



Limited health literacy is associated with reduced access to kidney transplantation

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Title

Limited health literacy is associated with reduced access to kidney transplantation

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For Peer Review Only

Abstract

Limited health literacy is common in patients with chronic kidney disease (CKD), and has been variably associated with adverse clinical outcomes. The prevalence of limited health literacy is lower in kidney transplant recipients than in individuals starting dialysis, suggesting selection of patients with higher health literacy for transplantation. We investigated the relationship between limited health literacy and clinical outcomes, including access to kidney transplantation, in a prospective UK cohort study of 2,274 incident dialysis patients aged 18-75 years. Limited health literacy was defined by a validated Single Item Literacy Screener (SILS). Multivariable regression was used to test for association with outcomes after adjusting for age, sex, socioeconomic status (educational level and car ownership), ethnicity, first language, primary CKD diagnosis, and comorbidity. In fully-adjusted analyses, limited health literacy was not associated with mortality, late presentation to nephrology, dialysis modality, haemodialysis vascular access, or pre-emptive kidney transplant listing, but was associated with reduced likelihood of listing for a deceased-donor transplant (hazard ratio, HR 0.68; 95% CI 0.51-0.90), receiving a living-donor transplant (HR 0.41; 95% CI 0.19-0.88), or receiving a transplant from any donor type (HR 0.65; 95% CI 0.44-0.96). Limited health literacy is associated with reduced access to kidney transplantation, independent of patient demographics, socioeconomic status, and comorbidity. Interventions to ameliorate the effects of low health literacy may improve access to kidney transplantation.

Keywords: Health Literacy; Kidney transplantation; Socioeconomic Status; Chronic Kidney Disease; Dialysis.

Introduction

Patients with advanced chronic kidney disease (CKD) who start dialysis are required to cope with the demands of a high-intensity treatment, often with a burden of increasing symptoms.¹ When medically appropriate, kidney transplantation offers superior clinical outcomes compared to dialysis,^{2,3} and leads to improvements in self-reported health.⁴ Over 80% of UK transplanted patients receive dialysis prior to transplantation,⁵ so are required to participate in investigations, discussions (including with potential living kidney donors) and shared decisions to prepare for transplantation at a time when their capacity to do so may be diminished.

Patients' capacity to cope with these communication challenges may be enhanced by adequate health literacy,⁶ which can aid understanding, appraisal and use of health-related information, as distinct from general literacy, language fluency or patient activation.⁷ 'Limited' health literacy (a below-adequate level defined by health literacy measures⁸) is common, affecting 20-25% of the dialysis population, but a significantly lower proportion of transplant recipients (14%), suggesting that patients with higher health literacy are more likely to be transplanted.^{9,10} Limited health literacy is associated with low socioeconomic status, so has been implicated as a mediator of socioeconomic inequity in health outcomes.¹¹ There is some evidence of independent associations between lower health literacy and adverse clinical events, increased healthcare use and mortality in CKD,⁸ but a lack of larger, prospective studies evaluating the effects of lower health literacy on renal replacement therapy and kidney transplant pathways.⁸

We aimed to identify independent associations between health literacy and clinical outcomes including access to kidney transplantation in UK patients starting dialysis.

Results

Figure 1 shows the processes of patient recruitment and data collection. In total, 2274 of 2432 patients eligible for inclusion responded to the Single Item Literacy Screener (SILS) health literacy question. Table 1 summarises patient demographics, clinical and socioeconomic characteristics, by limited vs adequate health literacy, and results of univariate analyses. Table 2 shows results of multivariable analyses.

Baseline characteristics

As in the baseline analysis of this group,¹⁰ patients with limited health literacy were more likely to have higher levels of comorbidity and lower socioeconomic status, including a lower level of educational attainment and reduced likelihood of car ownership.

Presentation, dialysis modality, and haemodialysis vascular access

Limited health literacy was associated with reduced likelihood of late presentation to nephrology care, but not after adjustment for primary renal diagnosis and comorbidity (Odds Ratio, OR: 0.70; 95% CI: 0.39-1.27). A lower proportion of patients with limited health literacy had peritoneal dialysis as their first dialysis modality, but this difference was not significant in multivariable models (unadjusted OR for peritoneal dialysis 0.73; 95% CI: 0.52-1.03). Limited health literacy was not associated with haemodialysis catheter use (unadjusted OR: 1.07, 95% CI: 0.86-1.33).

Access to transplantation and mortality

There was no significant difference between patients with limited vs adequate health literacy in pre-emptive deceased-donor transplant listing in univariate or multivariable analyses (Table 1 and Table 2). Figure 2 shows the specification of time-to-event variables for transplantation and mortality. In univariate analyses, patients with limited health literacy had a significantly lower likelihood of transplant listing after starting dialysis, living-donor transplantation and transplantation from any donor type, but no difference in mortality (Table 2, Figure 3). In fully-adjusted models (Table 2),

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3 patients with limited health literacy had a reduced likelihood of listing for deceased-donor transplant
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5 (n=1833; Hazard ratio; HR: 0.68; 95% CI: 0.51-0.91), living-donor transplantation (n=2180; HR: 0.41;
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7 95% CI: 0.21-0.80), and transplantation from any donor type (n=2178 HR: 0.65; 95% CI: 0.45-0.92).
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11 There was no difference between patients with limited vs adequate health literacy in likelihood of
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13 deceased-donor transplantation after listing (Supplementary results 1). There were no significant
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15 violations of the proportional hazards assumptions. (Supplementary results 2). Including patients
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17 with lower English fluency (Supplementary results 3; Table S1, Table S2), using Townsend
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19 deprivation index in place of socioeconomic status markers as covariates in multivariable models
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21 (Supplementary results 4; Table S3), or removing adjustment for clustering by renal centre
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23 (Supplementary results 5; Table S4) did not change overall results.
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27 For the three transplant outcomes, missing data affected 6-8% of cases, affected more Asian
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29 patients and those with diabetes as primary renal diagnosis, and largely related to missing SILS
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31 response. There was no difference in the significance of results when effect sizes were estimated
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33 after multiple imputation of missing data (Supplementary results 6; Tables S5, S6 and S7).
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37 Supplementary information is available at Kidney International's website
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42 Discussion

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45 In this UK cohort study of 2274 patients starting dialysis, limited health literacy was independently
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47 associated with reduced access to deceased-donor transplant listing, transplantation from a living-
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49 donor or transplantation from any donor type. Health literacy was not shown to affect protocol-
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51 driven systems for offering deceased-donor kidneys after listing.¹² The effect of limited health
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53 literacy in reducing access to transplantation is therefore likely to relate to patients' preparation for
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55 deceased or living-donor transplantation. Health literacy was not independently associated with
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57 dialysis modality, haemodialysis vascular access, pre-emptive transplant listing or mortality. The
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3 pathway to deceased-donor transplant listing could not be captured in a single variable because
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5 patients were recruited when starting dialysis, so those listed pre-emptively were considered in a
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7 separate analysis to those listed after starting dialysis. The absence of a significant association with
8
9 pre-emptive listing may relate to loss of statistical power.
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12 Pathways to deceased-donor transplant listing and living-donor transplantation depend on adequate
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14 clinician-patient communication and understanding to enable effective shared decision-making.
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16 Patients with limited health literacy may have reduced understanding of CKD, its consequences,⁸
17
18 and the benefits of transplantation. They may feel less able or comfortable speaking and asking
19
20 questions during clinical interactions⁶ let alone driving discussions about transplantation. Current
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22 shared decision-making resources may be unsuitable for patients with limited health literacy.¹³
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24 Limited health literacy is hypothesised to reduce patients' capacity to cope with the burden of
25
26 chronic disease and its treatment,¹ and associations with low socioeconomic status and
27
28 comorbidity^{10, 11} may further impede effective care. Patients with limited health literacy may lack
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30 understanding, so be less likely to discuss transplantation with family and friends, while social
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32 support mechanisms (providing opportunities for discussion) may be reduced by low socioeconomic
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34 status. Patients may be over-burdened by the process of dialysis preparation, preferring a 'short-
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36 term focus':¹⁴ deferring preparations for transplantation until established on dialysis. The associated
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38 reduction in time accrued on the transplant list may reduce the likelihood of transplantation.¹² The
39
40 recruitment of living donors presents a specific communication challenge, as a potential recipient
41
42 needs to engage a potential donor. Potential donors, most commonly family members, may also
43
44 have lower health literacy and health contraindications because of shared social disadvantages.¹¹
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46 Lastly, the process of preparing for a kidney transplant may invoke considerable psychological stress.
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48 Patients with lower health literacy, less able to rationalise and understand pathways to
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50 transplantation, may find this process more frightening, limiting their ability to engage with it.
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3 In studies from the USA, health literacy is inconsistently associated with transplantation, dialysis
4 catheter use, healthcare service use including emergency department attendance, and mortality.⁸
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6 Low health literacy has strong associations with low socioeconomic status,^{9,10} and there are
7
8 persistent socioeconomic disparities in CKD, its complications,^{15,16} and in access to kidney
9
10 transplantation.^{17,18} As such, limited health literacy may lie on the causal pathway between low
11
12 socioeconomic status and reduced transplant access, acting as a mediator in this relationship. If this
13
14 relationship exists, interventions which successfully ameliorate the effects of low health literacy in
15
16 clinical practice may have potential to improve outcomes, but also to reduce socioeconomic
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18 inequity. Possible interventions include health literacy-sensitive decision-making resources,¹⁹ specific
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20 communication techniques,²⁰ enhanced educational programmes with direct support,^{21,22} patient
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22 advocacy,²³ or supported navigation of care pathways.²⁴ Further investigation with mediation
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24 analysis may be appropriate, and has been used to investigate the role of health literacy in other
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26 patient pathways.²⁵
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33 The ATTOM study benefits from a large representative sample of the UK incident dialysis
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35 population,²⁶ 2-years follow-up, high data completeness, robustness to missing data and detailed
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37 comorbidity adjustment. Limitations include use of the SILS to measure health literacy. Health
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39 literacy is a multifaceted concept,⁶ so no measure can fully describe its different aspects, but longer
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41 comprehension tests such as STOFHLA (which tests comprehension of health related terms in
42
43 sample medical information) do directly test different health literacy skills such as reading
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45 comprehension and numeracy. The SILS instead measures patient-reported perceived need for help
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47 when reading health-related material. The use of the SILS with limited health literacy defined as
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49 responses 'Sometimes', 'Often' or 'Always' as in this study has moderate accuracy in detecting
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51 limited health literacy defined by STOFHLA in patients with diabetes (sensitivity 54%; specificity
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53 83%),²⁷ and on haemodialysis (Sensitivity 39%, Specificity 93%).²⁸ However, no health literacy
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55 measure can be relied on to provide a 'true' measure of health literacy because of the complexity of
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57 health literacy as a concept. Using a comprehension-based measure in studies with a large number
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3 of participants risks increasing research burden, reduced response rates (arguably more likely to be
4 reduced among those with health literacy), and non-response bias. These factors influenced our
5 choice of health literacy measure. Further, the simplicity of the SILS perhaps makes it more relevant
6 to use in clinical practice, where patients who report difficulty understanding written information
7 could quickly and easily be identified as at risk of reduced access to transplantation. Longer follow-
8 up would have increased statistical power with more events accrued. Recruitment was not universal,
9 but we estimate that over 50% of incident dialysis patients were recruited (based on comparison
10 with registry data from 2012), and comparison of patients recruited vs not recruited showed no
11 significant differences in demographics. We could not prospectively capture the processes of pre-
12 emptive transplantation or pre-emptive listing because patients were recruited when starting
13 dialysis. The baseline variable for pre-emptive deceased-donor transplant wait-listing does not
14 capture patients who were listed then transplanted before starting dialysis. Baseline comorbidity
15 data, while comprehensive, do not record severity of comorbidities or changes in comorbidity over
16 time, so residual confounding is possible. No data were available on whether transplant work-up
17 was performed or the results of this process, so any reasons for delay in transplant listing or
18 transplantation (whether clinical or related to other factors) were not known. The highest
19 proportion of missing data in complete-case analysis (Supplementary material 6) resulted from
20 missing exposure (SILS) data. For the transplantation variables, a low proportion (under 8%) had any
21 missing data in fully-adjusted analyses, and there was no significant difference in these outcomes
22 between incomplete and complete cases. In analyses of baseline data, multiple imputation did not
23 significantly change measured associations between health literacy and patient factors.¹⁰ Imputation
24 is unlikely to change results if the proportion of missing data is low.²⁹ Individual clinicians and renal
25 centres may vary in their practice of deeming a patient suitable for transplant listing.³⁰ Centre-level
26 differences in clinical practice are accounted for in our analysis by using robust standard errors,
27 similar to methodology used elsewhere.¹⁸ However, these methods do not investigate the reasons
28 for centre variation, which lies outside the scope of this study but is investigated by our research
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3 group in a current study. Lastly, these findings from observational data provide evidence of
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5 independent associations but do not prove causation.
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8 In conclusion, access to transplantation appears to be impeded by limited health literacy in a
9
10 significant proportion of UK incident dialysis patients. These effects are unlikely to be unique to
11
12 kidney transplantation processes, and may be applicable to other healthcare settings and disease
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14 pathways.³¹ The impact of limited health literacy on the actions and interactions of patients,
15
16 relatives and clinicians require further investigation. Examination of current practice and available
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18 support mechanisms, routine assessment for limited health literacy and development and testing of
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20 interventions to reduce its unwanted consequences would be helpful steps to improving equity of
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22 access to transplantation.^{32, 33}
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29 **Methods**

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32 This prospective, multicentre cohort study was part of the Access to Transplant and Transplant
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34 Outcome Measures (ATTOM) programme. Patients starting dialysis aged 18-75 years, recruited
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36 December 2011 through September 2013 from all 72 UK renal centres provided informed, written
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38 consent for data collection. ATTOM methodology,²⁶ and baseline associations between limited
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40 health literacy, demographics and socioeconomic status¹⁰ are published elsewhere. See **Figure 1** for
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42 the process of patient selection.
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46 *Baseline data*

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49 Within 90 days of starting dialysis, patients completed a questionnaire including demographics,
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51 individual-level indicators of socioeconomic status, and the Single Item Literacy Screener (SILS), a
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53 validated health literacy measure.^{27, 28} The SILS is 'How often do you need to have someone help you
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55 when you read instructions, pamphlets or other written material from your doctor or pharmacy',
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57 with responses 1-Never, 2-Rarely, 3-Sometimes, 4-Often and 5-Always. Responses 'Sometimes',
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3 'Often' and 'Always' were taken to represent limited health literacy, informed by validation against
4 the Short Test of Functional Health Literacy in Adults (STOFHLA, a 7-minute comprehension
5 assessment).^{27, 28} Primary renal diagnosis comorbidities, dialysis modality, vascular access and date
6 of first contact with nephrology services were collected by structured review of clinical notes.
7
8 Comorbidity was quantified using a Charlson comorbidity index modified for CKD populations
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10 (Supplementary methods 1, Table S8). Patients with self-reported English fluency below 'good' were
11 excluded from primary analyses, but included in a sensitivity analysis.
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14 15 16 17 18 19 20 *Prospective data*

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22 Date of deceased-donor transplant listing and transplantation were received from National Health
23 Service Blood and Transplant (NHSBT), and mortality data from the UK Renal Registry (UKRR),
24 censored two years after recruitment. 'Time to event' variables included time from starting dialysis
25 to listing for deceased-donor transplant, to transplantation from a living donor, to transplantation
26 from any donor type (living or deceased), and to death (Figure 2). As patients were recruited after
27 starting dialysis, those listed 'pre-emptively' (before starting dialysis) were not included in the time-
28 to-event variable for transplant listing, but considered in a separate binary variable. Patients
29 transplanted 'pre-emptively' were not included.
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41 42 43 *Analysis*

44 Univariate analysis examined associations between limited health literacy and: 'late presentation' to
45 nephrology (within 90 days of starting dialysis); initial dialysis modality; haemodialysis vascular
46 access; pre-emptive listing for deceased-donor transplant; time to listing for deceased-donor
47 transplant; time to living-donor transplantation; time to transplantation from any donor type and all-
48 cause mortality. After listing for transplant, deceased-donor kidney offers are governed by organ
49 allocation algorithms,¹² so are not influenced by health literacy, confirmed by analysis of time from
50 listing to deceased-donor transplantation (Supplementary results 1).
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3 Multivariable analyses were performed for all outcome measures, with sequential adjustment for
4 potential confounders known to be associated with the outcomes and with health literacy.^{9, 10, 17, 18, 34}
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6 These were defined *a priori* and included age and sex, ethnicity and first language, comorbidity and
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8 primary renal diagnosis, and indicators of socioeconomic status³⁵ (highest educational qualification
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10 and car ownership). Effect ratios with robust standard errors were calculated in order to account for
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12 clustering within renal centres.³⁶
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17 Sensitivity analyses were performed. First, the models were re-fitted including patients who
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19 reported English fluency below 'very fluent', adjusted for fluency level in multivariable models.
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21 Second, multivariable analyses were repeated with adjustment for 2011 area-level deprivation score
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23 (Townsend)³⁷ in place of individual markers of socioeconomic status. Third, results were compared
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25 with and without robust standard errors to account for clustering by renal centre.
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29 Data were described as mean (95% confidence interval), median [interquartile range], or number
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31 (percentage). Univariate analyses used t-tests, χ^2 test, and Kaplan-Meier analysis, and multivariable
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33 analysis used logistic regression, linear regression or Cox regression as appropriate. Statistical
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35 significance was defined *a priori* as $p < 0.05$. Proportional hazards assumptions were tested using
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37 Schoenfeld residuals. Analyses presented used complete-case analysis. For each analysis, the
38
39 proportion of missing data was calculated and results after multiple imputation of missing data are
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41 shown in the supplementary material. Patient characteristics and outcomes were compared
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43 between patients with missing vs complete data. All analyses used Stata 14.1 (StataCorp, USA).
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48 Supplementary information is available at Kidney International's website
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51 52 53 **Author Contributions**

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56 Dominic M Taylor performed the analyses, produced the figures and tables and wrote the
57
58 manuscript under the supervision of Rommel Ravanan, Paul Roderick and Simon Fraser. All other
59
60 authors are members of the Access to Transplant and Transplant Outcome Measures (ATTOM)

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3 research group, and along with Rommel Ramanan and Paul Roderick, designed and ran the ATTOM
4 study as a whole, and gave editorial and methodological advice during manuscript preparation.
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8 **Supplementary material headings**

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11 **Supplementary results 1:** Analysis of time from deceased-donor transplant listing to deceased-donor
12 transplantation.
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14 **Supplementary results 2:** Tests of the proportional hazards assumption
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16 **Supplementary results 3:** Analysis including patients with moderate English fluency (or lower)
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18 **Table S1:** Analysis including patients with moderate, low or no English fluency. Patient
19 characteristics and univariable analysis by limited vs adequate health literacy
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21 **Table S2:** Repeated multivariable analysis including patients with moderate, low or no English
22 fluency.
23

24 **Supplementary results 4:** Townsend deprivation score
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26 **Table S3:** Repeated multivariable analysis using Townsend deprivation score as a covariate
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28 **Supplementary results 5:** Clustering by renal centre
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30 **Table S4:** Effect ratios for each model before and after adjustment for clustering by renal centre
31

32 **Supplementary results 6:** Data completeness
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34 **Table S5:** Missing data for each outcome variable.
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36 **Table S6:** Comparison of demographics between patients with complete vs incomplete records for
37 three transplant outcome analyses
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39 **Table S7:** Comparison of results of multivariable analysis using complete cases only vs estimates
40 from multiple imputation
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42 **Supplementary methods 1:** Modified Charlson comorbidity index
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44 **Table S8:** Score weightings for modified Charlson index based on Hemmelgarn et al
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Tables

Table 1: Summary statistics and univariate analysis by limited vs adequate health literacy

Shown as frequency (%), mean (95% CI) or median [IQR]. Subgroup percentages may not total 100% because of rounding. Significant p values shown in bold. Detailed baseline characteristics and associations with limited health literacy have been published separately.¹⁰ Modified Charlson comorbidity index is described in supplementary material 1. Primary Renal Diagnoses were categorised according to UK Renal Registry (UKRR) criteria.

	Total: 2463	Health Literacy		p
		Adequate 1915 (84)	Limited 359 (16)	
<u>Demographics</u>				
Male		1243 (65)	231 (64)	0.84
Age		58 [47, 67]	58 [47, 66]	0.67
Ethnicity:				
White		1651 (86)	304 (85)	
Asian		113 (6)	22 (6)	
Black		126 (7)	27 (8)	0.42
Chinese		9 (0.5)	0 (0)	
Mixed-race		10 (1)	4 (1)	
First language:				
English		1800 (94)	338 (94)	0.94
Other (but with good English fluency)		114 (6)	21 (6)	
<u>Clinical features</u>				
Primary renal diagnosis				
Diabetes		398 (21)	166 (47)	
Glomerulonephritis		305 (16)	40 (11)	
Pyelonephritis		124 (7)	18 (5)	
Hypertension		127 (7)	18 (5)	<0.001
Polycystic Kidney Disease		173 (9)	18 (5)	
Renovascular Disease		62 (3)	10 (3)	
Other		430 (23)	37 (10)	
Uncertain		275 (15)	46 (13)	
Modified Charlson Comorbidity index:				
0		881 (46)	77 (21)	
1-2		668 (35)	182 (51)	
3-4		233 (12)	66 (18)	<0.001
>4		133 (7)	34 (9)	

		Health Literacy		
		Adequate	Limited	
<u>Socioeconomic status indicators</u>				
Highest educational qualification:				
	None	551 (29)	179 (50)	
	High School level	836 (44)	119 (33)	<0.001
	University level	331 (17)	22 (6)	
	Other qualification	189 (10)	39 (11)	
	Car owner	1440 (75)	198 (55)	<0.001
<u>Outcome measures</u>				
	Late presentation (<90 days before dialysis initiation)	291 (17)	32 (10)	0.003
	Peritoneal Dialysis as first dialysis modality	417 (22)	61 (17)	0.043
	Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality)	809 (55)	164 (56)	0.68
	Pre-emptive deceased-donor transplant listing	241 (13)	35 (10)	0.09
At 2 years from dialysis initiation:				
	Listed for deceased-donor transplant	750 (42)	96 (27)	
	Transplanted (living-donor)	162 (9)	7 (2)	
	Transplanted (any donor type)	337 (18)	31 (9)	
	Mortality	271 (14)	67 (19)	

Table 2: Analysis of outcome measures by limited vs adequate health literacy, with sequential adjustment for demographics, primary renal diagnosis, comorbidity (modified Charlson index) and socioeconomic status (highest educational qualification and car ownership)

Measures of effect shown for limited vs adequate health literacy depend on the regression model used (Logistic: Odds ratio, OR; Linear: β coefficient; Cox: Hazard ratio, HR). Categorical variables for Ethnicity, first language, primary renal diagnosis, Comorbidity (modified Charlson index) and highest educational qualification are specified as shown in Table 1; Significant p-values are shown in bold. Patients with missing data for any variable in model 6 are excluded from all models, such that models 1-6 include the same sample.

		Model					
		1	2	3	4	5	6
		Unadjusted	+ Age/Sex	+ Ethnicity, first language	+ Primary renal diagnosis, Comorbidity	+ Highest educational qualification	+ Car ownership
Late presentation (<90 days) n=2001	OR (95% CI) p	0.55 (0.33,0.94) 0.027	0.55 (0.32,0.93) 0.026	0.55 (0.33,0.94) 0.028	0.70 (0.39,1.27) 0.2	0.71 (0.39,1.28) 0.3	0.68 (0.37,1.24) 0.2
Peritoneal dialysis as first dialysis modality (vs haemodialysis) n=2214	OR (95% CI) p	0.73 (0.52,1.03) 0.08	0.73 (0.51,1.03) 0.08	0.73 (0.52,1.03) 0.08	0.76 (0.53,1.08) 0.1	0.84 (0.59,1.19) 0.3	0.93 (0.65,1.35) 0.7
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality) n=1741	OR (95% CI) p	1.07 (0.86,1.33) 0.6	1.06 (0.85,1.32) 0.6	1.05 (0.84,1.32) 0.6	1.12 (0.87,1.43) 0.4	1.12 (0.87,1.43) 0.4	1.09 (0.84,1.41) 0.5
Pre-emptive deceased-donor transplant listing n=2092	OR (95% CI) p	0.73 [0.52,1.02] 0.07	0.72 [0.52,1.01] 0.06	0.73 [0.52,1.02] 0.06	0.86 [0.60,1.21] 0.4	0.98 [0.68,1.41] 0.9	1.03 [0.71,1.49] 0.9
Likelihood of listing for deceased-donor transplant after starting dialysis n=1833	HR (95% CI) p	0.54 (0.41,0.73) <0.001	0.53 (0.39,0.72) <0.001	0.53 (0.40,0.71) <0.001	0.61 (0.45,0.82) 0.001	0.66 (0.49,0.88) 0.004	0.68 (0.51,0.91) 0.010
Likelihood of living-donor transplantation after starting dialysis n=2180	HR (95% CI) p	0.23 (0.11,0.51) <0.001	0.24 (0.12,0.49) <0.001	0.24 (0.12,0.48) <0.001	0.32 (0.16,0.63) 0.001	0.38 (0.20,0.75) 0.005	0.41 (0.21,0.80) 0.009
Likelihood of transplantation from any donor type after starting dialysis n=2178	HR (95% CI) p	0.47 (0.32,0.67) <0.001	0.47 (0.33,0.67) <0.001	0.47 (0.33,0.66) <0.001	0.54 (0.38,0.77) 0.001	0.62 (0.43,0.89) 0.009	0.65 (0.45,0.92) 0.016
Mortality n=2186	HR (95% CI) p	1.27 (0.88,1.85) 0.2	1.29 (0.90,1.85) 0.2	1.30 (0.91,1.86) 0.2	1.13 (0.79,1.63) 0.5	1.07 (0.75,1.54) 0.7	1.05 (0.73,1.49) 0.8

Figure Legends

Figure 1: Recruitment process

* The proportion of UK incident dialysis patients recruited to ATTOM is difficult to quantify because of differing start and end dates for each renal centre, although comparison with 2012 UK Renal Registry data showed that over 50% of incident dialysis patients under 75 years were recruited to ATTOM. A comparison of the characteristics of incident dialysis patients recruited to ATTOM and those registered with the UK Renal Registry (UKRR) showed no significant differences in age, sex or ethnicity after adjustment for missing ethnicity data in the UKRR record (data not shown).

† These patients were recruited after transplantation and re-recruited as incident dialysis patients after transplant failure

‡ Multi-organ transplants are subject to different organ allocation policies (compared to single-organ)

§ This is to account for the practice in some centres of listing before immediate suspension while investigations are performed to ensure fitness for transplantation

ATTOM: Access to Transplant and Transplant Outcome Measures

Figure 2: Specification of time-to-event variables

* This adjustment accounts for the practice of preparing patients for living-donor transplantation without adding them to the deceased-donor transplant waiting list, and assumes that the recipient is fit for transplantation 6 months before living-donor transplantation.

Figure 3: Univariate analysis of 'time to event' outcomes, with unadjusted Hazard Ratios (HRs) for limited vs adequate health literacy (HL)

Time-to-event outcomes specified as in Figure 2

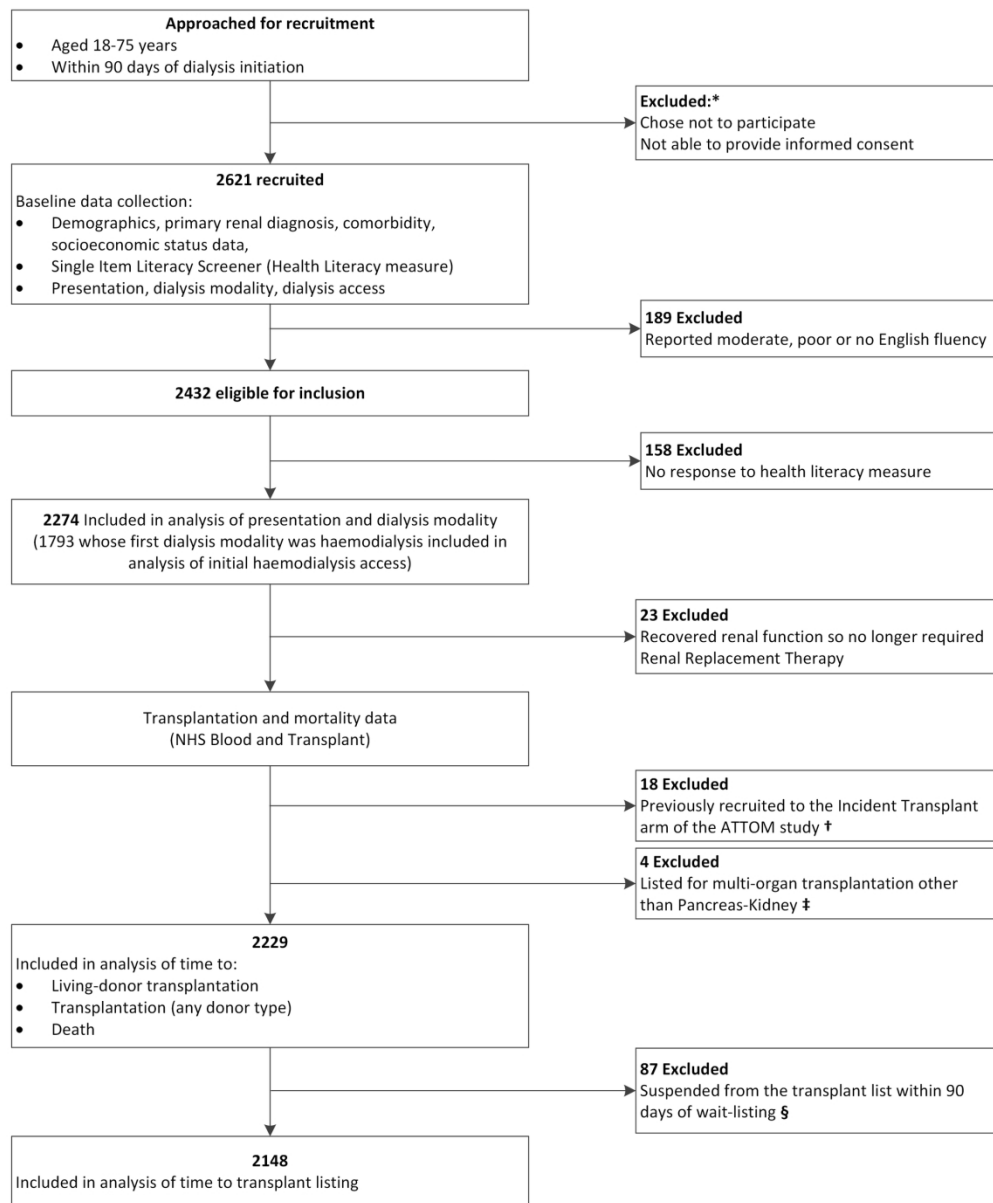


Figure 1: Recruitment process

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ATTOM: Access to Transplant and Transplant Outcome Measures

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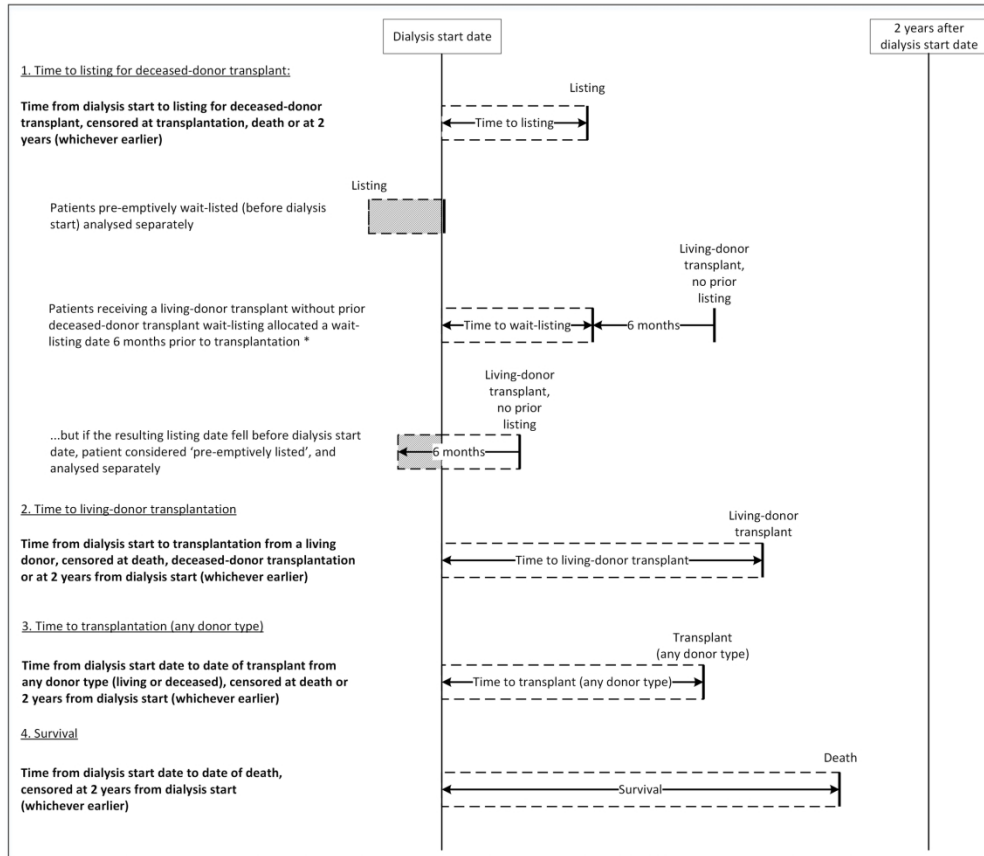


Figure 2: Specification of time-to-event variables

* This adjustment accounts for the practice of preparing patients for living-donor transplantation without adding them to the deceased-donor transplant waiting list, and assumes that the recipient is fit for transplantation 6 months before living-donor transplantation.

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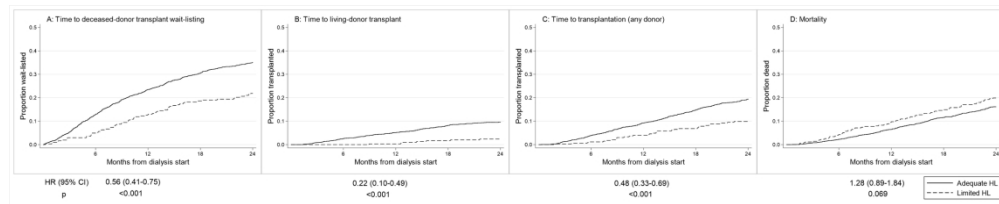


Figure 3: Univariate analysis of 'time to event' outcomes, with unadjusted Hazard Ratios (HRs) for limited vs adequate health literacy (HL)
Time-to-event outcomes specified as in Figure 2

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Supplementary results

1: Analysis of time from deceased-donor transplant listing to deceased-donor transplantation.

Patients were included if wait-listed prior to two years after dialysis start, and followed for two years from listing, until death or until removal from the transplant list, whichever was earlier. The proportional hazards assumption was not violated. The analysis included 802 patients. Hazard of deceased donor transplantation after listing for limited vs adequate health literacy was 0.92 (95% CI: 0.7, 1.25), $p=0.6$.

2: Tests of the proportional hazards assumption

Global tests of the proportional hazards (PH) assumption for the survival models shown in Table 2 were non-significant (no global violation of PH assumption). Individual-variable tests of the PH assumption were significant for some covariates in the model for time from dialysis start to transplant listing (one level of each of the categorical variables for ethnicity and primary renal diagnosis), the model for time to living-donor transplant (two levels of the categorical variable for ethnicity), and the model for time to any transplant (one level of the categorical variable for education and three levels of the categorical variable for primary renal diagnosis). Re-fitting each model with stratification of by these variables did not change the overall results.

3: Analysis including patients with moderate English fluency (or lower)

This analysis included 2463 patients, and included patients with moderate, poor or no English fluency. English fluency was then added as a categorical covariate in multivariable and mediation

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3 models (categories as in Table S1). Results of univariate analyses are shown in Table S1, and results
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5 of multivariable analyses are in Table S2.
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8 There were no differences in the significance of results when compared to the primary analysis.
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11 12 13 **4: Townsend deprivation score** 14

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16 Townsend deprivation scores^{S1} for each patient were derived from patient postcode and the UK
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18 census online Geoconvert service (<http://geoconvert.mimas.ac.uk>). These were used as covariates in
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20 multivariable models in place of individual-level markers of socioeconomic status. This did not
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22 change the overall significance of results compared to the primary analysis (Table S3).
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28 **5: Clustering by renal centre** 29

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31 Multivariable analyses were repeated with and without adjustment for clustering by renal centre
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33 (using robust standard errors). This adjustment did not significantly change results, shown in Table
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38 **6: Data completeness** 39

40 Table S5 shows the proportion of missing data for multivariable analysis of each outcome variable.
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42 The largest proportion of missing data was for analysis of 'late presentation' (18%). The
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44 transplantation and mortality variables had a far lower proportion of missing data (6-8%). The
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46 majority of missing data for these analyses is from missing exposure data (no answer to SILS
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48 question). Comparison of patient characteristics between those with complete cases vs missing data
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50 for the three transplant variables is shown in Table S6. Patients with Asian ethnicity or with diabetes
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52 as primary renal diagnosis are over-represented in the missing data group.
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57 Multiple imputation was performed to check for bias from the use of complete-case analysis, using
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59 'imputation by chained equations' to generate 30 imputed datasets. As there were differences in the
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3 subjects included in different analyses (see figure 1), four sets of imputed datasets were generated:
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5 one for baseline analyses of late presentation, dialysis modality, pre-emptive transplant listing, one
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7 for analysis of dialysis access, one for analyses of time to living-donor transplantation, any transplant
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9 or death, and one for analysis of time to transplant wait-listing. Estimated effect-sizes after full-
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11 adjustment for each outcome using 30 imputed datasets are shown in Table S7. There were no
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13 major differences in the significance of the results from these analyses compared to complete-case
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15 analysis.
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20 **References**

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Supplementary methods: Modified Charlson comorbidity index

This index was developed from Hemmelgarn et al (2003),^{S2} who adapted the original Charlson index^{S3} to more accurately predict outcomes in patients in End-Stage Renal Disease. Some changes were made to allow for the data available from the ATTOM study. Scoring for the Hemmelgarn modified Charlson index, and the scoring used for this study are shown in Table S8

Presence of rheumatological or peptic ulcer disease were not recorded in the ATTOM study, so were excluded from the scoring. Score weightings were unchanged from the Hemmelgarn modified Charlson index. Some definitions were altered to allow for subtle differences in the way comorbidities were recorded. The small number of patients (92; 1.3%) with missing data for one or more diagnoses included in the Charlson index were scored at 'zero' for that diagnosis, but their total score was still included in analyses.

References

- S2. Hemmelgarn B, Manns B, Quan H, et al. Adapting the Charlson Comorbidity index for use in patients with ESRD. *Am J Kidney Dis* 2003; 42: 125-132.
- S3. Charlson ME, Pompei P, Ales KL, et al. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *J Chronic Dis* 1987; 40: 373-383.

Table S1: Analysis including patients with moderate, low or no English fluency. Patient characteristics and univariable analysis by limited vs adequate health literacy

Shown as frequency (%), mean (95% CI) or median [IQR]. Subgroup percentages may not total 100% because of rounding. Significant p values shown in bold. Modified Charlson comorbidity index is described in supplementary material 1. Primary renal diagnoses were categorised according to UK Renal Registry (UKRR) criteria.

	Health Literacy		p
	Adequate	Limited	
Total: 2463	1982 (80)	481 (20)	
Male	1294 (65)	311 (65)	0.80
Age	58 [47, 67]	58 [47, 66]	0.64
Ethnicity:			
White	1,665 (84)	319 (67)	
Asian	152 (8)	111 (23)	
Black	135 (7)	39 (8)	<0.001
Chinese	12 (1)	5 (1)	
Mixed-race	12 (1)	4 (1)	
Language:			
English First Language	1,800 (91)	338 (70)	
Other first language, self-reported English			
Fluency:			
Good	114 (6)	21 (4)	<0.001
Moderate	54 (3)	58 (12)	
Poor or no English	13 (1)	64 (13)	
Modified Charlson Comorbidity index			
0	913 (46)	124 (26)	
1-2	692 (35)	230 (48)	
3-4	240 (12)	89 (19)	<0.001
>4	137 (7)	38 (8)	
Primary Renal Diagnosis			
Diabetes	417 (21)	216 (46)	
Glomerulonephritis	314 (16)	59 (13)	
Pyelonephritis	128 (7)	20 (4)	
Hypertension	128 (7)	24 (5)	<0.001
Polycystic Kidney Disease	178 (9)	21 (4)	
Renovascular Disease	65 (3)	11 (2)	
Other	444 (23)	53 (11)	
Uncertain	286 (15)	68 (14)	

	Health Literacy		
	Adequate	Limited	
Highest educational qualification:			
None	568 (29)	245 (51)	
High School level	858 (43)	156 (33)	<0.001
University level	355 (18)	39 (8)	
Other qualification	193 (10)	40 (8)	
No educational qualifications (vs any)	568 (29)	245 (51)	<0.001
Car owner	1479 (75)	272 (57)	<0.001
Late presentation (<90 days before dialysis initiation)	299 (17)	41 (10)	0.001
Peritoneal Dialysis as initial dialysis modality	424 (21)	81 (17)	0.028
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality)	839 (55)	223 (57)	0.39
Pre-emptive deceased-donor transplant listing	247 (13)	44 (10)	0.030
At 2 years from dialysis initiation:			
Listed for deceased-donor transplant	777 (42)	145 (31)	
Transplanted (living-donor)	167 (9)	15 (3)	
Transplanted (any donor type)	346 (18)	45 (10)	
Mortality	277 (14)	82 (17)	

Table S1: Repeated multivariable analysis including patients with moderate, low or no English fluency.

Measures of effect shown for limited vs adequate health literacy depend on the regression model used (Logistic: Odds ratio, OR; Cox: Hazard ratio, HR).

Categorical variables for ethnicity, English fluency, first language, primary renal diagnosis, comorbidity (modified Charlson index) and highest educational qualification are specified as in Table 1; Significant p-values are shown in bold.

		Model					
		1	2	3	4	5	6
		Unadjusted	+ Age/Sex	+ Ethnicity, first language	+ Primary renal diagnosis, Comorbidity	+ Highest educational qualification	+ Car ownership
Late presentation (<90 days)	OR	0.55	0.54	0.56	0.69	0.71	0.67
(n=2147)	(95% CI)	(0.36,0.83)	(0.36,0.83)	(0.34,0.92)	(0.39,1.21)	(0.40,1.25)	(0.38,1.19)
	p	0.005	0.005	0.023	0.2	0.2	0.2
Peritoneal dialysis as first dialysis modality (vs haemodialysis)	OR	0.73	0.73	0.75	0.78	0.87	0.96
(n=2395)	(95% CI)	(0.56,0.96)	(0.55,0.96)	(0.55,1.03)	(0.57,1.08)	(0.63,1.19)	(0.69,1.34)
	p	0.025	0.024	0.07	0.1	0.4	0.8
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality)	OR	1.11	1.10	1.04	1.09	1.09	1.05
(n=1892)	(95% CI)	(0.92,1.33)	(0.92,1.33)	(0.84,1.30)	(0.84,1.40)	(0.85,1.39)	(0.82,1.35)
	p	0.3	0.3	0.7	0.5	0.5	0.7
Pre-emptive deceased-donor transplant listing	OR	0.68	0.68	0.73	0.86	0.97	1.03
(n=2275)	(95% CI)	(0.51,0.92)	(0.50,0.92)	(0.53,0.99)	(0.63,1.16)	(0.71,1.34)	(0.75,1.41)
	p	0.013	0.013	0.046	0.3	0.9	0.9
Likelihood of listing for deceased-donor transplant after starting dialysis	HR	0.68	0.67	0.59	0.64	0.68	0.70
(n=1994)	(95% CI)	(0.54,0.85)	(0.52,0.87)	(0.47,0.74)	(0.50,0.82)	(0.53,0.88)	(0.54,0.91)
	p	0.001	0.002	<0.001	<0.001	0.003	0.008
Likelihood of living-donor transplantation after starting dialysis	HR	0.35	0.36	0.32	0.39	0.46	0.48
(n=2361)	(95% CI)	(0.21,0.57)	(0.23,0.56)	(0.21,0.51)	(0.24,0.63)	(0.28,0.75)	(0.30,0.78)
	p	<0.001	<0.001	<0.001	<0.001	0.002	0.003
Likelihood of transplantation from any donor type after starting dialysis	HR	0.50	0.51	0.51	0.58	0.65	0.68
(n=2358)	(95% CI)	(0.38,0.66)	(0.40,0.66)	(0.39,0.67)	(0.44,0.77)	(0.47,0.89)	(0.50,0.93)
	p	<0.001	<0.001	<0.001	<0.001	0.007	0.016
Mortality	HR	1.17	1.19	1.32	1.15	1.08	1.06
(n=2367)	(95% CI)	(0.82,1.68)	(0.84,1.69)	(0.93,1.87)	(0.81,1.63)	(0.76,1.53)	(0.75,1.49)
	p	0.4	0.3	0.1	0.4	0.6	0.8

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Table S3: Repeated multivariable analysis using Townsend deprivation score as a covariate

Measures of effect shown for limited vs adequate health literacy depend on the regression model used (Logistic: Odds ratio, OR; Cox: Hazard ratio, HR). Categorical variables for ethnicity, English fluency, first language, primary renal diagnosis, comorbidity (modified Charlson index) and highest educational qualification are specified as in **Error! Reference source not found.**; Significant p-values are shown in bold.

		Model				
		1	2	3	4	5
		Unadjusted	+ Age/Sex	+ Ethnicity, first language	+ Primary renal diagnosis, Comorbidity	+ Townsend deprivation score
Late presentation (<90 days) n=1993	OR (95% CI) p	0.56 (0.33,0.95) 0.032	0.56 (0.33,0.95) 0.030	0.56 (0.33,0.95) 0.033	0.71 (0.39,1.29) 0.3	0.68 (0.37,1.25) 0.2
Peritoneal dialysis as first dialysis modality (vs haemodialysis) n=2209	OR (95% CI) p	0.75 (0.53,1.06) 0.1	0.75 (0.53,1.06) 0.1	0.75 (0.53,1.06) 0.1	0.78 (0.55,1.10) 0.2	0.84 (0.59,1.21) 0.4
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality) n=1739	OR (95% CI) p	1.07 (0.86,1.34) 0.6	1.07 (0.85,1.33) 0.6	1.06 (0.85,1.33) 0.6	1.13 (0.88,1.44) 0.4	1.09 (0.84,1.42) 0.5
Pre-emptive deceased-donor transplant listing n=2087	OR (95% CI) p	0.73 (0.52,1.02) 0.06	0.72 (0.51,1.01) 0.06	0.72 (0.52,1.01) 0.06	0.85 (0.60,1.20) 0.3	0.94 (0.66,1.36) 0.8
Likelihood of listing for deceased-donor transplant after starting dialysis n=1828	HR (95% CI) p	0.56 (0.42,0.75) <0.001	0.55 (0.41,0.73) <0.001	0.54 (0.41,0.72) <0.001	0.62 (0.47,0.84) 0.002	0.66 (0.48,0.89) 0.007
Likelihood of living-donor transplantation after starting dialysis n=2175	HR (95% CI) p	0.24 (0.11,0.52) <0.001	0.24 (0.12,0.50) <0.001	0.24 (0.12,0.48) <0.001	0.32 (0.16,0.63) 0.001	0.35 (0.18,0.70) 0.003
Likelihood of transplantation from any donor type after starting dialysis n=2173	HR (95% CI) p	0.48 (0.34,0.69) <0.001	0.49 (0.35,0.69) <0.001	0.48 (0.34,0.68) <0.001	0.56 (0.39,0.79) 0.001	0.60 (0.42,0.86) 0.006
Mortality n=2181	HR (95% CI) p	1.26 (0.87,1.83) 0.2	1.28 (0.89,1.83) 0.2	1.29 (0.90,1.85) 0.2	1.12 (0.78,1.61) 0.5	1.11 (0.77,1.58) 0.6

Table S4: Effect ratios for each model before and after adjustment for clustering by renal centre

Measures of effect shown for limited vs adequate health literacy depend on the regression model used (Logistic: Odds ratio, OR; Cox: Hazard ratio, HR). Categorical variables for ethnicity, English fluency, first language, primary renal diagnosis, comorbidity (modified Charlson index) and highest educational qualification are specified as in **Error! Reference source not found.**; Significant p-values are shown in bold. Adjustment for clustering by renal centre used robust standard errors.

		Effect ratios, after adjustment for age, sex, ethnicity, first language, primary renal diagnosis, comorbidity, education and car ownership	
		Before adjustment for clustering	After adjustment for clustering
Late presentation (<90 days) n=2001	OR (95% CI) p	0.68 (0.44, 1.03) 0.07	0.68 (0.37, 1.24) 0.2
Peritoneal dialysis as first dialysis modality (vs haemodialysis) n=2214	OR (95% CI) p	0.93 (0.67, 1.29) 0.7	0.93 (0.65, 1.35) 0.7
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality) n=1741	OR (95% CI) p	1.09 (0.83, 1.43) 0.6	1.09 (0.84, 1.41) 0.5
Pre-emptive deceased-donor transplant listing n=2092	OR (95% CI) p	1.03 (0.68, 1.57) 0.9	1.03 (0.71, 1.49) 0.9
Likelihood of listing for deceased-donor transplant after starting dialysis n=1833	HR (95% CI) p	0.68 (0.51, 0.90) 0.007	0.68 (0.51, 0.91) 0.010
Likelihood of living-donor transplantation after starting dialysis n=2180	HR (95% CI) p	0.41 (0.19, 0.88) 0.023	0.41 (0.21, 0.80) 0.009
Likelihood of transplantation from any donor type after starting dialysis n=2178	HR (95% CI) p	0.65 (0.44, 0.96) 0.032	0.65 (0.45, 0.92) 0.016
Mortality n=2186	HR (95% CI) p	1.05 (0.79, 1.39) 0.8	1.05 (0.73, 1.49) 0.8

Table S5: Missing data for each outcome variable.

The first column shows the total number of patients eligible for inclusion in each analysis after the exclusions shown in Figure 1. For each analysis, number of patients with missing data for the outcome, exposure (SILS) and covariates are shown, and the proportion of eligible patients included in complete case analysis are shown in the right-hand column. In the fully-adjusted model for initial dialysis modality, 13 further observations were excluded because in one category of ethnic group, no patients were treated with peritoneal dialysis.

	Total eligible for inclusion (excluding moderate/low English fluency)	Missing data for outcome variable	Missing SILS data (if outcome data not missing)	Missing covariate data (If SILS/outcome data not missing and multivariable analysis performed)	Complete cases (% of total eligible)
Late presentation	2432	274	131	26	2001 (82)
Initial dialysis modality	2432	4	157	44	2227 (92) *
Dialysis access (if initial dialysis modality was haemodialysis)	1909	26	110	32	1741 (91)
Transplant listing	2000	5	126	36	1833 (92)
Living-donor transplantation	2382	5	152	45	2180 (92)
Transplantation (any donor)	2380	5	152	45	2178 (92)
Survival	2387	1	154	46	2186 (92)

Table S6: Comparison of demographics between patients with complete vs incomplete records for three transplant outcome analyses

	Transplant listing			Living-donor transplantation			Transplantation (any donor)		
	Complete cases n=1835	Missing data n=160	p	Complete cases n=2182	Missing data n=200	p	Complete cases n=2180	Missing data n=200	p
Median age [IQR]	59 [48-68]	60 [49-67]	0.90	58 [47-67]	58 [45-66]	0.34	58 [47-67]	58 [45-66]	0.33
Male	1204 (66)	99 (62)	0.34	1413 (65)	123 (62)	0.36	1411 (65)	123 (62)	0.36
Ethnicity:									
White	1585 (86)	109 (71)		1884 (86)	142 (74)		1882 (86)	142 (74)	
Asian	103 (6)	30 (20)		131 (6)	32 (17)		131 (6)	32 (17)	
Black	128 (7)	9 (6)	<0.001	146 (7)	13 (7)	<0.001	146 (7)	13 (7)	<0.001
Chinese	8 (0.4)	2 (1)		8 (0.4)	2 (1)		8 (0.4)	2 (1)	
Mixed-race	11 (1)	2 (1)		13 (1)	2 (1)		13 (1)	2 (1)	
English first language	1726 (94)	33 (94)	0.96	2050 (94)	44 (96)	0.63	2048 (94)	44 (96)	0.63
Modified Charlson index									
0	707 (39)	64 (40)		914 (42)	86 (43)		915 (42)	86 (43)	
1-2	694 (38)	70 (44)		813 (37)	85 (43)		810 (37)	85 (43)	
3-4	279 (15)	18 (11)	0.16	294 (13)	20 (10)	0.16	294 (13)	20 (10)	0.15
>_5	155 (8)	8 (5)		161 (7)	9 (5)		161 (7)	9 (5)	
Primary renal diagnosis: Diabetes	478 (26)	54 (39)	0.002	312 (14)	12 (7)	0.001	549 (25)	65 (38)	0.001
No educational qualifications (vs any)	1194 (65)	20 (71)	0.48	1475 (68)	29 (74)	0.37	1472 (68)	29 (74)	0.37

Table S7: Comparison of results of multivariable analysis using complete cases only vs estimates from multiple imputation

All results after adjustment for age, sex, ethnicity, first language, primary renal diagnosis, comorbidity, education and car ownership, with robust standard errors to account for clustering by renal centre. Results from imputed data are estimated from 30 imputed datasets.

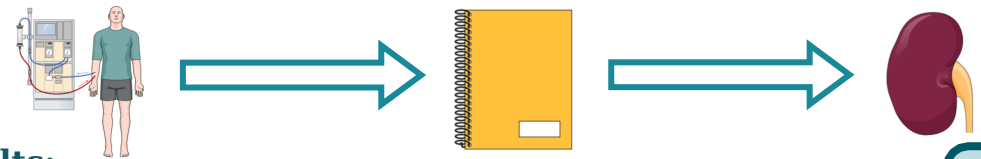
		Unimputed	Imputed
Late presentation (<90 days) n=2001 (complete-case analysis); n= 2432 (multiple imputation estimate)	OR (95% CI) p	0.68 (0.37,1.24) 0.2	0.66 (0.39,1.14) 0.136
Peritoneal dialysis as first dialysis modality (vs haemodialysis) n=2214 (complete-case analysis); n=2432 (multiple imputation estimate)	OR (95% CI) p	0.93 (0.65,1.35) 0.7	0.93 (0.66,1.32) 0.7
Dialysis catheter as first vascular access (vs fistula; if haemodialysis was first modality) n=1741 (complete-case analysis); n=1909 (multiple imputation estimate)	OR (95% CI) p	1.09 (0.84,1.41) 0.5	1.08 (0.83,1.41) 0.5
Pre-emptive deceased-donor transplant listing n=2092 (complete-case analysis); n=2432 (multiple imputation estimate)	OR (95% CI) p	1.03 [0.71,1.49] 0.9	1.04 (0.71,1.49) 0.9
Likelihood of listing for deceased-donor transplant after starting dialysis n=1833 (complete-case analysis); n= ____ (multiple imputation estimate)	HR (95% CI) p	0.68 (0.51,0.91) 0.010	0.70 (0.52,0.94) 0.016
Likelihood of living-donor transplantation after starting dialysis n=2180 (complete-case analysis); n=2377 (multiple imputation estimate)	HR (95% CI) p	0.41 (0.21,0.80) 0.009	0.40 (0.20,0.80) 0.009
Likelihood of transplantation from any donor type after starting dialysis n=2178 (complete-case analysis); n=2373 (multiple imputation estimate)	HR (95% CI) p	0.65 (0.45,0.92) 0.016	0.64 (0.44,0.93) 0.019
Mortality n=2186 (complete-case analysis); n=2378 (multiple imputation estimate)	HR (95% CI) p	1.05 (0.73,1.49) 0.8	1.05 (0.75,1.47) 0.8

Table S8: Score weightings for modified Charlson index based on Hemmelgarn et al

Comorbidity variables from Hemmelgarn et al.	Weight	Corresponding variable from ATTOM	Weight
Myocardial infarction	2	Myocardial infarction	2
Congestive heart failure	2	Heart failure	2
Peripheral vascular disease (includes Aortic aneurysm >6cm)	1	Peripheral vascular disease or aortic aneurysm repair	1
Cerebrovascular disease	2	Cerebrovascular disease	2
Dementia	1	Dementia	1
Chronic lung disease	1	Respiratory disease	1
Rheumatological /Connective tissue disease	1	Excluded	-
Peptic ulcer disease	1	Excluded	-
Diabetes without complications	2	Diabetes, excluding those with diabetes as primary renal disease	2
Diabetes with complications	1	Diabetes as primary renal disease	1
Leukaemia	2	Leukaemia	2
Lymphoma (includes myeloma)	5	Lymphoma or myeloma	5
Moderate/severe liver disease	2	Liver cirrhosis	2
Metastatic cancer	10	Metastatic cancer	10
	33		31

Limited health literacy is associated with reduced access to kidney transplantation

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Over 2000 UK adults:
 • starting dialysis
 • with good English fluency
 • aged 18-75 years...

Limited health literacy

was independently associated with reduced chance
 (adjusted for demographics, primary renal diagnosis, comorbidity and socioeconomic status)

- Transplant listing**
(HR: 0.68; 95% CI: 0.51-0.91)
- Living-donor transplantation**
(HR: 0.41; 95% CI: 0.21-0.80)
- Transplantation from any donor type**
(HR: 0.65; 0.45-0.92)

CONCLUSION:
 Limited health literacy is associated with reduced access to transplantation.
 Health literacy-related interventions may improve transplant access



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