Frank Nobels – President, Belgian Diabetes Forum

In Belgium we are generally good at treating conditions but not so good at preventing them, and this is also the case with diabetes

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Dr Frank Nobels, one of Belgium's leading endocrinologists and diabetologists, introduces the Belgian Diabetes Forum - a multi-stakeholder initiative which aims to create efficient policy engagement in diabetes and make better prevention of diabetes, better care and a higher level of well-being for people with diabetes a reality. Dr Nobels outlines the current level of care available to diabetics in Belgium; how the Forum works with patients, industry sponsors and the government; and his hopes for the future of diabetes prevention and care.

How did you arrive in your role and what is the mandate of the Belgian Diabetes Forum?

I am an endocrinologist and diabetologist based in Aalst at a large non-university hospital and I am also a guest professor at the Catholic University Leuven. I was previously the head of the Diabetes League, and I am currently the president of the Diabetes Forum, so all in all, I work both as a clinician and within the field of research and advocacy. The Belgian Diabetes Forum is a group that wants to take a closer look at Belgian diabetes care, at the good and the bad, and to better understand what we must do to improve the diabetes treatment level while advocating for improvements.

Diabetes is a condition that year on year is becoming a larger burden for countries across the world. What is the prevalence of diabetes in Belgium today?

The real answer is that we do not actually know the full prevalence here. An important part of our advocacy at the Belgian Diabetes Forum is the need for better data to understand the true impact of diabetes in Belgium. Belgian healthcare is strong in many aspects, but we lack vast and accurate data. We have health records with diagnoses at the level of physicians, and we know the nomenclature of all treatments (without diagnoses) at the social security level, but we do not have a system that links the two. Having advocated for the establishment of a health data agency of the kind that already exists in Denmark and Sweden, we were happy to see the recent announcement that such an agency is finally being created.

Approximately, one in ten Belgians over the age of 18 have diabetes, not including pre-diabetes. We believe that two-thirds of patients have been diagnosed and that the other third are still in the dark, but again this is an approximation.

What is the level of care available for Belgian patients that are diagnosed with diabetes?

We can classify Belgian diabetes care as follows: the broad base of the pyramid is formed by primary care, the middle part is shared care where the specialist team and the primary care team work closely together to provide diabetes support, and the narrow top of the pyramid consists of specialist care. The top and middle levels are excellent in comparison to other countries and are very well organised, while there is room for improvement at the base level. I directly want to make it clear that we are not criticizing the GPs. They simply need better support to ensure they can provide all chronic patients with the care they need. Fortunately, the Belgian Ministry of Health understands this gap and we are working with them to make changes.

If we look at the top level, known as diabetes convention, the person with diabetes receives tailor-made care by a multidisciplinary team with all the necessary technical support. The patients receive all the materials needed for their care, such as glucose meters, sensors, insulin pens or pumps. Providing this material right away goes hand in hand with education on how to use it and how best to incorporate it into managing diabetes.

This makes what we do very different to other nations and is what raises our level of care. 95 percent of Type-1 diabetics are using sensors and many have pumps that are directed by sensors (so-called hybrid closed loops). Within the allocated budgets, we can usually choose freely which technical materials we use for the patients. This freedom allows us to provide tailor-made care and is an extraordinary advantage of our system, compared to the much stricter regulations in most neighbouring countries. Years ago, I put in place a quality assurance system called the Initiative of Quality Assurance and Epidemiology in diabetes (IQED). This allows us to follow up and optimize our quality. We recently compared our results to the highest levels of care in the US and found we were at least equal and even better than them, so our diabetes convention system is certainly yielding excellent results and is much cheaper than US care.

The middle level of the pyramid is shared care, which we call the diabetes care trajectory. This was first set up in Aalst and Leuven in 2004 when we commenced a local program to promote collaboration between primary care and specialist diabetes team care for Type-2 diabetics that started more complex treatments as their condition worsened. This concept of shared care was later scaled up to the entire nation.

This diabetes care trajectory requires a three-way contract between the person with diabetes, the GP and the diabetologist. The GP steers the treatment pathway in collaboration with primary care paramedics. The specialist sees the patient once a year and helps to set out the main lines of therapy. The GP, nurses and dieticians of primary care can then contact the specialist team at any time to resolve any issues along the way. This has been highly successful as the strong relationships have built confidence and a teamwork mentality in treating the patient. This is vastly different from some surrounding countries, such as the Netherlands where I worked in the past. There the financing models for primary care and specialist care tend to discourage collaboration between them. This is not the case in Belgium where collaboration and mutual understanding between primary and specialist care is promoted.

These first two levels of care you mentioned are great, you could say world-class, but you are somewhat less optimistic about the basis of the pyramid. What challenges do you witness in this level of care?

GPs are definitively doing all they can to provide good chronic care, but they do not get enough support, and this is a trend across Europe. I have the impression that the further north you go in Europe, the better primary care is organized for chronic conditions. This is e.g. clearly better organised in the Netherlands. In Belgium, people are very often overwhelmed by acute care, such as during COVID, and do not have the time and support to optimally treat chronic conditions.

Good chronic care needs to be planned much more proactively and requires support from paramedics, eg in the case of diabetes from diabetes educators, and administrative staff. For example, it can help a lot to have a good plan to regularly measure HbA1c and other relevant parameters and to check feet, eyes, kidneys and cardiovascular parameters at least once a year. In addition to employee support, IT support with reminder pop-ups could also help in achieving this.

Previously, the Minister of Health set up a pre-trajectory program and dedicated some funds for diabetes education in primary care. The criteria of patients who could receive this education at first were quite restricted as they had to be under 70 with high BMI and/or hypertension. There was a fear that making it openly available to all Type-2 diabetics would blow out the budget. This was not the case as out of the 300,000 people projected to use the program, only 30,000 did. It was therefore a failure but equally an important learning curve for the future.

As a result, there came an awareness that changes were needed and the new system is currently being drawn up. It proposes that the program be open to all patients and that the primary care diabetes educator fulfils a central position. In the past, group education on lifestyle was financed, but GPs had no time to organise this, so now the diabetes educator, besides giving one on one education, will also set up regional group training for patients.

What are the hot topics on your agenda currently?

For sure the two topics I discussed earlier. That is, trying to obtain Belgian diabetes data through the new Health Data Agency. We are helping the government to set this up for diabetes and use this experience for other chronic non-communicable diseases. We really want to be catalysts for this change. Secondly, the drive for better support of primary diabetes care is one of our main goals.

The third topic on our agenda is that we want each patient to have a dashboard on their electronic device so they can track their own results. Currently, the patient has a log-in to see their own results at the hospital level. The problem is that it is just pure results, with so many terms and numbers that can be difficult to understand and can give patients anxiety. We want to use more visual aids, like graphs showing that green is positive for example, simple but effective. Really it is about giving information to people who are not medical professionals. This could be easily linked to the data system we must put in place first. Good examples for us are Scotland which has a visual system as well as individual goals on the dashboard so the patients can track their progress and Sweden which has a national diabetes registry.

How does the Forum take into consideration the voice of the industry?

It is important that they are also members of the Forum, and that we have a relationship with many different companies, so we are not influenced by just one voice. We all have common goals; that is to have better data, screening to diagnose undiscovered patients, early treatment with the correct medication, good follow-up, etc. These goals are mutual with the patient. When we discuss with the government, we let them know we are working also with the industry. We are very transparent in our relationship, and we find the equilibrium between being supported by the private sector and maintaining a strong neutral voice.

The Belgian Diabetes Forum is also part of a broader European endeavour. On a European level, 25 years ago the St Vincent Declaration put in place defined goals for diabetes care across the continent and this has pushed diabetes care forward in many areas. Today we are doing the same with the European Diabetes Forum. It is important that Europe has this common agenda as we can all collectively work together for change.

As a clinician working in the field, what has been your experience of the incremental advancements or game-changing innovations in diabetes treatment in recent years?

Innovation in diabetes is booming and in the last 10 years, the treatment options for both Type-1 and Type-2 diabetics have exploded.

In Type-2 diabetes we have a number of innovative medications that are amazing for patients. Furthermore, step by step we are moving into the field of precision medicine. Type-2 diabetics can range from obese to lean patients and old to young. We believe there are different mechanisms in play within each patient and are undertaking research to better understand this and construct more specific treatment pathways.

We also have witnessed in recent years that there are fewer Type-2 patients in the top tier of the pyramid that require multiple injections. Instead, they are remaining in the middle level with shared care, and we are able to keep them off insulin for a very long time, this is a huge step in the right direction.

A big part of diabetes is prevention. Is this taken into consideration enough in Belgium?

I must admit that in Belgium we are generally good at treating conditions but not so good at preventing them, and this is also the case with diabetes. One of the issues is how the governance portfolios are divided, as treatment is controlled at the federal level, while prevention is at the community level. This complicates concerted nationwide actions. But that said, there are many good regional initiatives. So we’re not giving up.

In terms of availability, are patients being able to access innovative treatments through reimbursement?

We have restrictions on certain treatments. For example, we would like to use GLP-1 receptor agonists for all Type-2 diabetics, because in addition to better glycemic control without promoting hypoglycaemia, they also offer weight loss and cardiovascular protection. But we can only use them for patients with bad glycemic control who are very obese (HbA1c above 7.5% and a BMI above 30 kg/m²). And an extension of reimbursement is only allowed on the basis of glycemic criteria without taking into account the beneficial effect on weight. Also, SGLT2 inhibitors, another class of medication that, in addition to better glycemic control, offer other benefits of cardiovascular and renal protection, can only be given to patients with an HbA1c level between 7 and 9%. So a patient who is very much out of control with a 9.5% reading must first lower his level with other medications before he can receive an SGLT2 inhibitor, otherwise he must pay for it out of pocket.

Within Type-1 diabetes we have all the new technology and in 2016 were the first nation in the world to give reimbursement for blood glucose sensors to all Belgian people with type 1 diabetes. Belgium was also the first country to host a real-world evidence study using this innovation and it is referenced a lot in publications.

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