

Ethnic inequalities in access to and outcomes of healthcare

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Background

- Large body of evidence from the US demonstrating racial/ethnic inequalities in access to health care and outcomes of health care.
- Insurance status is a key (but not the only) determinant of these.
- US healthcare systems with universal access (military and veterans Affairs) appear to have fewer inequalities.
- But evidence from the NHS, although limited, also suggests inequalities:
 - Greater use of primary care is not matched by greater use of secondary care;
 - Higher levels of dissatisfaction with care received;
 - Longer waits for appointments;
 - Poorer quality of practice infrastructure;
 - Language barriers during the consultation;
 - Less likely to get follow up services after initial consultation;
 - Longer waits for referral to specialist care;
 - Less likely to receive specialist treatments (revascularisation and thrombolysis).

Objectives

- Examine ethnic inequalities in access to health care:
 - Primary care (GP and Dentist);
 - Out- and day-patient hospital care;
 - In-patient care.
- Examine ethnic inequalities in the outcomes of care received for:
 - Hypertension
 - Raised cholesterol
 - Diabetes

Methods: sample and data collection

- Health Survey for England, ethnic minority (1999 and 2004) and cardiovascular (1998 and 2003) years
- Those aged 16-74
- Nationally representative samples (but does not include ethnic minority people living in very low density areas)
 - Stratified (NHS regions and socioeconomic profiles) and clustered sample
 - Addresses identified using the Postcode Address File (except the Chinese sample)
 - Ethnic minority sample also stratified according to Census data on ethnic density
 - Response rates vary by ethnicity (individual rate 60-70%)
- Ethnicity classified according to family origins
- Gives a large sample of Irish, Black Caribbean, Indian, Pakistani, Bangladeshi and Chinese respondents
- Language matched interviewers

Methods: measures for access

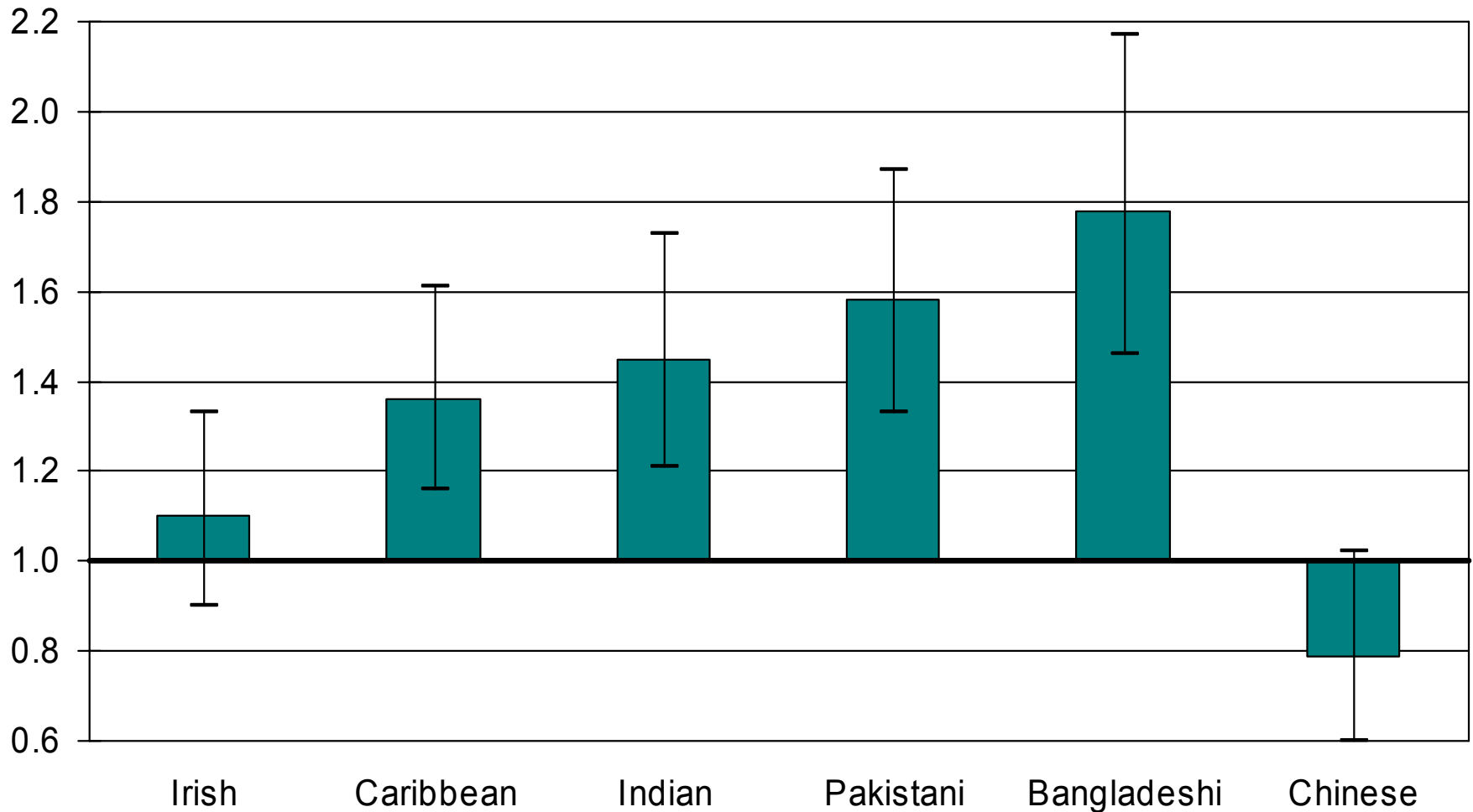
- Visited a GP for consultation in the last two weeks (HSE 1999 only)
- Been an in-patient (stayed overnight or longer) in the last year
- Attended a hospital as an out- or day-patient in the last year
- Have regular or occasional check-ups with a dentist (HSE 1999 only)

- Analysis using stata and accounting for sample weights (to adjust for unequal probabilities of selection) and for the stratification and clustering of the sample

- Models initially adjusted for age and gender; then for self-assessed health and limiting longstanding illness

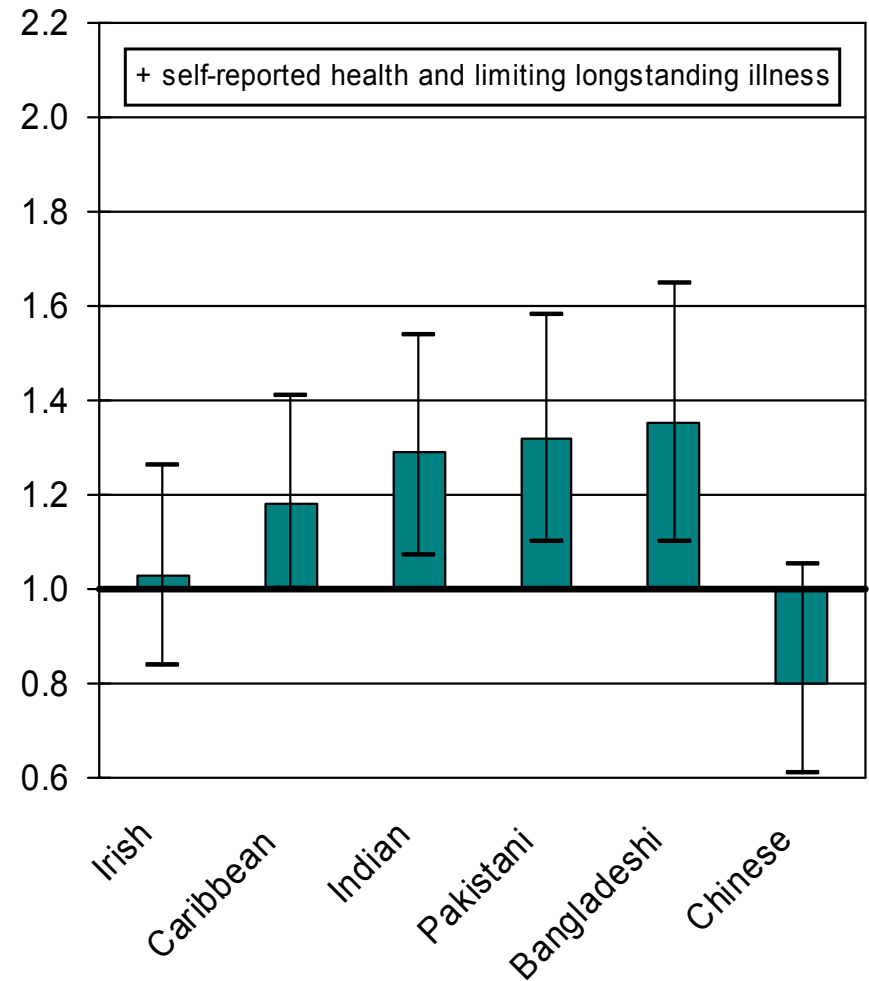
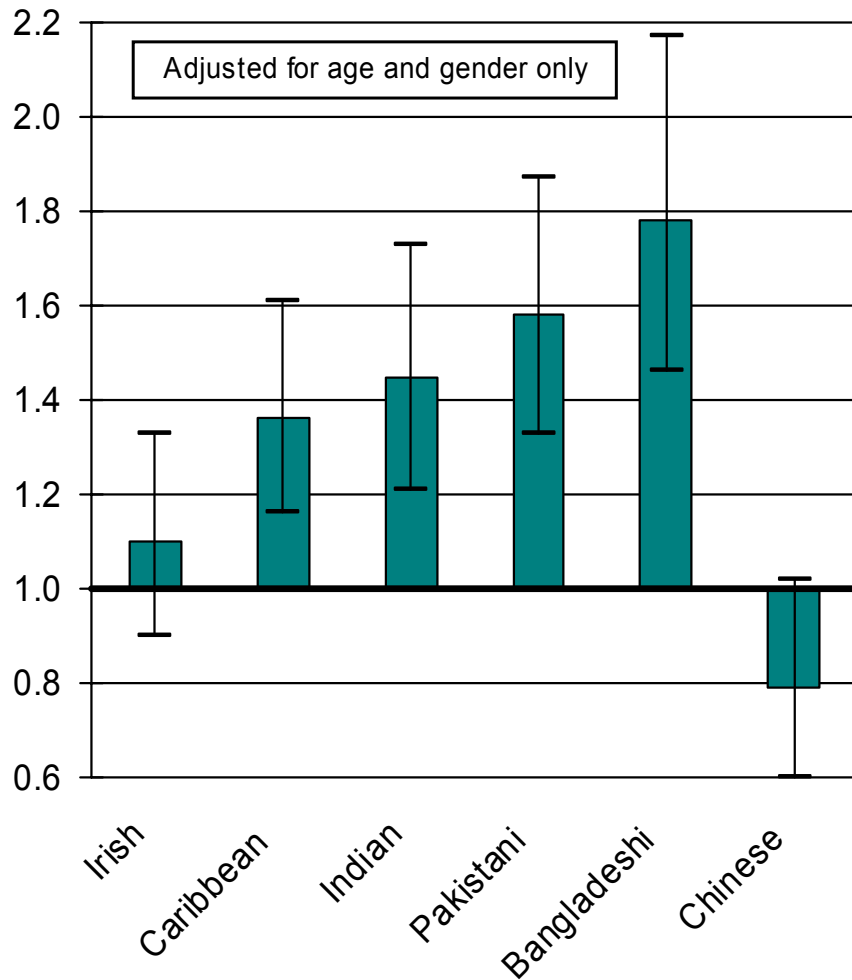
Visited a GP in the last two weeks

(odds ratio compared with white English, adjusted for age and gender)



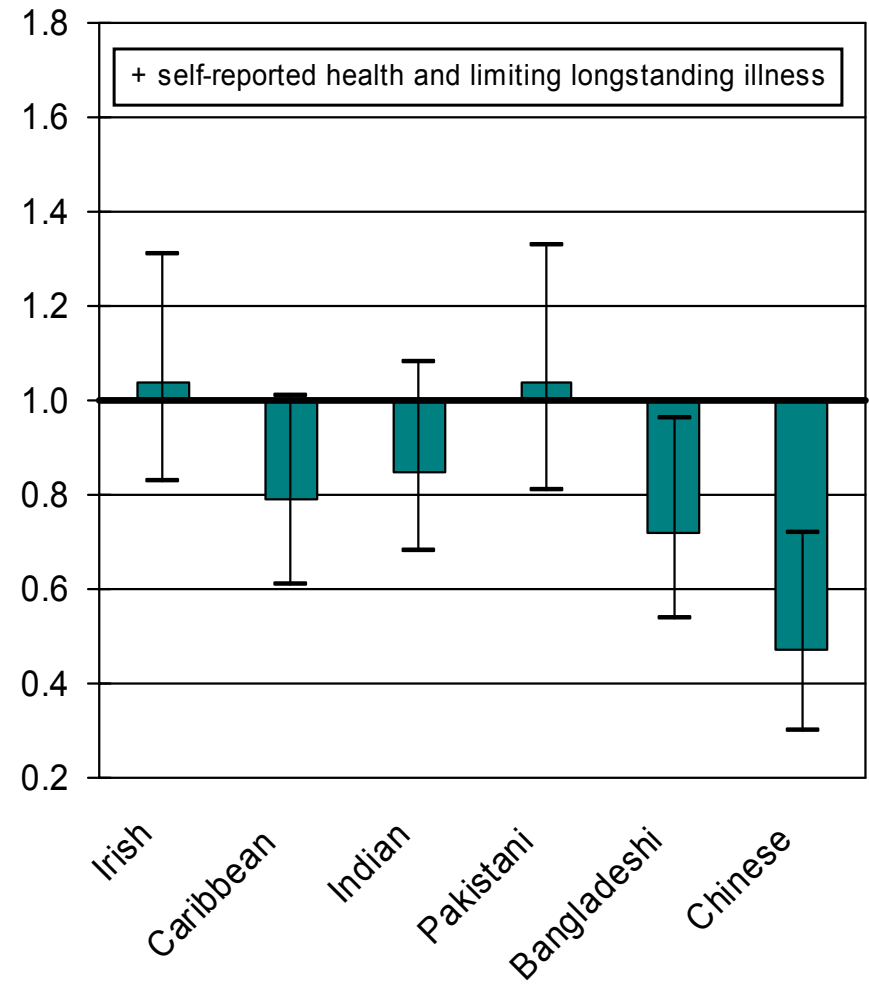
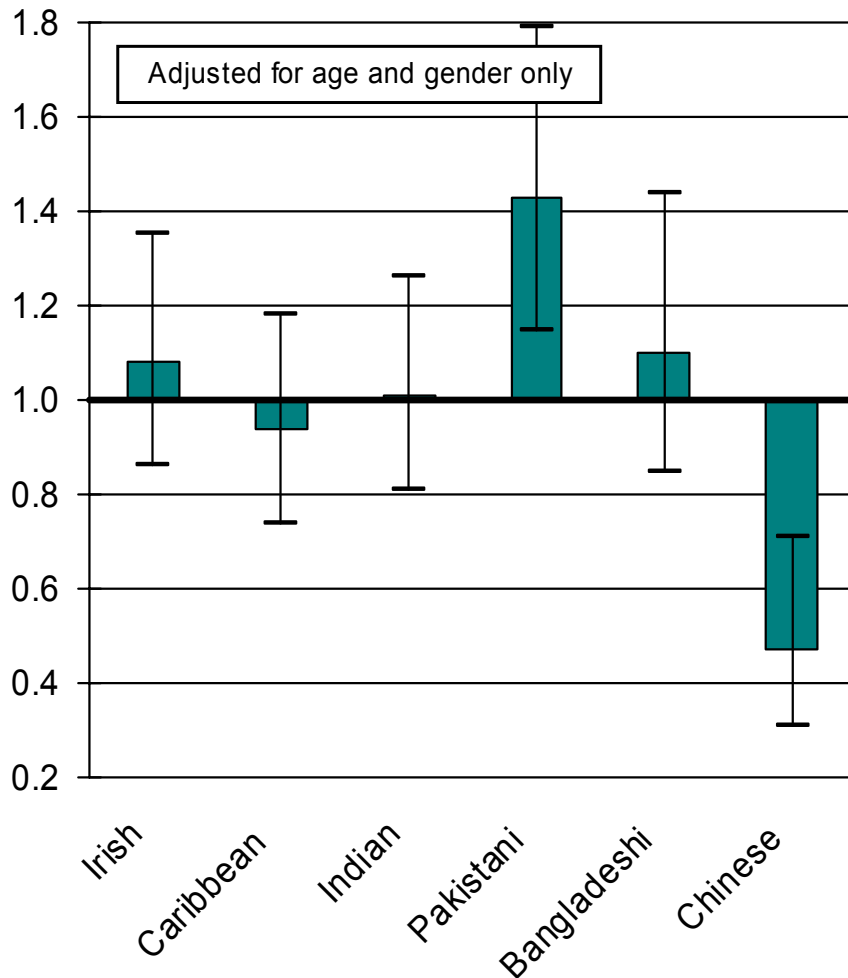
Visited a GP in the last two weeks

(odds ratio and 95% c.i., compared with white English)

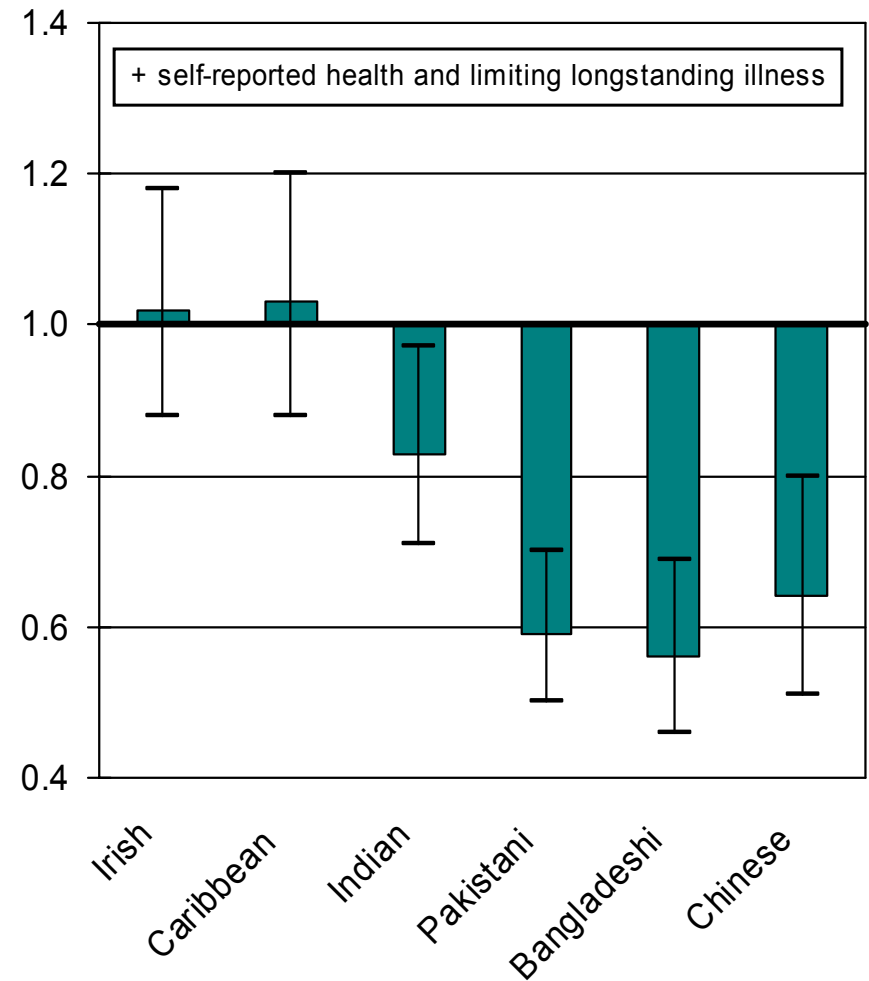
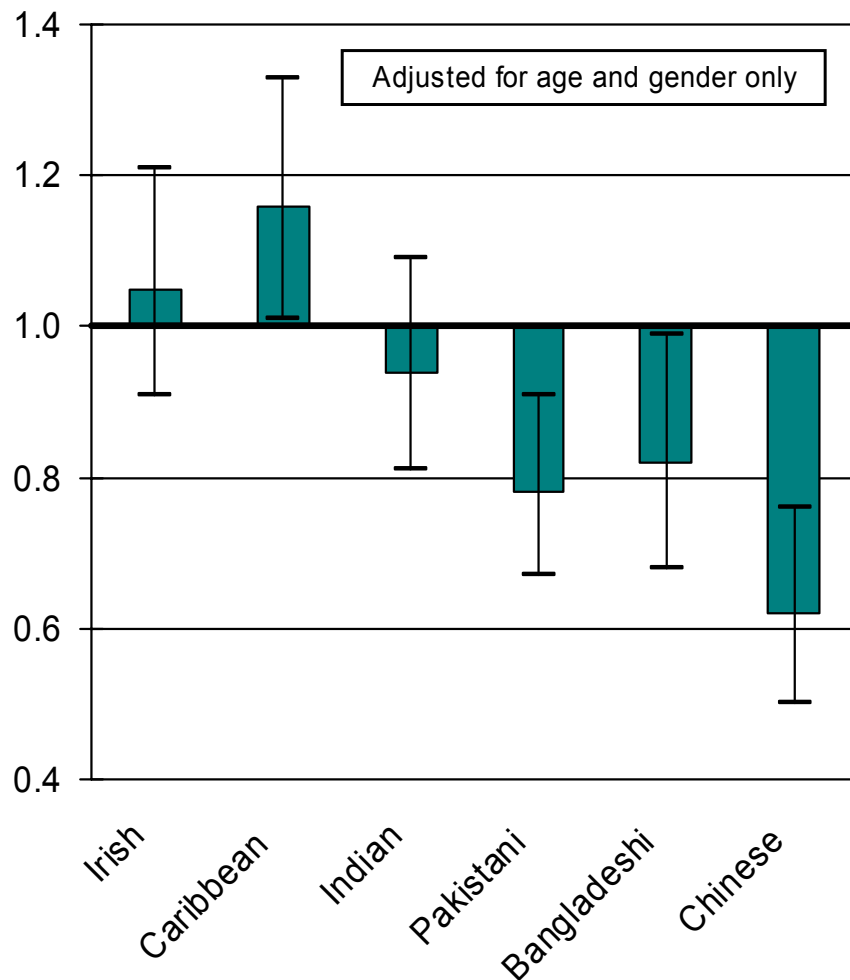


In-patient in the last year

(odds ratio and 95% c.i., compared with white English)

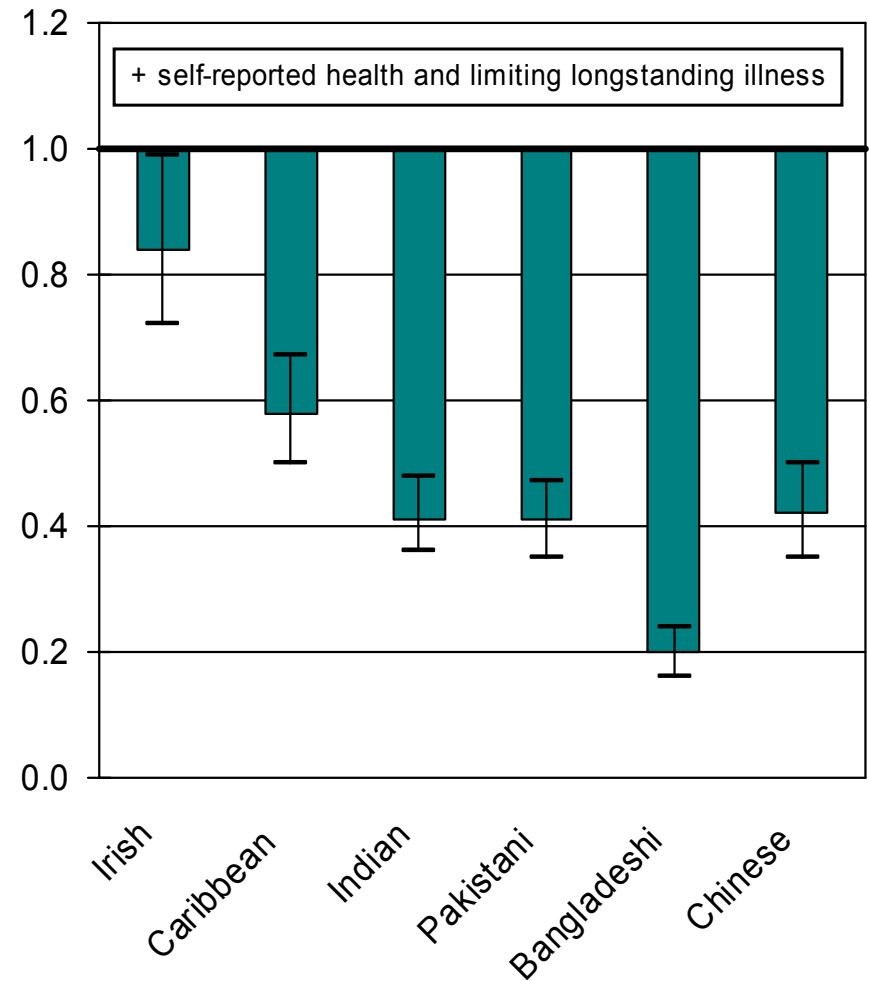
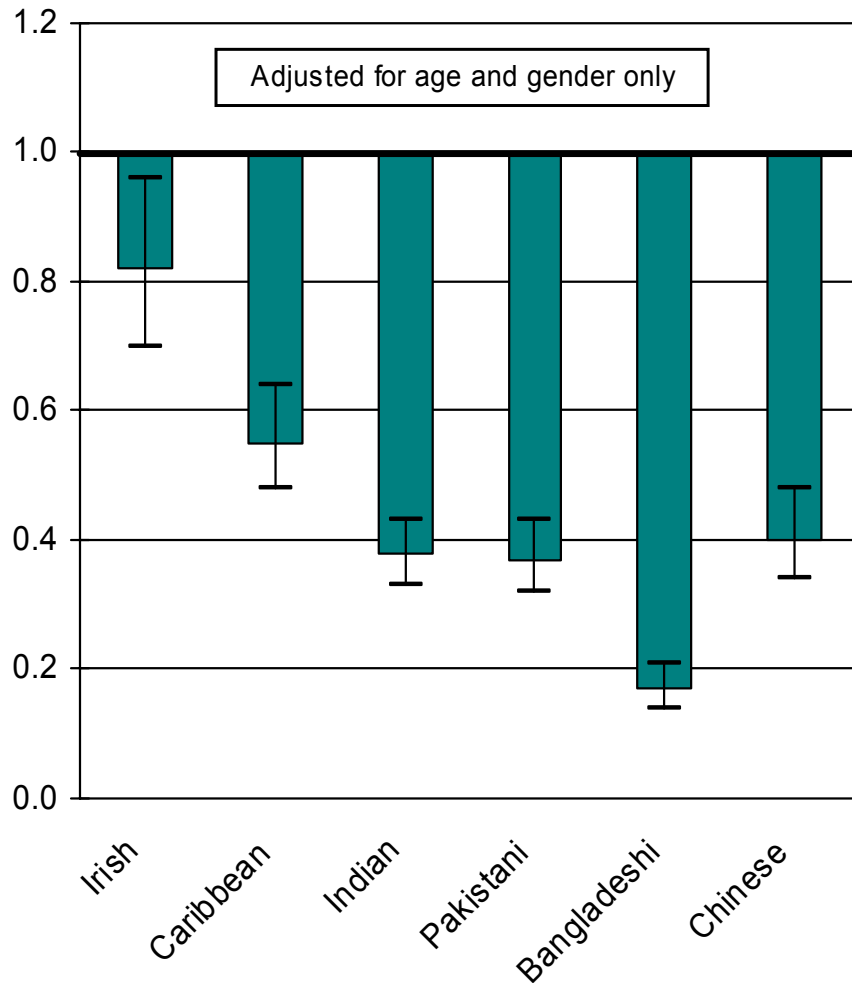


Out or day-patient in the last year (odds ratio and 95% c.i., compared with white English)



Visit dentist at least occasionally

(odds ratio and 95% c.i., compared with white English)

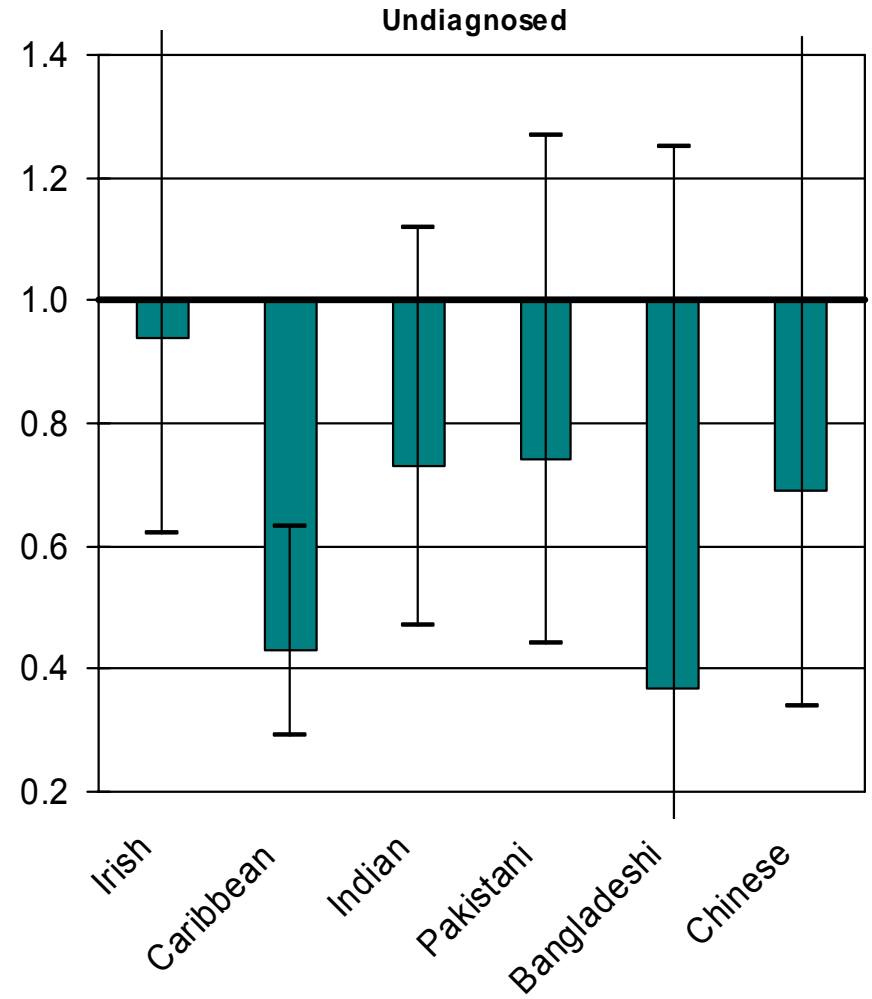
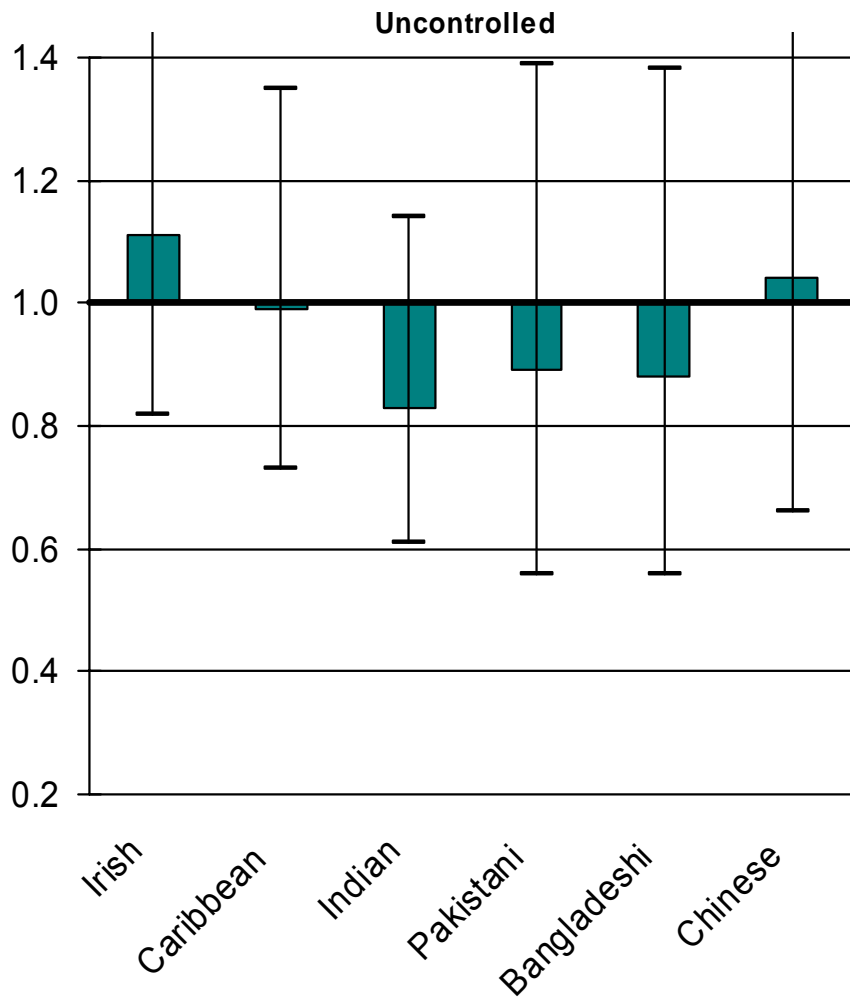


Methods: measures for outcome of care

- Hypertension (diagnosed or measured $\geq 140/90$)
 - Hypertensive controlled: BP $< 140/90$ but report diagnosis or treatment
 - Hypertensive uncontrolled: BP $\geq 140/90$ and report diagnosis or treatment
 - Hypertensive undiagnosed: BP $\geq 140/90$, but no report of diagnosis or treatment
- Raised total cholesterol (diagnosed or measured $\geq 5\text{mmol/l}$)
 - Controlled: cholesterol $< 5\text{ mmol/l}$ but report diagnosis or treatment
 - Raised uncontrolled: cholesterol $\geq 5\text{mmol/l}$ and report diagnosis or treatment
 - Raised undiagnosed: cholesterol $\geq 5\text{mmol/l}$, but no report of diagnosis or treatment
- Diabetes (diagnosed or measured HbA1c $> 6.5\%$)
 - Diabetic controlled: HbA1c $\leq 7.5\%$ with report of diagnosis or treatment
 - Diabetic uncontrolled: HbA1c $> 7.5\%$ and report diagnosis or treatment
 - Diabetic undiagnosed: HbA1c indicative of diabetes ($> 6.5\%$) not diagnosed or treated

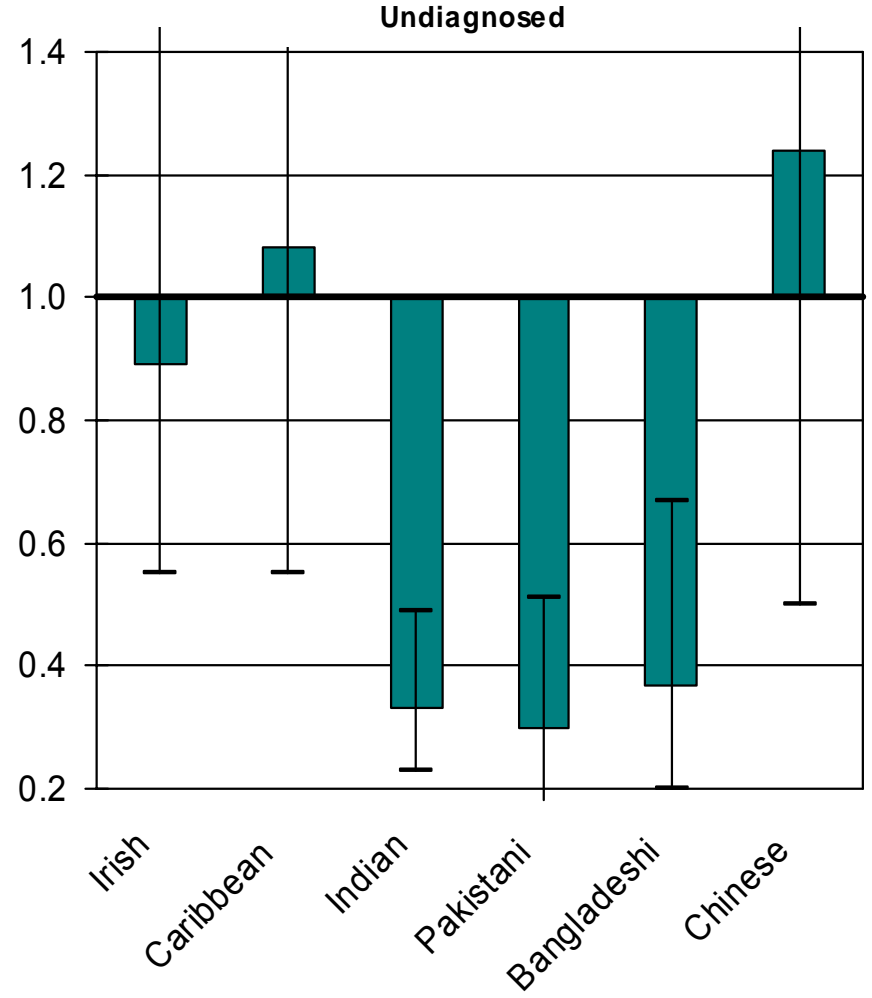
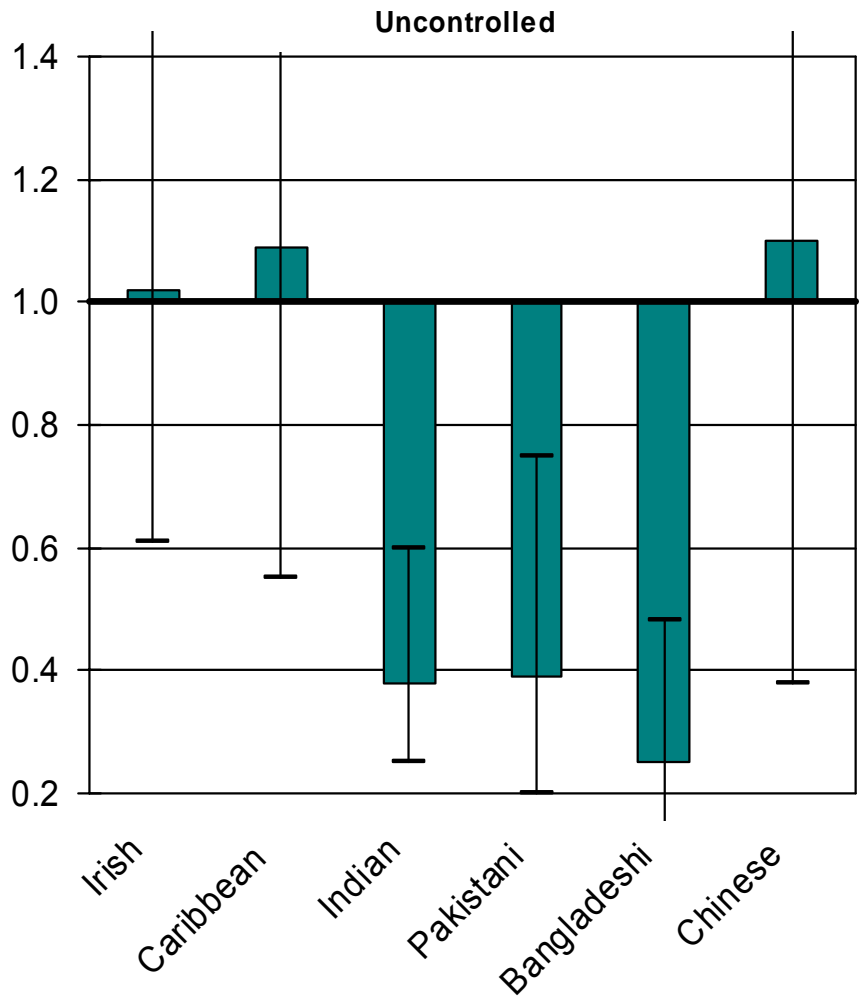
Treatment outcomes for those with hypertension

multinomial regression relative risks compared with 'controlled' and white English



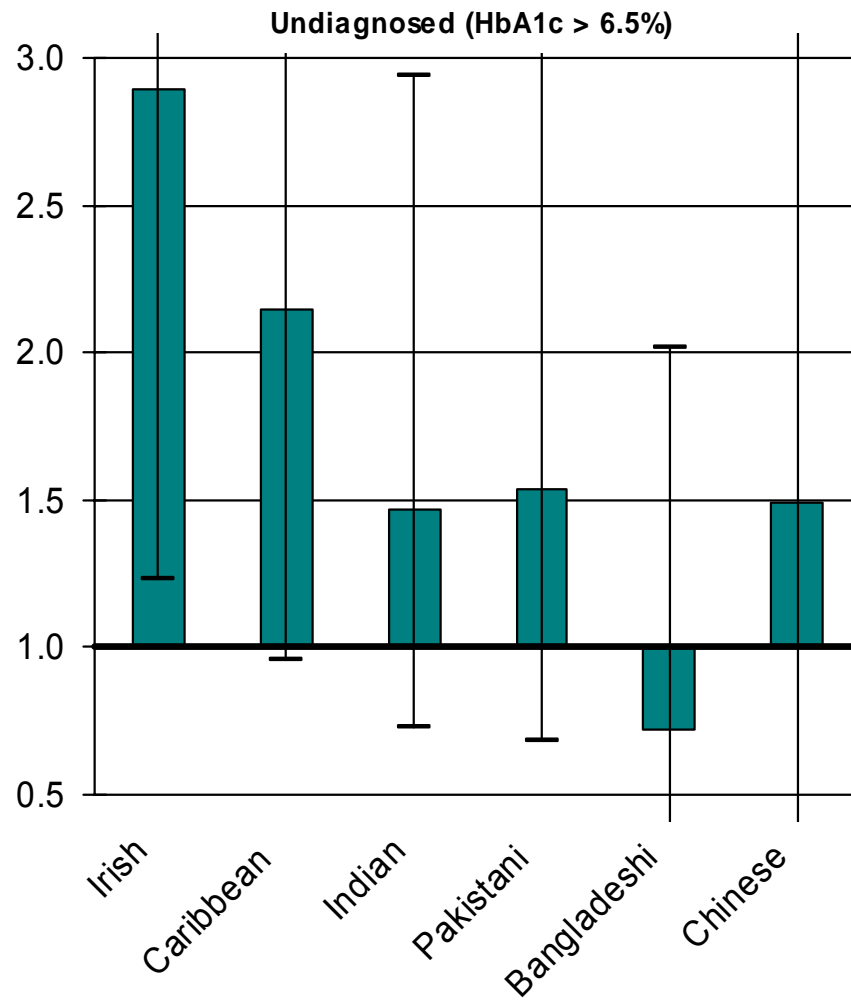
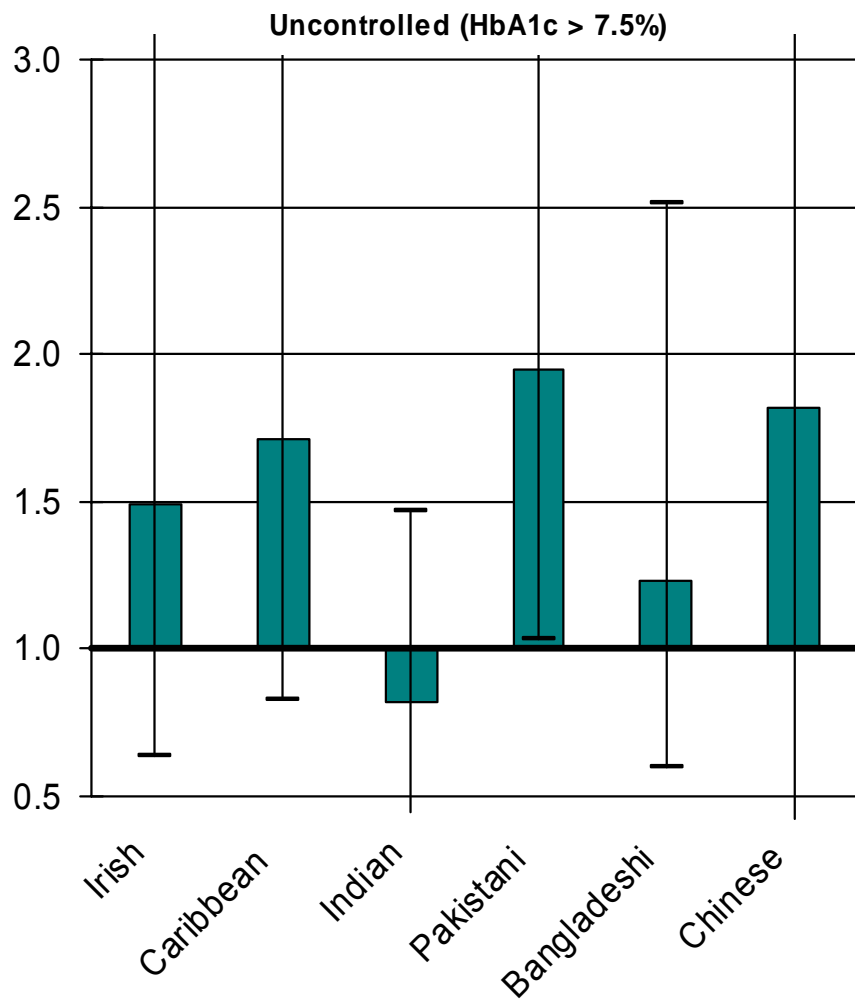
Treatment outcomes for those with raised cholesterol

multinomial regression relative risks compared with 'controlled' and white English



Treatment outcomes for those with diabetes

multinomial regression relative risks compared with 'controlled' and white English



Conclusions (1)

- No inequalities in access to GP services
- No inequalities in outcomes of care for hypertension, raised cholesterol and, possibly, diabetes
- Some inequalities in access to hospital services (particularly use of out- and day-patient services)
- Marked inequalities in access to dental services
- Limited subset of (important) conditions – contrary findings for other conditions and for reported levels of satisfaction with care received
- Conditions largely managed in primary care settings
- Response rates, sample size and power

Conclusions (2)

- Marked similarities between the US and UK in terms of ethnic inequalities in health and socioeconomic position
- Marked differences in terms of access to and outcomes of healthcare
- The effect of differences in healthcare systems – a health service with universal access?
- But discrepancy between primary care and secondary care in England
 - Differences in thresholds triggering primary care consultation (lack of evidence)
 - Differences in thresholds for referral by practitioners (contradictory evidence)
 - Use of private care (some limited evidence)