Data-driven policies needed to turn the tide on diabetes

The COVID-19 pandemic has exposed stark realities for governments and the global health community to face and learn from. One of these is that people living with non-communicable diseases (NCDs), including people living with diabetes, are paying the price for chronic underspending on health by governments. Diabetes is a devastating condition, which alongside cancer, cardiovascular diseases, chronic respiratory diseases, and mental and neurological conditions, has long been side-lined by politicians and policy makers. Only now, with mounting evidence of the linkages between NCDs and COVID-19, is this neglect being recognised as a failure of political leadership and public policy.1,2

Even before COVID-19, progress on NCDs was too slow and international solidarity to advance this agenda inadequate. Despite governments agreeing to the global NCD targets, and the specific target to halt the rise in diabetes and obesity by 2025,3 the probability of dying prematurely from diabetes increased by 5% between 2000 and 2016.4 For low-income and middle-income countries (LMICs) and the world’s poorest billion, the challenge is particularly acute, as highlighted by the Lancet NCDs and Injuries (NCDI) Poverty Commission.5 NCDIs account for more than a third of the burden of disease among the poorest people in the world5 and, partly due to unmet needs in access to care and social protection, these diseases are a major driver of premature deaths and catastrophic health-care expenditure. Next year marks the centenary of the discovery of insulin, yet access to this life-saving and essential drug is wholly inadequate for many people living with diabetes in LMICs. Globally, only half of people living with diabetes have access to the insulin they need, but in Africa it is only one in seven.6 Political rhetoric and commitments have yet to translate into sufficient and sustainable action for people living with diabetes worldwide, and particularly for those in LMICs.

Against such a backdrop, it is timely that the Lancet Commission on Diabetes7 makes recommendations to drive a change in policy responses worldwide and close gaps in diabetes prevention, care, data, and professional knowledge. The Commission’s emphasis on the use of data-driven approaches is pertinent and necessary. In the COVID-19 pandemic data and science have become a battleground issue, with some governments and other actors under-mining, suppressing, and censoring evidence and leveraging technology to amplify misinformation and disinformation; this infodemic is jeopardising progress against COVID-19.8 The Commission’s report is a welcome reminder of the need to put data at the centre of health policy, to drive evidence-informed decisions to improve population health and health systems design around patient needs, and to strengthen monitoring, surveillance, and accountability.

Unlike the vertical health programmes that still dominate global health, diabetes requires an integrated response that does not work in isolation or in silos and addresses the needs of patients with multimorbidity. Data and research into prevalence of multimorbidity, common clusters of conditions, and person-centred solutions in treatment and care are inadequate. The Commission encapsulates the evidence base, showing that multitiered societal and population-based prevention and integrated care across the life-course are crucial for tackling diabetes, as they are for NCDs more broadly, due to comorbidities and complications with cardiovascular disease, chronic kidney disease, dementias, cancer, disabilities, obesity, and mental health.

In many LMICs, where 80% of the global diabetes population live, health financing priorities remain...
largely focused on the unfinished business of the Millennium Development Goals—namely, HIV/AIDS, tuberculosis, maternal and child health, and nutrition. These priorities have yet to shift to encompass the more holistic Sustainable Development Goal (SDG) agenda adopted in 2015. The siloed approach does not recognise the high burden of NCDs in the same communities, with strong bidirectional relationships between diabetes and tuberculosis, HIV, cardiovascular disease, and mental health. There are untapped synergies to be realised from integrating diabetes screening and care into maternal, child, and adolescent health programmes. The Commission’s recommendations for using existing facilities and health professionals’ time to personalise and integrate care for people living with or at risk of diabetes and for investing in task shifting and team responses, such as training non-physicians, have the potential to sustainably improve access to diabetes care in LMICs.

Policy makers, funders, and health systems are failing people living with diabetes, in terms of prevention, screening, diagnosis, and timely care to prevent complications, and in so doing are creating additional demand for acute care and care for comorbidities. As the Commission highlights, there were 463 million people living with diabetes worldwide in 2019. Diabetes shortens life expectancy among individuals aged 40–60 years by 4–10 years, increases the risk of death from cardiovascular disease, renal disease, and cancer, and is a leading cause of non-traumatic lower extremity amputation and blindness. There are real lives behind these numbers, and the data-driven approach of this Commission must be complemented by the expertise of people living with diabetes as to their needs, demands for care improvement, desired solutions to guide the necessary changes, including health systems reform and policy formulation.

The four diabetes gaps identified by the Commission—prevention, professional knowledge, care, and data—resonate strongly with wider NCD gaps identified by the WHO Independent High-Level Commission on NCDs, which fed into the 2018 UN High-Level Meeting on NCDs. The evidence on diabetes prevention and care, recommendations on how to make progress, and the technical know-how are at the fingertips of governments and the international community. As ever, the challenge will be to ensure that the evolution of the evidence base becomes a driver for policy change and that data are followed by need-driven research, policy formulation, sustainable funding, and implementation of integrated diabetes care in line with the Commission’s recommendations.

As the world seeks to create a more sustainable, fair, and equal future in the wake of COVID-19, the NCD community must become more effective advocates for change. In celebrating the centenary of insulin discovery, we can create valuable opportunities to do so, with lived experience as the engine to drive further progress. We must collectively call on political leaders and governments to make good on their UN commitments with decisive, inclusive, and accountable leadership and appropriate investment if we are to reach the 2025 NCD targets and 2030 SDGs. Irrespective of the challenging financial landscape, investment now in tackling diabetes and other NCDs, including injuries, will prevent substantial and unsustainable health-care costs in the future.

I am the Chief Executive Officer of the NCD Alliance, a network of civil society organisations driving the NCD agenda, and declare no other competing interests.

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