

Editorial

Equity in Haematology

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‘Equity in haematology care’ is the theme of the Sri Lanka College of Haematologists for 2023. This is a timely concept which goes hand in hand with the current global trends in haematology.

The term equity as described in the Oxford English Dictionary is ‘the quality of being equal or fair; fairness impartiality; even-handed dealing’¹. Equity is a difficult concept to comprehend. The term itself has multiple definitions.

Health equity in its simplest form means, giving patients the care they need when they need it². The United States Institute of Medicine indicates that health equity is “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status”². Health equity as defined by the World Health Organization (WHO) is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability or sexual orientation), hence health equity is achieved when everyone can attain their full potential for health and well-being³.

Sri Lanka was considered a model for health equity by British author, Margaret Jones in her book ‘Striving for equity: health care in Sri Lanka from independence to the millennium, 1948-2000’. Health equity has been the primary aim of the government of Sri Lanka since independence in 1948. It was suggested then that it would be

achieved through Western curative and preventive medical institutions which were well-established by then. Therefore, it was believed that developing these institutions along the pathways that had proved successful in the developed world seemed to offer the most effective way forward. The Sri Lankan authorities were committed to provide a health delivery system that reached all groups, classes, genders, and ethnicities, and one that could match that of the West in terms of its benefits⁴. All Sri Lankans have the opportunity and accessibility to the state medical services without any barrier. However, with the current economic crisis maintaining the standards of care with equity has become the greatest challenge to the health authorities.

What should equity in haematology be? And how can we achieve equity in haematology?

Haematology, a medical specialty involved in both diagnostics and clinical management of blood disorders has historically been concerned in achieving equity in care. One such instance is the adoption of INR (international normalised ratio) for PT (prothrombin time) testing. INR is a value derived from the international sensitivity index (ISI), a quantitative measurement of the responsiveness of individual thromboplastin reagents and PT test systems. This is obtained from the comparison of local PT results with those of a WHO thromboplastin international reference preparation (IRP)⁵. INR has helped to achieve a global equity in the anticoagulation therapy with coumarins.

Being a diverse specialty that spans through a spectrum from laboratory diagnostics to patient care in four different but interconnected subject categories of general haematology, coagulation, transfusion medicine and haemato-oncology, achieving equity in care is challenging.

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Equity in laboratory haematology can be achieved through quality assurance which enables in providing precise and accurate laboratory results. Laboratory accreditation is the way forward. Provision of investigations including flow cytometry, immunocytochemistry, immunohistochemistry and genetic testing to all patients is indeed another challenging mission.

Decades of dedication and hard work has improved the haematology care in Sri Lanka where haemophilia patients receive clotting factors and transfusion dependent thalassaemia patients receive blood transfusions irrespective of where they live, their race, caste or creed. The life expectancy of these patients has increased and they live near normal lives with minimum visible differences in appearance with the rest of the community.

How did we achieve this when care for patients with haemophilia is very expensive? Ninety per cent of the cost of management of patients with haemophilia is for the cost of therapeutic products. Therefore, clotting factor concentrates remain largely inaccessible to nearly 75-80% of patients with haemophilia in low and middle income countries⁶. Then, how was this achievement made possible? This remarkable achievement was through generous sponsors. Through this 'humanitarian aid programme' of the World Federation of Haemophilia, clotting factor concentrates and other haemostatic products were donated by sponsors⁶. Will this be effective forever? A self-sustaining system is needed for all countries. 'Self-help is the best help'. Therefore, low and middle income countries will need to consider investing in developing technologies that can produce these products in their countries at a cost which is affordable in these economies. Then only equity in haemophilia care will truly be possible⁶.

The high quality service and standards of the national blood transfusion service is worth a note of appraisal for being the best in South Asia where blood and blood products are delivered to and from any corner of the island whenever needed which is an example for equity in care. Making bone marrow transplant available to our population is another recent landmark.

Where are we lagging behind in patient care? 'Awareness!' Our communities are very much unaware yet not inquisitive of their disease conditions, available health care services and how, when and where they could receive them. In an era where all people have access to various media platforms, neither health nor media services have a responsible and organised patient education and awareness system available and comprehensible in equity to all people.

Quoting Professor Alok Srivastava of the Department of Haematology, Christian Medical College, Vellore, India from his article 'Global haematology: The case for equitable haemophilia care', 'lack of awareness of health care professionals and absence of suitable infrastructure in low and middle income countries for the management of bleeding disorders are a problem. Compounded by the relative rarity of inherited bleeding disorders, these factors lead to their obscurity and low priority in health care. This unfamiliarity extends to the health care providers leading to poor resource allocation'⁶. This unawareness prevails regarding most of the blood disorders in our local health care system too.

Equity in clinical research is another important aspect to consider. As a country where research in haematology is still in its infancy, it is the duty of the professional associations and academic institutions to encourage and provide opportunity, resources and funding for local research, participation in international clinical trials and publication. Both researchers and participants should have equitable opportunity irrespective of gender, socioeconomic or racial barrier to avoid disparities in the results and outcome. American researchers have shown that disparities in cancer treatment as a major contributor to unpromising outcomes in cancer mortality that can be related to the underrepresentation of Black and other racial minorities in clinical trials⁷.

Is health equity a concept applicable only to the receiving end? The care givers too should be treated in equity. All health care workers involved in haematology i.e. doctors, laboratory personnel, nursing and supporting staff should have equitable opportunity and availability in learning, qualifying,

continuous medical education and professional development and research irrespective of their, age, gender, position and place of work. Facilities, grants and other necessary provisions should be equitable.

Gender equity in academic haematology is a topic that is actively discussed on international platforms. It is demonstrated that women in haematology are underrepresented in positions of leadership⁸. As a receptive to this American Society of Haematology (ASH) has recently created 'women in haematology working group' that will help identifying opportunities for career advancement for female haematologists. Their priorities include: effective strategies to increase participation and leadership roles for women in ASH committees, development of training modules regarding avoidance of implicit bias in speaker introductions and discussion, enhancement of online social media platforms for networking and mentorship development, creation of metrics by which to measure success including growth in the percentage of female speakers and committee chairs over time, among others⁸. However haematology being a female dominant specialty in this country such barriers may not occur. But these strategies are important to note as barriers do exist among us affecting equity in opportunity and leadership and with application of these modules we could overcome the barriers and achieve equity among haematologists.

Despite all the hard work through many generations achieving greater heights of a quality service, haematology in Sri Lanka is a specialty that is deprived of many opportunities. Equitable facilities to work i.e. infrastructure, equipment, consumables and staffing etc., opportunity in professional development, leadership, research, rewarding and recognition needs a concern. Most of all strategies should be implemented that haematologists and their services be made aware of to the patients and community in equity to all other specialties.

The American Society of Haematology (ASH) is currently committed to achieve diversity, equity and inclusion (DEI) in haematology through many

initiatives which is a timely and worthy cause that is worth to note of and adoption. 'ASH Statement on Diversity, Equity, and Inclusion': The American Society of Haematology (ASH) is committed to building and nurturing a global haematology community and workforce inclusive of diverse perspectives, talents, and experiences as it works toward one collective goal: helping haematologists conquer blood diseases worldwide. ASH stands in solidarity with our members and patients in communities that are targets of discrimination, harassment, and violence, and remains committed to combatting all forms of bigotry. The four-pronged approach to fulfilling the Society's commitment to diversity and inclusion is:

1. Inspiring, recruiting, and supporting researchers and clinicians from diverse backgrounds to pursue and succeed in careers in haematology and related fields.
2. Involving people with diverse perspectives, talents, and experiences in leadership, volunteer, and staff positions.
3. Providing resources and education to help build awareness of and seek to dismantle systemic racism and other forms of discrimination affecting our members and patients.
4. Advocating for policies and supporting programs that aim to eliminate health disparities in the care of haematology patients.

ASH welcomes and encourages engagement and participation of individuals in the Society regardless of their race, ethnicity, religion, age, sexual orientation, gender identity or expression, ability, national origin, or other attributes⁹.

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