

Access and financial barriers to care for people with diabetes within publicly-funded healthcare systems

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There are a few contributors to this issue of Diabetes Voice who have articulated the difficulties in access to care for persons with diabetes in low- and middle-income countries. It is also important to recognize that even in countries where publicly-funded health care exists, access to all necessary care is not guaranteed. Our research group, the Interdisciplinary Chronic Disease Collaboration at the University of Calgary, has undertaken a series of studies to better understand the role of financial barriers for patients with chronic medical conditions, including diabetes, in Canada.

Significance of financial barriers

Despite the common thought that Canada has universal health insurance, approximately 12 percent of Western Canadians with chronic conditions (such as stroke, heart disease, and diabetes) experience financial barriers to care.¹ Among those who have two or more chronic conditions, this figure is as high as 21 percent.¹ We have also demonstrated that those who experience financial barriers have significantly higher rates of hospitalization and mortality.²

In the Canadian context, many of these financial barriers may arise due to the structure of the provinces' public health insurance plans. Hospital and physician services are universally available free-of-charge. However, insurance for pharmaceutical services is provided only to some Canadians through a variety of provincial programs.³

What types of financial barriers do people with diabetes face?

We conducted a series of in-depth interviews to better understand the aspects of care to which persons with chronic diseases most commonly experience financial barriers. We asked participants (including 24 who had diabetes) to describe their experiences with financial barriers in detail.⁴ We found that in Alberta (Canada), people with diabetes frequently face financial barriers to accessing: their prescription medications, diabetes testing supplies, and healthy food.⁴

Regarding access to medications, one participant stated:

"I stopped taking my insulin for a long time because it was just getting ridiculous... what it [insulin] was costing. We just finished paying like a thousand dollars onto the account at the pharmacy where we get our stuff."

Many patients with diabetes face financial barriers to accessing testing supplies because they can't afford to test as frequently as they have been asked to by their healthcare providers:

"The doctors and nurses want me to do testing in the morning, two hours after every meal, and sometimes even one hour before a meal. That adds up to 4 or 5 lancets a day, 4 or 5 strips a day... If I were doing their exact schedule I would be spending about \$200 to \$300 a month on lancets and strips alone. I've broken that schedule."

Finally, many felt a significant tension between being able to afford their medications and testing supplies, and having sufficient funds left over to purchase the kinds of food that would enable them to adhere to the recommended diet for optimal glycemic control. One participant stated:

"We're not necessarily eating as healthy as we should be because of the money restraints of buying groceries. We're trying our best, but sometimes it [a food purchase] is just something that's gonna keep us full."

How do financial barriers affect individuals?

Throughout the interview process, we found that all aspects of some participants' lives were dramatically affected by their financial barriers, while others experienced financial barriers that had minimal impact on them. We explored this variation through a grounded theory analysis.⁵

The result of this research was the development of a new framework for understanding the between-patient variation in the impact of financial barriers on people's lives and health (Figure).⁶ We found numerous protective, predisposing and modifying factors that contribute to a patients' ultimate experience with their financial barrier. These factors, in conjunction an individual's worldview, influence a patient's degree of resiliency which determines how they cope with their financial barrier. Those with low degrees of resiliency appeared to be the ones most likely to experience the adverse outcomes described above.

What can be done to minimize financial barriers for people with diabetes?

Healthcare providers play a key role in modifying how patients experience their financial barriers (Figure). There are

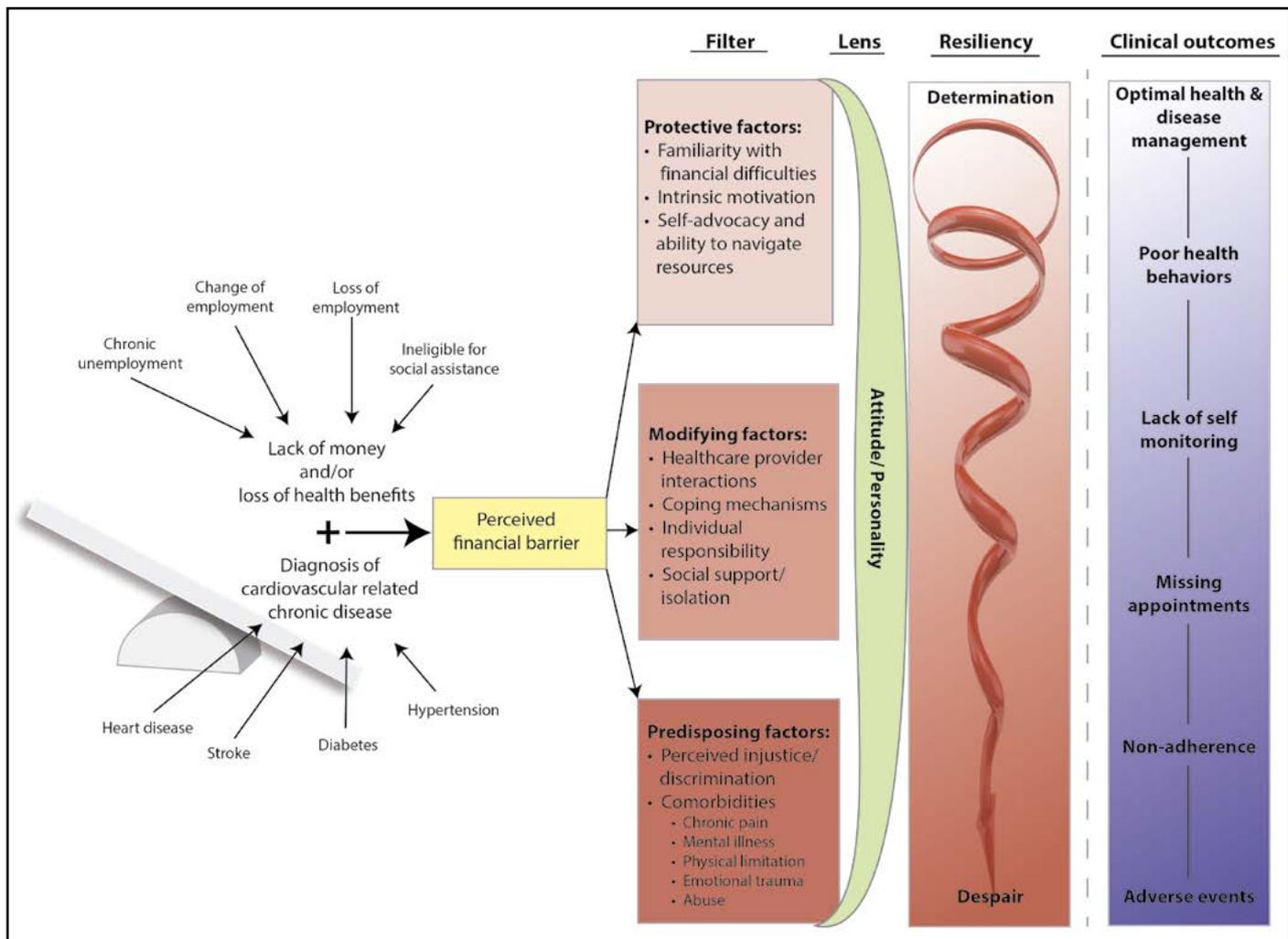


Figure: Understanding the process of financial barriers to care for patients with chronic diseases. Reproduced from: Campbell et al. (2016). *Medicine*: 95(49)

numerous ways that healthcare providers, including family physicians, endocrinologists, pharmacists, and diabetes educators, can be supportive of patients who experience financial barriers and those at risk of financial barriers. This often starts by asking patients about whether they have insurance that covers the cost of their medications and testing strips, and whether they struggle to afford any aspect of their care or self-management. Connecting patients to resources such as social workers or patient navigators may help patients develop strategies to reduce the impact of financial barriers. Unfortunately, providers also have the potential to exacerbate financial barriers by being unempathetic and by expecting their patients to comply with recommendations that they cannot afford. Physicians might also consider prescribing less expensive generic medications, or only those that are covered by individual insurance plans. Providers may also minimize financial barriers by limiting recommendations for self-monitoring to the minimum that is clinically indicated.

Decision-makers may be able to minimize the prevalence and impact of financial barriers, as certain healthcare and

social policies may protect individuals with diabetes from facing financial barriers while others predispose them to such barriers.

While the studies presented above were within a Canadian context, where healthcare provision is presumed to be 'universal', these studies are important for healthcare providers and decision-makers in all nations. Numerous studies have shown that financial barriers are problematic for people with diabetes in other settings, thus we may be prone to believe that finances are only problematic for patients in healthcare systems where no universal public access is in place. This series of studies serve to remind us that the management of diabetes is complex and challenging and that health insurers, public or private, may not fully cover the full spectrum of resources that are required for effective diabetes self-management. Optimal clinical care requires sensitivity to this important issue and empathy towards people living with diabetes who may struggle not only with their chronic medical condition, but also with the financial complications that come with it.

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