

## Guest editorial

# Community health workers for diabetes: can they help deliver improved care?

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Type 2 diabetes is a serious, life-limiting condition and is now widely acknowledged to be a global epidemic, with an estimated doubling of worldwide prevalence predicted within the next two decades.<sup>1</sup> Furthermore, the condition is known to disproportionately affect those who have the poorest access to health care; this includes the elderly, ethnic minority groups in Western societies and increasingly the populations of developing countries in Asia, Africa and South America.<sup>1</sup> Traditional hospital-based services in both developed and developing nations simply cannot deal with the numbers of patients with this disease. Health provision for diabetes which is accessible, effective and affordable is therefore a pressing need which must be addressed by all healthcare systems.

It has long been recognised that diabetes health care is most effective not only when it is structured and systematic,<sup>2</sup> but also when patients are empowered to manage their own condition as much as possible.

In many countries there have been significant improvements in the quality of diabetes care in primary care.<sup>3,4</sup> The components of such care (which include protocol driven reviews, regular follow-up and appropriate referral of complex cases) are delivered by primary care teams, mainly general practitioners (GPs) and practice nurses, and in recent years have resulted in significant improvements for patients. However, problems remain and important failings of diabetes care in the UK (and elsewhere) include inadequate emphasis on patient education and empowerment and poorer outcomes for the most disadvantaged groups. In particular it has been demonstrated that ethnic minorities,<sup>3</sup> the elderly housebound, those in residential care<sup>5</sup> and young adults<sup>6</sup> continue to have inadequate service provision in the UK.

In a linked study by Otero-Sabogal<sup>7</sup> and colleagues undertaken in a deprived US community, the findings of which are published in this edition of *Quality of Primary Care*, the authors suggest that in order to address these issues there now needs to be a move to

utilise a wider healthcare team which includes trained community health workers. In their model, Otero-Sabogal *et al* describe the positive impact of community health workers (in partnership with physicians) on biochemical markers such as glycaemic and lipid control. Of particular note (albeit in an uncontrolled pilot study) is the success of trained community health workers in engaging disadvantaged groups and using their language skills and knowledge of the community to promote education and engagement. Not surprisingly, they found that patients had much higher satisfaction levels from this approach to healthcare delivery.

This model of delivering diabetes care is potentially cheaper and is of obvious attraction to developing countries, where the availability of trained doctors and nurses is limited. It is also a model to help address inequalities in developed healthcare systems where traditional healthcare professionals may find it difficult to engage with minority groups.

This type of approach is not entirely novel in the UK, and has been tried on a limited scale with the use of peer education for cardiovascular disease prevention<sup>8</sup> and more extensively for expert patient programmes for chronic disease.<sup>9</sup> Whilst these initiatives have demonstrated some success, they have not been followed up with longer term funding, nor have they been mainstreamed into the healthcare system: this is partly because they have not been evaluated in a rigorous manner. The move of diabetes services from hospital to community raises many issues and highlights the importance of an evidence base for models of care delivery. Without such evidence it will not be possible to establish a consensus among clinicians and patients for such transformation of services.

If we are to move forward with using trained community health workers (or indeed other models of service delivery), more rigorous research (including randomised controlled trials) needs to be undertaken. These need to focus on the impact of such programmes on clinical and cost-effectiveness as well as

helping to identify effective methodologies to implement this evidence into service delivery. A model of how such programmes should be developed, evaluated and implemented is the DESMOND programme, a community based structured patient education programme for type 2 diabetes<sup>10</sup> which promises much for improving diabetes education and empowerment, including for hard to reach groups.

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## PEER REVIEW

Commissioned; not externally peer reviewed.

## CONFLICTS OF INTEREST

None.

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