Letter to the Editor

Diabetes management: Influential paradigms

This article may be cited as: Abazari P. Diabetes management: Influential paradigms. J Edu Health Promot 2015;4:31.

Sir,

Management of non-communicable diseases, including diabetes, is affected by paradigms governing the decisions of policy makers and planners of the health system. Thus, familiarity with these paradigms helps to gain knowledge and insight into the influencing patterns of the management of diabetes.

THE GLOBALIZATION PARADIGM

Increased communication between countries and open borders for exchange of ideas, economics, trade, and investment, has both beneficial and harmful effects on the health of communities. Direct and indirect globalization has caused the development of pandemic non-communicable diseases, including diabetes.[1,2] The major changes in human environment, human behavior, and lifestyle are associated with globalization, and these changes have led to an immense growth of obesity and diabetes.[2] The majority of people with diabetes suffer from type II diabetes. This type of diabetes is associated with lifestyle, inactivity, and obesity. Asia has shown the greatest increase in the number of diabetes cases in the world.[2-4] These risks have affected a large number of adults in the most developed countries, and they are rapidly rising in developing countries too. However, in comparison with the Western populations, the prevalence of overweight and obesity in Asia is relatively low, but overweight and obesity, parallel to economic development and the urbanization rate are rising sharply. Moreover, even being slightly overweight will be accompanied by a large increase in the risk of diabetes in Asians.[4,5] Many developing nations have experienced rapid economic and social changes along with a shift in habits, diets, and lifestyle. These changes have led to a positive energy balance in Asia. The traditional dietary patterns are almost destroyed after adaptating the current food environment, which has become a lot more technological and urban, in addition to increasing inactivity at the same time.[4] Thanks to global marketing, tobacco, alcohol, and high-salt and high-sugar foods are available in most countries. Unfortunately, a significant portion of global marketing is targeted at children less than 14 years of age. Worldwide, 600 million urban children, of ages between five and fourteen years spend more than 200 billion US dollars annually, and much of this amount is spent on inappropriate beverages, fast foods, cigarettes, and alcohol.[4]

THE ROLE OF INTERNATIONAL COOPERATION IN CONTROLLING DIABETES

Globalization and communication between nations provide many opportunities for the countries to learn from each other's knowledge. Low-income or moderate-income countries are able to strengthen their primary care services by using the experience of the Western Europe countries. At the same time, citing examples for prevention and caring in low-income or moderate-income countries can provide functional models of cost-effectiveness for high-income countries. Finally, aside from the intrinsic interest of sharing knowledge, cooperating on caring has profound implications for a global policy, as also for the social and economic relationships between nations.[3]

DIABETICS' EMPOWERMENT PARADIGM

Empowerment to help patients, particularly patients with type II diabetes, is planned for realistic targets, especially targets related to weight loss, nutrition, and physical activities. The goal of empowerment is the promotion of independence and self-regulation of the patients, in order to maximize the capacity and ability of the individuals for health and well-being. People are powerful when they have sufficient knowledge, to make decisions wisely. The knowledge provides sufficient resources to implement those decisions and the experience to evaluate the effectiveness of those decisions.[6] The empowerment approach will enable the entry of changes in the patient's daily life. On the other hand, empowerment makes the patient believe that he/she has a fundamental role in the treatment team and that he/she has the ultimate power for acceptance or rejection of the other team members' advice.[7]

BARRIERS TO EMPOWERMENT

One of the obstacles and challenges in the traditional paradigm of healthcare services is the pathological perspective of medical diseases. In this model, the healthcare provider is considered as a professional expert and the patient is a passive recipient of his/her services. In the medical model, usually the patient's metaphysical dimensions are neglected, including the social context. The patients feel they are being ignored and are helpless, with no desire to participate in the treatment.[6] The physicians are often disappointed and view the patient as an offender, due to their failed efforts in persuading the patient to comply with the recommendations

and failure to achieve the recommended outcome. They tend to label the patients as noncompliant.[8] The domination of the old paradigm on new techniques cause even the health workers and educators, particularly in the case of diabetes, to agree with the concept of empowerment as a helpful paradigm for patient self-management, but their subjective beliefs, which have been formed over the years, are inconsistent with the philosophy of empowerment. Thus, their efforts are focused on persuading the patients to follow the prescriptions. This kind of performance shows the deep domination of care — acute paradigm.[9] This paradigm is not able to cover the physicians training needs, to provide services to patients with chronic diseases, including diabetes.[10] This is due to the fact that even today, the medical schools have continued socialization of the physicians in an acute caring approach to the patient. The change has not been observed in the majority, despite the change in the number of physicians and healthcare systems. Increasing the speed in the change has a direct relationship with the growth of healthcare providers and researchers, who understand the need for a fundamentally different approach.[6]

INTEGRATED CARE PARADIGM

In order to minimize the economic burden of chronic diseases, including diabetes, on the health system and improving patient outcomes, health policies need serious changes. In the meantime, integrated care is recognized by many as a potential solution to facilitate a professional response to the complex needs of people with chronic diseases.[11] Achieving a system and goals needs collaboration between different parts of the organization or system. With this definition, integration is 'the glue' that holds the parts together and contributes toward achieving the goals and desired results. Expectation, formation, and institutionalization cannot be easily found and expected in an integrated care paradigm for healthcare systems. On the other hand, lack of integrity will cause unavailability of the patients, due to the required services being provided with a delay, reduced quality of services, and reduced patient satisfaction, thus, reducing the power of the health systems to provide effective cost caring for the patients.[12] The working group of the World Health Organization (WHO) believes that the integration superiority has a great ability to inspire a comprehensive and individualized approach to the multidimensional health needs. Integration is not meant to gather all parts of the health system or full integration. It must be accepted that the lack of complete discontinuity in the health system is inevitable. Even in the most carefully designed systems, healthcare workers must develop innovative methods to circumvent the disadvantages and gaps. Thus, integration is a step in the health system and the healthcare service process that helps to achieve a more comprehensive and more complete care.[12] The most important benefit of the integrated care models is their empowerment to provide *a more seamless care experience for the us* and they are more consistent, so the patient and her caregivers themselves are no longer required to coordinate various treatments among different service providers.

Therefore, the treatment will not have a stop–start nature. This will also avoid duplications in treatment or evaluation by the staff and the various health professionals, as also the unnecessary costs due to lack of coordination in preventive care.[13]

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REFERENCES

1. Beaglehole R, Yach D. Globalisation and the prevention and control of non-communicable disease: The neglected chronic diseases of adults. Lancet 2003;362:903-8.
2. Zimmet P, Alberti K, Shaw J. Global and societal implications of the diabetes epidemic. Nature 2001;13:782-7.
3. Narayan KM, Echouffo-Tcheugui JB, Mohan V, Ali MK. Global prevention and control of Type 2 diabetes will require paradigm shifts in policies within and among countries. Health Aff 2012;31:84-92.
4. Hu FB. Globalization of Diabetes. Diabetes Care 2011;34:1249-57.
5. Chan JC, Malik V, Jia W, Kadowaki T, Yajnik CS, Yoon KH, Hu FB. Diabetes in Asia. JAMA 2009;301:2129-40.
6. Anderson RM, Funnell MM. Patient empowerment: Myths and misconceptions. Patient Educ Couns 2010;79:277-82.
7. Weiss MA. Empowerment: A patient's perspective. Diabetes Spectr 2006;19:116-8.
8. Wens J, Vermeire E, Royen PV, Sabbe B, Denekens J. GPs' perspectives of type 2 diabetes patients' adherence to treatment: A qualitative analysis of barriers and solutions. BMC Fam Pract 2005;6:20.
9. Anderson RM, Funnell MM. Patient empowerment: Reflections on the challenge of fostering the adoption of a new paradigm. Patient Educ Couns 2005;57:153-7.
10. Stevens DP, Bowen JL, Johnson JK, Woods DM, Provost LP, Holman HR, *et al*. A Multi-Institutional quality improvement initiative to transform education for chronic illness care in resident continuity practices. J Gen Intern Med 2010;25:574-80.
11. Yeo SQ, Harris M, Majeed FA. Integrated care for diabetes-a Singapore approach. Int J Integr Care 2012;12:8.
12. Kodner DL, Spreeu wenberg C. Integrated care: Meaning, logic, applications, and implications-a discussion paper. Int J Integr Care 2002;2:12.
13. Lloyd J, Wait S, Health AF, Future T. Integrated care: A guide for policymakers. 2005: Alliance for Health and the Future. Available from: www.ilcuk.org.uk/./pdf_pdf_7.pdf [Last accessed on 10 Feb 2015].

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Quick Response Code:	Website: www.jehp.net
	DOI: 10.4103/2277-9531.154130