IDF Europe Expert Opinion: Continuous Glucose Monitoring in 2026

Considerations for Technology Selection in Modern Diabetes Care

Background

Continuous glucose monitoring (CGM) has transformed diabetes management and become an integral component of modern diabetes care by enabling continuous glucose assessment, informing lifestyle and treatment decisions and supporting individualised diabetes management[1]. A substantial body of evidence demonstrates that CGM use not only improves glycaemic outcomes and reduces exposure to hypoglycaemia but also supports self-management and enhances quality of life across diverse populations of people living with diabetes (PwD), including those with types 1 and 2[2,3].

Over the past decade, CGM technologies have evolved significantly. Devices available today may differ in several aspects, including sensor performance, alert functionalities, connectivity, interoperability with other diabetes technologies, user experience and data-sharing capabilities[1,3]. The technological evolution of CGMs should be acknowledged when evaluating current device options and developing policies related to access and procurement.

Principle 1: Recognition of the Evolution of CGM Technology

The CGM landscape has evolved rapidly, driven by continuous improvements in sensor design, digital health applications, analytical performance, usability and integration into clinical care. Historically, personal CGM systems were categorised into real-time CGM (rtCGM) or intermittently scanned CGM (isCGM), reflecting differences in device functionality and data access that characterised earlier generations of CGM technology[1]. However, as highlighted in the 2026 American Diabetes Association Standards of Care, this classification is becoming increasingly outdated and may no longer fully reflect the capabilities of contemporary CGM systems[1]. As a result, device selection should no longer rely primarily on the traditional isCGM/rtCGM classification, but rather on the characteristics, functionalities and performance of individual systems[1].

Therefore, the use of historical CGM classifications as a basis for access, reimbursement or segmentation risks reinforcing outdated assumptions about technology and clinical need. Newer-generation CGM systems should be recognised as an evolution beyond older categories: they preserve the essential benefits of previous CGM approaches while adding

functionalities that can enhance safety, support proactive management and deliver value across a broad spectrum of PwD. Contemporary CGM systems are increasingly defined not by historical classifications, but by the capabilities they offer to support safe, proactive and individualised diabetes management.

As diabetes technology continues to evolve, smartphone-connected digital ecosystems are becoming increasingly important enablers of innovation. Future advances, including AI-enabled decision support and personalised diabetes management tools, are likely to depend on robust digital platforms capable of integrating glucose data with advanced software solutions. Therefore, evaluation of CGM technologies should consider not only current device performance but also sustainability for the future.

Principle 2: Sensor Performance, Accuracy & Quality Should Be Key Considerations

The primary objective of CGM technology is to provide accurate, reliable and clinically actionable glucose information that supports therapeutic decision-making and PwD safety[1]. When evaluating CGM systems, particular attention should be paid to device performance, quality and reliability, supported by robust clinical evidence. This requires the use of standardised performance metrics and clinically meaningful measures that extend beyond a single accuracy metric to capture the ability of a device to provide dependable information that supports safe and effective diabetes management. Accordingly, evidence-based assessment of device performance should remain a cornerstone of technology evaluation and procurement decisions[4,5,6].

From a PwD care perspective, procurement frameworks and reimbursement policies should prioritise technologies capable of delivering the highest standards of clinical performance, supported by sound scientific evidence, based on individual PwD's needs.

Principle 3: Users Preference & Individual Needs as the Centre of Decision-Making

PwD have diverse clinical characteristics, lifestyles, treatment regimens, preferences and expectations; no single technology is optimal for everyone. Device selection should therefore be based on the specific needs, circumstances, preferences and skills of an individual. We advocate for person-centred care and shared decision-making when selecting diabetes technologies.

As a result, access policies should preserve the ability of healthcare professionals and PwD to choose the most appropriate technology for their individual situation. Maintaining

meaningful choice is important to support equitable access to the technology that best aligns with individual needs and preferences[7].

Conclusion

The evolution of CGM technology requires a shift away from historical device classifications and towards approaches that emphasise performance, clinical evidence and person-centred care. In this context, IDF Europe supports an evidence-based and user-centred approach to CGM technology selection.

As diabetes technologies continue to evolve, decisions related to access, reimbursement and procurement should recognise technological progress and be guided by three overarching principles:

1. Recognition of the substantial evolution of CGM technologies over time and the limitations of legacy device categories;
2. Prioritisation of sensor performance, quality, and clinical evidence, based on intended use and the individual needs of PwD;
3. Preservation of PwD choice and individualised care.

By moving beyond historical classifications and focusing on device capabilities, clinical evidence and individual needs, stakeholders can help ensure that advances in CGM technology translate into meaningful benefits for PwD.

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