when they generate competing guidelines without adequate justification.

How should we move forward then? At the least, the panel shows suggestions for organisations that are developing a duplicate guideline. A more utopian solution would be to divorce guidelines from organisational infighting altogether, an approach we believe would be warmly greeted by clinicians around the world. A guideline could be posted online, to act as the focus of ongoing discussion and modification. Last, but not least, we could make a concerted effort to do away with guidelines directed toward populations of patients that are too general by design, in favour of computer-generated individualised guidelines. These approaches would go a long way toward reduction of confusion and argument, and perhaps a return of guidelines to their intended purpose.

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Social determinants of diabetes and challenges of prevention

Type 2 diabetes, which accounts for roughly 90% of all cases of diabetes, is still widely perceived as a disease of affluence that is strongly associated with obesity and physical inactivity.1 This perception is mirrored in policy for international development, with the UN’s Millennium Development Goals (MDGs) making no mention of diabetes or related chronic diseases. Notably, diabetes was one of a small number of priority public-health conditions that were assessed in a recent publication developed to inform the work of the WHO Commission on Social Determinants of Health. The chapter about diabetes illustrates why this disorder and related chronic diseases are key targets for reduction of health inequity worldwide, and specifically in countries with low and middle incomes.7

Most people with diabetes live in low-income and middle-income countries; conservative estimates suggest that, of 285 million people with diabetes worldwide in 2010, 209 million (73%) live in countries with low and middle incomes.1 In high-income countries, prevalence of type 2 diabetes tends to be highest in people who are poor.7 Data from low-income and middle-income countries are scarce, and suggest that although the prevalence of diabetes is often highest in the wealthiest parts of the population, this gradient is reversing in some middle-income countries.1 However, a focus on the direction of the gradient alone would miss the fact that diabetes in low-income countries is highly prevalent in poor urban populations, with up to 15% of adults in this group affected.1 Furthermore, in some middle-income countries, including India and China, there is growing evidence that prevalence in rural areas is approaching that in urban areas.1 Even if in some countries diabetes is most common in the wealthy population, the economic and social consequences of the disease will undeniably be greatest in people who are poor. For example, patients from middle-income or low-income groups in Chennai, India, can spend a sixth to a quarter of their income on diabetes care.6 Additionally, diabetes in countries with low and middle incomes is predominantly a disease affecting men and women of working age, the breadwinners of families.
and communities, with 68% of all cases occurring in people aged 20–59 years.\textsuperscript{1}

The exclusion of diabetes and related chronic diseases from the MDGs has created a falsehood: that the communicable diseases regarded as most important to the world can be addressed without also addressing other common and increasingly prevalent diseases, such as diabetes. Diabetes is associated with a three-fold increased risk of tuberculosis, and is the only major risk factor for this disease that is projected to grow substantially during the coming decade.\textsuperscript{7} As the prevalence of diabetes increases, tuberculosis control might become more difficult. In India, around one in five cases of new smear-positive pulmonary tuberculosis is estimated to be attributable to diabetes.\textsuperscript{8} Poor progress towards the MDGs is associated with high chronic-disease mortality. A 10% decrease in mortality is associated with progress towards the child-health MDGs similar to that associated with a 40% or more rise in gross domestic product (GDP), or an 80% or more rise in GDP for progress towards the tuberculosis MDG.\textsuperscript{9}

Type 2 diabetes is affecting an increasing proportion of the population in both the poorest and richest countries, and in broad terms its underlying determinants are the same worldwide.\textsuperscript{2} Obesogenic environments fostering low levels of physical activity and access to energy-rich diets are the most important determinants. Their structure and content are strongly affected by economic and cultural globalisation. Food processing, for example, is one of the largest sources of foreign direct investment by transnational corporations in countries with low and middle incomes.\textsuperscript{10}

Approaches that target individuals at high risk of developing type 2 diabetes are unlikely to have a major preventive effect at a population level. This issue reflects both the difficulty of translation of high-risk approaches from complex trials into the real world—a challenge that has yet to be met in high-income countries with well resourced health systems—and the fact that a substantial proportion of diabetes will arise in individuals not identified as being at high risk.\textsuperscript{11} The real challenge, globally, is to shift population distributions of risk by modification of the obesogenic environment. This approach will probably need a broad range of policy measures, including measures designed to modify the built environment and those that affect food pricing and advertising. WHO’s Strategy on Diet, Physical Activity and Health\textsuperscript{12} provides a global framework to support member states in the development, implementation, and assessment of public policy, while also aiming to build a broad international alliance that is essential when risks are driven by transnational commercial interests.

In view of the worldwide epidemic of type 2 diabetes, the huge and growing effect of the disease in countries with low and middle incomes, the commonality of the underlying determinants across countries, and the importance of globalisation in driving those determinants, the prevention of diabetes and related diseases ought to be at the forefront of global efforts to reduce health inequity, alongside the targets of the MDGs. Let us hope that the decision of the UN General Assembly to hold a summit on chronic non-communicable diseases in September, 2011, is evidence of emerging, effective, international action for their prevention.

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We declare that we have no conflicts of interest.
