

Diabetes National Summary for 2002

Prepared for
District Health Boards and Local Diabetes
Teams
March 2003

Sandy Dawson [sandy_dawson@ moh.govt.nz](mailto:sandy_dawson@moh.govt.nz)
Chris Andrews christine_andrews@

Summary (1)

- This presentation summarises the results of the free “Get Checked” programs in New Zealand for 2002.
- “Get Checked” programs offer people with diabetes and their GP or primary care nurse the opportunity to check that the important tests have been completed each year, and to plan the year ahead. These programs improve the quality of care.
- Specific information is used in secure ways that protect privacy to report to Local Diabetes Teams (LDTs). LDTs include people with diabetes, clinicians, and DHB staff. LDT roles include using this information to monitor diabetes impact and services, and develop recommendations and targets for their DHB to consider.
- This presentation uses information provided by LDTs in their reports, and combines it nationally. It is intended primarily for use by LDTs and DHBs. Interpreting the information requires care and experience.

Summary (2)

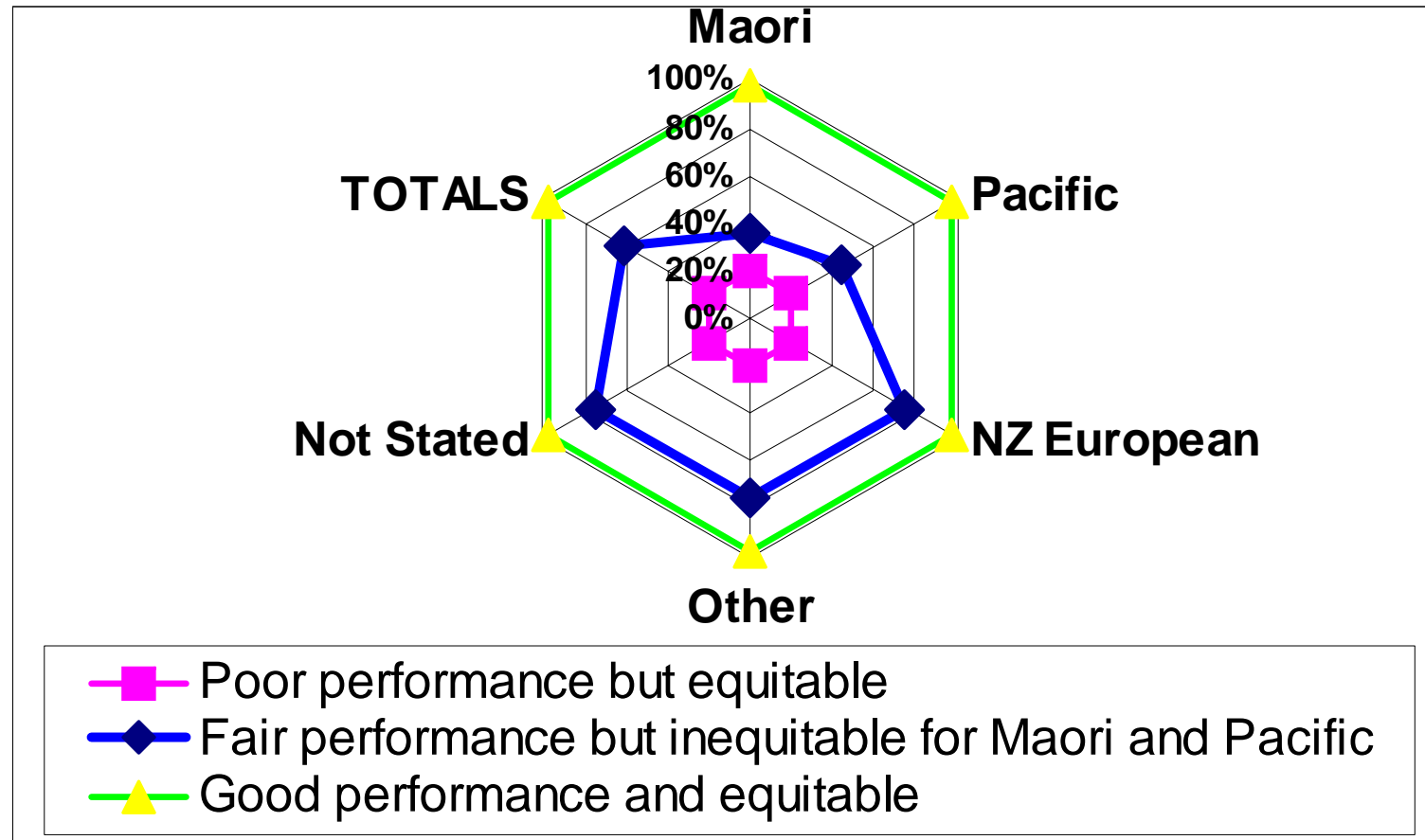
- Diabetes information and the way it is used is outlined in the MOH Diabetes Toolkit (www.moh.govt.nz).
- This presentation outlines:
 - Diabetes detection – how many people with diabetes are enrolled in free “get Checked” quality programs?
 - This is an indicator of access to primary care
 - How well are these people managing their different cardiovascular and diabetes risk factors?
 - This is an indicator of the effectiveness of overall care
 - What is the uptake of eye screening?
 - This is an indicator of integration / access to a specialised service
- Conclusions and a summary of national responses are provided.

Note: Feedback and benchmarking highlighting comparisons between DHBs is available separately.

Diabetes Information...

- Information is reported to Local Diabetes Teams by ethnicity:
 - Maori, Pacific, NZ European, Others, Not stated
- The number of people with diabetes with a free check in the calendar year is compared with the estimated number of people with diagnosed diabetes in each DHB (see MOH diabetes toolkit). This is “case detection”.
- The 2001 census is now used as a basis for estimating numbers. 2001 results and 2002 targets have been adjusted to make them compatible with new estimates.
- This indicator reflects the access to primary care diabetes quality programs.
- The information is presented in “radar plot” graphs, which are unusual but once you are familiar with them they are easy to interpret at a glance...

“Radar plot” graphs ...

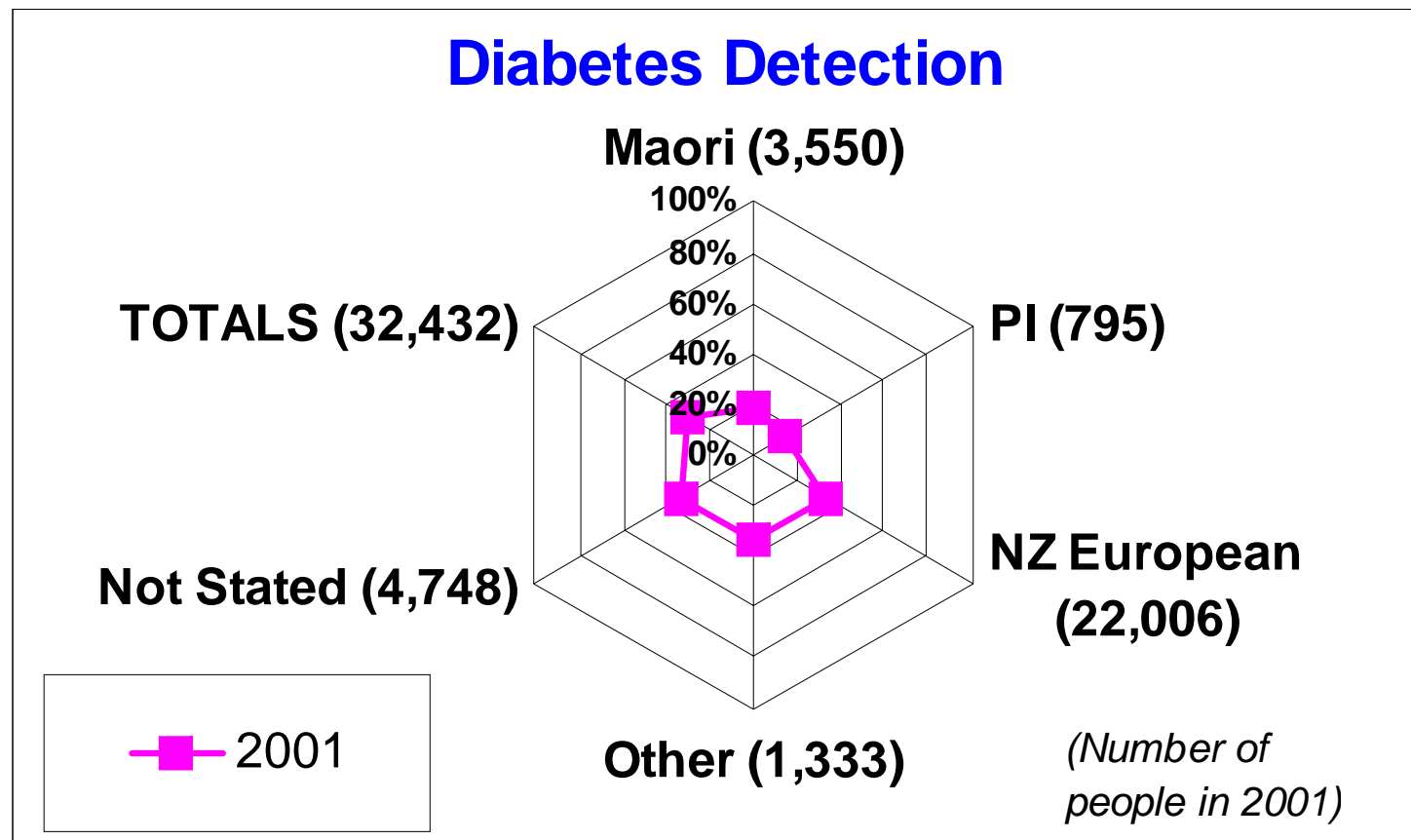


If the polygon is larger it indicates better overall system performance.

If the polygon is symmetrical it indicates equitable performance for all ethnicities.

The axis is distance from the centre. Actual numbers may be in brackets.

2001 diabetes detection...

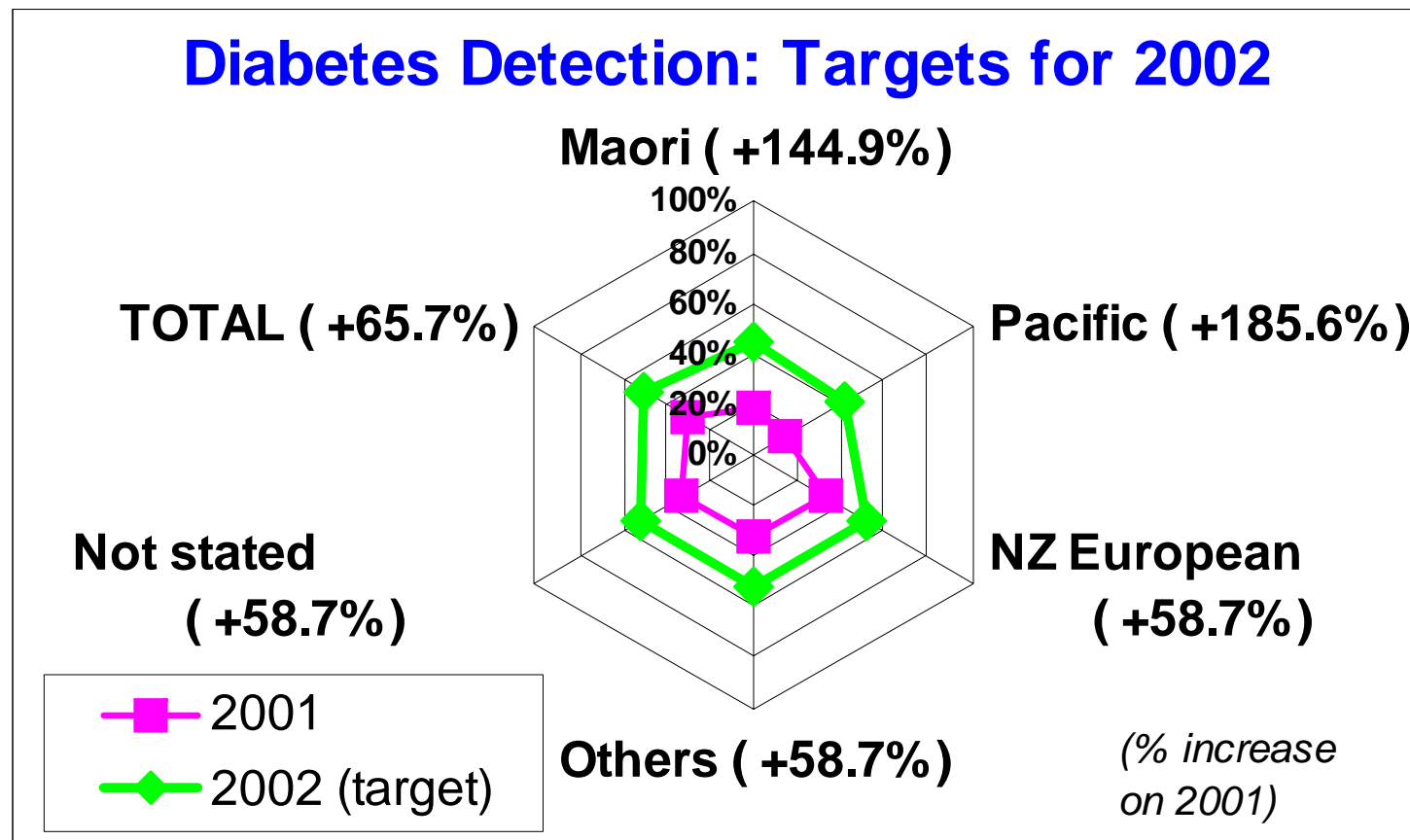


In 2001 there were 32,432 people with diabetes who had a “free annual check”.

This was less than 40% of the estimated number of people in New Zealand with diagnosed diabetes (see “TOTALS”).

Maori and Pacific were under- represented (about 20% of their estimated numbers).

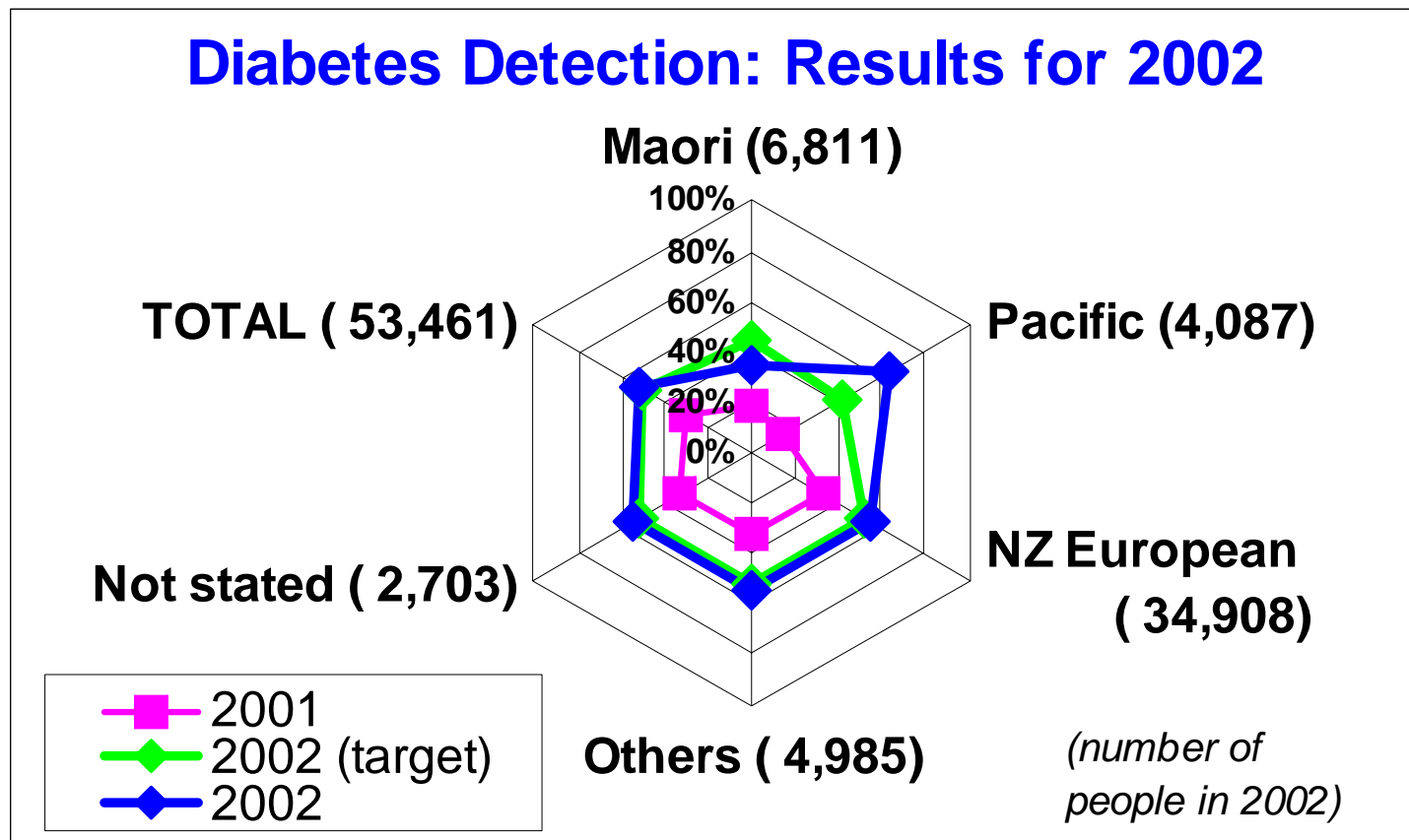
2002 Targets ...



DHBs with input from Local Diabetes Teams set targets for 2002.

Overall the targets represented an additional 65.7% increase in people getting free annual checks, and would have reduced inequalities for Maori and Pacific people

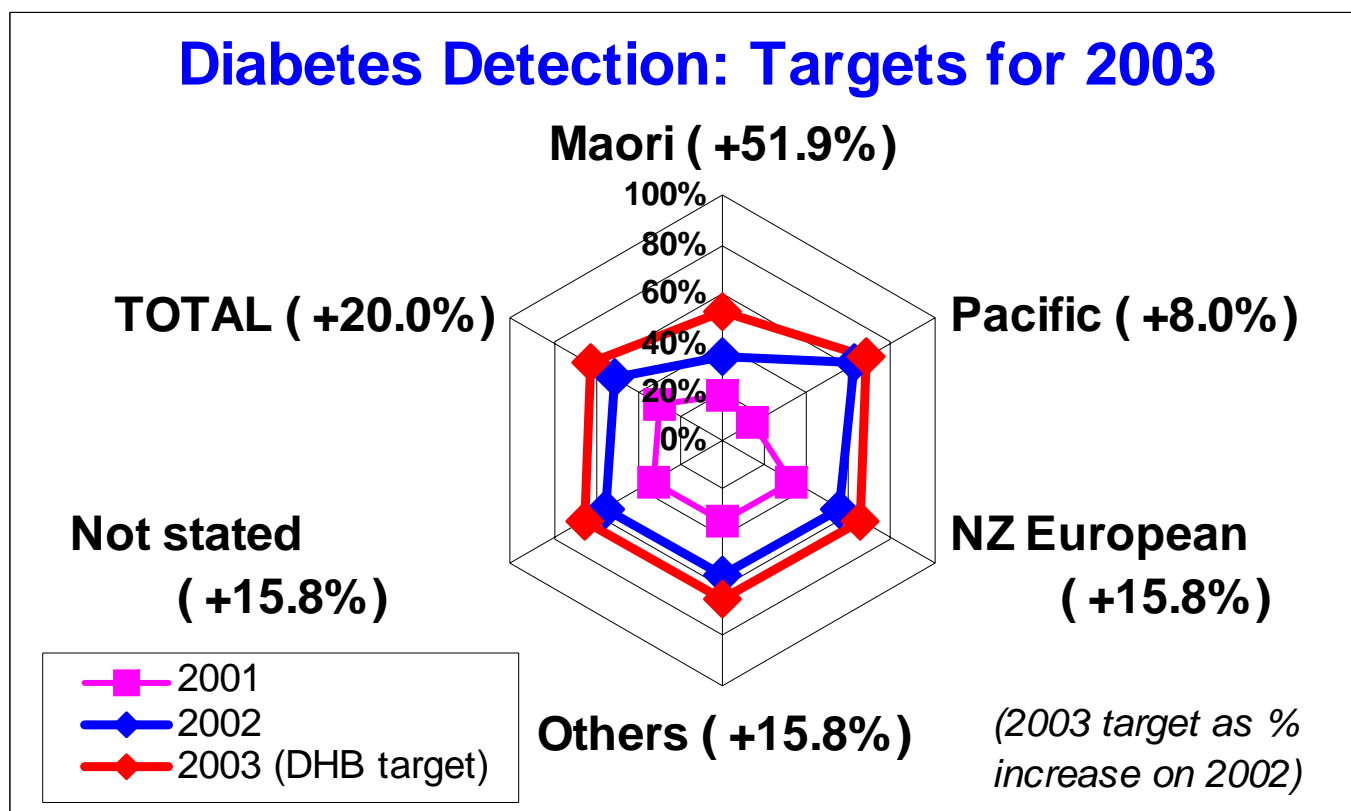
2002 Results ...



Actual results for 2002 improved by 72% to 53,461. This is 51% of the estimated people with diagnosed diabetes in New Zealand. Targets were exceeded for all except Maori. Diabetes detection improved for Maori, but relative inequality increased.

For Pacific people there was marked improvement of 55% more than the target, and more than equity with NZ Europeans.

2003 Targets...



NOTE that these are LDT recommendations, not necessarily accepted by DHBs. However LDTs are responding with targets to reduce inequality for Maori.

The overall improvement - if targets are reached - would clearly not be as great as between 2001 and 2002. However if this planned rate of improvement continues it would only take 3 years to meet or exceed 95% diabetes detection for all ethnicities.

Summary of Diabetes detection...

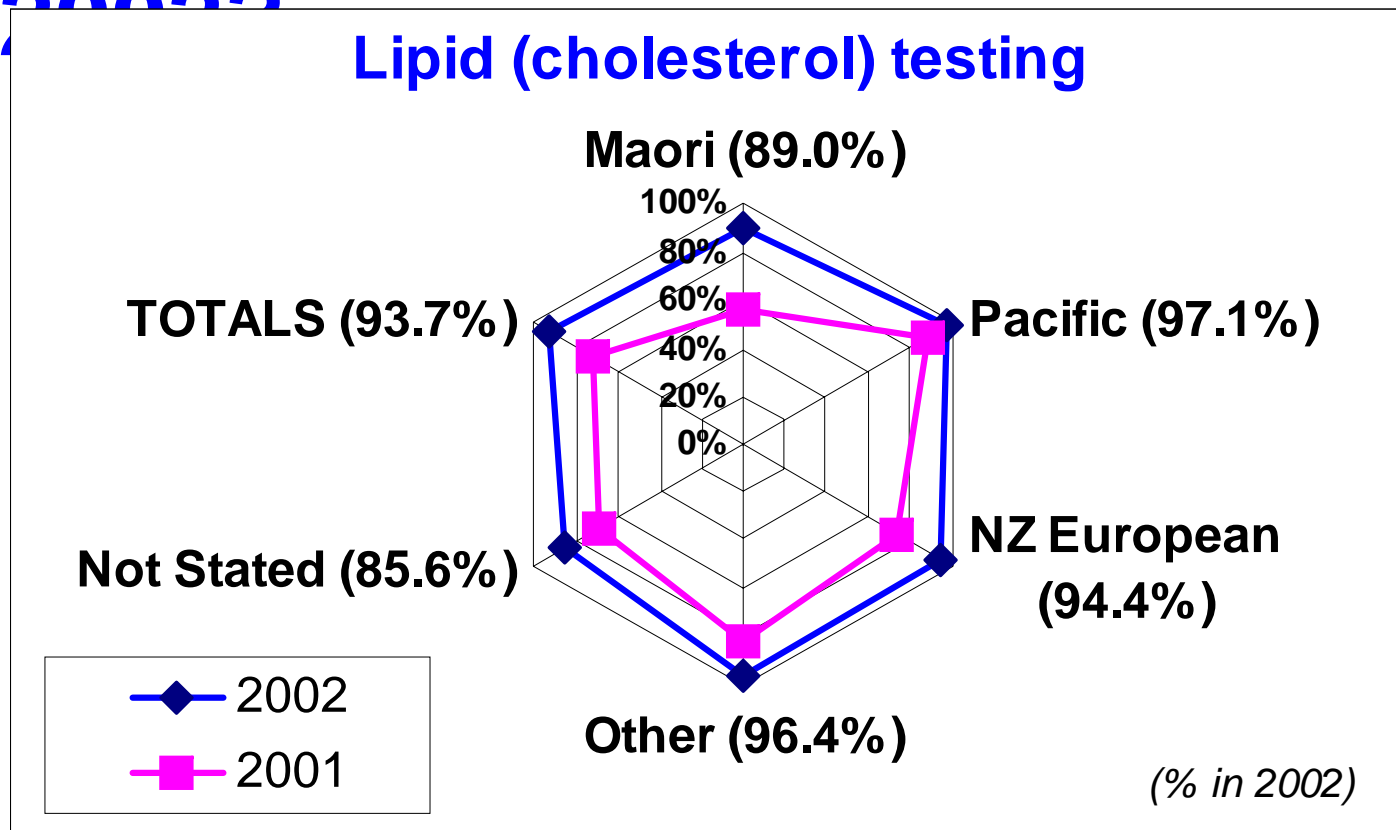
- 53,461 people had a free check in 2002. This represents 51% of all people estimated to have diagnosed diabetes.
- DHBs collectively exceeded their targets for all groups except Maori.
- Only 35% of Maori people estimated to have diagnosed diabetes had a free check in 2002.
- The best DHBs for all ethnicities combined are Hawkes Bay (77%) and Otago (70%).
- For Maori the best DHBs are Hawkes Bay (63%) and Northland (60%).
- Other DHBs should be capable of reaching the diabetes detection already present in Hawkes Bay, Northland, and Otago.

Cardiovascular information ...

- Cardiovascular disease (including heart attack and stroke) in people with diabetes is the cause of 70% of premature deaths, and has the greatest impact on quality-adjusted life years.
- Treatment to reduce this impact requires several approaches. These include initial assessment of lipids, blood pressure, and smoking. Specific information about these risk factors and their treatment is reported to LDTs.
- The optimum level of testing or prescribing cannot be established from the information reported to LDTs.

What happened to key measures of quality of care in 2002

Note: Not all people with diabetes need an annual cholesterol test (for example children & young adults with type 1 diabetes).

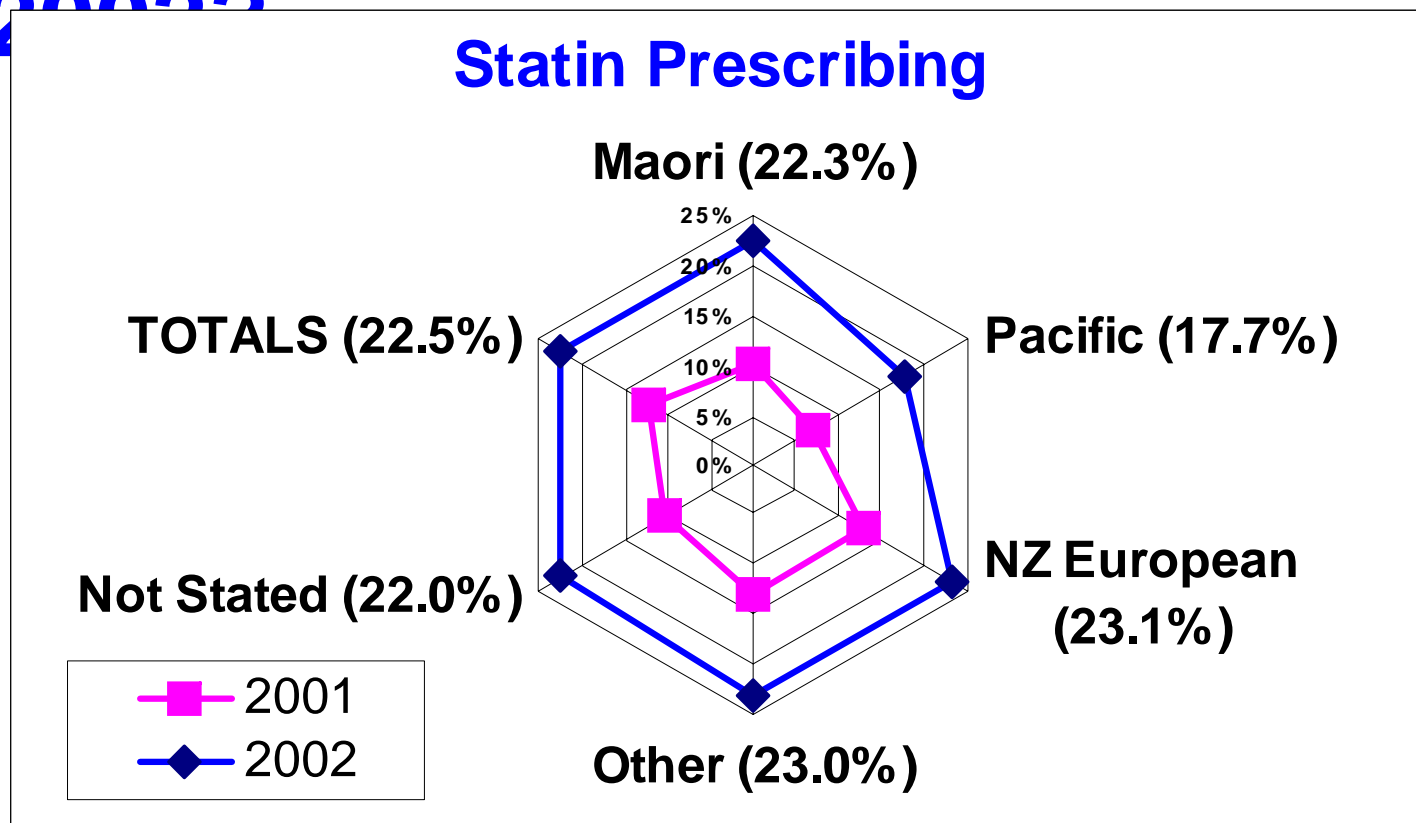


This was clearly inequitable for Maori in 2001. Only 60% had a cholesterol reported in the preceding year.

In 2002 overall improvement was marked with a substantial improvement in equality for Maori.

What happened to key measures of quality of care in 2002

Note:
 Pharmac substantially improved access to statins only after 4 months into 2002. Statin prescribing should continue to improve in 2003.



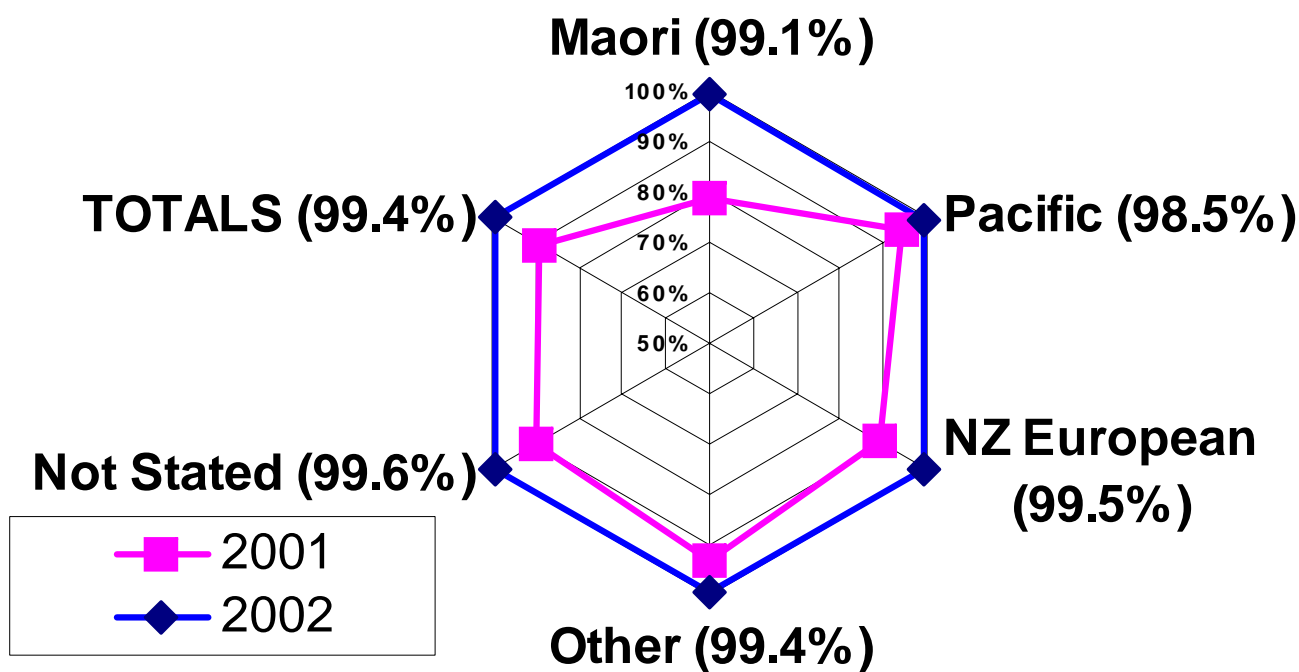
Access to statins was clearly inequitable for Maori in 2001, perhaps in part because cholesterol results were not available for many people.

In 2002 overall improvement was marked with a substantial improvement in equality for Maori (but not Pacific peoples).

What happened to key measures of quality of care in 2002

Note: Next year these indicators will change to reflect the new evidence-based guidelines, and the new criteria for access to statins.

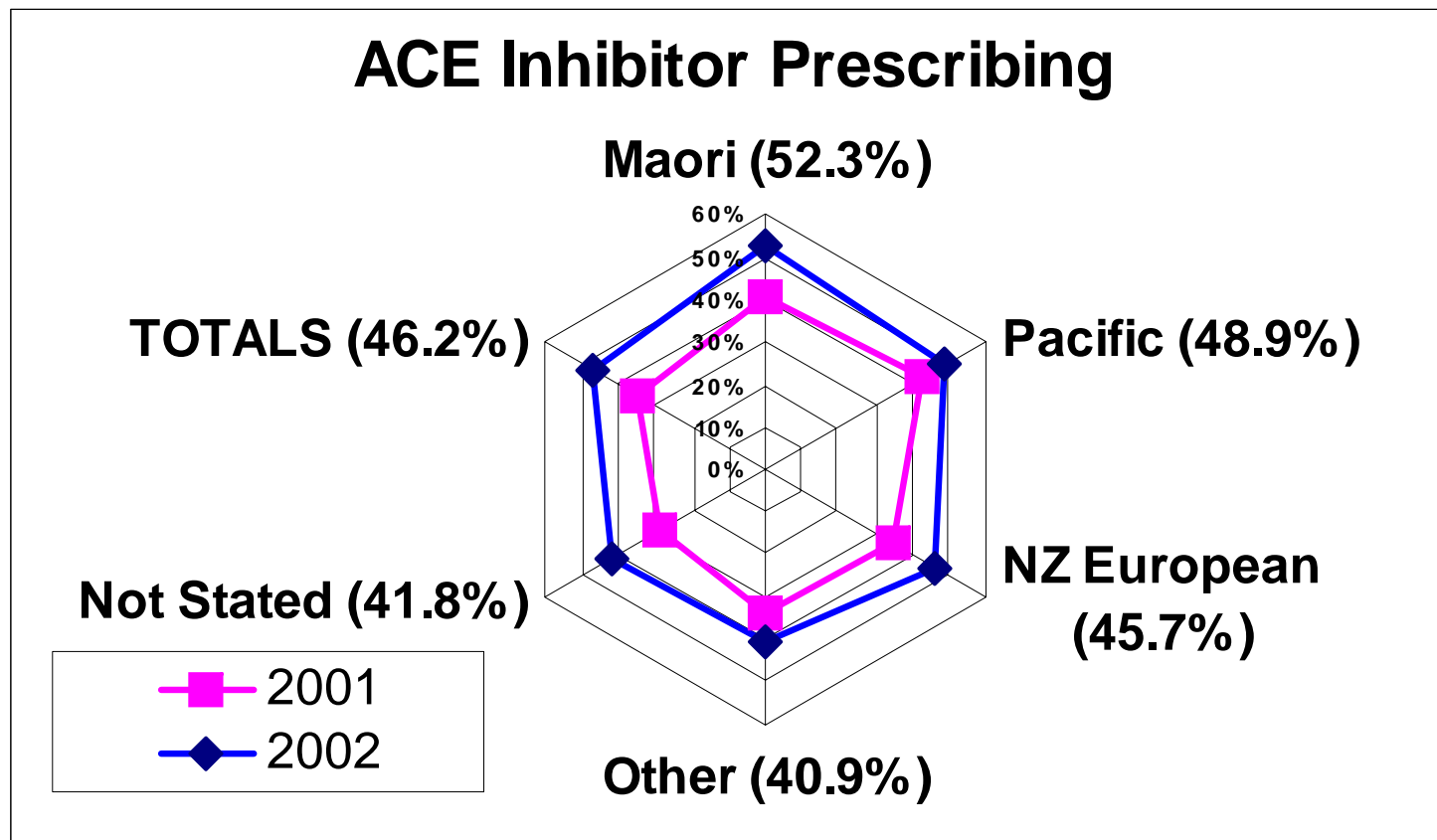
Cholesterol not more than 9 mmol/l



20% of Maori had very high cholesterol levels (>9mmol/l) in 2001, but by 2002 this proportion had been reduced to less than 1%. Lower rates of statin prescribing in Pacific remain important, but are not reflected in this indicator. People with high cholesterol may have started medication.

ACE inhibitor prescribing

Note: Next year these indicators will change to reflect the new evidence-based guidelines.

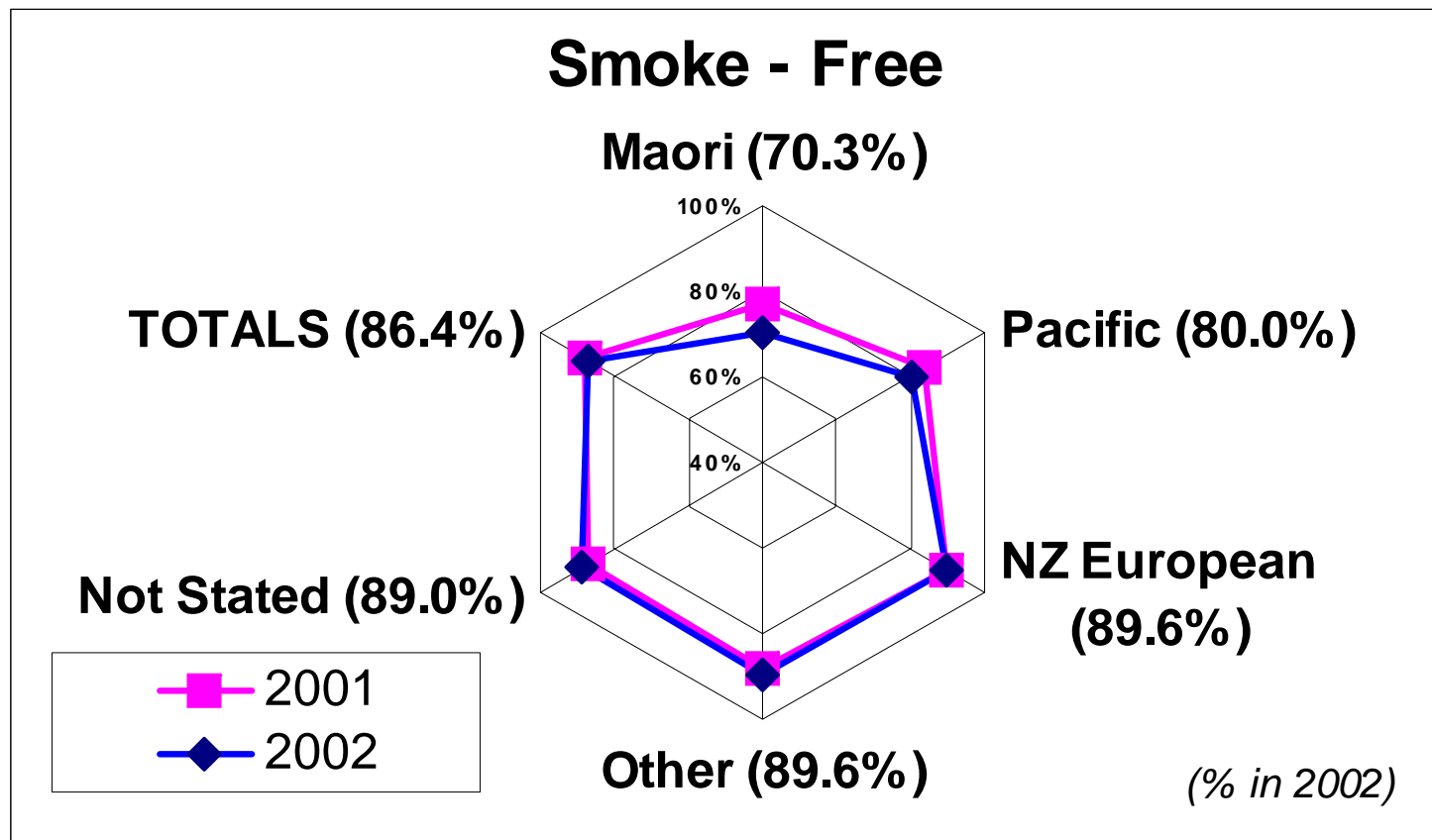


ACE inhibitors are important interventions for reducing cardiovascular disease (eg heart attacks and stroke), and renal failure.

ACE inhibitors should be, and are, more commonly prescribed in Maori and Pacific people with diabetes (to reduce the risk of renal failure).

Smoking...

Note: The "free check" IT systems will be improved to allow more focus on NRT and smoking cessation.

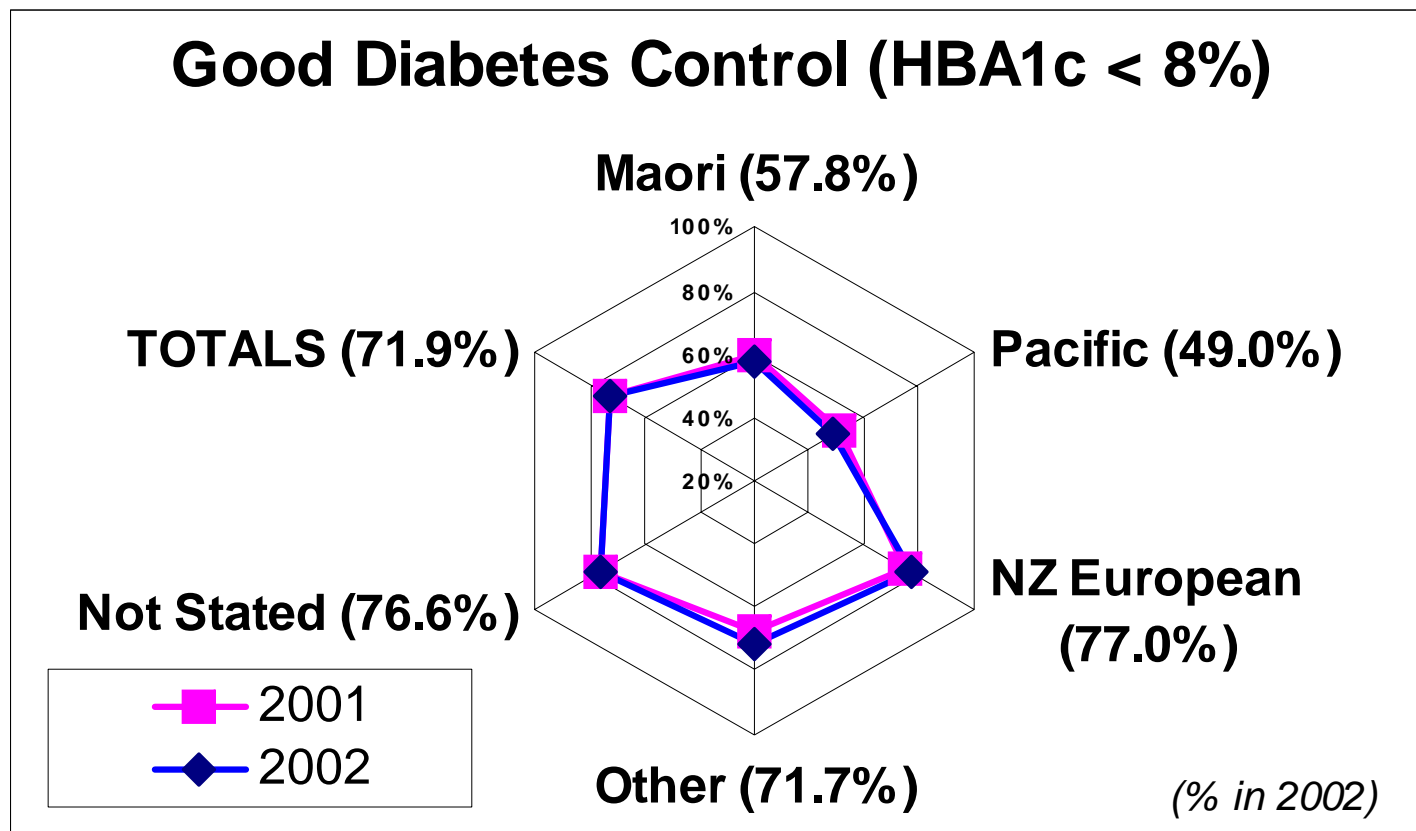


The proportion of people in 2002 who said they were smoke-free was lower than in the smaller number of people in 2001. Smoking may not be becoming more common – it may be that the extra Maori and Pacific people reached in 2002 were more likely to be smoking.

If smoking is becoming more common it might reduce or cancel the gains from statins in Maori and Pacific people.

Differences by ethnicity

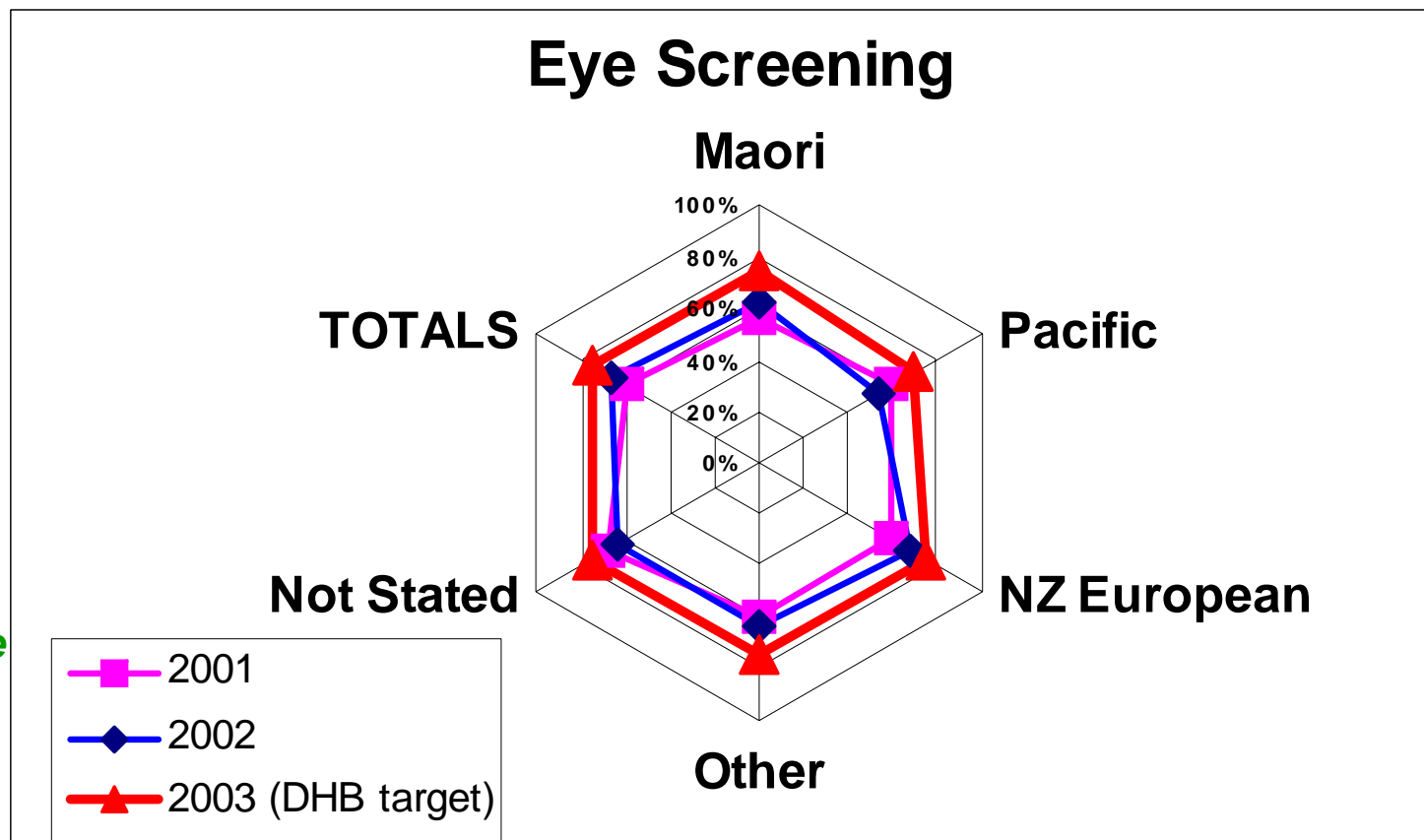
Note: If glycaemic control remains unchanged while life expectancy increases with lower CVS risk then renal failure, blindness, and amputation is expected to increase.



Glycaemic control was not equitable in 2001, and did not change in 2002 for any ethnicity.

Targets are agreed with each DHB for this indicator, but this indicator is unlikely to change without collaborative innovation programs.

Eye screening



Note: An estimated 70 people become blind as a result of diabetes each year.

Several DHBs are reviewing eye screening uptake.

4 DHBs have taken active and very affordable measures to improve eye screening uptake to more than 90% for all ethnicities. 2003 targets are similar to targets for 2002.

Conclusions

- Nationally the access to Get Checked programs increased by 72% to 53, 461 in 2002.
- An important priority for Maori is increasing diabetes detection. DHB targets for 2003 recognise this.
- Cholesterol testing; ACE inhibitor and statin prescribing; and the proportion of people with very high cholesterol are improving for all ethnicities.
- Maori and Pacific people with diabetes are more likely than other New Zealanders to have poor blood sugar control, and are more likely to smoke. Innovation and collaboration will be required to improve these critical risk factors.
- Eye screening uptake is a priority for improvement in all ethnicities.

Responses at national level

- The Ministry of Health has funded the New Zealand Guidelines Group to update of the evidence-based guidelines for diabetes and cardiovascular disease. The guidelines are due for launch in early July 2003.
- The information systems and indicators used in primary care and reported to Local Diabetes Teams (LDTs) will be enhanced to align with the updated guidelines.
- Diabetes detection (reported by ethnicity) will be a specific indicator for DHBs to monitor Primary Health Organisations. At least one other diabetes indicator may be included.
- The PHO funding includes “Services to Improve Access”. This is being used by some PHOs to find more people with diabetes. “Care Plus” pilots offer opportunities to improve diabetes treatment including lifestyle advice and specifically glycaemic control.
- Workshops with LDTs and DHBs is being organised, and the MOH Diabetes Toolkit is being updated.
- DHB benchmarking is separately available.
- Benchmarking with international centres is proposed.

Acknowledgements

- Many individuals and organisations have contributed to these results.
- Success in quality improvement requires teamwork at every level, but this two teams working together are the foundation:
 - People with diabetes and their whanau/families, and especially people who have been offered and accepted the opportunity to access a free annual check.
 - Primary health teams (GPs, nurses and receptionists) offering free checks, and ensuring that people with diabetes receive the best quality care each year.
- Primary care organisations (and especially emerging PHOs), secondary care diabetes services, Local Diabetes Teams, and District Health Boards are all using this population health information to improve access to care, the quality of care, and reliable follow-up.
- Others genuinely too numerous to record here who support people with diabetes, and are committed to reducing the incidence and impact of diabetes in New Zealand.