Disparities in Diabetes Prevention and Care

WHAT IS DIABETES?
Diabetes is a group of diseases marked by high levels of blood glucose, also called blood sugar, resulting from defects in insulin production, insulin action or both. Diabetes can lead to serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications.¹

As the American population ages and becomes increasingly diverse, the consequences of inadequate health care to low-income, underserved, uninsured and underinsured groups are becoming progressively serious, particularly for those who have or are at risk for developing diabetes. With nearly 24 million people (about 8 percent of the U.S. population²) already diagnosed with diabetes and the costs associated with this disease skyrocketing, it is critical not only to understand how and why disparities exist, but also to invest in prevention and management initiatives that can address the special needs of underserved communities.

Disparities in health care are often a result of environmental conditions, social and economic factors, insufficient health resources and poor disease management. With many causes for these critical gaps in care, success in reducing disparities can only come by addressing these factors together. That's why The Merck Company Foundation is launching the Alliance to Reduce Disparities in Diabetes (the Alliance) to employ a multi-pronged approach to addressing this critical issue.

Type 2 diabetes disproportionately affects people of certain racial and ethnic groups, including African-Americans, American Indians, Asian Americans, Hispanics/Latinos and Pacific Islanders.³ These groups also make up a disproportionate share of the poor and uninsured. They may live in substandard housing or in low-income neighborhoods with plentiful fast-food restaurants but lacking in grocery stores that carry healthy foods, resulting in higher rates of overweight and obesity. In urban neighborhoods, a lack of sidewalks and crime-free parks also may discourage the daily physical activity needed to maintain a healthy lifestyle.

However, even when minority populations do have access to good food and physical activity, many continue to receive a lower quality of care than non-minorities. A 2003 Institute of Medicine report cited stereotyping, biases, language and geographical and cultural barriers as possible explanations.⁴

A national report released in 2000 by the U.S. Department of Health and Human Services found that African-Americans, Mexican Americans and American Indians in particular were experiencing a sharp rise in the prevalence of type 2 diabetes.
The consequences of disparate care can be dire. According to the U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention, chronic conditions such as diabetes and its numerous complications (including nerve, heart and kidney disease) are the leading cause of death, disability and illness in the United States.

But it needn’t be so. Research has shown that lifestyle changes (such as being physically active, eating healthy and losing weight) can prevent or delay diabetes. Likewise, proper management of diabetes once diagnosed (e.g., maintaining glucose, cholesterol and blood pressure control) can significantly delay or prevent its numerous complications. Disparities in routine preventive care and treatment among racial and ethnic groups may therefore contribute to the higher prevalence of diabetes and its complications among these populations.

WHO HAS DIABETES?
Of those aged 20 years or older, data adjusted by population age finds:

- 6.6 percent of non-Hispanic whites have diabetes
- 7.5 percent of Asian Americans and Pacific Islanders have diabetes
- 10.4 percent of Hispanics have diabetes (12.6 percent of Puerto Ricans have diabetes, 11.9 percent of Mexican Americans have diabetes)
- 11.8 percent of African-Americans have diabetes
- 16.5 percent of American Indians and Alaska Natives have diabetes, though rates are higher in some tribes. Native Americans have the highest diabetes prevalence rates in the world.

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WHO PROVIDES COVERAGE FOR THEIR HEALTH CARE?
Of the U.S. population, those with diabetes (both diagnosed and undiagnosed) represent:

- 5.9 percent of those with private insurance
- 13 percent of those with government insurance (including Medicaid and Medicare)
- 5.4 percent of the uninsured

WHO ARE THE UNINSURED?
Members of racial and ethnic groups likewise make up a disproportionate share of the non-elderly uninsured population.

- 22.8 percent of African-Americans are uninsured.
- 35.7 percent of Hispanics are uninsured.
- 12.6 percent of non-Hispanic whites are uninsured.

Compared to insured adults, uninsured adults with diabetes are less likely to receive the proper standard of care, including regular glucose monitoring and preventive check-ups for their eyes and feet. This can lead to a greater risk of hospitalization and an increased risk of chronic disease and disability.

Poverty is a major factor in access to health care. Families earning less than $10,000 per year make up the greatest percentage of the uninsured (35.7 percent), compared to just 7.1 percent of those who earn more than $75,000 per year.

Poverty rates in the United States are:

- 25.9 percent for American Indians
- 22.1 percent for African-Americans
- 21.2 percent for Hispanics
- 7.5 percent for non-Hispanic whites
### American Indians and Alaska Natives

American Indians and Alaska Natives have among the highest poverty rates of all ethnic groups in the United States, earning about half of what the average American earns. Poverty rates are highest on Indian reservations, where substandard housing also contributes to poor health outcomes.  

The Indian Health Service (IHS) provides health care services to those eligible American Indians and Alaska Natives from federally recognized tribes, however, American Indians and Alaska Natives still suffer with diabetes at rates higher than most other Americans.

- Native Americans are 420 percent more likely to die from diabetes-related causes than other Americans.
- It is estimated that 30 percent of American Indians and Alaska Natives have pre-diabetes.
- American Indians and Alaska Natives have a death rate due to diabetes that is three times higher than the general U.S. population (2004).
- There was a 68 percent increase in diabetes from 1994 to 2004 in American Indian and Alaska Native youth aged 15-19 years.
- American Indians and Alaska Natives have a rate of diabetes-related kidney failure that is 3.5 times higher than the general U.S. population (2004).

### African-Americans

Many studies have shown that a gap exists between the tests recommended for proper management of diabetes — such as the hemoglobin A1C (a measure of blood glucose levels over time) — and the care patients actually receive. These gaps are greater among African-Americans than they are among non-Hispanic whites.

- Some studies find African-Americans in private managed care settings and those on Medicaid are less likely than non-Hispanic whites to receive annual A1C tests or eye screenings.
- A 2003 study found African-Americans in Veterans Affairs facilities were less likely than non-Hispanic whites to have a cholesterol check in the past two years, and had poorer control of cholesterol and blood pressure. Once detected, however, poor control was treated equally as intensively as it was for non-Hispanic white patients.
- A 2008 study by the National Kidney Foundation showed that diabetes-related end-stage renal disease among African-Americans increased in the 1990s and is now decreasing, although not significantly in the 2000s.

### Hispanics/Latinos

- Hispanics/Latinos have more complications and worse outcomes from diabetes-related complications than non-Hispanic whites.
- A 2007 nationwide study found Hispanics/Latinos with previously diagnosed diabetes were less likely than non-Hispanic whites to have a regular health care provider. They were also less likely to have had their A1C checked in the past year, or to have had a foot exam — even after controlling for access to care.
- Hispanics/Latinos previously diagnosed with diabetes but lacking a usual health care provider are less likely to self-monitor blood glucose levels on a regular basis, an important indicator of how well their diabetes is being controlled and a major predictor of developing complications.
- A 2007 national study of women with a history of gestational diabetes (a predictor of type 2 diabetes) found Hispanic/Latina women were substantially less likely than non-Hispanic white women with this history to have health insurance or access to a primary care physician.
Compared to insured adults, uninsured adults with diabetes are less likely to receive the proper standard of care, including regular glucose monitoring and preventive check-ups for their eyes and feet. This can lead to a greater risk of hospitalization and an increased risk of chronic disease and disability.