



# European Coalition for Diabetes

Working together for people living with diabetes across Europe

**EURADIA**  
*Alliance for European Diabetes Research*

**FEND**  
*Foundation of European Nurses in Diabetes*



**International  
Diabetes Federation  
Europe**

**PCDE**  
*primary care diabetes europe*

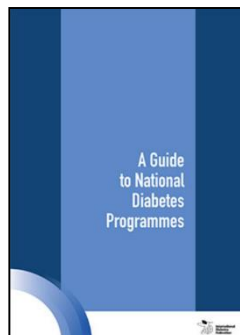


## Diabetes: a case study on strengthening health care for people with chronic diseases

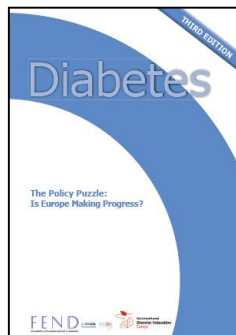
**Anne-Marie Felton**  
**European Coalition for Diabetes**  
Vilnius, Lithuania  
6 November 2014

# Diabetes: the policy story so far

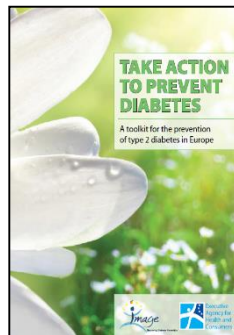
A considerable body of strategic evidence, good practice and many calls to action



Guide to National Strategies  
IDF Europe  
(2010)



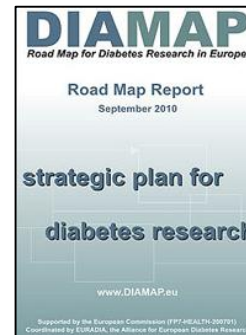
Diabetes: Policy Puzzle  
FEND, PCDE,  
EURADIA, IDF-Europe  
(2012)



Take Action to Prevent Diabetes  
IMAGE (2010)



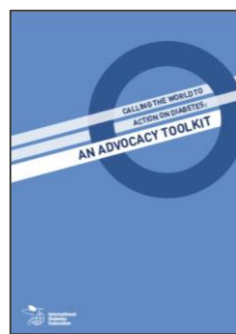
Diabetes Advocacy and Comms Toolkit  
IDF Europe  
(2010)



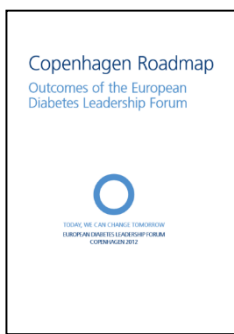
Road map for diabetes research in Europe  
EURADIA  
(2010)



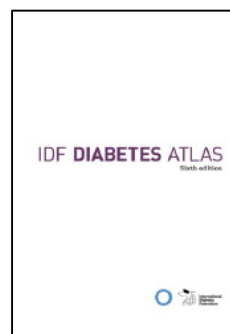
Joint Guidelines  
ESC & EASD  
2013



Diabetes Advocacy Toolkit  
IDF 2012



Copenhagen Roadmap  
EDLF & OECD  
(2012)



Diabetes Atlas (6<sup>th</sup> ed)  
IDF (2013)



ExPAND Policy Diabetes Toolkit  
ExPAND Group  
(2014)

# Diabetes: social and economic sustainability

More people in Europe living with diabetes:

Projected increase of **14m by 2035**  
...from **56m to 70m**

...more children with T1D and T2D <sup>(1)</sup>



Higher costs to healthcare:

...10% of all costs in 2013  
... cost increase from €109bn to  
**€117bn by 2035** in Europe: <sup>(1)</sup>

Major economic burden:

Indirect costs over **€100bn** in  
EU5 alone in 2010 <sup>(2)</sup>  
...and set to rise



# Inequalities in diabetes: key facts

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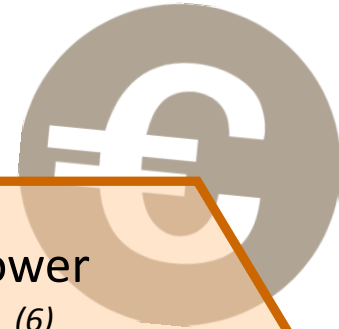
- Socially excluded and vulnerable groups face a higher burden of diabetes and greater barriers to prevention and care. <sup>(1)</sup>
- The risk of developing diabetes is **2.5 higher** in the lowest socio-economic groups than the general population, and up to **6 x** more likely in black and minority ethnic groups. <sup>(2)</sup>
- Burden of depression, pain and COPD approximately **double** amongst poorest people with diabetes vs the richest <sup>(3)</sup>
- WHO: health literacy of people with diabetes a priority, <sup>(4)</sup> levels grossly inadequate across Europe, particularly amongst poorerst <sup>(5)</sup>
- Disadvantaged groups have been shown to face barriers to quality and consistent preventative services and poor care due to low staff morale and low awareness of diabetes prevention <sup>(6)</sup>

## **IDF Consensus:**

*Screening and prevention programmes in diabetes must be sensitive to the needs, cultural and religious norms of individuals and ensure their involvement in intervention design and delivery to achieve maximum success. <sup>(7)</sup>*

# KEY INVESTMENT 1: diabetes prevention

Between 10-20% of us are living with pre-diabetic conditions... (1,2)



## Investment

## Why is this important?

## Return on investment

**Prevent diabetes in people at risk**

We could **halve** the number of people with Type 2 diabetes. (3,4,5)

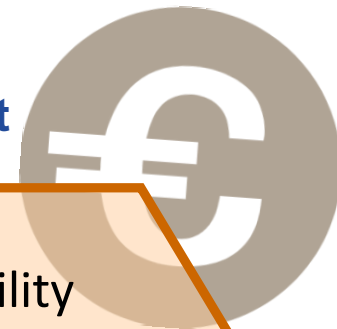
- Fewer deaths, lower healthcare costs (6)
- Increased social and economic productivity (6)

### How we do it:

- **Target** intensive behavioural change at people at high risk (e.g. diet, exercise, weight loss) ✓
- **Integrate** new educator roles into community care ✓

# KEY INVESTMENT 2: early diagnosis

Up to half of all cases of diabetes are undiagnosed. <sup>(1,2,3)</sup>



## Investment

## Why is this important?

## Return on investment

**Catch and treat diabetes as early as possible**

**Prevent or delay complications** <sup>(3-5)</sup> such as heart disease, stroke kidney disease, amputation

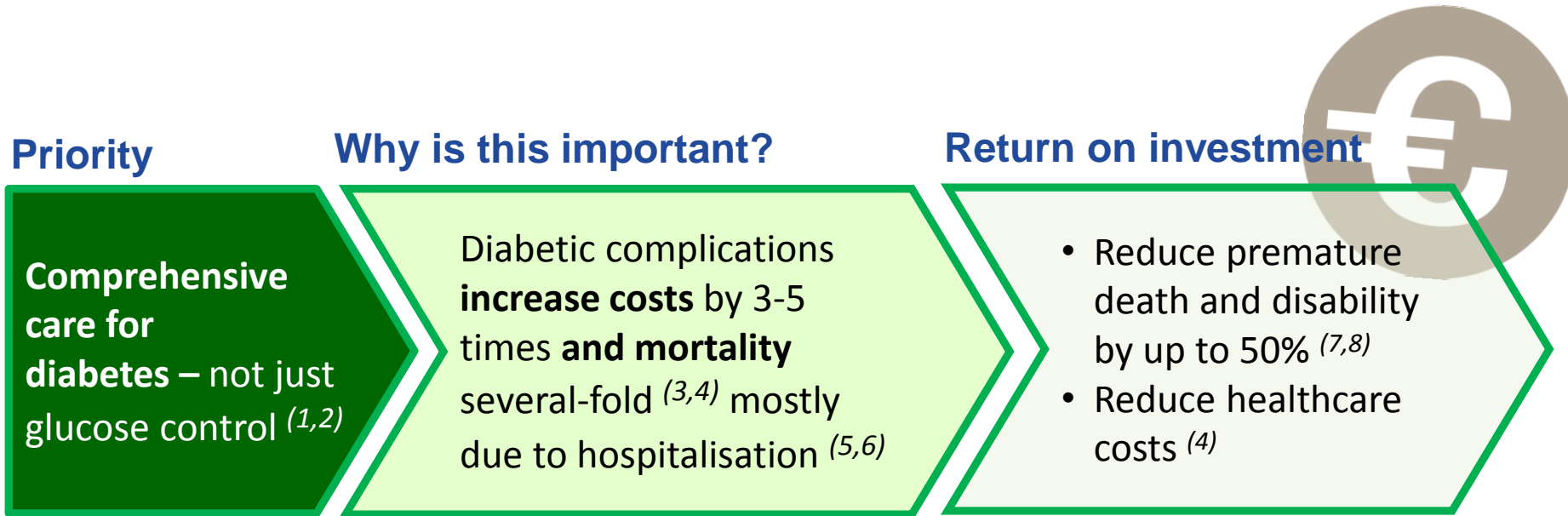
- Reduced disability and dependency <sup>(3-5)</sup>
- Fewer hospitalisations <sup>(3-5)</sup>

### How we do it:

- **Adopt** easy-to-use screening tools in everyday practice ✓
- **'Make every contact matter'** across all services ✓

# KEY INVESTMENT 3: person-centred care

Complications of diabetes include heart disease, stroke, and damage to eyes, kidneys, and nerves. <sup>(1,2)</sup>



## How we do it:

- **Control associated risk factors** (e.g. blood pressure, cholesterol and obesity) and **prevent complications**
- **Identify and remove** barriers to multi-disciplinary care



# KEY INVESTMENT 4: support to self-manage

Experts recognise the limits of 'paternalistic' medical models in improving diabetes care. <sup>(1,2)</sup>

Only 50% of patients currently achieve satisfactory glucose control <sup>(3)</sup>



## Priority

## Why is this important?

## Return on investment

**Patient education for self-management**

95% of diabetes management is self-management. <sup>(4)</sup>

- Better adherence <sup>(5,6)</sup>
- Improved glucose control and quality of life <sup>(5-9)</sup>
- Reduced healthcare costs <sup>(6,9)</sup>

## How we do it:

- **Provide** education by trained professionals to all people with diabetes
- **Adapt** education to disadvantaged groups
- **Ensure** basic medical supplies for daily self-management





# Making it happen: 4 gaps

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- NATIONAL LEADERSHIP
- RESEARCH & DATA
- INTEGRATED CARE
- EMPOWERMENT AND EQUAL ACCESS

**Addressed in the  
*European Parliament resolution of 14 March 2012 on  
addressing the EU diabetes epidemic  
(2011/2911(RSP))***

# NATIONAL LEADERSHIP

## **We need:**

- ✓ Adoption of diabetes and chronic disease as a major, pan-governmental priority for social and economic sustainability
- ✓ National strategies for the prevention, care and management of diabetes
- ✓ Funding for research, prevention, care and management of diabetes that reflects burden of ill health and enormous cost of failure

## **Yet in 2014:**

- ✗ Economic case for diabetes care seemingly poorly understood by governments <sup>(1,2)</sup>
- ✗ National diabetes strategies rare, and those that exist often poorly implemented <sup>(1)</sup>
- ✗ Diabetes a low priority for funding relative to other diseases <sup>(3)</sup>

# RESEARCH AND DATA

## We need:

- ✓ National registries and standardised data across and between countries <sup>(1)</sup>
- ✓ Monitoring and incentives systems based on consistent and accurate diabetes indicators (both processes and outcomes), with indicators endorsed by patients <sup>(1)</sup>
- ✓ Better information on cost effectiveness at the national and regional level

## **Yet in 2014:**

- X** Little understanding of true costs of diabetes, both direct and indirect <sup>(2)</sup>
- X** Process-driven reimbursement and poor financial accountability the norm <sup>(2)</sup>
- X** National diabetes registries in only half of all European countries, but those that exist often incomplete <sup>(2)</sup>
- X** No European clearing house for diabetes data

# INTEGRATED PREVENTION & CARE

## We need:

- ✓ Clinical guidelines for comprehensive management of diabetic co-morbidities alongside glucose control, protocols for joint working / information sharing
- ✓ National programmes to mainstream cost-effective and proven models of diabetes prevention, diagnosis and care into the community <sup>(1)</sup>
- ✓ Expansion of community nurse and educator roles, health checks and diabetes screening <sup>(1)</sup>

## **Yet in 2014:**

- X** Most GPs single handed, shortage of nurse and educator roles
- X** Disappointing progress in delivering comprehensive care models <sup>(2)</sup> and even basic care <sup>(3)</sup>
- X** Delay to diagnosis still as long as 7 years <sup>(4)</sup>
- X** Existing societal efforts to prevent chronic disease grossly insufficient <sup>(5)</sup>

# EMPOWERMENT & EQUALITY

## We need:

- ✓ Patient therapeutic education for self-management and care planning
- ✓ Citizen involvement in care
- ✓ Better understanding of barriers and outreach for excluded groups
- ✓ Urgent investment in health literacy approaches
- ✓ Fair access to care and basic supplies for all

## Yet in 2014:

- ✗ Limits in access to even the most basic care persist across Europe <sup>(1,2)</sup>
- ✗ Products on the market vary by country, even in EU, as dictated by varying clinical and cost containment criteria, and even supply issues <sup>(1)</sup>
- ✗ Price control regulation key but yet to be extended to all Europe/all diabetes products <sup>(1)</sup>
- ✗ Health literacy a major barrier, especially in deprived groups

# Conclusion

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## **WE HAVE**

- *the evidence*
- *the proven models for implementation*

## **WE NEED**

- *national strategies and effective leadership on diabetes and chronic disease*
- *better data, better accountability for outcomes*
- *new community-based prevention, care and management in diabetes*
- *to reach out to disadvantaged groups where the greatest burden of ill health lies*

**WE NEED TO ACT NOW**



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**International  
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**PCDE**

*primary care diabetes europe*



## Thank you

**Anne-Marie Felton**

European Coalition for Diabetes

Vilnius, Lithuania

6 November 2014

# The Joint Action on Chronic Diseases and promoting healthy ageing across the life cycle (JA-CHRODIS)\*

**\* THIS PRESENTATION ARISES FROM THE JOINT ACTION ON CHRONIC DISEASES AND PROMOTING HEALTHY AGEING ACROSS THE LIFE CYCLE (JA-CHRODIS) WHICH HAS RECEIVED FUNDING FROM THE EUROPEAN UNION, IN THE FRAMEWORK OF THE HEALTH PROGRAMME (2008-2013)**

