



THE 2014 EU SUMMIT ON CHRONIC DISEASES
Addressing the medical, social and economic burden of chronic diseases in the EU
Brussels, 3 and 4 April 2014

How do health systems respond to the challenge of diabetes

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Diabetes

is a common disease: 382 million people have diabetes in 2013;
by 2035 this will rise to 592 million
prevalence in Europe: 2.44-14.85

is a serious disease: diabetes increases the risk for many serious
health problems (hypertension, CVD, eye problems,
neuropathy, foot complications, nephropathy,...)

its complications can be prevented and controlled using
available knowledge

Diabetes can be prevented and controlled using available knowledge



The challenge facing health policy-makers today is how to put in place a response that better meets the needs of people with complex chronic health problems as diabetes.

Many health systems are still largely built around an acute, episodic model of care.

Responding to the challenges of a changing world

On the whole, people are healthier, wealthier and live longer today than 30 years ago

but

the nature of health problems is changing

the burden of chronic diseases increases

individuals present with complex symptoms and multiple illnesses

and

the substantial progress in health has been deeply unequal

What is health?

“...complete physical, mental, and social wellbeing.”

WHO 1948



“...the ability to adapt and self manage in the face of social, physical and emotional challenges.”

Organization of health-care delivery to improve the quality of care for people with chronic diseases

Putting people first

Person-centredness

Comprehensiveness and integration

Continuity of care

Regular point of entry into the health system

Enduring relationship

Chronic care model

Wagner 1998

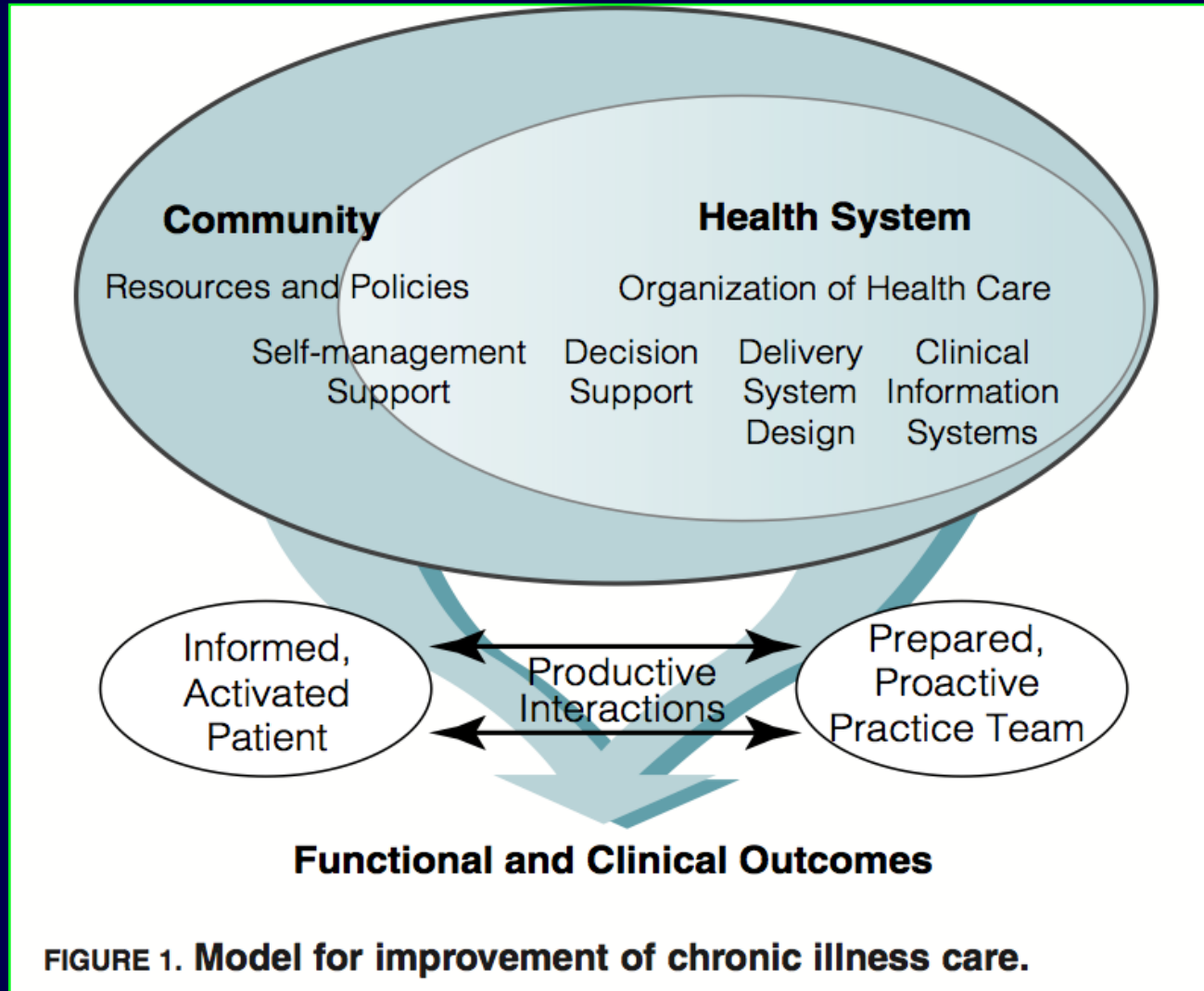


FIGURE 1. Model for improvement of chronic illness care.

“...we can improve care and outcomes. As the articles suggest, these improvements will not come easily.”

Four interacting components are considered key to providing high-quality care for those with chronic health problems:

- self-management support
- delivery system design
- decision support
- clinical information systems

Diabetes is considered a paradigm of chronic disease, and is often the first focus of many changes in disease management



The book brings together the approaches adopted by eight countries:

- Denmark, England, France, Germany, The Netherlands, Sweden
- Canada, Australia

Examination of the current situation through comparison of the "journey" in the health care system of a fictitious person with diabetes: 54-year-old-woman with type 2 diabetes, and co-morbidities,

The approaches adopted reflect the characteristics of each health system, in terms of their governance

Some common features

- multidisciplinary teams
- progressive introduction and strengthening of the coordination, continuity and interdisciplinarity of health care provision
- progressive increase in the role of nurses in managing many chronic diseases (nurse-led clinics, case management,...)



Some common weaknesses

- Care for people with chronic conditions not considered prestigious among health care professionals
- Fragmentation of care
- Staff shortages
- Lack of educational programmes and structures and of community resources
- GPs' reluctance to be involved in interdisciplinary teams
- Policy is greatly influenced by electoral cycles

Integrated care is what we all want

BMJ 2012; 344 doi: 10.1136/bmj.e3959 (Published 7 June 2012)

Cite this as: BMJ 2012;344:e3959

Fiona Godlee, editor, BMJ

Integrated care is one of those concepts that's hard to argue against.

Who among us would not want hospital staff to work closely with primary, community, and social care services?

If, by integrated care, we mean seamless, high quality care, it's obviously desirable.

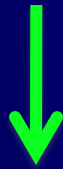
So why is it so hard to achieve? And why do we struggle to deliver it?

Sceptical, suspicious, unwilling, and obstructive clinical colleagues seem to have been the main opposition.

How do health systems respond to the challenge of diabetes



CHRODIS – Joint Action on chronic diseases



WP7 - Diabetes: a case study on strengthening health care for people with chronic diseases



WP7

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

Objectives

- To improve coordination and cooperation of Member States
 - To focus on aspects of primary prevention, identification of people at high risk, early diagnosis, secondary prevention, and comprehensive multifactorial care, with attention to equity, and how social determinants may affect people's access to care
 - To explore the significance of health literacy and patient empowerment
 - To support the development and implementation of Member States' National diabetes plans
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Expected outcomes

A set of good practices to address type 2 diabetes in a comprehensive manner in order to support Member States in a pragmatic and rational way towards more efficient diabetes strategies.

Recommendations to improve early detection and preventive interventions, to strengthen health literacy, patient empowerment and training for health professionals especially, and to develop National Diabetes Plans.

WP7 - Tasks

- 1. Prevention of diabetes: focus on people at high risk**
- 2. Secondary prevention of type 2 diabetes**
- 3. Health promotion interventions**
- 4. Education strategies and approaches**
- 5. National diabetes plans**

Identification of existing strategies

analyses and comparisons

recommendations



Knowledge and
expertise sharing



Generation of new
knowledge

All activities of WP7 will by all means support networking to create ground for innovative approaches to reduce the burden of diabetes also at policy level.



crosscutting, connecting & engaging stakeholders across sectors,



Thank you for your attention