

# Respiratory Health and Health Inequality and Inequity

In February 2020, the Institute of Health Equity published its landmark report, *Marmot Review 10 Years On*.<sup>1</sup> It highlighted that for the first time in 100 years, life expectancy has failed to increase across the country, and for the poorest 10% of women it has actually declined. The report went on to state that in the last decade, health inequalities have widened overall, and the amount of time people spend in poor health has increased since 2010.

In this, the first in our series on respiratory health, health inequality, and inequity we will be exploring some of the health inequalities that impact respiratory health, and in this issue we'll cover tobacco smoking.

Under the Equality Act 2010,<sup>2</sup> there are 9 protected characteristics. However, there are 'other' inequalities that are constantly evolving and changing according to the environmental, social and political issues of the time, both within the UK and globally. Healthcare professionals in primary and community care will often see these new challenges first as they are the closest in the health system to the experiences of entire communities.

## The nine protected characteristics under the Equality Act 2010(2)

- Age
- Disability
- Marriage and civil partnership
- Pregnancy and maternity
- Gender reassignment
- Race
- Religion or belief
- Sex
- Sexual orientation

Sometimes an inequality may be hidden or a patient may not be sure how or whether to share their situation. It is within the remit of the primary care health practitioner to utilise their consultation skills to create a safe space to elicit such a disclosure.

For example, in a respiratory consultation attending to diagnosis or review of asthma or COPD, there are several ways in which a patient may give a cue either voluntarily or involuntarily. There are also opportunities during non-respiratory consultations to explore respiratory health.

In general practice, there are also opportunities to explore potential hidden inequalities during other consultation scenarios. For example, a wound that is not healing may suggest poor housing, poor nutrition, tobacco or drug use and general enquiries about the broader daily experience can reveal what is happening. The same wound review can also be an opportunity

to talk about general health including respiratory health with questions about breathlessness and cough.

## Achieving equity as well as equality

The Equality and Human Rights Commission<sup>3</sup> describes equality as “ Ensuring that every individual has an equal opportunity to make the most of their lives and talents.” Equity, however, is about giving people what they need to make things fair and help them reach that same level of opportunity.

Much has been implemented in the last two decades to try and give every citizen equal access to healthcare. In the respiratory sphere, standards of care and quality in asthma and COPD have been developed by UK national guideline bodies such as the Scottish Intercollegiate Guidelines Network (SIGN) and the National Institute for Health and Care Excellence (NICE) to address variation between practices, localities, and regions. These standards have been translated into 'targets' for practices to achieve within the Quality and Outcomes Framework (QOF)<sup>5</sup> and these remain in some areas of the UK. In reflecting on the impact of asthma and COPD standards it can be said that every practice in the UK now has a register of people with asthma or COPD and as a consequence, there is a single system by which respiratory long-term condition care can be organised so that people are offered current standards of diagnosis and treatment.

## Did the QOF standards provide equal access to respiratory diagnosis and management?

Whilst we have a defined, measurable and comparable system that could ensure all have equal access to a basic standard of diagnosis and subsequent care, the reality is that not everyone receives the correct diagnosis and care. Variation remains<sup>6</sup> and the challenge is to understand why.

**Table 1. Consultation cues for exploring additional support due to inequalities and personal characteristics**

Scenario	Consultation cues	Potential problems and additional support needs
At Diagnosis	Patient unable to complete a peak flow diary, symptom score questionnaire	Poor literacy Financial support - Unable to afford PEFR meter prescription Learning disability Visual impairment Cognitive loss e.g. dementia Home testing not carried out due to cultural / peer group shame of having asthma
	Repeated failures to achieve a successful spirometry or FeNO trace	Poor coordination Cognitive loss Physical impairment
At review	Inhalers not brought to consultation review	Financial support - Unable to afford inhalers
	Not responding to treatment	The SIMPLES <sup>3</sup> process was designed for all people with asthma but may have particular application for people experiencing inequality
	Frequent exacerbations of asthma or COPD	Inhaled substance misuse
During therapies	Does not attend PR assessment or subsequent classes	Geographic isolation / transport poverty Literacy and understanding Fear of not fitting into group due to race, sexuality, gender reassignment
	Declines flu, pneumococcal or COVID immunisation	Cultural beliefs

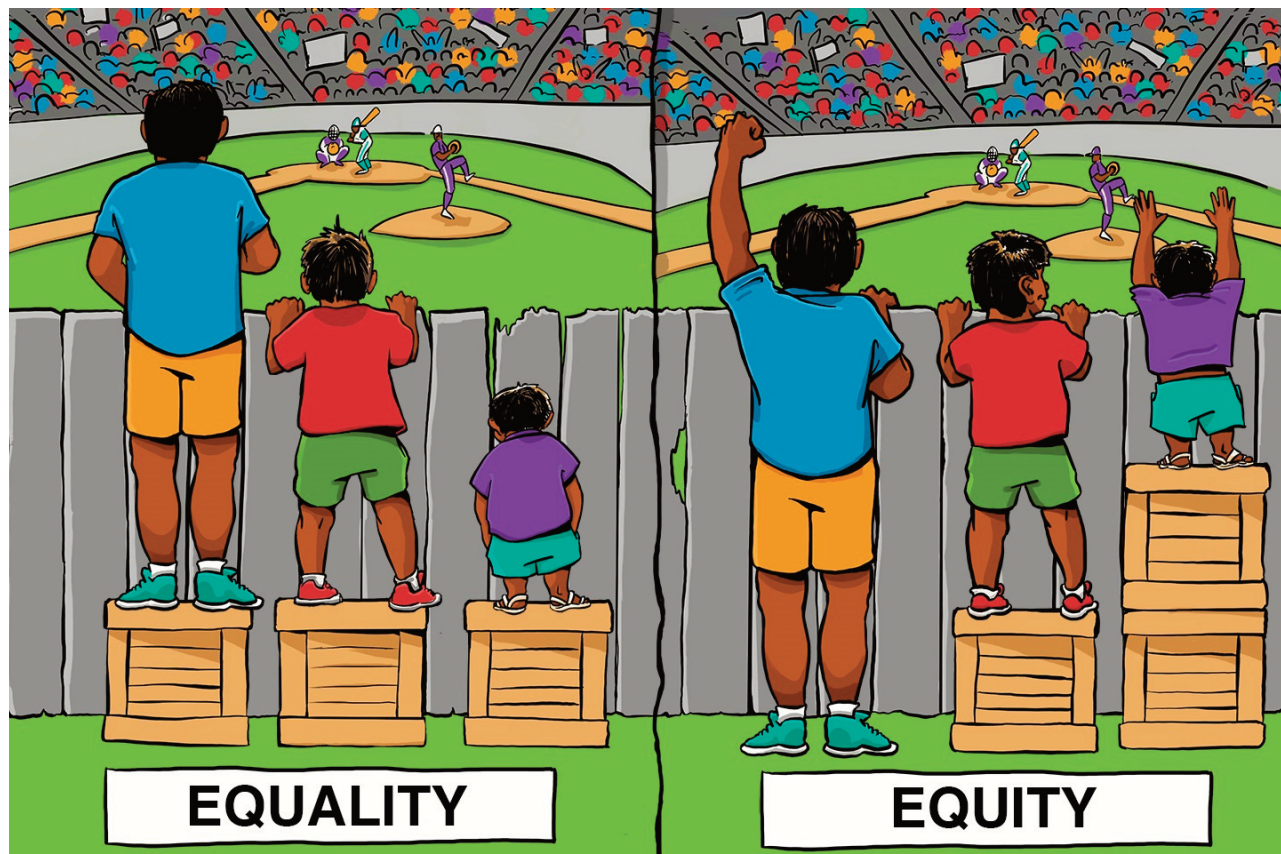


Image Credit: Interaction Institute for Social Change | Artist: Angus Maguire – see [interactioninstitute.org](http://interactioninstitute.org) and [madewithangus.com](http://madewithangus.com) respectively

**Table 2. Examples of the challenges of delivering UK respiratory standards due to inequity**

UK Standards	Challenges to achievement
Quality and Outcomes Framework (asthma/COPD) <sup>5</sup>	<p>AST 005/COPD 015 - Register Ability to register with a practice (PEH, asylum seeker)</p> <p>AST 011/COPD015 - Objective Diagnosis Ability to afford a PEFr meter or purchase salbutamol for a reversibility test. Ability to keep appointments (PEH, Mental illness) Ability to follow instructions (Dementia, LD)</p> <p>AST 007/COPD 010 - Annual review including questionnaire and PAAP (asthma), exacerbation and MRC breathlessness assessment (COPD) Ability to receive a recall / appointment (Digital exclusion, Geographic exclusion, PEH) Ability to comprehend / record questionnaire or PAAP (LD, Dementia, Mental Illness, Race, Language, Sensory Impairment)</p> <p>AST 008 - Smoking status/exposure in children and young people Ability of service to engage with teenagers Perceived openness of service to parents from deprived settings</p> <p>COPD 014 / BTS QS 1&amp;4 - Referral to Pulmonary Rehabilitation / Attend regular programme Ability to travel to a venue on a regular basis for 6 weeks (Geographic exclusion, transport poverty, financial poverty Perceived acceptance/rejection in a group setting (Race, Sexuality, Age, Gender reassignment)</p>
BTS Pulmonary Rehabilitation Quality Standards 2014 <sup>7</sup>	<p>BTS QS 3 - Referral after hospitalisation for COPD Ability to receive and act on an appointment letter (PEH, Asylum Seeker, Sensory Impairment, Race, Dementia)</p> <p>BTS QS 5 - Progressive exercise including aerobic and resistance Ability to stand and walk (Physical disability)</p> <p>BTS QS 6/7 - Education programme / Written plan for discharge activity Ability to comprehend, pay attention, hear, see and find relevant the educational content (Sensory impairment, cognitive impairment, mental illness, race, age) Ability to travel to and pay for exercise programmes (Poverty, geographic exclusion, digital exclusion)</p>

It is important for those of us working in primary care to reflect on practice respiratory performance through the lens of inequality. We must consider whether we are addressing inequity within our practice population. How can we identify patients who are most likely to suffer from health inequity? Are we doing anything about it?

Whilst primary care cannot re-house or re-school children exposed to traffic pollution and while bigger system and policy change is awaited, there is a role for primary care in recognising the problems and providing evidence-based advice and interventions to help manage the risk.

### Focusing on respiratory health risks that overlap the inequalities – smoking

Smoking is responsible for half the difference in life expectancy between the most and least advantaged in society and is the single largest driver of health inequalities in England. It is associated with economic poverty and it is more likely to sustain through generations where families already smoke. The expense of smoking makes an escape from poverty even harder. Smoking is also more prevalent in people with mental illness, those in contact with the justice system, looked after children (LAC) and LGBT+ people.<sup>8</sup>

Tobacco smoking remains, by far, the predominant cause of COPD,<sup>9</sup> and continued smoking increases exacerbation risk. The

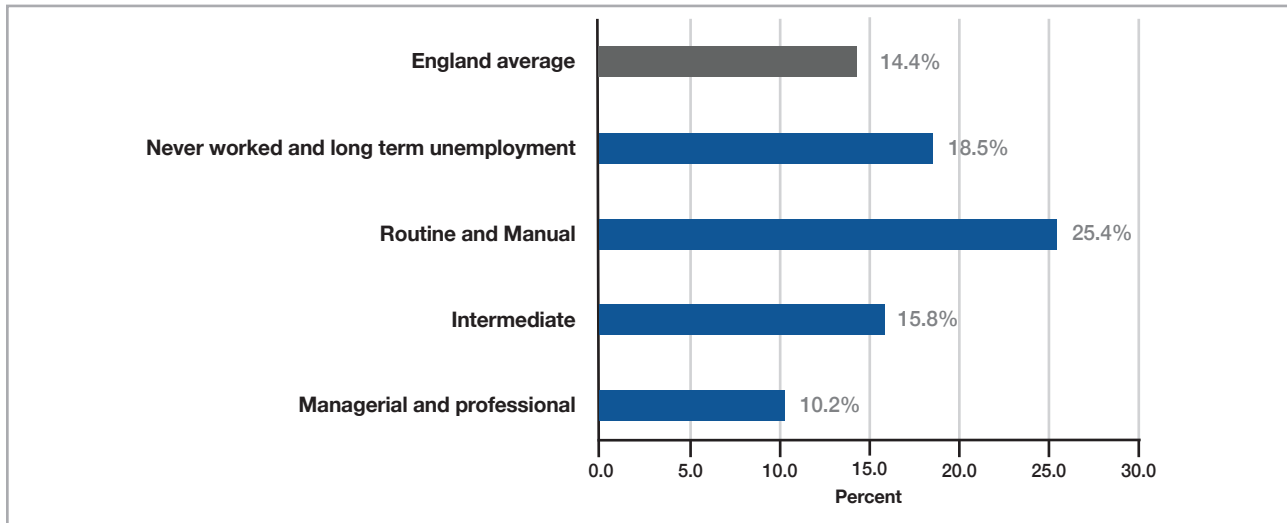
risk of an asthma exacerbation is also increased with exposure to active and passive tobacco smoking.<sup>10</sup>

Quitting tobacco is effective in reducing COPD exacerbations, asthma attacks and improves asthma control.<sup>11,12</sup> Quitting reduces the rate of decline of FEV1 in COPD in ex-smokers<sup>13</sup> and the earlier someone quits the better, though it is never too late.

### Smoking prevalence by socio-economic group, 2019 (Public Health England)

Smoking is associated with greater absolute mortality risk for individuals in lower socioeconomic groups. This suggests greater public health benefits of smoking prevention or cessation in these groups. However, it is important to highlight that tobacco use as a risk for early mortality exceeds the risk of having a lower socioeconomic status. A long-term, 28-year cohort Scottish study of 15,400 people showed that smokers in the highest socioeconomic group were more likely to die earlier than non-smokers in the lower SEG.<sup>14</sup>

In 2016, PCRS published its *Pragmatic Guide to Diagnosis and Management of Tobacco Dependency*. In this document, it was noted that there was significant underuse and under-dosing of the highly effective pharmacotherapies during quit attempts. To provide that step-up for people who find it harder to quit and who tend to suffer from inequality primary care must ensure



appropriate and adequate prescription to manage the higher nicotine withdrawal that these people experience when trying to quit.

The expert group who devised this guide concluded that with the utilisation of guideline and evidence-based tobacco cessation care, there could be a significant impact on 1. improved individual health outcomes and quality of life; 2. equitable socioeconomic and geographical distribution of healthcare resources; and 3. improved long-term population health outcomes including reducing health inequalities.

The Public Mental Health and Smoking Report<sup>15</sup> has several recommendations some of which are relevant and could be used by primary care as part of a step-up approach to addressing inequity:

- Maximise existing professional contacts to motivate **more quit attempts**.
- Connect people to **dedicated support**, to improve quit success.
- Maximise the uptake of **alternative sources of nicotine**, to increase quit success.
- **Improve skills and knowledge** of mental health professionals, to enable them to **motivate** and support quit attempts.

Read our article on the following pages to help you to support patients to quit tobacco. It includes information on the most recent treatments available and advice on supporting patients to instigate a quit attempt. You can also visit our tobacco dependency pages using the QR code shown.



Further articles covering pollution, poverty, poor nutrition, health literacy, and more will follow in future issues. You can find more information, tools, and resources on our campaign page using the QR code shown.



## References

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## Acknowledgements

PCRS wishes to thank Dr Noel Baxter for his support in the development of the PCRS resources in this campaign.