ATOPIC ECZEMA
Accelerating Care

Jen and her daughter, Hallie, impacted by Atopic Eczema

Recommendations for policy makers

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International Alliance of Dermatology Patient Organizations

It's time to act!

Atopic eczema is one of the most common skin conditions. The lives of millions of people with atopic eczema, and their caregivers and families, are significantly impacted by a disease that affects many aspects of physical and mental wellbeing and yet is rarely considered a serious disease.

For too long, skin diseases have been of low priority within healthcare systems and the impact they have on people's lives underestimated. But we now have a mandate for change. The 2025 World Health Organization (WHO) resolution on skin disease and the resulting global action plan calls for radical reprioritizing of care for skin disease, including atopic eczema.

We are a group of patient advocates from skincare patient organizations across the world, working in partnership with the International Alliance of Dermatology Patient Organizations, known as GlobalSkin, a global, patient-led non-profit organization.

Together we are committed to amplifying the voices of patients with atopic eczema to ensure this patient community is fully represented in healthcare conversations. We aim, through our knowledge and experience of the condition, to support policy makers and healthcare professionals in bringing about the changes required to improve the lives of patients with atopic eczema.

As the WHO resolution highlights, access to care is a vital element in addressing skin diseases. Healthcare policy makers at the national, regional and local levels are central to the formulation and implementation of approaches that enable and support access to care in atopic eczema.

Patient organizations have a large role to play. We can support policy makers beyond raising awareness and disseminating information about atopic eczema. We can be partners in the design, implementation, monitoring and evaluation of care pathways. We can identify real barriers to access, connect people with policy makers and trained healthcare professionals, support patient navigation and generate evidence from the patient perspective.

The recommendations in this document, based on the literature and our own experience, will encourage and support the development of healthcare policies that enable people with atopic eczema to access the care that they need.

Together, we can work to dismantle barriers to atopic eczema care and prioritize access for all.

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This report has been developed and produced with the Atopic Eczema Community, part of GlobalSkin. Special thanks go to the 2026 Policy Task Force members who have shaped the content of the report and recommendations:

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Patients at the heart of atopic eczema care

The WHO Global Action Plan on Skin Diseases (GAP-Skin), draws our attention to the billions of people from all countries and background who live with skin disease. One hundred and seventy-one million of these individuals have atopic eczema.[1] The condition is particularly common in children and young people: with up to 1 in 5 affected depending on where they live.[2]

This is not a cosmetic issue. Atopic eczema has a profound effect on the health and quality of life of those who live with it.[2] The condition often leads to intense itching and scratching, disturbed sleep, low self-esteem, social isolation and depression and anxiety.[2] Atopic eczema has also been linked with a 22% increase in rates of suicide.[3] The condition can have implications for long-term care and social participation and can affect the ability to study, choice of occupation and productivity.[2]

Further health implications for patients due to comorbidity include sinus infections, gastroenteritis, severe viral and bacterial skin infections, asthma, other allergies and even cardiovascular risk.[2]

A key challenge in the management of atopic eczema is access to care. Indeed, 42% of countries report inadequate or extremely poor access to dermatology services.[4] This is often due to low numbers of healthcare professionals trained in dermatology in both primary and secondary care. Patient pathways can be undefined and difficult to navigate.[5] Comorbidities create further complications for patients.

Other factors influencing access to care include long distances to a treating center and access to care available through privately funded routes only.[4] Misinformation is also common online, on social media or in widely held beliefs that prevent people with atopic eczema from accessing optimal care.[6]

This document outlines policy recommendations from the patient community to address current barriers to atopic eczema care. **These recommendations call on policy makers to work with the patient community to achieve the four overarching goals below. This document focuses on key aspects of reaching these goals.**

Four key goals to be met

Prioritize atopic eczema through planning provision of care that is integrated into broader healthcare systems

Enable access to high-quality specialist and primary care provided by appropriately trained healthcare professionals

Work to ensure care for all individuals with atopic eczema regardless of who they are and where they live

Support the provision of accurate information about atopic eczema that sets individuals on the right care pathway

1: Prioritize atopic eczema

Skin diseases have traditionally been low priority in terms of healthcare resource allocation despite the billions of people affected worldwide.[7] Atopic eczema is the most common chronic inflammatory skin disease with a significant impact on daily life. In fact, it has the greatest disease burden among skin diseases as measured by disability-adjusted life-years.[8]

The condition also has an adverse effect on the parents and caregivers of children and adolescents with atopic eczema: on their sleep, occupation, productivity, anxiety levels and social interaction.[9] Yet skin health has been poorly integrated into national planning for healthcare provision and investment and into broader health and development agendas.[7] For patients, this can mean delays in diagnosis, increased disability and inequities in care provision.[7] To improve patient access to care and consequently patient outcomes and quality of life, the WHO GAP-Skin advocates global, national and regional planning combined with community engagement to put the patient at the heart of integrated skin-health care services.[7]

Tools are available to support policy-makers, patients and clinicians in identifying priorities in atopic eczema care. Examples include the COLAPPIEL policy scorecard[10] to identify priorities in care provision and the Patient-Reported Impact of Dermatological Diseases (PRIDD) to assess the impact of the disease on the individual patient.

We urge policy makers to adopt the recommendations in the WHO GAP-Skin and we highlight the following recommendations for prioritizing atopic eczema in particular.

Policy recommendations

- I**ntegrate atopic eczema into national, regional and local skin-health strategies**, with dedicated responsibility, budgets, targets and monitoring
- **Partner with patient organizations to identify priorities** and incorporate patient and caregiver experience into policy development and evaluation
- **Measure the full burden of atopic eczema, including quality of life**, caregiver burden and relevant comorbidities, using validated patient-reported tools such as PRIDD
- **Build integrated atopic eczema care into broader health systems**, and connect primary care, dermatology, mental health, allergy/asthma services and underserved communities
- **Strengthen health worker skills and networks** to increase atopic eczema knowledge at all levels of the health system

Good practice example

The COLAPPIEL Policy Scorecard is a valuable resource for patient advocates and policy makers. A patient-led tool developed by a coalition of patient organizations, it uses evidence-based indicators to assess access to public healthcare services for six skin diseases including atopic eczema. The scorecard supports the identification of policy gaps and enables comparison between 14 Latin American countries. It can make barriers to care more visible and measurable and provides a framework to assess whether countries have public policies, clinical guidelines, diagnosis pathways, access to services, coverage mechanisms and reference centers.[10]

2: Access to specialist care

Demand for dermatology care is rising.[11] An aging population means higher levels of skin cancer and other age-related conditions. Changes in climate, pollution levels and lifestyle can all affect skin health.[11] Cosmetic procedures take up increasing amounts of dermatology time as do referrals from primary care.[12] Added to this, is the shortfall in trained dermatologists.

Shortages are particularly acute in low-income countries with a reported 0.37 dermatologists per 100,000 people.[4] A patient's access to care may be hindered not only by country of residence, but also by region or rural versus urban setting. They may not have the means to access specialist care through private healthcare which is a disproportionately large sector in dermatology.[4]

In view of these barriers to access, a patient with atopic eczema may face delays in seeing a dermatology specialist or indeed may not see a specialist at all. This may have further consequences if a patient has comorbidities requiring referral from dermatology to other specialties. Negotiating referral pathways can be complex and stressful for patients, especially given the high prevalence of anxiety and low self-esteem in people with atopic eczema,[2] and navigational support is required.

A multi-faceted approach is needed. Training, incentives and support are essential to increase the availability of specialist consultations. Technological and digital capabilities can further boost access. The role that dermatologists have in administering primary care training is also key.

Policy recommendations

- **Expand and adequately resource the dermatology workforce**, including training and incentives for underserved areas
- **Develop integrated referral and care pathways** connecting dermatology with primary care and relevant specialties, with support for patients to navigate these pathways
- **Ensure adequate numbers of dermatologists** to be able to provide training to primary care physicians, pharmacists and other primary care healthcare providers
- **Explore technological solutions** to increase dermatology capacity such as telehealth and AI driven diagnostic tools
- **Include the atopic eczema communities in strategic planning**, boards and committees to strengthen links between the clinical dermatology community and the patient community

Good practice example

Getting it Right First Time (GIRFT) is a national programme which is designed to improve medical outcomes and patient experience in the UK without the need for radical change or additional financial investment. GIRFT dermatology gathered and examined data from hospital trusts that was then discussed by clinical specialists and the hospital trusts. Their response to finding a UK-wide unwarranted variation in the provision of dermatology services included the development of networks to increase support for smaller dermatology services.[12]

3: Primary care expertise

Strengthening skin healthcare in primary care is central to the efficient provision of skin healthcare as a whole.[7] In atopic eczema, primary care workers play an important role in early recognition, in diagnosis and assessment and are also usually responsible for the management of mild-to-moderate cases, for referrals to specialist care and for supporting patient navigation.

However, atopic eczema is not always optimally managed in primary care.[2,13] Many primary care practitioners do not receive adequate training in atopic eczema. In the UK, dermatology training is not a compulsory part of GP training despite the fact that dermatology cases take up 15 to 20% of GP workload.[14] Primary care workers may not be confident in assessing atypical cases, or diagnosing other diseases that mimic atopic eczema. They may not be familiar with atopic eczema presentation in different ethnicities and skin colours. Comorbidities can make diagnosis and management complex.

Delays or unnecessary referrals can result from lack of primary care expertise or care pathways that are poorly defined. Standardized pathways, and clear referral criteria are central to supporting primary care workers in their management of atopic eczema. Access to specialist advice as and when required further supports optimal management in primary care, particularly where access to specialists is likely to remain limited.

Other frontline providers of care – nurses, pharmacists and other healthcare assistants – deliver a substantial proportion of dermatology care. In low-income countries, this is between 36 and 44%.[4] This group also requires atopic eczema training specific to their role and to know when to triage patients to doctors and dermatologists.

Policy recommendations

- **Provide dermatology and atopic eczema training** as a core part of education for existing primary care practitioners, including physicians, nurses, pharmacists and community health workers
- **Integrate compulsory dermatology training into medical school programs**
- **Give primary care professionals clear, evidence-based pathways** and referral criteria, including guidance on comorbidities and mental health
- **Strengthen links between primary care and the atopic eczema community** in order to bring the patient and caregiver perspective into the design, implementation, monitoring or evaluation of primary care initiatives
- **Leverage existing pathways and services for other skin-health conditions** such as neglected tropical diseases so that the same networks can be used to treat multiple skin-health conditions

Good practice example

Dermatologists and the primary care coordinator at Hospital La Paz in Madrid, Spain host regular online training sessions at a time convenient to primary care physicians. A range of dermatological conditions, including atopic eczema, is discussed and attendees can ask questions and request topics of interest. The project builds strong links between primary and secondary care as well as improving the quality of referrals to the dermatology unit at the hospital.[15]

4: Equitable access to care

Atopic eczema is a chronic disease that requires a long-term care plan and may need repeat consultations. Yet not all individuals with atopic eczema have access to care. For some this may be rooted in social inequality or the country or region where they live and for others in the uneven provision of healthcare.

Care pathways are not always well-defined or standardized. Inefficiencies in early care pathways or lack of dermatology training can mean trial-and-error management that delays a necessary escalation. Many individuals with atopic eczema do not know when to seek care or how to move through the healthcare system. This is especially difficult in countries with fragmented healthcare systems and regional inequities.

A patient who lives in a rural area may face a difficult or impractical journey. Almost 80% of dermatologists are based in cities.[4] Some patients may have the option of private care, which accounts for 35 to 49% of dermatology service provision, but most patients receive their care in a public setting.[4] Shortages of dermatologists in some settings may mean longer waiting times for patients.

All these imbalances, while more acute in some countries and regions, are present in high-, middle- and low-income countries.[4]

In addition, some populations, such as people with skin of colour and displaced populations, have been identified as facing an increased level of difficulty in accessing atopic eczema care.[16,17] Identifying barriers to care is the first step. Addressing them through the use of service delivery, care pathway adjustment and, where possible, digital technologies that enable the sharing of local and international expertise, is recommended as the next step.

Policy recommendations

- **Measure inequalities in access and outcomes** by geography, population and level of care, and identify and address the barriers to equitable care
- **Address identified gaps** by incentivizing both primary and secondary care health workers to focus on the geographies and populations that are underserved
- **Use telehealth and other validated digital approaches,** such as the WHO app[18], where distance or workforce shortages limit access to dermatology and mental-health expertise
- **Bring care closer to patients** through appropriately staffed community services, outreach and diagnostic hubs

Good practice example

In Argentina, the patient group, the Asociación Civil para el Enfermo de Psoriasis (AEPSO) has worked with a range of healthcare professional bodies to implement a series of national free detection campaigns for atopic eczema. The campaigns aim to facilitate early diagnosis, connect people with dermatologists and other trained healthcare professionals, and raise public awareness about the condition. People with signs or symptoms of atopic eczema can request a free appointment through AEPSO's website or by telephone.[19]

5: Accurate information

Accurate information can support patients and caregivers in making optimal decisions about their care and in managing their condition long term. This is particularly important in atopic eczema as treatment is usually administered at home and much of the care is non-pharmacological.

However, inaccurate information is prevalent on social media, online or can be passed from person to person.[6] Misinformation can include oversimplification of the causes of the condition or of suggested 'cures'.[6] Some misinformation is not only inaccurate but harmful.

People with atopic eczema may be particularly vulnerable to such information given the effect the condition has on daily life, and its associated stigma and psychological impact.

Contact between patient and healthcare provider can be infrequent, so information about how the patient can manage disease flare-ups and when to consult their healthcare provider is needed. Patient information can also advise patients on how to discuss their quality of life, sleep, mental health and comorbidities with healthcare professionals.

To be effective, information should be in local languages and in an accessible format, which may not be online. It is also required to be culturally appropriate and tailored to suit different levels of literacy.

The provision of effective, accurate patient information and supported self-care in patient–healthcare worker interactions throughout the patient journey can empower patients to play an active role in their own atopic eczema care. It can enable greater autonomy for the patient by reducing the need for visits to the physician or healthcare worker, as well as helping them navigate the healthcare system.

Policy recommendations

- **Map and assess existing resources and identify any gaps** in atopic-eczema-related information resources and knowledge
- **Include the atopic eczema community to identify or support the development and evaluation of materials** that reflect their specific medical, cultural and practical needs
- **Provide accessible, evidence-based information** throughout the patient journey, covering recognition, self-management, comorbidities, psychosocial support and navigation of healthcare systems

Good practice example

Eczema Support Australia is a member of the Quality Use of Medicines Alliance, a consortium of eight health and consumer organizations which is working to design and administer high quality education that equips people affected by atopic eczema with the skills and knowledge to manage the disease. This includes resources translated into several languages and guidance on questions to ask during atopic eczema healthcare consultations.[20]

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