



MANIFESTO
on ***ADHERENCE to***
TREATMENT in RESPIRATORY
ALLERGY



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The WAO White book on Allergy highlights the growing public health burden of allergic diseases and the need for better awareness, better care, better patient compliance and adherence and an integrated holistic approach towards addressing this issue via the collaboration of multi-field stakeholders.

We know.....

- Adherence to treatment in Chronic Diseases is less than 50%
- The Cost of Non Adherence highly impacts the burden of Chronic Diseases worldwide
- Barriers to Adherence are known
- Strategies for implementing Adherence do exist

We know.....

- “Poor adherence to treatment of chronic diseases is a worldwide problem of striking magnitude Adherence to long-term therapy for chronic illnesses in developed countries averages 50%. In developing countries, the rates of adherence are even lower. Undeniably, many patients experience difficulty in following treatment recommendations” *WHO ADHERENCE TO LONG-TERM THERAPIES: Evidence for action 2003*
- Adherence rates with the statin therapy in elderly patients with and without acute coronary syndromes, ranges from 22% to 45% after 2 years of treatment.(*Jackevicius et al JAMA 2002*). Data show that as many as half of all patients do not adhere in the US (*Cutler & Everett NEJM 2010*), and very recent data in European countries have confirmed similar data (*Braido et al Resp Res.2013*)
- The Cost of Non Adherence has a major negative impact on the burden of Chronic Diseases worldwide *WHO ADHERENCE TO LONG-TERM THERAPIES: Evidence for action 2003*
- In the US general population with “half of all patients not adhering to treatment”, the resultant cost of illness is more than 100 billions USD per year being spent on avoidable hospitalizations. *Cutler & Everett, NEJM 2010*
- Mortality rates and hospital admissions are reduced in patients with higher adherence to treatment. *Vestbo et al Thorax 2009*
- Treatment with ICS is too often discontinued in Asthma. *Postma N et al.. Pharmacoepidemiol Drug Saf 2008.*
- Nonadherence causes severe asthma exacerbations *Keoki Williams et al. JACI 2011*
- Reduction in lost productivity of 1 day per individual with allergic rhinitis per year would save over 500 million € a year in Sweden. *Hellgren et Allergy al 2010*

We know.....

- Barriers to Adherence
- **Barriers related to the patient**
- *presence of comorbid physical disorders*
- *cognitive difficulties*
- *psychiatric comorbidities*
- *age-related (children, adolescents and elderly have an increased risk of non-adherence)*
- *inadequate knowledge*
- *low expectations*
- *poor social and family support*
- *inadequate ability to coping with the disease*
- **Barriers related to the disease**
- *chronicity*
- *symptom stability*
- *absence of symptoms*
- **Barriers related to the treatment**
- *multiple daily doses*
- *presence of side effects*
- *complexity of the therapeutic regimes*
- *high lack of ease of use*
- *costs*
- **Barriers related to the doctor-patient relationship**
- *poor communication due to a poor relationship*
- *inappropriate doctor or patient behaviour*

Modified from Baiardini & Braidò 2013

We know.....

- **Appropriate education and appropriate interventions aimed at improving adherence would provide a significant positive return on investment through primary prevention (of risk factors) and secondary prevention of adverse health outcomes. *WHO ADHERENCE TO LONG-TERM THERAPIES: Evidence for action 2003***
- **“Increasing the effectiveness of adherence interventions may have a far greater impact on the health outcomes of the population than any improvement in specific medical treatments” *Sabate E. WHO Adherence Meeting Report. Geneva, World Health Organization, 2001.***

We know.....

- **Strategies for implementing Improved adherence exist.**
- **The largest economic benefits (such as by reducing the indirect costs arising from absenteeism), among the most common chronic diseases, is for Asthma and COPD (*Carls et al JOEM 2012*), thus supporting the importance and usefulness to invest in adherence.**
- **ACAAI/ACCP have published a combined Evidence based Guidelines on the Selection and Outcomes of aerosol therapies *Dolovich et al. Chest 2005***
- **The ERS Report *Laube et al.ERJ 2011*, took in consideration how difficult is the correct use of inhalers , mainly in aged or pediatric patients, thus listing “reccomendations” for a correct prescription of the inhaler device to patients, in order to increase adherence *Axelsson & Lotvall, APA 2012***
- **The World Allergy Organization published recently the direct correlation between doctors’ time devoted to patient education and compliance to treatment *Canonica et al. Allergy 2007* and the importance of patient and physician education (*Pawankar R, Canonica GW et al WAO White Book on Allergy*)**

We intend...

- To promote strategies for improving adherence to treatment to provide a better quality of life to our patients.
- To promote adequate and appropriate education about adherence at all levels, *patients, medical students, medical doctors, pharmacists, nurses.....*
- To promote new Technologies to implement Adherence to treatment

We intend.....

to promote

- Adherence as a priority Patient Related Outcome
- Adherence as priority step in Patient Education
- “Non Adherence” as Patients Moral Responsibility vs Social Community, since WHO declared: *poor adherence to long-term therapies severely compromises the effectiveness of treatment making this a critical issue in population health both from the perspective of quality of life and of health economics .*
*WHO ADHERENCE TO LONG-TERM THERAPIES:
Evidence for action 2003. Nonetheless patients need to be supported and educated, not blamed.*

We advocate.....

Partnerships, devoted to implement Adherence to Treatment, with:

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- ***Governamental Authorities***
- ***Patient Organizations***
- ***Foundations***
- ***NGOs***
- ***The Industry***
- ***Scientific Societies***
- ***Other stakeholders***

(Pawankar R WAO J 2012,

Pawankar R, Canonica GW et al WAO White Book on Allergy 2013)