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From Measurement to Transformation

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The Region That Suffocates in Silence

Latin America has an entire body of evidence capable of changing the lives of millions of people with chronic respiratory diseases.

The problem is that it never translates into public policy.

Imagine a disease that affects one in ten adults over the age of 35 across an entire region. That kills more people than road accidents in several countries. That devours hospital budgets through emergency visits that could have been prevented with spirometry, a 15-to-30-minute test. Imagine, furthermore, that 89% of those who have it do not know they have it.

This is the reality of chronic obstructive pulmonary disease (COPD) in Latin America. And alongside it, with fewer headlines but equal ferocity, is severe asthma – a condition still insufficiently distinguished from general asthma in many Latin American health systems. Asthma is the most common chronic respiratory disease in childhood : a condition that traps patients in an endless cycle of corticosteroids, emergency visits, and biological therapies that have yet to reach those who need them. Two diseases, one shared pattern of neglect.

To guide evidence-based decisions, the Respiratory Health Initiative at the Copenhagen Institute for Futures Studies (CIFS) has developed two fundamental tools: the COPD Index and the Severe Asthma Index. Their 2025 editions include, for the first time, six Latin American nations (Argentina, Chile, Colombia, Costa Rica, Mexico, Peru). Brazil was included in 2024[1].

TOOLS FOR CHANGE: THE RESPIRATORY HEALTH INDICES

The COPD Index and the Severe Asthma Index assess each country across five equally weighted dimensions (20% each):

- Policy context and legal frameworks.
- Healthcare access and coverage.
- Health system characteristics and capacity.
- Disease burden.
- Environmental factors (fuel use, biomass, air quality).

The indices are built from document reviews of official sources, structured surveys of clinical specialists, and in-depth interviews with regional experts. Quantitative indicators are normalized on a 0-to-10 scale using min-max transformation; qualitative ones are coded using evaluation criteria validated by an expert panel. The final score is expressed on a 0-to-100 scale. This structure makes it possible to identify not only where the gaps exist, but in which specific system dimension they are concentrated, enabling more targeted public policy interventions.

Now more than ever, it is necessary to allocate specific budgetary resources to chronic respiratory diseases. The data is there. The gaps are clear. The solutions, known.What is missing is the decision to turn them into action.

This editorial proposes going beyond diagnosis. We will spell out what needs to happen for the indices to stop being academic exercises and become genuine tools for public policy.

I. The 89% Ghost: The Patients Who Do Not Exist

There is an unwritten rule in Latin American public policy: if you do not appear in the government planning database, you do not exist. And if you do not exist, there is no budget for you.

According to the PLATINO study[2], which assessed five Latin American cities (São Paulo, Mexico City, Montevideo, Santiago, and Caracas), up to 89% of COPD patients did not have an established diagnosis before participating in the study. In other words, they were living with the disease without knowing it[2]. A similar finding emerged from the PREPOCOL study in Colombia[3]. There are no spirometers in primary healthcare centers. There are no screening protocols. There are no primary care physicians trained to recognize the disease.

"If the patient has no diagnosis, they do not enter the system. If they do not enter the system, they do not appear in the records. If they do not appear in the records, they do not exist for those who allocate resources. It is a chain of invisibility that perpetuates itself with each year of inaction."

The PLATINO study documented prevalence rates ranging from 7.8% in Mexico City to 19.7% in Montevideo. In Argentina, underdiagnosis reached 77.4% in adults over 40. The CRÓNICAS study in Peru documented a marked urban-rural gradient in COPD, with a higher disease burden in rural communities exposed to biomass smoke[4].

What is Spirometry?
Spirometry is the reference respiratory function test for the diagnosis and management of COPD and asthma. The patient exhales with maximum effort through a mouthpiece connected to a spirometer, which records air volume and flow.

The test takes between 15 and 30 minutes, is non-invasive, and can be performed in primary care settings. Its absence from the region's health systems represents an avoidable diagnostic barrier with a high human and economic cost.

The case of Puno, Peru, is particularly alarming: across approximately 400 public health facilities, there was not a **single functioning spirometer**. Not one. Four hundred health centers in a high-altitude region – where respiratory problems are more prevalent – where diagnosis is left to the physician's intuition, without instruments (Expert Roundtable, Dr. Checkley, May 2026).

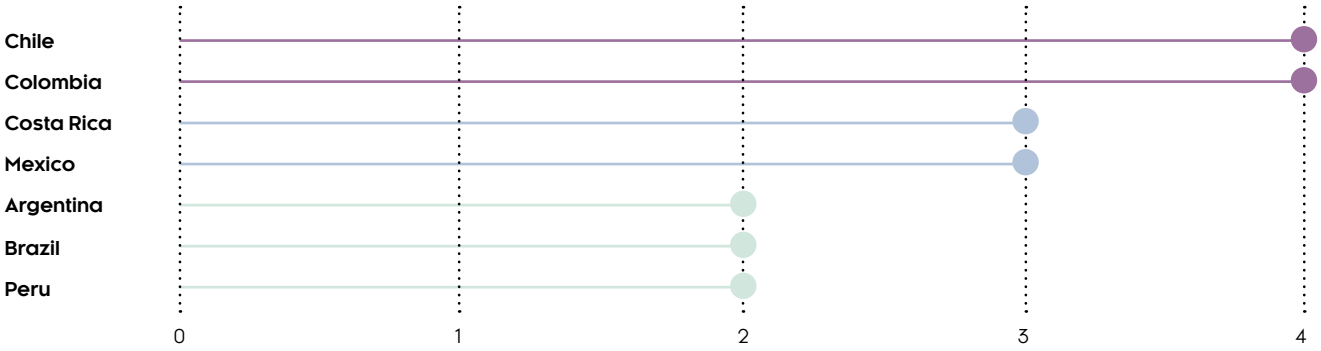
The cost paradox reveals another dimension of the problem. In Peru, a basic spirometry test costs around USD 10[5] in public facilities in Lima. In Mexico, the same test can cost up to USD 124 at a private clinic – more than a week's daily minimum wage – making diagnosis a privilege[6]. In Chile, by contrast, it is covered at no cost under the GES system (Explicit Health Guarantees)[7,8,9].

What is GES? (Explicit Health Guarantees, Chile)
GES is Chile's health guarantee system that ensures all citizens timely, quality access with financial protection to a defined set of priority diseases.

For COPD (GES No. 38), the system guarantees to people of any age: diagnostic confirmation by spirometry within 30 days of clinical suspicion, initiation of treatment from the moment of confirmation, specialist consultation within 45 days for high-risk cases, and zero co-payment for FONASA A, B, C, and D beneficiaries (Ministry of Health, GES Decree No. 29, 2025). For bronchial asthma in adults (GES No. 61, individuals aged 15 and over), the system guarantees: diagnostic confirmation within 20 days of suspicion, treatment from confirmation as indicated by the treating team, and specialist consultation within 60 days. The GES 2025–2028 Decree update — the largest reform of the system since its creation — explicitly incorporated biological therapies for severe uncontrolled asthma with T2 inflammation, reducing out-of-pocket spending on treatments that were previously inaccessible to the majority[9].

GUIDELINES AND BEST PRACTICES IN COPD CARE

Score



0 = without guidelines
1-4 = greater adherence and implementation

Figure 1. Guidelines and best practices in COPD care (Score 0–4). Chile and Colombia lead with the highest scores; Argentina, Brazil, and Peru show the lowest levels of adherence and implementation. **Source:** COPD Index 2025, Respiratory Health Initiative / CIFS.

The 2025 COPD Index documents that Costa Rica has an underdiagnosis rate of 88.7% and limited access to specialists as the main barrier for COPD patients. Colombia, despite having a comprehensive care pathway and near-universal coverage, presents significant implementation gaps and fewer than 1 pulmonologist per 100,000 inhabitants. Mexico has complete clinical guidelines but faces implementation gaps that considerably limit their real-world impact in the public system.[1]

SUMMARY OF COPD FINDINGS

Distribution of factors and total COPD score in Latin America

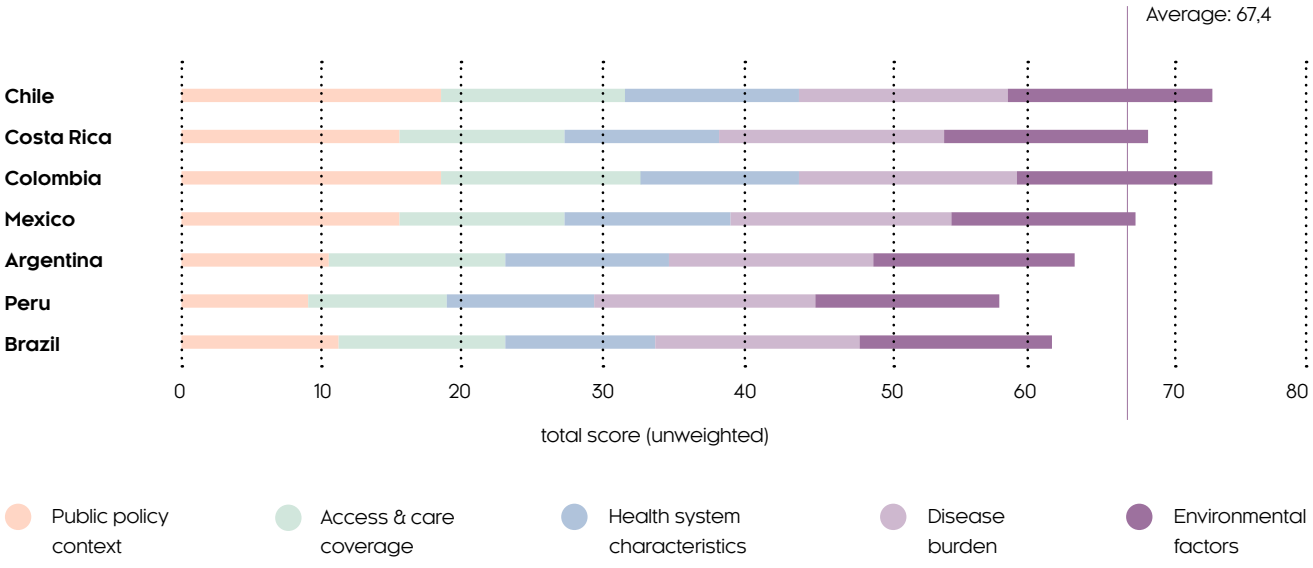


Figure 2. Factor distribution and total COPD score in Latin America (unweighted). Chile and Colombia lead with 74.0 and 74.1 points respectively; Peru obtains the lowest score at 58.7, reflecting its gaps in public policy and healthcare access. **Source:** COPD Index 2025, Respiratory Health Initiative / CIFS.

Are there alternatives to spirometry-based diagnosis? Yes. The PUMA Score – developed in Argentina, Colombia, Venezuela, and Uruguay – identifies high-risk patients by combining respiratory symptoms, risk factors, and a peak flow meter, without the need for sophisticated equipment[10]. Along the same lines, the COLA-[11] adds clinical criteria such as wheezing, productive phlegm, hospitalizations, and exposure to tobacco or biomass[11]. Neither replaces spirometry, but both open a door where today there is a wall.

The problem has never been a lack of tools. The problem is that diagnosing chronic diseases in vulnerable populations rarely holds a priority place on the political agenda. And until that changes – or until the cost of inaction becomes unsustainable – spirometers will continue to be insufficient.

II. The Other Silence: Severe Asthma That No One Treats as They Should

If COPD is the ghost of the system, severe asthma is its uncomfortable relative: visible in pediatrics, ignored in its severe form, and treated with a mixture of clinical resignation and budgetary indifference that would be implausible if it were not so common. From the clinical side, the pattern is well known: only the acute episode is treated, and follow-up is not done.

Asthma has a combined prevalence of 6.8% in adults in Latin America, but exceeds 15% in children under 14 in more than half of the countries, and according to the ISAAC study reaches 11% in Mexico, more than 27% in Costa Rica, and nearly 30% in El Salvador[12]. Severe asthma – the fraction that does not respond to conventional treatment and requires high doses of inhaled corticosteroids and biological therapies – continues to be treated as a footnote in health agendas. Sustaining the supply of medications is a challenge for health systems.

SUMMARY OF SEVERE ASTHMA FINDINGS

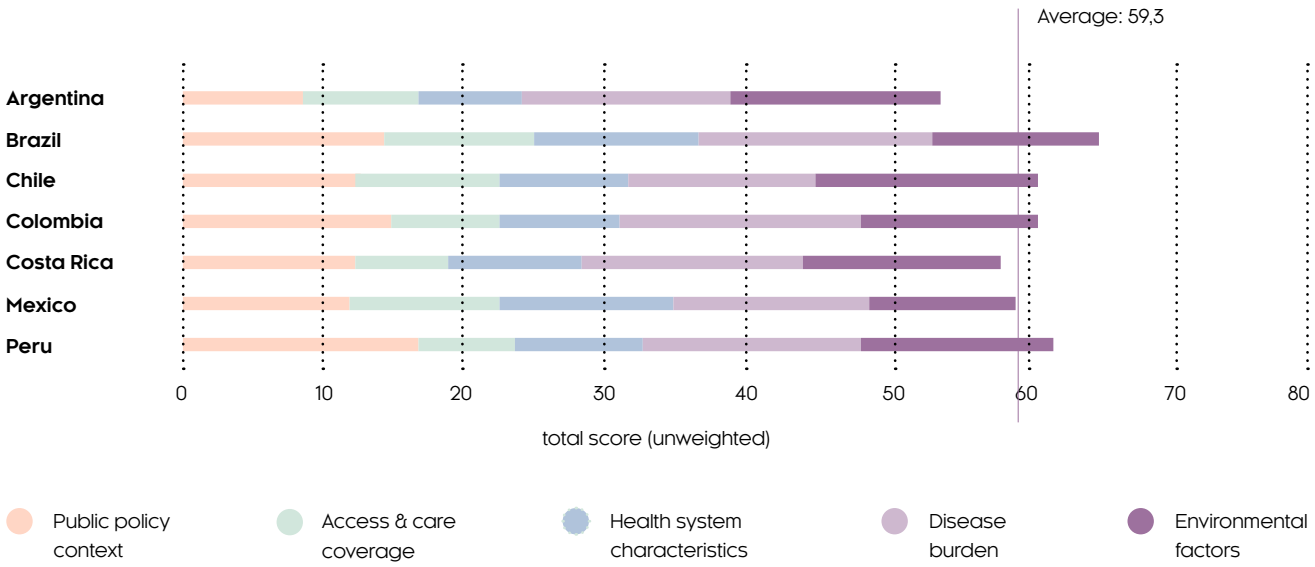


Figure 3. Summary of findings on Severe Asthma: total score by country (unweighted). Brazil leads with 64.5 points; Argentina presents the lowest score (53.4). The regional average is 59.3. **Source:** Severe Asthma Index 2025, Respiratory Health Initiative / CIFS.

The 2025 Severe Asthma Index reveals profound disparities[1b]. While some health systems have begun to align with GINA guidelines[13], others lack equitable care pathways. Access to allergy and immunology specialists is limited. Biological therapy – the intervention that radically transforms the quality of life of these patients – is inaccessible to the vast majority within the public system.

Brazil illustrates this paradox: the SUS covers some biologics and telemedicine is available, but unrestricted over-the-counter access to systemic corticosteroids facilitates their inappropriate use, and patients with severe asthma wait in the same queue as mild cases. The result: asthma hospitalization rates above the regional average, despite having one of the lowest smoking rates on the continent.

"Severe asthma does not need more clinical guidelines. It needs the correct use of inhaled anti-inflammatory therapies to be prioritized, along with access to biological therapies that have proven to transform patients' quality of life."

There is one dimension of the problem that deserves particular attention: patient empowerment. Asthma self-management through digital tools, written action plans, and therapeutic education is practically nonexistent in the region. A patient with severe asthma who does not understand their disease, who has no action plan, is a patient who depends entirely on emergency services. And emergency services are the most expensive and least efficient place to manage a chronic disease.

The Severe Asthma Index exists precisely to expose these fractures. To show which countries offer real access to biologics, which have functional referral pathways between primary care and specialists, and which have simply not addressed the problem. The underlying question is the same as for COPD: how many more editions of the index do we need before someone acts?

III. Gaps Between Clinical Recommendations and Effective Access to Treatment

Latin America has produced a notable volume of clinical guidelines – from GOLD[14], from GINA[13], national adaptations, regional consensus statements – that in practice prove very difficult to implement. Impeccably written, all of it, but it loses all meaning if the recommended medication is not accessible or if the patient is not educated to use it correctly. The great challenge of guidelines is precisely their adoption and implementation.

In Peru, the availability of long-acting bronchodilators in primary-level facilities does not exceed 20%. In Costa Rica, only three biologics are approved for severe asthma. In Mexico, biological therapies remain a mirage for the majority of patients in the public system.

THE GAP BETWEEN STATED POLICY AND ACTUAL ACCESS TO CARE FOR SEVERE ASTHMA

Severe Asthma Index 2025, selected dimensions

Figure 4. The gap between declared policy and real access to severe asthma care in Latin America. Colombia shows the greatest disparity: policy 75/100 vs. access 36/100 (–39 points). **Source:** Severe Asthma Index 2025, Respiratory Health Initiative / CIFS.

What is Triple Therapy for COPD?
Triple therapy for COPD consists of the combination of three inhaled drugs in a single device: a long-acting beta-2 agonist bronchodilator (LABA), a long-acting anticholinergic bronchodilator (LAMA), and an inhaled corticosteroid (ICS).

This combination — available in single-inhaler formulations, known as closed triple therapy — is indicated in patients with moderate-to-severe COPD who experience frequent exacerbations despite treatment with one or two bronchodilators.

Evidence shows that it significantly reduces exacerbations, hospitalization, and mortality in these patients. However, in most national formularies in Latin America, this combination is either unavailable or not funded, forcing patients to pay out of pocket or go without it.

"Diagnosing without treating is a broken promise. It means telling someone they have a chronic disease and then closing the pharmacy door in their face."

Chile's experience demonstrates that this is not inevitable. Through GES, Chile managed to fund access to biologics for severe asthma. This was not achieved through good intentions, but through two to three years of sustained work by the pulmonology society, patient organizations, and the National Institute of the Thorax before Congress. It was organized political engagement, not desk science[9].

The index makes it possible to identify at which points in the system the greatest barriers between clinical indication and effective access to treatment are concentrated. Is it a formulary problem? A cost problem? A bureaucracy problem? Each fracture requires a different intervention, and the indices are designed to pinpoint where efforts should be focused. The challenge is ensuring they are used with that intention.

IV. Evidence Without a System: The Data Nobody Adopts

Latin America possesses a valuable body of knowledge in respiratory health: prevalence studies, local cohorts, surveys, and high-quality clinical experiences. The challenge is that these findings are rarely integrated into health policy decisions.

There are no national registries for COPD or asthma in most countries. Death certificates underestimate respiratory mortality. Disease burden estimates[15] are incomplete because underreporting feeds a cycle of invisibility: no registry, therefore no funding; no funding, therefore no measurement; no measurement, therefore no registry

An emerging proposal is the creation of respiratory health observatories, coordinated through the Latin American Thoracic Association (ALAT)[16]. These would estimate the burden of incidence, prevalence, and mortality, and would integrate data systematically – enabling a minister of health to see, for the first time, how much not diagnosing COPD costs their country.

ALAT – LATIN AMERICAN THORACIC ASSOCIATION

Founded in 1997, ALAT is the leading regional medical organization dedicated to respiratory health in Latin America. It brings together national pulmonology societies from more than 15 countries and promotes research, continuing medical education, and clinical guidelines adapted to the regional reality.

In the context of this editorial, ALAT represents the natural platform for coordinating a regional respiratory health observatory under a consortium model with civil society, in which the scientific community provides technical legitimacy and patient organizations contribute the voice of those living with the disease.

But creating an observatory requires political will. And political will requires pressure. And pressure requires data. The cycle is hard to break, but not impossible. Civil society should not be an external guest to that observatory: its participation as an active member is what turns a technical exercise into a tool with real impact. What is needed are coordinated strategies among experts, patient organizations, and decision-makers – forums where the invisible is made visible. What is needed is for someone to take the first step.

V. The Role of the Patient Must Not Be Underestimated

The indices measure what systems report. But there is a dimension that only patient organizations can capture: real access. Not whether a treatment is approved, but whether the patient can actually receive it. Not whether a care pathway exists, but whether it functions.

In Mexico, organized patient representation for COPD remains incipient. This year, one organization began working specifically on COPD – a noteworthy development given the starting point – but the challenge remains enormous. A recent study with 143 Mexican patients revealed that 78.7% were unaware of any patient organization, while 78.2% stated they would participate in support groups if they existed.

Chile's experience is once again the necessary counterexample. When a coalition of patients, pulmonologists, and hospital institutions acted as one, it managed to influence Congressional decisions. It was not an act of charity; it was an act of organized power.

"The patient's voice is not an ornament for the final report. It is the only source of truth about what happens between written policy and lived reality. Ignoring it is equivalent to making decisions without the most important information."

The patient's experience must be treated for what it is: systematic evidence of diagnostic delays, administrative barriers, out-of-pocket costs, and treatment interruptions. It is not testimony: it is citizen auditing.

Just as advocates have fought for breast cancer, HIV, and pulmonary tuberculosis, the organized mobilization of patients with chronic respiratory diseases is an urgent necessity.

VI. Coalitions: Not to Copy Europe, but to Surpass It

Evidence alone transforms nothing. In 1964, the United States Surgeon General published the report that conclusively linked smoking to lung cancer[17]. Yet decades passed before that evidence was translated into policy. The lesson is clear: evidence needs coalitions to convert it into political action.

Europe attempted this with the International Respiratory Coalition, but the model has been slow, taking years to translate agreements into budgetary changes. Latin America can do better: ALAT as a regional platform, a shared majority language, consolidating research networks (REDINLAT), and an urgency that does not allow for five-year processes.

"Latin America does not need to copy the European model. It needs to take what works, discard what does not, and build coalitions that move at the speed of the crisis, not at the speed of the committee."

In practice, this means national coalitions with interlocutors in health and finance ministries – because without budgetary support, the best policy in the world falls short – with patient organizations not only as citizen auditors but as structural partners from the design stage. Patient organizations bring a level of experience, education, and knowledge in engagement that cannot be relegated to a peripheral role; otherwise, there is a risk of replicating excessively bureaucratic models that dilute the patient's voice rather than amplify it. The case of Chile with biologics demonstrates that this is possible: the respiratory society, patient organizations, and the National Institute of the Thorax acted as a unified front until they influenced Congressional decisions. The difference between an isolated effort and an effective coalition is structure, mandate, and timelines. It is worth noting that some countries have made progress in regulating the sale and distribution of nicotine products, although more work is needed to improve access to smoking cessation clinics, cessation medications, and the regulation of vapes and electronic cigarettes.

VII. The Elephant in the Room: Environment, Biomass, and the Future That Has Already Arrived

One cannot seriously discuss respiratory health in Latin America without addressing biomass fuel use, environmental exposures, and climate change. COPD in this region is deeply linked to adverse conditions that increase both disease exacerbations and their social consequences. This is evident in countries such as Peru, where smoking prevalence is low, but COPD cases arise from other causes: biomass and tuberculosis[4].

Exposure to wood smoke in rural and peri-urban kitchens is a risk factor as devastating as tobacco, yet it receives considerably less attention in the public agenda. Biomass is also a complex phenomenon with a **gender dimension that cannot be ignored**: it is women who, by historically assuming cooking and

household care tasks, accumulate the greatest daily exposure to wood smoke, becoming the most affected group and, paradoxically, the least visible in clinical records. Addressing this determinant requires policies that acknowledge this inequality and reach those who suffer it most.

Added to this is the near-nonexistent regulation of electronic cigarettes and vaping devices, and climate change, which exacerbates respiratory crises through increasingly frequent wildfires and air pollution episodes[18].

The respiratory health indices already incorporate these determinants as one of their five dimensions. The challenge now is for countries to integrate the environmental dimension not as an appendix, but as a cross-cutting axis of their policies, registries, and observatories.

What Must Happen – and What Will Happen if Nothing Does

The respiratory health indices tell Latin America exactly what it needs to hear: where the gaps are, how deep they run, and what is needed to close them. These indices are not built in a vacuum: they are nourished by the invaluable contributions of pulmonologists from across the region, who have provided data, clinical knowledge, and field perspectives through interviews and specialized consultations. They say that spirometers must be placed in health facilities, medications in pharmacies, registries in national systems, patients at decision-making tables, and budget in the line items that fund patient education, health personnel and communities, and the promotion of respiratory health.

They say that Chile proved it is possible, that Argentina developed screening tools that work without expensive equipment, that ALAT – in consortium with civil society – can coordinate a high-impact regional observatory, and that national coalitions are not a European fantasy but an urgent Latin American necessity.

They say all of this.

The respiratory health indices are not merely measurement instruments: they are catalysts for transformation. Their value lies in four fundamental capacities that make them indispensable tools for decision-making.

First, they enable the shift from perceptions to facts. For too long, decisions in respiratory health have been based on partial impressions, on the urgency of the moment, or on the inertia of what has always been done. The indices replace that logic with systematic, comparable evidence: hard data that make it possible to precisely identify where the gaps are and what their real magnitude is.

Second, they make data and findings accessible. The best evidence in the world is useless if it remains confined to specialized publications that do not reach those who design and implement policies. The indices translate epidemiological complexity into clear, visual, and actionable information, capable of informing a decision-maker or public policy-maker just as readily as a hospital director, a community leader, or a patient.

Third, they provide the foundation for building broad coalitions. When data are transparent and comparable, they become a common language that allows diverse actors – medical societies, patient organizations, the private sector, academia, and governments – to sit at the same table with a shared diagnosis. Without that common starting point, coalitions are built on good intentions; with it, they are built on evidence.

Finally, the indices enable leadership for change. They empower key actors – clinicians, managers, legislators, and patients – with solid arguments and international comparisons that allow them to demand, propose, and execute concrete transformations. A pulmonologist who presents to their health ministry an index that places their country below the regional average is not expressing an opinion: they are presenting a fact that demands a response.

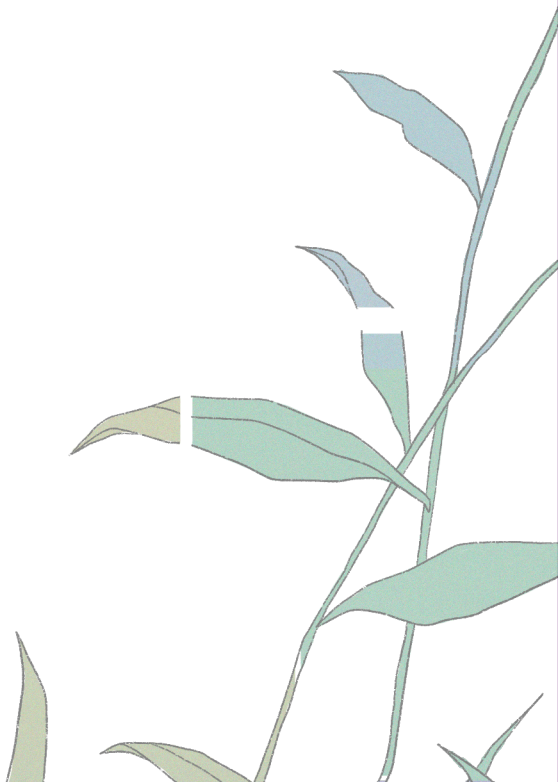
The question is not whether the information exists. The question is whether those with the power to act will continue waiting for the next edition of the index to tell them exactly the same thing – with the same gaps, the same invisible patients, the same orphaned data – or whether this time, finally, they will do something different.

"The data are already speaking. The indices are already pointing. The patients are already waiting. Civil society and the scientific community have the will to drive this change. The only thing missing is for those with decision-making power and resource allocation authority to decide that breathing is a priority."

The cost of inaction is not abstract. It is measured in lives cut short for lack of a ten-minute diagnosis. In avoidable hospitalizations that consume budgets. In premature deaths. In years of life potentially lost[24]. In years of productivity lost. In families who lose someone who could still be alive.

Latin America has everything it needs to move from measurement to transformation: science, tools, successful experiences, a committed professional community, and patients who deserve more than invisibility.

What it does not have is more time to waste.



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