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The only sensitive viscera they have is their wallet

La única víscera sensible que tienen es el bolsillo

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In January 1946, the presidential candidate at the time, J.D. Perón, popularized one phrase in a campaign speech in the extremely poor Northern area of the province of Santa Fe: "*We are the enemies of the selfish, who are capable of being indifferent to misery without any compassion in their hearts, because the only sensitive viscera they have is their wallet*". In politics, it seems that it is always the other person the one to carry the blame. Probably you're wondering what does this introduction have to do with the work of my colleagues. No need to be suspicious to know that the authors will use their findings to motivate changes in health politics. The rhetorical phrase of Perón wouldn't be applicable to the anesthetized public funds. Health-related expenditures are conceived as expenses, but the authors' intention would be to generate astonishment in the authorities so that they change certain behaviors. If these changes in behavior were made, healthcare expenditures would still be in the credit column, but as a result there would be an improvement in the morbidity and mortality rates, if scientific breakthroughs were applied.

The Pulmonology Service of the Hospital Ramos Mejía, in the city of Buenos Aires is of special note, due to its publications about critical topics of our specialty during the last decades. One of those topics is related to the costs associated with hospitalization for respiratory diseases such as asthma and[1] COPD.[2]

During 2018, there were 26 cases of hospitalization for COPD exacerbation.[3] Direct costs were calculated from the funder's perspective on 1462 dollars per patient; the cost per patient who was hospitalized at the ICU is almost seven times higher. Fortunately, only 3 patients required intensive care. With one simple calculation, we know that for Argentina there will be an overwhelming amount of 43 million dollars per year for COPD hospitalizations, since there are around 30.000 annual hospitalizations in the country for COPD.[4] If 11% of admissions to intensive care were applied on a national level, there would be another extra 33 million dollars.

Is it possible to lower the mortality and hospitalization rates for COPD in Argentina?

Smoking cessation, first, with availability of resources.

Another important aspect is that half of the patients only received SABAs (short-acting beta agonists) as treatment, despite the fact that there is scientific evidence on the significant reduction of morbidity and mortality with current treatments.[5]

Taking into account the profile of the patients described in this study, they surely fulfilled the criteria of triple therapy with LABAs (long-acting beta-adrenergic agonists) + LAMA (long-acting muscarinic antagonists) + ICS (inhaled corticosteroids) belonging to group D, in accordance with the year of hospitalization (2018), that would be group E of the GOLD 2023 report update.[6] With a dollar rate of $300, the hospitalization cost (1462 × 300/12 months= $36 550) would easily cover the best available pharmacological treatment per month. Another way of sensitizing the public wa-

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llet. One LAMA plus the ICS/LABA combination would cost 30,000 pesos per month, and the triple therapy with inhalator would only cost a bit less. The cost analysis didn't include indirect costs, such as absenteeism, alterations in the family environment and rehabilitation. It could be refuted that we don't know the exact amount we need to treat to avoid exacerbations, but in an intelligent editorial, David Halpin and Fernando J. Martínez[5] evaluated the positive impact of the last clinical trials. The triple therapy properly indicated in patients with 2 or more exacerbations in the last 12 months, or hospitalization, o eosinophilia of more than 150/dL was able to reduce mortality in a significant way. Halpin and Martínez say that the relevance of the absolute reduction of mortality is similar or better than the data of cardiovascular studies.[5] In these cardiovascular studies, population benefits are clear, though very modest on the individual level. Still, they have contributed to the global reduction of cardiovascular mortality.[5] The same will happen with COPD. Though not applicable, I want to express my admiration for Dr. Fernando J. Martínez, who speaks Spanish as good as English (he was born in Cuba and went to the United States when he was eight years old), and is the only pulmonologist who participates in the GOLD and pulmonary fibrosis recommendations.

Smoking cessation, home oxygen therapy and rehabilitation, as well as the availability of NIV (non-invasive ventilation) and high flow therapy in the intensive care unit are legitimate tools with maximum quality of scientific evidence. Furthermore, COPD drugs reached a high level of efficacy that modified the natural history of the disease, thus reducing mortality.[5] Why is the Argentinian hospitalized population deprived of resources and drugs which science has established as highly efficient and beneficial? It is important to explain that the wallet of the Argentinian population is emaciated and very sensitive. For that reason, the free provision of treatment has a determining function in any program.[7] Echoing the words of the authors: "*We must use systematic programs of COPD management to identify patients with risk factors and to educate and allow access to medication*". "*Some will criticize us for wanting to have the best original drugs for our patients, and that attitude denotes their moral limitations*". This phrase belongs to Dr. José Ingenieros, disciple of Dr. José María Ramos Mejía.[8]

In 1999, there were 33 hospitalizations for COPD exacerbation, and in 2018 there were 26. The sales of drugs for obstructive diseases changed dramatically. In 2000, the SABAs/ICS+ICS/LABAs sales ratio was 4.29, and in 2018, 0.91 due to a significant increase in the sales of ICS/LABA.[9] These data that could be interpreted as better prescription and sales wouldn't be including the most vulnerable population (50% of hospitalized patients only treated with SABAs).

With regard to the criteria that could be considered for the identification of technologies to be given high evaluation priority, the triple therapy for COPD fulfills them all.[10] The National Commission for the Evaluation of Health Technologies (CONETEC, for its acronym in Spanish) has defined the valuable dimensions/criteria for the evaluation of new technologies (CONETEC 2019): quality of the evidence, magnitude of clinical benefit, economic impact (budgetary impact and cost effectiveness), impact on equity and public health.[10] This topic easily exceeds the limitations of this editorial and its author.

Judith García Aymerich published the analysis of two important cardiology studies. She found a 5-year mortality of 50% if the patients had been hospitalized for COPD exacerbation at least once.[11] Pascansky et al showed 23% of inpatient mortality. Of the 20 patients who survived, provided there are no changes, 10 patients will be alive 5 years later. If new strategies aren't applied, the life expectancy of COPD will be worse than many oncological diseases. Maybe this information can help sensitize the anesthetized and deranged public funds.

Conflict of interest

The author declares that he is a researcher for Novartis and a speaker for AstraZeneca. He has no conflict of interest related to the editorial or the commented article.

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