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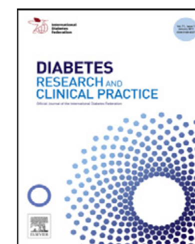
Diabetes Research and Clinical Practice

journal homepage: www.elsevier.com/locate/diabres



Review

Global Diabetes Survey—An annual report on quality of diabetes care

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ARTICLE INFO

Article history:
Received 12 November 2012
Accepted 12 November 2012
Published on line 16 January 2013

Keywords:
Survey
Type 2 diabetes
Quality of care
Diabetes mellitus

SUMMARY

Adequate quality of diabetes care and the best concept for the implementation of national diabetes plans remain controversial. In September 2011 the United Nations High Level Meeting on Non Communicable Diseases agreed on a consensus that national plans for the prevention and control of diabetes should be developed, implemented and monitored. The Global Diabetes Survey (GDS) is a standardised, annual, global questionnaire that will be used to assess responses of representatives from 19 diabetes-related stakeholder groups. It was designed with the goal of generating an annual report on the quality of national diabetes care and to compare findings from different regions and countries. The findings will be freely available for everyone's use and will be used to inform politicians and stakeholders to encourage the improvement of the quality of diabetes care in its medical, economical, structural and political dimensions.

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0168-8227/$ – see front matter © 2013 Published by Elsevier Ireland Ltd.
http://dx.doi.org/10.1016/j.diabres.2012.11.008

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1. Introduction

Currently we are experiencing an epidemic growth in the number of people with diabetes worldwide [1]. An estimated 366 million people, corresponding to 8.3% of the world's adult population has diabetes today but the prevalence is expected to grow to 552 million by 2030, corresponding to 9.9% of the adult population. It goes hand in hand with "westernization" of lifestyle, with consuming more energy-dense food as well as with decreasing physical activity. Driven by this development, diabetes affects more and more young people, especially in their working age. The growing economic burden in complex socioeconomic structures becomes obvious. The development of the diabetes epidemic is predicted to have a significant impact on the global economic growth [2].

This situation requires different approaches from national health care systems depending on national health care structures and their medical, environmental, social and economic means. In order to respond rapidly in a coordinated fashion to the health threat type 2 diabetes and its associated co-morbidities, it is necessary to assess the quality and structures of diabetes care in a standardized way presenting the goals, processes, responsibilities, availability and accessibility of diabetes care before implementation of a national diabetes plan (NDP) [3].

At the United Nations High Level Meeting for Non Communicable Diseases (NCD) in September 2011 in New York Ministers of Health requested an international cooperation and policy decisions on diabetes according to the present context of globalization of health issues [4]. There was a consensus across countries that national plans for prevention and control of chronic diseases be developed and implemented and that strategies to monitor progress on implementation be established. In May 2012 the European Diabetes Leadership Forum was held, hosted by the OECD and the Danish European Presidency, to discuss developing strategies on political, medical and patient centered level for improving diabetes prevention and care. Kofi Annan said at the meeting "*There is no other option than to act – to improve quality of diabetes care*." Key actions to improve the quality of diabetes care worldwide are seen as (1) implementation of diabetes prevention programs, (2) development of chronic care management programs in primary care, and (3) development of monitoring instruments and quality management strategies for diabetes prevention and care [5].

Adequate quality of diabetes care and the best concept for the implementation of national diabetes plans remains controversial. We need to improve our understanding about best "quality of diabetes care" to successfully translate existing knowledge into a sustainable comprehensive diabetes strategy [6].

2. The puzzle of quality of diabetes care

2.1. *Care structures*

Firstly the health care structures in many countries are known, but there is still a big variation in health care structures and systems. The response to ask a colleague about their quality of diabetes care will be that "its good", but a comparative benchmarking about care structures and processes does not exist internationally. The Euro Consumer Diabetes Index provided information about a very high variation of patient perceived quality of diabetes care in Europe [7]. Structures of diabetes care were assessed and further developed by projects like DE-PLAN [8] and monitored through the "Policy Puzzle" initiative [9]. The health care structures in other countries worldwide including developing countries differ significantly in a number of aspects [10]. In many countries diabetes disease management does not exist or is poorly understood. Chronic care management is often far away from developing [11]. The International Diabetes Management Practice Study showed lack of access to health care, cost of medications, and poor insurance coverage and lack of reimbursement for preventive care and diabetes education are major system level barriers to diabetes prevention and control [12]. Provider-level barriers include lack of guidelines for multiple chronic diseases and adherence to guidelines, failure to prioritize among multiple chronic medical issues and fragmentation of care and poor integration of physicians. Patient barriers are primarily related to therapy adherence, lack of diabetes education, low health literacy, lack of motivation, out-of-pocket medication costs and adverse side effects of recommended treatment [13,14].

2.2. *Health policy development*

Secondly health policy development is nationally driven with various competing competences and interests leading to a large variation of National Diabetes Policies [15] and is often lacking an evidence base of standardized assessment of the health care situation and conceptualization. Current projects from the IDF (BRIDGES) and also European projects like SWEET, DIAMAP [16] and GIFT indicate that this heterogeneity will be surpassed by the variation of determinants for policy development especially in low- and middle-income countries. Here a systematic investigation of the main components for the NDP implementation could provide a basis to optimize conditions under which diabetes policy and NDP development can be initiated.

2.3. *Health care professional education*

Thirdly health care professional education is well standardized in Europe (Bologna process) and medical education is standardized in many countries worldwide. A current

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