Universal health coverage and diabetes care affordable to all

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Diabetes is life-long and its management can be costly both for patients and national health systems. Many people living with diabetes in high-income countries, who are financially protected by universal coverage health systems, fight for access to new technologies, such as continuous glucose monitoring. However, many health systems in less-resourced countries are not able to provide standard diabetes care to patients without exposing them to economic vulnerability.

In this issue of *Diabetes Voice*, Larry Deeb, Chair of the IDF Task Force on Insulin, Test strips and Other Diabetes Supplies, highlights continuing issues with the availability of essential medicines for people with diabetes in IDF's new report of its Global Survey on Access to Medicines and Supplies for People with Diabetes**.** Published as a means to recognise and actively pursue improvements for the global supply of insulin and other essential diabetes medicines, IDF recommends several strategies to combat the problem including better supply chain distribution and procurement practices.

Managing diabetes requires insulin or oral hypoglycaemic agents, blood glucose monitoring, diabetes education, preventive tools, and treatment for complications. Access to trained health professionals and preventive services like education, healthy foods, and safe exercise spaces are also critical. Creating a formula that ensures equitable access to these provisions on an uninterrupted basis is not clear-cut. The World Health Organization's *Making fair choices on the path to universal health coverage* model[1] provides three dimensions that help conceptualize how access to diabetes care can be achieved:

- Ensuring widespread health **coverage** for the entire population.
- Including in this coverage the full **range of services** for diabetes care.
- Making costs for the range of services provided **affordable** to all.

Today, appropriate diabetes care is particularly important at the primary care level, where most people with diabetes are treated and therefore, where a healthcare team trained on best practice for type 2 diabetes is vital for success. Pablo Aschner, Chair of the IDF Working Group for the new IDF Recommendations For Managing Type 2 Diabetes In Primary Care reviews the rationale, methodology and the recommendations for PCPs and diabetes teams covering all fields of type 2 diabetes management worldwide.

Generally, less-resourced countries have basic public health systems that are free or provide services at a minimal cost, and cover most of the population. Yet, various needed diabetes care components are not usually provided due to high costs. James Elliott, a Trustee of T1International, provides his thoughts on the need for people living with diabetes, who lack access to care and essential medicines, to fight back with solidarity and activism.

Some less-resourced countries endeavour to ensure access to health through both public and private healthcare insurance schemes. The schemes may provide a wider range of services but are often beyond the reach of many people as they are costly and may be exclusive to governmental employees. Douglas Villarroel, Editor-in-Chief of *Diabetes Voice*, gives us his perspective from his home country Bolivia, where the public health system is not adequately serving the needs of people with diabetes.

When public health systems in less-resourced countries do provide components of diabetes care, the range of diabetes care services is often limited due to financial constraints. Provision is often at a basic level and provides oral hypoglycaemic agents, human insulin (in vials) and care reviews—if there is capacity. Syringes and HbA_{1c} testing may not be provided and blood glucose meters and test strips are rarely provided in low-income countries.[2] The SWEET Study Group describes their multinational initiative to improve diabetes care and outcomes in youth with all types of diabetes in low- and middle-income countries. Participation in SWEET has led to improvements in local standard protocols, support for care provider education and promotion of the need for multidisciplinary approach to diabetes care in many centres.

When care components are not supplied in public health systems, they must be accessed at premium prices at private pharmacies and paid for as out-of-pocket expenditures. For type 1 diabetes care[3], blood glucose monitoring can be the costliest component of care. The high expense of monitoring results in infrequent usage in less-resourced countries, with consequent risks of dangerous swings in blood glucose levels in people with diabetes. Elizabeth Snouffer, Editor of *Diabetes Voice*, reports on the care of people with diabetes

from the small province of Bali, Indonesia where she observes how access to blood glucose test strips can be the difference between a healthy future with diabetes or one at great risk for irreversible complications.

Even when some components are affordable, they may not be available due to stock outs in public pharmacies. Attaining components of care can be particularly acute for people living in regional and rural areas who often face extra financial burdens such as travel costs, accommodation, and lost salary.[4] One research group, the Interdisciplinary Chronic Disease Collaboration at the University of Calgary, make it clear that even in countries where publicly-funded healthcare exists, access to all necessary care is not guaranteed. They have undertaken to better understand the role of financial barriers for patients with chronic medical conditions, including diabetes, in Canada.

It is imperative that governments use the limited resources they have equitably and wisely. For instance, it is not appropriate for a less resourced government to buy analog insulin (which is more expensive than human insulin) when other components of care are not yet adequately provided.

Access to components of care is essential for people with diabetes in low-resourced countries. At the same time, prevention is indisputably better than treatment and many cases of type 2 diabetes are preventable through public health initiatives. Resources should be applied to promote healthy lifestyles, and consideration should be given to safe exercise spaces, nutrition guidance and other programs that ameliorate the lifestyle changes that have inevitably occurred with urbanization.

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