



Access to care and early detection of psoriatic disease

Managing psoriatic disease requires equitable access to care and early detection. Across the Americas, variations in healthcare systems and treatment affordability emphasize the need for tailored solutions.

African Americans use biologicals less than Caucasians, despite having more severe disease¹

13.3%

African Americans

46.2%

Caucasian individuals



26%

of people living in Latin America with diseases affecting the skin spend between **2 and 10 hours traveling** for each healthcare appointment.²

Equitable access to care

Many people with psoriatic disease living in the Americas face major hurdles in accessing healthcare services due to socioeconomic factors such as income, race and insurance coverage.³ In the US, people with lower incomes or inadequate insurance are at higher risk of hospitalization.³ In Latin America, those with private insurance are far more likely to seek medical attention than those relying on public healthcare.⁴

Early diagnosis and treatment

Early diagnosis and treatment are essential for improving health outcomes and quality of life for people living with psoriatic disease.⁵ With psoriatic arthritis, delaying a doctor's visit by just six months can lead to irreversible joint damage and long-term disability.⁶ There is a growing shortage of dermatologists and rheumatologists worldwide, especially in rural areas. As a result, many patients face long waiting times and have to travel long distances to get the care they need.^{7,8}

Access to biologics

Biologic treatments provide significantly improved outcomes for individuals with psoriatic disease⁹, but notable disparities persist between recommended therapies and their real-world availability throughout the Americas.¹⁰ Barriers to access include high treatment costs, poor treatment adherence, limited insurance coverage and storage issues.^{10,11}

Key advocacy asks

Addressing disparities in access to care and early detection for psoriatic disease requires a multi-faceted approach. Policymakers, healthcare providers and patient advocacy groups must work together to:



Enhance healthcare system capacity

Increase awareness and outreach to marginalized communities.

Strengthen healthcare infrastructure in under-served areas.

Expand telemedicine initiatives to facilitate remote consultations.



Ensure affordability and accessibility of treatments

Improve insurance coverage and affordability of treatments.

Increase funding and subsidies for biologic treatments.

Improve pharmacy access and distribution logistics.



Promote early diagnosis through primary care engagement

Strengthen psoriatic disease guidelines in primary care.

Provide enhanced dermatological training for general practitioners.

Educate patients on proper medication usage, storage and adherence.

1. Kerr GS, Qaiyumi S, Richards J, et al. Psoriasis and psoriatic arthritis in African-American patients—the need to measure disease burden. *Clinical rheumatology*. 2015;34:1753-1759.
2. COLAPPIEL. Survey of unmet needs in patients with skin diseases in the LATAM region. 2024;
3. Hsu DY, Gordon K, Silverberg JI. The inpatient burden of psoriasis in the United States. *J Am Acad Dermatol*. Jul 2016;75(1):33-41. doi:10.1016/j.jaad.2016.03.048
4. Coube M, Nikoloski Z, Mrejen M, Mossialos E. Persistent inequalities in health care services utilisation in Brazil (1998–2019). *International Journal for Equity in Health*. 2023/02/02 2023;22(1):25. doi:10.1186/s12939-023-01828-3
5. Gladman DD, Thavaneswaran A, Chandran V, Cook RJ. Do patients with psoriatic arthritis who present early fare better than those presenting later in the disease? *Ann Rheum Dis*. Dec 2011;70(12):2152-4. doi:10.1136/ard.2011.150938
6. Haroon M, Gallagher P, FitzGerald O. Diagnostic delay of more than 6 months contributes to poor radiographic and functional outcome in psoriatic arthritis. *Ann Rheum Dis*. Jun 2015;74(6):1045-50. doi:10.1136/annrheumdis-2013-204858
7. McMullen E, Kirshen C. Solutions for Addressing the Dermatologist Shortage in Rural Canada: A Review of the Literature. *J Cutan Med Surg*. Jul-Aug 2024;28(4):365-369. doi:10.1177/12034754241247521
8. Schmitt JV, Miot HA. Distribution of Brazilian dermatologists according to geographic location, population and HDI of municipalities: an ecological study. *An Bras Dermatol*. Nov-Dec 2014;89(6):1013-5. doi:10.1590/abd1806-4841.20143276
9. Mattei PL, Corey KC, Kimball AB. Psoriasis Area Severity Index (PASI) and the Dermatology Life Quality Index (DLQI): the correlation between disease severity and psychological burden in patients treated with biological therapies. *J Eur Acad Dermatol Venereol*. Mar 2014;28(3):333-7. doi:10.1111/jdv.12106
10. Maul J-T, Fröhlich F, Maul LV, et al. Access to psoriasis treatment in Brazil and Chile: A cross-sectional multicentre Global Healthcare Study on Psoriasis. *British Journal of Dermatology*. 2023;188(4):533-541. doi:10.1093/bjd/ljact128
11. Soriano ER, Zazzetti F, Alves Pereira I, et al. Physician-patient alignment in satisfaction with psoriatic arthritis treatment in Latin America. *Clin Rheumatol*. Jun 2020;39(6):1859-1869. doi:10.1007/s10067-019-04870-1