# Preface

There is now extensive evidence on the optimal management of diabetes, offering the opportunity of improving the immediate and long-term quality of life of those with the condition.

Unfortunately such optimal management is not reaching many, perhaps the majority, of the people who could benefit. Reasons include the size and complexity of the evidence-base, and the complexity of diabetes care itself. One result is a lack of proven cost-effective resources for diabetes care. Another result is diversity of standards of clinical practice.

Guidelines are one part of a process that seeks to address those problems. Many guidelines have appeared internationally, nationally, and more locally in recent years, but most of these have not used the rigorous new guideline methodologies for identification and analysis of the evidence.

Increasingly, national organizations have sought to use these new approaches, which are described in the IDF publication *Guide for Guidelines*. It was noted in that document that many countries around the world do not have the resources, either in expertise or financially, that are needed to promote formal guideline development. In any case, such a repetitive approach would be enormously inefficient.

Accordingly the International Diabetes Federation (IDF) has developed a global guideline. For reasons of efficiency the current initiative has chosen to use the evidence analyses of prior national and local efforts. This should also help to ensure a balance of views and interpretation.

A global guideline presents a unique challenge. Many national guidelines address one group of people with diabetes in the context of one health-care system, with one level of national and health-care resources. This is not true in the global context where, although every health-care system seems to be short of resources, the funding and expertise available for health care vary widely between countries and even between localities.

Published national guidelines come from relatively resource-rich countries, and may be of limited practical use in less well resourced countries. Accordingly we have also tried to develop a guideline that is sensitive to resource and cost-effectiveness issues. Despite the challenges, we hope to be found to have been at least partially successful in that endeavour, which has used an approach that we have termed 'Levels of care' (see next page).

Funding is essential to an activity of this kind. IDF is grateful to a diversity of commercial partners for provision of unrestricted educational grants.

# Levels of care

All people with diabetes should have access to cost-effective evidence-based care. It is recognized that in many parts of the world the implementation of particular standards of care is limited by lack of resources. This guideline provides a practical approach to promote the implementation of cost-effective evidence-based care in settings between which resources vary widely.

The approach adopted has been to advise on three levels of care:

## ■ Standard care

Standard care is evidence-based care which is cost-effective in most nations with a well developed service base, and with health-care funding systems consuming a significant part of national wealth.

Standard care should be available to all people with diabetes and the aim of any health-care system should be to achieve this level of care. However, in recognition of the considerable variations in resources throughout the world, other levels of care are described which acknowledge low and high resource situations.

## ■ Minimal care

Minimal care is the lowest level of care that anyone with diabetes should receive. It acknowledges that standard medical resources and fully-trained health professionals are often unavailable in poorly funded health-care systems. Nevertheless this level of care aims to achieve with limited and cost-effective resources a high proportion of what can be achieved by *Standard care*. Only low cost or high cost-effectiveness interventions are included at this level.

## ■ Comprehensive care

Comprehensive care includes the most up-to-date and complete range of health technologies that can be offered to people with diabetes, with the aim of achieving best possible outcomes. However the evidence-base supporting the use of some of these expensive or new technologies is relatively weak.

## Summary of the Levels of Care structure

### Standard care

Evidence-based care, cost-effective in most nations with a well developed service base and with health-care funding systems consuming a significant part of their national wealth.

### Minimal care

Care that seeks to achieve the major objectives of diabetes management, but is provided in health-care settings with very limited resources – drugs, personnel, technologies and procedures.

### Comprehensive care

Care with some evidence-base that is provided in health-care settings with considerable resources.

# Methodology

The methodology used in the development of this guideline is not described in detail here, as it broadly follows the principles described in *Guide for Guidelines*.

In summary:

- The process involved a broadly based group of people, including people with diabetes, health-care professionals from diverse disciplines, and people from non-governmental organizations (see *Members of the Guidelines Group*).
- Within the Group, a number of people had considerable experience of guideline development and health economics, and of health-care administration, as well as of health-care development and delivery, and of living with diabetes.
- Geographical representation was from all the IDF regions, and from countries in very different states of economic development (see *Members of the Guidelines Group*).
- In general the evidence analyses used were published evidence-based reviews and guidelines from the last 5 years; those used are referenced within each section. However, members of the Group were asked to identify any more recent publications relevant to the section of the guideline allotted to them, and encouraged to review details of papers referred to in the published guidelines. Key evidence-based reviews and meta-analyses are also referenced.
- The whole Group met to hear the synthesis of the evidence for each section of diabetes care, to address what recommendations should be made, and to make recommendations over what should be in each *Level of care* for each section.
- The results from the meeting were synthesized into written English by a scientific writer with a knowledge of diabetes, with the assistance of the initiative's chairmen; those drafts were then reviewed by the members of the Group who originally worked on each section, and amendments made according to their suggestions.
- The whole draft guideline was sent out for wider consultation to IDF member associations, IDF elected representatives globally and regionally, interested professionals, industry sponsors (of the guideline and of IDF generally), and others on IDF contact lists, a total of 378 invitations. Each comment received was reviewed by the two chairmen and the scientific writer, and changes were made where the evidence-base confirmed these to be appropriate.
- The revised and final guideline is being made available in paper form, and on the IDF website. The evidence resources used (or links to them) will also be made available. Versions are also being made available in descriptive form (in *Diabetes Voice*), and in language made accessible to people without technical medical training.
- Past experience of international diabetes guidelines is that they have a useful lifespan exceeding 5 years. IDF will consider the need for review of this guideline after 3-5 years.

# Members of the Guidelines Group

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## Consultees:

Comments on the draft were received from all IDF regions, coming from national associations, individuals, industry, non-governmental organizations, and IDF officers. All are thanked for their time and valuable input.

## Duality of interest:

Members of the Guidelines Group and consultees are acknowledged as having dualities of interest in respect of medical conditions, and in relationships with commercial enterprises, governments, and non-governmental organizations. No fees were paid to Group members in connection with the current activity. A fee commensurate with the editorial work was however paid to the spouse of one of the chairmen.