NEWS

New diabetes treatment and prevention strategies needed

Canapress

About 5% of Canadians (1.3 millon) now have diabetes, up from 3% a decade ago.

Aggressive team-based treatment and prevention strategies are needed to reverse the upward trend in diabetes rates across Canada, the Health Council of Canada says.

That will require a shift in health care attitudes from the current "find-it-and-fix-it" approach to a more comprehensive "prevent it" strategy, concludes the council in its report, *Why Health Care Renewal Matters: Lessons from Diabetes* (www.healthcouncilcanada.ca), which was released Mar. 5.

At least 1.3 million Canadians, or roughly 5% of the population, have diabetes, compared with 3% of the population a decade ago, according to the Health Council of Canada. Roughly 60 000 new cases are diagnosed annually.

It is estimated that 2.4 million Canadians could have the disease by 2016. The Canadian Diabetes Association says that direct spending on diabetes-related care in Canada rose to $5.6 billion in 2005, while the overall cost to the economy was $13.2 billion. Both figures are projected to rise exponentially in years to come, with the economic cost projected at $15.6 billion by 2012 and $19.2 billion by 2020.

Rising obesity rates and sedentary lifestyles are cited as the main culprits behind the growing incidence of diabetes, a point underscored by a report from Parliament's Standing Committee on Health entitled *Healthy Weight for Healthy Kids*. The all-party committee concluded one-quarter of Canadians aged 2–17 are overweight or obese and will live shorter lives than their parents due to obesity-related illnesses like type 2 diabetes.

Governments have responded to the increasingly alarming statistics over the past decade with myriad programs and initiatives, ranging from a renewal of the national ParticipACTION program and tax credits for children's exercise programs to community-based healthy living programs. Other organizations have more recently called for prohibitions on junk food ads and a ban on trans fats.

None of this is enough to turn the tide, argues the Health Council. They cite inadequate health care — including a lack of essential lab tests, procedures and drugs — as a significant problem in current diabetes care, and call for new prevention strategies and a fundamental shift in how health care is delivered.

Health care reforms across Canada, particularly in primary care, must be accelerated, says Dr. Danielle Martin, a member of the Health Council of Canada and a family physician at Women's College Hospital in Toronto. Specifically, she says jurisdictions need multi-layered health care teams, like the kind recently announced by the Ontario government, to manage diabetes patients. "A lot of the management portion has to do with inter-professional teams, and primary care has to do with giving people the tools to manage their own disease," says Martin.

The 70-page Health Council report profiles some effective programs, including collaborative, team-based systems in BC, Sask., and Nfld. and Labrador, which have led to "healthier patients and lower health care costs," and a London, Ont., program targeting the Latin American community.

"It's very easy to be doom and gloom on a topic like this, and it's not totally fair to those people out there actually making really significant inroads in their community," says Martin. "There are people who are trying and actually doing good work and we should be applauding them."

But more important than management is the need to shift to a prevention-focused health care approach, Martin says.

This is not easy to achieve as diabetes is proving to be an inherently complex disease, she adds. While a genetic link to type 2 diabetes was recently uncovered by an international research team led by Dr. Constantin Polychronakos of McGill University (*Nature* 2007;445:881-5), diabetes rates are entangled with broader societal issues, including socioeconomic status (which partly explains higher rates

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among First Nations and some immigrant populations); availability of healthy, affordable food in rural and remote areas; and public awareness of healthy lifestyles and choices.

Such complexity means Ottawa must coordinate prevention initiatives at provincial, territorial, federal and nongovernmental levels, says Karen Philp, vice president of public policy and government relations for the Canadian Diabetes Association.

Philp says the Association hopes a Health Canada policy review of the 6-year-old Canadian Diabetes Strategy (announced by Health Minister Tony Clement last year and awaiting terms of reference), will result in the Canadian Diabetes Association and other organizations becoming partners with the 3 orders of government in diabetes response planning, rather than having them serve as outside advisors.

From 1999–2005, the federal government spent $115 million on various projects under its diabetes strategy, including $58 million for an Aboriginal Diabetes Initiative. A national system for surveillance of chronic disease based on provincial and territorial health administration data was also developed. The Aboriginal initiative has been renewed at $190 million over 5 years under the First Nations and Inuit Health Branch at Health Canada. The Canadian Diabetes Strategy, now run under the Healthy Living and Chronic Disease Strategy, has an $18 million budget for 2006–07 with its future to be decided after the review.

The Association is also working on developing fact-based diabetes management approaches with the University of Western Ontario. The 2 recently partnered to launch a $5 million Chair of Diabetes Management and National Management Diabetes Strategy. Each has committed $1 million and both are seeking private funding sources to generate the remaining $3 million. The search has also begun to find a chair holder.

The Canadian Diabetes Association states that it believes a national pharmacare plan is needed to ensure no Canadian, particularly those with diabetes and other chronic diseases, spends more than 3% of their annual income on medication, devices or supplies prescribed by a physician.

While new strategies are being sought, Philp also urges medical practitioners to use the Canadian Diabetes Association's Clinical Practice Guidelines (www.diabetes.ca/cpg2003/chapters.aspx).

"They are evidence-based; they will tell you how to optimize the management and support for your patients with diabetes." Revised guidelines will be published in 2008. — Pauline Comeau, Ottawa

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Hospitals to report *C. difficile* and MRSA

Commencing next year, acute-care hospitals, nursing homes and other institutions will be asked to report their rates of either *Clostridium difficile* or methicillin-resistant *Staphylococcus aureus* as part of the process for obtaining Canadian Council on Health Services Accreditation (CCHSA).

But unlike increasing numbers of hospitals in the United States, where new legislation is forcing mandatory public disclosure of nosocomial infection rates, the Canadian institutions will not have to make their numbers public.

In Canada, performance measures in the area of patient safety, including infection control, are an "integral part" of the CCHSA's new accreditation program, says President and CEO Wendy Nicklin.

"We're being asked by clients and by our stakeholders to be more specific in this area because of the priority," says Nicklin. The CCHSA will request that all institutions seeking accreditation report on whichever infection is more pressing; *C. difficile* or MRSA.

Starting this year, CCHSA accreditation will be mandatory in Quebec. While not mandatory in other provinces, CCHSA accreditation is necessary for hospitals with Royal College of Physicians and Surgeons of Canada-approved residency programs.

The Council will use the information to help institutions resolve infection problems by providing them with prevention and control standards, Nicklin says, stressing that reporting infection rates is part of a quality improvement exercise, not a licensing requirement for the 923 institutions (and 3750 sites) it serves.

Although the Council encourages institutions to share their report externally, they aren't, and won't be required to do so. "It is their report to share," Nicklin says. "We release aggregate data and information about what the survey reports have shown and trends related to the nature of the recommendations."

By contrast, hospitals in the US will increasingly have no choice about releasing their infection information. As of February 2007, 14 US states had passed legislation requiring hospitals to publicize their rates of hospital-acquired infections. In addition, California and Rhode Island require hospitals to report on how well they are following infection control policies. Nevada and Nebraska report hospital infection rates to their respective health departments, but don't share the information with the public. Another 18 states are considering bills that would require some kind of public reporting of hospital infection rates.

Infections are one of the top 3 adverse events that patients in hospitals face, so the accreditation program is needed to improve patient safety, says Dr. Susan Brien, the Canadian Patient Safety Institute's director of operations for Quebec, Nunvaut and Atlantic Canada.

"One of the things that we know about the safety and quality business is that if you don't measure it, it doesn't change," Brien says, arguing that once institutions begin to collect the information about infection rates, their commitment to preventing and reducing hospital-acquired infections will improve.

Although Brien thinks it's important that patients know what the infection situation is at the hospitals that serve them, she's not convinced public reporting is the best way to pass on that information. Instead, she'd like to target hospital boards and surgeons.