

Challenges in healthcare provision

Advances in medicine have resulted in decreased neonatal and child mortality and greater longevity in the developed countries. However a declining birth rate has resulted in a significant proportion of the population being the retired and the elderly. Infectious diseases no longer pose a major health threat in the developed as opposed to the developing countries with the former showing an exponential increase in the prevalence of chronic non communicable disease, the associated morbidity proving a huge burden on healthcare budgets.

Obesity, diabetes mellitus and cardiovascular disease top the list of chronic non-communicable diseases. This issue includes an assessment of the care provided patients suffering from Type II Diabetes Mellitus in a primary health care setting and analyses the quality of care provided as measured by the ability to meet targets in disease control. Much has been achieved but so much more needs to be done. The author concludes that patient education and empowerment is crucial to improving outcomes in chronic disease. Naturally ensuring access to multidisciplinary care, medications and regular screening for complications remains important. Such care however does not and should not be the remit of tertiary centres but must and should devolve to community care. At a professional level, the establishment of guidelines for the follow up and management of chronic disease such as diabetes would aid healthcare providers to ensure that health care delivery in the community is evidence-based and that standards of quality care are adhered to and attained. On a national level, a public health campaign should educate the public as to the services available in the community and develop the concept that should problems arise, then there is scope for referral to a tertiary referral centre. The review article on Charcot's arthropathy, a complication of uncontrolled diabetes highlights the need for access to specialised care. The loss of productivity related to the onset of complications of diabetes, and indeed other chronic diseases, is deleterious to a country's economy and hence the focus should remain primary prevention. Whilst it may seem appreciably difficult to justify allocation of a significant proportion of healthcare budgets to primary prevention, the long-term benefit to patients AND healthcare providers have been proven again and again.¹ The recommendation is that three times a country's gross national income per capita is cost-effective. Furthermore with respect to secondary prevention, for example, achievement of glycaemic and blood pressure control in rural India decreased the prevalence of chronic kidney disease at a cost of 43 US cents per capita of the population.² There is no reason why Malta should not be able to achieve the same targets. Cutajar reports that HbA_{1c} level was controlled in 37.3%, systolic blood pressure

was controlled in 44.5%, cholesterol was controlled in 30% while LDL was controlled in 10.9% of patients. Considering that all patients suffering from diabetes mellitus have a constitutional right to free medication, then surely we can increase the percentage of patients achieving glycaemic and blood pressure targets.

With respect to diabetes, but certainly also in all chronic non-communicable diseases, global equity in healthcare provision remains one of the major challenges that healthcare professionals and providers have to face but perhaps we can learn from past experience. Why is it that for example a low income country such as Costa Rica can achieve the same rate of renal transplant as a high income country such as Norway?³ There are surely lessons to be learnt here in terms of the management of chronic disease. Even more important is the fact that studies have shown that the annual cost of maintaining a patient with a renal transplant is 25-33 per cent that of maintaining a patient on dialysis. The recipients' quality of life is significantly improved and their economic productivity is re-instated.

The evidence, is overwhelming be it for diabetes, heart disease⁴ or indeed other chronic non-communicable disease. The time for an in-depth analysis of what plagues healthcare is long overdue. Global equity in healthcare appears to remain the dream of those who are idealists but there are success stories out there and not necessarily in countries with a high GDP. Observation represents one of the fundamental principles of the scientific method coupled with analysis of outcomes, the solutions to the challenges that plague healthcare delivery become evident. An injection of resources is necessary but the long-term benefits to the community and the healthcare providers more than justify the expenditure. The burning question remains: Who has the foresight, and the courage to embark on this particular journey?

Josanne Vassallo
Editor

References

1. Macroeconomics and Health. Investing in health for economic development - Report of the commission on Macroeconomics and Health. Geneva. WHO 2001
2. Mani MK. Nephrologists sans Frontieres: Preventing chronic kidney disease on a shoestring. *Kidney Int* 2006; 70:821-3
3. White S, Chadban SJ, Jan S, Chapman JR and Cass A (2008) How can we achieve global equity in provision of renal replacement therapy? *Bulletin of the World Health Organisation* March 2008 86 (3) 229-237
4. Gaziano TA, Ople LH, Weinstein MC. Cardiovascular reconnection on a multidrug regimen in the developing world: a cost effective analysis. *Lancet* 2006; 368:679-86.