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Contents lists available at ScienceDirect

Health Policy and Technology

journal homepage: www.elsevier.com/locate/hlpt

Why do we fall short in reaching equity in telerheumatology?

The CoronaVirus Disease 2019 (COVID-19) pandemic has been a catalyst for advancing telehealth technology and increasing its use and integration in health care. The pandemic also forced a large number of disciplines to implement telehealth in patients with chronic conditions [1]. In particular, Telehealth in rheumatology, "telerheumatology", was identified as being well set to address a range of challenges associated with the COVID-19 pandemic [2].

Since the beginning of the COVID-19 pandemic, the Arab Adult Arthritis Awareness (AAAA) group, under the umbrella of the Arab League of Rheumatology Associations (ARLAR), has been raising awareness and providing advice to Arab patients with chronic rheumatic diseases through its extensive social media network and connections with individuals and patient associations [3].

Like in the UK, where clinicians have adopted SMS-based mobile phone video messages to target rheumatology patients with educational messages and a self-administered COVID risk score [4], some Arab rheumatology societies (Moroccan, Jordanian...) have also shared information with their patients via their own social media network. In this area, the American College of Rheumatology (ACR), and the European League Against Rheumatism (EULAR) have issued recommendations for the initiation, continuation, and exposure of treatment, the use of corticosteroids, biological therapy, and social distancing [5,6].

In Arab countries, a previous study among 2163 patients with rheumatic diseases [3] showed that the pandemic reduced access to rheumatology care by affecting visits to the rheumatologist, and medication persistence. It also had a significant negative influence on mental health and income. All these substantial impacts suggest an indirect deleterious effect of the pandemic on disease control and management. This impact may be greater than the potential direct impact of the infection [7]. The reduction in rheumatology visits was different in different regions, reflecting a difference in health systems and public policies.

Indeed, Telehealth can reduce inequities by providing easier access to care for patients living in rural or remote areas, and by promoting continuity of care, with cost-effective advantages in facilitating access to and use of health services and health education [3,8,9].

When asked about their attitude towards Telehealth during the peak of the COVID-19 pandemic, 98.8% of the Arab patients stated that they would accept a teleconsultation (50% via the internet and 48.8% via telephone). Therefore, best practice guidelines for the use of Telehealth in rheumatology (TIROL study) in the Arab region were developed under the umbrella of the ArLAR [10]. Four general principles and twelve good practice statements were developed and reached >80% consensus after three rounds of voting using a modified Delphi method.

Good Practice Statement number 11 indicated that "The technical

infrastructure should be improved for patients and physicians to enable an efficient and equitable access to Telehealth services across the countries and in vulnerable populations". (Level of Evidence 5 (Expert opinion); Level of Agreement 8.41/10; Consensus 100%). However, previous reports have identified the lack of a structural framework for Telehealth as a major barrier to its effective implementation in the rheumatology clinic [11]. Indeed, studies in the Middle East have shown that poor infrastructure is associated with low adoption of Telehealth [12].

The lack of a structural platform for Telehealth is consistent with the definition of physical access [13] (physical availability of the internet and electricity [14]) and the ability to maintain good-quality services over time [15] which is influenced by socioeconomic status and social network [16]. Moreover, resistance to change among patients and physicians has been also identified as a barrier. Indeed, to make Telehealth work, patients and physicians must want to engage with it and know how to do so. Many find it harder than others to accept the digitalization of healthcare [17]. Some authors even suggest "universal digital health precautions" assuming the patients don't know how to do it, unless proven otherwise [18].

The technical infrastructure must be improved for patients and physicians to enable effective and equitable access to Telehealth services in all countries and in vulnerable populations. In parallel, eHealth literacy should also be improved. eHealth literacy is defined as "the ability to search for, find, understand and evaluate health information from electronic sources and to apply the knowledge gained to solve a health problem" [19]. eHealth literacy includes, on one hand, an individual's ability to determine the reliability of online information and to protect their data [20,21]. On the other hand, it takes into consideration internet skills, and more specifically the effective use of the internet. Improving eHealth literacy will prevent the digital gap in the Arab countries from becoming entrenched and persistent.

First, achieving health equity in Telehealth will require mobilizing the resources of financial incentives and political will among hospital systems, insurance companies, and governments. Promoting digital equity in health will depend on policy implementation, the regulatory environment, system architecture and industry incentives [23–25].

Second, integrating the use of digital health into population health approaches will necessitate the acceptance that people come first, and technology comes second. If digital health were to be considered a 'good' using the concept of the commons, then it would be possible to make a case for digital equity [22].

Recently, the Lancet and Financial Times Commission on Health Governance in 2030 reflected on two current questions: how do we grow up in a digital world, and can digital technologies deliver health benefits

<https://doi.org/10.1016/j.hlpt.2022.100609>

Available online 23 February 2022

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for all? It concludes by calling for connectivity to be recognized as a public good and a human right [26].

To achieve this, we need the commitment of various key partners (scientific community, local leaders and patients) by adapting to the language, culture, administrative circuit, and familiarity of communities with digital services. We can also learn from foreign experiences and adapt them to our context to optimize collective efforts. In this perspective, rheumatologists should be encouraged to adopt a customized triage system to select the patients who are suitable for tele-rheumatology, taking into account the local technical, logistic, and cultural factors. Finally, ensuring that the end-users of the service and relevant community leaders influence the project more directly will be essential for its sustainability [8,27]. In this perspective, digital transformations cannot be stopped, but we have to learn how to keep adapting to them.

Funding

None.

Competing interests

None declared.

Ethical approval

Not required.

Acknowledgements

This editorial resulted from the proceedings of a session within the international webinar series in "Equity and Outcomes, Ensuring Fair Access to Healthcare" initiated by the Fellowship of Postgraduate Medicine (FPM). The FPM founded in 1918, provides authoritative updates on advances in medicine to health professionals around the world, through HPT and its other official publication the *Postgraduate Medical Journal*, and through conferences and webinars. The FPM, in partnership with HPT and the PMJ also makes international awards for trusted medical writing in social media and supports international awards for medical humanities (The Hippocrates Prize).

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Ihsane Hmamouchi^{a,*}, Nelly Ziadé^b

^a Rheumatology Unit, Temara Hospital, Laboratory of Biostatistics, Clinical Research and Epidemiology (LBRCE), Faculty of Medicine and Pharmacy, Mohammed V University, Rabat, Morocco

^b Rheumatology Department, Saint-Joseph Medical University and Hotel-Dieu de France Hospital, Beirut, Lebanon

* Corresponding author at: BP 6388 Rabat-Instituts, Rabat, Morocco.
E-mail address: ihsane.hmamouchi@gmail.com (I. Hmamouchi).