Local interview

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P65 (LC abs) - 7681 - Differences in Metabolic Control, Treatment and Associated Complications in Patients Living With Type 1 Diabetes Receiving Private or Public Health Care in Mexico.

- How significant are the differences in metabolic control and treatment between patients with type 1 diabetes receiving private or public health care in Mexico?
- What are some of the factors that are responsible for differences in management and treatment in patients with type 1 diabetes receiving private or public health care in Mexico?
- How important is it to reduce disparity and what solutions might be offered to minimize it?

Differences in metabolic control, treatment and associated complications in patients living with Type 1 Diabetes receiving private or public health care in Mexico. Background. Type 1 Diabetes (T1D) is the most common chronic endocrinological disease diagnosed during childhood. It requires continuous education, monitoring and treatment. An analysis was developed to learn if there were discrepancies in the level of metabolic control and complications between private and public healthcare in Mexico, based on the data obtained in the National Registry of patients with Type 1 Diabetes (RENACED DT1). Objective: Describe the sociodemographic characteristics, metabolic control, treatment and complications in patients receiving private or public health care registered in RENACED DT1.Methodology: Sociodemographic and anthropometric variables, metabolic control, diabetes education, type of insulin and delivery method used for treatment, glucose monitoring and acute and chronic complications were compared between patients receiving private vs public health care. Results Of the 1458 patients registered, significant differences between HbA1c levels were seen (7.8% private health care vs 8.7% public healthcare, $p<0.001$), achievement of glycemic goal HbA1c <7% (30.1% private healthcare vs 19.6% public healthcare, $p<0.001$). In private institutions, 47.1% of patients use an insulin pump and 44.7% a basal bolus regimen with insulin analogues (MDI) ($p<0.001$). Meanwhile in public institutions, 2.6% use an insulin pump and 84.8% use MDI ($p<0.001$). 30.4% of patients in private institutions check their blood glucose levels 6 to 10 times a day vs 14.3% of patients from public institutions ($p<0.001$). Continuous glucose monitoring is used in 46.4% of patients from private healthcare vs 5% from public healthcare ($p<0.001$). A larger number of patients from private healthcare use insulin to carbohydrate ratios to calculate meal insulin compared with patients from public healthcare (89.1% vs31.3%, $p<0.001$). No significant differences were found related to the incidence of mild to moderate hypoglycemia, but there was a higher incidence of severe hypoglycemia in the public sector compared to the private one (57 vs 43%, $p<0.001$). Also, a higher prevalence of diabetic nephropathy was found in patients from public vs private healthcare (82.9 vs 17.1%, $p=0.034$). Conclusions: Significant differences were found in glucose monitoring, carbohydrate counting and insulin delivery methods, between patients from public and private healthcare, which could explain the differences observed in metabolic control and diabetes associated complications. It is imperative that better public policies are implemented in public health, to reduce this health disparity.