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International experience on health care provision for patients with specific disease types: case of the UK

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Summary

The Ukrainian government began a significant reform of the healthcare system in 2011 with the aim to improve the equity and quality of health care in the country. The new system will be based on primary care provided by family doctors. The reforms do not currently address the concerns surrounding providing health care to groups of patients with particular disease types such as tuberculosis, HIV/AIDS, and cancer etc., even though this issue is essential for Ukraine due to a high proportion of the population with such diseases. To conduct any Ukrainian reform of healthcare provision for these groups, an analysis of international experience is invaluable.

This paper summarises the experience of the UK for providing health care for these, and other important, patient groups. This experience could be relevant to Ukraine as the British healthcare system is built on the approach of the GP as the first point of contact for most patients, and the primary giver of healthcare. This approach has been approved as the new model for Ukraine. In addition, the UK health care system is almost entirely financed from the government budget, which is also currently the case in Ukraine.

The UK evidence suggests that family doctors in Ukraine could be responsible for the diagnosis and treatment of patients with the types of diseases investigated in this paper. For this, family doctors would need access to tests required for screening and diagnosis of such disease as tuberculosis, HIV/AIDS, diabetics. The evidence also shows that it is beneficial to form surgeries for family doctors where several doctors would be present along with nurses. At the same time, the tight cooperation of family doctors and specialists doctors is necessary as they are often required to form a specialist health care team in order to provide proper and expert care for patients.

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1. Introduction

According to international definitions, Ukraine is now officially suffering from a range of disease epidemics, including tuberculosis and HIV/AIDS, which require urgent government attention. In addition, the country has a high cancer incidence rate as compared to other developed and emerging economies. Another group of patients that also require special attention are people with diabetes which, without proper treatment, can increase the risk of death from cardiovascular diseases. In 2011 the Ukrainian government initiated a health care reform, which is aimed at improving the equity and quality of the health care system in Ukraine in order to ensure the better health of population. However, the first stage of reform, which is taking place in four pilot regions (Donetska, Dnipropetrovska and Vinnytska oblasts, and city of Kyiv), does not envisage changing the approach for providing health care to patients with the particular diseases specified above. To ensure that the Ukrainian healthcare reforms can efficiently incorporate efficient and effective healthcare for these patients, an overview of international experience could be helpful.

The UK health care system is a useful comparison. Firstly, it is financed from general taxation which makes this system similar to Ukrainian system. It is also predominantly based on the primary health care provided by GPs, which has been selected as the new health care model for Ukraine. As such, an analysis of the UK's approach to provide health care services to vulnerable groups of patients could be of interest for policymakers in Ukraine.

Chapter 2 provides brief overview of healthcare system in the UK. In Chapter 3 we outline major issues related to providing health care to patients with the following types of diseases: a) tuberculosis, b) HIV and AIDS, c) diabetes. In addition, this chapter provides insights into treatment of individuals requiring replacement therapy for drug addictions, and for patients receiving palliative care. Finally, in chapter 4 we provide a number of short conclusions and draw some lessons for Ukraine.

2. Healthcare in the UK: The patient's perspective

In the UK, public healthcare is provided by the National Health System (NHS). This was established in 1948 and is an incredibly valued and important institution within the UK. Healthcare in the UK is a 'devolved matter', meaning that England, Wales, Northern Ireland and Scotland each have slightly different processes and arrangements for healthcare. However, the patient experience is largely similar across the devolved nations.

2.1 Emergency healthcare

If someone has a medical emergency, they can visit an Accident and Emergency Department at a hospital. Here they will be seen by a consultant. Depending on the severity of the emergency, they may be admitted to hospital – be given a bed and be able to stay – or if appropriate, they may be given necessary treatment and then discharged, e.g. given x-rays, prescribed medication etc.

2.2 Healthcare in the community

Most people in England will be registered with a General Practitioner (GP) – a doctor who has been trained in a wide range of medical issues. In most instances, an individual will have a local GP Surgery, or GP Practice – where several GPs are based – where they will make appointments to see their GP if they have a health concern. Some issues, such as sexual health and reproductive health advice, can be attended to by a Practice Nurse, who is also based at the GP Surgery/Practice.

When a patient visits the GP, they will discuss their concerns with the doctor. Depending on the individual's situation they may be given some advice, if necessary they may receive a prescription for medication, and if appropriate they may referred on to a specialist if the doctor feels this is required. In this instance, the

doctor will complete a referral form which will be sent directly to the specialist. The specialist will then contact the patient to let them know when their appointment will be.

Depending on the severity of the condition, local resources and demand, the patient may receive an appointment with the specialist very quickly, or they may need to wait several weeks or months to be seen.

Within the community there are also some specialist services which patients can access directly without a referral, for example a Sexual Health Clinic. These clinics offer a range of service including testing for sexually transmitted diseases, advice about sexual health, free contraception (including emergency contraception), HIV testing, and some vaccinations. Anyone can access these clinics, regardless of how old the patient is. Some require patients to make an appointment, others operate as 'drop-in' centres.

2.3 Charges

Healthcare in the UK under the NHS is 'free at the point of use' – there are no charges for seeing a doctor or for going to the hospital, regardless of the amount of treatment required. There is no system of informal payments. The NHS is paid for by the Government from general taxation.

The vast majority of medication in the UK is only available on prescription, with the exception of some basic medication, for example, for headaches or some skin conditions. If a patient needs medication they will receive a prescription. They can then visit a Pharmacy in order to exchange the prescription for the medication. There is a flat-rate fee for medication payable by the patient, regardless of the actual cost of the medication which is subsidised by the Government. In England at present, the charge is £7.65 for each prescription. In some instances, patients may be able to receive their medication free of charge, for example if they are on a low income and have completed the necessary paperwork to show this; if they have a specific disease such as TB; or if they have been prescribed contraceptives, such as the contraceptive pill[1].

Exceptions

Primary healthcare in the UK is available to all free of charge. However, not everyone is entitled to free NHS hospital treatment – only those who are considered to be 'Ordinarily Resident'. This is defined as anyone who is 'living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled.'[2]

All treatment provided at an NHS hospital, or by staff employed by the hospital may be subject to charges for those deemed not Ordinarily Resident, with the following exceptions, which are free to all:

- Treatment given in an accident and emergency department (excludes emergency treatment given elsewhere in the hospital);
- Treatment given in a walk in centre providing similar services to those of an accident and emergency department of a hospital;
- Treatment for certain communicable diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are charge free);
- Compulsory psychiatric treatment.
- Family planning services

Those who are not entitled to free hospital care should either take out private medical insurance or can pay for each treatment they receive – usually they will be asked to pay before each treatment.

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1 For more information about who can qualify for free prescriptions see http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx

2 For more information about who is required to pay for treatment in an NHS hospital, see http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH_074374

2.4 Private Healthcare

Estimates vary as to the proportion of the population with private medical insurance, but it is thought to be around 10 per cent. Private healthcare is sometimes funded by companies who provide it to their staff as part of their remuneration package, but private health insurance is also marketed directly to the public.

The main benefits of private medical insurance compared to the NHS are seen to be: faster access to treatment; a more comfortable care environment; and a wider choice of specialists, treatment facilities and timing of treatment. Occasionally, some drugs may be available to patients that aren't prescribed on the NHS.

Those who have private medical insurance still retain full access to NHS care, and some choose to combine the two, perhaps using their private healthcare insurance to facilitate quicker access, or access to a more convenient location, for specialist treatment.

3. Major principles of health care provision to vulnerable groups

3.1 Tuberculosis

3.1.1 *Tuberculosis incidence*

In the UK, 8,963 cases of tuberculosis (TB) were reported in 2011 – a rate of 14.4 cases per 100,000 of population. This is an increase compared to 2010. The vast majority of cases were found in urban centres, London alone accounted for 39 per cent of cases. Cases are particularly likely to occur amongst young people, those with specific social risk factors for TB and those from countries with high incidence rates of TB – in 2011, 74 per cent of cases occurred in individuals born outside of the UK[3].

Some specific groups are disproportionately affected by TB, including the homeless and those in poor housing, recent immigrants, particularly those who come from areas that have a high prevalence of TB and those living in inner city areas. For example, in 2011, 2.5 per cent of cases had a history of problem drug use, 3.5 per cent of alcohol misuse/abuse, 2.5 per cent of homelessness and 2.6 per cent had a history of being in custody. Approximately 8.6 per cent of cases had at least one of these risk factors, with 1 in 5 of these having more than one risk factor present[4].

3.1.2 *Screening and diagnosis*

Vaccinations

Until 2005, children were routinely vaccinated against TB at school before they reached 14 years of age using the BCG injection. This was discontinued after rates of TB fell to a very low level amongst the UK population. Currently, only those in specific risk groups are now offered the vaccine, for example those who:

- are more likely to be exposed to tuberculosis because of their job, for example a healthcare worker
- have recently arrived in the UK from an area with a high rate of tuberculosis infection
- are in close contact with someone who has been diagnosed with tuberculosis.

Children are likely to be offered the BCG vaccination only if their family live in an area with a high rate of tuberculosis infection, or if their parents or grandparents were born in a country with a high rate of tuberculosis infection.

Screening and diagnosis

[3] http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317134916916

[4] http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317134916916

Each area will have a Consultant in Communicable Disease Control (CCDC) at the Department of Health. The CCDC is ultimately responsible, alongside the TB Health Visitor, for screening for TB[5].

Awareness of TB should be maintained amongst the public and all health care professionals – for example District Nurses, Practice Nurses, GPs, School Nurses and Health Visitors are in a prime position to identify cases at an early stage. Information is also available for the public, which reinforces that TB is treatable and curable, and reduces any stigma attached to the diagnosis.

Potential cases of TB are identified through a range of sources, for example:

- Individuals showing clinical symptoms of TB are referred to the Chest Clinic via their GP
- All close contacts of index cases are offered screening in accordance with current (NICE) guidelines.
- New arrivals and long stay visitors to the UK from high prevalence countries (annual prevalence >40 cases per 100,000 population) should be screened for TB. Advice on who to screen is available from the World Health Organisation.

TB is a 'notifiable disease' under the Public Health (Control of Diseases) Act 1984 – the clinician making the diagnosis (usually the GP or a consultant in a hospital with responsibility for TB) must inform the Consultant in Communicable Disease Control (CCDC). The local TB Specialist Practitioner must also be informed.

In the community, the CCDC is ultimately responsible for controlling TB – working alongside the Chest Physician, GPs, Consultant Microbiologist and if appropriate, with the TB Health Visitor – for example in cases of contact tracing. All cases of confirmed TB are to be referred to the Chest Physician for treatment.

3.1.3 *Groups with specific risk factors*

Groups with specific risk factors, such as homelessness, are also regularly targeted for screening. For example, in London, there is a service called 'Find and Treat' which is a mobile x-ray screening unit which visits locations such as homeless hostels.

The UK Government has also recently introduced a pre-screening programme for immigrants. Under the new rules, people from 67 countries with high TB rates who wish to enter the UK for more than six months will be required to undergo pre-entry screening, followed by treatment if required, before a visa is granted[6].

There is no national screening programme for latent TB. The National Institute for Clinical Excellence (NICE) has recommended a screening programme for at risk migrants groups across the UK to screen for latent TB, but this has had poor take up with approximately 40 per cent of primary care providers failing to implement the screening. Anecdotal evidence suggests that this is primarily due to a lack of resources[7].

Prisoners are routinely screened for TB on entering custody through a health questionnaire and, if considered appropriate, a follow up chest x-ray and other screening tools.

3.1.4 *Treatment*

Individuals who have been diagnosed with active TB will be assigned a specialist TB treatment team. This team may include:

- a pulmonologist - a doctor who specialises in conditions that affect the lungs and breathing/ a Chest Practitioner
- an infectious disease specialist
- a TB nurse
- a health visitor - a qualified nurse with extra training

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5 See Paragraph 12, page 7, for detailed information about individual responsibilities

6 http://www.ukba.homeoffice.gov.uk/sitecontent/newsarticles/2012/august/07-india-tb-test

7 http://www.bbc.co.uk/news/health-18969099

- the patient's GP, and
- a pediatrician, if necessary.

The team may meet together, usually at the hospital, particularly at the beginning, to discuss the patient's case and the necessary treatment. Communication between the team members will also take place by telephone or email. Patients may also be assigned a key worker – for example a nurse or a health visitor who will act as the main point of contact between the TB team and the patient, as well as working to coordinate the patient's care programme.

TB is treated with a course of antibiotics of at least 6 months. Treatment completion is particularly important. In the UK, 84 per cent of patients in 2010 completed their treatment, compared to 78 per cent in 2001. In order to promote patient's adherence to a treatment programme, best practice guidelines[8] recommends involving patients from the outset in treatment decisions, and particularly emphasising the importance of adherence. Furthermore, every patient with TB should know the name of their key worker and how to contact them – the key worker has a responsibility to ensure adherence by supporting and educating the patients.

Directly Observed Therapy (DOT), where the patient is directly observed taking their medication, is not usually needed in most cases of TB, but best practice guidelines suggest doing a risk assessment for adherence to treatment for all patients. DOT should be considered for patients who have a high likelihood of poor adherence, and specifically, homeless people who are either living in a shelter or sleeping on the street. When making specific arrangements with an individual for DOT, it is important that the patient and their key worker are both involved in making these arrangements.

Drugs for the treatment of TB can be obtained free of charge by all patients, regardless of their residency status in the UK. This includes refused asylum seekers and illegal immigrants[9]. Free medication is available from certain locations, such as from a dedicated TB clinic. This is such so that people with TB are encouraged to be seen regularly in TB clinics where they can be properly assessed and their treatment supervised by TB experts.

However, if a patient is prescribed drugs for the treatment of TB by a GP they will be required to pay for their prescription, unless they are normally exempt from such charges, for example if they are on a low income.

3.1.5 *Treatment concerns*

During recent cohort reviews in North Central London between June 2010 and March 2011, a number of health service issues were raised by surveyed medical staff[10]. These issues were assessed for their level of public health risk and/or harm to the patient. Of these several were felt to be high risk, including:

- the difficulties of delivering 'Directly-Observed Treatment' to patients, particularly to those resident outside of the area under the jurisdiction of the relevant CCDC, outside of clinic hours or due to a lack of resources – this was identified as the issue most likely to impact patients, especially the most vulnerable who are least likely to complete their treatment.
- potential delays in the diagnosis of paediatric cases due to infrequent clinical sessions
- an insufficient identification of TB contacts, a high 'did not attend' rate of identified contacts, and limited opening hours of contact clinics. This is particularly of concern for public health as this system should identify potentially infectious undiagnosed cases of TB in the population, as well as latent cases of TB which could be prevented from developing into active cases.

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8 NICE, http://www.nice.org.uk/nicemedia/pdf/CG33quickreffguide.pdf

9 Under the National Health Services (Charges to Overseas Visitors) Regulations 1989 (amended), treatment for certain specified communicable disease including TB must be provided free of charge to all irrespective of the patient's residency status in the UK

10 http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1296687649609

Although this cohort study is specific to North Central London, the author's note that the conclusions may be relevant to other areas of London and indeed other parts of England where TB is prevalent.

3.2 HIV, living with HIV, and AIDS

3.2.1 *How many people have HIV in England?*

In 2010, there were approximately 91,500 people living with HIV in the UK – approximately 0.15 per cent of the population (or 1 in 650 people on average). A higher proportion of men to women have HIV, with 1 in 500 men living with HIV compared to 1 in 1000 women[11].

The number of people receiving specialist care for HIV has increased every year from 23,620 in 2011 to 69,424 in 2010. Of those receiving treatment, 51 per cent were infected through heterosexual contact, 44 per cent through sex between men, 2 per cent through injecting drug use, 2 per cent through mother-to-child transmission, and 1 per cent through receiving blood/blood products. In the UK, over half of people receiving specialist HIV care are white, and over a third are Black African.

Groups in the UK who are disproportionately living with HIV are gay and bisexual men, Black African women and men, Black Caribbean women and men, prisoners, and injecting drug users[12].

3.2.2 *Screening and Diagnosis*

It is not possible to get tested for AIDS as this term refers to a very specific list of illnesses that develop when HIV goes undiagnosed and untreated[13]. It is, however, possible to be tested for HIV.

People in the UK are able to have an HIV test whenever they wish. In addition there is an increasing amount of routine HIV testing, for example this is offered to people when they are tested for other sexually transmitted diseases, during antenatal care, and on registering with a GP. It is also recommended that sexually active gay and bisexual men receive an HIV test at least once a year.

Testing for HIV usually involves a blood test which is then sent to a laboratory for testing. Individuals who want to be tested can either go their GP or to a sexual health clinic. In addition some pharmacies also offer HIV testing and it is possible to order a test for home sampling which is then sent away – but these usually incur a charge whereas the other options are free.

In 2010, 2.1million HIV tests were performed in England; around half in sexual health clinics, around a third in antenatal settings, and around a quarter in primary and secondary care settings. Of all people attending a sexual health clinic in 2010, 69% received an HIV test.

Around half of adults aged 15 and over who were newly diagnosed with HIV in 2010 were diagnosed at a late stage of infection. People who are diagnosed late have a ten-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly. As well as increasing the risk of death, late diagnosis increases the possibility that that individual has unknowingly infected others prior to diagnosis. The group with the highest proportion of late diagnosis is heterosexual men (63%), then heterosexual women (58%), and then men who have sex with men (39%).

The new Public Health Outcomes Framework, which highlights specific measurement factors for public health in England in order to measure performance, specifically includes an indicator on late diagnosis of HIV – this highlights the importance of this issue[14].

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11 Health Protection Agency, 2011. HIV in the United Kingdom – source for all stats unless stated otherwise.

12 National AIDS Trust, www.nat.org.uk

13 The European AIDS case definition is based in the presence of one or more clinical AIDS defining illnesses.

14 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

3.2.3 *Treatment*

Since October 2012, HIV treatment is free for everyone in the UK. If someone receives a positive HIV diagnosis they will be referred onto a specialist HIV clinic where they will have more blood tests to assess how far the virus has progressed in order to determine the best course of treatment. The aim of treatment is to reduce the level of HIV in the blood and prevent or delay any HIV-related illnesses.

HIV is treated using a combination of different antiretrovirals (ARVs) in order to prevent HIV from becoming resistant to one single ARV. Patients usually take three or more types of ARV – known as combination therapy or highly active antiretroviral therapy (HAART). Some ARVs have been combined into a single pill, so that for some people recently diagnosed with HIV, treatment will involve taking just one or two pills a day. Adhering to the treatment schedule is extremely important as missing doses can risk the treatment becoming ineffective.

People with HIV can either be treated by their own GP, or by a specialist at an HIV clinic (located in a hospital) or sexual health clinic. Most people receive care and treatment for HIV from a specialist HIV clinic in the hospital, with check-ups usually every 3-6months. Patients will also have regular blood tests to monitor their health. HIV clinics are staffed by a range of healthcare professionals, including[15]:

- Doctors
- Staff nurses, who do routine examinations and tests and ask general health questions
- Nurse specialists with more in-depth knowledge. In some clinics they will perform the check-ups rather than a doctor.
- Pharmacists to dispense the drugs and advise on any issues related to taking medication
- Dieticians
- Health advisers who can give advice and information about sexual health issues
- Emergency/walk-in doctors if the patient needs to see someone urgently between check ups.

3.2.4 *Concerns*

In 2011, a Government Select Committee published a report entitled “No vaccine, no cure: HIV and AIDS in the United Kingdom - Select Committee on HIV and AIDS in the United Kingdom” which outlined a series of recommendations about HIV and AIDS in the UK[16]. Some of the key recommendations highlighted by the committee were as follows.

1. Further Government support for prevention is required and more resources should be provided at both national and local levels. The Government should also monitor the use of these resources to ensure they are being used for the purposes of preventing new HIV infections. Effective prevention could lead to significant long term savings, and yet the current levels of investment in national HIV prevention programmes are insufficient to provide the required level of intervention. As well as more resources, a broader range of evidence-based approaches are required.
2. Wider national sexual health campaigns should include HIV awareness, both to promote public health and prevent stigmatisations of groups at highest risk of infection – all sexual health campaigns commissioned by the Department of health should include HIV prevention. In addition, there should continue to be targeted HIV prevention campaigning aimed at high risk communities. This should include working with faith leaders.
3. The Government should prioritise HIV prevention research: establish an advisory committee to give leadership and coordination to biomedical, social and behavioural prevention research.

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15 Terrence Higgins Trust: http://www.tht.org.uk/myhiv/HIV-and-you/Your-healthcare/Your-HIV-clinic

16 http://www.publications.parliament.uk/pa/ld201012/ldselect/ldaids/188/18802.htm

4. There should be a continuing provision of needle exchange programmes.
5. It is crucial that as many as possible young people are able to access good quality sex and relationships education – this should also be included as part of the school education programme.
6. The data on HIV in prisons must be improved in order to produce a robust estimate of the prevalence and profile of HIV within the prison population. In addition, best practice for managing HIV in prisons must be made clearer through specific guidelines, including protocols for testing, prevention and treatment in prison. Whilst this is being produced, the Government should develop a guidance note for prison governors outlining best practice for managing HIV in prisons.
7. HIV testing should be routinely offered and recommended on an opt-out basis for new patients at GP practices, and to all general and acute medical admissions to hospital. Testing should also be expanded out into the community and local testing strategies should be put in place. GPs should receive training to help them to identify and care for those at risk, or living with, of HIV.
8. HIV treatment and care services should be commissioned at a national level, given their high cost and the variation in HIV prevalence nationwide. To ensure commissioning is responsive to differing patterns of need across the country, regional treatment and prevention service networks, appropriately supported and resourced by the Government, should be established. Furthermore, ARVs should be procured on a national scale in order to deliver savings for the Government and to standardise prices nationwide.
9. Government should commission NICE to develop treatment and care standards for HIV and AIDS. These should be developed in association with people living with and affected by HIV, along with service providers.
10. Innovative ways of delivering specialist services should be employed more extensively. This includes: home delivery of ARVs, flexible access to services (e.g. weekends and evenings), and virtual services (telephone and email) for stable patients who are successfully managing their own treatment.

3.3 Individuals with Diabetes

3.3.1 *Diabetics incidence*

There are currently around 2.9 million people in the UK with diabetes[17], around 4.45 per cent of adults[18]. Estimates suggest that a further 850,000 people across the UK have diabetes and are either unaware of it or do not have a confirmed diagnosis[19]. On current trends, it is estimated that 5 million people in the UK will have diabetes by 2025[20].

Type 2 diabetes is by far the most prevalent, with 90 per cent of sufferers. Just 10 per cent of sufferers have Type 1 diabetes. Diabetes is most prevalent in older adults. For example in England, adults with diabetes over the age of 75 account for 15.9 per cent of cases in men and 13.2 per cent of cases in women[21].

Diabetes is considered to be a relatively common health condition, with the risk factors for developing the condition dependent on a mixture of genes, lifestyle and environmental factors. Deprivation is a key risk factor for diabetes, often because deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diets, smoking, and poor blood pressure control – all of which are linked to a risk of

17 Quality and outcomes framework (QOF) 2011: England: http://bit.ly/qof2011e, Northern Ireland: http://bit.ly/qof2011ni, Scotland: http://bit.ly/qof2011s, Wales: http://bit.ly/qof2011w. (General source for many stats: http://www.diabetes.org.uk/documents/reports/diabetes-in-the-uk-2011-12.pdf)

18 Quality and outcomes framework (QOF) 2011

19 Figure based on data from AHPO diabetes prevalence model figures http://bit.ly/aphodiabetes and the QOF 2010 figures http://bit.ly/prevalence2010

20 Figures based on AHPO diabetes prevalence model: http://bit.ly/aphodiabetes

21 The Information Centre (2011). Health Survey for England 2010 http://bit.ly/HSE2010

diabetes or the risk of complications for those already diagnosed. For example, diabetes in Wales is almost twice as high in the most deprived areas compared to the least deprived, and in Scotland, the odds of developing Type 2 diabetes are 77 per cent higher for people from the most deprived areas compared with the most affluent.

In 2011, NHS spending on diabetes was almost £10 billion, equivalent to 10 per cent of the NHS budget[22] - 80 per cent of this is spent on managing potentially preventable complications[23].

3.3.2 *Diagnosis and screening*

Both Type 1 and Type 2 diabetes can be diagnosed by an individual's GP. A GP may request a urine and/or blood test in order to confirm a diagnosis.

3.3.3 *Treatment and access to medication*

As there is no cure for diabetes, treatment focuses on maintaining appropriate levels of glucose and controlling health symptoms so as to prevent problems from developing late in life. Treatment could include using insulin or medication. Diabetes care can be provided in a range of settings depending on the individual's needs – for example a GP surgery or a local hospital. Patients referred to a specialist may be seen in a health centre or at hospital.

Someone diagnosed with diabetes will be given a diabetes healthcare team which is responsible for managing the patient's condition and agreeing the care plan. The membership of this team may vary over time. It could include:

- a consultant physician/diabetologist
- a diabetes specialist nurse (DSN)
- a district nurse, midwife or health visitor
- a GP
- an ophthalmologist
- an optometrist
- a practice nurse
- a pharmacist
- a podiatrist
- a psychologist
- a registered dietician.

The team may meet, particularly initially, to discuss the patient's case and the necessary treatment. Further communication may be by email or telephone as necessary.

Across the UK there are national standards and guidelines for the care and prevention of diabetes. These vary across the devolved regions, but include information about prevention and early identification, management including partnership working between patients and their diabetes healthcare team, clinical care, treatment in hospitals, treatment for children and young people, gestational diabetes and integrated health and social care where necessary.

Someone with diabetes is supposed to receive a planned programme of nationally recommended checks each year. This should be part of personalised care planning that enables them and their healthcare professionals to jointly agree actions for managing their diabetes, and to meet their individual needs. Derived from both the NSF and NICE guidance on diabetes there are 9 Key Care Processes:

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22 Department of Health (2006). Turning the corner: improving diabetes care http://bit.ly/turning2006

23 Kerr, M. (2011). Inpatient Care for People with Diabetes - The Economic Case for Change. Available: http://www.diabetes.nhs.uk/areas_of_care/emergency_and_inpatient/

1. Blood glucose level measurement
2. Blood pressure measurement
3. Cholesterol level measurement
4. Retinal screening
5. Foot and leg check
6. Kidney function testing (urine)
7. Kidney function testing (blood)
8. Weight check
9. Smoking status check.

As well as receiving all of these checks, the healthcare team need to ensure that action is taken on the outcomes of the checks to ensure that peoples' diabetes is being managed effectively, and that they are being supported to self-manage their condition. For example if the weight check shows that the patient is overweight, the GP and the dietician will work together with the patients to help them to lose weight.

Box: The Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England and is part of the GP contract. The QOF was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. Participation rates are very high, with most Personal Medical Services (PMS) practices also taking part. Practices score points on the basis of achievement against each indicator, up to a maximum of 1,000 points. Results of GP practices' achievement against the QOF are published each year. The QOF is not about performance management, but incentivising and rewarding good practice. For 2011/12, 8,123 GP practices in England are included in the published results, covering almost 100 per cent of registered patients in England.

The QOF has four main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement.

a. Clinical domain: 87 indicators across 20 clinical areas (e.g. coronary heart disease, heart failure, hypertension).
b. Organisational domain: 45 indicators across six organisational areas - records and information; information for patients; education and training; practice management and medicines management.
c. Patient care experience domain: one indicator relating to length of consultations.
d. Additional services domain: nine indicators across four service areas (cervical screening, child health surveillance, maternity services and contraceptive services).

Source: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-framework-2011-12

If a patient requires medication to treat their diabetes they will be prescribed this, usually by their GP, or perhaps by a specialist hospital consultant if appropriate. Patients will be given a prescription which they can then exchange for the medication at a pharmacy. Depending on the individual, patients will receive sufficient medication for different periods of time. Usually, however, patients will be required to intermittently visit the GP, or a member of their healthcare team, to check on their progress in case a variation in the medication is required.

Those requiring treatment by medication can obtain this free of charge by completing a prescription exemption certificate.

3.3.4 *Areas of concern*[24]

Despite government attention to diabetes screening and the treatment for health concerns associated with diabetes, diabetes is still associated with around 24,000 excess deaths each year - half of which are result from cardiovascular disease[25].

[24] Diabetes UK, 2012. http://www.diabetes.org.uk/Documents/Reports/State-of-the-Nation-2012.pdf; The NHS Information Centre (2011). The National Diabetes Audit Executive Summary 2009–2010

For example, around half of individuals with diabetes do not meet their blood pressure targets – in other words more than 1.4 million of the 2.9 million people with diabetes have high blood pressure. Furthermore, over 800,000 people with diabetes are at high risk of future complications due to glucose control being above recommended levels - nearly 300,000 children and younger adults have high risk blood glucose levels, and some 144,000 dangerously high risk levels, which can lead to diabetic complications such as blindness or kidney failure. Children and young people with diabetes have the worst rates of very high risk glucose control and of the acute metabolic complication diabetic ketoacidosis (DKA) - 9 per cent of children and young people with diabetes experienced at least one episode of DKA in 2009–2010.

There is enormous variation in the standard of care received by those with diabetes across the UK, with the consequences of poor care management potentially fatal. In a recent report, Diabetes UK[26] highlighted a number of key areas of concern:

- Two-thirds of adults with Type 1 diabetes, and half of people with Type 2 diabetes fail to get the annual tests and investigations that are recommended in the national standards. In England, 96 per cent of children don't receive all the annual routine health checks they should, and adults aged 16–55 are less likely than older people to receive all their basic checks.
- The treatment that people receive varies greatly depending on where they live. In 2010 the number of people receiving all nine recommended tests and investigations ranged from 6 per cent to approximately 69 per cent, depending on where they lived. A low level of health checks can have a negative impact on the clinical outcomes for patients, potentially increasing the risk of diabetes-related complications.
- Although most people with diabetes (91 per cent) are getting their annual blood pressure check, not enough is being done to help individuals with identified high blood pressure bring it under control, thereby increasing their risk of diabetes-related complications such as heart disease, kidney failure and stroke.

3.4 Individuals on replacement therapy for drug addictions

3.4.1 *Replacement therapy for drug addictions*

In the UK, there are a variety of different treatment options for individuals who have a drug addiction – this includes different types of therapy, rehabilitation programmes, and replacement therapy. What treatment is most appropriate is currently an area of significant controversy in the UK, with the current Government strongly advocating an abstinence-based approach to tackling addiction[27], in contrast to previous administrations. In England in 2011-12, 197,110 individuals aged 18 and over were recorded as in contact with structured drug treatment services[28].

For individuals who are concerned that they may have an addiction, they can visit their GP or, in some cases, directly access a local specialist drug service[29]. If a patient is seen at a local drug treatment service, they will

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25 The Health and Social Care Information Centre. (2011). 7. National Diabetes Audit Mortality Analysis 2007-2008 . Available: http://www.ic.nhs.uk/webfiles/Services/NCASP/Diabetes/200910%20annual%20report%20documents/NHS_Diabetes_Audit_Mortality_Report_2011_Final.pdf

26 Diabetes UK is an NGO – they campaign for better treatment for people with diabetes in the UK.

27 For example, see a recent Government Position paper entitled, 'Putting Full Recovery First'. http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/recovery-roadmap?view=Binary

28 National Drug Treatment Monitoring System, 2012. Statistics for drug treatment activity in England 2011-12 http://www.nta.nhs.uk/uploads/statisticalrelease201112.pdf

29 A local specialist drug service, or community drug service, is part of the community health services. It is a separately commissioned service, although it may be geographically located in or near a hospital or other

first be assessed, and then allocated a key worker – this may be a doctor, a nurse, or a specialist drug worker. The key worker will help the patient to organise appropriate treatment, develop a personal care plan, and will be the main point of contact for the patient throughout treatment, including holding regular one to one sessions. Some GPs are specially trained and are able to make an assessment without referring a patient to the local drug service.

In addition to services provided by the NHS, there are also services provided by private providers (i.e fee charging) and voluntary organisations. These services might include residential rehab centres, structured day programmes, outreach, harm reduction services (such as free needle-exchanges), counselling services and other aftercare services to prevent relapse. These services are usually linked to the NHS in some way.

3.4.2 *Treatment for heroin addiction*

Individuals who are addicted to heroin and who wish to address their addiction may be prescribed a heroin substitute such as methadone. This will be prescribed at a level which minimises possible withdrawal from heroin in order to support the patient to stabilise their drug use, stop using illicit drugs, change risky behaviours such as sharing needles, and removing the need for criminal behaviour to fund a drug habit. Some people will remain on methadone for a very long period of time, known as 'maintenance', until they are ready to 'detox' and become drug-free.

For those who are ready to 'detox', the aim over time is to gradually reduce the quantity of methadone prescribed until the patient no longer has any withdrawal symptoms and is able to stop using the methadone completely. The rate of reduction and the length of time taken to become free of drugs can vary enormously depending on the patient.

GPs are responsible for prescribing methadone, usually on the advice and following an assessment by the local drug service. Some GPs who have been specially trained are able to perform the assessment themselves without the need for a referral.

Initially, patients will probably see their doctor quite regularly – at least several times a week to begin with - in order to adjust the dose of the methadone prescription to ensure that it is at the correct dosage. After this, the patient will receive a regular maintenance dose. It may take a few weeks to find the correct level of maintain dose which prevents any withdrawal symptoms.

Patients are able to get their methadone using the prescription at a local pharmacy. For the first months of treatment, all prescriptions for methadone should be dispensed on a daily collection basis.[30] The majority of patients will also be on a supervised consumption regime with the local pharmacy for the first three months where they are required to take their methadone daily in the presence of the dispensing pharmacist, doctor

healthcare setting. Services can be delivered by the NHS or by a voluntary organisation (NGO) that has been commissioned to provide this service. There may also be voluntary provision funded by other means. The staff at a community drug service could include a variety of different members of staff, including specially trained drugs workers and key workers, health visitors, nurses, counsellors and psychologists.

[30] There are also residential rehabilitation options. This is usually the case were community options have failed, or where the individual is at especially high risk of not adhering to their treatment. (http://www.nhs.uk/Livewell/drugs/Pages/Herointreatment.aspx)

or nurse to ensure they are taking it correctly and in the correct dosage and until they are able to continue to take it correctly unsupervised[31].

A daily dispensing regime may be continued for the first year of prescribing. As a trusting relationship develops between the patient and prescriber this may be relaxed incrementally. It is advised not to prescribe more than a week's worth of methadone at any one time. The exact pattern of collection will vary depending on the individual – for example, for a patient who is in employment, a daily collection regime may interfere with their responsibilities[32].

Patients who are receiving treatment using methadone are strongly encouraged to attend therapy and counselling sessions to support them to manage or reduce their drug use and to help them to address any psychological and lifestyle issues which may impact on their ability to stop using drugs. This may be provided by the local drug service, or perhaps a local voluntary agency and ideally will include psychosocial care.

Studies of the effectiveness of methadone treatment have found that individuals who are receiving methadone treatment are more likely to adhere to their treatment programme, and less likely to use illegal drugs compared to those who either receive no treatment or who receive a placebo. Higher doses of methadone are more effective than lower doses. Furthermore, there is evidence that methadone treatment reduces mortality, reduces HIV-risky behaviour and reduces levels of crime compared to no treatment[33].

3.5 Individuals requiring palliative care

3.5.1 *Palliative care in the UK*

In the UK, palliative care exists to ensure that individuals who are close to the end of their life receive the best care to make them as comfortable as possible by relieving pain and other symptoms, as well as providing social, psychological and emotional support. Palliative care can include:

- medical and nursing care
- pain and symptom control
- rehabilitation
- therapies, including physiotherapy and complementary therapies
- spiritual support
- practical and financial advice
- bereavement care for patients' carers, families and friends

Palliative care may be offered either after, or alongside other treatments, such as chemotherapy for cancer suffers. This is particularly true in instances of young people who may live with life-limiting conditions for extended periods of time.

It is possible to receive palliative care in a hospice (either as a resident or as a day patient), in hospital, at home or at a residential home.

In the UK, there are (for adults):

- 220 hospice and palliative care inpatient units

[31] NICE: http://publications.nice.org.uk/methadone-and-buprenorphine-for-the-management-of-opioid-dependence-ta114

[32] http://www.addictionadvisor.co.uk/THLmedicalguidelines/C5.pdf

[33] NICE: http://publications.nice.org.uk/methadone-and-buprenorphine-for-the-management-of-opioid-dependence-ta114

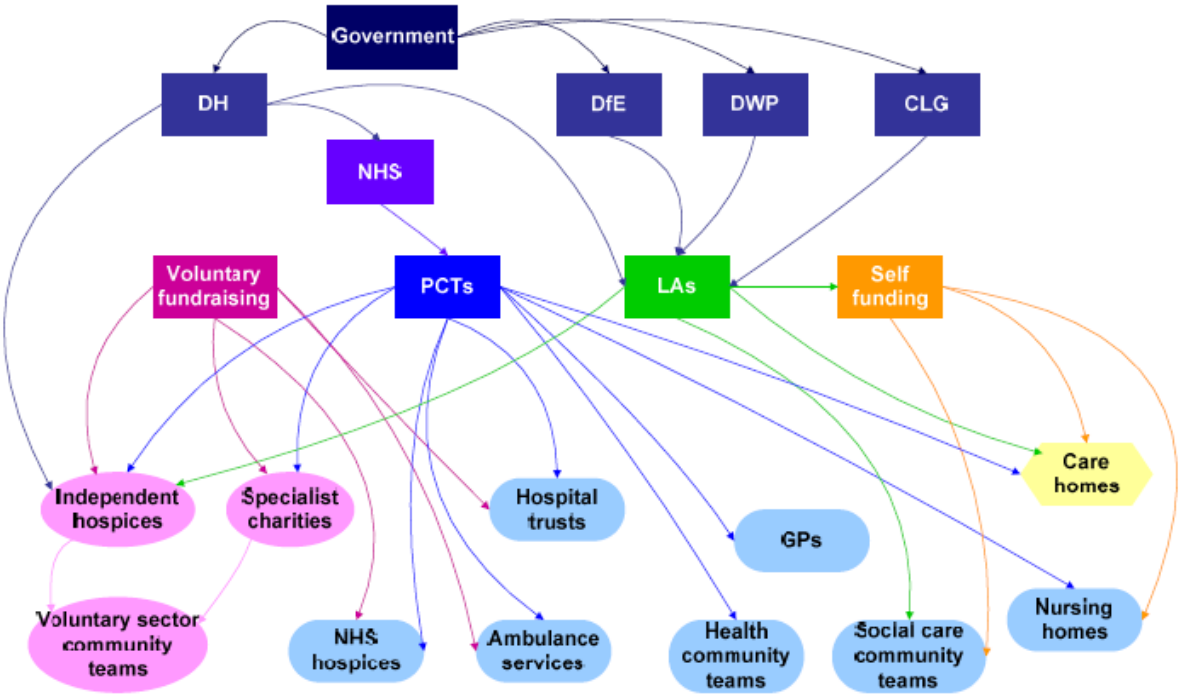
- 3,175 hospice and palliative care beds
- 288 home care services
- 127 Hospice at Home services
- 272 day care centres
- 343 hospital support services[34].

£1.4million is spent on hospice care every day in the UK, with adult hospices in England receiving approximately 34 per cent of their funding from the Government[35]. All NHS services are provided free of charge to the patient.

End of life care is provided for patients with a range of conditions, including cancer, heart failure, respiratory failure, chronic renal failure, hepatic failure, some neurological diseases such as multiple sclerosis and motor neurone diseases, and AIDS.

Overall, the UK is known for one of the best palliative care services in the world. Palliative care is provided by a plurality of providers from NHS to voluntary sector.[36] The lack of integration between these parties (see Figure) is considered as one of major drawbacks of the system. This results in lower transparency as well as divergence of care provided in different localities.

Figure: Main funding flows for end of life/palliative care



Source: Funding the Right Care and Support for Everyone Creating a Fair and Transparent Funding System; the Final Report of the Palliative Care Funding Review, July 2011, p. 21, http://palliativecarefunding.org.uk/PCFRFinal%20Report.pdf

34 http://www.helpthehospices.org.uk/about-hospice-care/facts-figures/#Hospice-and-Palliative-Care-Directory-2011

35 http://www.helpthehospices.org.uk/about-hospice-care/facts-figures/#Hospice-and-Palliative-Care-Directory-2011

36 Funding the Right Care and Support for Everyone Creating a Fair and Transparent Funding System; the Final Report of the Palliative Care Funding Review, July 2011, http://palliativecarefunding.org.uk/PCFRFinal%_percent20Report.pdf

3.5.2 *Hospices*

Most palliative care is provided in a hospice – a specialist residential unit run by a team of doctors, nurses, social workers, counsellors and trained volunteers. These units are usually smaller than hospitals and are able to provide more individualised treatment. The teams are physically based at the hospice and work closely together to provide necessary care for the patients.

Around 250,000 people are cared for by hospices in the UK each year – either in a hospice or at home. People are usually referred to a hospice either by their GP or by a hospital doctor. A district nurse can also refer a patient.

Hospices are free and someone may be referred at any point after the diagnosis of their illness. As well as long term residential care, hospices also offer respite care, where a patient can stay for a short period of time, allowing carers some time off from caring.

Most hospice services are managed and predominantly funded by the voluntary sector. Although they receive government funding, this does not cover all the costs for providing palliative care.[37] However, there are also NHS hospices that are mainly funded by government.

3.5.3 *Nursing care at home*

Those who wish to remain at home can receive palliative care in their own home from a range of healthcare professionals, including hospice staff, district nurses, and community palliative care nurses. They may also receive social care services and equipment from the local authority following a social care assessment to determine what is required to support the individual. All NHS services are offered free of charge but some of the services provided by the local authority – the social services care – may be chargeable.

The patient's GP can arrange for NHS services such as district or community nurses to visit to give injections if required and other care such as changing dressing, or for hospice staff to visit the individual at home. A district nurse will coordinate the patient's care at home – they will also work with the local social services team to ensure the right care and support is provided. In addition, community palliative care nurses give specialist advice on managing illnesses and are clinical specialists in pain and symptom control. Patients can access these nurses either through district nurses or through their GP.

Some hospices and palliative care teams provide hospice services in a patient's own home – complementing the service provided by the district nurse. In some cases this may be 24 hour care. This may be referred to a Hospice at Home services.

The GP remains responsible for the patient's medical care, including prescribing medications. Patients who are prescribed morphine may either be prescribed it in tablet form, or for injectiong. Patients are able to give themselves injections as necessary as per their prescribed dosage.

3.5.4 *Residential care homes*

If a patient is already living in a residential care home, they may choose to stay there rather than move to a hospice or hospital. Residential care homes can seek accreditation under the 'End of Life Gold Standards Framework'[38] to indicate that their staff are specially trained and that they have good links with local GPs.

3.5.5 *Hospitals*

Within hospitals there are palliative care teams that work alongside medical and nursing staff as well as other health and social care professionals. Their role is to provide advice and support to hospital staff on controlling symptoms, including pain management. The team also supports patients and carers and will advise on care and treatment plans, including when and where patients will receive care.

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37 On average, adult hospice receives only 34% of their running costs from government funds.

38 http://www.goldstandardsframework.org.uk/

Teams can include doctors, nurses, and social workers, or may just be a single nurse. They often work very closely with local hospices.

3.5.6 *Policy and Legislation*

In 2008, the UK Government published an End of Life Care Strategy[39] with the aim to improve end of life care in the UK. Each year, the Government reports against this strategy. The latest report was published in October 2012[40].

In 2009, it also published a series of 'quality markers and measures' for end of life care[41]. Although these quality markers are not mandatory, they are of use to local healthcare providers and care commissioners to help to plan their services. The top ten quality markers for providers are:

1. Have an action plan for the delivery of high quality end of life care, which encompasses patients with all diagnoses, and is reviewed for impact and progress.
2. Institute effective mechanisms to identify those who are approaching the end of life.
3. Ensure that people approaching the end of life are offered a care plan.
4. Ensure that individuals' preferences and choices, when they wish to express them, are documented and communicated to appropriate professionals.
5. Ensure that the needs of carers are appropriately assessed and recorded through a carer's assessment.
6. Have mechanisms in place to ensure that care for individuals is co-ordinated across organisational boundaries 24/7.
7. Have essential services available and accessible 24/7 to all those approaching the end of life who need them.
8. Be aware of end of life care training opportunities and enable relevant workers to access or attend appropriate programmes dependent on their needs.
9. Adopt a standardised approach (the Liverpool Care Pathway or equivalent) to care for people in the last days of life.
10. Monitor the quality and outputs of end of life care and submit relevant information for local and national audits.

3.5.7 *Key concerns*

There are a range of charities and voluntary organisations that campaign on issues around end of life care. Some of their key concerns include:

- A lack of Government funding for hospices – hospices currently only receive around 32 per cent of their funding from government sources. Other funding sources include charitable donations, local community and business support, and income from retail activity.

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39 Department of Health, 2008. End of Life Care Strategy. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

40 Department of Health, 2012. End of Life Care Strategy Fourth Annual Report http://www.dh.gov.uk/health/files/2012/10/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version.pdf

41 Department of Health, 2009, End of life care strategy: quality markers and measures for end of life care http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101681

- Ensuring that people have a right to choose their care and treatment, including where they receive treatment and, ultimately where they die. In some places, a lack of community care options, such as 24/7 care, prevents someone from remaining in their home.
- Campaigning for social care services[42] to be provided free of charge to terminally ill patients. Under the current model, the process of working out what can or cannot be provided free of charge can sometimes take a long time – several weeks or even months, during which time the patient's condition, and their needs, may have changed significantly.

4. Conclusions and key lessons for Ukraine

The UK evidence suggests that the attention to groups of patients with specific disease types, which are focussed on in the Policy Brief, is essential in order to ensure a high standard of care for these patients. The GPs play the most important role of diagnosis as well as treatment. They are responsible for the patient's care in all cases. At the same time, the coordination of the work of GP's alongside specialist doctors is essential for high quality treatment. In particular, they are often united into teams in the cases of particular disease types in order to provide better care to vulnerable patients. At the same time, patients with TB, HIV or diabetics have a right to receive treatment either at the office of GPs or at hospital or clinics from specialists. This right is maintained as timely treatment of these patients is among priorities of health care system in the UK.

Taking into account the experience of the UK, the following lessons for Ukraine could be drawn:

- GPs (family doctors) could be responsible for screening and diagnosis of tuberculosis, HIV/AIDS, and diabetes. For this, GPs should be equipped with test-screening systems, which allow them to screen patient for tuberculosis, HIV/AIDS as well as diabetics. But what is more essential, GPs should have respective competences and knowledge. Therefore, additional training is needed. Some work could be done by GP nurses, who also need better training;
- GPs could be responsible for the treatment of groups of patients with specific disease types;
- The formation of GPs surgeries where several GPs are working with nurses could be beneficial;
- There should be tight links between GPs and doctors at the secondary level to enable them to work in teams for treating vulnerable patients in the most efficient way;
- International evidence also reveals that the integration and coordination between care and services provided by the Government and voluntary sector is required. It could allow for more efficient care provision to groups of patients with specific disease types as well as effective use of available at each level funding. In particular, in Ukraine the voluntary sector is more developed for HIV/AIDS patients; however, their integrity and coordination is weak. At the same time, the Government should play prior role in opening hospices in all regions of Ukraine for people that require palliative care.

Besides, the public's awareness of the signs and symptoms of tuberculosis and diabetics should be increased. It also relates to some types of cancer. Moreover, efforts should be taken to increase the availability and uptake of self-management activities and education for those individuals with specific types of diseases (including tuberculosis, diabetics and cardiovascular diseases). Therefore, Ukrainians should be encouraged to take more responsibility for their health, via, for example, official information campaigns.

[42] Social care services include services provided by the local authority to help ensure that a patient can remain in their own home for as long as possible, for example, making modifications to the bathroom and kitchen to make them more user-friendly, putting in handrails throughout the property, or building wheelchair ramps into the property where necessary.

5. Appendix

Appendix 1. GP practices relating to Diabetics

The Quality and Outcomes Framework sets out a range of national quality measures for GP practices specifically relating to Diabetes.[43] These are:

- DM02 The percentage of patients with diabetes whose notes record BMI in the preceding 15 months
- DM10 The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months
- DM13 The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)
- DM15 The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)
- DM17 The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less
- DM18 The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March
- DM19 The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes
- DM21 The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months
- DM22 The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months
- DM26 The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.
- DM27 The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
- DM28 The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
- DM29 The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.
- DM30 The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less.
- DM31 The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less.

43 http://www.ic.nhs.uk/webfiles/publications/002_Audits/QOF_2011-12/qual_outc_fram_tech_anne_2011_12_anx.pdf

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Economic Summary for Ukraine

Economic summary is a review and brief analysis of the key economic indicators and policy measures of the year. It is published in January using the available statistics and annual estimates and updated in May when the most of previous year data becomes publicly available. The product is distributed among subscribers.

Business Tendencies Survey

Business Tendency Surveys are comprised of two surveys. The first one – Industries – is prepared on the basis of quarterly surveys of industrial enterprises managers. The second – Banking – is based on the survey of banks managers. There are four publications for each of the component of the Business Tendencies available to participants of the surveys and to subscribers.

Policy Papers

The policy papers are the joint product of the German Advisory Group for Economic Reforms in Ukraine and the IER aimed at providing economic policy recommendations to Ukraine's policy makers. The recommendations are based on the careful analysis of Ukraine's situation, state-of-the-art economic theory, and best international practices. The papers are available for policy makers and – with some time lag – for general public.

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