Concerns over the consequences of regional disparities for elderly French type 2 diabetes patients in the Gerodiab study

The French GERODIAB survey is a 5-year prospective, multicentre, observational follow-up study designed to analyze the relationship between glycaemic control and morbidity/mortality in patients aged ≥70 years with type 2 diabetes [1]. Regional disparities in the prevalence of diabetes have been reported in France [2], and a previous article has dealt with possible regional differences in the management of elderly diabetic patients [3].

A total of 56 diabetic/geriatric centres sequentially recruited 987 subjects visiting outpatient departments from all parts of metropolitan France. Details of the protocol and a description of the sample population at the time of inclusion have been previously reported [1]. Five regions were defined according to French geographical telephone area codes: Île de France (IDF); North West (NW); North East (NE); South East (SE); and South West (SW). Based on the general French population, there was a balanced distribution of patients and centres throughout each region [4].

To simultaneously analyze different factors across all five regions, patients’ scores for four domains were calculated: individual characteristics; metabolic factors; complications of diabetes, and geriatric scales. The results observed for the 987 patients in the GERODIAB cohort at baseline showed that elderly diabetics living in the NW region had the most at-risk individual factors, the highest frequency of metabolic anomalies, the most frequent degenerative diabetic complications and the greatest ageing decline. The NE region also had poor results for all specific scores, but with less intensity, while the SW region showed intermediate results. The IDF and SE regions shared the best specific scores (Fig. 1). Although many factors may be contributing to these interregional differences, it was concluded that socioeconomic factors and disparities in healthcare access are perhaps among the most important explanatory factors.

These results raise several questions related to the healthcare system and the provision of medical care, especially in rural areas that are far away from cities and administrative influence. In addition, economic status is lower among the elderly, although interregional differences can be found – it is, for example, most likely to be higher in the IDF and SE. This suggests that in regions, such as the NW and NE, elderly diabetic patients have an overall poorer economic situation and more difficult access to healthcare, especially in rural areas. In addition, unless there are improvements in the future, it is highly likely that their situation will progressively worsen.

Should our society accept such disparities, especially the unequal access to healthcare that seems particularly acute in the elderly? To put it another way, should the healthcare system focus on the working population living in cities, while leaving vulnerable populations to fend for themselves in the countryside? This also brings the issues of medical just deserts and centralization of health policies to the forefront. Diabetes should be considered an important contributor to dependence in elderly people and, as such, is deserving of specific allocation of resources.

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In conclusion, corrective interventions are now required and need to be quickly implemented to improve the management of elderly people with diabetes wherever they live.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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References


J.-P. Le Floch a,∗
J. Doucet b
B. Bauduceau c
C. Verny d, the SFD/SFGG Intergroup

a Service de diabétologie et endocrinologie, clinique médicale de Villecresnes, 8, boulevard Richerand, 94440 Villecresnes, France
b Service de médecine interne gériatrie thérapeutique, hôpital Saint-Julien, Rouen University, CHU de Rouen, 76031 Rouen cedex, France
c Service d’endocrinologie, hôpital Bégin, 69, avenue de Paris, 94160 Saint-Mandé, France
d Service de gérontologie, CHU de Bicêtre, 12, rue Séverine, 94276 Le Kremlin Bicêtre cedex, France

∗Corresponding author. Tel.: +33 1 45 95 57 57; fax: +33 1 45 69 75 84.
E-mail addresses: jplefloch@dietvill.com, jplf2006@yahoo.fr

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