

access for better health

STATE OF EQUITABLE ACCESS

What it takes to accelerate equitable access to treatment



access
for **better**
health

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01 Foreword

Equitable access to treatment is often discussed as though it were a single problem with a single solution. In reality, equitable access is a pathway—and every part of that pathway matters.

A medicine can be available, but still out of reach. A patient may be diagnosed, but unable to afford treatment. A health worker may be trained, but lack the tools, guidance or time needed to provide quality care. A government may have a policy in place, but not the financing or infrastructure to deliver it targeted and consistently. These are connected points of failure in the systems people rely on to live healthier lives.

This is why equitable access cannot be achieved through short-term interventions alone. It requires solutions that are evidence-based, integrated into health systems and supported by sustainable financing. It requires us to understand what works, for whom, in which context—and what it will take to sustain and scale it.

The urgency is clear. Noncommunicable diseases are placing a growing burden on individuals, families, communities and economies, with the greatest impact often felt in places least equipped to respond. At the same time, innovation is expanding what is possible in prevention, diagnosis and treatment. The question is whether our care models, systems, partnerships and financing models will evolve quickly enough to ensure that progress reaches the people who need it most.

At Novo, equitable access is central to our Social Responsibility commitment. We are focused on strengthening the conditions that enable people to access appropriate treatment and care—from generating evidence and testing locally relevant models, to supporting health-system integration and more sustainable approaches to financing. We do this with partners because no single organisation can close the access gap alone.

The most durable solutions are built with—not for—the people, communities and health systems they serve. They respond to local realities, reflect the experience of people and healthcare professionals, and endure beyond a pilot or funding cycle. Global commitments and investment can enable local action, while local experience should shape how future solutions are designed, scaled and sustained.

This report brings together the scale of the challenge, the progress already being made and the opportunities ahead. It is intended to support a practical conversation about how we can move from commitment to implementation—and from isolated success to lasting change.

Equitable access will be achieved by building pathways that are reliable, inclusive and designed to create lasting health.

By **Carissa Vados**,
Global Head of Social Responsibility, Novo





“Noncommunicable diseases are not just preventable or treatable; they are also largely ignored. Yet the truth is, if NCDs were a virus, the world would be in lockdown”.

Dr Hans Henri P. Kluge
WHO Regional Director for Europe

02 The Global Burden of Noncommunicable Diseases: Scale, Gaps and Progress

Non-communicable diseases (NCDs) impact every age group, health system, and country. While they're often viewed as a concern for older populations, the numbers tell a different story: roughly 18 million people die prematurely from NCDs each year, and for people under 70 years old, NCDs outpace every other cause of death combined. The burden falls unevenly, too, as NCDs disproportionately affect the most underserved communities in LMICs, where nearly three quarters of global NCD deaths occur[1].

Globally, obesity and diabetes are among the fastest-growing NCDs. Global diabetes prevalence in adults doubled between 1990 and 2022[2] and if current trends continue, nearly 50% of the world's population will be living with either overweight or obesity by 2035[3].

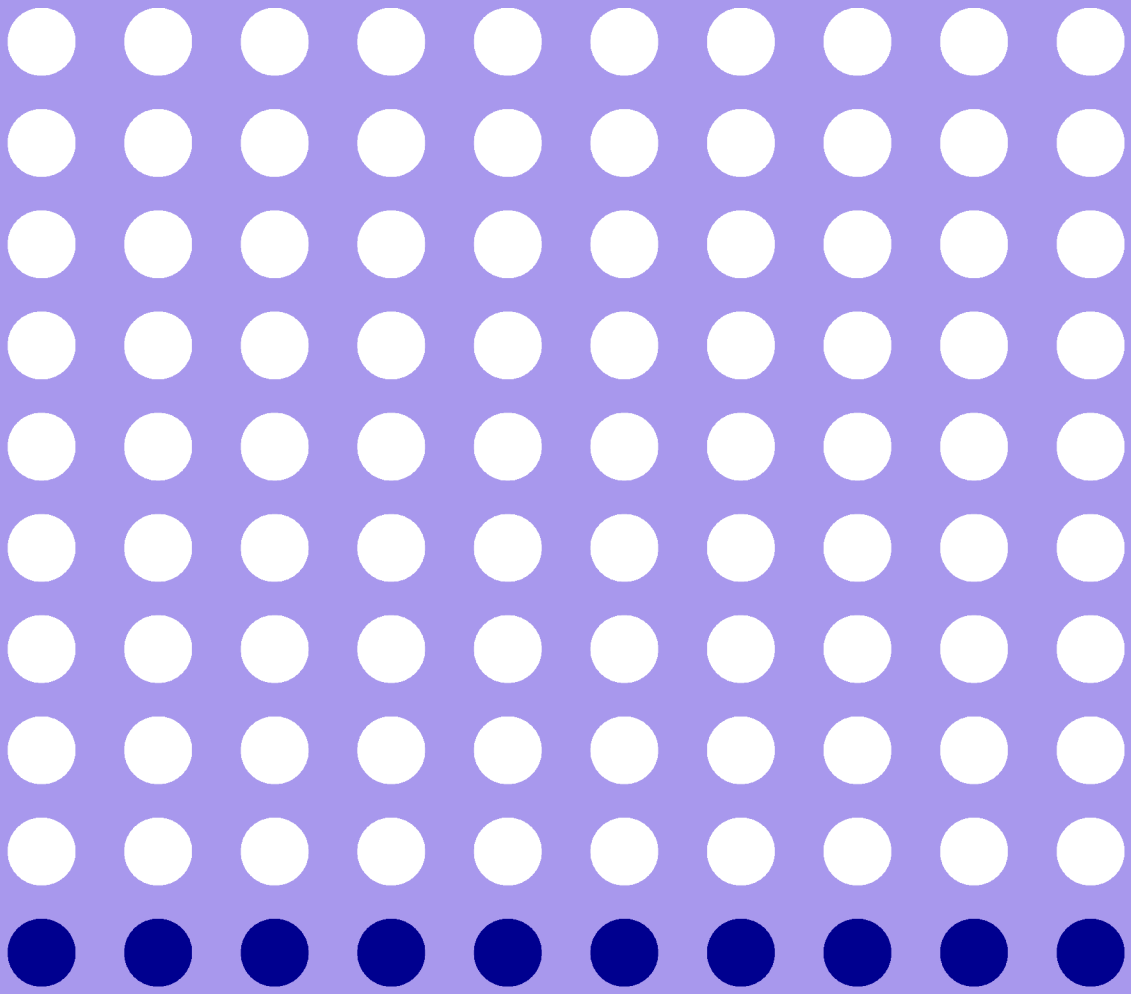
While both obesity and diabetes are preventable and treatable, the gap between what medicine and treatment can achieve and what patients receive remains wide.

While some NCDs are preventable, type 1 diabetes (T1D) is a distinct, chronic autoimmune condition cannot be prevented and requires lifelong insulin for survival. An estimated 9.5 million people were living with T1D globally in 2025, with growth rates most accelerated in lower-income countries: 20% prevalence increase in the last four years[4].

T1D is not the only non-preventable, lifelong condition where the pattern is the same. The most common inherited blood disorder, sickle cell disease (SCD), affects an estimated 7.74 million people globally, primarily in sub-Saharan Africa, which accounts for nearly 80% of global cases[5].

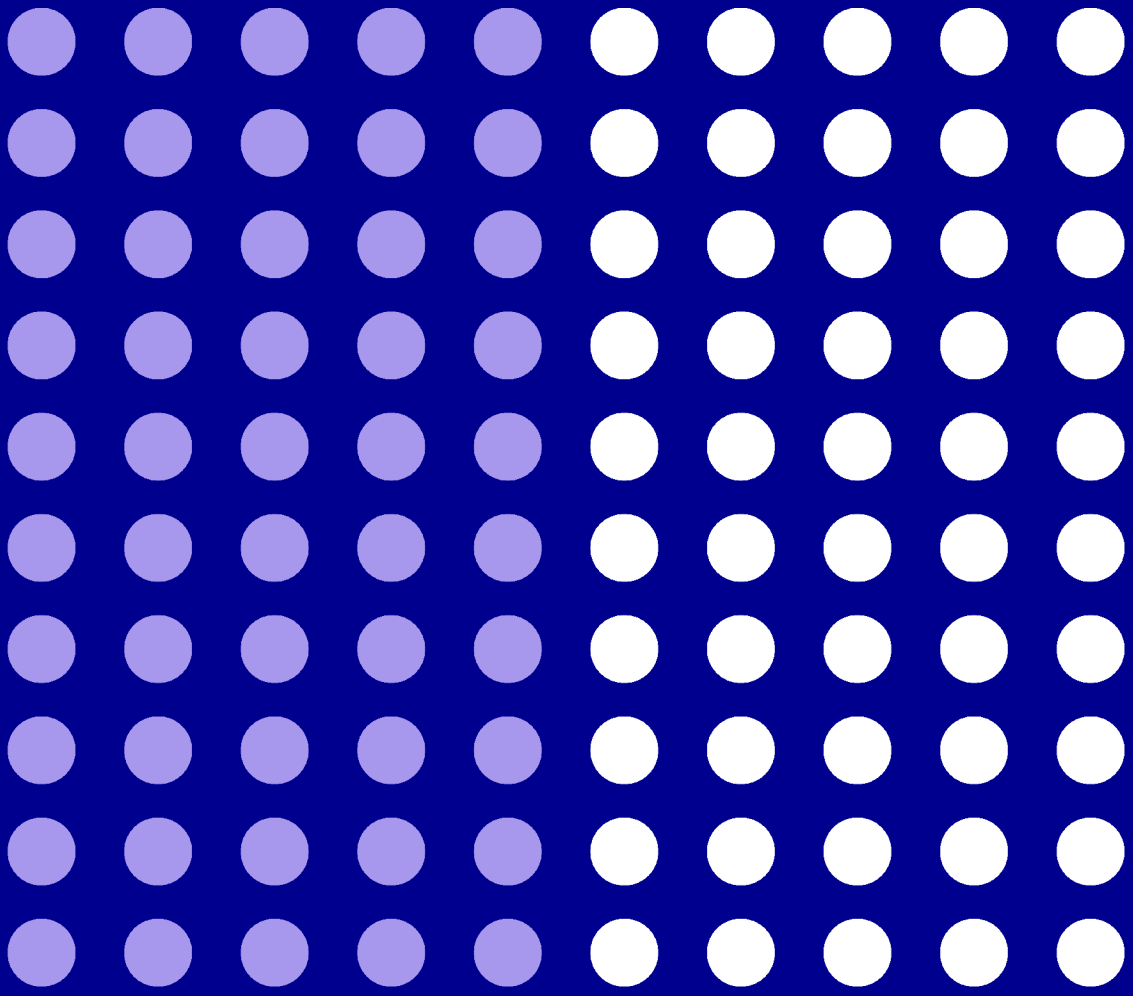
No one is exempt from the factors that exacerbate NCDs, but access to help can be unfairly distributed.





Less than 10%

of the people who could benefit from obesity treatment like GLP-1's are expected to have access to it by 2030[7]



Only half

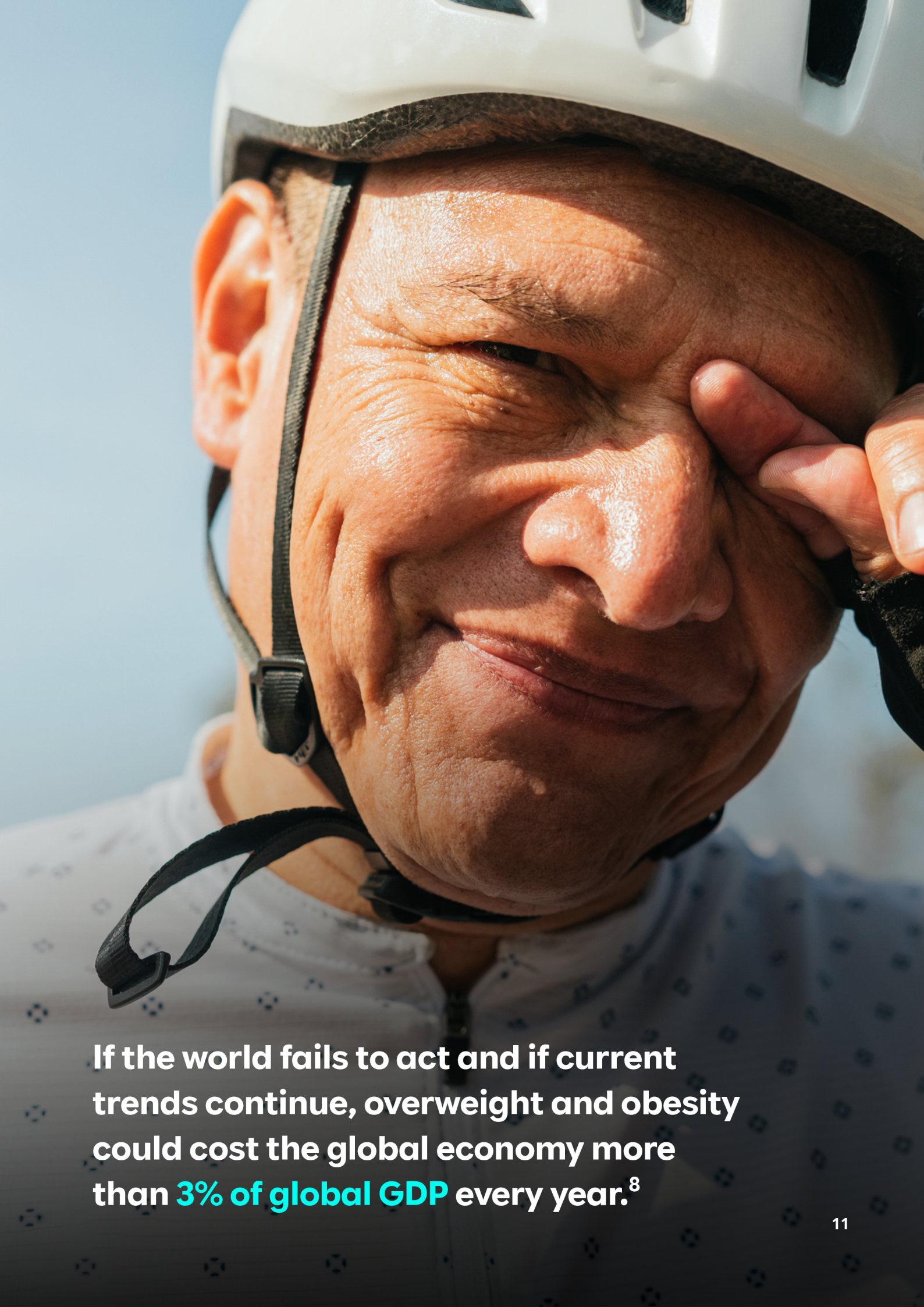
of people who need insulin can reliably obtain it, with treatment coverage lowest in LMICs[10]



New, innovative and essential treatments could have life-changing impact, but they remain out of reach for far too many people, especially in low- and middle-income countries (LMICs) and underserved populations.

By 2030, fewer than 10% of people who could benefit from GLP-1 therapies are projected to have access to them by 2030[6], and only 50% who need insulin can reliably obtain it[7]. Barriers include diagnostic capacity, treatment affordability, lack of workforce and the speciality training they need, supply chain reliability and much more.

This burden does not just fall on underserved families, their communities, governments or health workers. It falls on the global economy.



If the world fails to act and if current trends continue, overweight and obesity could cost the global economy more than 3% of global GDP every year.[8]

03 Grounds for Optimism and the **Path Forward**

Despite the scale of the challenge, progress is possible. NCDs are increasingly gaining attention at the highest political levels, creating an important momentum to move from recognition to action. With stronger commitments, better financing, and integrated health systems designed to reach underserved communities, countries can make meaningful progress in reducing preventable disease and premature deaths linked to NCDs.





When the United Nations' Sustainable Development Goals were introduced in 2015, they included a target to reduce premature mortality from non-communicable diseases by one third through prevention and treatment. In 2019, the World Health Assembly extended the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2030 and called for an Implementation Roadmap to accelerate progress. That roadmap supports action toward nine global targets with the greatest impact on NCD prevention and management[9].

The 2025 UN Declaration on NCDs, which calls for integrated action, stronger health systems, and more equitable access to prevention, diagnosis and care, sharpens the urgency. WHO Director-General Dr Tedros Adhanom Ghebreyesus has called it “the most comprehensive to date”: the first declaration to address NCDs and mental health together, incorporating lessons from the COVID-19 pandemic and setting concrete 2030 targets, including 150 million fewer tobacco users, 150 million more people with hypertension under control, and 150 million more people with access to mental health care[10].

That commitment is already translating into results: ten countries in the European region have achieved a 25% reduction in premature mortality from the four major NCDs[11], proof that stronger health systems and public health measures can move the needle at scale.

Alongside political commitment, innovations such as GLP-1 therapies play a significant role across the human life course in tackling the challenge, when paired with stronger financing and equitable and sustainable access models that gets them to people who need them[12].

WHO's 2025 guideline notes that GLP-1 therapies can reduce obesity-related harms when used as part of broader care[13]. This progress extends beyond obesity-specific guidance: WHO's 2025 Essential Medicines List update added GLP-1 receptor agonists as a preferred treatment option for eligible people with type 2 diabetes, and WHO has expanded its prequalification pathway to include GLP-1 medicines such as semaglutide for type 2 diabetes treatment[14] — widening the normative and regulatory architecture supporting affordable access.

To ensure that the communities and countries that are hardest hit by NCDs experience progress, more work is needed.

It will require committed and expanded collaboration between health ecosystem partners to generate evidence, implement and scale solutions that embed and sustain equitable access to treatment, particularly in places where the gap is widest.





2015

All UN member state adopted the Sustainable Development Goals including **SDG 3.4.1 to reduce premature mortality from NCDs by one-third by 2030.**

2025

175 countries adopted the UN Political Declaration on NCDs. Sickle cell disease was explicitly recognised by 193 countries. **WHO added GLP-1 therapies to its Essential Medicines List**[19], and later issued the first global guideline for GLP-1s.





Around 7 million lives could be saved by 2030 through cost-effective NCD interventions in low-income countries[21].

04 Equitable Access in Practice



Novo's work in equitable access traces back over a century when the company started manufacturing insulin and built its founding purpose around making it available beyond those who could pay for it.

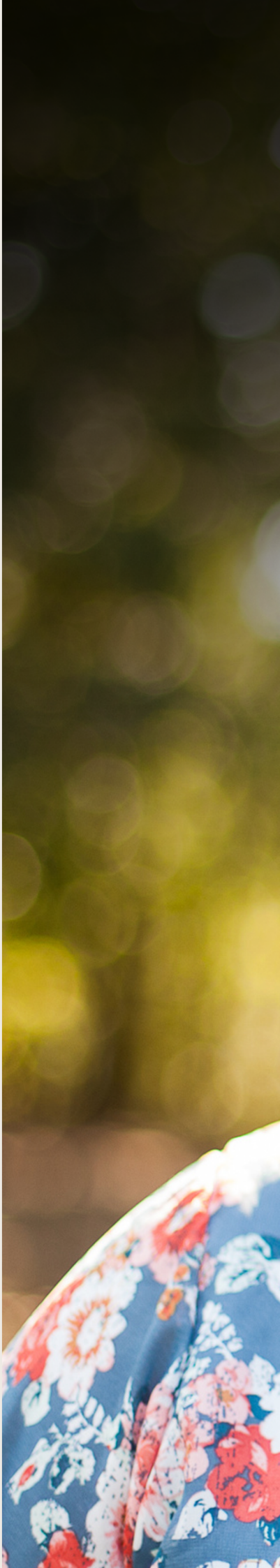
Equitable access is never *only* global or *only* local: global commitments and financing create the conditions for local delivery, and what is learned in local delivery — what works, what does not, how to embed it, what it costs — feeds back into how global partners design and scale the next commitment. Novo's Access for Better Health and its partners embrace this local-global approach and are already working across three pillars: evidence generation and innovation, health-system integration and sustainable financing. We aim to share learnings and knowledge as we go, so that everything we do draws directly on our own, and importantly, our partners' experience.



Learn more about what Access for Better Health does

PILLAR 1.
Evidence and Innovation

Equitable access models need evidence before they scale. A model that works in one public health system may fail elsewhere if financing structures, cultural context, or patient pathways differ. Well-designed implementation pilots, registry-based research and health economic analysis show not only whether a model works, but why: who it reaches, which barriers emerge, what it costs and what a government or partner would need to sustain it.



IN PRACTICE

Novo is building evidence with a range of partners from across public, municipal, and private sector. In Brazil, a two-year public-sector pilot with the Ministry of Health is expanding Wegovy® access to at least 1,000 patients, with Novo providing medicines, training, and monitoring. In Denmark, a 100-participant, 24-month pathway is testing combined medication and health-competency support in a high-burden municipality. In the Pacific Island countries, Novo has partnered to fund a three-year research program aimed at developing and implementing scalable, youth-centred models of care.

On sickle cell disease (SCD), Novo is exploring programmes in partnership with governments to build integrated care and referral pathways, strengthening health delivery and improving diagnosis and care retention in low-resource settings.



PILLAR 2.
Embedding Access into Systems

Lasting access depends on embedding solutions into the systems that deliver care: healthcare worker training, national guidelines, financing structures, and partnerships that continue beyond a pilot or funding cycle. Like evidence generation, no single actor can do this alone. Governments, multilateral organisations, civil society, and the private sector each contribute with different capabilities, from policy alignment and service delivery to community trust and operational reach.



IN PRACTICE

Changing Diabetes in Children (CDiC) shows what embedding access into systems looks like in practice. Launched in 2009 around the ambition that no child should die from diabetes, it provides free, holistic care to more than 90,000 children and adolescents with type 1 diabetes across 30 low- and middle-income countries, built through insulin provision, trained healthcare providers, and established clinics. The model shifts from direct support toward government-owned capacity as health systems mature. And across Africa and Indonesia, iCARE has expanded diabetes access since 2021 — capping insulin prices in Kenya, reducing them in Cote d'Ivoire, and building 17 public-private partnerships that have reached over 600,000 people living with diabetes and trained more than 5,000 healthcare professionals. In Colombia, iCARE is piloting an employer-linked insurance model across four companies and roughly 25,000 employees.



Beyond its own programmes, Novo works through global coalitions that make it easier for countries to access and integrate quality-assured treatment: following and referencing WHO's Essential Medicines List and submitting to Prequalification processes, which expand what is available for public procurement; supporting efforts toward a healthier, more sustainable insulin market. Novo also partners with initiatives such as ALIGN T1D and the Coalition for Access to NCD Medicines and Products to strengthen the wider ecosystem around type 1 diabetes and NCD treatment access.

PILLAR 3.
Sustaining Access at Scale

Sustainable progress on obesity and diabetes treatment access requires financing models that outlast short-term grants and reach populations at scale. Durable progress depends on domestic budgets, blended public-private investment, and in-country capacity that sustain prevention, diagnosis, treatment, and care. This makes sustainable financing especially urgent: NCDs receive less then 2% of development assistance for health[15], even as the burden grows, and the need for stronger investment becomes increasingly clear.

The economic case is strong: a global investment of just USD 3 per person per year in proven "Best Buy"[16] interventions for NCDs could generate USD 1 trillion in economic gains and sustaining that investment through 2035 could deliver a seven-fold return[17].



IN PRACTICE

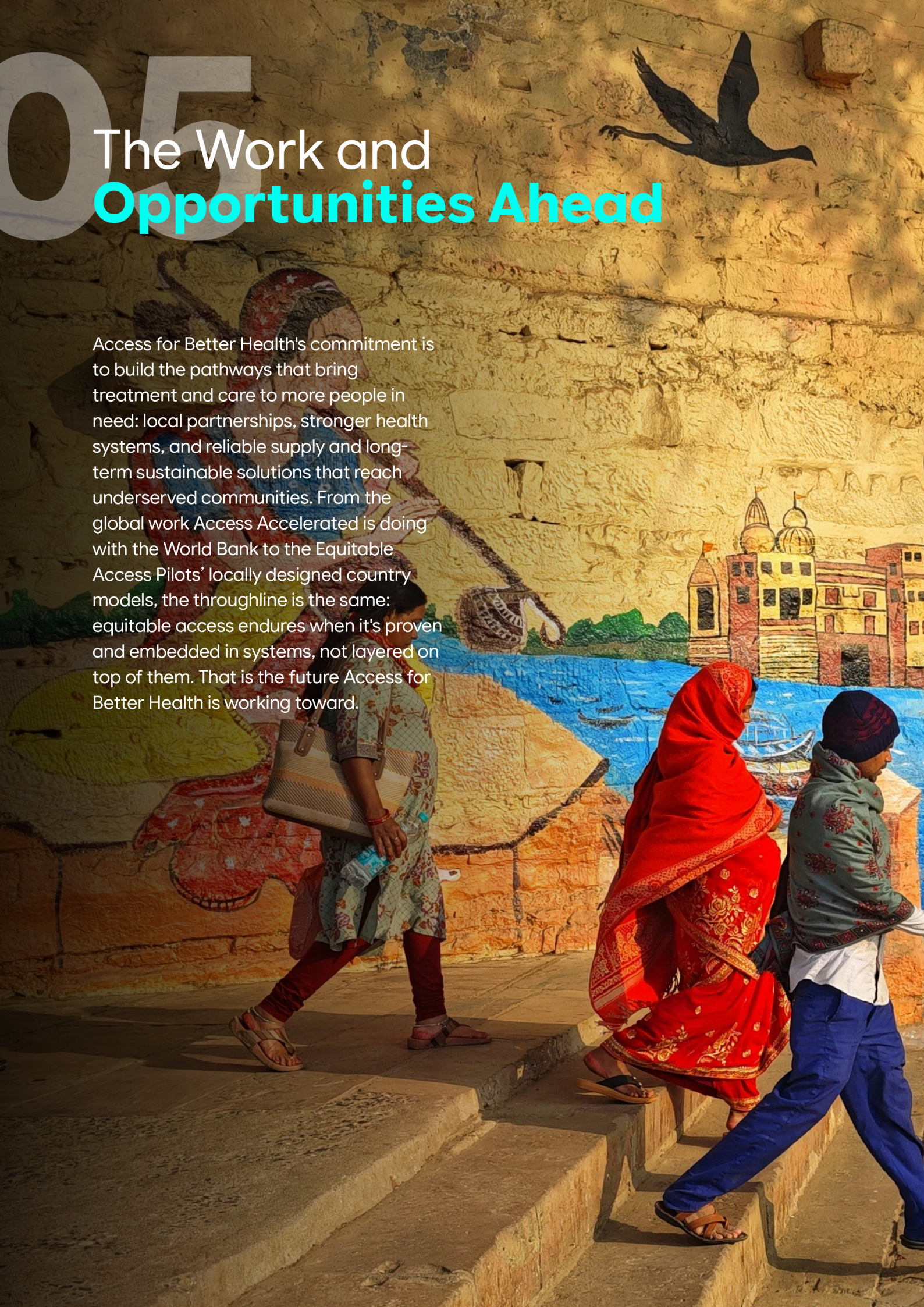
Since joining Access Accelerated as a core member in 2024, Novo has partnered with the initiative, alongside the World Bank, to translate global commitment on NCDs into practical financing support for LMICs. From 2020 to 2022 alone, Access Accelerated helped partners leverage an additional USD 3.7 billion for NCD programmes[18], with its Financing Accelerator Network for NCDs (FAN) providing regional technical assistance and catalytic seed funding that has strengthened institutional capacity and expanded best-practice sharing across LMICs[19].



05

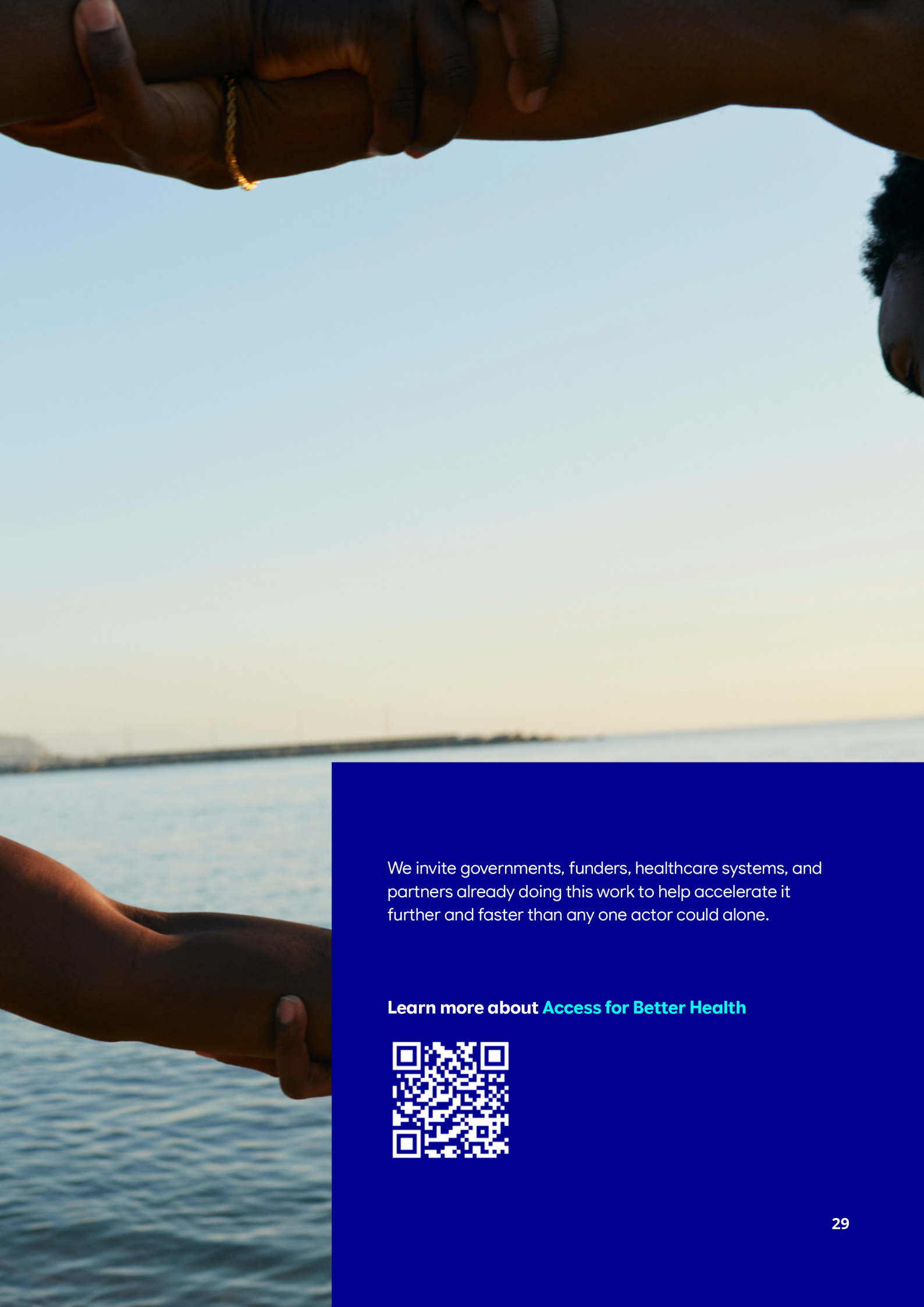
The Work and Opportunities Ahead

Access for Better Health's commitment is to build the pathways that bring treatment and care to more people in need: local partnerships, stronger health systems, and reliable supply and long-term sustainable solutions that reach underserved communities. From the global work Access Accelerated is doing with the World Bank to the Equitable Access Pilots' locally designed country models, the throughline is the same: equitable access endures when it's proven and embedded in systems, not layered on top of them. That is the future Access for Better Health is working toward.









We invite governments, funders, healthcare systems, and partners already doing this work to help accelerate it further and faster than any one actor could alone.

Learn more about Access for Better Health

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[14] WHO: Model list of essential medicines, 2025

[15] WHO: Global NDC Contract 2020 - 2030, n.d.

[16] "Best Buys" are WHO's shortlist of the most cost-effective NCD interventions for obesity and diabetes. This spans measures like sugary drink taxes, primary-care scale-up for early diabetes detection and management, and low-cost generic medicines such as metformin and insulin.

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