



STATE *of* HEALTH

THE MILAN DIALOGUE

THE MISSING *chapter*

Cardiometabolic health and the economics
of acting earlier in Europe



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THE MILAN DIALOGUE

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Europe is not short of effective clinical solutions in cardiometabolic care. What it lacks is the systematic detection, continuity of care, and accountability needed to translate those solutions into better outcomes. This paper argues that the economically relevant question for European health systems is not simply what earlier, better-organised care costs, but what is ultimately spent on late, fragmented care — and what social and economic returns earlier action would generate. Yet, despite Europe's growing recognition of health as an economic investment, there is still no agreed framework for testing that proposition.

ABOUT THIS PAPER

This is a discussion document prepared as a pre-read for participants in the Milan Dialogue: it is not a consensus statement, nor a guideline, nor a position of any scientific society, university or company. It names no medicine, therapeutic class or manufacturer; where treatment is discussed, it is discussed at the level of how care is organised, sequenced and evaluated. Type 2 diabetes is used as the entry point because it is the most fully documented cardiometabolic condition in Europe, but the argument is intended to apply to the cardiometabolic cluster as a whole — dysglycaemia, excess weight, hypertension, dyslipidaemia and impaired renal function, which occur together far more often than they occur alone. The term is used in the singular throughout, deliberately: the subject is one interacting cluster, not a list of separate conditions, and the plural would concede the separation this paper questions.



EXECUTIVE SUMMARY

The context. The EU Cardiovascular Health Plan of December 2025 places cardiovascular disease, diabetes and obesity inside the Union's competitiveness agenda, with targets to 2035 and instruments dated 2026 and 2027. "Health is an investment" has ceased to be an advocacy claim to become an official European position. The question has therefore changed: not whether health belongs in the competitiveness conversation, but whether Europe has the methods, the data and the institutional habits to act on a claim it has now made.

What the evidence shows. Cardiometabolic disease is the sharpest available test, and the answer is uncomfortable. Clinical strategy has changed decisively: from driving a single laboratory value towards a threshold to protecting organs — early, simultaneous and sustained control of glycaemia, body weight, blood pressure and lipids. However, delivery has not followed. Across 63 studies and more than 1.6 million people with type 2 diabetes, only 12% reach the glycaemic, blood-pressure and lipid targets together, and in Europe and North America glycaemic target attainment has not measurably improved since 1997. Two decades of therapeutic advance have not moved the proportion of Europeans reaching the targets those advances were designed to reach.

Where the failure actually sits. Section 3 examines five European systems through the instruments each has built to hold itself to account. The pattern is common to all five and does not track wealth, prevalence or speed of market access. England, which has Europe's most detailed diabetes audit, records 45.2% of people with type 2 diabetes at all three treatment targets; and when its guideline changed to recommend organ-protective treatment for people with established cardiovascular disease, NICE's own analysis found that eighteen months later fewer than one in five had it — and that prescribing was no more likely in those at high cardiovascular risk than at low risk. Germany, with the fastest route in Europe from authorisation to availability, reports that 16% of national deaths are diabetes-related and that people with type 2 diabetes more often die while still of working age. The Cour des comptes, auditing one of the Union's least affected countries, judges French quality-of-care indicators — early care in particular — unsatisfactory, with close to 30% of newly managed patients already at an advanced stage. The mechanism is time: in a UK primary-care cohort the median interval from crossing the glycaemic threshold to adding a second oral agent exceeded seven years for people already taking two, and time above target is not recoverable.



The economic impact of cardiovascular disease, and the measurement problem.

Cardiovascular disease costs the EU more than € 282 billion a year, € 47 billion of it due to lost productivity; in 2021 alone Europe lost 256 million working days to illness and disability and 1.3 million working years to premature death. The composition is consistent wherever documented: most of it is generated by complications rather than by the metabolic condition itself, glucose-lowering medicines are a small minority of direct spend, and much of the burden falls outside the health budget — in Spain a well-controlled patient costs the system around € 883 a year against up to € 2,133 for one who is not. Yet Europe still evaluates on cost per defined daily dose, from a payer perspective, over a single line of therapy, while committing only 3% of health expenditure to prevention. Such a framework is blind to most of the burden, and blind in one direction: it sees the cost of acting and not of not acting.

The proposition.

Europe has built shared machinery for “does this work better?” — joint clinical assessment under the Health Technology Assessment Regulation, deliberately confined to relative clinical effectiveness and safety — and, even there, comparing one treatment against standard of care within a single indication rather than taking the pathway view this paper argues for. It has built nothing comparable for “what does delay cost, and to whom?”, nor an agreed method for estimating that cost so that a societal perspective can be applied. That is the institutional gap this paper identifies. Closing it requires five methodological commitments — a societal perspective by default, a time horizon matched to the biology, the pathway rather than the line as the unit of assessment, the risk cluster rather than the biomarker as the clinical object, and explicit equity weighting — none of which requires a member state to cede a national competence.

What this paper asks.

No endorsement is sought. Section 7 puts four questions instead: where each system generates its largest avoidable cardiometabolic cost, and whether that cost is visible to whoever holds the budget that would fund earlier action; which problems are European and which national; what mechanism would narrow variation without displacing national pricing and reimbursement decisions; and who is not reached by what already exists.

KEY FINDINGS, WITH SOURCES

- 1 Europe reopened its competitiveness debate without a health chapter.** The 2024 report on European competitiveness devoted more than 400 pages to productivity without addressing the health of the workforce that produces it — an omission identified immediately in the European health policy literature.^{1,2} The EU Cardiovascular Health Plan of December 2025 closes part of that gap and does so explicitly on economic grounds.³
- 2 The economic figures are now official.** Cardiovascular disease costs the EU more than € 282 billion a year, of which € 47 billion is lost productivity. In 2021 alone Europe lost 256 million working days to illness and disability, and 1.3 million working years to premature death.³ More than three-quarters of cardiovascular deaths in the EU are linked to modifiable risks, with metabolic factors — hypertension, diabetes and obesity — accounting for 68%; and of the fifteen risk indicators the OECD tracks, eight have worsened and the remaining seven show persistently high population exposure.⁴
- 3 The gap is not in what medicine knows.** Clinical strategy has moved from treating a single number to protecting organs: early, simultaneous and sustained control of glycaemia, body weight, blood pressure and lipids. Delivery has not followed. Pooled across 63 studies and 1,618,972 people with type 2 diabetes, 44% reach the glycaemic target, 41% the blood-pressure target and 47% the lipid target — and 12% reach all three. In Europe and North America there has been no measurable improvement in glycaemic target attainment between 1997 and 2023.⁷ And when England changed its national guideline to recommend organ-protective treatment for people with established cardiovascular disease, NICE's own analysis found that eighteen months later fewer than one in five of them had it — and that prescribing was no more likely in those at high cardiovascular risk than in those at low risk.²⁸
- 4 The gap is in where the money is counted — and it is the same gap in every system we examined.** England's national audit puts 45.2% of people with type 2 diabetes at all three treatment targets.²⁷ France's supreme audit institution reports quality-of-care indicators, and early care in particular, as unsatisfactory, with close to 30% of newly managed patients already at an advanced stage.³⁰ Germany's diabetes society puts the annual cost of treatment and its sequelae at some € 36 billion, and notes that people with type 2 diabetes more often die while still of working age.²⁹ In Spain a well-controlled patient costs the system around € 883 a year and a poorly controlled one up to € 2,133.³² In Italy roughly nine-tenths of attributed cost arises from complications, and glucose-lowering medicines account for under a tenth of direct spend.^{16,19} Yet comparative assessment is still routinely conducted on cost per defined daily dose, from a payer perspective, over a single line of therapy — a measurement convention, not an economic finding, and one that systematically conceals the cost of delay.

5 Europe has begun to harmonise how it assesses clinical benefit. It has not begun to harmonise how it values avoided cost. The EU Health Technology Assessment Regulation deliberately stops at relative clinical effectiveness and safety; economic evaluation, pricing and reimbursement remain national.²⁴ Meanwhile the median interval between EU marketing authorisation and availability to patients is 532 days, ranging from 56 days in one member state to 1,201 in another.²³

6 The proposition we put to the room is methodological, and therefore testable. The economically material question for European health systems is not what earlier, better-organised cardiometabolic care costs, but what late and fragmented care costs — and Europe currently has no agreed method for answering it. Developing such a framework is a European task that can be pursued without encroaching on member states' national competencies.



1. THE CHAPTER THAT WAS LEFT OUT

In September 2024 Europe was handed a diagnosis of its own economic condition. The report on European competitiveness ran to more than four hundred pages, identified low productivity as the central problem, and prescribed investment in skills, technology, energy and capital markets.¹ It said almost nothing about whether Europeans are well enough to work. The omission was noticed at once: poor health reduces labour-market participation and productivity, most sharply in the groups least able to absorb it; health systems are themselves engines of innovation and regional economic activity; and health provision is one of the visible expressions of the European social contract.² A competitiveness strategy that treats the workforce as a given, rather than as something that can be protected or lost, is incomplete by construction.

Fifteen months later, part of that chapter was written. On 16 December 2025 the European Commission published the first EU Cardiovascular Health Plan — the Safe Hearts Plan — within a package framed around “the long-term resilience and competitiveness of the health sector”³ The Plan is candid about the arithmetic. Cardiovascular disease remains the leading cause of death and disability in the Union, claiming 1.7 million lives a year and affecting some 62 million people; the economic cost exceeds € 282 billion annually, of which € 47 billion is lost productivity; and in 2021 alone, illness, disability and premature death cost Europe 256 million working days and 1.3 million working years. It records that cardiovascular death rates are nearly 6.3 times higher in some member states than in others, and that regional mortality ranged in 2022 from 139 to 1,196 deaths per 100,000. It names diabetes and obesity not as adjacent problems but as principal risk factors, and states that its purpose includes contributing to “a stronger, more resilient and more competitive EU”.³

This matters for how the argument is now made. “Health is an investment” has until recently been an advocacy claim; it is now, in the cardiovascular and cardiometabolic domain, an official European position with targets, dates and instruments attached. The question in front of Europe has therefore changed. It is no longer whether health belongs in the competitiveness conversation. It is whether Europe possesses the methods, the data and the institutional habits to act on the claim it has just made.

We believe cardiometabolic disease is the sharpest available test of that question, for three reasons. It is chronic, so its costs accumulate across working lives rather than arriving as a single episode. It is largely modifiable — through both pharmacological advances and changes in the conditions that shape diet and physical activity, which are social and environmental as much as individual, so the counterfactual is real rather than rhetorical. And it is the area in which the distance between what clinical science

establishes and what health systems deliver is both widest and best measured.

The direction of travel is not in dispute. Diabetes prevalence in the EU rose by 22% between 2012 and 2022 and has doubled since 1990, reaching 7.8% of the population; hypertension affects almost a quarter of adults and is rising; over half of adults are overweight, and overweight among adolescents rose from 17% to 21% between 2014 and 2022.³ The macroeconomic consequence has been modelled: across OECD and EU countries, overweight and its associated diseases are projected to reduce GDP by 3.3% on average, to absorb 8.4% of health expenditure, and to reduce the effective workforce by the equivalent of tens of millions of full-time workers a year — with around 70% of all health expenditure on diabetes attributable to overweight.²⁰ These are modelled projections and should be read as such. But they describe the same mechanism the Commission now describes in its own documents, and they place cardiometabolic health squarely inside, not adjacent to, the productivity question.

The remainder of this paper sets out the distance between knowledge and delivery and argues that closing it is primarily an organisational and methodological challenge rather than a scientific one.

2. WHAT HAS CHANGED IN THE CLINIC – AND WHAT HAS NOT CHANGED IN THE SYSTEM

The clinical paradigm in type 2 diabetes has shifted decisively over the past decade, and the shift is not cosmetic. Care has moved from treating to a target — driving a single laboratory value towards a threshold — towards treating to benefit: acting early and simultaneously on the several metabolic parameters that together determine cardiovascular and renal outcomes, and sustaining that control over time. The 2022 and 2026 clinical guidance documents state the position plainly: pursuing glycaemic control and pursuing other goals, including weight management and organ protection, are complementary rather than mutually exclusive tasks.^{10,11} European cardiology guidance for people with diabetes assumes the same logic.¹²

The rationale is cumulative exposure. Cardiovascular and renal risk in dysglycaemia is driven less by the value of any single parameter on any single day than by the integral of adverse metabolic exposure over years. That is why the long-term follow-up of intensive early glycaemic control continues to show benefit decades after the intervention period ended, and why multifactorial early intervention has shown mortality benefit sustained over long horizons.^{13,14} The corollary is uncomfortable: time spent above target is not recoverable. A patient brought to control after ten poorly controlled years is not in the same position as one controlled from diagnosis, even if the two look identical on a chart today.

Clinicians agree on this. A modified Delphi consensus among seventeen Italian cardiologists, diabetologists, endocrinologists and internists reached unanimous agreement — 100% — that management of type 2 diabetes should rest on simultaneous control of glycaemia, body weight, blood pressure and lipids through an early multifactorial approach, with targets maintained over time.⁹ The same panel, however, reported that simultaneous control of all those parameters is currently achieved in no more than about 30% of the patients they manage, and 88% agreed that management in Italy remains predominantly glucocentric, often at the expense of comprehensive cardiovascular risk management.⁹ Practitioners are describing a gap between their own standard and their own practice.

The international data confirm that this is not an Italian peculiarity. The most recent systematic review and meta-analysis on target attainment — 63 studies, 1,618,972 people with type 2 diabetes, 2006 to 2025 — found 44% at the glycaemic target, 41% at the blood-pressure target, 47% at the lipid target, and only 12% at all three

simultaneously. Meta-regression found no significant improvement in glycaemic target attainment in Europe and North America across the period 1997 to 2023.⁷ A separate pooled analysis of nationally representative surveys in 100 countries, benchmarked against the WHO Global Diabetes Compact targets, found that even in high-income countries only about 70% of people with diabetes had been diagnosed, and that among those diagnosed, 74% met a deliberately lenient glycaemic threshold of HbA1c below 8.0%, and 59% were receiving guideline-indicated lipid-lowering treatment. Of the 100 countries examined, eight met the diagnosis target and seven the glycaemic target.⁸

Two decades of therapeutic advance, and no measurable movement in the proportion of Europeans reaching the targets those advances were designed to reach. This is a strong signal about where the constraint sits. If the limiting factor were pharmacological, attainment would have improved as the pharmacology improved — but it has not. The limiting factors are therefore organisational — how and when people are found, how care is sequenced across professionals and settings, whether outcomes are recorded, and whether what is recorded is acted upon. The Safe Hearts Plan reaches the same conclusion from the system side: continuity of care is lacking, pathways are fragmented, common standards are absent, only six member states use electronic health records to monitor cardiovascular outcomes systematically, and most member states lack comprehensive national registries for cardiovascular disease and diabetes at all.³ A system cannot manage what it does not measure and cannot improve what it does not manage.





3. FIVE EUROPEAN SYSTEMS, ONE COMMON PATTERN

The European aggregates in the previous section conceal the fact that matters most politically. This is not a story about laggard systems. It is a story that is held in the systems Europe regards as its most advanced. In what follows we take five countries and use, wherever we can, the instrument each of them has built to hold itself to account: a national clinical audit, a supreme audit institution, a national payer's own expenditure mapping, a scientific society's annual report. These are not advocacy sources. They are the mechanisms by which each system reports on itself, and their findings are markedly more uncomfortable than anything an external observer would say.

3.1 England: the guideline changed, the prescribing did not

The National Diabetes Audit is the most granular national instrument of its kind in Europe. For 2024–25 it covered 3,713,155 people with type 2 diabetes in England and found that 45.2% achieved all three treatment targets for blood glucose, blood pressure and cholesterol, and that 58.2% had all eight recommended annual care processes recorded — with completion ranging from 38.6% to 73.5% between commissioning bodies.²⁷

More instructive is what happened when the national guideline changed. In February 2022 NICE updated its type 2 diabetes guidance to recommend that organ-protective treatment be offered to people with established cardiovascular disease or heart failure, and considered for those at high cardiovascular risk. Eighteen months later, in a cohort of 587,826 people with type 2 diabetes, NICE's own analysis found that 19.5% of those with cardiovascular disease held a current prescription for it; 29.4% of those with heart failure; and 30.5% of those with both. Among people at high cardiovascular risk the figure was 19.9%. Among those at low cardiovascular risk it was 20.2%. Prescribing was lower in people over 60, in women, in Black people and in more deprived areas.²⁸

The sequel matters, because it shows what measurement can do. In February 2026 NICE revised the guideline again — moving organ-protective treatment to first-line therapy from diagnosis rather than after glycaemic failure, broadening it further for people with established cardiovascular disease, and setting out distinct pathways by comorbidity. The same analysis of inequitable prescribing sat among the evidence behind an explicit mandate in the revised guidance to ensure equal access to appropriate treatment for everyone living with type 2 diabetes.^{28,36} An audit found a delivery failure; eighteen months later the guideline was rewritten to address it. That loop — measure, publish, revise — is what most European systems cannot currently close, because they do not collect the data that would start it.

Two conclusions follow, and neither is about price. Availability was not the constraint: the treatment was authorised, reimbursed and recommended. And prescribing was not directed by risk — the near-identical figures for high and low cardiovascular risk mean that the guideline's central instruction, to reach the people who stand to benefit most, was not being executed at all.

3.2 Germany: fastest access in Europe, and still a gap

Germany illustrates the same point from the opposite direction. The German Diabetes Society and the national patient organisation report, in their 2026 annual health report, more than nine million people with diagnosed diabetes and around eleven million including the undiagnosed; that people with diabetes are disproportionately affected by cardiac, renal and eye disease; that 16% of all deaths in Germany are diabetes-related; and that the annual cost of treatment and its sequelae is in the region of € 36 billion, the fourth highest of any country.²⁹ The same organisations state the socio-economic case in terms no economist would improve on: people with type 2 diabetes incur roughly twice the care costs of people without it, have more days of sickness absence, are more often certified permanently unfit for work, and more often die while still of working age.²⁹

Germany also has among the shortest intervals in Europe between European authorisation and patient availability — a median of 56 days in the most recent survey, against 532 across Europe as a whole.²³ The German case is therefore the clearest available demonstration that speed of listing is necessary but not sufficient. Where availability is fastest, the shortfall sits downstream of listing: in detection, in pathway design, and in whether the indicated patient is actually reached.

3.3 France: a supreme audit institution's verdict

In July 2025 the Cour des comptes published a report devoted specifically to the prevention and early management of diabetes. Its findings deserve to be reported in substance, because they come from the body constitutionally charged with auditing French public spending. France is among the least affected countries in the Union, and yet: indicators of the quality of care, and of early care in particular, remain unsatisfactory; indicators for follow-up and preventive examinations are improving only slowly; the number of hospital admissions for complications has fallen only marginally since 2013, which the Court reads as a sign of weak improvement in early management; and close to 30% of people newly taken into care for diabetes in 2021 already had advanced disease.³⁰

In 2023 some 3.8 million people in France were being treated for diabetes, 92% of them type 2, and the national payer's own expenditure mapping attributes more than € 10 billion of reimbursed expenditure to the condition.^{30,31} The Court's conclusion was not that France should spend more, but rather, spend earlier: it recommended that every patient be offered a structured pathway — therapeutic education, nutritional intervention, adapted physical activity — at the point of diagnosis, and a restructuring of the long-term-illness scheme so that such a pathway could be reimbursed at all.³⁰





3.4 Spain: the price of poor control, stated plainly

Spain has one of the highest adult diabetes prevalences in Europe, at 14.8%, and the Spanish Diabetes Society reports that 30.3% of people living with diabetes in Spain are undiagnosed.³² Its own account of the problem is worth setting alongside the European documents: the Society's president has described the principal concerns as underdiagnosis and the absence of early diagnosis and, once diabetes is diagnosed, the lack of access to quality education and adequate follow-up, together with the fact that a substantial proportion of patients do not reach targets for glycaemic control or for the associated cardiovascular risk factors.³²

Spanish work also states the economics in the single most compact form we have found anywhere. Direct costs of diabetes account for some 8.2% of total Spanish health expenditure; and a patient whose diabetes is well controlled costs the system in the region of € 883 a year, while a patient who is not can cost up to € 2,133.³² The ratio is the argument. Nothing about it depends on the price of any particular treatment.

3.5 Italy: the composition of the bill

Italy provides the most complete published picture of where cardiometabolic money actually goes. The annual social cost of type 2 diabetes is of the order of € 20 billion, of which roughly 46% is direct healthcare expenditure and the remaining 54% falls elsewhere — on patients, families, employers and the social security system.¹⁶ Average direct cost is approximately € 2,800 per patient per year, of which hospital admissions account for around 41% and non-diabetes medicines for a further 31%, while glucose-lowering medicines account for under 9%.¹⁹ Of the total cost attributed to diabetes, on the order of 90% is generated by complications and around 10% by the metabolic condition itself.¹⁶ In Italian real-world data, mean annual direct cost rises from roughly € 2,000 for type 2 diabetes alone to about € 4,400 with chronic kidney disease, € 4,300 with heart failure and € 6,900 where both are present.¹⁷ An Italian expert panel that reached unanimous agreement on the need for early, simultaneous control of glycaemia, weight, blood pressure and lipids, reported that such control is currently achieved in no more than about 30% of the patients its members manage.⁹

	Burden	What the national instrument reports	Source
England	3.71 million with type 2 diabetes (2024–25)	45.2% at all three treatment targets; 58.2% with all eight annual care processes, ranging 38.6–73.5% between commissioning bodies; 19.5% of those with established cardiovascular disease on the recommended organ-protective treatment 18 months after the guideline changed, against 20.2% of those at low cardiovascular risk ^{27,28}	National clinical audit; national HTA body
Germany	>9 million diagnosed; ~11 million including undiagnosed	16% of all deaths diabetes-related; ~€ 36 bn a year in treatment and sequelae; roughly twice the care costs of people without type 2 diabetes, more sickness absence, more permanent incapacity for work, more death while of working age ²⁹	Scientific society and patient organisation

	Burden	What the national instrument reports	Source
France	3.8 m treated (2023), 92% type 2	Quality-of-care indicators, and early care in particular, judged unsatisfactory; hospital admissions for complications barely reduced since 2013; close to 30% of newly managed patients already at an advanced stage ³⁰	Supreme audit institution; national payer
Spain	14.8% adult prevalence, among the highest in Europe	30.3% undiagnosed; direct costs ~8.2% of national health expenditure; a well-controlled patient costs the system ~€ 883 a year, a poorly controlled one up to € 2,133 ³²	Scientific society
Italy	~€ 20 bn annual social cost	~90% of attributed cost generated by complications; >40% of direct cost hospital admissions and <9% glucose-lowering medicines; cost rising from ~€ 2,000 to ~€ 6,900 with renal and cardiac comorbidity; simultaneous control achieved in ≤30% of patients ^{9,16,17,19}	Peer-reviewed national analyses; expert consensus

Sources are national audits, supreme audit institutions, national payers, scientific societies and patient organisations. Definitions, target thresholds, data years and case-finding methods differ between countries; the figures are not directly comparable with one another and are presented as five independent national verdicts rather than as a league table.

3.6 Obesity: the same pattern, one step earlier

This paper treats cardiometabolic disease as one cluster, so obesity is a useful paradigm: it is the part of the cluster where Europe's instruments are newest. In all five systems an instrument now exists. In none of them is the entitlement to treat it yet complete.

Italy recognised obesity as a chronic, progressive and relapsing disease in Law 149 of 3 October 2025, and provided for its prevention, diagnosis and care to enter the essential levels of assistance.³⁷ Obesity has not yet been added to the annex of the 2017 decree that operationalises those levels, so the entitlement is declared rather than exercisable; the national programme is funded at € 700,000 for 2025, € 800,000 for 2026 and € 1.2 million a year thereafter, against a population of roughly four million adults with obesity.³⁷ The national registry maintained by the Italian society for obesity and metabolic surgery records that 54% of some 26,600 procedures were carried out in the north and 8% in the islands; the coordinator of that society's national guidelines has estimated that surgery would be indicated for around 20% of people with obesity but only reaches 2-3%.³⁸

Germany's Federal Joint Committee established a structured disease-management programme for adult obesity in November 2023, released by the health ministry in April 2024, with a paediatric equivalent agreed in November 2024. The patient representatives on the Committee recorded that nutritional and behavioural therapy could not be included, because neither is a standard benefit of statutory health insurance for obesity, and that pharmacological weight-loss treatment is excluded by statute.³⁹ England has a National Obesity Audit within its national clinical audit programme, and a survey of all forty-two

commissioning bodies found five reporting no specialist weight-management provision at all.^{40,41} France's 2026–2030 obesity roadmap rests on a network of 42 specialist centres, but three regions have none, only twelve regions had integrated an obesity component into their regional health plan by the end of 2024, and the ministry itself notes that the absence of systematic tracking in the national health data system limits any detailed understanding of care pathways.⁴² Spain has no national plan yet: the health ministry undertook in March 2026 to bring one forward, and the two relevant scientific societies have asked for obesity to be added to the national benefits catalogue and for the criteria governing access to surgery to be harmonised across the autonomous communities.⁴³

The pattern repeats, one step earlier in the sequence: recognition of the disease has arrived ahead of the entitlement to treat it. A law, a programme or an audit that is not attached to a funded pathway does not produce care. It produces a diagnosis and a queue — and, on the evidence above, a queue whose length depends on the region a person happens to live in.

3.7 What the five have in common

Returning to type 2 diabetes, four things are true across all five systems. **First, the shortfall does not track wealth, prevalence or speed of market access.** England has universal coverage and the most detailed audit in Europe; Germany has the fastest route from authorisation to availability; France has among the slowest prevalence growth in the Union. All three report the same failure to convert an established clinical strategy into delivered care.

Second, much of the shortfall sits upstream of, and independent of, whether a treatment appears on a reimbursement list. The English data make this unusually clear: a recommended, reimbursed, available treatment reaching fewer than one in five of the people for whom it was recommended is not a pricing problem — though a positive appraisal brings no additional budget, so budget-holders must absorb new recommendations within existing envelopes.

Third, the delay is measurable. In a UK primary-care cohort of 81,573 people with type 2 diabetes, the median time from crossing the glycaemic threshold to intensification with an additional oral agent was 2.9 years for those on one agent and exceeded 7.2 years for those already on two.³³ In a more recent cohort of 13,916 people whose glycaemic control remained suboptimal after treatment had already been escalated, 52.5% received no further intensification at all, and late intensification was associated with a materially higher risk of macrovascular complications in those under 65.³⁴ A systematic review of 53 studies found delays of more than a year to be the norm.³⁵ Time above target is not recoverable, which is why these intervals are not administrative details but the mechanism by which avoidable cost is created.

Fourth, wherever it is measured, the shortfall is socially patterned — by age, sex, ethnicity and deprivation in England, by education and income in Italy, and by region in every system that reports at regional level.^{25,27,28}

3.8 Direct and indirect barriers

It is worth separating the two kinds of obstacle, because they call for different instruments and because conflating them is the fastest way to lose a payer's attention. **Direct barriers** concern whether a therapy is available and reimbursed at all: authorisation-to-availability intervals, reimbursement listing, restricted-condition listing. These are the subject of §4.3, and the European variation in them is large. **Indirect barriers** concern whether an available, reimbursed therapy actually reaches the person for whom it is indicated; whether that person has been diagnosed; whether prescribing is gated to a specialist the patient cannot easily reach; whether intensification happens when the threshold is crossed; whether the prescribing budget and the hospital budget belong to the same decision-maker; whether outcomes are recorded at all. The Commission's own assessment names both. It records that the suboptimal use of cardiovascular medications is an important gap in care across the EU, that continuity of care is lacking and pathways fragmented, that common standards for treatment and care are absent, and that innovative treatments and technologies are not equally accessible across the Union.³

The country evidence suggests the indirect barriers are, in the wealthiest systems, the larger of the two — and that they are systematically less visible, because no budget line records them and no indicator is routinely published against them. That is a strong argument for measurement before it is an argument for spending.

3.9 Why the way Europe measures this hides the delay

Set against the composition of cost documented above, the allocation of European health spending is difficult to defend on its own economic logic. The Commission states in the Safe Hearts Plan that nearly 80% of cardiovascular disease can be prevented, and that prevention nonetheless receives only 3% of total healthcare spending “despite being the most cost-effective investment”.³ Eurostat puts preventive care at 3.7% of current health expenditure in the EU in 2023 — 2.9% before the pandemic, and inflated in 2021–22 by the reclassification of pandemic response — with national shares ranging from 0.9% to 5.2%.²² Whichever figure one prefers, the structure is the same: a system that generates the large majority of its cost downstream while committing something in the region of three cents in the euro upstream is not organised around its own economics.

THE ANALYTICAL POINT

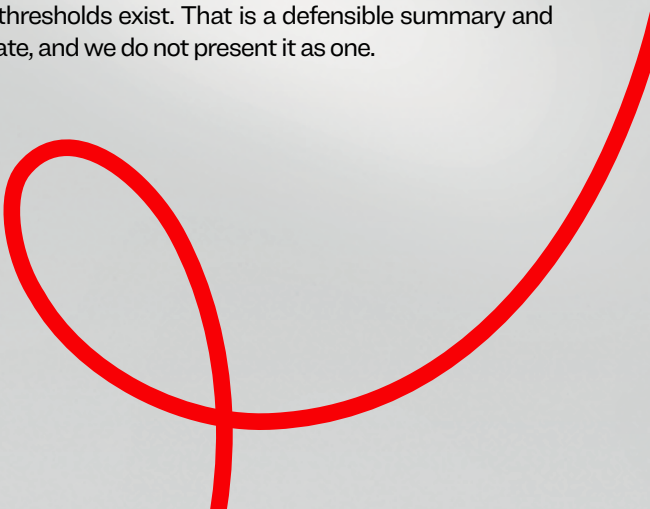
Across every system examined here, the large majority of what type 2 diabetes costs is generated downstream of the point at which it could have been prevented or delayed, and glucose-lowering medicines account for a small minority of direct spending. A comparative assessment framework built on the price of those medicines is therefore examining a small and unrepresentative fraction of the relevant economics — and is silent on the variable that the national data identify as decisive, which is time.



Consider the conventions in routine use. Comparative evaluation of chronic cardiometabolic treatment across Europe still leans heavily on cost per defined daily dose. That convention carries four assumptions, each questionable and none usually stated. It assumes that the benefit–risk profiles of the options compared are broadly interchangeable. It assumes that the defined daily dose corresponds to the dose actually prescribed. It excludes costs generated or avoided elsewhere in the system. And it is static rather than dynamic: it prices a line of therapy rather than a therapeutic pathway, at a moment rather than over a trajectory.

The perspective problem compounds it. More than half of the societal cost of type 2 diabetes in Italy is borne outside the health service, and the German figures on absence, incapacity and working-age mortality describe the same displacement; yet the great majority of published economic evaluations adopt a payer or health-system perspective. That choice is administratively comprehensible — a payer answers for its own budget — but it means the evaluation is structurally blind to the majority of the burden, and blind in a systematic direction: it sees the cost of acting and not the cost of not acting. When productivity is the stated policy objective, as it now is at European level, an evaluative framework that excludes productivity is not merely incomplete. It is pointed out the wrong way.

There is a further difficulty, and it is better stated by the authors than discovered by the reader. The evidence base on therapeutic *pathways* — as distinct from single comparisons at a single line — is thin. A structured review of the economic literature on treatment sequences in type 2 diabetes over the last decade identified 185 records, of which 141 remained after de-duplication, 66 were assessed in full text and 4 met criteria for synthesis.⁴⁴ Those four rest largely on simulation models rather than observed outcomes, because real-world data require time to mature and registration trials are not designed around sequences. Their consistent finding is that using more recently introduced agents earlier in the pathway produces both greater effectiveness and greater cost, with an incremental cost per unit of effect that is material but generally below the thresholds used where thresholds exist. That is a defensible summary and also a modest one; it is not a mandate, and we do not present it as one.



4. THREE GAPS, AND THE EUROPEAN INSTRUMENTS THAT COULD CLOSE THEM

The Safe Hearts Plan is organised around three pillars — prevention, early detection and screening, and treatment and care — with cross-cutting work on digital innovation, research and inequalities.³ It also asks member states to develop or implement a national cardiovascular health plan by 2027; to date, twelve of the twenty-seven Member States have implemented or are currently implementing a national cardiovascular plan.^{3,45} Read alongside the evidence above, three specific gaps stand out, each with a live European instrument and a date attached. We offer them as a starting point for discussion, not as a settled list.

4.1 Detection: twenty-two million people who do not know

In the International Diabetes Federation (IDF) Europe Region, 65.6 million adults were living with diabetes in 2024, and 33.6% of them — about 22 million people — were undiagnosed. Behind that sits a larger reservoir of dysglycaemia: some 39.7 million adults with impaired fasting glucose and 45.9 million with impaired glucose tolerance.⁶ Undiagnosed disease is untreated disease, and the years before diagnosis are the years in which cumulative exposure does its work. The Plan addresses this directly, with a 2035 target that at least 65% of people aged 25–64 and at least 80% of those aged 65 and over should have blood glucose measured once a year by a health professional, and a Council Recommendation on health checks proposed for 2026 to give member states a common protocol where none has existed.³ The open question is not whether the target is right. It is what a measurement target becomes if it is not attached to a pathway: a test that identifies risk without a defined route to management converts an undiagnosed patient into a diagnosed but unmanaged one, and moves cost rather than avoiding it.

4.2 Continuity: outcomes that are not recorded cannot be improved

A person living with cardiometabolic disease in Europe is likely to encounter a general practitioner, a diabetes specialist, a cardiologist, a nephrologist and a nursing team, in a sequence that is rarely designed and often not documented end to end.¹⁵ The Plan records fragmented pathways, absent common standards, six member states systematically monitoring cardiovascular outcomes through electronic health records, and most member states without comprehensive cardiovascular or diabetes registries; a Council Recommendation on personalised treatment and monitoring is proposed for 2027.³ The economic significance is direct: the avoided-cost argument cannot be validated in a system that does not record whether cost was avoided. Registries and interoperable outcome data are not administrative housekeeping. They are the measurement infrastructure without which “health as investment” remains an assertion.

4.3 Access: the same authorisation, twenty times the wait

This is the direct barrier described in §3.8, and the European variation in it is large. Of 168 medicines centrally authorised in the EU between 2021 and 2024, close to half were unavailable to patients somewhere in Europe as of January 2026. Median time from marketing authorisation to availability was 532 days, ranging from 56 days in the fastest market to 1,201 in the slowest. The share fully available on public reimbursement lists fell from 42% in 2019 to 28% in 2025, while the share available only under restricted conditions rose from 6% to 17%.²³ The source is produced by the European pharmaceutical industry association with IQVIA; readers should weigh its provenance, and we note it for that reason. Its methodology is long established, and it remains the reference series on the question.

The consequence for this discussion is a design point rather than a grievance: an identical European policy proposition produces materially different effects in different member states, and a framework built without that in view will not survive contact with national implementation. It also cuts the other way. The variation is itself the argument for European method. Pricing and reimbursement are national competences, and this paper does not propose otherwise. But shared standards, common protocols and aligned evidence requirements narrow variation without displacing national decisions — and Europe has just built the machinery to do exactly that in the clinical domain.

Gap	What the evidence shows	Live European instrument
Detection	About 22 million adults with undiagnosed diabetes in the IDF Europe Region (33.6%), plus ~40 million with impaired fasting glucose and ~46 million with impaired glucose tolerance. ⁶	Safe Hearts Plan, Pillar 2. Council Recommendation on health checks proposed for 2026 ; 2035 targets of ≥65% (25–64 y) and ≥80% (65+ y) annual blood-glucose measurement. ³
Continuity and outcome measurement	12% of people with type 2 diabetes at glycaemic, blood-pressure and lipid targets together; no European improvement in glycaemic attainment 1997–2023; six member states monitoring CV outcomes via EHR. ^{3,7}	Safe Hearts Plan, Pillar 3 and the digital cross-cutting theme. Council Recommendation on personalised treatment and monitoring proposed for 2027 ; European Health Data Space. ³
Timely and equitable access	Median 532 days from authorisation to availability, 56–1,201 days across markets; full reimbursement availability down from 42% to 28% since 2019. ²³	EU HTA Regulation. Joint clinical assessment operating since January 2025 for new oncology substances and advanced therapies, extending to selected high-risk devices in 2026 , orphan medicines in 2028 and all new medicinal products from 2030 . ²⁴

The three are one system rather than a list. Prevention reduces the number of people who will ever need detection; detection identifies those who would otherwise present with established organ damage; continuity and access determine whether those identified avoid the complications that generate most of the spend. Each is weakened by the absence of the others.

5. WHAT “HEALTH AS INVESTMENT” WOULD HAVE TO MEAN METHODOLOGICALLY

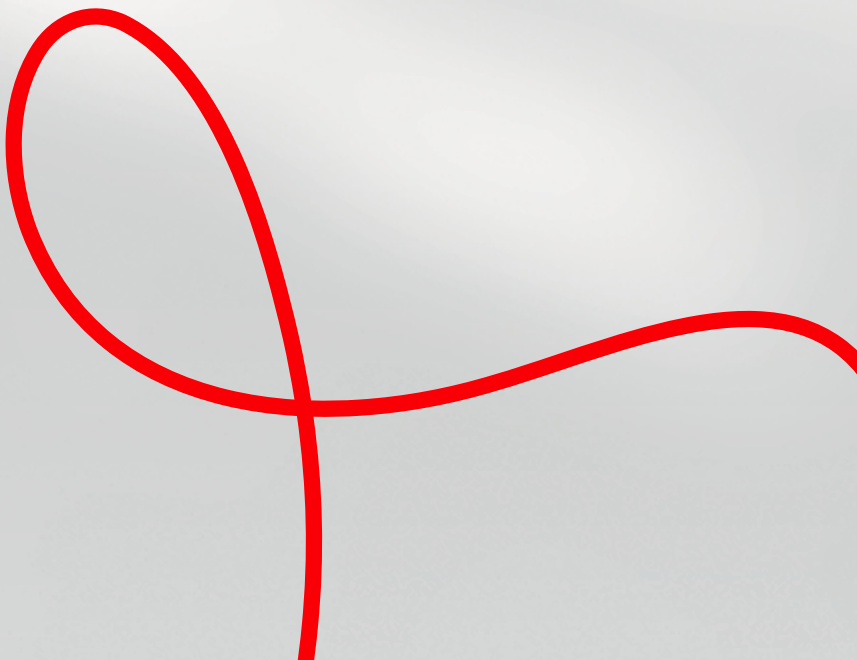
Here is the specific institutional gap we want to put on the table. Under the EU Health Technology Assessment Regulation, joint clinical assessment has been operating since January 2025 for new oncology active substances and advanced therapies, extending progressively to selected high-risk medical devices in 2026, orphan medicines in 2028 and all new medicinal products from 2030. By design, joint clinical assessment is confined to relative clinical effectiveness and safety; economic evaluation, pricing and reimbursement remain the responsibility of member states.²⁴ That boundary was deliberate and defensible. Its effect is that Europe has now built shared machinery for the question “does this work better?” but has built nothing comparable for the question “what does delay cost, and to whom?”

Answering that second question consistently would require five commitments. None of them requires a member state to cede a national competence, and each is technically achievable now.

- **The societal perspective as default, not as sensitivity analysis.** When more than half of a condition's cost falls outside the health budget, an evaluation restricted to the health budget is not conservative — it is biased in a known direction. Where a payer perspective is required for budgetary accountability, both should be reported, side by side and with equal prominence.
- **A time horizon matched to the biology, with cost-effectiveness and budget impact kept separate.** Cumulative metabolic exposure operates over decades; appropriation cycles operate over twelve months. Conflating the two produces either false promises of near-term cash release or false rejections of genuine long-term value. Present the incremental cost-effectiveness question and the affordability question as two distinct questions with two distinct answers, because that is what they are.
- **The pathway as the unit of assessment, not the line.** Chronic cardiometabolic care is a trajectory of successive decisions, and the cost of a decision at one point is partly determined at another. The evidence base for evaluating sequences is currently thin and largely model-based; that is an argument for building it, not for continuing to evaluate as though sequences did not exist.
- **The risk cluster as the clinical object, including the phase before diagnosis.** Hyperglycaemia rarely occurs alone. It clusters with excess weight, hypertension, dyslipidaemia, metabolic liver disease and declining renal function, and its consequences are counted in cardiology, nephrology and hepatology budgets rather than in the diabetes line. Assessment confined to glycaemic outcomes understates both the burden and the value of acting earlier. The tens of millions of Europeans with impaired fasting glucose or impaired glucose tolerance belong within the framework, not outside it.

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- A thick red line that starts at the top center and curves downwards and outwards, ending near the top right corner.
- **Explicit equity weighting.** The social gradient in cardiometabolic disease is steep and well measured. In Italian surveillance data, self-reported diabetes prevalence is several times higher among adults with primary education than among graduates, and markedly higher among those reporting economic difficulty than among those reporting none;²⁵ at European level, cardiovascular mortality varies by an order of magnitude between regions.³ Earlier detection and more precise intervention that reach only the already well-served would widen the gap they were introduced to close. Distributional consequences should be modelled deliberately, not discovered afterwards.

Whether the right vehicle is a methodological annex to existing European guidance, an OECD–Commission benchmarking exercise of the kind the Plan already foresees for national preventive spending, or something else, is precisely the sort of question this room is qualified to answer. Our claim is narrower and, we hope, harder to dismiss: that Europe has committed to an economic argument for which it has not yet agreed to an accounting standard.

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6. THE COUNTER-ARGUMENTS, STATED

An argument of this kind attracts four serious objections. We state them in the form a skeptical payer, finance ministry or health journalist would put them, because an argument that has not survived its best objections has not been tested.

The objection	Our response
Savings from prevention and earlier action materialise over horizons that sit poorly with annual budget cycles, and finance ministries are right to discount promises they cannot verify.	Correct, and this is why cost-effectiveness and budget impact must be presented separately. Long-term value should not be advanced as near-term cash release. The honest claim is that a defined sum spent earlier buys a larger stream of avoided cost later — not that next year’s budget falls.
“The cost of inaction” has become a universal framing, deployed by every actor in the field for every condition, and has lost its discriminating power.	A fair criticism of the rhetoric, not of the arithmetic. The defence is specificity: a small number of sourced figures, a clearly stated counterfactual, and the national gap identified in the room — rather than a single headline European number.
Avoided cost is modelled, not observed. Models can be built to produce the answer their sponsor requires.	Also fair, and the reason we have stated the thinness of the sequence literature explicitly rather than in a footnote. The remedies are procedural: state assumptions, work in ranges rather than point estimates, declare funding, and invest in the registries that would let observation replace simulation.
An economic case for earlier and more complete intervention, advanced in a clinical setting, is difficult to separate from a case for higher spending on innovation.	We accept the force of this. Our specific proposition concerns detection, continuity and method of evaluation — none of which is a purchasing recommendation, and two of which would reduce spending if they worked. The test of good faith is whether the argument still holds when no product is named. We have written it so that it does.

A closing observation on framing. The failure described in this paper is a failure of architecture, not of clinicians working inside it. And the argument closes better on the value of action than on the cost of inaction: a system persuaded of what it stands to gain behaves differently from one told what it is losing.

7. FOUR QUESTIONS FOR THE ROOM

This paper is deliberately open at the end. The Milan Dialogue is designed so that the substantive contribution comes from the participants rather than from the convener, and the following are the questions we would most like to see tested against national experience.

- 1. Where, in your system, is the largest avoidable cardiometabolic cost generated** — and is it currently visible to whoever holds the budget that would have to fund the earlier intervention? And where the benefit accrues to a different budget or actor from the one that pays, or arrives only in the longer term, is the obstacle one of visibility, of misaligned incentives, or of timing?
- 2. Which of the problems described here are genuinely shared across Europe, and which are national?** The distinction determines what a European instrument can and cannot fix.
- 3. What European mechanism would narrow variation in detection and access without displacing national pricing and reimbursement decisions?** Is a shared method for valuing avoided cost feasible, or is the national heterogeneity of cost structures too great?
- 4. Who is not reached by what already exists?** Every measure discussed here can widen inequalities as easily as narrow them, depending on how it is implemented.

8. A NOTE ON THE EVIDENCE USED HERE

- Prevalence and expenditure figures for the IDF Europe Region are modelled estimates and are presented as such; regional expenditure is reported in US dollars in the source, and euro equivalents circulating elsewhere are conversions rather than source figures.⁶
 - Target-attainment proportions are pooled across studies using differing target definitions and differing populations, and are best read as an order of magnitude and a trend rather than a precise proportion.^{7,8}
 - The five national profiles in §3 draw on instruments built for domestic accountability, not for cross-border comparison. Target thresholds, case-finding methods, data years, cost perspectives and denominators differ between them. They should be read as five independent national verdicts, each authoritative within its own system, and not as a ranking. Where we describe a pattern common to all five, that pattern is qualitative.
 - Italian cost figures derive from national analyses of different vintages and different data sources — a prevalence-based social cost estimate, administrative-data cost splits and real-world multimorbidity analyses — and are not directly transferable to other health systems.^{16,17,19}
 - The obesity instruments compared in §3.6 are of different kinds — a statute, a payer programme, a clinical audit, a ministerial roadmap and a scientific-society proposal — and are at different stages of implementation. They are not equivalent to one another, and none is a target-attainment audit of the sort available for type 2 diabetes. One figure is drawn from a congress statement, and one source is a preprint; both are marked as such in the reference list.³⁷⁻⁴³
 - Studies of treatment intensification use differing definitions of therapeutic inertia and differing thresholds; the intervals reported are medians drawn from primary-care records over defined observation windows, and should not be read as current practice in any named system.³³⁻³⁵
 - The access data are produced by the European pharmaceutical industry association with IQVIA. Its provenance is stated so that readers can weigh it.²³
 - Projections of a 90% rise in cardiovascular prevalence and a 73.4% rise in deaths between 2025 and 2050 are global modelled projections, cited by both the European Commission and the OECD in a European context; they should be read as such.³⁻⁵
 - Consensus findings reflect expert opinion rather than primary clinical data, and the Delphi cited was conducted in Italy; its topics are broadly applicable, but its results may reflect national clinical perspectives.⁹
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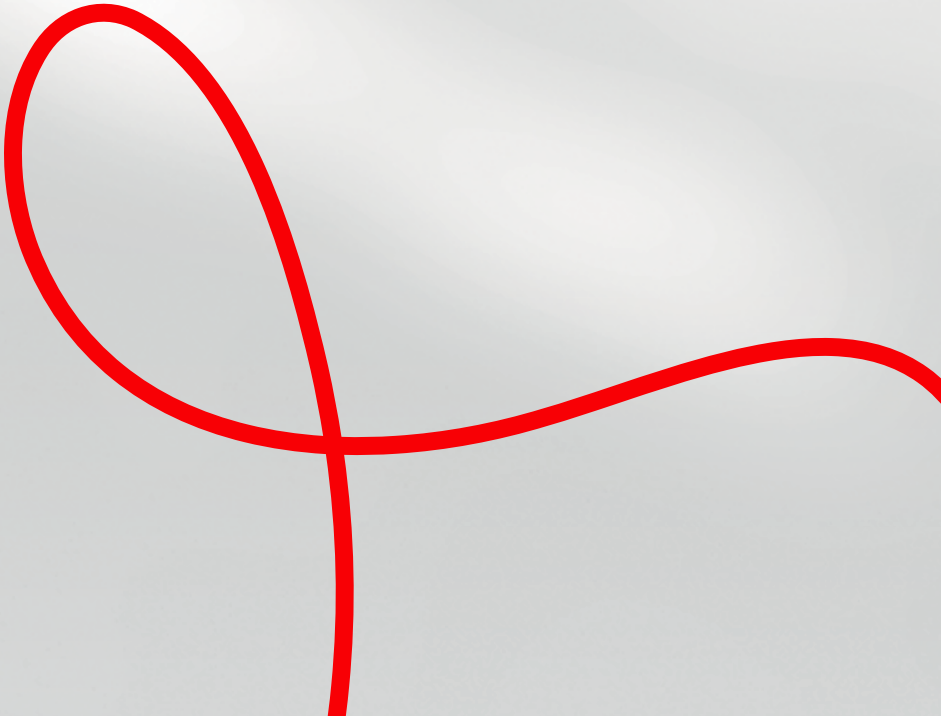


DECLARATIONS

Role of the convener, funding disclosure and independence statement. “State of Health - The Milan Dialogue” is convened by Eli Lilly and Company. Eli Lilly and Company provided financial support for the preparation of this paper and supported aspects of the information-gathering process. The paper was authored independently by the individuals named herein, who retain full responsibility for its analysis, interpretation, drafting and conclusions. Eli Lilly and Company did not exercise editorial control over the substantive academic content, analysis or conclusions. Any review by Eli Lilly and Company was limited to matters of factual accuracy, legal and compliance requirements, and formatting, and did not extend to determining the authors’ analysis or conclusions.

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THE MISSING *chapter*

Cardiometabolic health and the economics
of acting earlier in Europe