



The lower quality of preventive care among forced migrants in a country with universal healthcare coverage

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ABSTRACT

Objective. To assess the association between socio-demographic factors and the quality of preventive care and chronic care of cardiovascular (CV) risk factors in a country with universal health care coverage.

Methods. Our retrospective cohort assessed a random sample of 966 patients aged 50–80 years followed over 2 years (2005–2006) in 4 Swiss university primary care settings (Basel/Geneva/Lausanne/Zürich). We used RAND's Quality Assessment Tools indicators and examined recommended preventive care among different socio-demographic subgroups.

Results. Overall patients received 69.6% of recommended preventive care. Preventive care indicators were more likely to be met among men (72.8% vs. 65.4%; $p < 0.001$), younger patients (from 71.0% at 50–59 years to 66.7% at 70–80 years, p for trend = 0.03) and Swiss patients (71.1% vs. 62.7% in forced migrants; $p = 0.001$). This latter difference remained in multivariate analysis adjusted for gender, age, civil status and occupation (OR 0.68; 95% CI 0.54–0.86). Forced migrants had lower scores for physical examination and breast and colon cancer screening (all $p \leq 0.02$). No major differences were seen for chronic care of CV risk factors.

Conclusion. Despite universal healthcare coverage, forced migrants receive less preventive care than Swiss patients in university primary care settings. Greater attention should be paid to forced migrants for preventive care.

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Background

Quality of care, defined by Campbell et al as “whether individuals can access the health structures and processes of care which they need and whether the care received is effective” (Campbell et al., 2000), is increasingly the focus of policy makers and the public. Standard indicators of quality of preventive care have been developed in the United States (US) for systematic monitoring of quality of care (Asch et al., 2006; HEDIS, 2007; McGlynn et al., 2003). Since 2004, a systematic performance monitoring has also been conducted in the United Kingdom (UK) (Roland, 2004).

Using RAND's Quality Assessment Tools (McGlynn et al., 2003), a study in 12 metropolitan areas found slightly lower quality of care associated with lower income (Asch et al., 2006). Some other studies (Gray et al., 2007; Schofield et al., 2011; Wortley, 2005) found

differences in delivered care according to socio-demographic characteristics, particularly ethnicity.

However, continental Europe, and more specifically Switzerland, suffers from limited documentation about the quality of preventive care, with only few data on the quality of preventive care according to socio-demographic status. A previous Swiss study found shortfalls in pre-natal preventive care for undocumented compared to legally settled migrants (Wolff et al., 2008).

Migrants may be at particular risk of receiving less preventive care, due to numerous obstacles, such as language barriers, differences in health problems compared to the local population or inadequate knowledge of the local healthcare system ((FOPH), Federal Office of Public Health (2012); Barnett, 2007; Bodenmann et al., 2007; O'Donnell et al., 2007).

Among a random sample of 966 patients followed in university primary care settings in Switzerland, a country with universal health coverage, we aimed to determine which subgroups of the population received less preventive care and chronic care of cardiovascular (CV) risk factors, and to explore the socio-demographic determinants of variation in quality of care.

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Methods

Study design and patients

We abstracted medical charts from a random sample of patients followed by primary care physicians (PCP) in four Swiss university primary care settings (Basel, Geneva, Lausanne, and Zürich) in a retrospective cohort study (Collet et al., 2011). We randomly selected 1889 patients from electronic administrative data of all patients aged 50–80 years followed in 2005–2006. We limited our sample to this age group to have a high enough prevalence of examined indicators (e.g., CV risk factors, eligibility for cancer screening). We did not include 591 patients followed for <1 year to have adequate time to assess preventive care, 125 patients without outpatient visit to a PCP, 117 patients who were followed only in specialized clinics, and 54 patients from whom medical charts could not be found (who likely left the clinical setting for another practice). We further excluded 36 patients with unknown legal status, leading to a final sample of 966 patients.

Clinical quality indicators

As previously described (Collet et al., 2011), we selected 33 clinical health care quality indicators from RAND's QA Tools (Asch et al., 2006; McGlynn et al., 2003) regarding preventive care and the chronic care of CV risk factors: 14 indicators aimed at preventive care (physical examination: 3; alcohol: 2; smoking cessation: 5; cancer screening: 2; influenza immunization: 2) and 19 at chronic care of three major CV risk factors (hypertension: 4; dyslipidemia:

2; diabetes: 13). Chosen indicators focused on processes of care as opposed to outcomes of care, because they represent the activities that clinicians control most directly (McGlynn et al., 2003). We did not include preventive care indicators that were not applicable to our local guidelines or PCP settings, or indicators for conditions with likely low prevalence in our sample (e.g. asthma).

Chart abstraction and variables description

Centrally trained medical students abstracted medical charts with a chart abstraction form (Collet et al., 2011). In addition to the 33 indicators, we abstracted socio-economic and socio-demographic covariates, such as gender, age, civil status, occupation, birth place, legal status and comorbidity covariates (Table 1), with a chart abstraction form derived from the TRIAD study (Translating Research into Action for Diabetes) (Kerr et al., 2004).

Legal status was grouped into 3 categories: Swiss nationality, Residence permit holders, and Forced migrants (Bartlett et al., 2004). Swiss nationals are Swiss passport holders. Residence permit holders are either foreign-born citizens who have migrated to Switzerland or offspring of non-Swiss parents living in Switzerland who have not applied for or received Swiss citizenship. Residence permits have a predefined renewable period of validity, allowing the holder to legally work on the territory. Forced migrants are defined as people who have been forced to leave their home due to various reasons such as environmental, famine or developmental ((IOM), International Organization for Migration (2004); Urquia and Gagnon, 2011). This group includes asylum seekers and undocumented immigrants who are mostly former asylum seekers with rejected requests. Asylum seekers are immigrants waiting for a decision

Table 1
Characteristics of a random sample of 966 adults aged 50–80 years in 4 Swiss university primary care settings (Basel, Geneva, Lausanne, Zürich) followed over 2 years (2005–2006).

	Overall	Swiss nationality	Residence permit holders	Forced migrants ^a	P-value for difference
No. patients	966	560	325	81	
Women, no (%)	431 (44.6)	247 (44.1)	132 (40.6)	52 (64.2)	0.001
Age					
Mean, yr (SD)	63.5 (8.3)	65.2 (8.1)	62.2 (7.9)	57.3 (6.0)	0.004
Range, min – max	50 – 80	50 – 80	50 – 80	50 – 80	
Civil status (n = 960), no (%)					<0.001
Married	490 (51.0)	262 (47.0)	199 (61.8)	29 (35.8)	
Divorced, separated	225 (23.4)	144 (25.9)	58 (18.0)	23 (28.4)	
Single	145 (15.1)	95 (17.1)	34 (10.6)	16 (19.8)	
Widow/-er	100 (10.4)	56 (10.1)	31 (9.6)	13 (16.0)	
Occupation ^b (n = 948), no (%)					<0.001
Retired	357 (37.7)	254 (46.3)	102 (32.0)	1 (1.3)	
Employed	279 (29.4)	164 (29.9)	78 (24.5)	37 (46.3)	
At home	111 (11.7)	62 (11.3)	48 (15.0)	1 (1.3)	
Social aid	106 (11.2)	54 (9.8)	52 (16.3)	0 (0.0)	
Unemployed	95 (10.0)	15 (2.7)	39 (12.2)	41 (51.3)	
Birth Place ^c (n = 964), no (%)					<0.001
Switzerland	459 (47.6)	459 (82.3)	0 (0.0)	0 (0.0)	
Europe + North America	349 (36.2)	71 (12.7)	257 (79.1)	21 (25.9)	
Eastern Mediterranean Region	32 (3.3)	8 (1.4)	21 (6.5)	3 (3.7)	
African Region	34 (3.5)	8 (1.4)	16 (4.9)	10 (12.3)	
Latin America	55 (5.7)	5 (0.9)	10 (3.1)	40 (49.4)	
South East Asia + Western Pacific	35 (3.6)	7 (1.3)	21 (6.5)	7 (8.6)	
Cardiovascular risk factors ^d , no (%)					
Hypertension	725 (75.1)	425 (75.9)	250 (76.9)	50 (61.7)	0.014
Dyslipidemia	598 (61.9)	347 (62.0)	212 (65.2)	39 (48.1)	0.016
Diabetes	284 (29.4)	140 (25.0)	125 (38.5)	19 (23.5)	<0.001
Family history of early CHD ^e	97 (10.0)	62 (11.1)	28 (8.6)	7 (8.6)	0.46
Smoking status ^f (n = 947), no (%)					
Former smokers	169 (17.8)	110 (19.6)	55 (16.9)	4 (4.9)	0.001
Current smokers	242 (25.6)	145 (25.9)	80 (24.6)	17 (21.0)	0.48
At risk consumers or binge drinkers ^g	127 (13.1)	84 (15.0)	40 (12.3)	3 (3.7)	0.02

^a Forced migrants comprised 31 asylum seekers and 50 undocumented immigrants. 3 patients whose asylum request had been rejected were grouped with undocumented immigrants. For 36 patients, legal status was unknown.

^b Occupation was reclassified accordingly: 2 part-time worker patients were defined as "Employed", 2 patients in education were assigned to "At home", 1 patient who was seeking social aid was classified as on "Social Aid".

^c Birth place was classified according to the WHO Region classification: North America was gathered with Europe, Algeria with Eastern Mediterranean Region, Somalia with Africa.

^d Criteria of dyslipidemia, hypertension and diabetes are defined in Appendix Table A.

^e Early Coronary Heart Disease (CHD) was defined as a CHD event in male relatives <55 years or in female relatives <65 years. 1 patient had his family history of early CHD not documented.

^f Smoking status was defined as: Former smoker = stopped smoking ≥6 months before baseline; current smoker = smoking at baseline or stopped <6 months before baseline. 19 patients had their smoking status not documented.

^g At risk drinking was defined as >14 drinks per week for men <65 years or >7 drinks per week for others. Binge drinking was defined as >4 drinks per occasion for men <65 years or >3 drinks for others.

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