The 2016 global and national burden of diabetes mellitus attributable to PM$_{2.5}$ air pollution

Benjamin Bowe, Yan Xie, Tingting Li, Yan Yan, Hong Xian, Ziyad Al-Aly

Summary

Background PM$_{2.5}$, air pollution is associated with increased risk of diabetes; however, a knowledge gap exists to further define and quantify the burden of diabetes attributable to PM$_{2.5}$ air pollution. Therefore, we aimed to define the relationship between PM$_{2.5}$ and diabetes. We also aimed to characterise an integrated exposure response function and to provide a quantitative estimate of the global and national burden of diabetes attributable to PM$_{2.5}$.

Methods We did a longitudinal cohort study of the association of PM$_{2.5}$ with diabetes. We built a cohort of US veterans with no previous history of diabetes from various databases. Participants were followed up for a median of 8-5 years, we and used survival models to examine the association between PM$_{2.5}$ and the risk of diabetes. All models were adjusted for sociodemographic and health characteristics. We tested a positive outcome control (ie, risk of all-cause mortality), negative exposure control (ie, ambient air sodium concentrations), and a negative outcome control (ie, risk of lower limb fracture). Data for the models were reported as hazard ratios (HRs) and 95% CIs. Additionally, we reviewed studies of PM$_{2.5}$ and the risk of diabetes, and used the estimates to build a non-linear integrated exposure response function to characterise the relationship across all concentrations of PM$_{2.5}$ exposure. We included studies into the building of the integrated exposure response function if they scored at least a four on the Newcastle-Ottawa Quality Assessment Scale and were only included if the outcome was type 2 diabetes or all types of diabetes. Finally, we used the Global Burden of Disease study data and methodologies to estimate the attributable burden of disease (ABD) and disability-adjusted life-years (DALYS) of diabetes attributable to PM$_{2.5}$ air pollution globally and in 194 countries and territories.

Findings We examined the relationship of PM$_{2.5}$ and the risk of incident diabetes in a longitudinal cohort of 1729108 participants followed up for a median of 8-5 years (IQR 8-1-8-8). In adjusted models, a 10 µg/m³ increase in PM$_{2.5}$ was associated with increased risk of diabetes (HR 1-15, 95% CI 1-08-1-22). PM$_{2.5}$ was associated with increased risk of death as the positive outcome control (HR 1-08, 95% CI 1-03-1-13), but not with lower limb fracture as the negative outcome control (1-00, 0-91-1-09). An IQR increase (0-045 µg/m³) in ambient air sodium concentration as the negative exposure control exhibited no significant association with the risk of diabetes (HR 1-00, 95% CI 0-99-1-00). An integrated exposure response function showed that the risk of diabetes increased substantially above 2-4 µg/m³, and then exhibited a more moderate increase at concentrations above 10 µg/m³.

Interpretation The global toll of diabetes attributable to PM$_{2.5}$, air pollution is significant. Reduction in exposure will yield substantial health benefits.

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Introduction Air pollution is an important global health problem. PM$_{2.5}$—the most widely studied air pollutant—is associated with increased risk of cardiovascular disease, pulmonary disease, kidney disease, and other non-communicable diseases, and contributed to about 4-2 million premature deaths in 2015. A growing body of evidence strongly suggests an association between PM$_{2.5}$ and the risk of diabetes. The Lancet Commission on pollution and health published its report in October, 2017, and it provided a comprehensive review of the effect of the so-called pollutome on human health. The Commission outlined a glaring deficiency in evidence and provided a set of recommendations to fill important knowledge gaps. One of the recommendations outlined by the Commission is to “define and quantify the burden of diabetes attributable to PM$_{2.5}$ air pollution”. An assessment of the global and national burden of diabetes attributable to PM$_{2.5}$ would provide a better understanding of the epidemiology of diabetes, identify endemic areas, and further contribute to the global and national discussions.
on the hazardous effect of air pollution on diabetes. Therefore in this study, we aimed to further define the relationship of PM$_{2.5}$ and diabetes, using a longitudinal cohort study design. We also aimed to characterise an integrated exposure response function to characterise the risk of diabetes across all PM$_{2.5}$ concentrations experienced by humans. The integrated exposure response function was non-linear in that risk increased substantially above PM$_{2.5}$ concentrations of 2.4 µg/m$^3$, and then exhibited a more moderate increase in risk at concentrations above 10 µg/m$^3$. Additionally, the study suggests that in 2016, there were about 3.2 million cases of incident diabetes, and about 8.2 million healthy life years lost due to diabetes attributable to air pollution. The burden varied substantially by geography and was most pronounced in less developed countries.

### Added value of this study

This study addresses the research recommendation and provides evidence that ambient PM$_{2.5}$ pollution is associated with increased risk of diabetes. We examined the association in a longitudinal cohort of about 1.7 million US veterans, in which we control for relevant individual-level variables and ecological characteristics. We tested a positive control, as well as negative outcome and exposure controls to address concern about spurious causal inference. The study synthesised previous evidence to build an integrated exposure response function to characterise the risk of diabetes across all PM$_{2.5}$ concentrations experienced by humans. The integrated exposure response function suggests modest reductions in PM$_{2.5}$ will ameliorate the burden of diabetes. Finally, we observed that the burden of diabetes attributable to PM$_{2.5}$ exhibited substantial geographical variability, and was more skewed towards regions that are least prepared to cope with the consequences of this excess burden. The results will possibly be helpful to promote the public’s awareness about the effect of PM$_{2.5}$ pollution on the risk of diabetes, and serve to inform and guide policy making aimed at addressing health consequences of environmental air pollution.

### Methods

#### Longitudinal cohort study design

We did a longitudinal cohort study of the association of PM$_{2.5}$ with diabetes. A cohort of US veterans with no previous history of diabetes was built by linking the US Department of Veterans Affairs’ databases with the US Environmental Protection Agency’s (EPA) Community Multiscale Air Quality Modeling System of PM$_{2.5}$, where time of cohort entry was set as date of last outpatient blood panel between Oct 1, 2003, and Sept 30, 2004. Further details on these datasets and cohort construction are provided in the appendix (pp 2–3). Participants were followed up for a median duration of 8-5 years. The outcome of incident diabetes was defined by International Classification of Diseases-9 code, diabetes medication prescription, or an HbA$_1c$ measurement more than 6.4% (≥46.4 mmol/mol); and participants were censored at death or end of follow-up (Sept 30, 2012). PM$_{2.5}$ exposure value was assigned on the basis of county of residence at time of cohort entry. Cox proportional hazard models were used to examine the relationship between PM$_{2.5}$ and the risk of diabetes, with censoring at death or end of follow-up. Selection of covariates was informed by previous studies. All models were adjusted for age, race, sex, estimated glomerular filtration rate, systolic blood pressure, hyperlipidaemia, chronic lung disease, cardiovascular disease, body-mass index, smoking status, use of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker, percentage of people in poverty in each county of residence, population density of county of residence, number of admissions to hospital before beginning of follow-up, and how many times serum creatinine was measured before beginning of follow-up. Further details on data sources, variable definitions, and statistical analyses are included in the appendix (pp 2–11). Missing data were not imputed. In analyses, a 95% CI of a hazard ratio (HR) that does not include unity was considered significant. In all analyses, p<0.05 was considered significant.

We additionally curated data from the US County Health Rankings datasets and controlled for US county level characteristics in the following six domains: health outcomes, health behaviours, clinical care, social and economic factors, physical environment, and demographics. We
also did a restricted cubic spline analysis to characterise
the morphology of a non-linear association between PM₂·₅
and the risk of diabetes; assessed exposure in quartiles;
assessed exposure in time-varying models, where geo-
ographical location was updated as participants moved and
average annual exposure was matched to geographical
location at any specific time; used the National Aeronautics
and Space Administration’s (NASA) Socioeconomic Data
and Applications Center’s Global Annual PM₂·₅ Grids
from Moderate Resolution Imaging Spectroradiometer,
Multi-angle Imaging Spectroradiometer, and Sea-Viewing
Wide Field-of-View Sensor’s aerosol optical depth remote
spaceborne satellite sensing data as an alternative data
source for exposure; varied the spatial resolution of
exposure definition where we assigned exposure levels on
the basis of the nearest air monitoring station within
30 miles, 10 miles, and 5 miles; assessed the relationship
between PM₂·₅ and risk of all-cause mortality as a positive
call-outcome control; assessed the relationship between ambient air
sodium concentrations and risk of diabetes as a negative
control; assessed the relationship between ambient air sodium
concentrations and risk of all-cause mortality; and assessed the relationship between
PM₂·₅ and the risk of lower limb fracture. Further de-
celerations on these sensitivity analyses are provided in the
appendix (pp 5–11).

The use of a negative control is a valuable complement
to other epidemiological methods and serves to identify
and resolve both suspected and unsuspected sources of
spurious causal inference including confounding,
mismeasurements, and other biases, as well as design
or analytic flaws. Ambient air sodium concentration is
measured by air monitoring stations; however, there
is no biological basis to support an association
between sodium concentrations in the air and the risk
of diabetes. Therefore, ambient air sodium is an
appropriate negative exposure control. The negative
outcome control was selected on the basis of the criteria
outlined by Lipsitch and colleagues. There is no
previous knowledge of and no biological or mechanistic
plausibility to explain an association between PM₂·₅
and the risk of lower limb fracture. We therefore considered
it a suitable negative outcome control.

Integrated exposure response function
An integrated exposure response function based on
GBD methodologies was built to assess the risk of
diabetes due to PM₂·₅ across the spectrum of PM₂·₅
exposure concentrations around the world. A
literature review was done, where we evaluated currently
available literature on the associations between risk of
diabetes and PM₂·₅. Passive smoking, and active smoking
for the use in building an integrated exposure response
function. Passive smoking and active smoking were used as proxy exposures for high concentration of
PM₂·₅, because published literature on PM₂·₅ tends to be
from developed countries with these values on the lower
end of the spectrum, therefore, leaving a scarcity of
evidence on the relationship at higher concentrations of
exposure. Exposure attribution, as estimated by
previous studies, is derived from breathing rate (ie,
average volume of air breathed per minute), and the
PM₂·₅ mass per cigarette, or ambient exposure due to
living with someone who smokes.

Studies were included in the building of the integrated
exposure response function if they scored at least a four
on the Newcastle-Ottawa Quality Assessment
Scale—nine-point scale for assessing quality of
cohort studies—and were only included if the outcome
was type 2 diabetes or all types of diabetes. Active
smoking studies were only included if they contained a
recorded dose-response of cigarettes per day, which was
necessary for assigning a corresponding PM₂·₅ exposure
value, and if the reference group consisted of those who
had never smoked. Passive smoking studies were
included if the reference group had never smoked and
were not exposed to passive smoke. Passive smoke was
assigned a PM₂·₅ exposure of 35 µg/m³, and active
smoking 667 µg/m³ per cigarette per day. Selected
studies, along the Veterans Affairs longitudinal
cohort study presented here, were included in building
the integrated exposure response function; details on
included studies are presented in the appendix
(pp 12, 19–28).

The integrated exposure–response function fits avail-
able epidemiological data using a Bayesian hierarchical
modelling approach, and is based on GBD methodology,
which has been described elsewhere in detail. The
theoretical minimum risk exposure level (TMREL) was
assigned on the basis of a uniform distribution of PM₂·₅
from 2·4 µg/m³ to 5·9 µg/m³, representing exposure
values between the minimum and fifth percentiles of
exposure distributions from outdoor air pollution
cohort studies. TMREL by its definition should
minimise individual-level and population-level risk and
be theoretically possible to achieve, but not necessarily
affordable or feasible to achieve. Studies were
weighted using the quality effects approach. Results
were obtained from 1000 sets of simulated values. The
mean and 95% uncertainty intervals (UIs) are
presented.
and mortality in hierarchical models. The GBD Population Estimates dataset provided population size. Country income classifications were obtained from the World Bank. The population attributable fraction (PAF) of diabetes due to PM, represents the proportion of diabetes that would be eliminated if the PM, exposure was reduced to concentrations equal to or less than the TMREL. The PAF of diabetes due to PM, exposure above the TMREL was calculated with a GBD 2016 equation, using risk estimates from the integrated exposure response function. The TMREL was set as a uniform distribution between 2.4 μg/m³ and 5.9 μg/m³, for which levels under the TMREL were treated as contributing no risk. The attributable burden of disease (ABD), defined as the number of incident cases of diabetes per year attributable to PM, exceeding the TMREL, was calculated using estimates of diabetes from the GBD 2016 study multiply by the PAF of diabetes due to PM, exceeding the TMREL.

YLD due to diabetes is a measure of the burden placed on a population due to the ill-effects of living with diabetes. YLL due to diabetes is a measure of the burden placed on a population due to dying prematurely from diabetes. The DALY due to diabetes is a summary measure of YLD and YLL, and represents the total years of healthy life lost due to ill-health, disability, or early death due to diabetes. YLD, YLL, and DALYs of diabetes due to PM, were estimated by multiplying the diabetes-specific GBD values of the corresponding measure by the PAF of diabetes due to PM, exceeding the TMREL. Details of these measures are discussed in the appendix (pp 13–15).

Uncertainty in measurements was factored in our estimations through the generation of measures from a distribution of 10,000 estimates, and the median and 95% UIs are reported. Further details on estimation and UIs are presented in the appendix (pp 14, 15). Burden measures are reported as values, rates per 100,000 population, and age-standardised rates per 100,000 population. World maps of age-standardised ABD, YLD, YLL, and DALY rates are presented. Age-standardised DALY rates were additionally analysed by World Bank income classification and the socio-demographic index quintile.

Statistical analysis
We did all analyses in SAS (version 7.1). We generated maps using ArcMap (version 10.5). The study was approved by the Institutional Review Board of the VA Saint Louis Health Care System (Saint Louis, MO, USA).

Role of the funding source
The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results
We examined the relationship of PM, and the risk of incident diabetes in a longitudinal cohort of 1729108 participants followed up for a median of 8.5 years (IQR 8.1–8.8). The demographic and health characteristics of the cohort participants are detailed in the appendix (pp 16–17). PM, concentrations obtained from EPA ranged from 5.0 μg/m³ to 22.1 μg/m³. In models adjusted for individual-level sociodemographic and health characteristics, a 10.0 μg/m³ increase in PM, exposure was associated with increased risk of diabetes (HR 1.15, 95% CI 1.08–1.22; table 1). Because characteristics of geographies might confound the association between PM, and the risk of diabetes, we curated the US County Health Rankings’ datasets and built analyses additionally controlling for 55 US county-level variables in the six domains aforementioned. Models additionally adjusting for US county characteristics yielded consistent results in that an increase in PM, was associated with increased risk of diabetes (HR 1.12, 95% CI 1.02–1.24; table 1). A spline analysis suggested that the relationship between PM, concentrations and the risk of incident diabetes increased with increased concentrations of PM, and then nearly plateaued at concentrations exceeding 12.0 μg/m³ (figure 1). The results were consistent in analysis considering PM, in quartiles; in that compared with quartile 1 (5.0–10.1 μg/m³), the risk was increased in quartile 2 (consisting of PM, concentrations of 10.2–11.8 μg/m³; HR 1.08, 95% CI 1.05–1.13) and then nearly plateaued in quartiles 3 and 4 (consisting of PM, concentrations ≥11.9 μg/m³; HR 1.13 [95% CI 1.07–1.18] for quartile 3, and 1.14 [1.10–1.19] for quartile 4; table 1). Results were consistent when exposure was treated as time varying (HR 1.18, 95% CI 1.10–1.25), where it was updated as cohort participants moved from one location to another and as PM, estimates changed over the duration of follow-up (table 1).

We additionally considered PM, estimates derived from NASA’s spaceborne satellite sensors as an alternative data source to define ambient PM, exposure concentrations. Analyses considering these data yielded results consistent with those shown using exposure data obtained from the EPA ground-based air monitoring stations (HR 1.13, 95% CI 1.11–1.15; table 1). Results were consistent in models where exposure concentrations were assigned on the basis of the nearest air monitoring station within 30 miles, 10 miles, and 5 miles (appendix p 18).

We examined the association of PM, and the risk of all-cause mortality where a priori observations suggest that an association is expected (ie, the positive outcome control). Our results showed a significant association between PM, concentrations and the risk of death (HR 1.08, 95% CI 1.03–1.13; table 1). We tested the association between ambient air sodium concentrations and the risk of diabetes (ie, a negative exposure control);
the results showed a non-significant association (HR 1.00, 95% CI 0.99–1.00; table 1). There was also no significant association between air sodium concentrations and the risk of all-cause mortality as a negative exposure control (HR 1.00, 95% CI 1.00–1.01) and no significant association between PM2.5 and risk of lower limb fracture as a negative outcome control (1.00, 0.91–1.09; table 1).

A summary table listing the studies used in the analysis of synthesising the integrated exposure response function is provided in the appendix (pp 19–28). The integrated exposure response function showed that the risk of diabetes increased substantially for PM2.5 concentrations above the lower bound of the TMREL of 2.4 µg/m³ then exhibited a more moderate increase in risk at concentrations above 10 µg/m³ (figure 2).

In 2016, the global burden of incident diabetes attributable to PM2.5 was, in 1000s, 3002.9 (95% UI 2208.6–3798.9). Globally, ABD per 100 000 population was 40.62 (95% UI 29.9–51.4), and age-standardised ABD per 100 000 population was 40.4 (29.7–51.1; table 2).

Global diabetes DALYs attributable to long-term exposure to PM2.5 were 8.2 million (95% UI 5.8–11.0), consisting of 4.1 million (2.4–6.2) YLD and 4.1 million (3.1–5.1) YLL. The 2016 global YLD, YLL, and DALYs for the ten most populated countries. ABD, YLD, YLL, and DALYs for the 194 countries and territories are provided in the appendix (pp 29–53). Among the ten most populated countries, China had the highest ABD of 600.3 (95% UI 447.2–757.3), followed by India with an ABD of 590.5 (447.0–737.1), and then the USA, with an ABD of 149.5 (85.2–210.3) in 1000s (table 2).

Pakistan had an ABD per 100 000 population of 58.8 (95% UI 44.1–74.4), followed by the USA with an ABD per 100 000 population of 46.3 (26.4–65.1), and then India with an ABD per 100 000 population of 44.9 (34.0–56.0). Age-standardised ABD showed that Pakistan had the highest with 72.6 (95% UI 54.4–91.8), followed by India with 48.7 (36.9–60.8), and then Bangladesh with 48.6 (37.2–60.2) incident cases of diabetes per 100 000 population. There was substan-

<table>
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<tr>
<th>Exposure (data source)</th>
<th>Outcome</th>
<th>Sample size</th>
<th>Event rate</th>
<th>Incident rate per 100 000 person-years</th>
<th>HR (95% CI)</th>
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<tbody>
<tr>
<td>Primary model PM2.5* (EPA) Diabetes 1 729 108 397 966 (23.0%) 3414.9 1.15 (1.08–1.22)</td>
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<td>Additionally controlled for US county characteristics PM2.5* (EPA) Diabetes 1 301 070 300 500 (23.1%) 3426.2 1.12 (1.02–1.24)</td>
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<td>Exposure as quartiles 5.0–10.1 µg/m³ PM2.5* (EPA) Diabetes 1 446 334 94 564 (21.2%) 3087.6 1.00 (Ref)</td>
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<td>10.2–11.6 µg/m³ PM2.5* (EPA) Diabetes 1 442 939 102 456 (23.1%) 3431.4 1.08 (1.05–1.12)</td>
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<td>11.9–13.6 µg/m³ PM2.5* (EPA) Diabetes 1 408 580 98 439 (24.1%) 3604.6 1.13 (1.07–1.18)</td>
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<td>13.7–22.1 µg/m³ PM2.5* (EPA) Diabetes 1 431 255 102 507 (23.8%) 3566.1 1.14 (1.01–1.19)</td>
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<td>Time-varying exposure PM2.5* (EPA) Diabetes 1 1729 108 397 966 (23.0%) 3414.9 1.18 (1.10–1.25)</td>
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<td>Alternative exposure data source PM2.5* (NASA) Diabetes 1 1670 031 383 894 (23.0%) 3410.9 1.13 (1.11–1.15)</td>
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<tr>
<td>Positive outcome control PM2.5* (EPA) All-cause mortality 1 1729 108 300 500 (21.3%) 2740.7 1.08 (1.03–1.13)</td>
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<tr>
<td>Negative exposure control Sodium† (EPA) Diabetes 1 301 070 191 826 (23.4%) 3484.8 1.00 (0.99–1.00)</td>
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<tr>
<td>Negative exposure control Sodium† (EPA) All-cause mortality 1 301 070 273 240 (21.1%) 2718.8 1.00 (1.00–1.01)</td>
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<tr>
<td>Negative outcome control PM2.5* (EPA) Lower limb fracture 1 1729 108 96 165 (5.6%) 740.0 1.00 (0.91–1.09)</td>
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*HRs for every 10 µg/m³ increase in PM2.5. †HRs for every IQR increase (0.045 µg/m³) in sodium. HR=hazard ratio. EPA=US Environmental Protection Agency. NASA=National Aeronautics and Space Administration.

Table 1: Analyses of the Veterans Affairs longitudinal cohort study of the association of PM2.5 and diabetes

![Figure 1: Spline analysis of PM2.5 and the risk of diabetes](image-url)
Figure 2: Integrated exposure response function of the association between PM$_{2.5}$ and diabetes

A histogram of the distribution of PM$_{2.5}$ exposure among the countries is presented in the background in grey. The populous countries ABD per 100 000 population; the burden was high in central and eastern Europe as well as central Asia, Russia, and Australia and New Zealand had low estimates of age-standardised DALYs (figure 4B; appendix pp 36–51). Finally, our estimates suggest that in 2016 there were 206 105 (95% UI 153 408–259 119) global deaths from diabetes attributable to PM$_{2.5}$ exposure.

### Discussion

Our results suggest that there is a significant association between increased PM$_{2.5}$ exposure and the risk of diabetes. Additionally, our integrated exposure response function suggests that risk is significant at concentrations below those recommended by regulatory agencies. Finally, we observed substantial geographical variation in the burden of diabetes attributable to air pollution, for which we estimated that in 2016, there were about 3·2 million cases of incident diabetes and about 8·2 million years of healthy life lost due to diabetes attributable to elevated concentrations of PM$_{2.5}$.

The association of PM$_{2.5}$ pollution and the risk of diabetes is remarkably consistent across a number of studies from different populations; it is consistent when using EPA or NASA data to define exposure, and it passed the scrutiny of application of both positive and negative controls. The application of negative exposure and outcome controls is especially important to identify non-causal associations and serves as an important complement to other epidemiological methods for improving causal inference. The biological mechanism underpinning the association is based on the premise that pollutants enter the bloodstream where they might interact with tissue components to produce pathological effects. This mechanism is now supported by evidence both in experimental models and humans that inhaled nanoparticles, which when sufficiently small can enter the bloodstream and interact with distant organs—including liver tissue—and exhibit affinity to accumulate at sites of vascular inflammation. Furthermore, experimental and human evidence suggests that exposure to ambient air pollutants can lead to clinically significant disturbances in the autonomic nervous system. Among the ten most populated countries, India had the highest DALYs (1 625·8, 95% UI 1 193·7–2 104·8), followed by China (1 251·5, 828·5–1 753·3), and then Indonesia (400·0, 261·7–544·5), in 1000s (table 3). DALYs per 100 000 population showed Indonesia as the highest with 155·1 DALYs (95% UI 101·5–211·1), followed by India with 123·4 (90·7–159·9), and then the USA with 108·5 (59·3–163·9). Age-standardised DALYs per 100 000 population showed Pakistan as the highest with an age-adjusted DALY rate of 221·7 (95% UI 159·0–291·6), followed by Indonesia with 189·4 (124·4–255·7), and then India with 165·5 (122·5–212·3; table 3). Mapping of the geographical distribution of age-standardised DALYs across the world showed populations in Central America, north Africa and the Middle East, southern sub-Saharan Africa, south Asia, and several countries in southeast Asia exhibited high age-standardised DALYs (figure 4B; appendix pp 36–51). Canada, Greenland, several countries in central and eastern Europe as well as central Asia, Russia, and Australia and New Zealand had low estimates of age-standardised DALYs (figure 4B; appendix pp 36–51). Finally, our estimates suggest that in 2016 there were 206 105 (95% UI 153 408–259 119) global deaths from diabetes attributable to PM$_{2.5}$ exposure.

### Table 2: Attributable burden of diabetes associated with PM$_{2.5}$ exposure globally and for the top ten most populous countries

<table>
<thead>
<tr>
<th>Country</th>
<th>PM$_{2.5}$ exposure concentration (μg/m$^3$)</th>
<th>Attributable burden of disease in 1000s (95% UI)</th>
<th>Attributable burden of disease per 100 000 population (95% UI)</th>
<th>Age-standardised attributable burden of disease per 100 000 population (95% UI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>157·2 (447·2–757·3)</td>
<td>43·9 (32·7–55·4)</td>
<td>47·9 (36·9–60·8)</td>
<td>47·9 (36·9–60·8)</td>
</tr>
<tr>
<td>India</td>
<td>72·6 (447·0–737·1)</td>
<td>44·9 (34·0–56·0)</td>
<td>48·7 (36·9–60·8)</td>
<td>48·7 (36·9–60·8)</td>
</tr>
<tr>
<td>USA</td>
<td>8·3 (85·2–210·3)</td>
<td>46·3 (26·4–65·1)</td>
<td>48·7 (36·9–60·8)</td>
<td>48·7 (36·9–60·8)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>15·0 (69·1–141·0)</td>
<td>40·7 (26·8–54·7)</td>
<td>41·3 (27·3–55·4)</td>
<td>41·3 (27·3–55·4)</td>
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<tr>
<td>Brazil</td>
<td>11·1 (31·0–68·6)</td>
<td>23·8 (14·8–32·7)</td>
<td>23·6 (14·7–32·5)</td>
<td>23·6 (14·7–32·5)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>63·0 (84·2–141·9)</td>
<td>58·8 (44·1–74·3)</td>
<td>72·9 (54·4–91·8)</td>
<td>72·9 (54·4–91·8)</td>
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<tr>
<td>Nigeria</td>
<td>36·9 (13·7–31·6)</td>
<td>13·3 (9·6–17·1)</td>
<td>21·1 (15·2–27·1)</td>
<td>21·1 (15·2–27·1)</td>
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<tr>
<td>Bangladesh</td>
<td>87·0 (53·4–86·5)</td>
<td>43·1 (33·0–53·5)</td>
<td>48·6 (37·2–60·2)</td>
<td>48·6 (37·2–60·2)</td>
</tr>
<tr>
<td>Russia</td>
<td>15·8 (29·3–49·0)</td>
<td>24·8 (16·3–33·6)</td>
<td>19·9 (12·2–27·0)</td>
<td>19·9 (12·2–27·0)</td>
</tr>
<tr>
<td>Japan</td>
<td>13·1 (22·2–48·3)</td>
<td>27·7 (17·7–38·4)</td>
<td>21·8 (14·0–29·7)</td>
<td>21·8 (14·0–29·7)</td>
</tr>
<tr>
<td>Global</td>
<td>42·3 (2208·6–3798·8)</td>
<td>40·6 (29·9–51·4)</td>
<td>40·4 (29·7–51·1)</td>
<td>40·4 (29·7–51·1)</td>
</tr>
</tbody>
</table>

UI=uncertainty interval.
population-weighted PM2·5 exposure, but also of attributable diabetes at the global and national levels. Exposure has increased by 11·2% from 39·7 µg/m³ in 2000 to almost 44·0 µg/m³ in 2015. From 59·7 to 66·8 µg/m³, the risk of diabetes increased substantially between 1% and 3% of the overall global diabetes burden. The high risk is driven in part by the fact that concentrations are higher at the global and national levels, and that the risk of diabetes is more than doubled. The findings also indicate that in the most polluted countries a modest increase in PM2·5 concentration of air pollution might be unsafe, in concentrations greater than 10 µg/m³. The findings are consistent with recent data2,3,88 suggesting that even low concentrations of PM2·5 will yield small reduction in risk; however, given the large populations living in heavily polluted countries, even small incremental reductions in PM2·5 will yield substantial reduction in the burden of diabetes attributable to air pollution and non-communicable diseases.

The all-cause attributable DALYs of diabetes associated with PM2·5 exposure globally and for the top ten most populous countries are shown in Table 3. The risk also nearly plateaued and subsequently exhibited minimal increase in risk.4 The non-linear integrated exposure response function is congruent with observations from other methods in glucose and insulin homeostasis. 

Table 3: YLD, YLL, and DALYs of diabetes associated with PM2·5 exposure globally and for the top ten most populous countries

<table>
<thead>
<tr>
<th>Country</th>
<th>YLD in 1000s (95% UI)</th>
<th>YLD per 100000 population (95% UI)</th>
<th>YLL in 1000s (95% UI)</th>
<th>YLL per 100000 population (95% UI)</th>
<th>DALYs in 1000s (95% UI)</th>
<th>DALYs per 100000 population (95% UI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>4081·6 (2364–6158)</td>
<td>55·2 (32·0–83·3)</td>
<td>57·0 (33·1–85·8)</td>
<td>41·4 (33·7–51·6)</td>
<td>56·0 (41·8–66·9)</td>
<td>600·0 (44·8–74·5)</td>
</tr>
<tr>
<td>China</td>
<td>829·8 (455·0–1274)</td>
<td>60·7 (33·3–92·2)</td>
<td>70·0 (46·4–86·7)</td>
<td>78·8 (57·4–94·9)</td>
<td>31·0 (29·3–38·2)</td>
<td>91·6 (60·6–128·3)</td>
</tr>
<tr>
<td>India</td>
<td>693·3 (3967–10409)</td>
<td>52·7 (30·7–79·1)</td>
<td>70·9 (54·6–88·7)</td>
<td>107·2 (76·3–138·1)</td>
<td>108·9 (89·3–128·1)</td>
<td>165·5 (122·5–202·3)</td>
</tr>
<tr>
<td>USA</td>
<td>2162·2 (1078–3542)</td>
<td>67·0 (33·4–109·7)</td>
<td>134·4 (76·8–188·5)</td>
<td>41·6 (23·8–58·4)</td>
<td>39·4 (29·4–49·8)</td>
<td>108·9 (70·3–146·5)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1240·6 (655–1938)</td>
<td>48·1 (25·4–76·8)</td>
<td>275·8 (183·4–363·4)</td>
<td>106·9 (71·1–140·9)</td>
<td>135·2 (103·1–167·3)</td>
<td>221·7 (159·9–289·1)</td>
</tr>
<tr>
<td>Brazil</td>
<td>71·6 (36·8–116·1)</td>
<td>34·1 (17·5–55·4)</td>
<td>120·5 (75·6–162·5)</td>
<td>62·3 (39·6–83·5)</td>
<td>190·0 (119·6–291·1)</td>
<td>98·1 (60·3–138·0)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120·0 (69·2–180·1)</td>
<td>62·9 (36·3–94·3)</td>
<td>62·9 (49·9–90·7)</td>
<td>127·7 (92·3–176·4)</td>
<td>252·5 (178·4–337·2)</td>
<td>32·2 (23·8–43·9)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>261·0 (14·3–39·7)</td>
<td>14·1 (8·1–21·5)</td>
<td>18·1 (12·1–25·3)</td>
<td>45·4 (30·1–63·5)</td>
<td>192·2 (117·9–271·1)</td>
<td>221·7 (159·9–289·1)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>78·8 (45·0–118·3)</td>
<td>48·7 (27·8–73·1)</td>
<td>63·3 (36·8–94·2)</td>
<td>87·5 (56·6–109·9)</td>
<td>102·3 (74·4–133·4)</td>
<td>151·0 (111·6–194·4)</td>
</tr>
<tr>
<td>Russia</td>
<td>64·6 (35·6–101·4)</td>
<td>44·3 (24·4–69·4)</td>
<td>32·3 (17·8–50·6)</td>
<td>28·2 (15·9–46·3)</td>
<td>39·2 (25·1–59·8)</td>
<td>46·8 (28·3–69·4)</td>
</tr>
<tr>
<td>Japan</td>
<td>89·0 (45·7–144·3)</td>
<td>70·8 (36·3–114·8)</td>
<td>41·9 (21·4–68·0)</td>
<td>13·3 (8·7–17·7)</td>
<td>10·6 (6·9–14·1)</td>
<td>5·1 (3·3–6·8)</td>
</tr>
</tbody>
</table>

YLD=years of life lived with disability. U=uncertainty interval. YLL=years of life lost. DALYs=disability-adjusted life years.
more prominent as major causes of disease and death, and the contribution of air pollution to non-communicable diseases in general, and specifically to diabetes will probably become even more pronounced. The forces of demographic expansion, ageing, epidemiological transition, and rapid industrialisation in low-income and lower-to-middle-income countries will probably increase the burden of health loss and death due to air pollution. The burden of health loss from diabetes attributable to PM$_{2.5}$ pollution is not insignificant in well developed countries and in geographies with relatively lower air pollution. Developing a better understanding of the effect of low concentrations of pollution (those currently considered safe) on health should be also be addressed by funding agencies and the scientific community. Scientific evidence to define concentrations of particulate matter that are safe is needed to inform advocacy and guide policy making.

This study has several limitations. Our analyses neither considered the source of PM$_{2.5}$, nor the chemical composition and toxic content of PM$_{2.5}$, which might vary within and among countries; however, studies have shown that estimates using non-specific PM$_{2.5}$ biomass alone will underestimate the burden of disease attributable to PM$_{2.5}$ pollution. Our study focused on quantitating the burden of diabetes associated with PM$_{2.5}$ exposure (ie, the Lancet Commission on pollution and health research recommendation number two); however, evaluation of the burden of diabetes associated with exposure to other pollutants including carbon monoxide, nitrogen dioxide, and others should be undertaken in future research. Although we accounted for several individual-level and county-level health characteristics, used two different data sources to define exposure, and took care to vary the spatial resolution of exposure definition, our analyses do not account for individual-level differences in socioeconomic status, physical activity, and PM$_{2.5}$ exposure; however, the successful application of both a negative exposure control and negative outcome control lessens the concern about residual confounding. Our analyses do not provide insight into the subnational level; this level is particularly important because several countries are especially large and there is likely to be substantial national geographical variation in both PM$_{2.5}$ and underlying morbidity and mortality rates related to diabetes (eg, in India and China) that is not captured in our analyses. In this study, we used estimates for incident diabetes generated by the GBD study group, and although these Bayesian estimates are considered robust, they are limited by the quality of the available data. Furthermore, variability and inconsistency of data collection methods and tools across the countries could influence geographical variations. Because data for the relationship of PM$_{2.5}$ and the risk of diabetes was primarily derived from studies done in countries with relatively lower PM$_{2.5}$ air pollution (eg, USA, Canada, and western Europe), we relied on active and passive smoking as proxies for exposure to higher concentrations of PM$_{2.5}$ pollution to build our integrated exposure response function; this analytical strategy is well accepted, widely used, and represents the optimal methodological approach to quantitate the risk of disease associated with PM$_{2.5}$ exposure given the available data.

Our study also had key strengths, such as the examination of the relationship between PM$_{2.5}$ and the risk of diabetes in a longitudinal cohort for which we also tested a positive control, negative exposure control, and negative outcome control to resolve concerns about causal inference. We also leveraged the availability of data from GBD 2016, which is the most comprehensive compilation and analysis of global health information available. We use GBD methodologies including the concept of DALYs to comprehensively capture the burden of disease across the world and a measure of uncertainty.

In conclusion, we provided evidence for a relationship between PM$_{2.5}$ and the risk of diabetes, we synthesised available evidence and integrated it to build an exposure response function describing the risk of diabetes at each level of ambient PM$_{2.5}$ exposure, and we quantitated the burden of diabetes including the number of incident cases of diabetes per year, and the years of healthy life lost due to diabetes attributable to PM$_{2.5}$.

![Figure 3: Age-standardised DALYs per 100 000 population of diabetes by World Bank income group (A) and sociodemographic index quintile (B)](https://www.thelancet.com/planetary-health)

![Figure 4: Age-standardised burden of incident diabetes attributable to PM$_{2.5}$ per 100 000 population (A) and age-standardised DALYs due to incident diabetes attributable to PM$_{2.5}$ per 100 000 population (B)](https://www.thelancet.com/planetary-health)
Age-standardised attributable burden of disease per 100 000
0·00–17·67
17·68–21·99
22·00–24·55
24·56–27·63
27·64–33·07
33·08–39·48
39·49–45·64
45·65–57·78
57·79–72·64
72·65–332·73

Age-standardised DALYs per 100 000
0·00–38·39
38·40–52·31
52·32–74·44
74·45–99·36
99·37–126·57
126·58–154·34
154·35–170·66
170·67–199·56
199·57–305·95
305·96–1318·02
The contributions do not represent the views of the US Department of Veterans Affairs. Each author contributed to the overall work.

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**Declaration of interests**

We declare no competing interests.

**References**


