A first step on a shared journey

Global Summit Summary Report

Global Diabetes Policy Summit:
Making early action a political priority

Wednesday 18 – Thursday 19 November 2015
Barcelona, Spain

International Diabetes Federation

AstraZeneca

PCDE primary care diabetes europe

unite for diabetes

Asset ID: 943,935.011
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This meeting was organised and funded by AstraZeneca in partnership with
the International Diabetes Federation (IDF) and Primary Care Diabetes Europe (PCDE)

"We […] were really impressed by the high level of all discussions, interesting approaches to the promotion of healthy lifestyles among risk groups and wide opportunity to contact openly with colleagues from other countries to share best practice."

"The session by the Honourable Keith Vaz MP was very encouraging."

"Thank you for the opportunity to attend extremely well conducted and useful Summit at Barcelona."

"Excellent - interactive with no boring lectures."

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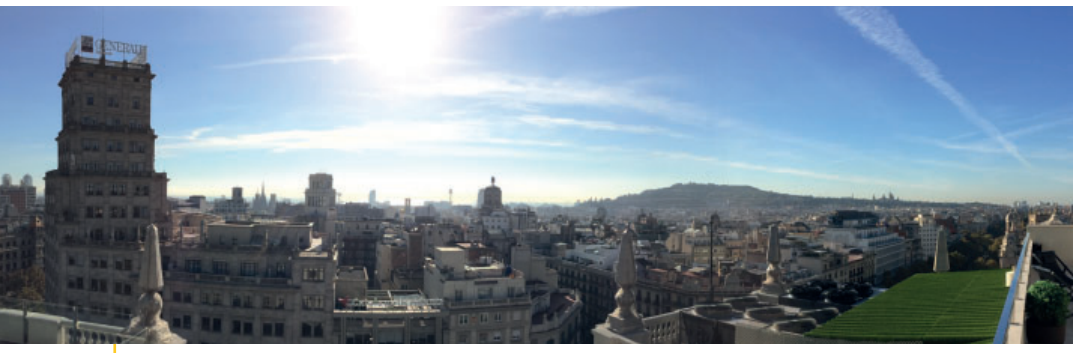


November 2015
Global Diabetes Policy Summit
Barcelona, Spain

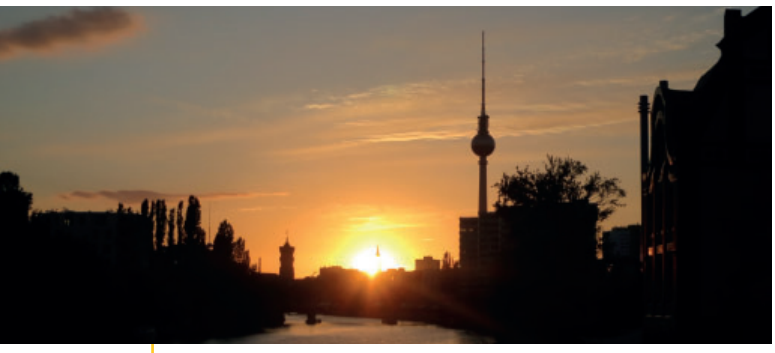
2016
Local action
Worldwide

"[The new Australian national diabetes strategy] … includes a goal for promoting the early detection of type 2 diabetes. Unfortunately like most national strategies in the world, that's where it stops! There is no plan for implementation and no policies in order to achieve it. So now our real work begins"

Professor Stephen Colagiuri, Australia

"We diagnose a person with diabetes and then what? So many are not under control and things are getting worse"

Dr Shaukat Sadikot, International Diabetes Federation President-Elect



November 2016
Global Diabetes Policy Forum
Berlin, Germany

2017
G7 Summit
Rome, Italy

"…we are all aware of the epidemic and we talk about it but most of this is talking amongst ourselves – and somehow it doesn't penetrate. And somehow if you look at governments' agendas, diabetes is down the list of governments and health ministers… why isn't it a main issue? Where did we fail and how can we change it?"

Professor Itamar Raz, Israel

AstraZeneca, the International Diabetes Federation and Primary Care Diabetes Europe are committed to driving a multi-year campaign to turn the evidence for the prevention, early detection and initial management of diabetes into action to help people with diabetes achieve better outcomes and a better quality of life.

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The political response to type 2 diabetes needs focus, momentum and action



A shared belief in the above statement brought AstraZeneca, the International Diabetes Federation and Primary Care Diabetes Europe together to host the first Global Diabetes Policy Summit.

Across the world, type 2 diabetes is still not taken seriously enough by the public, politicians, health systems, many healthcare professionals, and even by many patients. Meanwhile, 415 million people around the world have diabetes, 193 million have diabetes but don't know it, one person dies from diabetes every six seconds, and the disease costs our health systems 12% of all health expenditure[1].

We can do better, and we must do better – for the 415 million adults who have diabetes today, the 642 million who will have diabetes by 2040[2], and for the sustainability of our health systems.

There is more evidence than ever before on the impact and burden of diabetes, on how to try to prevent the disease and on how to effectively diagnose and treat the disease much earlier than what we see today in most countries. We have consensus on approaches to managing diabetes, and new tools making it easier to treat. Yet barriers stand in the way regarding access to treatments, access to support for patients to understand and manage their condition; and access to the healthier lifestyles that can prevent the disease for many people. These barriers create a critical gap between what we know can be done and what is seen in practice.

To bridge this gap, we in the diabetes community must work together and challenge ourselves to increase understanding of type 2 diabetes among the stakeholders who can have an impact on policy in order to prevent or control diabetes. We need to agree priorities at a country-level and convene the local stakeholders needed to address them. Countries must share experiences and learnings to ensure the translation of good practices is as easy as possible.

Thank you to all those who took part in the Global Diabetes Policy Summit. We have taken an exciting first step together on a shared journey towards making early action in diabetes a political priority; and hopefully towards impacting positively on millions of people's lives around the world.

Fouzia Laghrissi-Thode
Vice President GPPS Therapy Area,
Cardiovascular & Metabolism, AstraZeneca

Professor Johan Wens
Chair, PCDE

Dr Petra Wilson
CEO, IDF

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About the Global Diabetes Policy Summit

The Global Diabetes Policy Summit was convened by AstraZeneca, the International Diabetes Federation and Primary Care Diabetes Europe to make early action in diabetes a political priority.

At the Summit, participants discussed the challenges facing health systems in taking early action on diabetes and shared evidence and best practice examples in support of prevention, early diagnosis and initial management of type 2 diabetes.

Chaired on day one by Professor Andrew Boulton, President of EASD, and by the Summit partners on day two, participants – including health officials, policymakers, patients, patient representatives, and leading diabetes experts from 17 countries – held discussions in international and national groupings.

> "…things are terrible, and unless we all get up and do something about it, things aren't going to work out"
>
> Dr Shaukat Sadikot, International Diabetes Federation President-Elect

There are numerous challenges facing the diabetes community which were discussed, including:

- The complexity of diabetes as a disease: this poses challenges to communicating why, and how, we need to tackle it.
- There exist widespread perceptions of diabetes as a disease which 'lacks urgency' in comparison to other diseases – such as cancer and heart disease – and this can stand in the way of more rapid action to tackle the disease on diagnosis.
- There can be a political sense of inevitability about the size and continuing growth of the problem – and perceptions that type 2 diabetes is self-inflicted disease. This often makes it feel too challenging for many policymakers to take on.

Yet, during the discussions, some consensus emerged regarding how to best translate existing evidence of what works in caring for people with diabetes into political action. With this in mind, what does the diabetes community need to do in the next ten years to enact effective, lasting change?

- Agree what works best in our countries and bring those solutions to life through adaptation – there are best practice examples, from prevention to management, in all corners of the world. Partnership working, to encourage replication and local adaptation of programmes that work, can help us tackle the challenges we face.
- Work with governments but do not wait for them to take action first – we should be ambitious in the goals we set, but also be focused and proactive. We don't have to wait for new budgets; we can work within resources available now and define simple ways to improve outcomes. The key is to develop a plan around which to rally support.
- Strong communications and smart campaigning – we must frame our engagement in a way that meets the needs of policymakers, being particularly mindful to genuine financial pressures. We should be ready to be disruptive, or to engage stakeholders who can be, to break the status quo, and bring fresh perspective and ideas.

We may all agree that there is no shortage of 'meetings' about diabetes. However, the partners of the Global Diabetes Policy Summit are determined that this was, and will prove itself to be, a different kind of meeting: one where engagement and dialogue between events is as much a feature as the event itself and where international discussion translates into national action.

The discussions at the Global Diabetes Policy Summit are reflected in the following pages. The most important discussions are yet to come.

> "We are pioneers during the next two days…This is a unique opportunity so please talk, interact, share, and steal ideas, so that by exchange we will fight this disease"
>
> Ludovic Helfgott, President, AstraZeneca Spain

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Prevention

Discussion led by Professor Kamlesh Khunti and Dr Jean Michel Borys, facilitated by Professor Andrew Boulton

Overview

There are two key approaches to preventing type 2 diabetes that need to be actively promoted: changes in environments to make healthy choices easy choices, and the implementation of programmes to identify populations at high risk, who are then given support to make lifestyle changes.

Both approaches require engaging target audiences, tailoring communications, and using a range of strategies and media. The evidence for prevention is strong, and we must convince decision makers of this and persuade them not to wait for 'certainty' that may never come.

Prevention is already a priority in many countries. Many in the diabetes community believe that setting targets could help in the prevention of type 2 diabetes, but consideration is needed as to what such targets could be.

Discussion

The issue of 'prevention' is widely discussed in type 2 diabetes. A range of strategies exist, all aimed at containing the growth, or even reducing the burden, of the disease on individuals and health systems.

'Upstream' strategies seek to address the underlying risk factors for the development of type 2 diabetes, 'midstream' strategies are aimed at intervening in high risk populations and 'downstream' strategies address the management of the disease, aiming to prevent costly complications.

Intervening at the beginning – upstream strategies

In large parts of the world, people have moved from a time when calories were hard to find, and exercise was part of everyday living, to the opposite: consuming calorie-dense food and experiencing sedentary lifestyles. In order to address the obesity epidemic that drives a large proportion of new cases of type 2 diabetes, there are three main environments that require intervention:

1. Food environment – there is an urgent need to reduce children's and adults' exposure to high fat, high sugar and highly-processed foods

2. Physical environment – even small changes can have a positive effect on tackling sedentary lifestyles: for example, in Mexico, staircases were made attractive by painting them in different colours to encourage people to use stairs rather than escalators

3. School environment – we must instil knowledge about what constitutes a healthy lifestyle to counter the exposure to unhealthy foods coming from external sources such as TV, media and advertising

If behaviours are to be changed, initiatives across these three environments need to be supported by efforts to 'market' the prevention of type 2 diabetes. Healthy choices need to be transformed into easy choices, while policymakers' understanding of the public's awareness and attitudes needs to increase. Altering how information is presented to the public can help: for example, changing the message from 'do 30 minutes of physical activity five days per week' – which some people may find difficult – to simply encouraging people to stand more, instead of sit, may be one way of promoting a more accessible approach to tackling sedentary lifestyles.

"People who sit more have a two times higher risk of diabetes, 2.5 times higher risk of cardiovascular disease and a 50% higher risk of mortality[3]."

Professor Kamlesh Khunti, UK

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Best practice in prevention case study: EPODE

www.epode-international-network.com

EPODE is one example of a community action programme that aims to prevent childhood obesity by changing social and behavioural norms, local environments and local policies to promote healthier lifestyles. The initiative saw 40% fewer overweight and obese children in intervention sites when compared to control sites.

The Epode methodology involves four main pillars:

It is essential to obtain buy-in from all stakeholders if change is to be both successful and sustained. An example was shared from the UK where buy-in from key groups was not achieved. There was an initiative whereby only healthy foods were offered within schools. However, fast food outlets were easily accessible just outside these schools, and fast food was even handed to children through school fences by their parents.

Success in preventing type 2 diabetes is possible if all stakeholders understand the benefits of change, and if desired behaviours are made 'fun'. Decision makers are sometimes cautious about saying the wrong thing publicly, especially given the links to type 2 diabetes and being overweight. As such, communication to the public needs to be clear, tailored, and accompanied by evidence and examples.

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Identifying and managing high risk populations – midstream strategies

Midstream strategies for prevention involve identifying populations who are at high risk of developing diabetes, and providing interventions to delay or halt progression. There is a wealth of evidence in this area, reflected in the UK's National Institute for Health and Care Excellence (NICE) diabetes prevention guidance, developed in 2012.

Studies have shown the ability to reduce incidence of diabetes through diet, exercise or diet and exercise alone in a population shown to be at risk of diabetes; including increased but non-diabetic blood glucose levels (Impaired Glucose Tolerance, IGT).

These studies have also shown that it is cost-effective to screen for IGT and then provide intensive lifestyle interventions.

It was acknowledged at the Summit that there are concerns regarding affordability of these interventions. In these studies, interventions are intensive and require significant human resource. However, US experience suggests that lay community-led and electronic media assisted interventions lead to similar reductions in weight, which is a promising sign for scaling such solutions in lower income settings and generally.

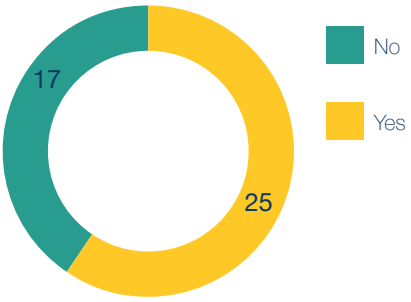
Key to this midstream approach is a two-stage screening programme involving a risk screening questionnaire followed by a definitive blood test.

Key ingredients for success in identifying and managing high risk populations were suggested as:

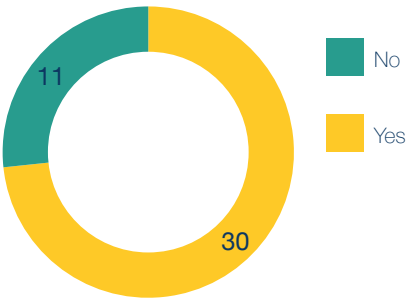
- A trained workforce
- A quality-assured programme that is evidence-based
- Infrastructure for programme delivery
- Marketing to support programme uptake

Poll of participants following the discussion

I believe that diabetes prevention is a national priority in my country



I believe national targets are an effective way to prevent type 2 diabetes in my country



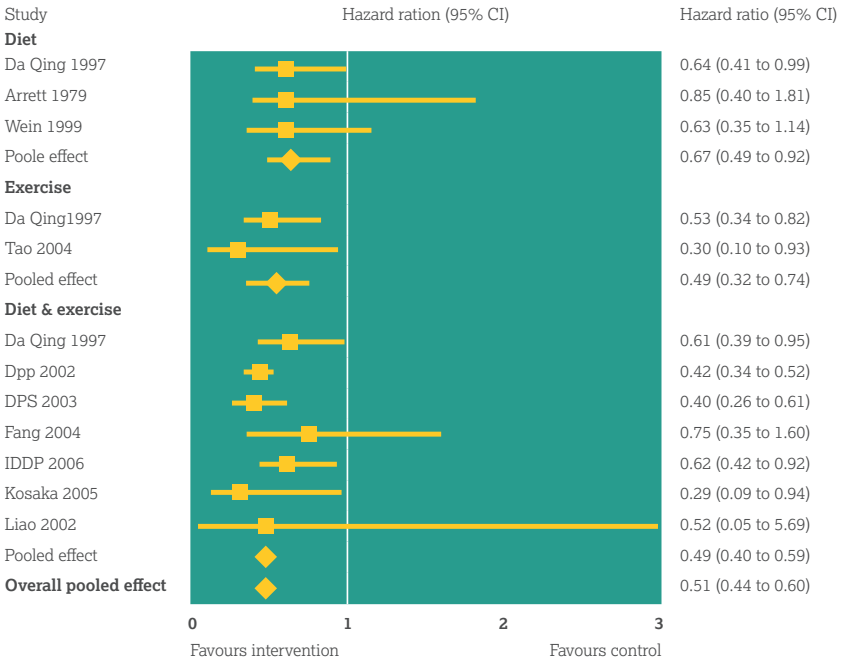
"Lifestyle changes can really make a difference and halt the progression to diabetes in its tracks"

Dr David Cavan, Director of Policy and Programmes, International Diabetes Federation

"The main problem is how do we activate the patient? We need to use more and more digital resources: for example, the study in India, where a simple SMS did much more than anything else can do."

Professor Itamar Raz, Israel

Lifestyle and pharmacological interventions reduce the rate of progression to type 2 diabetes in people with impaired glucose tolerance. Lifestyle interventions seem to be at least as effective as drug treatment



Adapted from Gilles, C et al, Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis, 2007[4]

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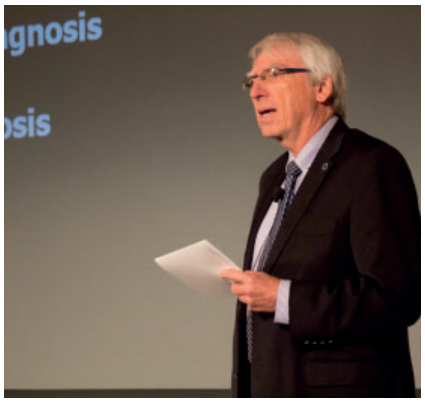
Early Diagnosis

Discussion led by Professor Torsten Lauritzen and Professor Stephen Colagiuri, facilitated by Professor Andrew Boulton

Overview

The evidence and argument for the early diagnosis of type 2 diabetes is strong when it is combined with interventions to prevent diabetes and detection of other conditions/CV risk factors. When screening for type 2 diabetes, for each case detected, two people will be found with elevated but non-diabetic glucose levels (IGT or "prediabetes") and six will be found with cardiovascular risk factors[5].



There is a short-term cost associated with diagnosing more people with diabetes and we need to be realistic about this. We need to show clearly that this investment is worth it for the good of patients, for the cases of diabetes that will be prevented or delayed through a linked prevention programme, and also for the longer term sustainability of health systems.

Finally, it is essential that high-quality treatment follows screening, otherwise return on investment in early diagnosis is reduced.

Discussion

"[The new Australian national diabetes strategy] …includes a goal for promoting the early detection of type 2 diabetes. Unfortunately like most national strategies in the world, that's where it stops! There is no plan for implementation and no policies in order to achieve it. So now our real work begins"

Professor Stephen Colagiuri, Australia

Diagnosing diabetes early can have a significant impact. However, it is crucial to the strength of the argument that a risk-based approach is about the diagnosing of the disease more than 'just' diabetes.

Given that screening for type 2 diabetes can identify people with prediabetes and those with cardiovascular risk factors – as well as those with the condition already – an early diagnosis programme therefore offers health systems the opportunity to have an impact across a range of costly long-term conditions.

Modelling based on the ADDITION study shows that diagnosing diabetes early leads to a reduction of 30-40% of cardiovascular risk and a reduction of 15-25% in mortality[6]. The ADDITION study also showed that there is no long-term psychological harm from screening, and that it is feasible to undertake screening in primary care.

A variety of respected bodies now support early detection policies. These include: US Preventive Services Task Force, Diabetes Australia, Diabetes UK, National Institute for Health and Care Excellence (NICE – UK), the Canadian Task Force on Preventive Health Care, the Danish Health Authorities (in a draft paper), the American Diabetes Association, American Association of Clinical Endocrinologists; and American Academy of Family Physicians and the International Diabetes Federation.

We must ensure that good treatment follows early diagnosis. In the ADDITION study, people with more severe diabetes at the time of diagnosis received treatment that lowered their risk of early death to the same as the background, non-diabetic population, but those with less severe diabetes had a 7-year mortality rate that was twice that of those with the most severe diabetes. This finding could be clearly linked to under-treatment of this population. The return on investment in early diagnosis is undermined if the treatment that follows is not good.

A framework for taking action on early detection was set out at the Summit:

Consider what programme options you want to adopt

- **A diabetes-specific programme** – This is not the option selected by most systems
- **A programme linked to a diabetes prevention programme** – In terms of early detection or prevention there is a lot of overlap because the risk assessment is the same for both. There are a number of examples including the "Life Programme" in the state of Victoria in Australia which has been effective in recruiting a lot of people

- **A programme linked to a broader vascular disease reduction programme** – This is the most commonly adopted approach. Finland offers a strong example and another can be found in the NHS health check in the UK which has gone even broader to identify people to reduce health disease, stroke, diabetes, renal disease and dementia. The WHO recommends combining early detection of diabetes with a cardiovascular risk reduction programme.

Select a procedure for early diagnosis

- **The best practice is to adopt a two-step approach:** identify those at high risk then do a blood test. There are a number of risk assessment tools around the world but a simpler version, which is being adopted by the NHS in England, is to focus on people who are older between the ages of 40-74, and to focus on those who are obese, plus or minus hypertension.

Ensure development of a strong implementation strategy: how do we go about engaging people to want to have their risk assessed, or be aware?

- Public awareness campaigns and self-assessment
- Focusing on health professionals in primary care, including practice nurses
- Workplace programmes – more and more are being implemented

Address barriers to early diagnosis

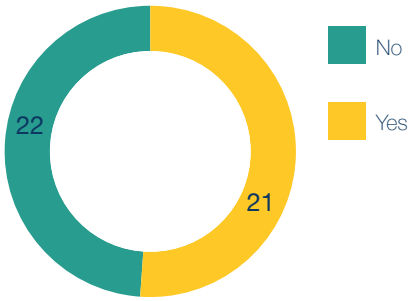
- There is a debate on the methods of the early detection of anything. However, there are few downsides to screening programmes in diabetes, and benefits outweigh the harms
- There is a view that diabetes isn't that serious a problem. This applies to the general population, to politicians and policymakers; and also to many health professionals who prioritise screening for cancer but don't think we need to screen for diabetes
- If countries are going to screen for undetected diabetes, they have got to have the services available to deal with people and treat those they discover
- There is no simple answer to this concern - early diagnosis results in upfront treatment costs and it will take another 8-9 years for spending to return to the level it would have been at the beginning had early diagnosis not been achieved.

Engaging people in risk identification and screening is a challenge that must not be overlooked. In Canada, social media-based engagement has had good impact in encouraging people to self-test. It is important to utilise channels outside of healthcare, but also recognise and optimise the opportunities within healthcare for opportunistic screening. It was noted that, in Denmark, 80% of patients visit their primary care physician each year. Opportunistic screening should reach almost all within 3-4 years.

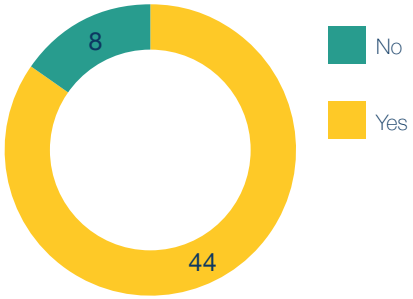
> "I do think that people find it difficult to be attracted to screening programmes for diseases they think aren't a major threat to them, and diabetes is in that category."
>
> Professor Stephen Colagiuri, Australia

Poll of participants following discussion

I believe there is political appetite to implement type 2 diabetes early diagnosis policies in my country



I believe my country has the infrastructure and resource to implement an effective, national detection programme for type 2 diabetes



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Initial Management

Discussion led by Dr Nicky Lieberman and Dr Sanjay Kalra, facilitated by Professor Andrew Boulton

"We diagnose a person with diabetes and then what? So many are not under control and things are getting worse"

Dr Shaukat Sadikot, International Diabetes Federation President-Elect

Overview

Spreading better practices in the early and intensive management of type 2 diabetes needs to be a priority. For this to happen it is essential for the management of the disease to be made simpler for primary care professionals to fit in to a crowded list of priorities.

We also need to ensure the simultaneous, and effective, communication of the benefits of better treatment, and pursue progress with a sense of urgency. As such, we do not need to wait for the support of government, or the perfect evidence base for early and intensive management.

Discussion

There is strong expert consensus on the importance of providing good, early treatment for people with type 2 diabetes. The key challenge to be addressed is applying the consensus at scale and across all levels of care. This is needed in a disease with such a high prevalence as diabetes.

In Israel there has been a steady increase in the number of people with diabetes achieving good control of their blood glucose levels. Experiences from Clalit, the leading health insurance company, were shared at the Summit. Clalit, like other insurance providers in the country, recognise the case for investment in better diabetes care and have put continuous quality improvement in place. This has been done ahead of government involvement.

With 85% of diabetes patients treated by primary care, education within primary care can be the main engine of improvement. A computerised quality improvement model – like the one seen in Israel – can support decisions made in the clinic and encourage a positive approach to achieving control.

The Israel experience has seen reductions in coronary interventions, amputations **and in spending per patient.**

The approach in India to driving change was summarised by Dr Sanjay Kalra as a three-step approach: 'amplification, intensification and simplification'. Efforts are currently underway to amplify awareness of diabetes based on an understanding of what will drive changes in attitude and behaviour.

While clinicians may be interested in reducing HbA1c, a patient may be more concerned, for example, with erectile dysfunction or another diabetes or treatment-related factor. Conscious decisions also need to be made about whether negative or positive messages are used to help patients achieve good control.

"A positive message would be: 'diabetes may not cause renal disease, it's poorly controlled diabetes that causes renal disease.' A negative message would be: 'if you don't control diabetes, your kidneys will fail.'"

Dr Sanjay Kalra, India

To date, experience in India suggests that communication aimed at concerns that are truly felt by the audience are the key.

When there is an absence of a political focus on diabetes, it can be helpful to find 'back doors' to enter in order to put diabetes on the agenda, and to intensify attention and instigate action. In India, the diabetes community has taken advantage of a programme on maternal health to leverage the importance of screening for gestational diabetes. The diabetes community has also linked to environmental concerns by communicating the importance of appropriate disposal of plastics and metals used in treatment.

Simplification includes the approach to treatment guidelines. Existing guidelines are considered useful by healthcare professionals, but need to be respected by the professionals at whom they are aimed; and recognised as being guidance rather than absolute rules. Guidelines often describe a 'best case scenario' where a patient is diagnosed early and proceeds through treatment options sequentially. In practice, people are often diagnosed late and need their treatment intensified rapidly in order to obtain control.

"We need to ask: can this be implemented in real life? Can I translate it into practice or not?"

Dr Francesc Xavier Cos, Spain

Guidelines that advise clinicians to intensify treatment if control isn't achieved within three months can have the unintended consequences of encouraging some to wait three months before intensifying, when they could – and should – intensify earlier. Primary care professionals in India are encouraged to perform a "metabolic triage" of patients, leading to different treatment paths.

"Sometimes you make mistakes and sometimes you succeed but if you're going to wait for people to publish fully evidence-based papers, we won't advance at all"

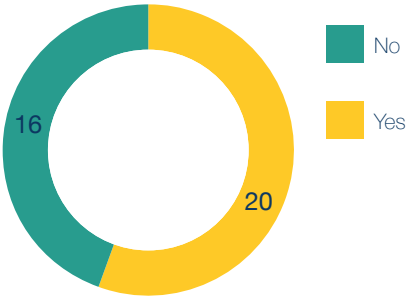
Dr Nicky Lieberman, Israel

"…we want the complex made simple. There are too many smart people in the medical field who make the simple complex because that's their training…"

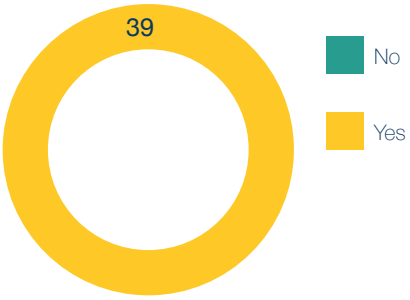
Rick Blickstead, Canadian Diabetes Association, Canada

Poll of participants following discussion

I believe that there is consensus exists in my country around how diabetes initial management policies should be implemented



I believe that clear national guidelines on initial management would enable individuals to have better control of their type 2 diabetes



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A roadmap for early action – what's next?

"The mission of the Summit is to take the evidence we have and have had for years and do a proper systematic multi-year effort to turn it into action, so we can help people with diabetes achieve better outcomes and a better quality of life. We are doing this by kicking off the campaign this week with you."

Toke Skovlund, Global Government Affairs, AstraZeneca

The Global Diabetes Summit is more than a single event. It kicks off a multi-year effort which will see national discussions taking place in 2016 and involving more people in a similar international meeting late in 2016 to check on countries' progress in developing and implementing plans. The international aspect of such a campaign is critical for both sharing learnings and for effective advocacy.

Engaging policymakers is a key part of this journey

The Summit received a presentation, by video link, from Keith Vaz MP, a member of the UK Parliament and chair of its diabetes group. He has type 2 diabetes, diagnosed as a result of a blood test during a visit to a clinic for a photo opportunity.

Merely communicating the scale of the diabetes challenge, with increasing prevalence around the world, will not bring about change. We need to bring solutions and clear actions that policymakers can act upon. In the area of primary prevention, there is currently a strong focus on the debate around action on food and drink with a high sugar content. Involvement of figures, such as the UK celebrity chef Jamie Oliver, help to raise awareness of such actions well beyond normal policy audiences.

Partnerships between organisations and at all levels of society are also key. National parliamentarians can be effective champions for change by engaging a broad range of stakeholders, but we need to work hard to involve and support them. Keith Vaz urged that the diabetes community in each country should 'adopt an MP' the same way that he has been 'adopted' by leading clinicians and diabetes stakeholders in the UK.

World Diabetes Day is a great opportunity to engage national parliaments, and the suggestion of encouraging the annual presentation of progress against diabetes in a debate in parliaments around the world – in addition to broader awareness-raising activities – was well-received.

The Summit closed with discussion about how to engage policymakers, facilitated by Dr David Cavan and led by Professor Itamar Raz, Claude Sokolowsky and Rick Blickstead.

When we talk about 'engaging policymakers' we need to remember that this doesn't just include parliamentarians or national-level officials. 'Policy' is developed and implemented by a variety of stakeholders throughout health systems and across societies. Particularly impactful can be policymakers and influencers at the local level. We need to plan to engage with and involve all these stakeholders, address the full range of issues that impact diabetes and commit to scrutinising performance and monitoring progress.

We should be ambitious in the goals we set, but also be focused and proactive. We don't have to wait for new budgets: we can work within the resources available to us now and define simple ways to improve outcomes. The key, according to discussion at the Summit, is to develop a plan around which to rally support.

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"…we are all aware of the epidemic and we talk about it but most of this is talking amongst ourselves – and somehow it doesn't penetrate. And somehow if you look at governments' agendas, diabetes is down the list of governments and health ministers… why isn't it a main issue? Where did we fail and how can we change it?"

Professor Itamar Raz, Israel

It is often said that politicians have a focus that is relatively short-term, knowing that they need to be re-elected in a few years' time. It was suggested that we should step back from this thought. We can present plans for tackling diabetes that show impact – and the opportunity to claim success – in the short term as well as the significant impact on outcomes in the long term. Short-term views, whether they are present or not, should not be a barrier to action.

"Be proactive – you have to push the politician – they will never come to you."

Professor Itamar Raz, Israel

The diabetes community around the world is finding it appropriate and helpful to work with colleagues in related disease areas. We need to respond to the fact that governments predominately want to move away from working at the level of single diseases. However, we should be mindful that sometimes we will need to articulate, clearly and strongly, priorities and needs specific to diabetes.

"The system and the policymakers are a means to the end not an end in itself"

Rick Blickstead, Canadian Diabetes Association, Canada

Finally, strong communications and smart campaigning are essential. We need to ensure that we frame our engagement in a way that meets the needs of policymakers, being particularly mindful to genuine financial pressures. We should be ready to be disruptive, or to engage stakeholders who can be disruptive, break the status quo, and bring fresh perspective and ideas.

It was suggested by delegates that the diabetes community must also find, and support, the patient voice – evidence persuades, but stories motivate. In France, the diabetes patient association website attracts 250,000 unique visitors each month, and provides a newsletter that has 100,000 subscribers. They observed that policymakers respond to large numbers of people, and these numbers can get attention if the diabetes community can help them to find their voice.

It is our shared duty to do precisely this.

'Bad things happen not because of bad people. Bad things happen because good people aren't willing to do something about it'

Dr Shaukat Sadikot, International Diabetes Federation President-Elect

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References

1. International Diabetes Federation, *IDF Diabetes Atlas Seventh Edition Update,* 2015

2. International Diabetes Federation, *IDF Diabetes Atlas Seventh Edition Update,* 2015

3. Wilmot, EG et al, *Sedentary time in adults and the association with diabetes, cardiovascular disease and death: systematic review and meta-analysis,* 2012. Diabetologia.55(11): 2895-905

4. Gilles, C et al, *Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis,* 2007. BMJ. 10, 334 (7588): 299

5. Lauritzen, T et al, *Screening for diabetes: what do the results of the ADDITION trial mean for clinical practice?,* 2013. Diabetes Management. 3(5): 367-278

6. Herman, WH et al, *Early Detection and Treatment of Type 2 Diabetes Reduce Cardiovascular Morbidity and Mortality: A Simulation of the Results of the Anglo-Danish-Dutch Study of Intensive Treatment in People With Screen-Detected Diabetes in Primary Care (ADDITION-Europe),* 2015. Diabetes Care. 38: 1449-1455

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