

A comparative study of how the healthcare systems of the United States and the United Kingdom shape type I diabetes outcomes

By Kareena Gunawardana

AUTHOR BIO

Kareena Gunawardana was diagnosed with type 1 diabetes at age 12, a pivotal moment that shaped her passion for healthcare advocacy and reform. Residing in San Francisco, she actively participates in local health campaigns and collaborates with organizations like Breakthrough T1D and the American Diabetes Association to influence diabetes legislation and policy. Through her work on this paper, Kareena seeks to highlight the disparities in diabetes management within the healthcare systems of the U.S. and U.K., driven by her firsthand experiences and her involvement in advocacy. Her aim is to spur reforms that ensure equitable and effective healthcare for all individuals living with diabetes.

ABSTRACT

This comparative analysis explores the management of type 1 diabetes within the healthcare systems of the United States and the United Kingdom, highlighting the challenges faced by individuals in both countries despite their differing healthcare models. The United States employs a privatized, insurance-based system, while the United Kingdom operates under a government-funded National Health Service (NHS). This paper examines the accessibility of care, management of Hemoglobin A1C levels, and the disparities faced by ethnic and socioeconomic groups in both countries. Despite the contrasting healthcare structures, both nations exhibit similar negative outcomes in type 1 diabetes management, with significant inequalities affecting poorer communities and minority groups. These groups tend to have higher average HbA1C levels and less access to essential diabetes care, exacerbated by systemic issues such as insurance coverage gaps in the U.S. and long wait times and decentralized funding in the U.K. The findings underscore the need for systemic reforms to provide equitable access and effective diabetes management for all individuals.

Keywords: *type 1 diabetes, health, healthcare, United States, United Kingdom, hemoglobin A1C, disparities, insurance, accessibility, socioeconomic, chronic disease, comparative systems*

INTRODUCTION

This comparative paper explores the effectiveness of healthcare systems for the treatment of type 1 diabetes in two developed countries with contrasting healthcare models: the United States (U.S.) and the United Kingdom (U.K.). type 1 diabetes is a chronic autoimmune disease that causes the cessation of insulin production by the pancreas. Because type 1 diabetes often develops at a young age, those diagnosed must manage the condition for most of their lives (Desmond et al., 2024). Continuous access to medical care and insulin is essential, as blood glucose levels can fluctuate dangerously at any time. Without proper management, extremely high blood sugar levels can lead to serious complications, including blindness, amputations, and even death (Beyond type 1 Editorial Team, 2018).

The U.S. and U.K. differ significantly in their approach to healthcare—the U.S. with its privatized, insurance-based system and the U.K. with its government-funded National Health Service (NHS) and private care as an alternative. This paper looks at the quality of care provided, the accessibility of treatments and supplies, and the overall management of Hemoglobin A1C (HbA1C) levels. HbA1C measures the percentage of hemoglobin in a patient's blood that is coated with glucose, a crucial indicator of long-term glycemic control in type 1 diabetes patients. This paper finds that while the U.S. and U.K. have vastly different approaches to healthcare, both nations end up with similar negative outcomes in terms of successful type 1 diabetes management: Although all ethnic and socioeconomic groups are diagnosed with type 1 diabetes at relatively the same rate as each other, poorer groups and minority communities tend to have higher average HbA1C levels and less access to diabetes care in both countries (*National Diabetes*, 2024). In the U.S., a smaller percentage of these groups are insured compared to the national average (Keisler-Starkey et al., 2023).

This paper first explores diabetes care in the United States, outlining how the healthcare system operates and how a person's social standing can influence their treatment. Next, it examines the healthcare system in the U.K., highlighting the challenges brought about by its decentralization and how individuals navigate these issues through the use of private healthcare. Finally, the paper compares the health outcomes of both systems, initially looking at overall trends and then focusing on how factors like race and economic status affect the quality of care.

AMERICAN HEALTHCARE SYSTEM EXPLAINED

Access to and structure of healthcare in the U.S.

The United States is one of the few developed nations without a universal healthcare system, relying instead on a complex network of private insurers, employer-sponsored plans, and government programs. This absence of a nationwide system has sparked ongoing debate, with some viewing healthcare as a fundamental human right and others seeing it as a service best provided through private markets. Some Americans appreciate the current system's flexibility and emphasis on individual choice, which aligns with broader cultural values of personal responsibility and limited government intervention.

How people access healthcare in the U.S. varies widely depending on age, income, and location; however, the most common ways healthcare is accessed are through employer-provided insurance, Medicaid for low-income individuals and families, Medicare for those over 65, or individual marketplaces established by the Affordable Care Act (ACA). As of 2022, 54.5% of the American population relied on employment-based insurance, 18.8% relied on Medicaid, 18.7% utilized Medicare, and 9.9% purchased coverage directly from insurance marketplaces. Additionally, the ACA, signed into law on March 23, 2010, has largely improved the standard of medical care through the establishment of the Ten Essential Benefits and the Prohibition of Discrimination Based on Pre-existing Conditions and improved accessibility to medical care through Medicaid expansions (Keisler-Starkey et al., 2023). First, this section discusses what parts of health care insurance must cover in the U.S. Then, it explains each part of the American healthcare system respectively, with a focus on access to type 1 diabetic care.

Coverage of insurance (ten essential benefits and prohibition of discrimination based on pre-existing conditions)

The ACA has set federal requirements for basic insurance coverage that apply to all types of insurance. The ten essential benefits and prohibition of denial of insurance based on pre-existing conditions are most applicable to type 1 diabetes care. The ten essential benefits are mandatory benefits that all approved health plans must provide. They include laboratory services, emergency services, prescription drugs, mental health and substance abuse services, maternity and newborn care, pediatric services, rehabilitative services and devices, ambulatory services, hospitalization, and preventative and wellness services (*Information on Essential*, 2025). While all can be helpful in some cases, the benefits that pertain most to type 1 diabetes are prescription drugs and preventative and wellness services. Unfortunately, this portion of the ACA does not mandate coverage of diabetes monitoring devices such as Continuous Glucose Monitors (CGMs) or insulin pumps, but most states mandate coverage of diabetes devices. The ACA does, on the other hand, mandate that insulin be covered as a prescription drug, a provision that before the ACA was not guaranteed and dependent on the specific plan and insurer (Vaida, 2024).

Whether insulin costs for people with diabetes have a cap is decided on a state-by-state basis unassociated with the ACA and, therefore, is usually restricted to state-regulated plans. Leading this initiative, Colorado set a precedent by capping insulin copayments at \$100.00 per month for all diabetics, a measure that has since been adopted by 25 states and the District of Columbia. However, this leaves residents in approximately half of the states without such caps on insulin prices (*State Insulin*, 2023).

Additionally, the ACA prohibits insurance providers from denying coverage or charging larger premiums based on pre-existing conditions (Ortaliza & Cox, 2024). This is especially beneficial for people with type 1 diabetes, as the most common ages of diagnosis are in childhood, between ages 4 and 7 and 10 and 14 (Mayo Clinic Staff, 2024). Consequently, many individuals have a pre-existing condition well before they are able to obtain a healthcare plan and, prior to ACA reforms, were charged

an exorbitant amount due to their ongoing conditions and consistent dependence on insulin. This reform has been significant in ensuring fair access to healthcare for type 1 diabetics.

Employer-provided insurance

The most common way people access healthcare in the U.S. is through employer-provided insurance. Employer-provided insurance can be traced back to World War 2 when companies wanted to attract workers but could not raise wages as they were frozen. To quell this issue, they began offering benefits—healthcare being one of them. Additionally, employer contributions toward health insurance are exempt from taxes, making it an economically beneficial choice for both employers and employees (Claxton et al., 2024).

Employer-provided insurance isn't free; employers typically deduct a portion from employees' paychecks to cover part of the health insurance premiums. With the lowest coverage employer-provided plans, the ACA mandates that employees pay less than 9.1% of their family's income. This percentage can vary depending on the plan's coverage level (*Employer-Sponsored Health*, 2024). Most insurance plans are often categorized into tiers such as platinum, gold, silver, and bronze. Platinum plans, offering the most comprehensive coverage, may have higher premiums but potentially lower out-of-pocket costs for medical services, while bronze plans usually have the lowest premiums but higher costs when care is needed (*Health Plan*, n.d.). No matter which plan is chosen, employer-provided insurance is usually a better option than individually bought plans, as the employer covers a percentage of the premiums (*KFF* 2023, 2023).

Under the ACA, employers are mandated to offer insurance that comprehensively covers essential health benefits and provides adequate coverage for their employees. Employers are taxed if they do not provide minimum essential coverage (10 essential benefits) to 95.0% of their full-time employees and their dependent children and are punished if the coverage they offer does not provide minimum value (60.0% or bronze level coverage) (*Employer Shared*, 2025). Additionally, employers can be charged a penalty for each employee enrolling in subsidized Marketplace coverage (*Employer Mandate*, 2025). As of March 2023, 80.8% of workers work for an employer that offers employer insurance, and 75.3% of workers are eligible for insurance at their jobs. However, these numbers drop when looking at lower-income workers making less than 200.0% of the Federal Poverty Level, with only 60.6% of employers offering insurance and only 49.50% eligible. Overall, almost everyone who has access to employer-provided insurance opts for it (74.4%). The remaining workers are either dependent on someone else's employer-sponsored insurance (14.6%), enrolled in some type of public insurance (4.6%), or remain uninsured (3.7%) (Claxton et al., 2024).

Medicaid and Medicaid expansions

Medicaid is a public program that provides health coverage for low-income workers. Many low-income workers, who may work a similar number of hours per week as high-income workers, often do so through multiple part-time jobs rather than a single full-time job (Glynn, 2018). In this situation,

and for many low-income workers in general, employer-provided healthcare is not an option or provides minimal coverage. In instances like these, Medicaid is something that people opt for. With Medicaid expansions, if a person makes less than 138.0% of the Federal Poverty Level (\$20,783 in 2024), they can qualify for Medicaid (Harker & Sharer, 2024).

Medicaid eligibility was broadened to include all adults within the specified income range through these expansions, ensuring that more people could receive health coverage under the program. Previously, only adults with dependents qualified, leaving over 55.0% of Americans with incomes low enough to be eligible for Medicaid without access to it, 31.0% of whom were single adults (Williamson et al., 2016). However, Medicaid expansions are enacted on a state-by-state basis. So far, 41 states, including the District of Columbia, have adopted these expansions, while 10 have not, with most deniers being southern states (Harker & Sharer, 2024). States without Medicaid expansions have stricter eligibility requirements, resulting in a larger coverage gap. In these states, 30.0% of low-income workers are unable to qualify for Medicaid but also cannot afford to buy healthcare, compared to 22.0% in states with Medicaid expansion. This leaves an additional 8.0% of people in non-expansion states without access to necessary health coverage (Williamson et al., 2016).

Insurance marketplaces

To increase accessibility to healthcare plans, especially for those who do fall into a coverage gap, the ACA created nationwide health insurance marketplaces and subsidies. Anyone can shop for and compare different health insurance plans and find one that fits their needs. Participants can choose from the various plan levels—bronze, silver, gold, and platinum—depending on specific healthcare needs and ability to pay (*Health Plan*, n.d.). Because people who shop for healthcare this way are often lower income, the ACA provides subsidies designed to make this form of healthcare affordable. There are two main types of subsidies, the first being premium tax credits and the second being cost-sharing reductions. Premium tax credits help lower the cost of premiums for plans paid through the marketplace, with qualification and amount dependent on income relative to the Federal Poverty Line. Cost-sharing reductions help reduce out-of-pocket costs such as deductibles and copayments; however, individuals must enroll in Silver plans to access them (*Saving Money*, n.d.).

Medicare

As people age and leave the workforce, they can no longer access the employer-sponsored healthcare that most working Americans rely on. Once they reach the age of 65, they can access Medicare, another government-sponsored insurance program. Medicare is also available, though much less commonly, to certain younger adults with long-term disabilities. As of 2022, 98.9% of adults over 65 access Medicare (Lindstorm et al., 2024).

Medicare is structured into four main parts: Part A, Part B, Part C, and Part D. Part A provides hospital insurance, covering inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care. Part B offers medical insurance for outpatient services, doctor visits, preventive care,

and durable medical equipment. Part C (Medicare Advantage) is an alternative provided by private insurers that combines Parts A and B, often including Part D, and may offer extra benefits like vision, dental, and hearing coverage. Part D is prescription drug coverage, helping lower medication costs.

Beneficiaries can choose between Original Medicare (Parts A and B) and Medicare Advantage (Part C). Those with Original Medicare can purchase a Medigap (Medicare Supplement Insurance) policy from private insurers to help cover additional costs like copayments, coinsurance, and deductibles, but they must enroll in Part D separately for prescription coverage. Medicare Advantage plans (Part C) bundle Parts A, B, and usually D into a single plan, providing additional benefits but potentially restricting provider networks (Ochieng et al., 2024; Freed et al., n.d.).

Cost considerations play a key role in plan selection. Part A is usually premium-free for those who have paid Medicare taxes for at least 10 years; otherwise, monthly premiums in 2025 are \$285 or \$518 based on work history. The inpatient hospital deductible is projected to be \$1,676 per benefit period in 2025. Part B has a standard monthly premium of \$185 in 2025 (higher-income beneficiaries pay more) and an annual deductible of \$257. Part C (Medicare Advantage) costs vary by plan, but enrollees must continue paying the Part B premium, and some plans may charge an additional premium. Part D costs depend on the selected plan, with an average monthly premium estimated at \$45 in 2025 and a standard deductible projected at \$590 (Schwarz, 2024). As of 2025, Part D out-of-pocket costs are capped at \$2,000 annually, ensuring better financial protection for beneficiaries. These cost structures provide flexibility for individuals to choose coverage based on their healthcare needs and financial situation (*Medicare & You 2025*, 2025).

THE BRITISH NATIONAL HEALTHCARE SERVICE (NHS) EXPLAINED

Accessing healthcare in the U.K.

The healthcare system in the United Kingdom is relatively simple when compared to the system in the United States. The two main types of healthcare are public and private. Everyone born in the United Kingdom is assigned a unique National Health Service (NHS) number at birth, which they can use to access universal and free healthcare funded and managed by the government. However, if they choose, citizens can opt for private healthcare. As of 2022, 22.0% of British people had used some form of private healthcare.

Structure of healthcare system

The NHS consists of independent facilities, including hospitals and specialized clinics, which work together under Integrated Care Systems (ICSs) to deliver coordinated and comprehensive healthcare. Originally, in 1948, the NHS was designed for a population with a shorter life expectancy and predominantly acute conditions. However, as life expectancy has increased and the need for ongoing, complex care has grown, ICSs have been put in place. ICSs combine all aspects of health in specific areas and have relevant partners (Integrated care partnerships) and boards (Integrated care

boards) to oversee health goals for communities. By adopting a multi-faceted and connected approach to health management, ICSs enable the NHS to more effectively manage long-term conditions like type 1 diabetes, which require a comprehensive care strategy encompassing primary physician care, technology utilization, lifestyle and dietary management, and psychological support for living with a chronic illness. However, the system and funding are decentralized to allow for more local power and decision-making, meaning specific facilities may benefit more than others (*The Journey*, 2023).

Alternatively, a private healthcare option does exist, though it is much less popular. Private healthcare is typically run by commercial companies but can also be managed by non-profit organizations. Some of the biggest names are Circle Health, HCA Healthcare, and Nuffield Health. Private healthcare has positive and negative aspects. For example, patients can choose to be treated whenever and wherever they like; however, they are responsible for all fees. Because there is already a universal healthcare system in place, the NHS does not subsidize any private healthcare costs (*What Is Private*, n.d.).

NHS healthcare coverage

The NHS covers all aspects of healthcare, including emergency visits, surgeries, preventative measures, ambulance services, and ongoing treatments, free of charge. All medications associated with hospital visits are also provided at no cost. Prescription medicine and diabetic devices are either subsidized or free. Individuals living with diabetes are guaranteed free insulin to manage their blood glucose levels without incurring any costs.

Satisfaction with NHS

While medical care through the NHS is free compared to the more costly U.S. system, overall public satisfaction with the NHS is low. Issues like workforce shortages, lack of budget, and the COVID-19 pandemic have led to dissatisfaction with waiting times for General Practice and hospital appointments and the widespread view that the government doesn't spend enough money on the NHS. As of November 2022, a survey conducted by The Health Foundation found that only a third (33.0%) of people think the NHS provides good service nationally, a stark drop from 43.0% in May 2022 and 44.0% in November 2021 (Buzelli et al., 2023). A survey conducted by The Kings Fund in 2022 found that dissatisfaction spanned across all ages, income groups, sexes, and political affiliations. The survey revealed significant dissatisfaction with social care services, which are relevant to type 1 diabetes care. These services are designed to support individuals affected by age, disability, or other challenging circumstances. A shocking 14.0% of individuals said they were satisfied with social care in 2022, with dissatisfaction hitting 57.0% (Morris et al., 2023).

Use of private healthcare

Due to the dissatisfaction with accessing healthcare services mentioned above, many British people have shifted to private healthcare (Clayton, 2023). In 2022, the number of adults opting for some

type of private health insurance increased to 22.0%, nearly doubling from 12.0% in 2019 (Fleck, 2023). Of that 22%, 46.0% report switching because they couldn't secure NHS appointments quickly enough, and 24.0% find it easier to schedule appointments with private healthcare providers. In addition, 63.0% of people would consider using private healthcare if they needed specialized treatment in the future. In contrast to the NHS, satisfaction with private healthcare is high. Out of those who have utilized it, 73.0% feel positively. It's important to note that access to private healthcare is more common among wealthier individuals. Around 51.0% of individuals in the upper middle class (social grades A and B) have utilized private healthcare services, in contrast to about 33.0% of the lower middle class (C1), 26.0% of the skilled working class (C2), and 19.0% of the working class and those at the lowest economic levels (D and E) (*Going Private*, 2023).

COMPARING THE U.S. AND U.K. HEALTHCARE SYSTEMS

Though the U.S. and the U.K. have very different systems, the outcomes of successful type 1 diabetes management remain similar. This section explores these outcomes by analyzing how lack of access to insurance in the U.S. contributes to inadequate management of type 1 diabetes and by examining how systemic issues within the NHS disproportionately affect lower-income regions in the U.K., making it more difficult for these communities to manage blood glucose levels. Specifically, in the U.S., lower-income communities (which tend to be predominantly minority ethnic groups) are more likely to be uninsured, leading to poorer management of diabetes. On the other hand, in the U.K., minorities are more likely to live in deprived areas, resulting in reduced access to necessary care. In both contexts, poorer communities and people of color experience more negative outcomes, while whiter and richer areas receive better care.

DISPARITIES IN INSURANCE COVERAGE AND TYPE 1 DIABETES MANAGEMENT ACROSS RACIAL AND ETHNIC GROUPS

Out of the 9.3% of the American population who are living with diabetes, 5.0% (or 1.45 million) of them have type 1 diabetes (Beyond type 1 Editorial Team, 2018; *About Diabetes*, 2012). Under the U.S. healthcare system, less than a third (33.0%) of these individuals consistently meet their target blood glucose level. As discussed below, this lack of success does not impact every community equally.

Racially disproportionate lack of insurance

The inability to receive health insurance disproportionately impacts minority communities, which in turn impacts their ability to successfully manage their type 1 diabetes. As of 2022, non-elderly American Indian and Hispanic populations had the highest uninsured rates at 19.1% and 18.0%, respectively. Nonelderly Native Hawaiians and Other Pacific Islanders also faced higher uninsured rates at 12.7%, followed by Black populations at 10.0%. In contrast, the uninsured rate for their white counterparts stood at 6.6% (Hill et al., 2025).

Insurance's impact on type 1 diabetes management

Lack of insurance is directly related to the ability to achieve goal HbA1c levels. Data from the Affordable Care Act's implementation shows that newly insured patients experienced an improvement in HbA1c levels from 8.24% to 8.17% (with most type 1 diabetics' goal being 7.0%). This contrasts with uninsured patients, who saw increased HbA1c levels (8.12% to 8.29%) over the period studied. This clearly demonstrates the importance of continuous health insurance coverage for consistent diabetes management and healthy HbA1c levels (Marino et al., n.d.).

Furthermore, an American Diabetes Association study analyzing data from 12,035 adults with type 1 diabetes that showed how different factors influence the achievement of optimal HbA1C levels, it was discovered that in addition to the fact that only 23.0% of participants could maintain an A1C below 7.0%, the utilization of advanced management technologies like Continuous Glucose Monitors (CGM) and insulin pumps, coupled with private health insurance, significantly enhanced diabetes control, with odds ratios of 1.28 and 1.47 respectively. Conversely, the study showed that different races struggled in diabetes management comparatively: non-Hispanic Black and Hispanic individuals, who were less likely to be insured and have access to this diabetes technology than other participants, had significantly more difficulty achieving these health targets, with markedly lower odds ratios of 0.46 and 0.52, respectively (Akturk et al., n.d.).

Effectively, type 1 diabetes management through the United States healthcare system is closely linked to one's ability to access insurance. For Black and Hispanic individuals, who are disproportionately more likely to be uninsured, managing blood glucose and maintaining a healthy A1C can be significantly more challenging.

CHALLENGES TO NHS HEALTHCARE ACCESS AND DIABETES MANAGEMENT AMONG RACIAL AND SOCIOECONOMIC GROUPS

In the United Kingdom, around 6.0% of the population lives with diabetes, with 8.0% of that, or roughly 321,600 people, having type 1 diabetes. Similar to the U.S., from 2021 to 2022, just 32.6% of those achieved their target HbA1c levels (*National Diabetes*, 2023). Like the U.S., the failure to maintain healthy HbA1c levels disproportionately affects people of lower income and, therefore, minority groups.

Racially disproportionate lack of quality care and quality care's impact on type 1 diabetes management

In contrast to the United States, everyone can access public health care. Therefore, the point of interest lies in the success of the system itself. As stated earlier, public satisfaction with the NHS is low, mainly due to long wait times and the inability to secure appointments. This is critical when thinking about successful diabetic care as consistent and easy access to tools and technology is a key tool for managing blood glucose— The National Diabetes Audit 2021-22 shows that the ability to control HbA1c successfully has a strong correlation with access to diabetes supplies, specifically diabetes technology such as pumps and glucose monitors. While 50.4% of the total type 1 diabetic population

wears glucose monitoring devices, white individuals are more likely to utilize these technologies, with 12.1% using insulin pumps and 52.0% using wearable glucose monitors. This contrasts sharply with Black individuals, where only 4.3% use insulin pumps and 33.4% use wearable monitors, highlighting significant racial disparities in healthcare access (*National Diabetes*, 2023).

The difference in access to these medical devices is not a coincidence. To access and know how to use diabetic technology, diabetics must have regular and accessible appointments. The NHS has made this difficult, especially for people living in poorer areas. Experts at the Health Foundation have estimated that general practitioners in poorer areas of the United Kingdom receive approximately 7.0% less money per patient than those in wealthier areas of the country. In a system that is very decentralized, where diabetics live and how funded nearby medical care centers are is essential. Minorities are much more likely than their white counterparts to reside in the most health-deprived 10.0% of neighborhoods in the U.K. Specifically, 16.0% of the Pakistani population, 12.3% of the Arab population, 10.7% of the Chinese population, and 10.6% of the Black African population live in these areas compared to just 8% of the white population (*People Living*, 2020; Jivraj & Khan, 2013).

Though a different and theoretically more fair system, there is still a strong relationship between race and access to healthcare. Deprived neighborhoods are more likely to house people of color, which leads them to have worse quality healthcare and, in turn, worse control of their type 1 diabetes.

CONCLUSION

Ultimately, the U.S. and U.K. fall at equal levels of overall successful diabetes management of about 33.0%. Both systems lead to inequality in diabetes care access, with the lower income and minority groups in each country receiving lower quality care and having lower success rates in their diabetes management.

In the U.S., the absence of universal healthcare leads to varied access dependent on insurance type, with employer-provided insurance, Medicaid with Medicaid expansions, and Medicare being the main sources of coverage. Protections from the ACA, including prohibiting discrimination based on pre-existing conditions and mandatory essential benefits, have improved access to insulin and other diabetes-related care. However, many low-income and minority individuals remain uninsured, limiting their access to essential diabetes technologies like Continuous Glucose Monitors and insulin pumps. This disparity contributes to poor glycemic control, which disproportionately affects lower-income and minority racial and ethnic groups.

In the U.K., the NHS provides universal healthcare, offering free access to insulin and diabetic treatments. Despite the theoretical equity of this system, decentralized funding and systemic inefficiencies, such as long wait times and staffing shortages, disproportionately impact low-income and minority populations. Residents of more deprived areas—where minorities are overrepresented—face reduced access to advanced medical technologies, hindering effective diabetes management. Ultimately,

in both the U.S. and U.K. healthcare systems, lower-income individuals and minorities face disproportionately worse outcomes in managing type 1 diabetes.

Addressing these disparities demands a multi-pronged approach. For the U.S., enhancing policies to fully implement Medicaid expansion and bolstering ACA provisions could mitigate some disparities. For the U.K., increasing funding for the NHS and streamlining services through improved infrastructure could alleviate pressure on the system. Both countries can also benefit from investing in community health programs that offer localized support and education, utilizing telemedicine to expand access to specialist care, and prioritizing research into the social determinants of health that influence diabetes outcomes. These measures would not only reduce healthcare inequalities but also improve overall management of type 1 diabetes, ensuring that all individuals, regardless of background or income, have the resources they need to manage their health effectively.

REFERENCES

About Diabetes. (2012). U.S. House of Representatives Diabetes Caucus.
<https://diabetescaucus-degette.house.gov/facts-and-figures>

Akturk, H. K., Rompicherla, S., Rioles, N., Desimone, M., Weinstock, R. S., Haw, S. J., Ziemer, D. C., Dickinson, J. K., Agarwal, S., Ebekozien, O., Polsky, S., & T1D Exchange Quality Improvement Collaborative. (n.d.). Factors Associated With Improved A1C Among Adults with Type 1 Diabetes in the United States. *Clinical Diabetes* 2023.
<https://diabetesjournals.org/clinical/article/41/1/76/147772/Factors-Associated-With-Improved-A1C-Among-Adults>

Bengfort, H. (2023, October 19). *The complete history of employer-provided health insurance*.
<https://www.peoplekeep.com/blog/the-complete-history-of-employer-provided-health-insurance>

Beyond type 1 Editorial Team. (2018, September 10). *type 1 Diabetes Statistics*. Beyond type 1.
<https://beyondtype1.org/type-1-diabetes-statistics/>

Buzelli, L., Williamson, S., Gardner, T., & Cameron, G. (2023, February 23). *Public perceptions of the NHS: a winter of discontent*. The Health Foundation.
<https://www.health.org.uk/reports-and-analysis/briefings/public-perceptions-of-the-nhs-a-winter-of-discontent>

Claxton, G., Ray, M., & Winger, A. (2024, May 28). *Employer-Sponsored Health Insurance 101*. Kaiser Family Foundation.
<https://www.kff.org/health-policy/101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction>

Clayton, A. (2023, July 20). *'The link between race and wealth is difficult to dismantle'*. The Young Foundation. <https://www.youngfoundation.org/the-link-between-race-and-wealth-is-difficult-to-dismantle/>

Desmond, S., Selvin, E., & Fang, M. (2024, April 19). *Research Gaps Around type 1 Diabetes*. Retrieved April 6, 2025, from <https://publichealth.jhu.edu/2024/type-1-diabetes-research>

Employer Mandate. (2025). Cigna Healthcare. <https://www.cigna.com/employers/insights/informed-on-reform/employer-mandate>

Employer shared responsibility provisions. (2025, January 24). IRS. <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions>

Employer-Sponsored Health Coverage: What You Pay. (2024). https://ca.db101.org/ca/programs/health_coverage/private_medical/program2b.htm

Fleck, A. (2023, February 8). *Overburdened NHS Pushes More Brits To Go Private* [Chart]. Statista. <https://www.statista.com/chart/29261/share-of-uk-paying-for-private-health-insurance/>

Freed, M., Fuglesten Biniek, J. F. B. A. D. A. T. N. P. N. 1. 2., Damico, A., & Neuman, T. (n.d.). *Medicare Advantage 2025 Spotlight: A First Look at Plan Premiums and Benefits*. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/>

Glynn, S. J. (2018, May 18). *An Unequal Division of Labor*. Center for American Progress. <https://www.americanprogress.org/article/unequal-division-labor/>

Going Private 2023. (2023). Independent Healthcare Providers Network. <https://www.ihpn.org.uk/going-private-2023/>

Harker, L., & Sharer, B. (2024, June 14). *Medicaid Expansion: Frequently Asked Questions*. Center on Budget and Policy Priorities. Retrieved April 14, 2025, from <https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0>

Health plan categories: Bronze, Silver, Gold & Platinum. (n.d.). Healthcare.Gov. <https://www.healthcare.gov/choose-a-plan/plans-categories/>

Hill, L., Ndugga, N., & Artiga, S. (2025, February 13). *Health Coverage by Race and Ethnicity, 2010-2023.* Kaiser Family Foundation. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>

Information on Essential Health Benefits (EHB) Benchmark Plans. (2025, January 14). Centers for Medicare and Medicaid Services. <https://www.cms.gov/marketplace/resources/data/essential-health-benefits>

Jivraj, S., & Khan, O. (2013, December). *Ethnicity and deprivation in England: How likely are ethnic minorities to live in deprived neighbourhoods?* The University of Manchester. <https://hummedia.manchester.ac.uk/institutes/code/briefingsupdated/ethnicity-and-deprivation-in-england-how-likely-are-ethnic-minorities-to-live-in-deprived-neighbourhoods%20%281%29.pdf>

The journey to integrated care systems. (2023). NHS England. <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/the-journey-to-integrated-care-systems/>

Keisler-Starkey, K., Brunch, L. N., & Lindstrom, R. A. (2023, September 12). *Health Insurance Coverage in the United States: 2022.* United States Census Bureau. <https://www.census.gov/library/publications/2023/demo/p60-281.html>

KFF 2023 Summary of Findings Employer Health Benefits. (2023, December). Kaiser Family Foundation. <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey-Summary-of-Findings.pdf>

Lindstorm, R., Keisler-Starkey, K., & Brunch, L. (2024, April 18). *Percentage of Older Adults With Both Private Health Insurance and Medicare Decreased From 2017 to 2022.* United States Census Bureau. <https://www.census.gov/library/stories/2024/04/older-adults-health-coverage.html>

Marino, M., Angier, H., Springer, R., Valenzuela, S., Hoopes, M., O'Malley, J., Suchocki, A., Heintzman, J., DeVoe, J., & Huguet, N. (n.d.). *The Affordable Care Act: Effects of Insurance on Diabetes Biomarkers.* *Diabetes Care* 2020. <https://diabetesjournals.org/care/article/43/9/2074/35878/The-Affordable-Care-Act-Effects-of-Insurance-on>

Mayo Clinic Staff. (2024, March 27). *Type 1 diabetes.* Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/type-1-diabetes/symptoms-causes/syc-20353011>

Medicare & You 2025. (2025). Medicare.Gov. <https://www.medicare.gov/publications/10050-medicare-and-you.pdf>

Morris, J., Schlepper, L., Dayan, M., Jefferies, D., Maguire, D., Merry, L., & Wellings, D. (2023, March 29). *Public satisfaction with the NHS and social care in 2022.* The Kings Fund. <https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-and-social-care-2022>

National Diabetes Audit 2021-22, type 1 Diabetes - Overview. (2023, October 12). NHS England. Retrieved April, 2025, from <https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit-type-1-diabetes/nda-type-1-2021-22-overview>

National Diabetes Statistics Report. (2024, May 15). Center for Disease Control. <https://www.cdc.gov/diabetes/php/data-research/index.html>

Ochieng, N., Cubanski, J., & Neuman, T. (2024, September 23). *A Snapshot of Sources of Coverage Among Medicare Beneficiaries.* Kaiser Family Foundation. <http://A Snapshot of Sources of Coverage Among Medicare Beneficiaries>

Ortaliza, J., & Cox, C. (2024, May 28). *The Affordable Care Act 101.* Kaiser Family Foundation. <https://www.kff.org/health-policy-101-the-affordable-care-act/?entry=table-of-contents-what-did-the-aca-change-about-health-coverage-in-the-u-s>

People living in deprived neighbourhoods. (2020, June 16). Gov.UK. <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest/>

Saving money on health insurance. (n.d.). Healthcare.Gov. Retrieved April 14, 2025, from <https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>

Schwarz, C. (Ed.). (2024, November 14). *CMS Announces 2025 Premiums and Deductibles for Medicare Parts A and B.* Medicare Rights Center. <https://www.ncoa.org/article/what-you-will-pay-in-out-of-pocket-medicare-costs-in-2025/>

State Insulin Copay Caps. (2023). American Diabetes Association. <https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps>

Vaida, B. (2024, August 22). *Will Insurance Cover Diabetes Monitoring Devices for At-Home Care?* <https://www.goodrx.com/conditions/diabetes/diabetes-monitoring-devicesa>

What is private healthcare? (n.d.). Freedom Health Insurance. <https://www.freedomhealthinsurance.co.uk/about-private-healthcare>

What You'll Pay in Out-of-Pocket Medicare Costs in 2025. (2024, December 5). National Council on Aging. Retrieved April 14, 2025, from <https://www.ncoa.org/article/what-you-will-pay-in-out-of-pocket-medicare-costs-in-2025/>

Williamson, A., Antonisse, L., Tolbert, J., Garfield, R., & Damico, A. (2016, June 10). *ACA Coverage Expansions and Low-Income Workers*. Kaiser Family Foundation. <https://www.kff.org/report-section/aca-coverage-expansions-and-low-income-workers-issue-brief/>