Limitations recognised in this study: the control group consisted of people drawn from the hospital environment (student nurses or hospital workers). Results may have been influenced by the fact these people were used to meeting patients continuously and were a homogeneous group not representative of the general population.

Our intention was to trace all patients with diabetes included in the first study. Unfortunately we failed to do this. However, we conclude that this illustrates one of the difficulties associated with conducting longitudinal studies in a developing country.

In conclusion, the current results show that the SF-36 health-related questionnaire needs to be expanded to include issues dealing with basic needs and economy. Furthermore, the very performance of the data collection and the involvement of hospital staff and nurse educators as participants in the current study may hopefully enhance the understanding of patients with diabetes in clinical work.

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Conflict of interest:
None

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A good new Austrian year

John Bowis, MEP

'*Gruss Gott!*', as we are now becoming accustomed to say by way of greeting. The UK recently handed the baton of the EU Presidency to Austria for the first six months of 2006. In particular, we send our warmest greetings to Maria Rauch-Kallatt, Austria's Health Minister, who has promised that one of the Austrian presidential priorities will be to focus on diabetes. Austria aims to intensify the exchange of expertise and to discuss potential steps at EU level and hosted a conference in Vienna in February .

The European Union comes into its own when it shares best practice and sets out recommendations for high standards in diagnosis, treatment, care and prevention. We saw this with the EU's work and recommendations on cancer screening: no Member State now wants to be seen to be left behind in extending screening programmes to those citizens who are most at risk.

The European Parliament is taking the opportunity, provided by Austria's commitment to raising the profile of diabetes on the European health agenda, to call for an EU Diabetes Strategy and a Council Recommendation on diabetes prevention, diagnosis and control. A Written Declaration to this effect was tabled at the January Plenary of the Parliament. It was the first

Declaration of 2006, which should make it easy to remember when – as I hope they will – all nurses involved in diabetes write to their local MEP(s) asking them to sign *Written Declaration Number 1*.

A Recommendation would not be binding for Member States. However, it would provide a legal framework for improving the collection of data, taking appropriate primary prevention measures, encouraging the development of screening programmes and monitoring and evaluating outcomes, while respecting Member States' responsibility for the delivery of healthcare services.

We are learning more about how each country in Europe tackles diabetes and beginning to piece together the components for an EU framework for action. In November, FEND and the International Diabetes Federation (IDF-Europe) jointly published *Diabetes, the Policy Puzzle: towards benchmarking in the EU 25*. Later, we held a meeting in the Parliament for MEPs to hear some of the fascinating summaries from this excellent audit of the status of type 2 diabetes in the EU. In February, the Austrian Health Institute presented a study containing a compilation of relevant policy measures in the field of diabetes prevention in the EU.

There is considerable variation in approaches to policy within the EU: only 11 of the 25 Member States have a national framework or plan for diabetes and there is generally a lack of adequate human and financial resources to implement the national plans that do exist. Yet we know that health complications from diabetes represent between 5% and 10% of total healthcare expenditure; the time has come to raise prevention, screening and treatment standards across Europe. An EU Strategy could provide the detailed guidelines and the political spur to achieve this. The *Policy Puzzle* document arms us with the facts and comparisons to put pressure on our respective Health Services and Ministries.

While the following is not an exhaustive list – readers might like to suggest additions, deletions or improvements – effective guidelines should surely include the following areas of action:

1. Collection of data on the costs of diabetes prevention and treatment (to optimise limited resources and assess approaches)
2. Policies to promote a healthy lifestyle
3. Primary screening and diagnosis for defined targeted populations
4. Secondary screening (such as eye screening) and prevention of complications in patients with diagnosed diabetes
5. Policies to ensure services are comparable between geographical areas
6. Education and training of healthcare professionals (both specialist and non-specialist)
7. Encouragement of a holistic approach in which healthcare professionals work with patients and across sectors (from primary and secondary care and community care, to social services and educational institutions)
8. Individualised care plans for people with diabetes (including education, a self-management plan, a review schedule and a named specialist)
9. Measurable targets and evaluation (including evaluation through the use of information technology)
10. Enhanced commitment to research into prevention, treatment and care.

I am always conscious of the good fortune of those of us who live or work with diabetes in Europe and the developed world (despite the very real challenges we face), compared with our brothers and sisters in the least developed countries of our world. In the United States, 98% of children diagnosed with type 1 diabetes continue living with it six years later; in sub-Saharan Africa only 1% survive that long. It is a death sentence: a child in rural Mozambique, for example, will live no more than seven months because of the cost and lack of access to insulin, and the inadequacies of their health service; in Mali, where a dose of insulin costs $10, a year's supply would cost a family 38% of its total income. Even in countries like Zambia, where the price is subsidised, the $2 dose is impossible for the many poor individuals who subsist on less than $1 a day.

Insulin is, of course, only part of the story. Syringes and needles, testing strips and equipment – which we take for granted – are not adequately available or affordable and in countries where AIDS is rife; the risks of sharing are obvious but not always avoidable. The epidemic of type 2 diabetes is sweeping across Africa, as nearly everywhere else in the world. Every day, I remind myself of those awesome and awful statistics: 3.1 million people die each year from AIDS and 3.2 million people die each year from diabetes. And then people tell me I sometimes harp on too much about 'neglected' diseases and that we should concentrate our resources on the 'big three' of TB, AIDS and malaria. I take nothing from those who strive in those fields. But, I shall continue to 'harp on' until we take other killers and disablers, such as diabetes, just as seriously.

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