Optimising diabetes care in hard-to-reach groups

The prevalence of type 2 diabetes varies across different social and cultural groups. In the past 10 years in the UK, health inequalities have increased, and have been shown to exist between men and women, social classes and ethnic groups (Wanless, 2003). Older people and those suffering from mental health conditions or learning disabilities also have worse health experiences than the rest of the population (Department of Health [DH], 2001). Access to both primary and secondary care differs among populations, as does the quality of some of these services and this, in turn, impacts health outcomes. To ensure equitable access to healthcare services, it may be necessary to provide tailored services, so that disadvantaged groups who start from a lower baseline, end up with the same opportunities as everyone else.

So who are these hard-to-reach groups of people with diabetes? The underpinning issue is often where people of low socioeconomic status may have made poor lifestyle choices; often they are overweight, physically inactive and smoke. Cultural issues as well as genetic susceptibly are important. Type 2 diabetes is six times more common in people of south Asian descent compared with white people, and three times more common in black African and African-Caribbean people (DH, 2001).

Other hard-to-reach groups should also be considered, including socially excluded people, travellers, prisoners, homeless people, refugees and asylum seekers, and people with learning difficulties or mental health conditions, all of whom may receive poor-quality diabetes care. This may extend to people in nursing and care homes, as well as disaffected people with type 1 diabetes, who have opted out of conventional care.

What does QOF tell us?

Universal health care is free at the point of delivery, but this does not mean that it is evenly accessible. The Quality and Outcomes Framework (QOF), introduced in 2003, has helped to document the prevalence of diabetes in different regions of the UK, often matching areas of social deprivation to an increased prevalence of diabetes (The Information Centre, 2009). It would also seem to be having an impact on some diabetes and cardiovascular outcomes. QOF appeared to incentivise general practices to improve hypertension care in a South West London population, greater than was produced by the underlying trend (from years 2000–2003) in the white, black and south Asian groups (Millett et al, 2009). The same study did, however, find the HbA_{1c} reduction was greater in the white group than the black or south Asian populations.

The need to perform regular audit of care as part of QOF should ensure that all people with diabetes on a practice's register receive care.

Strategies

Documented successful strategies to contact and deliver health care to hard-to-reach groups are difficult to find. Many interventions have sought to improve health inequalities – in particular, access to health services – by counteracting the effects of diversity (cultural and language differences).

A key facet to improving diabetes care in hard-to-reach groups is to discuss health care and treatment in a language that the person can understand, and with relevance to their personal and family context. Healthcare professionals in primary care should also seek out information on bilingual educational materials, as well as community resources tailored to specific groups.

Services need to be appropriate to individuals' needs, taking into account ethnicity, language, culture, religion, gender, disability, age and location. Ultimately, one way to assess a sophisticated economy, such as that of the UK, is by the way it deals with the less advantaged or marginalised in its society. While much is already being done, recognition of inequalities and concerted action remain imperative. ■

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This issue of *Diabetes & Primary Care* focuses on delivering diabetes care to hard-to-reach groups, with comment pieces and articles on care home residents (page 332), black African and African-Caribbean people (336), and a UK Turkish population (359).

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