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Authors’ reply

Elif Hindié and colleagues ask about improving lung health in low-income and middle-income countries (LMICs), and we are particularly encouraged by the focus on the frequently neglected field of lung health in LMICs. We welcome Jamilah Meghji and colleagues’ Review about improving lung health in low-income and middle-income countries (LMICs), and we are particularly encouraged by the focus on the frequently neglected field of lung health in LMICs.

Lung health in LMICs: tackling challenges ahead

We welcome Jamilah Meghji and colleagues’ Review about improving lung health in low-income and middle-income countries (LMICs), and we are particularly encouraged by the focus on the frequently neglected field of lung health in LMICs.

MSH reports grants from Movember and Prostate Cancer Foundation of Australia that supported this Correspondence; personal fees from Janssen, Mundipharma, Astellas, Merck Sharpe & Dohme, and AstraZeneca, unrelated to this Correspondence; and research support from Endocyte and Advanced Accelerator Applications (a Novartis Company), unrelated to this Correspondence. SS reports grants from Novartis/AAA, AstraZeneca, Merck Sharpe & Dohme, and Genetech; and personal fees from AstraZeneca, Merck Sharp & Dohme, Bristol Myer Squibb, and AstraZeneca, unrelated to this Correspondence. LE reports personal fees from AstraZeneca, Janssen, and Astellas, unrelated this Correspondence. RJF declares no competing interests.

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chronic respiratory diseases. However, we find that insufficient attention was paid to the role of primary care, which is the keystone for universal health coverage and, therefore, the route to improved prevention, diagnosis, and individualised and holistic treatment for most of the population. The interconnection between primary care and public health can address the social determinants of health and promote community participation, which are crucial to lung health across the lifecourse.

Challenges to be addressed include inadequate investment in recruitment and reimbursement; education; status; and power in decision making processes; as well as the limited respiratory prescribing rights of family doctors. The potential of primary care leadership is not considered. Nevertheless, primary care is essential for prioritisation at the individual patient level and the community level to manage all non-communicable diseases. Common risk factors such as air pollution, tobacco dependence, insufficient physical activity, and poverty affect the prevalence of all non-communicable diseases.

In situations where there is no family medicine strategy, the Practical Approach to Care Kit approach might be important; however, there is much more to be gained by promoting a service led by family medicine that is funded, implemented, evaluated, and endorsed by governments, academics, and disease specialists with the support of international research and advocacy organisations, such as the International Primary Care Respiratory Group.

Without this vision, tackling respiratory diseases will remain challenging.

EMK reports grants from the National Institute for Health Research Global Health Research Unit on Respiratory Health (RESPIRE) and Seqirus UK, and personal fees from AstraZeneca and GlaxoSmithKline. EMK is also board director of the International Primary Care Respiratory Group. RJ reports personal fees from Boehringer Ingelheim. All other authors declare no competing interests.

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Jamilah Meghji and colleagues deliver a welcome wake-up call about chronic respiratory diseases in stretched health systems. However, the proposed solutions in their Review could be strengthened by a preventive approach addressing crucial contributors of chronic respiratory diseases. In short, we expected a stronger plea for clean air to improve lung health in low-income and middle-income countries (LMICs). Although air pollution contributes substantially to the burden of cardiorespiratory diseases in LMICs, the Review barely evokes the high amounts of urban air pollution in LMICs and the urgent need to reduce emissions from anthropogenic sources. Meghji and colleagues acknowledge the adverse effects of exposure to biomass smoke, but they temper these effects because of the limited success of clean stove trials. However, these largely unsuccessful trials do not imply that biomass smoke is harmless for the lungs.

Furthermore, work-related chronic respiratory diseases received scant attention in the Review. “Occupational exposures” is mentioned just once and the terms work, dust, mining, and silicosis are absent. Nevertheless, most commodities—including metals needed for modern technology—are extracted, sometimes by children, from mines in LMICs, often in extremely unhealthy conditions, thus possibly leading to silicosis and increased likelihood of tuberculosis. Lung-damaging exposures also occur in manufacturing, construction, agriculture, transport, street vending, or menial jobs across formal and informal sectors, contributing to various chronic respiratory diseases. Putting work-related chronic respiratory diseases on the agenda will enhance awareness of this important field of pulmonology among policy makers and clinicians, many of whom are unfamiliar with occupational diseases. The rationale for including working conditions in strategies to improve lung health is that they are probably more amenable to prevention by regulatory measures than are those caused by poverty, inadequate health services, or general pollution.

In conclusion, we applaud the authors’ proposals to improve lung health, but we urge that consideration goes beyond medical solutions towards a global health approach. The respiratory community must advocate, together with patients and civil society, for the right to breathe clean air in homes, cities, and workplaces.