The future of diabetes care in Ireland

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A few years ago I would have written that diabetes care in Ireland was at a crossroads, poised between primary and secondary care with neither adequately resourced. To some extent this is still true, but there are now some signposts offering direction, and some leadership has arrived to accelerate progress.

Currently, diabetes care for adults is provided by primary and secondary care in equal measure, with primary care dominating in rural areas and most attending secondary care in the cities, particularly in Dublin and its suburbs where 10 diabetes centres exist, of which at least five are tertiary care centres. Galway and Cork have large centres, while Limerick and Waterford have diabetes centres managed by solitary consultants. Most of the remainder of the country is poorly served, with many diabetes clinics in district hospitals run by a single diabetes nurse, often supported by one or more non-endocrinology trained physicians.

Diabetes care in the primary care setting is extensive, but similarly haphazard. In a 2004 survey, over 90% of GPs were offering diabetes care for some of their patients with diabetes but only 13% claimed to offer structured care (O'Sullivan, 2006). Most care in this setting is for people with type 2 diabetes, but in many parts of the country, GP-based care is a fallback position when people have given up attending a distant hospital clinic, and people with type 1 diabetes are just as likely to default in this way.

However, there is still plenty to be positive about. A number of organised schemes see well-developed structured care provided to thousands of people with diabetes in Dublin, the Midlands, the West and the north-east. The Diabetes Interest Group in Cork continues to make progress in developing its own standards and auditing its patients' care (Hill et al, 2009), while groups in Limerick and Mayo are getting organised for a structured approach. I have a sense that the importance of well-organised diabetes care as opposed to more informal care has now sunk in here.

A major barrier to widening this experience to the entire country has been the lack of a remuneration package in general practice. Yet when the East Coast Area Diabetes Shared Care Programme (ECAD; Health Service Executive, 2008a) for shared care in south-east Dublin and Wicklow invited new members, another 15 practices have joined and are now training up in preparation. This influx will treble the size of this scheme and I would estimate that 2500 patients will be involved. At this scale, it is reasonable to expect the same level of support and resources as any large hospital diabetes centre.

At a political level, things have started to move since the publication of the Diabetes Expert Advisory Group's report (Health Service Executive, 2008b). A National Clinical Director for Diabetes has been appointed (Professor Richard Firth from the Mater Hospital, Dublin), and he will be supported by a representative group, including a GP Clinical Lead, Dr Velma Harkins, who has led the successful Midlands Diabetes Scheme for a number of years. There is political commitment to take on the first set of graduates from the new school of podiatry, a move that is essential to fill a long-standing deficiency in this area, and a successful retinopathy screening service in the north-west is being expanded to encompass the entire Western region. An increasing amount of diabetes education is being delivered in primary care, including X-PERT, DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) and CODE (Community Orientated Diabetes Education) – a course delivered by the Diabetes Federation of Ireland.

Of course, these developments are frustrated to some extent by the recession, with a complete freeze on recruitment and a reduction of all health budgets. However, at this point, the evidence for the effectiveness of primary care-managed diabetes is well established, and the cost-effectiveness of this care must support continued development, including some movement of resources into primary care. Planning and preparation for change can continue despite the recession. ■