platform to include a functional National Diabetes Register that provides robust, actionable information to support clinical care.

v. Develop a people-centric diabetes register that is part of a population register, covering a range of long-term conditions, with provision to enable targeted support for people with unmet need.

B. Slowing the progression of diabetes through proactive interventions

Ensure gestational diabetes postnatal follow-up and intervention.

i. Publish the diabetes in pregnancy guidelines.
ii. Deliver wrap-around lifestyle interventions and support for people with gestational diabetes during pregnancy and postnatal.
iii. Monitor provider adherence to postnatal HbA1Cs for people with gestational diabetes.

Ensure equitable access to weight management therapies.

iv. Create new surgical bariatric pathways to ensure equitable access for priority populations including pre and post-surgical care for people receiving bariatric surgery.
v. Fund evidence-based medical bariatric clinics.
vi. Expand and support access to primary/community weight management initiatives.

C. Improving access to quality care for families living with diabetes

Targeted prevention lifestyle interventions

i. Fund targeted outreach, education, and support services to promote healthy behaviours and prevent the development of long-term conditions.
ii. Evaluate, fund and scale-up successful diabetes prevention and management programmes led by priority populations, rural communities and NGO's.

Improve access to a range of interventions to support diabetes remission for people with newly diagnosed diabetes

iii. Programmes that support type 2 diabetes remission.

Increase access to retinal photoscreening

iv. Increase access to retinal photoscreening in primary and community care settings by expanding the capability of the kaiāwhina workforce.
v. Evaluate the role of Artificial Intelligence (AI) in supporting retinal photoscreening.

Improve foot screening and foot care

vi. Pilot a Foot Care Assistant Level4 micro credentialing pilot programme.
vii. Develop MDT footcare clinics in the community.

Improve access and appropriate use of medications for people with diabetes

viii. Align New Zealand's diagnostic threshold for diabetes and pre-diabetes with international standards to facilitate timely and appropriate diagnosis of diabetes and to minimize the risk of overdiagnosis of pre-diabetes.
ix. Support the use of medicines with an equity focus by improving access and appropriate use.
x. Develop and publish combined cardiovascular, kidney, and metabolic guidelines to support the optimal use of medicines based on international best

Provision of continuous glucose monitors (CGMs) for type 2 diabetes management

xi. Support provision of CGMs for people most likely to benefit.

D. Strengthening the diabetes workforce and leveraging modern technologies

Provide the workforce and families with digital tools and technology, that enable optimal management and reduce the administration burden.

i. Investigate digital systems used to deliver diabetes care in community and primary care settings, and identify opportunities to optimise management, administration tasks and interoperability.
ii. Support the development of digital systems that enable family-centred diabetes management applications.

Training, upskilling, and provide continuing professional capabilities

iii. Advocate for registered nurse prescribers to prescribe all internationally recognised and proven medications for diabetes to improve equitable access to medicines.
iv. Fund the training and employment of diabetes-specific unregulated workforce (e.g. kaiāwhina), with a focus on growing the Māori and Pacific workforce.
v. Fund diabetes-related continuing professional education for registered health professionals.
vi. Upskill the Healthline workforce to ensure diabetes advice is clinically and culturally safe, and responsive to the needs of people living with diabetes.

Grow and diversify the primary and secondary diabetes workforce

vii. Identify and influence allocation of Health Workforce Plan resources, with a focus on priority populations in diabetes-specific roles, including:
    - Registered dietitians, specialising in diabetes
    - Diabetologists, specialist endocrinologists
    - Kaiāwhina, non-regulated workforces and community leaders
    - Mental health support including psychologists' expert in diabetes
    - Diabetes midwife specialists, maternity
    - Nurse practitioners, diabetes nurse specialists, registered nurse prescribers
    - Ophthalmologists, optometrists
    - Podiatrists' expert in the diabetic foot, orthotists
    - Prescribing pharmacists
    - Physiotherapists
    - Social workers

viii. Increase and fund the frontline diabetes workforce.

ix. Expand integrated models of care to increase equitable access to specialist services for management of diabetes primary care.

E. Confronting the drivers of diabetes

The health system is advancing a range of initiatives to create healthier environments and reduce non-communicable diseases by addressing modifiable risk factors such as nutrition, physical activity and harmful alcohol use.

Addressing the social and commercial drivers of diabetes - *Public health interventions*

i. Review the national weight management guidelines.

ii. Funding work with industry to reduce sugar in processed food and beverages

iii. Partnering across government to address food insecurity and improve food policy.

iv. Building health-promoting environment in schools, workplaces and health care settings.

v. Supporting community-led action to improve nutrition and increase food security

vi. . Using the alcohol levy to support alcohol harm prevention and minimisation initiatives, including community led action.

vii. Updating New Zealand's "low risk drinking guidelines" and alcohol and health advice.

viii. Updating the national nutrition guidelines for children and young people.

Achievements

The approach for diabetes in New Zealand has been in development since 2023. Therefore, it is important to acknowledge there has been progression of some key actions and initiatives in the NDR. Achievements include:

i. Establishment of Mahitahi Matehuka National Diabetes Network to provide clinical leadership focused on identifying and progressing clinical priorities in the NDR.

ii. Undertake a Diabetes Baseline Review which has collated the FY2024/25 diabetes related expenditure under Vote Health totalling $2.1 billion.

iii. Diabetes Retinal Screening Model of Care pilot has been completed. This pilot has tested increasing access to retinal photoscreening in primary and community care settings by expanding the capability of the kaiāwhina workforce.

iv. Integrated Diabetes Model of Care pilot has been completed. This pilot has focused on Pacific peoples and tested culturally grounded, community-led and integrated models of care which delivered tailored interventions focused on prevention, management and remission of Type 2 diabetes.

v. Registered nurse prescribers can prescribe all internationally recognised and proven medications for diabetes, facilitating equitable access for whānau.

The actions that have progressed to date have utilised baseline funding allocations. The completed pilots are being evaluated as part of a quality improvement approach to inform on-going development, effectiveness and sustainability.

Next steps

Key actions that will be delivered during the January to June 2026 period:

i. Publish the National Diabetes Roadmap and Diabetes Baseline Review
ii. Establish a National Diabetes Roadmap Oversight Group
iii. Develop a Diabetes Roadmap Implementation Plan with priorities, actions and costings.

Conclusion

The NDR is a comprehensive, equity-focused strategy that seeks to significantly impact the diabetes epidemic in New Zealand through prevention, early intervention, and high-quality care. By actively addressing systemic inequities and ensuring meaningful

community involvement in the design and delivery of solutions. The NDR aims to significantly reduce the burden of diabetes on patients, whānau, and the healthcare system.

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