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EDITORIAL

Tuberculosis: a reminder to humankind about inequality in access to healthcare

Tuberculosis: un recordatorio para la humanidad sobre la inequidad en el acceso a la atención de la salud

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Humanity has achieved major milestones in public health, yet efforts to make health care strategies more accessible have not been sufficient to meet the needs of all populations[1]. A clear example is tuberculosis (TB), which, despite being one of the oldest diseases affecting humankind[2], remains one of the deadliest preventable and treatable infections worldwide, currently surpassed only by COVID-19[3]. Both diseases, of zoonotic origin, have forcefully demonstrated the need for greater creativity in health care delivery.

This situation is particularly noteworthy because, despite the global strategic efforts proposed by the World Health Organization (WHO) in 2020 to "End TB" (End TB Strategy milestones), the targeted 35% reduction in deaths and 20% reduction in incidence have not been achieved. The projected number of TB cases expected for 2023 was 10.8 million worldwide, of which only 8.2 million were detected; 2.05 million people did not receive treatment coverage, and 175,923 were diagnosed and treated as having multidrug-resistant TB or rifampicin-resistant TB[4,5]. By 2025, a 75% reduction in mortality and a 50% reduction in incidence rate vs 2015 indicators had been expected. This goal remains far from being achieved, as it is not as simple as increasing target percentages – particularly given the setback caused by the COVID-19 pandemic[6] and the need to reorganize health systems in the postpandemic period.

The reality of people living with TB in different parts of the world should prompt us to address the social determinants that perpetuate prevalence and incidence. Historical reviews show that the most rapid declines in incidence and mortality occurred in the 1950s, with advances in universal health coverage and access to effective treatments, linked to social and financial development[4,7].

In Mexico, according to GBD 2023 data[8], individuals living with TB may lose 32.42 disability-adjusted life years (DALYs) per 100,000 population. Of these DALYs, the fraction attributable to comorbidities could reduce the burden of disability and disease by 20.75 DALYs with cessation of alcohol addiction, 19.09 DALYs if high body mass index levels were modified, 11.73 DALYs with normal glycemia, and 10.92 DALYs if tobacco use were discontinued. These figures reflect the living conditions of people with TB, who are profoundly vulnerable, as they die prematurely and under conditions that prevent them from achieving a quality of life that allows them to develop, work, and contribute to society. Furthermore, they highlight areas of opportunity to be addressed in health services and public policies in a coordinated manner.

In light of the national context and in accordance with international commitments under the End TB Strategy, national policy must emphasize integrated,

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patient-centered preventive care at all levels. How can this be achieved? By strengthening governance within agencies that provide care to populations made vulnerable by poverty, migration, homelessness, malnutrition, alcohol and tobacco use, people living with HIV/AIDS, and persons deprived of liberty; and, more broadly, by emphasizing screening among individuals living with obesity and diabetes. Likewise, in the identification and prevention of close contacts, care strategies should incorporate a strong component of solidarity and empathy to reduce discrimination and stigma, while promoting social and economic support to sustain adherence to TB treatment and management of comorbidities.

Regarding public policy, it is essential to create technical-administrative mechanisms that integrate intersectoral efforts combining health and social development actions for these populations. Innovation should include research in the management of clinical-community services to enable the implementation of sustainable (financially and workforce-sustainable) care models tailored to the realities of affected populations; fostering shared responsibility among stakeholders; limiting transmission chains; updating the technological infrastructure for bacteriologic and drug-resistance diagnostic capacity within the National Public Health Laboratory Network in high-incidence states; and applying basic science findings to promote the development and production of optimized fixed-dose combination formulations for TB treatment[9] to reduce adverse events and improve therapeutic adherence.

The 2025-2030 health sector program has established guidelines for this and other nationally prioritized diseases, as well as mechanisms for achieving them[10]. It is critically important to integrate multidisciplinary working groups more directly involved in patient care – clinicians, nutritionists, psychologists, managers, and researchers – along with civil society organizations and individuals surrounding patients living with TB, so that we may work together to impact service delivery and the training of human resources within communities and health care facilities.

In this context, the journal *Neumología y Cirugía de Tórax* (NCT) joins this effort by providing space for the scientific dissemination of actions that improve population quality of life. This issue presents a survival analysis of a 5-year cohort of 125 patients living with TB in one of the states with high incidence rates, where the authors contribute clinical, radiologic, epidemiologic, and health services evidence. These results can and should serve as a critical evaluation leading to the redirection of primary, secondary, tertiary, and quaternary preventive actions[11] at all levels of care to improve diagnostic suspicion sensitivity, ensure appropriate clinical interpretation during follow-up visits to identify poor prognostic factors, prevent multidrug resistance, and strengthen patient safety measures. They should also inspire the development of new service delivery models that, in the short term, contribute to reducing health inequities.

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