

Developing or Developed?



Diabetes is a global problem, so it's hardly surprising that integrated care approaches are underway around the world. **Dr Eleanor Kennedy** looks at what healthcare professionals here can learn from Sri Lanka and Sweden

Like inkblots, integrated care can be a tricky one to give a precise meaning to and, to different people, it can mean quite different things. In 2001, a World Health Organisation position paper defined it as 'a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion'¹. More recently, Diabetes UK published a report which stated that, for adults with diabetes, integrated care is about 'designing a system that focuses on the patient's perspective of care'². In this, the charity stressed that the key enablers of integrated care are: integrated IT systems, aligned finances and responsibility, care planning, clinical engagement and leadership and robust clinical governance.

The history of integrated care

The concept of integrated care in diabetes is not a new one. In 1971, Malins and Stuart published a short report about changing the way a small number of patients with diabetes were

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offered care³. Firstly, the hospital responsible for their secondary care offered all the patients the opportunity to be seen there in a single day and, secondly, the GP practice in question invited the staff from the diabetic clinic to visit the practice 'for the benefit of the patients and the instruction of those who were used to working solely in the hospital service'. The conclusions of this experiment were that the hospital team could enjoy 'the opportunity of seeing patients for once under ideal conditions in which the background to diabetes can be discussed in a leisurely way' while the benefits to the GP were that 'He no longer feels that the clinical care of an interesting disease is being taken from him'. Most importantly, however, the patient

groups felt that '...during consultation their personal and social circumstances are fully taken into account'

Although over 40 years since the paper's publication, these conclusions are still as relevant today as they were in the early 1970s. But what does this emphasis on a comprehensive person-centred approach actually mean in terms of day-to-day service delivery, patient management and treatment pathways outside of the UK?

A Tale of Two Countries

In Sri Lanka, diabetes management very much depends on where you live. Dr Prasad Katulanda, Senior Lecturer in Medicine at the University of Colombo, endocrinologist and the immediate past-President of the Endocrine Society of Sri Lanka explained. "Management of diabetes is very diverse and varied in Sri Lanka as it is in many other developing countries." In a country with a population of just over 20 million, patients are managed in both the government and private sectors. However, any patient from anywhere in the country can walk into a government clinic or hospital for diabetes care, if they

want, and he or she is provided with absolutely free treatment. Those who seek treatment in the private sector need to pay for the consultations and treatment from savings or from private insurance policies.

Dr Katulanda continued: "There are many differences in the care of diabetes even within the government sector. In tertiary care hospitals endocrinologist-led diabetes clinics exist. However, there are only about a dozen such clinics across the country. In the majority of these clinics, structured and comprehensive diabetes care is provided including periodic screening for

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complications, education and treatment. But most of the government sector patients are still managed at secondary care hospitals.”

Almost 5,000 miles away in Sweden, integrated care is, perhaps as expected, more standardised in a country famed

for its ‘cradle to grave’ welfare state which is characterised by universal access. Professor Christian Berne, Professor of Medicine at the University Hospital, Uppsala, said that diabetes is essentially treated effectively by multidisciplinary teams consisting of specialist endocrinologists, diabetes nurses, dietitians and psychologists. As in the UK, patients benefit from annual reviews, although there are still issues. “Much of the podiatry assessment is outsourced and patients are examined in private practice,” Prof Berne explained. “Moreover there is a shortage of endocrinology specialists in Sweden and, while some clinics have psychologists as part of the team, not all do.” Looking to bridge some of the skills gaps, from this year, nurses will be able undertake a year of full-time academic study to become specialist diabetes nurses and over 1,200 district nurses have already completed other formal diabetes training

This sentiment is echoed by Dr Stefan Jansson, from the Family Medicine Research Centre at Orebro University in Sweden and family physician, who stresses that, while the multidisciplinary team which encompasses a number of specialists is commonplace in many GP practices across the country, issues remain with access to dietitians and, particularly, to

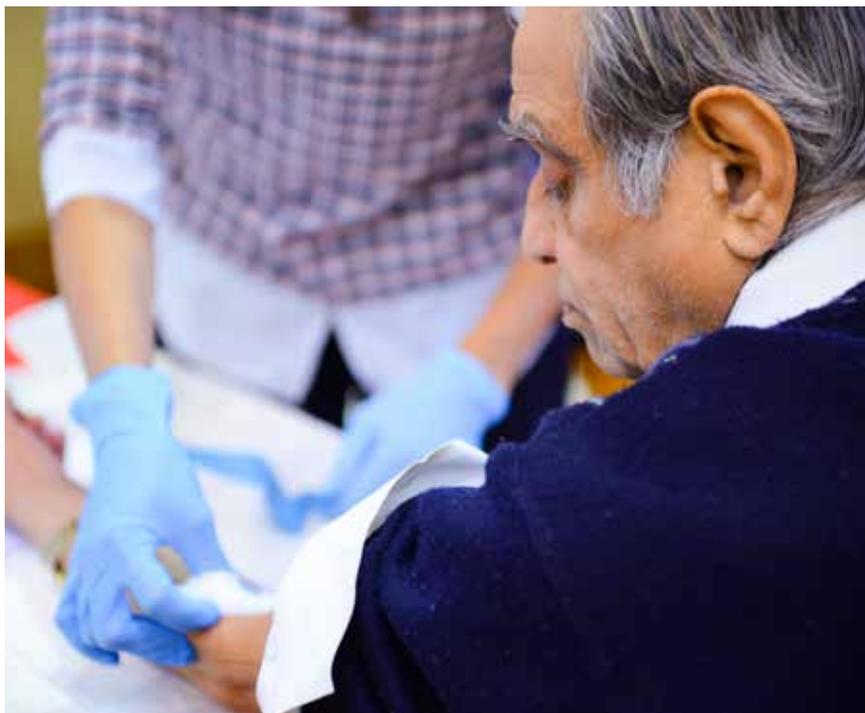


structured education. “Locally, groups meet and, in some locations, several healthcare centres may come together to host such meetings. These are good ways to talk with patients but they do not act as a surrogate for proper individual structured education.” New guidelines that will be published in early 2015 put the focus firmly on developing and embedding this type of education offering across Sweden. But this is further complicated by the fact that, thanks to Sweden’s blossoming multicultural population, over 100 different nationalities are living in the country. It is a challenge to develop structured education programmes for many of the minority ethnic populations that have arrived in Sweden. Prof Berne said: “There just isn’t a critical mass of many of these different populations to allow us to develop and deliver education programmes in a cost-effective way.”

The scene in Sri Lanka

Back in Sri Lanka, since many clinics are not dedicated diabetes clinics, physicians find it difficult to provide care similar to the endocrinologist-led government clinics. There are a few small hospitals and government clinics, which are manned by non-specialist doctors. The level of care at these clinics is elementary and the structured care of diabetes does not happen, except for blood glucose monitoring and pharmacological treatment. The government hospitals provide most of the currently available oral therapies for people with diabetes including





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metformin, sulphonylureas and insulin. However, in these latter situations, insulin is provided as vials and syringes and not by pen devices.

Also in Sri Lanka, some patients with diabetes also self-treat with native, indigenous herbs or get treatment from private Ayurvedic, homeopathic or Unani practitioners. Such treatment can sometimes be during the initial period after diagnosis or episodically while seeking co-treatment from Western allopathic doctors. “In many situations, the level of care of some patients, particularly those living more remotely, depends upon the affordability of the treatment and the enthusiasm of their local doctors,” said Dr Katulanda. “This is particularly important, as recognised tests like HbA1c and microalbuminuria are not widely available in the free government clinics.”

While both countries, like the UK, are striving towards effective multidisciplinary teams delivering

improved clinical engagement and leadership, integrated IT systems remain more distant goals. One long-standing initiative that continues to close this gap is the Swedish National Diabetes Register. It is because of this that Sweden has the best healthcare system to tackle diabetes when compared to the other member states of the European Union, according to the 2014 Euro Diabetes Index⁴. The registry is currently the largest diabetes register in the world and offers a unique opportunity to monitor the quality of care in terms of risk factors and the potential complications of diabetes⁵. With over 350,000 patients registered, it is a formidable strength that will continue to underline the need for integrated IT systems.

Conclusion

It is clear that, while integrated care may mean different things to different people, countries as geographically and historically diverse as Sweden and Sri Lanka are striving to deliver effective models of care to people with diabetes that incorporate many of the elements of an integrated care pathway. In most countries – and the UK is no exception – ageing populations, coupled to the increased prevalence of chronic diseases means that healthcare systems are being forced to shift the emphasis away from the acute care that was required by earlier generations towards encouraging strong self-care messages

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and preventive strategies that are delivered by multidisciplinary teams. Increasingly these teams are in primary care settings. However, regardless of the model, there are recognised resource implications, including a paucity of specialist nurses, dietitians, podiatrists and education experts who help to shape these multidisciplinary teams.

Investment in many areas of integrated care is, therefore, needed in order to ensure that, whether you live in a rural setting or in an urban one, whether you are young or old, whether you are rich or poor, the standard of care is the same. But with the number of people with diabetes increasing in almost all quadrants of the world, this investment is going to have to be quite substantial. So the question is, can the global healthcare system invest to such a level that the hoped for return on investment is obtained, and the fabled tipping point, where these self-care messages and preventive strategies hit home, is finally reached?

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