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The benefits—and inequities—of improved diabetes care

Primary care clinicians care for the vast majority of the 34 million individuals in the United States with type 2 diabetes; these patients make up about 11% of visits in most practices.[1,2] Maximizing their health requires that we make the most of the ever-growing number of medications and devices that can be used to manage diabetes, while being sensitive to the health care inequities that limit patient access to the best care we have to offer.

A growing number of effective Tx options. In the past few years, we have seen the number of new drug classes for treating type 2 diabetes climb steadily. Within-class effects and adverse effects vary widely, demanding familiarity with the proven benefits of each individual drug. The advent of oral and injectable agents that include glucagon-like peptide 1 (GLP-1) receptor agonists and sodium glucose cotransporter 2 (SGLT2) inhibitors now supplement an expanding list of reliable basal insulins. Never before have we had such effective drugs with fewer adverse effects to manage glycemic control. New evidence supports adding selected medicines from these categories to reduce the risk of cardiovascular disease, heart failure, or chronic kidney disease in patients at risk—regardless of the level of glucose control.

We can expect amplified inequities in diabetes clinical outcomes to continue unless we develop a better system of distributing these life-changing medicines to Americans who need them.

The benefit of more achievable goals. When the ACCORD (Action to Control Cardiovascular Risk in Diabetes) trial began in 1999, the UKPDS (United Kingdom Prospective Diabetes Study) had just demonstrated that lower blood sugars resulted in lower morbidity in patients with type 2 diabetes. Colleagues insisted that an extrapolation of UKPDS results suggested that low blood sugars were better, and that it would be unethical to allow a patient to maintain an A1C of 7.5% if less than 6.0% was possible.

By 2008, the ACCORD trial demonstrated that more lives were saved with a less aggressive approach, and family physicians could breathe a sigh of relief as they addressed other important comorbidities of diabetes. However, the tools we used in ACCORD were rudimentary compared to today's approaches. As glycemic control becomes safer and more effective, demands for further normalizing glycemic control to minimize complications are inevitable.

Devices have transformed care, too. A wide variety of new continuous monitoring devices, delivery systems, and self-management tools provide more options for ensuring that treatment is less disruptive and more effective than ever before. Inevitably, the advent of these major advances also brings new and serious challenges. Practices will need to transform to support the demands and the needs of our patients.

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Practice transformation is necessary if primary care is to continue the delivery of high-quality diabetes care. The link between practice diabetes performance measures and the introduction of enhanced patient-centered care teams providing proactive outreach is clear.[3]

Our biggest challenge. Despite advances in the science, perhaps the biggest challenge in diabetes care is the inevitable inequity in access to new medications. The average wholesale price of glargine has soared to $340 per month, while the most effective new GLP-1 receptor agonists are close to $1000 per month.[4]

Although primary care doctors have always tried to accommodate the uninsured, the stark differences between new and old medicines now resembles a 2-tiered system. We can all celebrate advances in diabetes care and work hard to learn when and how to best use them, but those advances are accompanied by an uncomfortable awareness of the enormous inequity of prescribing regimens that haven't been considered best practice since the 1990s to patients who simply can't afford better medicine.

We can expect amplified inequities in diabetes clinical outcomes to continue unless we develop a better system of distributing these life-changing medicines to those Americans who need them. Some state legislatures have made progress by supporting limited access to affordable insulin. However, ensuring that all patients with diabetes have access to modern insulin and effective medications is a national responsibility that needs a national response. Universal access to the modern tools of basic health care is a long-overdue treatment for an expanding epidemic of inequity. JFP

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