Saint Vincent: A new responsibility for general practitioners?

> '...The outcome of our work has confirmed our belief that the goals of the St Vincent Declaration, to which all are committed, are attainable in the United Kingdom.'
>
> — Report of the St Vincent Joint Task Force for Diabetes, 1995[1]

Introduction

PRIMARY care will have a key role if the new deal for people with diabetes described in the Saint Vincent Joint Task Force Report[1] is to succeed. The challenges of St Vincent include a major attack on the long-term, disabling complications of diabetes. The goals for these are:

(1) to decrease retinopathic blindness and end-stage diabetic renal failure by one-third or more;
(2) to halve amputations for diabetic gangrene;
(3) to reduce the aggravated morbidity and mortality from coronary heart disease and stroke; and
(4) to normalize the outcome of pregnancy in women with diabetes.

There is now good evidence that most of these distressing and disabling sequelae of diabetes may be delayed or prevented.[2]

The complications of diabetes constitute not only a serious threat to life and health, but are also enormously costly in health and social resources. Earlier estimates that the direct (clinical) costs of diabetes account for 5% of the total National Health Service (NHS) budget[3] have recently been more accurately calculated at 8–9%.[4] In the USA in 1992,[5] diabetes claimed nearly 15% of total health care expenditure. It is estimated that over half of the direct costs of diabetes go to the management of diabetic complications. The indirect costs, in lost production, social support and relief of distress, are at least as large as the direct ones.[6,7]

A strong message from the St Vincent Declaration to people with diabetes, to the health care professions, to those who allocate resources and to the general public is that the disability and premature death, for so long associated with diabetes, can now in large part be delayed or prevented. General practitioners and practice nurses will be at the forefront of a challenging but achievable national initiative to help lift the threat of the complications of the disorder from the life of people with diabetes, and to relieve the national economy of its enormous financial burden. Investment now will reap an ultimate, hugely desirable dividend.

Improving diabetes management

Findings from the landmark US Diabetes Control and Complications Trial (DCCT)[8] in insulin-dependent diabetes confirmed what clinicians had long suspected — that the better the blood glucose control, the greater the reduction of risk for the retinal, renal and neurological complications of diabetes. These conclusions are very likely also to be applicable to people with non-insulin-dependent diabetes (NIDDM, Type 2); epidemiological studies also show strongly suggestive positive relationships between levels of glycaemic control and frequency of complications.[9] Randomized clinical trial evidence from the United Kingdom Prospective Diabetes Study (UKPDS) should provide much needed information in a few years, including costs and benefits of improved glycaemic control in NIDDM.[10]

For NIDDM patients, usually in their sixties and seventies, atherosclerotic arterial disease, with myocardial ischaemia, stroke, claudication and gangrene, is the predominant hazard.[11,12] Detection, correction and response monitoring of the major risk factors ranks in importance alongside good diabetic control. Increased urinary albumin excretion, even in the subclinical microalbuminuric range, is an independent marker of raised cardiovascular as well as renal risk and calls for redoubled protective effort.

Facing the new challenge

For patients, the good news is that better control of diabetes, early detection and treatment of markers of complications and reversal of major cardiovascular risk factors will result in a healthier and longer life. Less good is the news of the additional care, concern and costs required to achieve these. Improving blood glucose control, seeking and correcting abnormal arterial pressure, plasma lipids and undesirable life-styles, and regular screening of eyes, feet and urine, will make considerable demands on patients and those who care for them. If the essential high quality of this undertaking is to be maintained, both groups need the motivation of recognizing the outstanding ultimate value of this long-term systematic effort.

New challenges, new responsibilities, new burdens?

General practitioners and their teams are already coping with many new responsibilities. Therefore, the additional challenge of the St Vincent diabetes initiative may evoke mixed feelings. However, the great majority of practices are already signed up for the Chronic Disease Management Programme for diabetes. Fortunately, diabetes is a team effort, and the special skills and the increased workload will be spread among the members of the primary care team.

The existing CDM practice list of people with diabetes is an excellent starting point for establishing, step by step, a 'risk and action' profile for each individual diabetic patient, ultimately covering the major clinical target areas of St Vincent. In any case, these are all central to good diabetes care. The state of the eyes, condition of the feet, level of the blood pressure (and lipids), protein in the urine, sensible diet and lifestyle advice, and all the other St Vincent requirements are no more (and no less) than the elements of sound doctoring.

What St Vincent demands is getting these elements organized, and systematically and competently performed. Modern information technology should ease this task, helping to run the practice but also making year-on-year improvements in care easier to assess, problems easier to spot and remedy, and anonymized data available for local, regional and national research and analysis. The local diabetes specialist team should be eager to offer whatever assistance it can in achieving all of this. If it is not, we would like to hear about it!

National and local strategy for diabetes care

Those now responsible for the allocation of resources and the setting of priorities will need to review and renew their strategies for diabetes care in the light of the St Vincent Declaration and the DH/BDA Task Force Report.[1] A recent letter to Health Authorities and Trusts from the NHS Executive has drawn attention to this Report and its recommendations; more detailed guid-

ance for the implementation of St Vincent will form part of the NHS Executive's clinical effectiveness programme. This letter puts both purchasers and providers of care on notice that they should square up to the way services for people with diabetes are provided.

Local diabetes services advisory groups

A Task Force recommendation which calls for early action is the establishment of a Local Diabetes Services Advisory Group (LDSAG)[13] in each locality. The LDSAG should include local commissioners, primary and specialist diabetes care providers; and also, importantly, people with diabetes themselves and lay caregivers. Many disciplines are involved in diabetes care — nutritionists, chiropodists, and the clinical disciplines of ophthalmology, nephrology, cardiology, obstetrics, cardiovascular surgery and others. These should contribute as necessary. The purpose of the LDSAG is to review local service provision for diabetes in the light of the agreed St Vincent Task Force recommendations, to identify inadequacies, and to advise on improved strategies and future developments.

Representative general practitioner and practice nurse involvement with these local groups are of critical importance. Already operating well in some areas, LDSAGs have been found invaluable in helping to set realistic strategies and to bring multidisciplinary and multiagency service provision together. General practitioners might ask, 'Do I have a Local Diabetes Services Advisory Group? Could I contribute to one?' There is clear potential advantage for the patient in improving professional collaboration and integration between primary care and hospital-based specialist diabetes services. Where one exists, the local Diabetes Centre should become a resource, in joint 'ownership', a focal point and a professional meeting place where local needs and concerns can be discussed and solutions sought.

Registers and guidelines

The Task Force Report also raised the question of developing 'population-based diabetes registers' to assist in covering the clinical needs of all patients and to help collect key clinical information. Given interprofessional confidence locally, it should be possible to resolve difficulties over confidentiality, access, control, use and ownership of the data. Clearly, this is an area with opportunities for maintaining a joint professional overview of the successes — and the shortfalls — in the local programmes of diabetes care.

Diabetes research and development in general practice

There is a great need for research and development studies in diabetes at the primary care level, and at the important interface between general practice and the locality diabetes specialist team. Well-conducted population-based studies of diabetes and its complications, the impact of social, emotional and economic factors, and the effective long-term application of preventive strategies are among the areas of great value both to knowledge generally and to improved health outcomes specifically. They are also areas of enquiry and observation to which primary care conditions are particularly well fitted.

The British Diabetic Association, in the process of launching its Primary Care Section, is keen to support research and development, to offer its help and extend its activities generally to where so much patient care is now being provided. Again, the local diabetes specialist team should be able to offer technical and perhaps organizational and logistic assistance if required.

Good clinical care is at the heart of the Saint Vincent initiative. Many localities have prepared and are working to excellent clinical guidelines. These are often founded on models from the Royal Colleges and the British Diabetic Association,[14] but need to be developed locally and modified where necessary to meet local conditions. However, they help to ensure that everyone works to common standards and speaks the same clinical language, of particular importance in collecting information to see if the St Vincent targets are being hit.

Diabetes care requires above all the regular, systematic surveillance of patients at risk, something that general practice is especially good at. Professional collaborative effort between general practitioners working through the Chronic Disease Management Programme and their colleagues in the network of diabetes specialist teams and Diabetes Centres could make a unique contribution in the UK to the achievement of the St Vincent goals and to the greatly improved well being of people with diabetes.

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References

1. St Vincent Joint Task Force for Diabetes. *The report.* London: Department of Health and British Diabetic Association, 1995.*
2. Clark CM, Jr, Lee DA. Prevention and treatment of the complications of diabetes mellitus. *N Engl J Med* 1995; **332:** 1210-1217.
3. Laing W, Williams R. *Diabetes: a model for health care management.* London: Office of Health Economics, 1989.
4. Currie CJ, Gill L, Peters JR. Costs of diabetes related complications. Abstract P 162, Spring Meeting, Medical & Scientific Section, British Diabetic Association, Dublin, 1996. *Diabetic Medicine* 1996; **13:** in press.
5. Rubin RJ, Altman WM, Mendelson DN. Health care expenditures for people with diabetes mellitus, 1992. *J Clin Endocrinol Metab* 1994; **78:** 809A-809F.
6. American Diabetes Association. *Direct and indirect costs of diabetes in the USA in 1992.* Alexandria, VA: American Diabetes Association, 1993.
7. Olsson J, Nilsson S, Persson U, Melander A, Tollin C. Comparison of excess costs of care and production losses because of morbidity in diabetic patients. *Diabetes Care* 1994; **17:** 1257-1263.
8. Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin dependent diabetes mellitus. *N Engl J Med* 1993; **329:** 977-986
9. Nathan DM. Inferences and implications. Do results from the Diabetes Control and Complications Trial apply in NIDDM? *Diabetes Care* 1995; **18:** 251-257.
10. Turner R, Cull C, Holman R. United Kingdom Prospective Diabetes Study 17: the effect of improved metabolic control on complications in NIDDM. *Annals Int Med* 1996; **124:** 136-145.
11. Moss SE, Klein R, Klein BE. Cause-specific mortality in a population-based study of diabetes. *Am J Public Health* 1991; **81:** 1158-1162.
12. Stamler J, Vaccaro O, Neaton JD, Wentworth D. Diabetes, other risk factors, and 12-year cardiovascular mortality for men screened in the Multiple Risk Factor Intervention Trial. *Diabetes Care* 1993; **16:** 434-444
13. British Diabetic Association. *Guidance on local diabetes services advisory groups.* London: British Diabetic Association, 1995.*
14. British Diabetic Association. *Recommendations for the management of diabetes in primary care.* London: British Diabetic Association, 1993.*

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