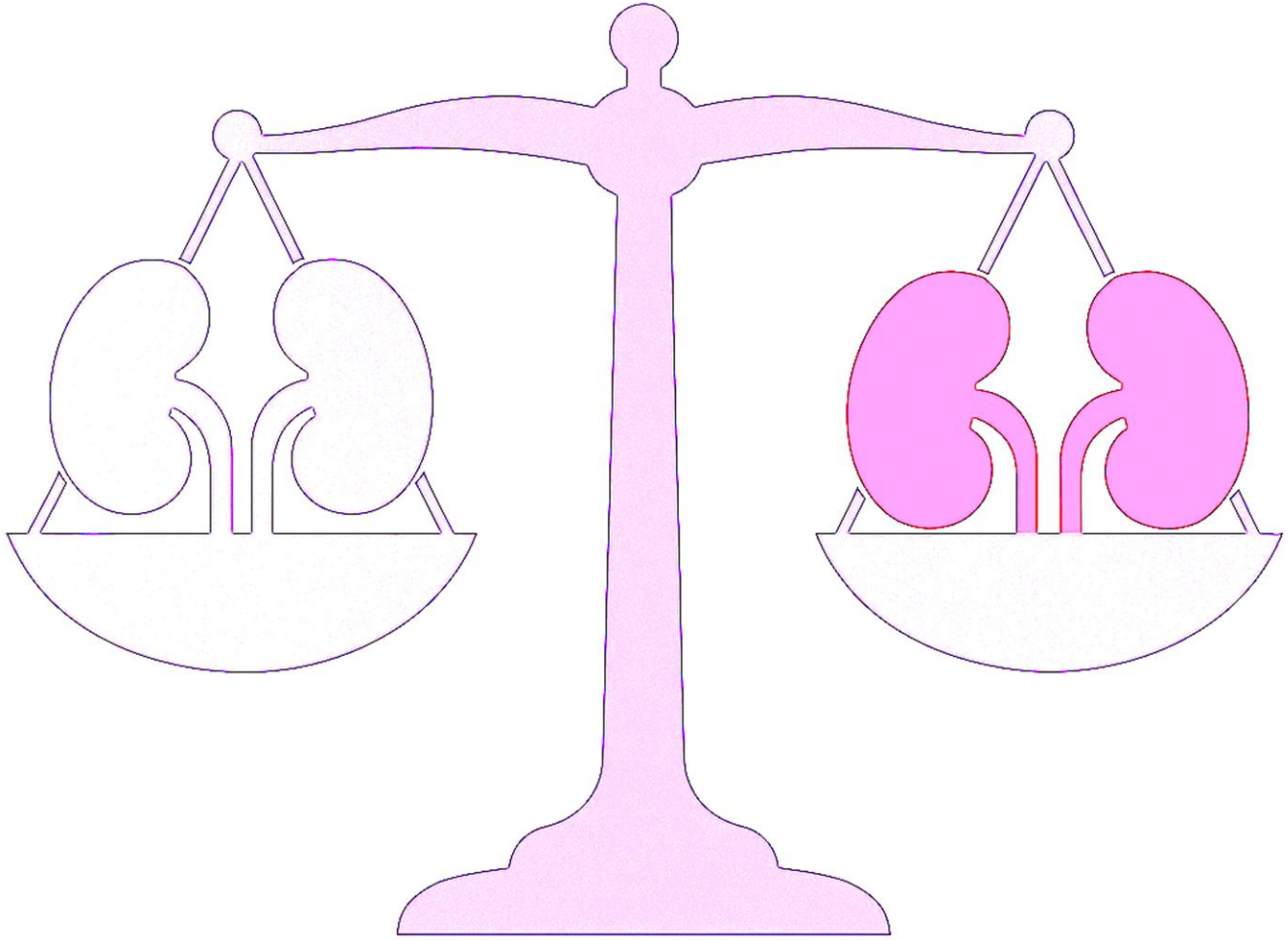


Is the care we provide fair?

Simon Sawhney, University of Aberdeen

Overview

Our responsibilities

Kidney health equity and our care

Towards feasible actions

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

THE PRIMARY CARE PUZZLE

Immeasurable Excellence — What Happens to Medicine without the "Good Doctor"?

Lisa Rosenbaum, M.D.[1]

"Signs of cultural decay are everywhere:

*in patients' voices when they say, **"My doctors never talk to each other"***

*in massive clinician chat chains where everyone's **waiting for someone else to take responsibility***

*in discharge summaries where patients with complex conditions and low health literacy receive **boilerplate instructions** to follow up with doctors they don't even have."*

International Code of Medical Ethics: Responsibilities of the "Good Doctor"

WORLD MEDICAL ASSOCIATION

1. *Promote the **health and well-being** of individual patients by providing competent, timely, and **compassionate care**.*

   *Responsibility to **society as a whole**, including future generations.*

2. *Must practise medicine **fairly and justly** and… **without bias**.*

3. ***Prudent stewardship** of the shared resources with which the physician is entrusted.*

What role for the “Good Kidney Service”?

Who else has a role:

- **wider society?**
- **other health roles?**
- **our patients/public?**

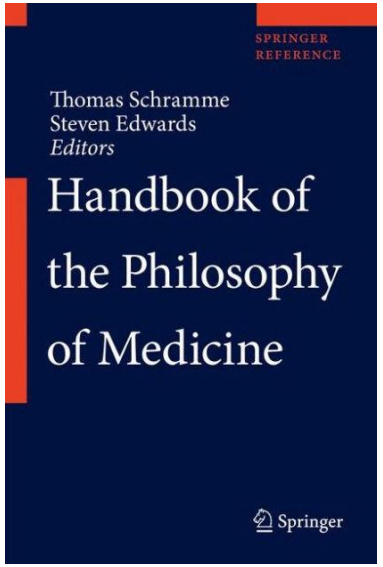
Prevent / treat kidney failure

Prevent wider mortality and morbidity

Improve wellbeing

Efficient or fair?

What about patient responsibility?



"A person who is (1) **informed** about and

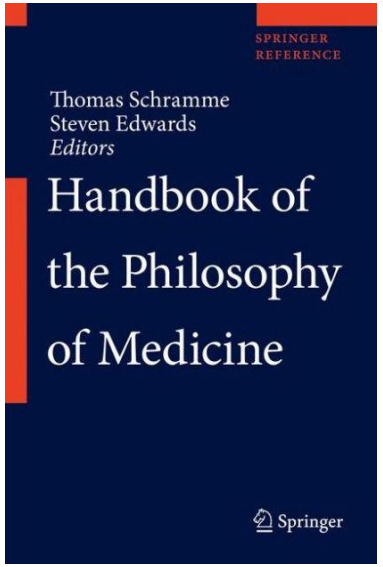
(2) **understands** the health risks that result from a

(3) certain **behaviour**, or from refusing healthcare **interventions**, and is

(4) ***able to choose*** not to engage, or decide differently."

Dickens (on workhouse owners): *"Rule that all poor people should have the* ***alternative*** *(for they would compel nobody, not they), of* ***being starved by a gradual process in the house, or by a quick one out of it.***"

What about patient responsibility?



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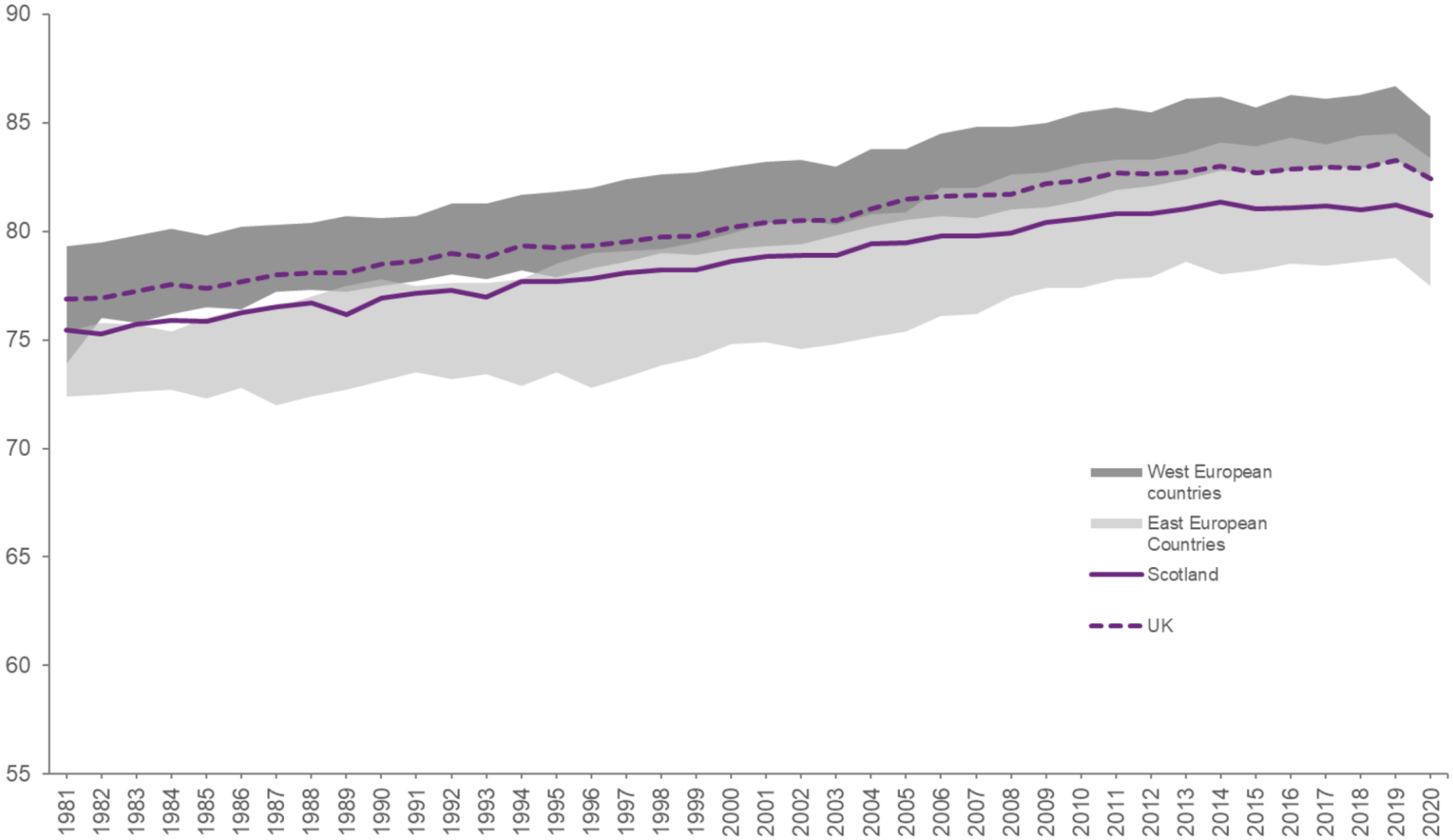
Co-responsibility of individuals, health service and society (policy, workplace, schools)

Trust & understanding:	***"They are nae worrying about it… so I just think, well what's the point"***
Healthy choice:	***"I have to go down to the foodbanks. They give me salty foods, so I have no option"***
Work and stress:	***"My manager would tell me 'I need to quit because they are sick of paying an invalid'"***
Can access care:	***"I dinna hae the money to put petrol in"***

Wider context:
Life expectancy falling behind

Public Health Scotland

The Health Foundation



Widening inequalities:

Working ages

Men

Ethnic groups

Deprivation

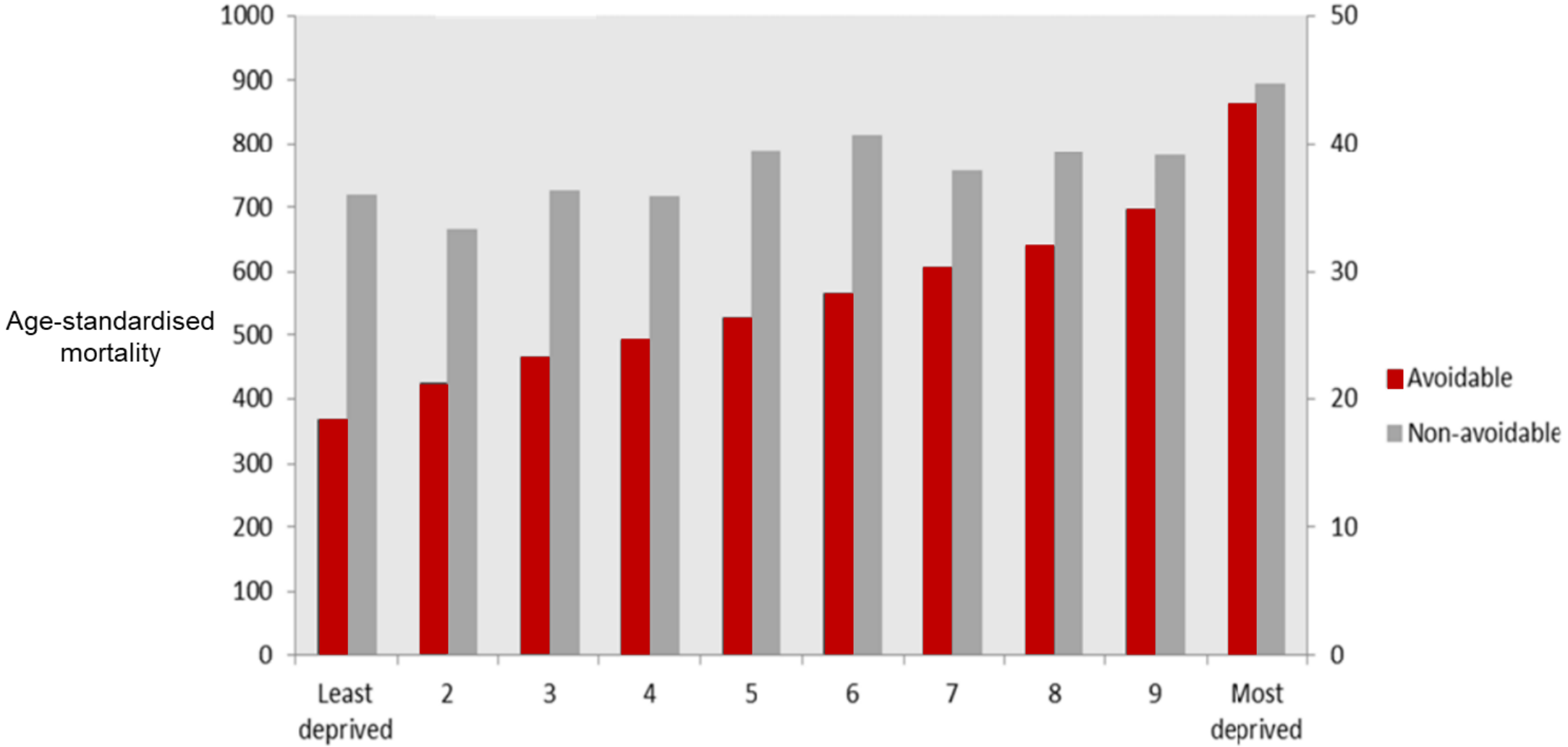
Key concerns:

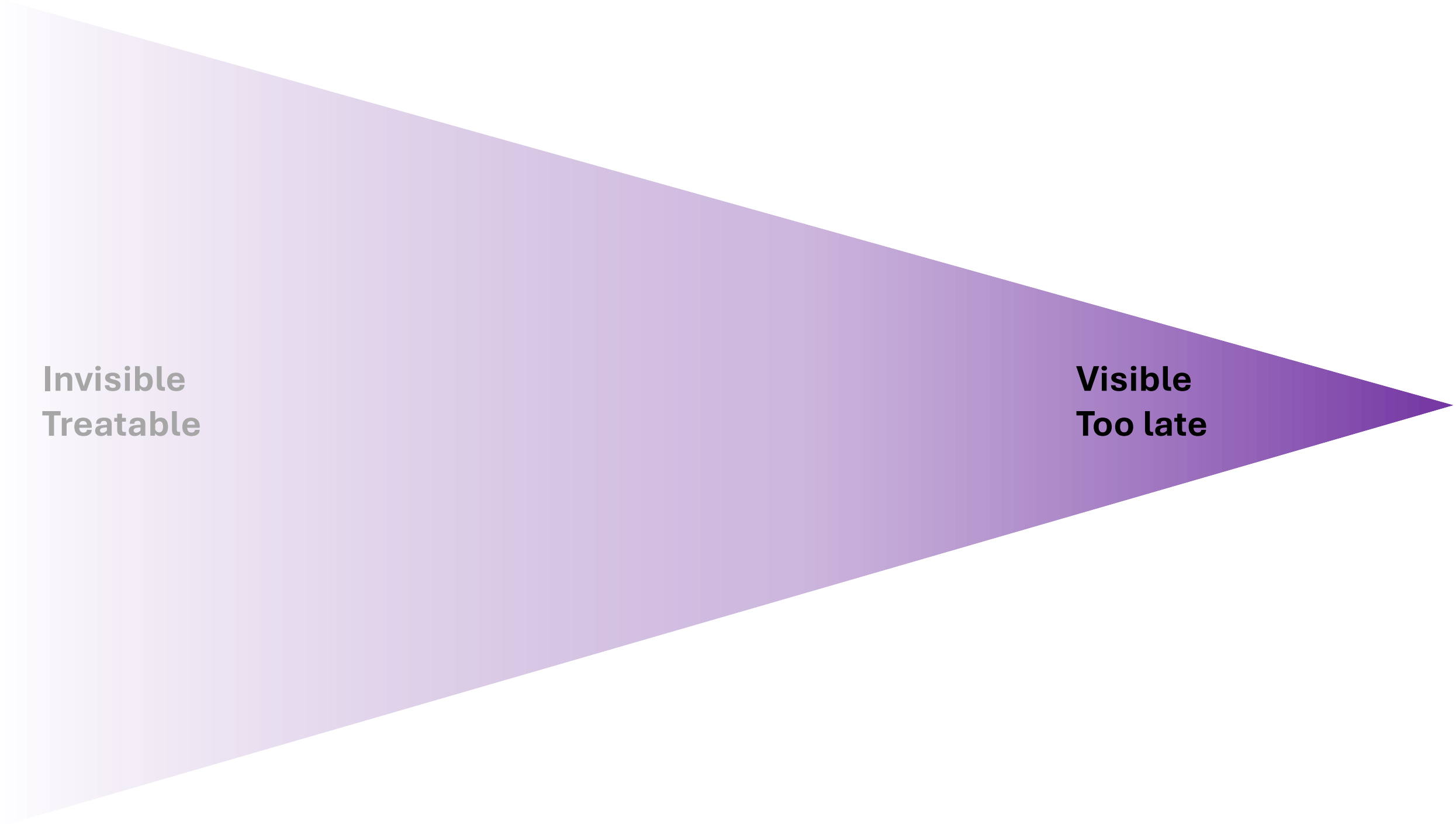
Years of good health

Mental Health

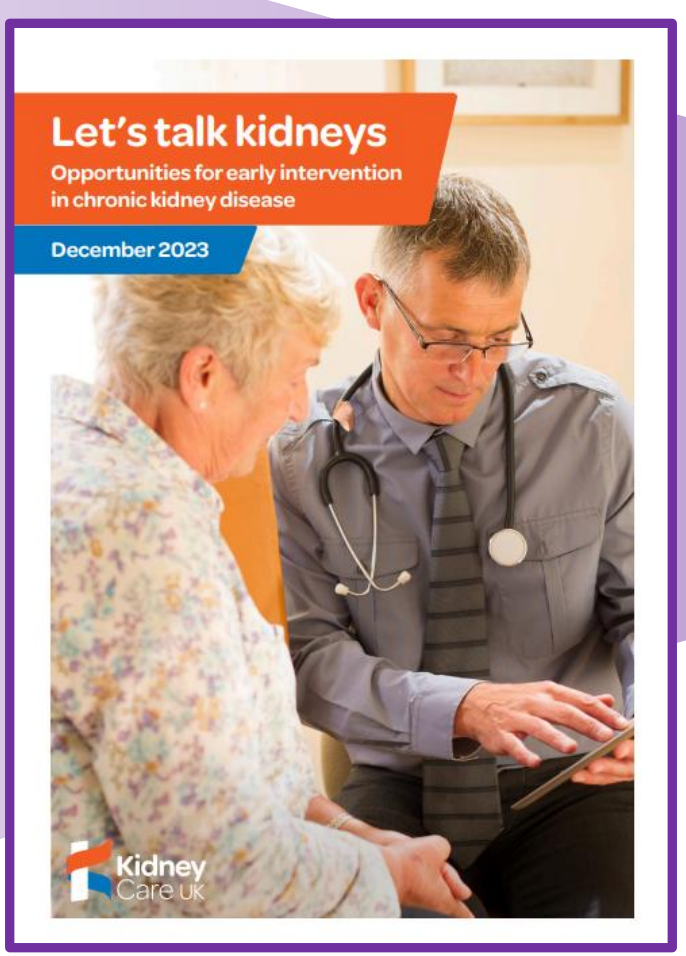
Long term conditions

More treatments could mean less fair




Invisible
Treatable
Visible
Too late

Invisible
Treatable



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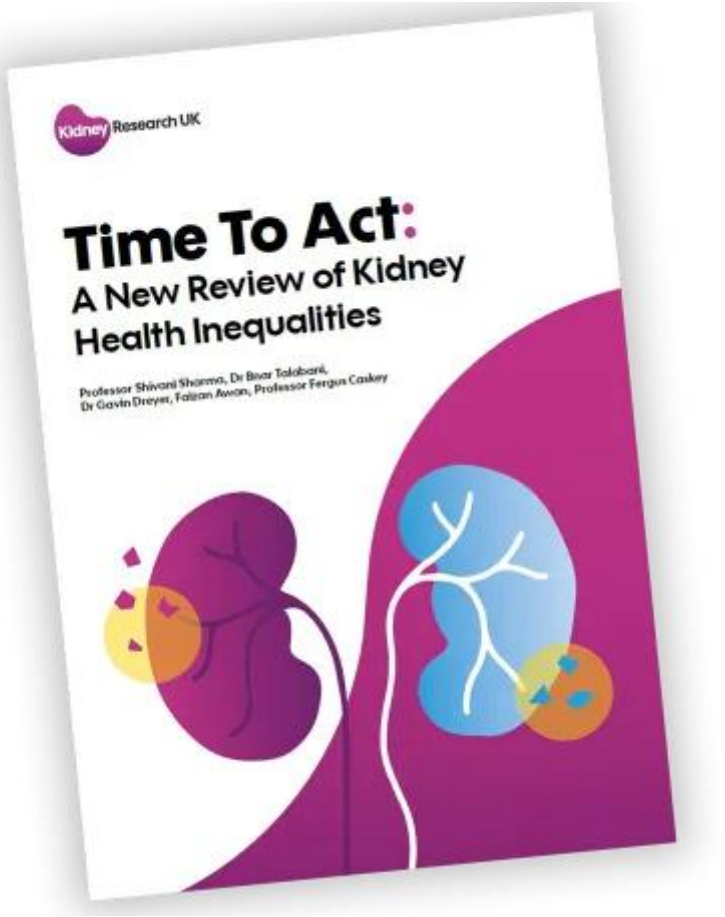


"multiple overlapping contexts such as gender, sex, ethnicity, education, finances, health literacy, freedoms, social support, geography, culture, and beliefs that interact with each other as well as systems and wider societal factors"

Inequities in health outcomes

Kidney disease impacts some communities much more than others:

South Asian adults
develop kidney disease younger
than white adults[13]

People from low socioeconomic groups are
more likely to develop chronic kidney disease
than those in higher socioeconomic groups[14]

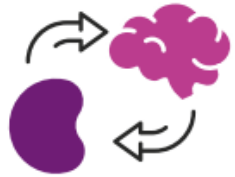
Acute kidney injury is
more common in men than women
after accounting for socioeconomic status, ethnicity, alcohol intake and smoking history[15]

Disease progresses faster in some people:

People of Black, Asian or mixed heritage are
more likely to experience kidney failure
than people of white heritage[16]

Under-70s living in deprivation are
more than twice as likely to progress to kidney failure
than those in more affluent areas[17]

More men than women
start treatment for kidney failure[17]



Mental health conditions are associated with
faster disease progression and worse outcomes
for people with kidney disease[18]

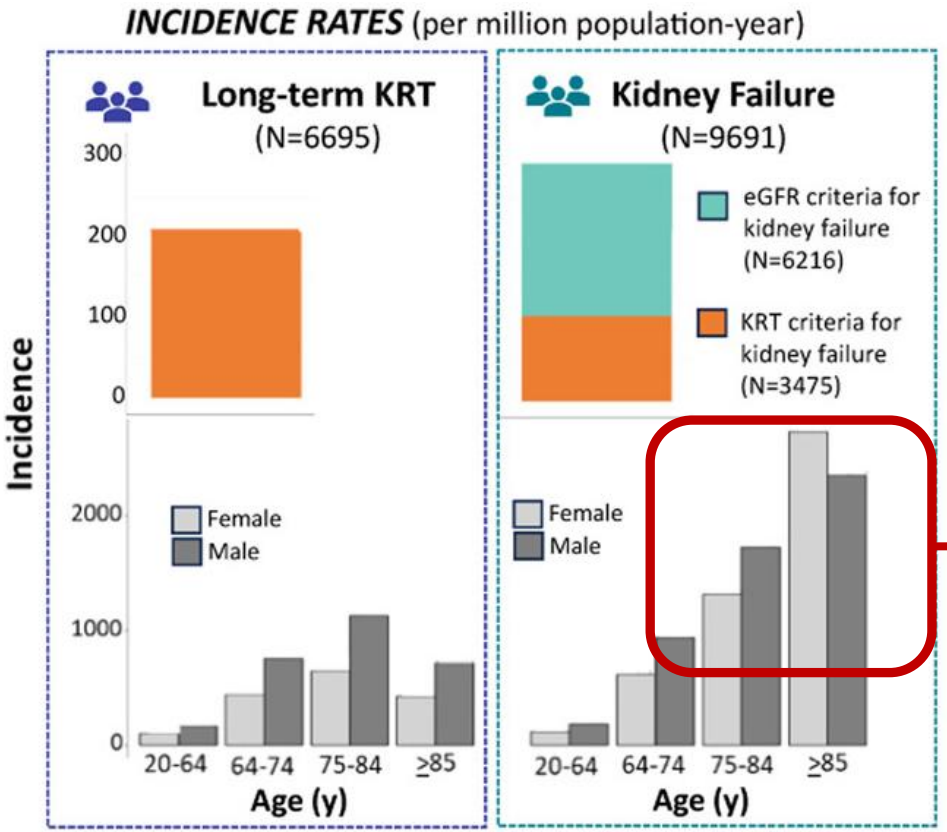
What do we know of Kidney care role within this?

Prevent / treat kidney failure

Prevent wider mortality and morbidity

Improve wellbeing

Inequity in kidney failure



Not discussed in reports of Kidney Failure care

Disproportionately women and older ages

Probably other disadvantaged groups?

Liu, JAMA Int Med, 2025
Liu, Kidney Int, 2025

Inequity in early care, morbidity & mortality

Deprived households get inferior care:

Twice as likely to present (too) late

60% more likely to get treatment in A&E

75% more likely to miss appointments

Inconsistent organisation of care:

ACR check in **19% cardiovascular vs 85% diabetes**

Kidney Int, 2024:106(5):928-942

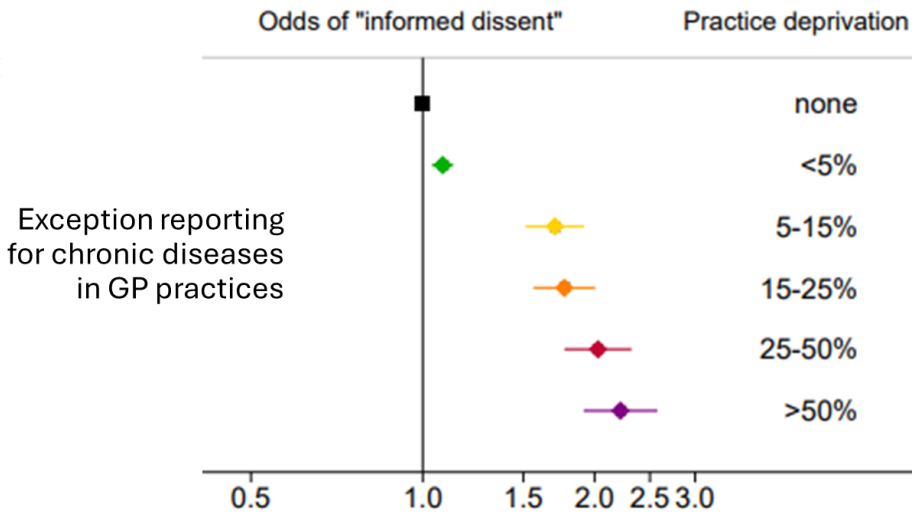
Inequity in early care, morbidity & mortality

NHS Health Check:

"Individuals most likely to attend the Health Check programme included those from **more socioeconomically advantaged backgrounds**"

QOF Exclusions:

"Hard to reach patients are receiving **suboptimal care**"

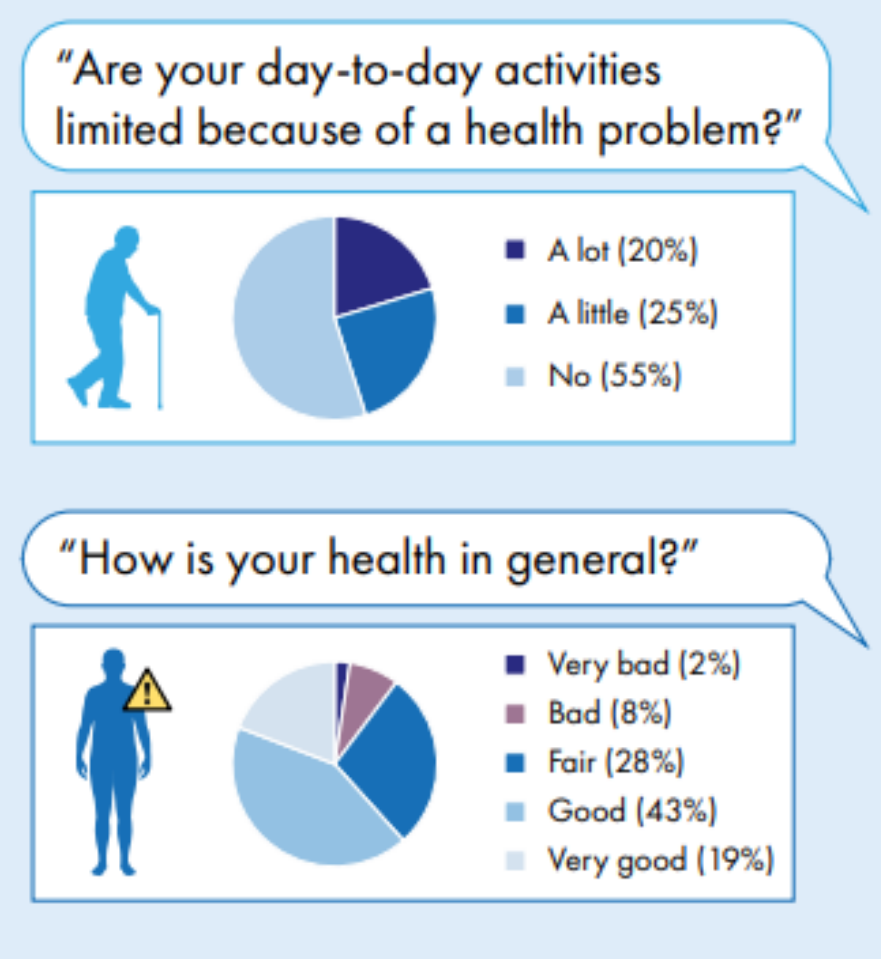


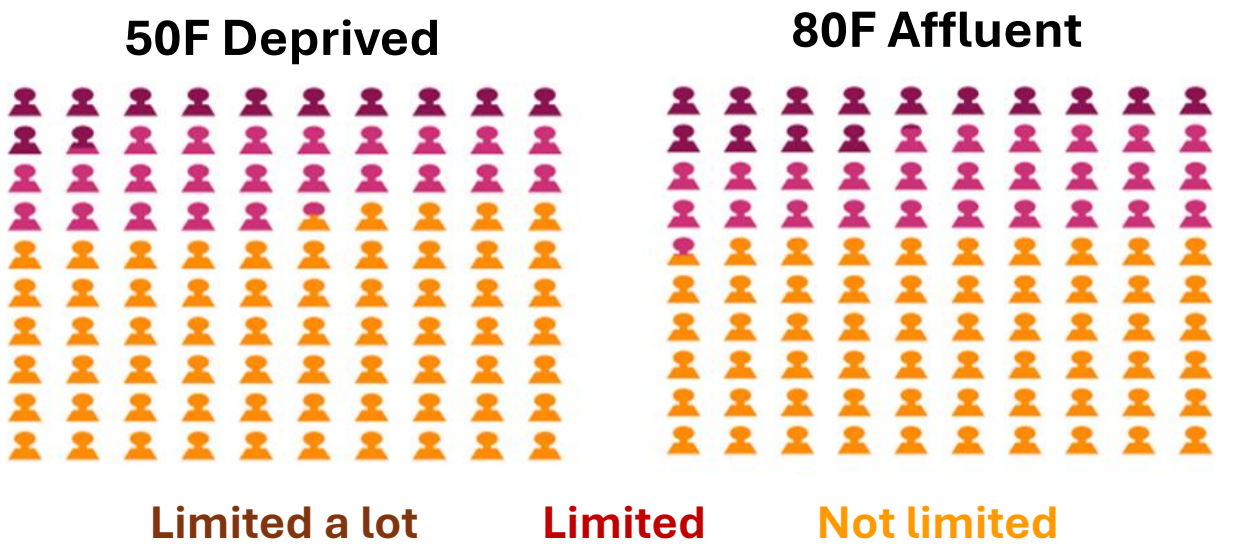
Influenced by organisation of care:

ACR check in **19% cardiovascular vs 85% diabetes**

Kidney Int, 2024:106(5):928-942; Lowrie, BMC Med 2017

Inequity in wellbeing





WHO (plain English): ***"Well-being is about more than being happy all the time. It's about feeling able to cope, recover from pressure, and keep going in a healthy way at work and at home."***

Cowan, CKJ, 2026

Is their health issue really a money issue?

Personalised care conversation skills will help you to identify, understand, support and refer people with money-related health issues, achieving the outcomes that most matter to them.

Get the free toolkit

www.personalisedcareinstitute.org.uk/money-talk

Personalised Care Institute

Money & Pensions Service

Cost of living and health

Kang AJKD 2025:
Impact of income in T2 Diabetes (South Korea)

*One year **transiently** in the lowest income quartile associated with **catastrophic decline** to kidney failure, HR 1.50 (1.32-1.71)*

Morton KI Reports 2018:
Impact of CKD on income (SHARP trial)

*Advanced CKD associated with increased odds of **falling into poverty**, OR 1.51 (1.09-2.10)*

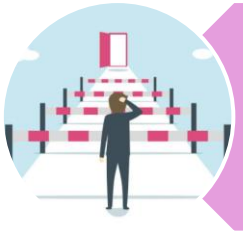
Aregawi Soc Sci Med PH 2025
Citizen's Advice on Prescription (Liverpool)

*"Saving to the NHS from **reduction** in antidepressant **prescribing**, mental health related **GP consultations** and mental health related **A&E attendances** was estimated to be £91 per person"*

Big but feasible priority tasks from stakeholders

Patients, HPs 1º/2º care, public health, counsellors, social prescribers

Improve kidney health **messaging**: trusted, consistent, usable



Reduce **barriers** to care access & engagement

Provide a **whole-person** approach to care

Dr Magda Rzewuska-Diaz
Equity Implementation Scientist

Questions for implementing new treatments

Drug:
SGLT2 inhibitors; Nonsteroidal MRAs; GLP1-agonists; IgA nephropathy therapies; targeted immunomodulators; Tolvaptan for PKD

Non-drug:
New diagnostic and risk tools (e.g. KFRE); Expanded use of point of care; Kidney BEAM; “My Kidneys & Me”; HIDDEN CKD and CKD case-finding; Peer support / care navigation

Will each of these widen or narrow inequities?

Could they be better tailored or targeted?

Who else is implementing within this area or similar areas?

What are our roles as patients and health professionals?