A report from IDcare: Health care utilization in primary and specialist care among people with intellectual disability (http://www.lupop.lu.se/idcare)

Healthcare use in older people with intellectual disabilities compared to the general population – A Swedish register study before and during COVID-19

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Conclusions

- Older people with intellectual disabilities (ID) have higher risks of unplanned healthcare. This may indicate that they have unmet healthcare needs.
- As people with ID have higher levels of comorbidities, a similar or decreased risk of planned somatic and privately organized healthcare suggests that they are not well monitored by the health system.
- The significant interaction between periods seems to be because of greater reduction in healthcare in the general population during the pandemic compared to people with ID.

Background & aim

It is well-known that older people with intellectual disabilities (ID) have higher levels of several somatic and psychiatric comorbidities and overall greater healthcare utilization than the general population. A great and known healthcare need would imply high levels of planned healthcare, while unplanned healthcare could be a sign of unmet healthcare needs. Thus, to understand if older people with ID are receiving the healthcare they need, different types of healthcare utilization should be investigated. There are studies that have reported that people with ID have lower access to healthcare than the general population. During the COVID-19 pandemic access to healthcare was decreased for non-COVID-19 conditions in the general population. It is unknown if the use of healthcare was affected in the same way in people with ID.

The aim of this study was to assess healthcare utilization patterns among older people with ID, before and during the COVID-19 pandemic, compared to the general population.

Methods

We identified all people living in Skåne on January 1st, 2014, and who were 65 years or older. People with diagnosis of intellectual disability or Down syndrome, or with LSS support, were included in the ID cohort. After excluding family members of people with intellectual disability, the remaining people comprised the gPop (general population) cohort. See the flowchart to the right for details.

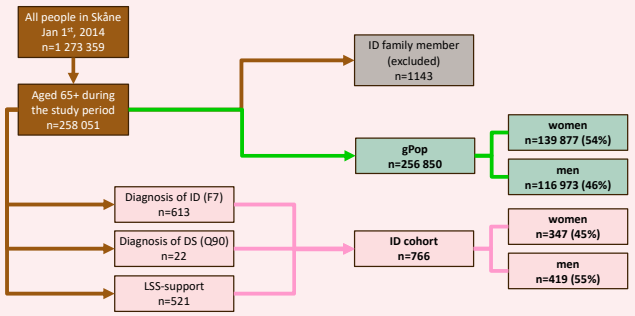
Healthcare utilization data was collected from Skåne Health Care Register for pre-pandemic (2014-2019) and pandemic (2020-2021) periods. Healthcare data included public primary care, privately organized care, psychiatric outpatient specialist care, psychiatric inpatient care, somatic outpatient specialist care, and somatic inpatient care and if the contact were planned/unplanned. Analyses were performed using Poisson regression, estimating relative risks (RRs) with 95% Confidence Intervals (CIs).

Results

Older people with ID had higher risk for unplanned, but not planned, contacts in public primary care and somatic specialist care during both the pre-pandemic and pandemic period. They had increased risk of both unplanned and planned contacts in psychiatric specialist care during both periods. However, they had decreased risk of privately organized care during both the pre-pandemic and pandemic period. During the pandemic period, some risks, particularly unplanned, were even more pronounced. For details see table 1 below.

Table 1: Relative risks (RRI with 95% confidence intervals (CIs) for ID cohort vs gPop

Healthcare type		RR (95% CI) Pre-pandemic	RR (95% CI) Pandemic	P-value Interaction
Public primary care	Total Unplanned Planned	1.3 (1.3-1.3) 4.6 (4.4-4.9) 1.2 (1.1-1.2)	1.4 (1.4-1.5) 4.7 (4.1-5.3) 1.3 (1.3-1.4)	0.001 0.759 0.001
Privately organized care	Total Unplanned Planned	0.3 (0.3-0.3) N/A 0.3 (0.3-0.3)	0.2 (0.2-0.3) N/A 0.2 (0.2-0.3)	0.115 - 0.116
Psychiatric outpatient specialist care	Total Unplanned Planned	5.0 (4.7-5.4) 1.9 (1.5-2.3) 6.5 (6.0-7.0)	8.2 (7.1-9.3) 3.0 (2.0-4.5) 10.4 (9.0-12.0)	<0.001 0.049 <0.001
Psychiatric inpatient specialist care	Total Unplanned Planned	2.5 (2.0-3.2) 2.4 (1.8-3.1) N/A	3.1 (1.7-5.7) 3.3 (1.8-6.0) N/A	0.575 0.358
Somatic outpatient specialist care	Total Unplanned Planned	0.7 (0.7-0.8) 1.2 (1.2-1.3) 0.6 (0.6-0.6)	0.9 (0.8-0.9) 1.2 (1.1-1.3) 0.7 (0.7-0.8)	<0.001 0.685 <0.001
Somatic inpatient specialist care	Total Unplanned Planned	1.2 (1.1-1.2) 1.4 (1.3-1.4) 0.5 (0.5-0.6)	1.3 (1.2-1.5) 1.5 (1.4-1.6) 0.7 (0.6-1.0)	0.026 0.234 0.019



Flowchart of study population identification

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