

### 3. Current Barriers

An underlying feature of diabetes services in New Zealand is the poor availability of services and access. This section briefly describes some of the main barriers to access. Section 7 further discusses each of the available services and, by relating them to typical cases, shows how the appropriateness and accessibility of services compare (generally unfavourably) with international practice. The barriers include:

- Cost of personal items
- Location of services
- Language barriers
- Inadequate health education

It is because of these barriers to access not seen in the UK, Scandinavia or Canada that there is likely to be a large number of people with undiagnosed diabetes and IGT in the population who are not receiving treatments which may delay complications.

#### 3.1 Personal Costs of Items Required to Manage Diabetes

While there are many barriers for people with diabetes using the services that are available, the cost of professional services is clearly a significant barrier. The nature of diabetes is such that even the healthiest people with diabetes will incur direct personal costs at some stage. These costs can include setting aside enough time for daily medical interventions such as insulin injections, tablets and other related private personal costs such the purchase of, for example, monitoring equipment and eye glasses.

A member of Diabetes New Zealand compiled a list of the type of items needed and the actual costs incurred. The table on the next page illustrates the financial burden on many people with diabetes, and it also shows that many are not purchasing some of the services they need to manage their diabetes because of cost.

These costs will increase significantly for those people who do not have a High User Card (HUC) or a Community Services Card (CSC). Many people with diabetes do not follow recommended care because of these high personal costs.

While individually, the personal items each may seem insignificant, in aggregate they represent a large proportion of a low-income earner's disposable income. For example, they represent more than 5% of the disposable income of someone on the average wage. Further, it may be difficult for a low-income person to feel these costs should take priority compared to other necessities for low-income earners such as housing, food<sup>57</sup> and their children's education.

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<sup>57</sup> Parnell W, Reid J, Wilson N, 2001.

Table 8: Personal Items for People with Diabetes

| Item  | Cost per year with HUHC and CSC | Remarks  |
|---|---------------------------------|--|
| Membership to Diabetes NZ                                     | \$20                            | For Diabetes Supply Scheme                                       |
| Medic Alert   | \$20                            | To avoid mistreatment  |
| Visit to doctor x 4   | \$100                           | For prescription renewals and diabetes related problems          |
| Lancets   | \$0                             | Blood Glucose management. Free from Diabetes Supply Scheme       |
| Testing Strips ( supply scheme otherwise up to \$17 per week) | \$0                             | Blood Glucose management. Free from Diabetes Supply Scheme       |
| Blood glucose meter   | \$0                             | Blood Glucose management   |
| Leather shoes x 2   | \$200                           | Soft leather shoes may help to reduce foot ulcers and discomfort |
| Natural fibre socks x 3                                       | \$20                            | Same as above  |
| Batteries for meters x 2                                      | \$10                            |  |
| Healthier food (based on \$20 per week)                       | \$1,040                         | Lower fat foods, more fresh fruit and vegetables <sup>(a)</sup>  |
| <i>Common Extras</i>  |                                 |  |
| Glasses   | \$300                           | Eye sight problems develop                                       |
| Dressings   | \$10                            | For foot abrasions   |
| <b>Total</b>  | <b>\$1,600</b>                  |  |

(a) Some dietitians put together budgets which show cost savings

Source: Based on the opinion of a single member of Diabetes New Zealand – this is similar to costs quoted in the USA for personal non medical items of US\$1000 for people with diabetes.

### 3.2 Location

As outlined in Section 7 in this report, there are a number of inadequacies in the location of services for diabetes related treatments. Amongst the most alarming examples of the extent of inaccessibility is for eye screening. Poor access to eye screening is a cause of high transport costs for people with diabetes. It is totally unacceptable that some regional areas of New Zealand have no access to a mobile eye screening camera which may prevent loss of visual activity by regular two-yearly photography and early intervention where required.

The second issue with location is that if patients are required to travel significant distances, this imposes an additional cost and organisational barrier on them<sup>58</sup>. In a

<sup>58</sup> Simmons D, Kenealy T, Scott D, 2000.

barriers to care survey<sup>59</sup> undertaken in the North Shore region, transportation issues were frequently documented as the reasons for not attending appointments. Of the people surveyed, the people that had the most difficulty are those without cars, those who are disabled or those who rely on public transport. This represents a large proportion of families in low socio-economic areas.

A third factor may be the location of health services in relation to the places where people work. There are limits to the likelihood of workers who mainly work from 9am to 6pm being able to get time off work to attend GP and specialist visits<sup>60</sup>. The majority of practitioners operate during normal working hours. This can impose a significant barrier on people who are unable to obtain leave from workplaces.

### 3.3 Language Barriers

Language as a barrier to quality health care cannot be over-estimated. Given the projected increase in Pacific Island people expected to be diagnosed, the current Ministry of Health/HFA diabetes strategy is failing to deliver services that are understandable to ethnic minorities. Under the funding system for GPs with Community Services Cards, there is some funding provided for language services for Pacific Islanders in rural Health Centres. Language barriers for patients are a significant reason why ethnic minority groups are unlikely to attend GP and specialist visits and why education levels about their condition are so low<sup>61</sup>. There is a need for more Pacific Island health workers/nurses. It is best for people to be educated by their own people because of deep seated cultural beliefs which may pose barriers to acceptance and understanding.

### 3.4 Waiting Lists

The barriers to care survey indicated that the waiting lists were a significant reason for not attending appointments<sup>61</sup>. Many respondents to the survey were shocked at the delay in getting to see a specialist practitioner at the diabetes clinics. Reducing this delay is very important especially given that many patients when first diagnosed do not have physical complications. This, coupled with lack of education about diabetes means that they are likely to not make the best choices about lifestyle. There is also strong evidence that long-term outcomes are related to good education from the time of diagnosis.

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<sup>59</sup> Survey undertaken by Sue Pearson, 2000.

<sup>60</sup> Personal experience D W Beaven and L Tuula – who ran a Pacific Island dedicated clinic for 2 years 1993-95.

<sup>61</sup> Survey undertaken by Sue Pearson, 2000.

### 3.5 Education

The greatest barrier indicated in the survey<sup>62</sup> is the lack of appropriate health education of the person with diabetes. Many people with diabetes indicated that they had not been told about the complications of diabetes and that many GPs and nurses had not been able to tell them where to get information about diabetes. More alarming, many patients admitted that they did not understand why their blood sugar levels went up and down.

There is a wealth of good material from international studies over 20 years to show that 20 hours or more of diabetes education is needed in the first year of diagnosis. This is important to supplement other management and pharmaceutical strategies when they are being implemented if they are expected to show measurable outcomes later. This evidence from the 1980s is now accepted by US Health agencies and both Blue Cross and Blue Shield, who pay for such education, if it is provided by accredited diabetic nurse educators.

### 3.6 Conclusion

There are many barriers to diabetes services. These barriers are restricted access to services that would otherwise delay complications, especially for undiagnosed diabetes and also for IGT. The lack to access to early intervention means that there is less opportunity to improve lifestyles and to delay complications of diabetes.

Key barriers to access are lack of skilled services in many regions and lack of strategic planning for workforce (see especially Section 8.2 Nature of Current Service Provision).

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<sup>62</sup> Survey undertaken by Sue Pearson, 2000.