Improving Access to Care Among Marginalized Diabetics in the United States

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On my honor as a University student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments.

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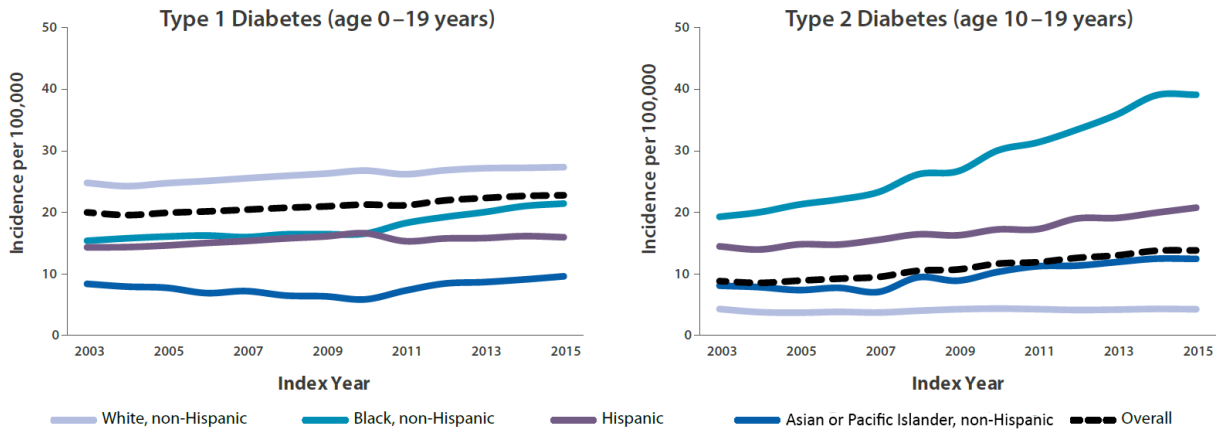
In the United States, access to healthcare among diabetics is often deficient, especially among marginalized populations. According to the U.S. Centers for Disease Control and Prevention (CDC), "37 million Americans have diabetes (about 1 in 10), and approximately 90-95% of them have Type 2" (2021). High costs and other barriers limit diabetics' access to the insulin they need. According to a critical care doctor at Harvard Medical School, "16.5% of people who use insulin report rationing" (Thomas, 2022); people from marginalized groups are more likely than others to resort to rationing. Advocacies strive to improve access to care among indigent or marginalized diabetics.

According to the U.S. Food and Drug Administration (FDA), deficient access to healthcare, inconsistent diabetes management, poor diet, and endemic obesity have contributed to a rise in diabetes (2020). The problem is acute among low-income, predominantly nonwhite populations suffering from Type 2 diabetes (fig. 1).

Figure 1

Incidence of Type 1 and 2 diabetes in U.S. children and adolescents by race and ethnicity, 2003-15 (CDC, 2022)

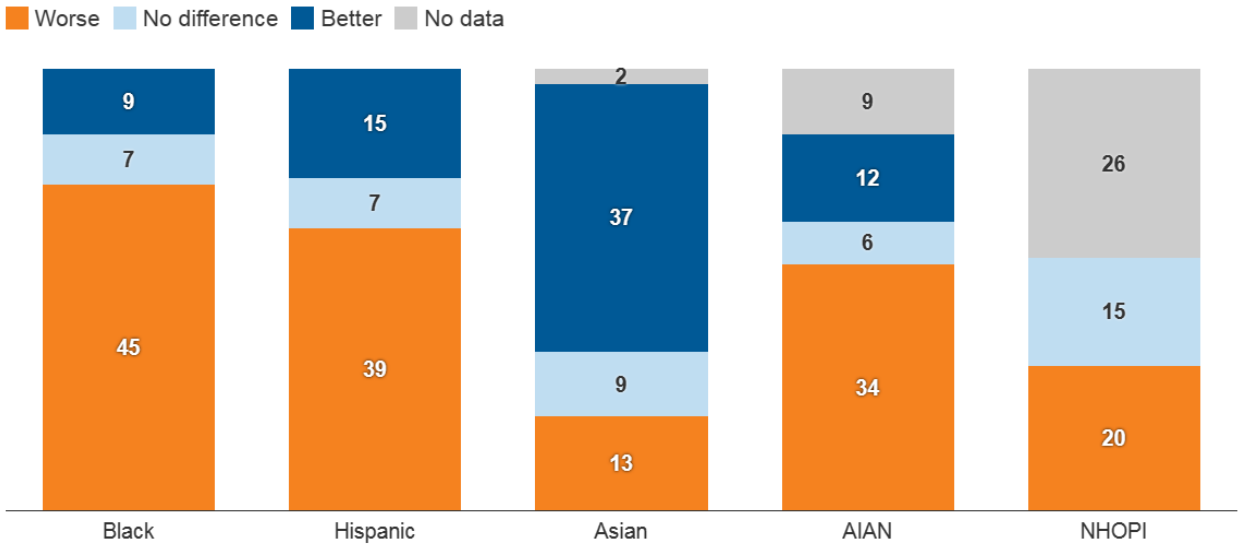


In Hispanic and Black populations, the prevalence of diagnosed Type 2 diabetes is 2-4 times greater than among the U.S. general population, and 4-8 times greater than among the white population (fig. 1).

Poverty rates correlate with the prevalence of Type 2 diabetes. According to the U.S. Census Bureau, in 2021, Black, American Indian and Alaska Native, and Hispanic peoples made up 60.9% of people in poverty in the United States (Creamer et al., 2022). People living with poverty typically have limited access to healthcare and may be unable to afford a trip to the doctor's office (fig. 2).

Figure 2

Health and health care among people of color compared to white people (Hill et al., 2022)



The deficits in access to healthcare among Black, Hispanic, and American Indian or Alaska Native (AIAN) people is astounding (fig. 2). Aguayo-Mazzucato et al. (2019) found that among U.S. Hispanics with annual incomes under $20,000, the incidence of diabetes exceeded that among Hispanics earning more than $75,000. People of color and low-income people are more likely to get diabetes, in part because they are less likely to have sufficient access to

healthcare. U.S. Hispanics generally report below average median household income, greater poverty rates, and have the highest frequency of uninsured persons (Aguayo-Mazzucato et al., 2019). Education also plays a critical role in the prevalence of diabetes. Adults with only a high school diploma were at greater risk of Type 2 diabetes than adults with a bachelor's degree or more (Aguayo-Mazzucato et al., 2019). Access to education can improve incomes and prepare people to manage their health more successfully. Poverty and poor access to education and healthcare contribute to the greater prevalence of Type 2 diabetes among marginalized groups in the U.S. Advocacies therefore demand policy reforms to bridge the gaps in the prevention and care of diabetes among people of color.

Literature Review

An existing piece of work studies "diabetes complications in racial and ethnic minority populations in the USA" (Haw et al., 2021). This report reviews epidemiologic trends in diabetes complications specific to racial and ethnic minorities. It also looks at differences in microvascular and macrovascular complications of diabetes, health care utilization, diabetes prevention efforts, and interventions aimed to reduce racial and ethnic disparities and their limitations. Haw's et al. report goes beyond the scope of this research problem by reviewing the microvascular and macrovascular complications. However, the research problem proposed falls in line with this paper in terms of health care utilization, prevention efforts, and reducing racial and ethnic disparities.

The researchers found that for Hispanic and Black adults with Medicare, there was a significantly higher risk of readmission after the initial discharge than there was for White patients. They found that the rates of Emergency Department use and hospitalization and hospital

charges for these admissions for diabetes complications were higher among Black and Hispanic patients. They also found that being uninsured or having public insurance was associated with hospital readmission, and that ethnic minority individuals were more likely to be uninsured or have public insurance. Access to care is also a limiting factor in screening as individuals in racial and ethnic minorities are less likely to have a usual source of care than White patients. The researchers argue that the variation in quality of care may also prevent minority groups from being identified as high risk. As a way to help solve these problems, the researchers found that culturally tailored education programs as well as health system and population health management changes have been effective.

Although the research paper mentions improvements in education have been helpful, they do not discuss how education programs have been implemented through the help of either legislation or advocacy groups. It also does not mention the impact pharmaceutical companies have on achieving health equity. All these topics are expanded on throughout this essay, and it will be seen how advocacy groups play a critical role in achieving health equity.

Reform in State and Federal Legislation

Advocates

There are some advocacies that actively persuade legislation change in state and federal governments for diabetes management. One of these advocacies is the Diabetes Advocacy Alliance (DAA), which strives to advance legislation and policies for people with and at risk for diabetes to ensure health improvement and to eliminate health disparities (DAA, 2023). In a letter sent to the National Academics of Sciences, Engineering, and Medicine, the DAA encourages the Centers for Medicare and Medicaid Services' (CMS) "to review the body of

literature on the effectiveness of medical nutrition therapy for treating prediabetes, and to cover medical nutrition therapy for Medicare beneficiaries diagnosed with prediabetes" (Martin et al., 2022). The letter cites that Medicare covers this type of diabetes care for people with diagnosed diabetes, but not for individuals with prediabetes (Martin et al., 2022). Prediabetes is when an individual has a higher than normal blood sugar level, and without lifestyle changes, adults and children are at a high risk to develop Type 2 diabetes (De Filippis, 2022). Although this personalized nutrition plan is covered by insurances for people with diagnosed diabetes, the DAA is urging government officials to offer this plan to people who are at extreme risk of Type 2 diabetes, like minority groups. With the support of insurance coverage on a nutrition plan, the number of cases of diagnosed diabetes could drastically decrease because a healthy diet could be more affordable.

Another group that is promoting change within Congress is the American Medical Association (AMA). This professional association supported the National Diabetes Clinical Care Commission Act introduced by Senator Jeanne Shaheen in 2015, which focused on "improving diabetes care delivery, patient outcomes, and cost effectiveness" (AMA, 2023). In a letter to Senator Shaheen, the AMA and other organizations with similar interests in diabetes prevention wrote, "we look forward to working with you to achieve passage by the Senate as soon as possible" (Abbott et al., 2015). This form of advocacy has the potential to be the most influential in invoking change because Congress has a lot of authority and power. By lobbying for the improvement of diabetes care and its cost effectiveness, the AMA can influence the ability for marginalized groups to receive the care they need at an affordable price. As health equity is one of association's goals, it is reasonable to assume accessible care for minority groups was a priority when this bill was introduced.

Opposition

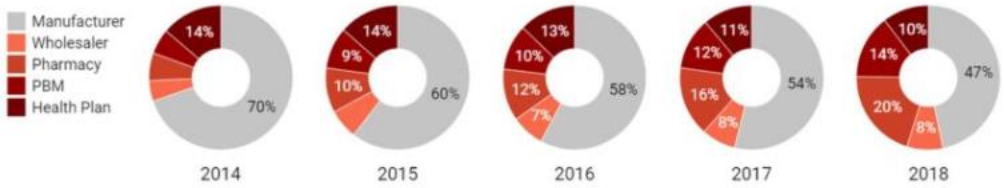
Some organizations object to some public policy efforts to improve access to care for diabetics. The Federalists Society opposes legislation in Minnesota to give insulin to patients who cannot afford it, contending that such policies are "positively immoral" because they inflict "an injustice" on pharmaceutical companies (Sandefur, 2020). A trade organization for biopharmaceutical research companies, Pharmaceutical Research and Manufacturers of America (PhRMA), strive to build a better health care system by being patient-centered in innovation, affordable, and accessible (PhRMA, 2023). However, PhRMA filed a lawsuit against the state of Minnesota after the proposed legislation to give insulin to patients who cannot afford it saying that the "Act violates the Takings Clause of the Fifth and Fourteenth Amendments, which prohibits Minnesota from taking manufacturers' private property for public use" (PhRMA, 2020). This lawsuit goes against the trade organization's mission which is to be affordable and accessible to everyone. It is evident that the organization is not appealing to the patients suffering from diabetes, but rather the pharmaceutical companies manufacturing insulin.

Another trade organization that opposes legislation being pushed through Congress is America's Health Insurance Plans (AHIP), a trade association for insurers. In 2022, the House of Representatives voted in favor of a bill to cap out-of-pocket costs on insulin at $35 a month (Ollstein et al., 2022). In an article written about the bill, more than a half-dozen pharmaceutical lobbyists say that "the insurance industry is doing more to oppose the bill than drugmakers are doing to support it" (Ollstein et al., 2022). As the insurance companies have a large financial stake in the bill being passed, it is not a surprise that AHIP opposes this legislation. In a statement released by AHIP following the passing of the bill, they claim that "insulin prices are too high because Big Pharma alone sets and controls the price" and that the legislation

"empowers Big Pharma to raise insulin prices" (AHIP, 2022). Despite these claims, this bill severely hurts insurance companies in the revenue gained from insulin sales, where they have already seen a decrease in their shares of expenditures from 14% in 2014 to 10% in 2018 (fig. 3).

Figure 3

Share of insulin expenditures received by each distribution system participant, 2014-2018 (Hedt, 2021).



Although insurance companies and trade associations like AHIP do not announce their financial motives publicly, the reason why they oppose legislation being passed to support individuals with diabetes obtaining affordable insulin is because it further decreases their share in the expenditures. Instead of advocating for a life-saving drug that many low-income, marginalized individuals cannot afford, insurance companies oppose legislation that would help these marginalized people based on their financial stake. Many of these organizations claim that health equity is a priority, but their actions in opposing legislature to ensure health equity refute their claims.

Progress

With the help of advocacies like the DAA and AMA, legislative bodies have put pressure on insulin manufacturers like Eli Lilly and Co. to reduce their prices. In March of 2023, Eli Lilly announced that they will cut insulin prices "up to 70% and expand a program that limits out-of-pocket monthly costs" for consumers (Alltucker, 2023). This aggressive price reduction by a Big

Pharma company comes after the Affordable Insulin Now Act being passed by the House of Representatives in 2022. The bill "caps cost-sharing under private health insurance for a month's supply of selected insulin products at $35," which is set to begin in 2023 (Congress, 2022). The bill is currently being introduced to the Senate before passing the legislation (Congress, 2022). Lilly's Chair and CEO, David Ricks, announced that the current healthcare system provides insulin to most people with diabetes, but "it does not provide affordable insulin for everyone and that needs to change" (Eli Lilly and Company, 2023). The healthcare system that Ricks references only allows people with a stable income and who can afford the previous high prices of insulin to receive the care they need. It is evident that through the help of legislative bodies and lobbyists like the DAA, pharmaceutical companies are making their products more accessible to lower income individuals. Although this is a major step in making insulin more affordable to the vast number of marginalized, low income individuals with diabetes, there is still a lot of progress still to be made in education and health management.

Senator Jeanne Shaheen and Representative Kim Schrier introduced the Expanding Access to Diabetes Self-Management Training Act to the Senate and House of Representatives in 2021. This bill states that Medicare coverage of diabetes must be expanded for "outpatient self-management training," and that "CMS must test a model in which such training is provided virtually" (Congress, 2021). According to CMS, outpatient self-management training services is defined as "educational and training services furnished… to an individual with diabetes by a certified provider" (CMS, 2022). This act contributes to the goal of educating people with diagnosed diabetes and people with prediabetes on ways they can manage their health to either combat diabetes or prevent it. Many marginalized individuals either have or have a high chance of getting Type 2 diabetes, so with this education training being covered by insurance makes the

treatment process more affordable. In some cases, people with Type 2 diabetes do not need insulin as regularly as people with Type 1, so education and self-management is the best treatment plan. However, for many low-income people, this type is coverage is not readily available. Making affordable health insurance for the lower class is something that also needs to be taken into consideration when trying to make diabetes management for affordable and accessible to marginalized groups.

The American Rescue Plan Act, signed into law by President Biden and introduced by Representative John Yarmuth in the House of Representatives in 2021, provided relief to the impact of COVID-19 on the economy, public health, state and local governments, individuals, and businesses (Congress, 2021). One of the bills main objectives however was to "lower or eliminate health insurance premiums" for "lower- and middle-income families" (White House, 2023). This plan drastically reduces monthly insurance fees and helps many uninsured Americans gain coverage (White House, 2023). Although this bill signed by the Biden administration is a way to help many low-income people navigate health insurance after the COVID-19 pandemic, it also allows low-income diabetics to have access to the outpatient self-management training services described previously. With the American Rescue Plan Act providing affordable insurance to low-income people and the Expanding Access to Diabetes Self-Management Training Act allowing self-management training to be covered by insurance, marginalized diabetics can receive the proper care they need. The bill also provides even more affordable access to insulin with the help of insurance coverage. Therefore, with affordable health insurance, low-income, marginalized diabetics can receive the proper care they need, thus achieving health equity, which is a basic human principle.

Vying for Pharmaceutical Cooperation

The CDC's Office of Minority Health and Health Equity (OMHHE) promotes inclusion of marginalized populations in clinical trials of drugs, biologics, vaccines, and medical devices for diabetes treatment (FDA, 2020). OMHHE is developing programs to improve health equity (CDC, 2020). One pharmaceutical company that is trying to include marginalized populations in clinical trials is Merck. Merck is trying to "lower health disparities by enrolling a wide range of participants in [their] clinical trials to make sure that [their] vaccines and medicines work across ethnicities, races, and genders" (Merck, 2023). They are doing this by selecting clinical trial sites that reflect diverse patient population and are working with members and organizations of the communities (Merck, 2023). Although Merck specializes in areas outside of insulin manufacturing, it is promising to see a big pharmaceutical company understanding that there are major health disparities across communities of color. These health disparities have caused gaps in science and the development of lifesaving treatments for these minority communities.

More evidence of efforts to improve health equity in clinical trials can be seen by Pfizer and Genentech, who partnered with Ohio State University Wexner Medical Center and College of Medicine and the African American Male Wellness Agency. These two big name pharmaceutical and biotechnology companies engaged with "almost 450 community members in 25 states and five countries to create solutions to barriers of access, awareness, discrimination, and racism and workforce diversity" to improve clinical trial diversity (Henderson, 2023). Researchers and pharmaceutical companies are placing more emphasis on reaching patients in marginalized communities who have been underrepresented in clinical trials.

With this focus on health equity by the CDC, FDA, and big name pharmaceutical companies like Pfizer and Merck, there is hope for many marginalized communities that they will receive the

proper care they need, as equally as everyone else. This also should include a higher representation for people suffering from diabetes in these communities, therefore leading to proper treatment and management.

The Black Women's Health Imperative (BWHI) is the only U.S. nonprofit striving to improve care access and equity among Black women. BWHI claims to "lead the effort to solve the most pressing health issues that affect Black women and girls" through "bold new programs and advocating health-promoting policies" (2022). BWHI has partnered with Aveeno, a skin and hair company, to "raise awareness around chronic disease and Black skin health" (Ligon, 2022). It is promising to see that health equity efforts are not solely centered around pharmaceuticals, but reaching out to consumer healthcare companies like Aveeno. Although Aveeno products are not a lifesaving drug like insulin, partnerships with organizations like the BWHI is encouraging for marginalized communities because they are finally being having a voice in healthcare products. Spreading these efforts across all different types of companies that make products for the health benefits of consumers is a step in the right direction to creating a better health system for underrepresented communities.

Building Infrastructure in Marginalized Communities

Before building health infrastructure in marginalized communities, local, state, federal, and companies must first work with these communities. These communities are more often than not are represented by Community-Based Organizations (CBOs). In California, 21 different CBOs worked with policymakers and community leaders for how they can improve efforts to support an equitable recovery from the social, economic, and health effects of the COVID-19 pandemic (ChangeLab Solutions, 2022). With more emphasis being placed on building better

support systems for marginalized communities, it is reasonable to assume that this will help in managing diabetes as well.

In an interview with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), Earle Chambers, PhD, MPH, who is the director of research at the Albert Einstein College of Medicine, says that healthcare professionals should be "trying to connect [patients] to resources" (NIDDK, 2020). Chambers continues to say that "having a robust referral system and the infrastructure to connect patients with services is important" (NIDDK, 2020). To Chambers, the ability for healthcare professionals to immediately connect their patients to the resources they need is an important aspect in building health infrastructure in low-income communities. This process can be implemented by consistently working with CBOs to determine the appropriate resources available in these communities. If these resources are not available in marginalized areas, then like in California, CBOs can work with community leaders to make these resources accessible.

According to the CDC, CBOs can help people within their community enroll in the National Diabetes Prevention Program, which can prevent or delay Type 2 diabetes (2022). They can also help people with diabetes take steps to lower their blood sugar and manage their condition through diabetes self-management education and support services (CDC, 2022). CBOs can offer these types of services by becoming recognized by the American Diabetes Association (CDC, 2022). If CBOs in marginalized communities can be accredited, they can legally provide services that help manage diabetes. Alluding to Chambers point earlier, CBOs can be the reference that healthcare professionals use when treating their patients. It is crucial for advocacies and community-based organizations to be in constant contact with healthcare professionals, political leaders, pharmaceutical and consumer healthcare companies, and

insurance providers so that the people suffering from diabetes in marginalized communities can immediately receive the care they need without going through multiple middle parties.

Conclusion

There are many health inequities for marginalized diabetics in the current healthcare system. However, through the work of advocacy groups and trade organizations, progress has been made by way of legislation being passed, pharmaceutical cooperation, and educational programs being created that provides more affordable and accessible care to marginalized individuals with diabetes. The work to achieve health equity for all is not finished however, more efforts in education and self-management can be implemented in racial and ethnic minority communities through community-based organizations and legislation. Until the prevalence of diabetes in Black, Hispanic, and other minority communities can be significantly reduced, the need for educational programs and affordable treatment plans is paramount. Proper diabetes management in marginalized communities is not limited to only diabetes, but also to other chronic diseases and health problems. Creating this infrastructure in low-income communities has numerous health benefits and is one step closer to not only achieving health equity, but equality for all.

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