

Why Do Some Children Have Access to Technological Innovations in Diabetes Care and Others Do Not?

July 27, 2021

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After months of classic diabetes symptoms – a hunger that could never be satisfied, an unappeasable thirst, my initial response to my 10-year-old daughter’s diagnosis of Type 1 diabetes (T1D) was, “So, she’ll take insulin.” Life would go on. Lucky for us that genetically modified bacteria were producing standardized insulin, and glycemic testing could be accomplished with a simple finger stick. But even luckier than getting diagnosed in the 21st century was our access to care: we had private insurance

through my job. A multidisciplinary team of experts was available to us: endocrinologists, ophthalmologists, dietitians, diabetes educators with a direct line to a team of psychiatrists, psychologists, and clinical social workers. These teams were up to date. Soon my daughter’s blood sugars were being captured in real time by a continuous glucose monitor and insulin was being delivered 24 hours a day/7 days a week via a Bluetooth® controlled pump. Teenage angst amplified by diabetes? Caregiver and working mother overwhelmed by the realities of caring for a child with a chronic disease? The psychosocial care team was “on it.”

In this issue of *Pediatrics*, Sherr et al study ([10.1542/peds.2020-048942](#)) trajectories of glycemic control (as HbA1C) in three cohorts of T1D children over a 10 year-long period – cohorts of subjects residing in high income countries such as the United States, Australia, and Germany. This article shows that even in countries with a national health insurance program, ethnic minorities still comprise an outsized proportion of children with deteriorating HbA1c patterns. This health disparity might be due in part to implicit bias by physicians and substandard care, e.g. lack of prescriptions for long-acting insulin in those being treated via insulin injections or inadequate advice around the frequency of glucose testing via fingerstick. These shortcomings can and should be addressed through provider education. However, as the accompanying commentary by Hawkes et al states ([10.1542/peds.2021-050333](#)), it is important to address systemic racism in the provision of care. No amount of provider training can counter insurance plans that cover neither

continuous glucose monitors nor insulin pumps, or create what may seem to families unattainable conditions for approval..^{1,2} And ethnic minorities are often covered by such insurance plans, if they have insurance at all. Without societal pressures to expand insurance to cover these highly effective technologies, provider-level interventions to reduce implicit bias and increase medical competency may be inconsequential for those when it comes to improving health outcomes for those who are underrepresented and underserved by the current health care system..

References:

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2. <https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity>.

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