

studies were identified through searches of PUBMED, CINAHL, EMBASE (Excerpta Medica), and Cochrane databases. Reference lists of all relevant papers were reviewed for additional eligible articles. Randomised and non-randomised studies of the effect of contact with a podiatrist on risk of LEAs in people with diabetes (type 1 or 2) were included. Two reviewers independently assessed titles, abstracts, and full articles to identify eligible studies. Meta-analysis was performed separately for randomised and non-randomised studies.

Results Four hundred and ninety-nine titles were retrieved from searches of electronic databases. Duplicates (138) were removed and 361 titles/abstracts were reviewed. Nineteen papers were considered for review after initial screening of titles and abstracts. Three further studies were identified as potentially eligible from reference checking. After reviewing the full text articles, 6 studies met the inclusion criteria. The identified studies were heterogeneous in design (2 RCTs and 4 cohort studies) and included people with diabetes at both low and high risk of amputation. In a meta-analysis of available data from RCTs, the pooled RR of LEA was 1.4 (95% CI 0.2–9.3). The pooled RR from available cohort studies suggested a protective effect of podiatry but the estimate was unreliable, RR of 0.7 (95% CI 0.09–5.68).

Conclusion There is very limited data available on the effect of contact with a podiatrist on risk of LEA in people with diabetes. Further research in this area is warranted. An adequately powered RCT with a reasonably homogenous population regarding risk profiles would be the ideal way to answer this question if possible. A systematic review looking at the effect of podiatry as part of a multidisciplinary foot team on the risk of LEA in people with diabetes would also be prudent.

PS12 **DIABETES AND PRE-DIABETES PREVALENCE RATES IN THE SURVEY OF LIFESTYLES, ATTITUDE AND NUTRITION (SLAN) IN THE REPUBLIC OF IRELAND**

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Background To date estimates of the prevalence of diabetes in Ireland have been based on models of UK data. Since 2009 the International Expert Committee has recommended that the diagnosis of diabetes and pre-diabetes can be made on the basis of HbA1c levels. The objectives of this study are to estimate the prevalence of diabetes and pre-diabetes in a nationally representative sample of adults living in private households in Ireland and to assess whether the discrepancy between self-report and objective diabetes status is influenced by socio-demographic characteristics.

Methods Estimates were based on a nationally representative sample of participants in the Survey of Lifestyles, Attitude and Nutrition (SLAN) whom provided a blood sample at the physical examination. Diabetes was diagnosed based on an HbA1c level $\geq 6.5\%$ or self-report of occurrence of diabetes or reporting of diabetes medications. Pre-diabetes was diagnosed based on HbA1c level $\geq 5.7\%$ and $< 6.5\%$ and no self-report of diabetes or diabetes medications. Prevalences are reported with their 95% confidence intervals. Comparisons between men and women were carried out using the design-adjusted χ^2 test. A p-value of less than 0.05 was considered statistically significant.

Results The overall response rate among eligible adults (18+ years) was 62% for the main survey (n=10,364) and 66% for the physical examination substudy (aged 45+, n=1202). Among the 1202 participants who underwent a physical examination, 8 were excluded because they did not complete the questions on diabetes history and 65 were excluded from the analysis because they did not have HbA1c measurements. Among the remaining 1132 participants,

54 had diagnosed diabetes and 34 had undiagnosed diabetes based on HbA1c levels. Based on the HbA1c threshold, prediabetes was found in 214 individuals. The overall prevalence of diabetes was 7.7% (95% CI 6.2–9.4) and of pre-diabetes was 18.7% (95% CI 16.5–21). Prevalence of both diabetes and pre-diabetes were higher among men than women. A logistic regression model was used to investigate risk factors for undiagnosed diabetes.

Conclusion The prevalence of diabetes and pre-diabetes in this study is high. Pre-diabetes is a well-established risk factor for progression to diabetes and of cardiovascular disease. Despite efforts to increase awareness and screening for diabetes, some individuals with diabetes remain undiagnosed. Undiagnosed diabetes is highest in younger men (46–64 years). Increased efforts are required to improve detection of diabetes and pre-diabetes and thus, identify and manage this high-risk population.

PS13 **EQUITY OF ACCESS TO HEALTH CARE AND TREATMENT OF NON-COMMUNICABLE DISEASES IN SCOTLAND AND HONG KONG**

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Background Providing equitable access to health care is a goal for most health systems. The long-term and costly nature of treating non-communicable diseases may present particular challenges for equity of access (equal treatment for equal need), though few previous studies have considered this. This study compares equity of access to health care in Scotland and Hong Kong, with a particular focus on treatment for non-communicable diseases (NCDs). Since Scotland's health care is largely tax-funded, while Hong Kong has a mixed medical economy (shared between public and private sectors) we expected to see greater equity of access to health care in Scotland, particularly for treatment of NCDs.

Methods In two large, population-representative household surveys - the Scottish Health Survey (2008–9) and Hong Kong's Thematic Household Survey (2010) - we assessed associations between health care utilisation (GP consultations, specialist consultations, admissions to hospital, and utilisation specifically for NCDs) and socioeconomic position (income, occupation and education) using multi-variable logistic regression. We also controlled for 'need for health care' (age, sex, self-rated health and chronic conditions).

Results After controlling for need, in Scotland: utilisation of GP consultations and GP consultations for cardiovascular disease (CVD) were not associated with any measure of SEP; utilisation of specialist care, however, was positively associated with income (OR 1.27 for highest versus lowest income quintile, 95% CI 1.08 – 1.50), though this was attenuated by additionally adjusting for education, and the association was even stronger for specialist CVD consultations (OR 1.68, 95% CI 1.12 – 2.54); and hospital admissions were negatively associated with income (OR 0.73, 95% CI 0.57 – 0.94). In Hong Kong, utilisation of all types of health care was positively associated with income and occupation, except for care for chronic conditions; most associations were attenuated after additionally controlling for health insurance cover.

Conclusion Taking utilisation rates as a proxy for access to health care, our results suggest that in Scotland, access to primary care is highly equitable, but that people on low incomes or with poor education may have restricted access to specialist treatment, especially for CVD. This could be due to GP referrals giving preference to higher SEP patients. Surprisingly, we found that, whilst access to care in Hong Kong was generally better for people with high SEP, treatment of chronic conditions was more equitable than in Scotland, showing that fully tax-funded health systems do not necessarily provide more equitable access to all forms of care than systems of mixed funding.