

WP 7

Diabetes: A Case Study on Strengthening Health Care for People with Chronic Diseases

TASK 5

SECOND DRAFT OF THE POLICY BRIEF ON NATIONAL DIABETES PLANS



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Belgium	European Patients' Forum (Diabetes league, Belgian Diabetes Association)
Bulgaria	National Center of Public Health and Analyses
Croatia	Andrija Stampar (Institute of Public Health)
Denmark	Danish Diabetes Association
Finland	National Institute for Health and Welfare (THL)
France	French National Authority for Health
Germany	TU Dresden (TUD)
Greece	"Sotiria" General Hospital of Athens
Iceland	Directorate of Health - Ministry of Welfare
Ireland	European Institute of Womens Health (The Health Service Executive(HSE), Diabetes Ireland (NGO)
Italy	National Institute of Health
Latvia	Latvian Diabetes Association
Lithuania	Vilnius University University
Netherlands	NIVEL (Netherlands Institute for Health Services Research)
Norway	The Norwegian Directorate of Health
Portugal	APDP - Diabetes Portugal
Romania	Romanian Federation of Diabetes Persons Associations
Slovakia	DIADOR (DIAbetický DORast), Slovakian diabetes Society
Slovenia	National Institute of Public Health
Spain	Health Technology Assessment Agency of Carles III health institute
Sweden	Swedish National Board of Health and Welfare
United Kingdom (England)	National Health Service (NHS) England

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1 National Diabetes Plans in Europe: Do they support changes in health systems to strengthen diabetes prevention and care?

Policy Brief – Second Draft 14 October 2015

POLICY BRIEF: BROAD POLICY MAPPING

The main objectives of a **broad policy mapping** are: 1. To provide policy makers with insights into what is happening in practice in a particular policy area across Europe (and beyond, where appropriate); 2. To give an overview of the state of development with regard to the issue across Europe.

A **broad policy mapping** considers a large range of country experiences for a wide-ranging review of the policy area. It combines a review of documentary evidence and the collecting of evidence directly from experts in a particular policy area in different countries. This allows us to tackle areas where the published literature provides only limited insight.

A Policy Brief provides evidence for policy making, not policy advice

1.1 Key messages [one page of bullet points]

[to add]

1.2 Executive summary [3 page outline of the key issues and findings]

[to add]

2 Main brief

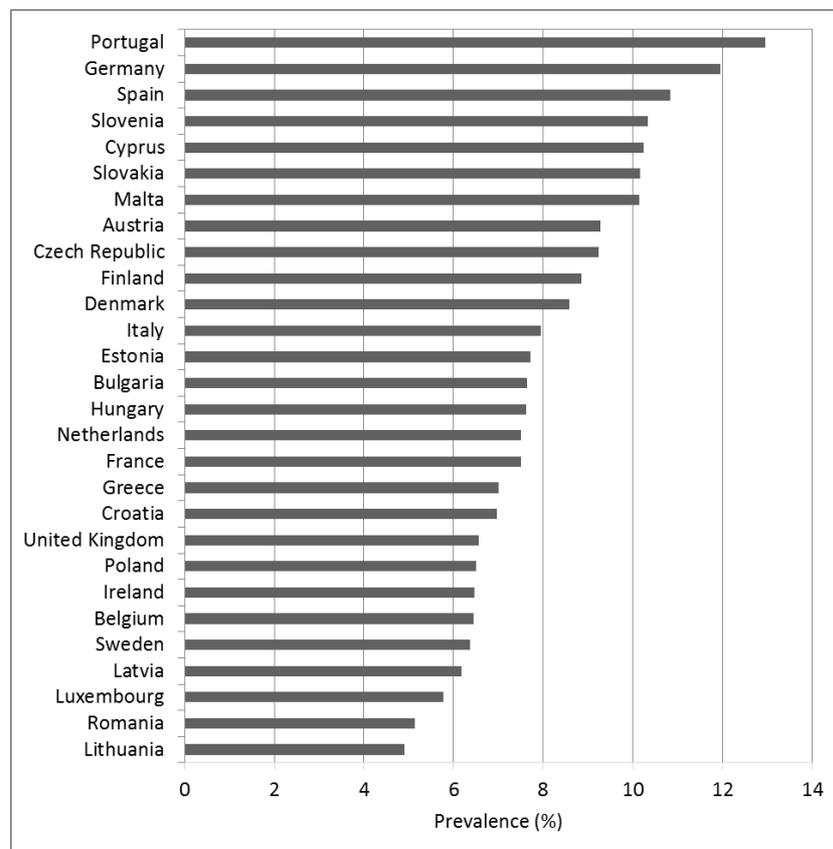
Introduction

Diabetes occurs as a consequence of the human body being unable to produce sufficient amounts of the hormone insulin, which regulates blood glucose, or to use insulin effectively.ⁱ People with diabetes are unable to metabolise glucose appropriately and as a result blood glucose levels remain above normal threshold levels and over time cause blood vessel damage. This can lead to long-term damage and disabling and potentially fatal health complications. In high-income countries, diabetes is a leading cause of cardiovascular disease, blindness, kidney failure and lower-limb amputation.

The most common form of diabetes is type 2, which typically occurs in adults, although it is increasingly seen in young people, including children.ⁱⁱ Type 1 Diabetes typically occurs in children or young people and the prevalence of type 1 diabetes is also increasing, although at a much lower level than type 2.

Globally, the number of people with diabetes has doubled during the past 20 years, making it one of the most important public health challenges facing health systems today. The most recent estimates by the International Diabetes Federation suggest that in 2013 there were 382 million people living with diabetes globally.ⁱ This estimate is similar to that previously forecasted for 2030, suggesting that the burden of diabetes has consistently been underestimated during the past two decades.ⁱⁱ It is currently estimated that by 2035 the number of people with diabetes will have risen to almost 600 million as the population ages.ⁱ In the absence of comparable national diabetes registers it is difficult to reach a precise understanding of the country-specific diabetes burden [add ref Policy Puzzle: 9].ⁱⁱⁱ Figure 1 shows estimated prevalence data for countries in the European Union in 2013, with national prevalence rates ranging from around 5 per cent in Lithuania and Romania to over 10 per cent in Malta, Slovakia, Cyprus, Slovenia, Spain and Germany.ⁱ

Diabetes is associated with a high individual, social and economic burden, with the global expenditure on diabetes estimated at US\$376 billion in 2010, and this expenditure has been projected to rise to US\$490 billion in 2030.^{iv} More recent estimates by the International Diabetes Federation placed global expenditure on diabetes in 2013 at US\$548 billion, and this is projected to increase to US\$627 in 2035).ⁱ In 2013, expenditure in the US accounted for more than one-third of the global expenditure (at US\$299 billion), followed by the European region, at US\$147 billion. Among high-income countries, diabetes-associated expenditure per person with diabetes ranged from US\$3,295 in Spain, US\$3,501 in Italy and US\$3,994 in the UK to US\$9,800 in the US, US\$9,873 in Switzerland and US\$10,369 in Norway.

Figure 1 Estimated prevalence of diabetes in 28 EU Member States, 2013

Source: International Diabetes Federation (2013) [i]

Aspects of the pathophysiology and causal pathways for type 1 and type 2 diabetes remain inadequately understood, challenging the effective treatment of type 2 diabetes in particular.^v It is clear that those with type 1 diabetes cannot survive without a regular supply of insulin, while type 2 diabetes is largely preventable and complications can be avoided or delayed through a combination of lifestyle changes, oral medications or insulin therapy, depending on the status of the condition and of the stage of the disease.^{vi} Effective treatment reduces the risk of disability or fatal complications and its optimal management requires coordinated inputs from a wide range of health professionals, access to essential medicines and monitoring, and, ideally, a system that promotes patient empowerment and integrated care. A health service that is unable to integrate these elements for the management of diabetes is unlikely to be able to meet the needs of people with diabetes as well as other chronic conditions.

A core target of the St Vincent Declaration was to “elaborate, initiate and evaluate comprehensive programmes for [the] detection and control of diabetes and of its complications with self-care and community support as major components”. However, although countries in Europe have made progress towards enhancing the care of people with diabetes, the investment in and development of comprehensive programmes for the prevention and treatment of diabetes has varied across countries, with differences in the

relative priorities that countries place on research, prevention, treatment, management and self-management.

This policy brief seeks to

3 What is the policy question?

What is the focus of the review?

FOR DISCUSSION and AGREEMENT AT THE WORKSHOP – the following points have been proposed in response to the circulation of the first draft of this brief. The number of objectives should be no more than 3-5; please note that the listed points are not objectives as such but questions or statements. Against this background please (re-)consider the OBJECTIVES this Policy Brief should pursue in advance to the workshop on 20 October. In doing so please keep in mind:

- the overarching aims and objectives of JA CHRODIS more generally
- other published work on diabetes programmes in Europe (e.g. Policy Puzzle)
- to include only objectives that are actually answerable by work carried out in WP7
- the overarching aims of this type of policy brief (policy mapping), i.e. (i) to provide policy makers with insights into what is happening in practice in a particular policy area across Europe (and beyond, where appropriate); (ii) To give an overview of the state of development with regard to the issue across Europe.

Proposed list of objectives as suggested by JA CHRODIS partners+:

- Relevance of NDP?
- What is the current status of policies across Europe?
- Where are the gaps in policies?
- What are the trends in actions taken?
- Where has there been a demonstrated commitment?
- Is the capacity of infrastructure to tackle diabetes adequate?
- A policy brief that supports the development in practice of an NDP – not a plain summary. Country findings should identify the criteria that support the development of an IDP.
- Guidelines on how successful NDPs were and why and what are their essential elements (ER – i.e. and assessment).
- Explore how European countries are progressing national diabetes care
- Outline countries development of national diabetes programmes and their effect on services
- Contrast the response of different European countries to the current diabetes epidemic ?
- WP7 goal was to have an overview of NDP development, implementation and sustainability with support to individual countries through exchange of good

practices. This is the context within which the Policy Brief would examine the results of the mapping process. So the aim and objectives would include: describing the outputs of the mapping process (which it does), clarifies unanswered questions (which it is starting to do), highlights good practices which have the potential for scalability or exchange (does the mapping allow this?).

Box 1: Defining a National Diabetes Plan

- any formal strategy for improving diabetes policy, services and outcomes that encompasses structured and integrated or linked activities which are planned and co-ordinated nationally and conducted at the national, state or district, and local level; and
- a systematic and co-ordinated approach to improving the organisation, accessibility, and quality of diabetes prevention and care which is usually manifested as a comprehensive policy, advocacy and action.

A National Diabetes Programme is a systematic and co-ordinated approach to improving the organisation, accessibility, and quality of diabetes prevention and care which is usually manifest as a comprehensive policy, advocacy and action plan covering the:

- Main types of diabetes (type 1 diabetes, type 2 diabetes and gestational diabetes)
- Whole continuum of care from primary prevention to treatment and palliative care
- Resources, services and systems that support prevention and care

Source: IDF (2010: 6)

Box 2: Methodological approach

The mapping of national diabetes plans (NDPs) across EU Member States used a data collection template, which was developed based on the 2010 International Diabetes Federation Guide (IDF Guide) for the development of national diabetes programmes. Questions derived from the IDF Guide were supplemented with questions related to the current status of NDPs in European Union Member States, along with open-ended questions to collect experiences of NDP preparation and implementation, with a specific focus on sustainability and roll-out.

The questionnaire was piloted in September 2014 with JA CHRODIS partners and national leads completing it for their own countries to test the feasibility of the survey instrument. At the end of September 2014, the questionnaire was then emailed to all project partners; for countries where there was no partner able to complete the questionnaire, respondents were identified through the European Patient Forum.

Potential respondents were provided, in advance and by email, with comprehensive information about the project, including that their participation in this project would provide insights and challenging solutions at the policy level with diabetes serving as a model for other complex chronic and preventable diseases. Respondents were also informed, that the information provided would not be used to examine the performance of policies or programmes in any given country, to rank countries according to their policies and programmes or as a benchmarking tool.

To ensure common understanding of the terms used in the questionnaire, the IDF Guide (2010) was used as a reference and respondents were encouraged to consult it for further clarification, if needed. In addition, project researchers clarified points as necessary with respondents after completion of the questionnaire (please see below).

The questionnaire comprised of four core parts with 36 questions eliciting information on:

- A. Current NDP status as of 31 August 2014.
- B. Experiences relating to the process of NDP preparation, implementation, sustainability and spread as well as of the most important changes, including past and future activities in relation to NDP.
- C. The areas the NDP covers.
- D. Evidence of adherence to core standards as proposed by International Diabetes Federation.

It took approximately 45 to 60 minutes to complete the questionnaire.

The respondents were asked to email the completed questionnaire a few days before a scheduled teleconference with the research team which gave the researchers the opportunity to study the responses carefully and then discuss them with the respondents. Most respondents agreed to have such a discussion about the information provided, and to clarify points as necessary. When it was not clear how a response should be categorised, the IDF Guide and its definitions were strictly used to define the questions more precisely. Part A required special discussion, since several countries could not fit their country's experience into the questionnaire categories as presented. In this case, respondents were encouraged to provide a description of the situation. The questions in Part B also had to be discussed with most of the respondents. It was necessary to strongly emphasise that the questions were asking about the experiences their institutions were having. It had to be stressed that these questions were of great importance even in countries that do not have a National Diabetes Plan.

A revised version of the completed questionnaire was then emailed to the lead researcher and checked again for completeness. If unsure, the respondents were contacted again. The last response was given in January 2015.

4 The evidence

4.1 The majority of countries surveyed currently have a formal national diabetes plan in place

At the time of writing, seven of the 22 countries that responded to the survey had no formal NDP as defined for the purposes of this study in place (Austria, Belgium, Bulgaria, France, Germany, Latvia, and Lithuania). Two countries had concluded a previous NDP plan and not (yet) developed a follow-up (Denmark, Finland), while in the Netherlands, the NDP has been succeeded by a new national strategy and implementation of 'Diabetes Care Standards'. In Norway, diabetes was included as part of an overall strategy targeting chronic diseases more broadly. Austria, France and Germany reported not having a NDP in place as such but referred to a national diabetes disease management programme (DMP) as the major approach to addressing diabetes through both disease specific and non-specific measures. The development and implementation of a NDP was reported to be a legal requirement in Croatia and Spain.

The NDP was usually endorsed or led by the Ministry of Health, but only half the countries appeared to have dedicated funding attached to the NDP. Most NDPs were reported to have documented implementation or action plans for the NDP, while in Denmark the process was seen as both a top down and bottom up process in that the National Board of Health established a national diabetes steering group that discussed the requirements for and content of the NDP, but pressure for action came from ‘below’, in particular the Danish Diabetes Association. In Greece, the development of the NDP was seen to be a ‘bottom-up’ process driven by non-government organizations, including the diabetes associations, patient organizations and individual health professionals with a vision for a better future in the management of diabetes at the national level. However, at present there are currently insufficient funds for the development of an NDP in Greece. Respondents in around half the countries reported to have a steering committee or task group in place, although these groups were typically only established for the duration of the plan (for example in Denmark).

4.2 National diabetes plans typically take a broad approach, capturing prevention and treatment and seeking to place the patient at the centre

Most of the plans focused on diabetes broadly, covering type 1 and 2 diabetes, along with gestational diabetes. Most countries that have a dedicated NDP in place tend to target the whole population although guidelines (or their equivalent) in place in Finland, Italy, and Norway and Slovenia do not target prevention among children and adolescents specifically. The stated overarching aim of a NDP was typically reported to ensure equitable access to prevention and, where included, care (four countries did not address the provision of services, equipment and medical supplies).

Generally, NDPs as described by survey respondents take a patient-centred approach and people with diabetes were consulted about their needs in order to develop the plan, although not all countries appeared to include diabetes patients in the group responsible for NDP implementation. It was noted that NDPs typically focused on ensuring equal access to health care regardless of geography, socio-economic status, language, culture or ethnicity. However, only half of the NDPs as described by respondents took into account individual differences, preferences and cultural diversity in developing the plan.

NDPs typically include prevention, early diagnosis, routine care and services, and patient education in all countries although respondents in some countries noted that specific aspects might be covered within other national-level programmes or guidelines such as in Italy, Denmark and Spain. Respondents for the Netherlands highlighted that the NDP placed the position of the individual at the centre and also seeks to identify legal or regulatory barriers. In all countries, it was reported that the NDP addresses environmental interventions aimed at minimising exposure to and reducing risk factors for diabetes, particularly healthy food; in some cases this was addressed by other programmes targeting nutrition and diet specifically (Austria, Denmark, France, and the Netherlands). Plans or programmes addressing healthy public policies were reported to be in place for all countries; the only exception was Greece, where the existence of relevant policies was not explicitly mentioned as part of the NDP. In Slovenia, it was difficult to identify existing healthy public policies and then to establish links

between them and the NDP. Half of the NDPs described in this survey also cover healthy urbanization, while only a small number of plans specifically also covered healthy businesses. A broad scope requires strong multi-sectoral working. In Slovenia, this was seen to be beyond the scope of the NDP, which was developed under the auspices of the ministry of health.

Identifying high risk individuals and preventing the onset of diabetes in high risk individuals was a common aspect of NDPs across the countries in the data collected although about a third of countries that did report having a NDP in place did not include early detection of diabetes among groups at risk. The respondent from Norway highlighted the potential downsides of risk profiling, which could lead to over-diagnosis and pathologising selected groups and this formed a subject of ongoing debate in the country. Workplace interventions for individuals at risk did not typically form a core part of NDPs and community awareness campaigning was also not universally included in NDPs or other plans or programmes.

All countries that did report having a NDP in place included routine care of diabetes as part of the plan, although this was at times addressed as part of (separate) clinical guidelines and protocols rather than explicitly within the NDP (France, Spain and Denmark); this was also the case in Norway, which, as noted above, included diabetes in a wider national programme targeting chronic diseases. Routine care as specified within the NDP (or, where this was covered under a clinical guideline) tended to cover monitoring of the processes and elements of care, self-management support and patient education, along with dietary advice, physical activity, complications screening, and regular clinical monitoring.

Only half the countries included a human resources strategy as part of the NDP; where the NDP did not explicitly address human resources, this is typically covered under other strategies, for example targeting chronic diseases more broadly (Norway and France). A dedicated human resources strategy can be seen as an important element given the crucial role of frontline staff in the implementation of an NDP.

NDPs typically included some form of monitoring and surveillance, and this appeared to be mostly focused on monitoring and surveillance of diabetes prevalence and incidence or access to services and clinical outcomes. Most countries reported to have some form of system in place for the collection of data on diabetes; respondents from Finland, Greece and Norway did not specifically mention having such systems in place. The Netherlands reported to having developed a set of indicators to measure aspects of the quality of diabetes care to be reported annually by an organization representing primary care. Respondents from Slovenia highlighted the challenges of establishing routine data collection systems, which was attributed, mainly, to the inability of those in charge to reach an agreement on ownership of the system and their accountability, but also to the challenge of ensuring compatibility between databases. The monitoring of costs associated with plan implementation appeared to be less frequently used, as was the monitoring of community awareness. According to the questionnaire survey data, only five countries included monitoring and surveillance of all these aspects (Croatia, Slovenia, Slovakia, the Netherlands and England). In Finland, an annual national survey was conducted to monitor awareness of the programme.

Most countries reported to have an evaluation strategy for the NDP in place; respondents from Denmark, France, Greece, Ireland, Norway and England did not specifically mention that their NDP included an evaluation strategy. However, most countries noted that the development of the plan was informed by some form of situation or needs assessment, and most also reported to have some form of baseline data available.

4.3 There are a range of factors facilitating the development, implementation and sustainability of national diabetes plans, including: [...to be added].

The NDPs in place generally took a few of years to develop, ranging from three months in Norway up to six years in the Netherlands. However, respondents from Norway and Slovenia reported time constraints a hindrance to development; for example, the respondent from Slovenia noted that the development of the NDP had to be undertaken on top of day-to-day work, thus placing considerable constraints on those involved.

Important drivers of NDP development were described to be structural problems in caring for people with diabetes, such as lack of standardized treatment regimes, lack of transition management, and the undersupply of specialized structures (e.g. out-patient units for foot care) leading to poor outcomes (England, Austria). Evidence of costs associated with diabetes care was also seen to be influential (Austria, Finland, Ireland), along with evidence on the effectiveness of prevention. Respondents from Belgium and Spain reported the key role played by lead individuals in driving the agenda for developing a national strategy, and many countries noted the importance of clinical specialists and the Ministry of Health in facilitating the passage of the NDP, its implementation and sustainability (Belgium, Bulgaria, Croatia, Lithuania, Portugal, Slovakia, Slovenia, Spain and England). National diabetes associations and patient organizations also played an important role such as in Denmark, Finland, Greece and Slovenia. We noted above how for example in Denmark the Danish Diabetes Association pushed for the NDP to be developed and provided considerable input into the final document. Ensuring a broad collaboration among key stakeholders was considered of core importance in most countries, and the lack of involvement of patient groups was considered a hindrance to NDP development by respondents from Norway and Spain.

Respondents from Italy highlighted the role of supranational policies such as those developed by the United Nations and the European Union in stimulating the development of a national diabetes programme, while the actual implementation of the NDP was facilitated by active participation from specialist clinical associations and patient organizations.

The fluidity and flexibility of the collaborative way the NDP was developed in Slovenia was noted as an important facilitator for development and implementation because the process itself as perceived to have created a momentum for implementation. The need for flexibility was also noted by respondents from Denmark and Greece, who highlighted the requirement for the NDP to be revised in response to changes in the organization of health services more broadly as countries continue to reform their health systems towards better meeting the needs a changing fiscal and demographic environment.

Respondents from several countries further stressed the availability of dedicated financing in enabling the development, implementation and sustainability of a NDP (Netherlands, Slovakia, Portugal), while the absence of such sustainable funding was seen to pose considerable barriers towards the implementation of a comprehensive strategy (Bulgaria, Croatia, Greece, Italy, Ireland, Norway). For example, in Italy, regional health authorities are responsible for local implementation of the NDP, but they claimed that its implementation would have required additional funding would be required for extra staff and staff training, services, including community services, supplies and infrastructure, along with public health communication campaigns. Respondents from Spain noted that, from their experience, dedicated financing would be required to facilitate the actionable aspects of the NDP. However, and similar to Italy, the NDP in Spain was developed at the national level whereas its implementation and financing depended on the regions, which were required to adapt the NDP to their local needs. For these reasons, the NDP in Spain did not include specific activities to be implemented locally as this is in the remit of the regions, and accordingly, dedicated funding was not allocated either.

To ensure that adequate financial and human resources were made available, some respondents noted the importance of having political support from the Ministry of Health (Greece, Lithuania, Slovakia). Overall, the importance of strong political commitment to making diabetes prevention and care a policy priority was noted by respondents from several countries (Spain, England), and such commitment was seen to be necessary for implementation (Croatia, France, Greece, Ireland, England) as well as programme sustainability.

Scaling up programmes developed at the regional level to cover the whole country was noted as a barrier to implementation by some respondents. For example, respondents from Austria highlighted that regions that did not implement the DMP as they lacked the financial resources for bonus payments to physicians or the political will on the part of regional health insurers, regional doctors associations or regional governments to implement it. Ensuring commitment from regional administrations for implementation was reported to be a challenge in Portugal and resource constraints at the municipal level were noted as a potential barrier to national roll-out in Sweden. Regional and provider autonomy were seen as barriers to country-wide implementation in Italy and Finland, and respondents perceived this to pose considerable challenges for implementation in Spain and UK-England. In Finland, this was seen to be manifested in different hospital districts and municipalities having differing, incompatible electronic patient records, which in themselves were seen to pose a barrier to implementing the NDP when it was in place. Respondents from Italy highlighted that successful implementation and sustainability would need to be able to rely on strong nationwide leadership.

The implementation of NDP can also be supported by complementary plans and policies. One example was given by respondents from Croatia, citing the National Insurance Health Plan, which incentivises family doctors to implement NDP protocols. Consistency in the incentives to implement the NDP was also seen to be important to facilitate implementation. Respondents from Denmark reported a lack of connection between action plans set out in the NDP and actual incentives to implement the plan, which was seen as a key impeding factor for implementation. Similarly, the lack of an action plan was seen to hinder implementation

in France and there was a perception that specific objectives related to diabetes in the national strategy for health would be needed to make implementation of the NDP more successful. In several countries, patient associations were not only important in driving the development of NDPs as described above but they also played a crucial role in implementation, such as in Denmark, Norway and the Netherlands, respondents highlighted the importance of the national diabetes association in ensuring implementation. For example, in the Netherlands the National Diabetes Federation was the coordinator of the NDP and most of the project managers for different components were appointed by the Federation which also coordinated communication between the ministry of health and those implementing the plan. In Denmark, the diabetes association was seen to play the role of an overseer, that is monitoring of implementation and identifying risks such as inequalities in access to care between regions, as well as acting as ‘responsible partner’ in working to implement the NDP with regions, the ministry of health and the National Health Board. In Belgium, which at the time of writing, did not have an NDP in place, the Flemish diabetes association implemented and coordinated a programme for gestational diabetes. Respondents from Denmark further noted that there had been a sense that ‘something had to change’ and that there had been sufficient good will among stakeholders to enact such change; this kind of enthusiasm was also noted as an important factor for implementation by respondents from Finland. In Slovenia, cooperation and collaboration between stakeholders involved were seen as central to implementation of the NDP and this was achieved through the creation of a steering group, which was seen to act as ‘multiplier’ in that members of the steering group relied on strong networks at their respective institutions to mobilize as many people as possible for implementation. Clarity of an NDP was seen to facilitate implementation in Slovenia and Slovakia, and respondents from Sweden viewed the active communication at local level to be of key importance in ensuring implementation. Respondents from Finland also noted that a more focussed agenda could potentially have made implementation easier at local level as it had numerous goals and target groups (e.g. high risk prevention, comprehensive care, population level activities, etc.).

The availability of human resources was also noted as an important factor in NDP development, implementation and sustainability. Examples presented included recruiting a dedicated specialist in podiatry or diabetes care nurses in Ireland, or developing the training of diabetes nurses in Lithuania and Slovenia. A number of country respondents further highlighted the need to have the right mix of staff in place to facilitate implementation of the NDP. For example, respondents from Italy reported the challenges in creating partnerships between primary and secondary care levels to build multidisciplinary teams, which were seen to be essential to enhance diabetes care. These challenges can mainly be related to a lack of experience and resultant resistance among both professionals and institutions to work in multidisciplinary teams; it was noted that the development of systems for information sharing between physicians and patients could have facilitated this. For Finland it was noted that the involvement of communication officers responsible for the internal and external communication of the plan would have been beneficial. Changing the attitudes and values of staff working in the system was seen as a key barrier to implementation in Slovenia, while engaging health professionals was also seen as a challenge. Several countries highlighted the key role of ensuring ‘ownership’ of the NDP by all stakeholders, including health care staff and institutions at the local level for implementation and sustainability (Ireland, Norway, Portugal, Slovakia, Slovenia, Spain).

There was a small number of facilitators identified by respondents seen to improve implementation that appeared to be more specific to individual countries. For example, the respondent for England highlighted the role of the purchaser in improving the quality of care as they play a key role in improving services and outcomes for their local populations through their purchasing by holding providers to account and being held to account by the ministry. Respondents from Slovenia noted that there was a need to give the NDP and its Steering Group a clearer executive role to increase its capacity to make systemic changes.

We propose to insert here a case study of Finland, elaborating on how the NDP achieved long-term impact beyond its formal ending through for example creating the conditions that permitted implementation of prevention and management models in participating regions, which were subsequently adopted by other regions, etc.

- The DEHKO (spell out) programme in Finland was initiated by a strong and dedicated patient organization and further facilitated by support from national authorities. Public sector, primary health care, specialized health care, third sector (NGOs), private companies (pharmaceutical, food, and medical supplies industry), research institutes, universities, decision makers both nationally and locally were already involved and engaged at the very beginning of the planning.
- Communication and dissemination were selected as priority areas in the project. The programme achieved excellent media visibility and was well known among professionals, patients, the general population, and political decision-makers.
- The programme provided a general framework for activities which facilitated the relatively free implementation of the project by different partners. As a result, new models and practices were developed "bottom-up" based on local needs, resources and initiative.
- Tools to support self-efficacy, self-management and patient-centred care were developed. Many models, methods, tools, and outlooks fostered by the programme were adopted by other regions and actors.
- The need for education and training was identified and the demand was satisfied. The training of health care professionals emphasized the adoption of new, patient-centred tools and techniques in prevention and care. The approach has thereafter been included in the health care professionals training curriculums and training services offering, e.g., continuous education courses.
- Some hospital districts have established a Prevention Unit. Private service providers have developed new products and services, especially related to the prevention of type 2 diabetes.
- DEHKO operated together and collaborated with other health promotion programmes. The legacy of the DEHKO is continued in the "One Life" programme which is a concerted action by several patient and public health organizations.

Similar to the experience reported by Finland (see [Textbox](#)), respondents from Slovenia and England highlighted the role of improvements in the quality of diabetes care over time that were seen to have promoted the sustainability of changes introduced by the relevant NDP. Routine monitoring of processes and outcomes were seen to be key to inform care provision and improvement strategies overall (Norway, Sweden). Respondents from Greece noted the importance of being able to draw on existing diabetes prevention and management models

based on those developed by the European Association of the Study of Diabetes or the American Diabetes Association guidelines in facilitating sustainable implementation of the NDP.

There was a perception that innovative practices developed at the local level may serve as a model for scale up and disseminate good practices more widely. However, although many countries reported on successful projects at local level, further scale up was typically not mentioned. For some, scale up was not necessarily seen as desirable (Norway) although it was not clear why this might be the case. A number of countries highlighted the role of informal exchanges of ‘best practices’, through for example networking meetings (Portugal, Sweden). Respondents from England reported on more formalized exchange mechanisms, such as the set-up of national bodies (such as NHS Diabetes, the National Diabetes Information Service and the NHS Institute), which were tasked with the spreading of good practice. Respondents from Spain noted that exchange was a standard procedure for the identification, collection and dissemination of good practice on health action in the context of the national health system, which was established by the Deputy Directorate General of Quality and Cohesion. Each year, the Ministry of Health in Spain calls for applications to be included in the catalogue of good practices in several priority areas. The regional health services submit their selected good practices for evaluation by a committee according to pre-established criteria. The selected good practices are published on the website of the ministry. A small number of countries reported on the challenges face in promoting the wider take up of new practices, frequently citing resistance from health professionals particularly at the primary care level as one barrier, but also a lack of resources available for scaling up, along with institutional inertia (Portugal, England).

Several countries reported on observed impacts of the NDP, typically highlighting improvements in the quality of diabetes care as noted above (Finland, England) and strengthened screening and prevention (Finland, France, Ireland, Portugal, Spain). Denmark and the Netherlands mentioned the introduction of new guidelines to have resulted from the national diabetes plan or programme, with Slovakia adding that guideline introduction was accompanied by new equipment and greater availability of new diabetes drugs. The NDP was also seen to have brought a renewed focus on data sharing and quality in Denmark and the launch of larger research studies in Slovakia. It was perceived to have fostered greater collaboration between stakeholders (Italy, Netherlands, Slovenia). Austria reported evidence of enhanced patient satisfaction with the care they received under the DMP. In England, enhanced patient adherence with treatment was reported.

[TABLE X: ADHERENCE TO INTERNATIONAL DIABETES FEDERATION CORE STANDARDS to add]

4.4 What we don't know

Data presented in this policy brief are based on a structured survey and although great care was taken in verifying information collected from countries, differences in understanding and interpretation of questions and definitions will prevail, both across and within countries [REF]. For example, representatives from different organizations are likely to have different perspectives on a given national initiative, reflecting their professional and disciplinary background, such as academia, the civil service or non-government sector. The extent to which different stakeholders expressed different views varied between countries and it was beyond the scope of this work to further triangulate divergent views within a given setting. For this reason it is important that the questionnaire also accessed the narratives behind the development and implementation of NDPs. These narratives generally helped to inform the analysis by aiding understanding of the dataset.

Data presented here reflect a snapshot of experiences of developing and implementing NDPs in European countries in place as in September 2014. Although great care has been taken to update the information presented as much as possible, more recent developments will likely be missed. The use of a survey instrument also limits the extent to which more subtle nuances of the development and implementation in different settings will be captured, and it is possible that some policies of historical note have been overlooked.

5 Findings and evidence-based options

The following points were proposed by reviewers of the first draft of this brief and should be discussed further at the workshop:

- It is possible to list the facilitators and barriers as identified in this survey and offer some suggestions for the ongoing monitoring and evaluation of the performance and reviews of NDP's?
- What is the impact of having (or not having) an NDP? What works and what doesn't? What are the recommendations? More country case studies may be useful.
- Is a NDP necessary at all? Is the real important difference the presence or absence of a strategic framework dedicated to diabetes? What facilitates / inhibits the development of such a framework? Is it better for it to be covered under a broader NCD strategy?

6 Conclusions

The following points were proposed by reviewers of the first draft of this brief and should be discussed further at the workshop:

- Perhaps we should use the Policy Puzzle conclusions as a starting point?
- How much do local conditions influence NDP processes – are we looking to recommend an ideal NDP or local modifications of some general framework?
- How far are we from a European Diabetes Plan?

- Ideally the conclusions should answer the ‘so what?’ question – what is the impact of this for policy-making, what are the associated challenges / opportunities and what might future developments in the field be?

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