HEALTH INEQUALITIES IN DIABETES

Who gets diabetes?

1. Diabetes does not impact upon everyone in our society equally. Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to people with Type 2 diabetes. Those who are overweight, physically inactive or have a family history of diabetes are at increased risk of developing diabetes. People of South Asian, African, and African-Caribbean descent have a higher than average risk of developing Type 2 diabetes, as do less affluent individuals and populations. Socially excluded people, including prisoners, refugees and asylum seekers, and people with learning difficulties or mental health problems may receive poorer quality care. More than one of these risk factors may apply to some individuals.

2. The knowledge that people have about their diabetes also varies considerably

Black and minority ethnic groups

3. Compared with the white population, Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent. It is also more common in people of Chinese descent and other non-Caucasian groups. The average age at diagnosis is also comparatively younger in these groups. The risk of death from diabetes is between three and six times higher, with these groups also being particularly susceptible to the cardiovascular and renal complications of diabetes. Death rates from heart disease are two to three times higher in those of South Asian descent whilst death rates due to stroke are three times higher in those of
African and African-Caribbean descent. Rates for renal replacement therapy are up to four times higher in both groups.

**Older people**

4. The prevalence of diabetes rises steeply with age: one in twenty people over the age of 65 in the UK have diabetes and this rises to one in five people over the age of 85 years. The diagnosis of diabetes may be delayed in older people, with symptoms of diabetes being wrongly attributed to ageing. Older people may experience discrimination in the degree of active management offered compared with younger people.

5. Older people with complex needs require multidisciplinary care, which is well co-ordinated across primary, secondary and residential care and social services. Given the relatively high use of hospital services by older people, hospitals can offer an effective intervention point for earlier diagnosis and better management of diabetes in older people. Information, education and support should be provided for older people to help them manage their diabetes.

6. A significant proportion of older people with diabetes in residential and nursing care will have diabetes. As part of the modernisation of the regulatory system, national standards for care homes for older people were published on 2 March 2001\(^1\). They will ensure that residents’ health care needs are recognised and met, and that they are cared for by staff who are properly trained.

**Less affluent and socially excluded communities**

![Prevalence of Diabetes, by deprivation category: England and Wales 1994-98](image)

Source: GP Research Database; insulin and non-insulin treated diabetes

7. Type 2 diabetes is more prevalent among less affluent populations. Those in the most deprived one-fifth of the population are one-and-a-half times more likely than average to have diabetes at any given age.

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8. Both mortality and morbidity are increased by socio-economic deprivation. Morbidity resulting from diabetes complications is three-and-a-half times higher in people in social class V compared with those in social class I. This inequality in outcome has many causes. Whilst deprivation is strongly associated with higher levels of overweight and obesity, physical inactivity, smoking and poor blood pressure control, other factors include poorer blood glucose control; lower education, employment and housing status; worse access to services; and referral bias. In addition, those who are socially excluded may experience a sense of hopelessness that will militate against them developing confidence to manage their diabetes and any complications.

9. High risk, hard to reach groups are overrepresented in the prison population. People with diabetes living in custodial settings should be managed in line with the standards set out in this NSF. Close partnership working between the prison health care team and local NHS diabetes services is essential.

**Gender**

10. The frequency of diabetes in England is higher in men than in women. However, women with diabetes are at relatively greater risk of dying than men with diabetes - in comparison with women and men who do not have diabetes. This may be because gender compounds other aspects of inequality. For example, women often bear the brunt of poverty, and socio-economic differences in the prevalence of diabetes are more marked for women, probably because of differences in smoking rates, food choices and the prevalence of obesity. There is some evidence to suggest that women are less likely to receive routine surveillance checks for the long-term complications of diabetes. Pre-menopausal women with diabetes do not have the same protection against coronary heart disease as women who do not have diabetes. Women also tend to take on the main role of carer if another member of the family has diabetes.

**Disability**

11. People with physical disabilities, sensory impairment and learning disabilities have the same rights of access to NHS services as everyone else. They are likely to have the same predisposition to diabetes as the population as a whole, but other risk factors should also be borne in mind. For example, many people with learning disabilities have problems with their weight and communication difficulties may lead to delayed diagnosis with consequent complications.

12. The recent Government White Paper *Valuing People*\(^2\) set out a strategy for learning disability for the 21st century. Health facilitators will be appointed by June 2003 to help general practitioners and primary care teams to identify people with learning disabilities. They will act as advocates for people with learning disabilities and ensure that they gain full access to all the health care they need, whether from primary or secondary NHS services. By June 2005 everyone with a learning disability should also have a Health Action Plan which encompasses a range of health measures including general fitness and records of any screening tests.

13. Many people with diabetes will be covered by the provisions of the Disability Discrimination Act 1995 (DDA). The DDA makes it unlawful to treat any person

less favourably on the grounds of their disability. Service providers are under a duty to make reasonable adjustments to practices, policies or procedures that make it impossible or unreasonably difficult for disabled people to use a service. This is particularly important when considering the provision of information in suitable formats, e.g. large print Braille or audio tape for those with visual impairment. All public sector agencies have a responsibility to try to ensure that the information they produce is user-friendly and accessible to disabled people.

**Implications for service planning**

14. Reducing health inequalities is a core strand of *The NHS Plan* and, as the diabetes NSF is implemented, particular regard will need to be given to:

- identifying the need for services, including unmet need (for example, where there may be a high number of at risk groups but low take up of services, or late presentation)
- planning and delivering services on the basis of need, including reaching those who may not currently be accessing services or are accessing them late
- ensuring the active involvement of users in service development
- ensuring services are appropriate to individuals’ needs, such as ethnicity, language, culture, religion, gender, disability, age and location
- applying clinical audit criteria and performance management
- measuring and monitoring the health inequalities gap to ensure it is narrowing.