

Medications to the north, patients to the south

Medicamentos ao Norte, doentes ao Sul

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“*Medicaments au Nord, malades au Sud...*” (“Medications to the north, patients to the south...”) So stated Bernard Kouchner, the then French Minister of Health (and current Minister of Foreign Affairs) of France, in order to call attention to the inequities in AIDS treatment: the gap between the broad availability of medications to treat AIDS in countries located in the central northern hemisphere (France, for example) and the lack of such medications to treat HIV-infected and AIDS patients in peripheral countries located on the African continent. That statement, which remains valid, can also be applied to asthma, for a variety of reasons, including the failure of many governments and government officials to recognize the extent and repercussions of this disease. This is illustrated in the study conducted by Rodrigo et al., published in this issue of the Brazilian Journal of Pulmonology,⁽¹⁾ in which the authors profiled patients with acute severe asthma, hospitalized in Spain or in one of a number of Latin-American countries. *Mutatis mutandis*, many of their findings reflect the fact that, south of the equator, budgets established for the health sector in general, as well as for increasing the availability of essential medications in particular, are insufficient. In 1997, the World Health Organization estimated that over 95% of Western Europeans had access to essential drugs, compared with, at most, 80% of Latin Americans.⁽²⁾ There is no indication that any substantial changes have occurred within the last ten years, and there continues to be a clear divide between countries in the northern hemisphere and those in the southern hemisphere. Chronic noncommunicable diseases and chronic respiratory diseases—asthma in particular—have been neglected in the public health policies of developing countries, despite the fact that such countries have the highest rates of asthma-related morbidity and mortality.⁽³⁾

In their article, Rodrigo et al. showed that the frequency of the use of inhaled corticosteroids and long-acting β_2 -agonists was four to six times higher among the patients hospitalized in Spain than among those hospitalized in

the Latin-American countries studied. Due to a lack of first-line medications in Latin America, the use of theophylline was two to three times higher in the latter group than in the former.

What are the other repercussions of a shortage of essential medications? The number of admissions to intensive care units has dropped in Spain, whereas it has risen in Brazil and neighboring countries. Lack of access to treatment translates to poor management of asthma between attacks, resulting in a higher frequency of emergency room visits, hospital admissions and, possibly, deaths. Anachronistically, the hospitalization rate has risen during this new era, in which the order of the day is “dehospitalization”. In addition, in the words of the authors themselves, the lower proportion of patients with moderate to severe asthma using long-acting β_2 -agonists “*suggest[s] that a considerable number of these patients received suboptimal treatment*”. The authors of another study evaluating asthma in Latin-American countries came to the same conclusion.⁽⁴⁾

Another northern hemisphere country (Spain) and a number of southern hemisphere (Latin-American) countries have been studied. Regardless of the geographic setting, the phenomenon that might be called “health care apartheid” still exists. Other, equally deleterious, effects, added to the aforementioned clinical repercussions, result in patients and their families being penalized in multiple ways by the lack of medications. They are further affected by the direct and indirect costs of hospitalization. Rodrigo et al. showed us that the mean hospital stay was one week, which, obviously, results in an equal duration of work absenteeism.⁽¹⁾ In terms of the hospitalization of patients with severe asthma, the popular adage “Time is money” has been confirmed in studies conducted in Brazil. One year after asthma had been included in a program of control, including pharmacological treatment at no charge to the patient, there was a reduction in the number of asthma-related hospitalizations and emergency room visits, as well as an improvement in asthma

patient quality of life, together with, notably, a savings of approximately US\$1,500.00 to each family budget.⁽⁵⁾ The overall cost of asthma to the average family has been shown to be 29% of the total household income.^(5,6)

As a rule, national asthma control programs are scarce in Latin-American countries. In Brazil, such programs have been created at the municipal level in a small number of cities and have been initiated by a few health care professionals and officials who have recognized the relevance of the problem and have sought to implement measures that are known to be efficacious.⁽⁶⁻⁸⁾ Although such initiatives could be considered timid in view of the dimensions of the challenge, they undoubtedly constitute a strategy to radically transform the panorama described by Rodrigo et al.⁽¹⁾ The lack of attention given to asthma in public health policies is onerous not only to the patients and their families but also to society as a whole and to worker productivity. There are strategies that have been proven to be effective in the control of asthma,⁽⁶⁾ and such strategies should be more widely implemented. In Brazil, the annual number of asthma-related hospitalizations is nearly 250,000, and the consequent cost to the Unified Health Care System—in Brazilians reais (R\$)—is approximately R\$ 100 million. The cost of a single hospitalization would cover a full year of preventive treatment for six to ten patients, thereby breaking the vicious cycle of health care fragmentation. Since the resources are obviously available, attempts should be made to shift the allocation of these resources from the reactionary (recurrent hospitalizations) to the proactive (primary care, including the Family Health Program) and to build an efficient system of referral and counter-referral among the primary, secondary and tertiary levels of health care.

In addition to the commitment of various medical societies, such as the Brazilian Thoracic Association and the Latin-American Thoracic Association, there are, at the international level, programs such as the Global Initiative for Asthma and multiple other groups, organized by the Global Alliance against Chronic Respiratory Diseases (GARD) and led by the World Health Organization, all participants in the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases,⁽⁹⁾ which is aimed at the prevention

and control of chronic diseases. The 2008-2013 Action Plan developed by the GARD defined the objectives, activities, indicators and goals for the prevention and control of chronic respiratory diseases, as well as adopting the strategy known as the *Practical Approach to Lung Health*⁽¹¹⁾ for the holistic primary care treatment of patients with respiratory symptoms. As a consequence, there is now strategic planning, at the global level, to guide national implementation of initiatives by multisector partnerships among governments, academic institutions and professional health care societies, together with other public and private entities, to combat asthma and other chronic respiratory diseases. The plan encourages a narrowing of the gap between the enormity of the epidemiological impact of these diseases and the timidity of the current governmental policies, recommending that respiratory health be given the attention necessary in order to ensure the rights of citizens to “breathe freely” (the GARD slogan). This right is incompatible with the scenario described by Rodrigo et al. in this issue.⁽¹⁾

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