Interpreting ethnic inequalities in healthcare consumption: a conceptual framework for research

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Background: The increasing diversity of the Western-European population demands identification of potential ethnic healthcare inequities. We developed a framework that helps researchers in interpreting ethnic inequalities in healthcare consumption in equity terms. From this framework, we develop recommendations for the design of future studies. Methods: The framework was developed by analysing three typical studies on ethnic inequalities in healthcare consumption with respect to the potential of interpreting their results as healthcare inequities. Results: Analysing the effects of ethnic variations in healthcare consumption on health outcomes provides important clues about the presence of potential ethnic healthcare inequities. Interpretation of ethnic variations in healthcare consumption as potentially inequitable requires appropriate adjustment for medical need for healthcare, patient preferences and treatment adherence. Because of the central position of medical need, studies need to be disease-specific and based on standardized assessment of risk factors and disease characteristics. A longitudinal study design is necessary to prevent reverse causation. Conclusion: The framework shows that ethnic inequalities in healthcare consumption can be justified if healthcare received meets the need for healthcare in all groups and is in accordance with informed patient preferences. It also shows that ethnic equality in healthcare consumption may hide healthcare inequities. We recommend further research on ethnic healthcare inequities using multi-ethnic cohort designs combined with linkage to healthcare registries. We also recommend research to identify clinically relevant ethnic differences in disease profiles and optimization of treatment regimens.

Introduction

Modern developed societies aim to ensure equal opportunities for health, independently of one’s ethnic background. The ‘capabilities approach’ of Sen and Nussbaum provides a moral foundation for policies to reach this.1,2 Conceived as equal opportunities to achieve health, this capability principle requires that every individual has the real opportunity to be as healthy as possible. This ideal has not yet been realized. To address the health disadvantage of ethnic minority groups, a detailed insight into the factors and mechanisms shaping the health disadvantage of ethnic minority groups is warranted.

Ethnic inequities in healthcare, either in accessibility or quality, constitute a possible explanation for the health disadvantage of ethnic minority populations. Healthcare is deemed accessible if there are no financial, geographical, time, or cultural barriers to healthcare consumption. High quality of care means safe, effective, efficient, timely and patient-centred care.3 Equity of care—defined

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as equal access and quality across population subgroups—is a distinct performance indicator for any healthcare system. The increasing ethnic diversity of the population of Western Europe requires an analysis of ethnic health-care equity. For example, 11% of the current population of the Netherlands is of non-Western ethnic origin, with an estimated increase to 16% by 2050. In Amsterdam and other major Dutch cities, 35% of the population has a non-Western ethnic background.

The international research literature on ethnic inequity in care can be confusing because of lack of a standardized nomenclature. In the United States, 'ethnic disparity' is a common term that reflects shortfalls in care for specific ethnic groups. Following the Institute of Medicine (IOM) definition, healthcare disparities are differences in healthcare received by different groups that are not due to differences in the underlying healthcare needs or preferences of members of the groups. In European literature, 'inequality' and 'inequity' are common terms. In this article, we use ethnic healthcare inequality as a purely descriptive term for a difference in care consumption between ethnic groups.

Healthcare inequity points to ethnic differences in care consumption that are unjustified, implying explicit choices about what inequalities are justifiable. In this article, we follow Whitehead, who defined healthcare equity as equal care for equal need, resulting in equal care consumption given equal need. The concept of 'need' has been heavily discussed in the literature. Culyer argued that ill health is insufficient to define need and proposed 'capacity to benefit'. Ill health represents a need for healthcare only if there is an available supply of an effective healthcare intervention. The IOM report (2003) used health status indicators to evaluate the equity of the US healthcare system in treating clinically comparable groups similarly, although ethnic differences in health status may have systematic historical and structural causes. However, equity of the current health system needs to address current health status of the population.

The definition of equity as equal care for equal need is coherent with Aristotle's conceptualization of 'horizontal' and 'vertical' equity. Horizontal equity means equal care for equal need ('treat like as like'), whereas vertical equity requires care to be unequal if need is unequal ('treat unlike as unlike'). Until now there has been little focus on vertical healthcare inequity; most research has focused on horizontal ethnic equity, assuming ethnic equality in need. Ethnicity-specific differences in disease and treatment, such as different treatment of hypertension in people originating from West-Africa, constitute an application of the concept of vertical equity. However, a lot is unknown about these differences, and not all existing knowledge has been incorporated in professional guidelines. Research to identify ethnic differences in disease profiles and optimizing treatment regimens is recommended.

Studies on healthcare inequity have often relied on analysis of ethnic inequalities in healthcare consumption. However, not all ethnic inequalities in healthcare consumption represent inequities, whereas equal care consumption may hide ethnic inequities in care: the care consumption by the majority is not the gold standard. We developed a framework to help researchers in their interpretation of ethnic inequalities in healthcare consumption in equity terms. Thereto, we qualitatively analysed three studies from the international literature that in our opinion reflect the scientific development in empirical research on ethnic inequalities in healthcare consumption over the years.

### Three Types of Studies

We propose to classify empirical studies that analysed ethnic inequalities in healthcare consumption in three groups:

(i) Studies that document ethnic differences in healthcare consumption.

(ii) Studies that document ethnic differences in healthcare consumption, complemented by a comparison across ethnic groups of care delivered with guideline-recommended care.

(iii) As (ii), but with additional analysis of the association between ethnic variations in quality of care delivered and health outcomes.

An example of the first type is Stronks et al., who analysed consumption of healthcare services by ethnic origin using linked health insurance and health survey data for a general population sample (see table 1 for characteristics of the study population). Country-of-birth criteria were used to define ethnicity. After controlling for age and sex, general practitioner (GP) care consumption was significantly higher among most immigrant groups compared with the ethnic Dutch, whereas hospital admission rate and use of specialist services such as physiotherapy were not significantly different. Self-rated general health was significantly worse in the Moroccan and Turkish groups, but adding this variable to the statistical model did not account for the differences in care utilization, nor did socio-economic status indicators.

Can the differences in healthcare consumption as observed in this study be interpreted as ethnic healthcare inequities? We see two drawbacks. First, adjustment for ethnic variations in medical need was performed using self-rated general health. Second, the consequences of the observed differences in healthcare consumption for health outcomes could not be analysed.

Goddard and Smith illustrated the importance of appropriate conceptualization of need. Self-rated general health data do not represent the presence or severity of pathology or disease. It is a measure of subjective (or perceived) health, and can be viewed as the driving variable for healthcare-seeking behaviour. In the analysis of the match between need for healthcare and care consumption, professionally defined need (i.e., a professional judgement about people's health status and their need for medical care, further referred to as 'medical need') variables are superior. This requires detailed data on disease severity, and disease-specific studies are considered more meaningful. Additionally, reverse causation may have occurred in this study: subjects may have reported good health because of healthcare consumption. The observation that items on self-rated health are prone to cross-ethnic variations in interpretation further limits its usefulness in the analysis of ethnic inequity in care. Stronks et al. themselves acknowledged that

### Table 1 Study characteristics of three studies on ethnic inequalities in healthcare consumption

<table>
<thead>
<tr>
<th>Study</th>
<th>Study population</th>
<th>Design</th>
<th>Healthcare consumption</th>
<th>Need</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stronks et al., 2001</td>
<td>1422 ethnic Dutch, 139 Surinamese, 25 Antillean, 229 Moroccan, 85 Turkish inhabitants of Amsterdam</td>
<td>Cross-sectional</td>
<td>Registries</td>
<td>Self-rated health, self-reported chronic conditions</td>
<td>No</td>
</tr>
<tr>
<td>Fassaert et al., 2010</td>
<td>6413 GP patients with common mental disorders (CMD)</td>
<td>Prospective</td>
<td>Quality of CMD care indicators derived from registries</td>
<td>GP-recorded diagnosis of CMD</td>
<td>No</td>
</tr>
<tr>
<td>Fischbacher et al., 2009</td>
<td>10509 patients with diabetes (including 176 South Asians)</td>
<td>Prospective</td>
<td>Quality of diabetes care indicators derived from registries</td>
<td>Professional diagnosis of diabetes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
adequate adjustment for residual ethnic variation in need requires additional information on medical need.

As the authors also acknowledged, additional analysis of the consequences of the ethnic differences in healthcare consumption found for health outcomes might have provided a clue about the potential inequity of these ethnic differences in healthcare consumption. If in this case equal specialist care consumption reflected an example of ‘unlike treated as like’, health outcomes would have been worse in the ethnic groups that were under-treated. However, no outcome data were available for this specific study.

An example of the second type of study is provided by Fassaert et al.,16 who explored ethnic differences in indicators for quality of GP care for common mental disorders (CMD), see table 1. The authors’ choice of indicators for guideline adherence included at least five consultations in a specified period, prescription of psychotropic drugs, and/or referral to a mental health specialist (the choice of the indicators was limited by data availability from electronic medical records). Of these patients, 43% received adequate treatment according to these indicators. Only patients from Surinamese/Antillean descent were less likely to receive guideline-recommended care than the ethnic Dutch. Apart from low guideline adherence in general, this study thus provided evidence for ethnic variations in guideline adherence.

Studies of this type add information to studies that document ethnic differences in healthcare consumption (as in the first type of study, above). By comparing actual care consumption with guideline-recommended care, they add a new layer to the interpretation of healthcare consumption that introduces the opportunity to interpret care consumption data in terms of quality of care. Because medical practice guidelines are disease-specific, appropriateness of care consumption can only be judged in a disease-specific study.

Does this approach allow for conclusions on ethnic care inequity? This study was not hampered by some of the limitations of the first type of study. Medical need was analytically taken into account using a standardized diagnostic code as registered by the GP, which is an improvement when compared with patient self-assessment. Care consumption was measured subsequent to the diagnosis, and the interpretational layer of guideline adherence was added. However, it still lacked an analysis of the relationship between ethnic differences in professional guideline adherence and health outcomes of treatment, and the GP-recorded diagnosis of common mental disorders, as a proxy for medical need, contained no information on the severity of the disorder. Moreover, till now practice guidelines have often been based on the medical needs of the ethnic majority population. Guideline adherence is a valid starting point for analysing ethnic variations in quality of care, assuming ethnic equality in medical need. The confirmation or rejection of this assumption requires analysis of the effect of guideline-recommended care on health outcomes by ethnicity. And finally, there is evidence that some ethnic minorities tend to a lower consumption of standard mental health services because of a tendency to solve mood disorders by other means, such as seeking religious help.17

Such potential patient preferences for care that may result in ethnic differences in care consumption were not accounted for.

An example of the third type of study is Fischbacher et al.,18 who used the Diabetes Audit and Research in Tayside, Scotland (DARTS) database to compare processes of care and diabetes outcomes between South Asians and the white majority population in 2003–04. The DARTS database contains details of all patients known to have diabetes in the region. In November 2003, the database contained 10 509 patients (176 South Asians) with type 2 diabetes living in Tayside. Similar to Fassaert et al., the study made use of comparisons of care consumed with guideline-recommended care. Analysis of ethnic variations in diabetes care consumption showed no significant differences between South Asians and non-South Asians in the recording of some guideline-recommended assessments (HbA1C, cholesterol, blood pressure, retinal screening), and showed statistically significant differences that were in favour of the South Asians for others [more recordings of structured clinical review, body mass index (BMI)]. In contrast to Fassaert et al., however, further analysis linked healthcare consumption to health outcomes. After confounder adjustment for age and sex, South Asians were statistically significantly more likely to have retinopathy (diabetes health outcome). Numbers for those with stroke, coronary bypass surgery and foot ulcers were too low for valid estimation of ethnic differences. Turning to intermediate outcomes of care, HbA1C levels were significantly worse in South Asians. The authors concluded that ethnic variations in diabetes health outcomes (indicator: retinopathy) and diabetes control (indicator: HbA1C) were present, despite equality in professional guideline adherence. In other words, diabetes health outcomes were worse in the South Asian group despite equal care.

Does this study design allow for conclusions on ethnic inequities in care? The typical added value of this type of study is found in the analysis of the impact of ethnic differences in care consumption on health outcomes. However, patients’ treatment preferences (e.g. for insulin treatment) were not analysed. The potential relevance of patient preferences in explaining ethnic differences in healthcare consumption is suggested by studies from the US and the UK that showed treatment differences by ethnicity for cardiovascular disease.19,20 Additionally, valid analysis of ethnic differences in diabetes treatment outcomes requires data on other patient determinants of health outcome, notably health behaviour (e.g. diet, exercise) and therapy adherence.

The finding of worse health outcomes despite equal care consumption in Fischbacher’s study may suggest ethnic differences in disease profile. The finding of no ethnic differences in intensity of treatment (in this specific study, the proportion treated with insulin) may in fact point to under-treatment of South Asian patients with diabetes, because in this case equal treatment resulted in unequal health outcomes. It is possible that patients with diabetes of South Asian origin have a higher need for healthcare and need a more extensive or different treatment regimen. The study presented could then be an example of equal healthcare consumption hiding ethnic inequity in care. However, as pointed out by Culyer (1995), this is only true when the more extensive or different treatment regimen is effective.9 Maybe diabetes outcome will be worse in this group, whatever good the treatment.

These three reports illustrate what additional information we need to label inequalities in healthcare consumption as inequities. Below, we propose a framework to facilitate this interpretation process.

Proposal: Framework for Interpreting Ethnic Variations in Healthcare Consumption

We propose a framework that combines and elaborates several existing models: Andersen’s behavioural model of determinants of healthcare consumption,14 its clinical specification by Rathore,21 and a model for implementing the IOM definition of inequities in mental healthcare.22

Associating ethnic variations in healthcare consumption with health outcomes provides clues about the presence of horizontal or vertical ethnic inequities in care. When simplified, it all fits into a 2 × 2 matrix (table 2). After adjustment for age and sex as confounders, further analysis is needed to identify a situation as potentially inequitable, taking the following factors into account:

(i) Medical need, approximated by disease severity. It requires careful conceptualization and standardized measurement, and, if relevant for the treatment indication, it needs to include co-morbidity. The central position of medical need in the interpretation of ethnic inequalities in care consumption requires disease-specific studies.13

(ii) Patient factors that determine healthcare consumption, most notably treatment preferences. Ethnic groups may vary in their preferences for certain treatments. If ethnic variations in preferences for preventive or curative treatment choices are based
The framework presented here allows for identification of the results of comparisons of healthcare consumption by ethnicity as reflecting potential ethnic healthcare inequities. The framework also acts as a guide to design future studies on ethnic healthcare inequities. Application of the framework in design and execution of future research on healthcare inequities will allow for substantiation of ethnic healthcare inequities and their relevance, and for identification of levers to counteract them.

**Conclusion**

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Key points

- Ethnic inequalities in healthcare consumption do not necessarily represent inequities that warrant action. Ethnic inequalities in healthcare consumption can be justified if healthcare received meets the need for healthcare in all groups. Ethnic equality in healthcare consumption may hide healthcare inequities.

- Associating ethnic variations in healthcare consumption with health outcomes provides clues about the presence of ethnic healthcare inequities.

- Medical need must be accounted for, which means that empirical studies need to be based on standardized measurements of disease characteristics.

- Patient preferences and adherence to therapy recommendations that explain ethnic inequalities in healthcare consumption and in health outcomes may represent equitable care if they are truly well-informed, and do not reflect adverse living conditions.

References