# Long Thesis Abstract

**Aim:** Diabetes is an important barometer of health system performance. This chronic condition is a source of significant morbidity, premature mortality and a major contributor to health care costs. There is an increasing focus internationally, and more recently nationally, on system, practice and professional-level initiatives to promote the quality of care. The aim of this thesis was to investigate the ‘quality chasm’ around the organisation and delivery of diabetes care in general practice, to explore GPs’ attitudes to engaging in quality improvement activities and to examine efforts to improve the quality of diabetes care in Ireland from practice to policy.

**Methods:** Quantitative and qualitative methods were used. As part of a mixed methods sequential design, a postal survey of 600 GPs was conducted to assess the organization of care. This was followed by an in-depth qualitative study using semi-structured interviews with a purposive sample of 31 GPs from urban and rural areas. The qualitative methodology was also used to examine GPs’ attitudes to engaging in quality improvement. Data were analysed using a Framework approach. A 2nd observation study was used to assess the quality of care in 63 practices with a special interest in diabetes. Data on 3010 adults with Type 2 diabetes from 3 primary care initiatives were analysed and the results were benchmarked against national guidelines and standards of care in the UK. The final study was an instrumental case study of policy formulation. Semi-structured interviews were conducted with 15 members of the Expert Advisory Group (EAG) for Diabetes. Thematic analysis was applied to the data using 3 theories of the policy process as analytical tools.

**Results:** The survey response rate was 44% (n=262). Results suggested care delivery was largely unstructured; 45% of GPs had a diabetes register (n=157), 53% reported using guidelines (n=140), 30% had formal call recall system (n=78) and 24% had none of these organizational features (n=62). Only 10% of GPs had a formal shared protocol with the local hospital specialist diabetes team (n=26). The lack of coordination between settings was identified as a major barrier to providing optimal care leading to waiting times, overburdened hospitals and avoidable duplication. The lack of remuneration for chronic disease management had a ripple effect also creating costs for patients and apathy among GPs. There was also a sense of inertia around quality improvement activities particularly at a national level. This attitude was strongly influenced by previous experiences of change in the health system. In contrast GP’s spoke positively about change at a local level which was facilitated by a practice ethos, leadership and special interest in diabetes.

The 2nd quantitative study found that practices with a special interest in diabetes achieved a standard of care comparable to the UK in terms of the recording of clinical processes of care and the achievement of clinical targets; 35% of patients reached the HbA1c target of <6.5% compared to 26% in England and Wales. With regard to diabetes policy formulation, the evolving process of action and inaction was best described by the Multiple Streams Theory. Within the EAG, the formulation of recommendations was facilitated by overarching agreement on the “obvious” priorities while the details of proposals were influenced by personal preferences and local capacity. In contrast the national decision-making process was protracted and ambiguous. The lack of impetus from senior management coupled with the lack of power conferred on the EAG impeded progress.

**Conclusions:** The findings highlight the inconsistency of diabetes care in Ireland. The main barriers to optimal diabetes management center on the organization and coordination of care at the systems level with consequences for practice, providers and patients. Quality improvement initiatives need to stimulate a sense of ownership and interest among frontline service providers to address the local sense of inertia to national change. To date quality improvement in diabetes care has been largely dependent the “special interest” of professionals. The challenge for the Irish health system is to embed this activity as part of routine practice, professional responsibility and the underlying health care culture.