MDForLives

THE GLOBAL PULSE OF HEALTHCARE · ENDOCRINOLOGY & DIABETES CARE INSIGHT REPORT

Complex Diabetes Care: When HbA1c Is Only Part of the Decision

Healthcare-professional perspectives on glycemic control, obesity, kidney and cardiovascular risk, treatment sequencing, adherence, access, and outcomes beyond HbA1c.

GLYCEMIC STATUS → COMORBIDITY RISK → THERAPY CHOICE → LONG-TERM OUTCOMES

46	6	69.6%	9001530
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	SGID

WHY THIS REPORT

Complex diabetes care becomes difficult when several correct priorities compete for the same treatment decision.

A patient may need better glycemic control while also living with obesity, declining kidney function, cardiovascular disease, heart failure, hypoglycemia risk, treatment burden, or affordability constraints. In that setting, the question is rarely just “what lowers HbA1c next?” It is which intervention creates the best overall trade-off for this patient now.

That tension is visible throughout the MDForLives survey. Respondents still place substantial weight on HbA1c and the glucose profile, but their treatment choices also shift with CKD, heart failure, obesity, cost, tolerability, adherence, and the possibility of cardiovascular or kidney benefit even when HbA1c remains suboptimal.

The report examines how healthcare professionals navigate those competing priorities, where treatment optimization breaks down, what outcomes justify staying with a therapy, and which developments could make complex diabetes care more effective.

> **Survey frame:** 46 survey records with a 69.6% completion rate across the USA, UK, Canada, Italy, France, and Germany. Substantive question bases range from 34 to 38 responses. Internal operational, required-text, after-question, and honeypot fields were excluded from analysis.

CLINICAL CONTEXT

Current diabetes guidance increasingly treats therapy choice as a risk-management decision, not only a glucose-lowering decision.

The ADA 2026 Standards of Care recommend person-centered medication selection that considers glycemic effectiveness together with cardiovascular and kidney disease, weight, hypoglycemia risk, cost and access, adverse effects, tolerability, and individual preferences.

For adults with type 2 diabetes and established or high cardiovascular risk, heart failure, or CKD, the same guidance places SGLT2 inhibitors and/or GLP-1 receptor agonists with demonstrated benefit directly into the treatment plan, in appropriate patients, irrespective of the need for additional glucose lowering. The CKD section and cardiovascular section reinforce the importance of organ protection, while the obesity section positions weight management as a major treatment goal alongside glycemic management.

This report uses those recommendations as external clinical context. The percentages that follow are MDForLives survey findings and should be read as respondent selections, not as guideline recommendations or population estimates.

EXECUTIVE SUMMARY

Six findings that show why complex diabetes care increasingly extends beyond HbA1c.

01

57.9%

Obesity leads the comorbidity challenge

Obesity is the condition most often selected as complicating diabetes management.

02

55.3%

HbA1c still anchors decisions

HbA1c and the glucose profile remain the most selected assessment influencing treatment choice.

03

44.4%

SGLT2 inhibition leads the next step

After inadequate glycemic control, adding an SGLT2 inhibitor is the most selected next action.

04

42.9%

Benefit can extend beyond HbA1c

Cardiovascular risk reduction is the leading reason to continue therapy despite suboptimal HbA1c.

05

45.7%

Adherence is the biggest complex-care barrier

Poor treatment adherence leads affordability, access, and fragmented care as the selected barrier.

06

35.3%

Earlier cardiorenal detection leads future needs

Respondents most often select earlier cardiorenal risk detection as the development that could transform care.

01

COMORBIDITY LOAD

Obesity is the comorbidity most often selected as complicating diabetes management

57.9% select obesity, compared with 31.6% for chronic kidney disease and 10.5% for cardiovascular disease.

CONTEXT

Obesity can change glycemic targets, weight goals, insulin requirements, cardiovascular risk, treatment tolerability, and the practicality of long-term medication use at the same time.

WHAT THE DATA SHOWS

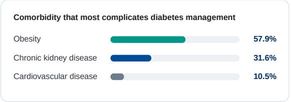
Obesity leads the question at 57.9%. CKD follows at 31.6%, while cardiovascular disease accounts for 10.5%.

THE INSIGHT

Respondents appear to see obesity as part of the treatment architecture of diabetes rather than a separate problem to address after glycemia is controlled.

WHY IT MATTERS

The ADA 2026 obesity guidance positions weight management as a primary treatment goal alongside glycemic management in appropriate people with type 2 diabetes and overweight or obesity.



02

DECISION INPUTS

HbA1c still anchors treatment decisions, but renal markers are already part of the decision frame

55.3% select HbA1c and the glucose profile; 23.7% select eGFR and albuminuria.

CONTEXT

HbA1c remains a familiar measure of glycemic exposure, yet complex diabetes care increasingly requires HCPs to judge kidney function, albuminuria, weight, cardiovascular risk, and treatment safety alongside the glucose profile.

WHAT THE DATA SHOWS

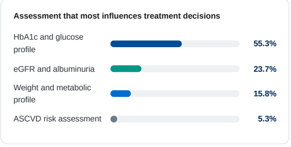
HbA1c and the glucose profile lead at 55.3%, followed by eGFR and albuminuria at 23.7%, weight and metabolic profile at 15.8%, and ASCVD risk assessment at 5.3%.

THE INSIGHT

Glycemia remains the starting signal, but renal status is already materially influencing treatment decisions for a substantial share of respondents.

WHY IT MATTERS

Current ADA CKD guidance makes kidney assessment clinically consequential because medication selection and organ-protection goals can change with CKD and eGFR.



03

INITIAL THERAPY

The first treatment priority is split rather than dominated by one default approach

Metformin-based therapy and GLP-1 receptor agonists are tied at 33.3% each.

CONTEXT

Modern treatment selection depends on more than glucose-lowering potency. Weight, CKD, cardiovascular disease, hypoglycemia, tolerability, access, and patient preferences can all change what makes sense first.

WHAT THE DATA SHOWS

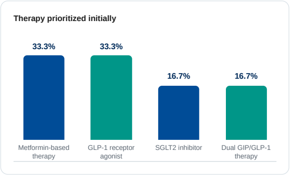
Metformin-based therapy and GLP-1 receptor agonists each receive 33.3%. SGLT2 inhibitors and dual GIP/GLP-1 therapy each receive 16.7%.

THE INSIGHT

The even split suggests that respondents are not operating from one universal first-line sequence. The starting point appears sensitive to the clinical profile they are trying to improve.

WHY IT MATTERS

The ADA 2026 pharmacologic guidance similarly emphasizes person-centered choice, including comorbidities, weight, hypoglycemia, cost, adverse effects, and preferences.



04

OPTIMIZATION FRICTION

Cost and access limit treatment optimization more often than treatment complexity

38.9% select cost or access as the leading limitation, followed by adverse effects or tolerability at 30.6%.

CONTEXT

Clinical choice only becomes treatment when the patient can obtain the medication, tolerate it, understand how to use it, and continue it over time.

WHAT THE DATA SHOWS

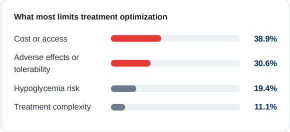
Cost or access leads at 38.9%. Adverse effects or tolerability follow at 30.6%, hypoglycemia risk at 19.4%, and treatment complexity at 11.1%.

THE INSIGHT

The survey places practical access and tolerability ahead of regimen complexity as optimization barriers. The gap between preferred and feasible care may therefore emerge before the prescription is implemented.

WHY IT MATTERS

ADA 2026 guidance explicitly recommends assessing financial obstacles and working across the care team to reduce cost-related barriers where possible.


What most limits treatment optimization

05

NEXT-STEP INTENSIFICATION

After inadequate glycemic control, SGLT2 inhibition is the most selected next step

44.4% prefer adding an SGLT2 inhibitor; 33.3% prefer adding a GLP-1 receptor agonist.

CONTEXT

When control remains inadequate, HCPs can intensify the current regimen, move toward insulin, or add a therapy that also addresses cardiovascular, kidney, or weight-related priorities.

WHAT THE DATA SHOWS

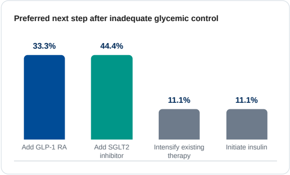
SGLT2 inhibitors lead at 44.4%, followed by GLP-1 receptor agonists at 33.3%. Intensifying existing therapy and initiating insulin each account for 11.1%.

THE INSIGHT

The preferred next step shifts toward newer classes with potential benefits beyond glycemia rather than simply escalating the existing regimen.

WHY IT MATTERS

For appropriate people with type 2 diabetes and CKD, heart failure, or ASCVD risk, current guidance gives SGLT2 inhibitors and GLP-1 receptor agonists a role that is not dependent on HbA1c alone.


Preferred next step after inadequate glycemic control

06

HIGH-RISK SUBGROUPS

Advanced CKD and heart failure are the clearest reasons to change treatment strategy

34.3% select advanced CKD, followed by heart failure at 25.7%.

CONTEXT

Comorbidity can change medication choice, dosing, safety, expected benefit, and what counts as a successful outcome. In CKD and heart failure, organ protection becomes part of the treatment objective.

WHAT THE DATA SHOWS

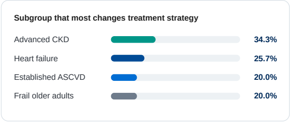
Advanced CKD leads at 34.3%. Heart failure follows at 25.7%, while established ASCVD and frail older adults each account for 20.0%.

THE INSIGHT

Kidney and heart failure status appear to exert more influence on treatment strategy than the other listed subgroups.

WHY IT MATTERS

The ADA cardiovascular and CKD sections connect therapy selection directly with cardiovascular and kidney outcomes in appropriate patients.


Subgroup that most changes treatment strategy

07

BENEFIT BEYOND GLYCEMIA

Cardiovascular risk reduction is the leading reason to continue therapy despite suboptimal HbA1c

42.9% choose cardiovascular risk reduction; 28.6% choose weight reduction and 20.0% kidney protection.

CONTEXT

A treatment may be doing something clinically important even when glycemic control is not yet where the HCP wants it to be. The decision can then become whether to replace that therapy or retain its benefit while solving the remaining gap elsewhere.

WHAT THE DATA SHOWS

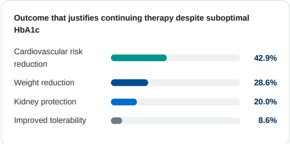
Cardiovascular risk reduction leads at 42.9%, weight reduction at 28.6%, kidney protection at 20.0%, and improved tolerability at 8.6%.

THE INSIGHT

Respondents are explicitly valuing outcomes beyond HbA1c, with cardiovascular benefit most likely to justify continuing a therapy.

WHY IT MATTERS

This aligns with current guideline logic in which cardiovascular and kidney benefits can influence therapy choice irrespective of the need for additional glucose lowering.


Outcome that justifies continuing therapy despite suboptimal HbA1c

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08

CARE DELIVERY

Poor treatment adherence is the biggest selected barrier to complex diabetes care

45.7% select poor treatment adherence; medication affordability follows at 34.3%.

CONTEXT

Complex diabetes care often asks patients to manage multiple medications, monitoring, lifestyle changes, appointments, side effects, and competing health priorities. Every additional requirement can create another point where the plan loses momentum.

WHAT THE DATA SHOWS

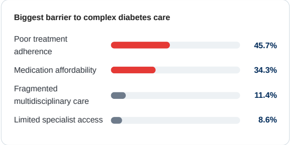
Poor treatment adherence leads at 45.7%. Medication affordability follows at 34.3%, fragmented multidisciplinary care at 11.4%, and limited specialist access at 8.6%.

THE INSIGHT

The leading barrier is not a shortage of treatment options. It is sustaining the treatment plan in real life.

WHY IT MATTERS

The ADA 2026 systems-of-care guidance emphasizes person-centered team care, financial considerations, and integrated long-term management of diabetes and comorbidities.


Biggest barrier to complex diabetes care

09

WHAT CHANGES NEXT

Earlier cardiorenal risk detection is the most selected development for transforming complex diabetes care

35.3% select earlier cardiorenal risk detection, followed by more effective combination therapies at 29.4%.

CONTEXT

The earlier kidney and cardiovascular risk becomes visible, the earlier treatment can be organized around prevention rather than waiting for the complication to dominate the clinical picture.

WHAT THE DATA SHOWS

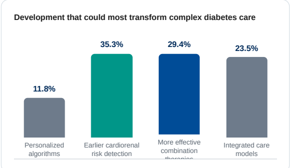
Earlier cardiorenal risk detection leads at 35.3%. More effective combination therapies follow at 29.4%, integrated diabetes care models at 23.5%, and personalized treatment algorithms at 11.8%.

THE INSIGHT

Respondents prioritize earlier recognition of risk over a purely algorithmic future. Better combination therapy and more integrated care also rank ahead of personalized algorithms.

WHY IT MATTERS

The future need suggested by the survey is not simply a more powerful drug. It is a system that identifies risk sooner, selects the right combination, and makes multidisciplinary care easier to execute.


Development that could most transform complex diabetes care

OPEN RESPONSE LENS

When HCPs describe complex cases, competing risks change the treatment plan before they change the goal.

The open-ended question asked respondents to describe a complex diabetes case in which competing risks changed their treatment strategy, what drove the decision, and what remained challenging.

Renal function frequently changed the sequence

Responses referenced CKD, albuminuria, high creatinine, advanced renal impairment, and situations where kidney function altered drug selection or made metformin unsuitable.

Cardiorenal benefit often outweighed a glucose-only view

Several responses described selecting or adding SGLT2 inhibitors or GLP-1-based therapy because of cardiovascular, kidney, or heart-failure priorities.

Weight and tolerability remained active trade-offs

Obesity, insulin-related weight gain, gastrointestinal intolerance, and the need to preserve weight or metabolic benefit appeared repeatedly in case descriptions.

Hypoglycemia and treatment burden complicated simplification

Respondents mentioned hypoglycemia risk, insulin management, polypharmacy, multiple providers, and complicated regimens as reasons the “best” clinical option could still be hard to execute.

Affordability and adherence could override the plan

Medication cost and patient adherence appeared as practical constraints, reinforcing the quantitative finding that access and sustained use are central to optimization.

No single trade-off dominated every case

Some responses prioritized glycemia, others kidney or cardiovascular risk, and others tolerability or weight. The open comments reinforce that complex diabetes care is inherently individualized.

These themes are qualitative summaries of usable open-ended responses. They were not formally coded into percentages.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about complex diabetes care and treatment decisions.

How should chronic kidney disease change diabetes treatment choice?

Kidney function and albuminuria can change both medication choice and the value assigned to treatment outcomes. ADA 2026 guidance recommends therapies with demonstrated kidney and cardiovascular benefit for people with type 2 diabetes and CKD, while also accounting for eGFR, hypoglycemia risk, tolerability, and the individual clinical context.

When are SGLT2 inhibitors prioritized in type 2 diabetes?

SGLT2 inhibitors are prioritized when heart failure, chronic kidney disease, or cardiovascular risk makes cardiorenal protection a treatment goal. Their use should reflect kidney function, safety considerations, current therapy, and individual treatment priorities rather than HbA1c alone.

When are GLP-1 receptor agonists considered in complex diabetes care?

GLP-1 receptor agonists may be considered when glucose lowering, weight management, cardiovascular risk reduction, or kidney-related benefit is relevant. Selection should still account for tolerability, contraindications, access, and the person's broader treatment goals.

Why might a diabetes therapy be continued when HbA1c is still above target?

A treatment can provide clinically meaningful benefits beyond glucose lowering. Depending on the therapy and the individual, cardiovascular risk reduction, kidney protection, weight benefit, lower hypoglycemia risk, or improved tolerability may support continuation while the overall regimen is further optimized.

How does obesity influence diabetes treatment decisions?

Obesity can increase cardiometabolic complexity and make weight an important treatment outcome alongside glycemia. Current guidance recommends considering therapies that support both glucose and weight goals when clinically appropriate, while using person-centered and nonjudgmental care.

What should healthcare professionals consider when cost or adherence limits treatment optimization?

Treatment plans need to be clinically effective and realistically usable. When cost, access, treatment burden, or adherence is limiting care, healthcare professionals may need to simplify regimens, discuss affordability directly, consider lower-cost alternatives where appropriate, and involve the wider care team or support services.

COMPLEX DIABETES CARE LENS

What this means at four points in a treatment decision.

The survey suggests that complex diabetes care becomes more coherent when the HCP makes the competing priorities explicit rather than trying to optimize each one separately.

1. Start with the whole risk profile

Review glycemia together with kidney function, albuminuria, cardiovascular disease, heart failure, weight, hypoglycemia risk, frailty, and other comorbidities that can change the treatment sequence.

2. Define what the therapy is meant to protect

Be explicit about whether the main objective is glucose lowering, cardiovascular risk reduction, kidney protection, weight benefit, tolerability, or a combination of these outcomes.

3. Surface friction before intensifying

Ask whether cost, access, adverse effects, hypoglycemia, complexity, or adherence is the real reason the current plan is not delivering its intended benefit.

4. Reassess the regimen, not just the HbA1c

When one outcome improves and another remains suboptimal, decide whether to retain a useful therapy and solve the remaining gap elsewhere rather than assuming the treatment has failed.

CLOSING PERSPECTIVE

Complex diabetes care is becoming a problem of prioritization, sequencing, and implementation - not simply escalation.

The survey shows that HbA1c remains highly influential, but it sits inside a much wider clinical decision. Obesity is the comorbidity most often selected as complicating management; CKD and heart failure most often change treatment strategy; and cardiovascular risk reduction is the leading reason to continue therapy even when HbA1c remains suboptimal.

That is a meaningful shift in how treatment success is framed. A therapy may be retained for cardiovascular, kidney, or weight benefit while another part of the regimen addresses residual glycemic risk. Conversely, a pharmacologically attractive option may be impossible to optimize if the patient cannot access it, tolerate it, or stay with it.

The open responses make the trade-offs concrete. HCPs describe renal dysfunction changing drug choice, cardiovascular risk driving SGLT2 or GLP-1-based decisions, hypoglycemia complicating insulin management, obesity and weight influencing tolerability and preference, and cost or adherence narrowing the options that are realistically available.

The forward-looking signal is equally practical. Respondents place earlier cardiorenal risk detection first, followed by more effective combinations and integrated care. The opportunity is therefore not to replace clinical judgment with a single algorithm, but to give HCPs earlier risk visibility, more usable treatment combinations, and care pathways that make complex decisions easier to sustain.

Keep glycemia in context

HbA1c matters, but it should be read alongside kidney, cardiovascular, weight, and safety priorities.

Let comorbidity change the sequence

CKD, heart failure, ASCVD, obesity, and frailty can alter what "next" means.

Define benefit beyond one metric

Cardiovascular, kidney, weight, and tolerability outcomes can remain clinically valuable even when glycemia needs further work.

Treat feasibility as part of efficacy

Cost, access, adherence, and treatment burden determine whether the intended plan can actually work.

Help future diabetes-care insights reflect the trade-offs HCPs manage in real practice.

Join MDForLives to share professional perspectives on treatment sequencing, cardiorenal risk, obesity, access, adherence, and complex diabetes care.

Join the Panel

REFERENCES AND DATA SOURCE

1. **MDForLives internal survey report.** All Markets Report for SGID 9001530, Project: Engagement Campaign | Endo Insight Survey_Oct. 46 survey records, 69.6% completion rate. Country metadata: USA, UK, Canada, Italy, France, and Germany. Substantive question bases range from 34 to 38 responses.
2. **American Diabetes Association Professional Practice Committee.** Improving Care and Promoting Health in Populations: Standards of Care in Diabetes - 2026. *Diabetes Care*, 2026.
3. **American Diabetes Association Professional Practice Committee.** Obesity and Weight Management for the Prevention and Treatment of Diabetes: Standards of Care in Diabetes - 2026. *Diabetes Care*, 2026.
4. **American Diabetes Association Professional Practice Committee.** Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes - 2026. *Diabetes Care*, 2026.
5. **American Diabetes Association Professional Practice Committee.** Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2026. *Diabetes Care*, 2026.
6. **American Diabetes Association Professional Practice Committee.** Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes - 2026. *Diabetes Care*, 2026.

External sources provide clinical context. Survey percentages represent MDForLives respondent selections and are reported separately from external evidence.

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The Global Pulse of Healthcare

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