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for new publications other than those increasingly influenced by the pharmaceutical industry, and above all, to create spaces for independent research and publications.

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Response to "Published evidence and transformations in the management of diabetes"

Respuesta a la carta "La evidencia publicada y las transformaciones en el abordaje de la diabetes"

***Perner**, Mónica Serena*[1]

[1]Physician. Specialist in Epidemiology. Researcher and professor, Universidad Nacional del Comahue, Consejo Nacional de Investigaciones Científicas y Técnicas, Argentina. serenaperner@gmail.com

Firstly, I would like to thank María Amelia Linari for her letter (1) as a member of the Executive Committee of the Argentine Diabetes Society (SAD) [*Sociedad Argentina de Diabetes*], one of the institutions referred to in the article of my authorship published in *Salud Colectiva* (2). This scientific association was selected as an indispensable actor in the construction of the knowledge required to manage such a complex issue as diabetes, given both its history and its potential influence in health professionals involved in diabetes management. Therefore, I believe that it is of great priority to engage in conversations that can further the discussion.

In this sense, Emma Dominguez Alonso states:

> Diabetes mellitus, particularly type 2, is a disease whose development and evolution are directly related to social factors. Unhealthy lifestyles, lack of indispensable knowledge for the prevention and adequate control of the disease, the inaccessibility of high-quality health care services, among others, favor the development of the disease and, at the same time, have a negative influence on the prognosis. The social origin of all of these conditioning factors classify diabetes mellitus, with ever increasing evidence, as a social disease. (3 p.305)

Different studies have analyzed the social determinants, showing, for instance, the impact that differences in body weight (as marker of the socioeconomic differences) have in the incidence of (4) and mortality due to type 2 diabetes (5).

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Additionally, type 2 diabetes is not distributed equally among different social groups: it shows a larger incidence, greater complications and higher mortality rates in those with lower socioeconomic levels as well as among women and ethnic minorities (6). Possible explanations for this social pattern of diabetes have been given, such as the availability and accessibility of food and areas in which to carry out physical activity, differences in access to health care and health information, and healthy behaviors within the different socioeconomic groups (4).

Nancy Fleischer and Ana Diez Roux mention that "the information available since the beginning of the 1960s shows that a low socioeconomic level [...] is generally associated with greater morbidity and mortality due to heart disease in high-income countries" (7 p.642). There is an increasing amount of research showing the effect of social inequities in cardiovascular disease in high-income countries but, according to these authors' review (7), these types of studies are scarce in Latin America, where "in general, particularly with respect to obesity, diabetes and diet, health inequalities were more pronounced among women and in urban areas" (7 p.644).

In this respect, I agree with María Amelia Linari when she claims that it is "crucial to understand in depth the factors that can be beneficial or harmful to health" (1 p.279). Therefore, I believe we should deepen our knowledge regarding inequalities in health care. I also agree that we need to individualize treatment according to the "characteristics, conditions and history of each diabetes patient" (1 p.280). In order to deal comprehensively with such a complex issue as diabetes, it is important to gather information at the local level. We need to build strategies and interventions at the individual level but that are at the same time are articulated with population level; that is, we must have an individualized approach with a focus on health inequalities, according to the profile of our population.

In the approach to diabetes (prevention, diagnosis and treatment), it is important to reconsider these concepts. Many innovations and therapeutic changes have been contributions of great value and practical application, with great impact on the quality of life of those with diabetes. However, innovations that approach diabetes from a health inequalities perspective are few.

In Carlos Tajer's words, as long as the pharmaceutical industry remains "one of the most lucrative, with high profitability for shareholders," it will promote the incorporation of discoveries "within a context of growing health care costs." For this reason, "many clinical trials are conceptually oriented towards the positioning of the drug in the market rather than the specific interests of the patient or the community" (8 p.277).

According to Maarten Boers, cited by Antonio Ugalde and Nuria Homedes (8), "the enormous financial interests involved in the development of new drugs exert pressure on the scientific analysis and the presentation of the results obtained from the most important clinical trials" (9 p.311). In so doing, economic benefits take priority over the need to address health issues.

If research is funded by the pharmaceutical industry, the profit motive will come first. Consequently, the focus will be placed on treatment with drugs, the incorporation of new drugs and the initiation of pharmacologic treatment as early into the disease as possible, reducing the values considered normal to include more people as diabetic in early drug treatment.

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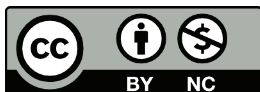

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