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Citation for published version:

Ryan, D & Sabroe, I 2021, 'Identifying and addressing health inequalities in asthma care', *European Respiratory Journal*, vol. 58, no. 6. <https://doi.org/10.1183/13993003.01829-2021>

Digital Object Identifier (DOI):

[10.1183/13993003.01829-2021](https://doi.org/10.1183/13993003.01829-2021)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

European Respiratory Journal

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Identifying and addressing health inequalities in asthma care

In this month's ERJ, Håkansson et al^{Hakansson ref} describe the existence of inequalities affecting asthma care in the Danish healthcare system, demonstrating the persistence of the inverse care law of health first described by Hart 50 years ago.ⁱ This states that resources and opportunities to receive care are concentrated most in those areas that need them least. Their findings are striking because of the widespread perceptions that Scandinavian-style tax and spend systems generate high investment in social support, healthcare, and wellbeing, and yet significant health inequalities still exist here. Whilst increasing levels of disease severity should prompt more referrals to specialist care, Håkansson shows that referral for expert asthma support still happens far too infrequently, and that the chances of referral are affected by four main domains of age, gender, employment status and educational attainment, as well as proximity to major centres of care, confirming that even when financial barriers to care are minimised, inverse care persists.ⁱⁱ

Other studies from Sweden and the UK demonstrate, inevitably, that inequalities in asthma care are widespread and problems of under-referral are global.^{iii iv} It is distressing to see the continuing poor access for the most disadvantaged to expert asthma care. We are depriving them of access to full assessment, diagnosis and management including asthma phenotyping, optimizing adherence, treating breathing pattern disorders, or escalating appropriate patients to biologics resulting in potentially life-changing benefits. Minimising inappropriate use of corticosteroids and treating related/confounding presentations such as persistent airway infection in TH2-low/non-eosinophilic asthma can be likewise life-changing.^v

We do not know in Håkansson's study what proportion of people with severe asthma have had previous specialist assessments and been returned to primary care for ongoing management, which may affect analyses of levels of secondary care input. Patients who had assessments performed in specialist care prior to the advent of biologic therapies being employed, may benefit from return to specialist care. We also do not know of any study or country, which describes service pressures in specialist-care which may limit referral or drive early return of care back to primary care. However, Håkansson's paper shows how epidemiological data can facilitate identification of the characteristics of those who are less likely to receive expert care. Partly as a consequence of a global pandemic, movements addressing racism within society as a whole, and examination of the range of socio-cultural factors affecting health, the impacts of social determinants of health are being examined and publicly discussed as never before. The responsibility of the medical profession to engage with these questions of justice has never been clearer. Good things may come from this last 18 months of deep distress, as for example the rapid adaptation to remote consultations during the pandemic may help to overcome problems of distance from centres. However, we should all ask what we can do and advocate for at personal and systems levels to see real change.

To effect change, we need to understand how guidelines and research data play out in the messy real world, and frameworks are being promoted to help complement trial data.^{vi} Implementation guideline recommendations will achieve less than we would wish if we ignore the social situations of the patient and clinician. Guidelines, to a large extent written by specialists, fail to recognise the challenges existing in primary care, particularly in low- and middle-income countries and have yet to take into account social determinants of health. They furthermore tend to focus on single conditions, and do not put them in context with co-morbidities that require individual clinicians to make individual adjustments to personalised

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3 care planning.^{vii} Asthma guidelines also often lack explicit referral criteria to specialist care.
4 Differentiating difficult to treat asthma from severe asthma lies at least in part within the
5 domain of primary care and requires systematic continuous critical review to modify factors
6 such as ongoing tobacco smoking, poor inhaler technique and enhancing medication
7 adherence.^{viii} Such an approach should assist in identifying those who will benefit most from
8 referral, but for consistency a similar approach to assessment needs to be adhered to in
9 specialist care to optimise outcomes ^{ix} although the evidence suggests this is not currently
10 happening.^x
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14 These findings suggest that a more formal socio-economic assessment of the patient might be
15 incorporated in both diagnosis and management. Importantly, this also requires a high level
16 of vigilance and awareness by clinicians of any constraints in their practice imposed by local
17 social factors, including practical matters such as travel distances, and any underlying
18 assumptions or inadvertent bias made in personal practice. To do this, clinicians also need
19 tools such as data that help them see more clearly the environments in which they operate.
20 Many of the factors identified in this study are captured in the electronic medical record, but
21 such data needs to be amenable and easily accessible in order to be useful. What is also clear
22 is that factors will differ in their impact from country to country so any assessment solution
23 will need to be nation specific.^{xi}
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27 This all sounds like a very big mountain to climb but there are developments in primary care
28 which may help to facilitate this. Uniquely, for example, Netherlands primary care has its
29 own set of guidelines which are clear and accessible and give recommendations on when to
30 refer.^{xii} The ten years asthma plan undertaken in Finland demonstrated that systematic
31 improvement in asthma care reduces morbidity, mortality and reduces costs, but to do so
32 requires a change of direction by health planners particularly in the provision of knowledge
33 and skills training and increased availability of near patient diagnostics.^{xiii} This bottoms up
34 policy from a high income nation also translates to low and middle income nations,
35 demonstrating that significant health gains can be made.^{xiv}
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39 It remains distressing that specialists and primary care systems do not yet talk to each other in
40 ways that result in the identification of all of those with most to benefit from care. Even in the
41 systems with highest levels of tax/spend, inequalities exist as demonstrated here. Strong
42 systems change and political will can influence outcomes for people with asthma, as part of
43 the creation of fairer societies with more equal opportunities for all. However, rather than
44 waiting for initiatives at a national level there is no reason why specialists and primary care
45 physicians should not work together in local networks to achieve better care and outcomes
46 for their patients. We must also be wary of simple calls to drive more referrals from primary
47 care to distant secondary care centres. If we truly take account of such social determinants of
48 health, we need to be asking secondary care centres what they will do to increase access,
49 reach distant communities, and overcome inequities in the care of the people referred to
50 them, and perhaps the people they have never had the chance to meet.
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54 In keeping with the Scandinavian theme, the Danish philosopher Knud Løgstrup described a
55 human ethical demand in which we have an innate, automatic responsibility to act for the
56 good of those whose lives and needs are to some degree in our hands. We should fulfil this
57 demand spontaneously, as a consequence of our common humanity. Håkansson's study,
58 discussed here, enables us to more clearly see the need and to identify the component factors
59 that are responsible. This in turn is perhaps the first step in formulating an approach to
60 counter this problem by creating a care framework which facilitates "identification and early

referral of these patients”, working to help us address the injustices of health inequalities.

Hakansson ref

words: 1627

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ⁱⁱ Watt G. The inverse care law today. *The Lancet*. 2002 Jul 20;360(9328):252-4.

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