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EDITORIAL

Improving the provision of allergy care

It is heartening to see three separate papers on allergy [1—3] in this issue of the Primary Care Respiratory Journal (PCRJ). Clearly there is increasing recognition of the important role played by allergy in asthma, and the role of allergic sensitisation in accompanying disorders such as rhinitis, food allergy and eczema. If this trend continues it may become necessary in the future for the editors to consider changing the journal title to the ''Primary Care Allergy and Respiratory Journal''.

The UK National Health Service (NHS) has been wrong-footed by the present unexpected allergy epidemic. Current provision of allergy services is patchy and inadequate and in the main provided by doctors with only limited allergy training. Many of these doctors are struggling to keep pace with ever-increasing numbers of referrals, often to the detriment of their own services. Most do not have the facilities or experience to investigate complex multi-system disorders outside their own focused area - for example, there are only a handful of hospitals able to investigate drug allergy. Today's NHS must acknowledge that numbers of patients with allergy are not only increasing at an alarming rate but also that their presentation may often be severe or even life-threatening and their management more complex. Furthermore, the next five to ten years will see the advent of new and expensive bioengineered pharmaceutical agents capable of remarkable health benefits in targeted individuals with allergy. Without a network of trained specialist allergists in each region of the UK with the ability to identify the subset of patients who may benefit, it is likely that the NHS drug budget will spiral further out of control.

The discussion paper by Ryan and colleagues [1] attempts to address the shortage of allergy services by accepting the inability to obtain funding for an expansion of allergy services in secondary care. Instead of advocating the need for more specialist allergy centres, the authors have accepted the status quo and have advanced their own model for promoting ''minimum standards in primary care''. In addition, the authors propose a nationwide network of practitioners, either nurse practitioners (PwSIs) or general practitioners (GPwSIs) with a special interest in allergy, who would provide nationwide coverage of primary and intermediate care for allergy sufferers. The authors admit that this would not be a cheap option and propose to spend substantial resources on widespread training for GPs, practice nurses, and pharmacists, and then train large numbers of GPwSIs or PwSIs around the country.

Clearly it is unrealistic to expect the Department of Health or individual Primary Care Organisations (PCOs) to fund such a national programme for the two or three years' training required. The authors admit that improved access to allergy training is a prerequisite to improving delivery of allergy services in primary care. With the limited number of hard-pressed hospitals specialising in allergy this begs the question of who would provide the training and support for GPwSIs. The authors mention that there are similar models in Sports Medicine, ENT and dermatology, but the crucial difference between these models and their proposed model for allergy is that these are mature specialties with large numbers of secondary care centres already providing governance, infrastructure, education, and training; they can therefore readily provide a training base for GPwSIs. Without a similar

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network of specialist allergy centres the proposed model propounded by Ryan et al. [1] is unlikely to succeed.

Paradoxically, an increase in provision of allergy services at primary care level will increase the need for advice from and referral to secondary care, a need which cannot currently be met. The research paper in this issue by Ryan, Grant-Casey and colleagues [3] highlights the current deficiencies in allergy training in a group of 188 GPs who had a self-declared interest in rhinitis. Not one of these GPs was able to meet the minimum standard laid down in a specialist consensus document on the investigation and treatment of rhinitis [4]. It is unlikely that this situation would have arisen if the GPs had been linked to local specialist allergy centres.

Many of the authors of the discussion paper [1] were also involved in the production of *Allergy: the unmet need*, the recently published document of the Royal College of Physicians [5]. This document provides a carefully considered approach by advocating improved education and training at all levels, starting at undergraduate level, together with an increase in hospital training posts (at 'specialist registrar' level) in allergy. This should eventually lead to increased numbers of allergy specialists in each region of the country, which could then provide a hub for local training. These specialists would operate in both secondary and tertiary centres, since it is unrealistic to expect organ-based specialists to be able to treat all the different organs involved in a patient with systemic allergic manifestations; for example, asking an ENT surgeon treat eczema is not the way to proceed. Another important recommendation was the creation of GPwSIs and practice nurses in allergy. Thereafter, the model proposed by the authors is more likely to be successful [1].

The authors of the discussion paper also suggest that allergy testing is not always required in a patient with allergic symptoms in primary care and have advanced the concept of pharmacotherapy without identification of specific triggers [1]. Although in some cases this may be appropriate, it is difficult to see how a primary care model such as this is far removed from current practice. Even in mild to moderate hay fever it is essential to identify specific seasonal triggers in order to plan prophylactic treatment each year [6]. Many patients have pets leading to persistent symptoms of asthma, rhinitis or eczema, and targeted lifestyle changes can lead to significant improvements [7]. Moreover, once patient expectations are increased, demands for investigation of specific triggers will increase but will not be available because of a lack of allergy clinics. The study by de Vries and colleagues in this issue [2] highlights considerable national differences in treatment of asthma and health funding. In the UK it is highly unlikely that an asthmatic patient would have seen an allergist and had skin testing, and the patient would be unlikely to know whether their asthma was allergic or non-allergic. The fact that half of the asthmatics in this unselected sample of patients in the Netherlands were sensitised to house dust mite may come as a surprise to non-allergists but is consistent with UK figures [8]. Furthermore, there is no doubt that in many of these patients allergic sensitisation is central to the underlying mechanism of atopic asthma judged by the success of anti-IgE therapy in patients with severe asthma [9].

Many of the goals inherent in the discussion paper [1] should be welcomed, but a stand-alone primary care model has inherent shortcomings. Expansion of allergy services, like in all other similar models, has to be from ''top down''. It is vitally important, at a time of increasing need for allergy service provision and in the aftermath of the Select Committee Report on the provision of allergy services [10], that both primary and secondary care work closely together to bring about a sea-change in the way allergy is perceived, not only by the Department of Health but by patients and the media. There is no doubt that the majority of allergy care will continue to be provided in primary care and that standards have to be improved, but it is important first to develop the means to achieve this. Therefore, expansion of secondary care must precede any proposed primary care initiatives. If this does not occur, and without the support of a local allergy specialist centre, training and by implication, the standard, of primary care allergy will not improve.

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