

Asthma in Australia 2005

A recent report outlines the good and the bad news about asthma

Asthma is a common chronic condition among Australians, particularly children. In recent years, federal and state governments have responded to community and health professionals' concerns by investing in strategies to improve asthma management.¹ Coinciding with this, new pharmaceutical formulations have become available for managing asthma. The latest publication from the Australian Centre for Asthma Monitoring and the Australian Institute of Health and Welfare, *Asthma in Australia 2005*,² provides a timely review of the good and the bad news about asthma over the past few years (Box).

The prevalence of asthma is high in Australia compared with other countries,³ affecting 14%–16% of children and 10%–12% of adults. However, *Asthma in Australia 2005* shows that, after a substantial rise in the number of children with asthma during the 1980s and early 1990s, this trend has reached a plateau. Although this pattern is consistent with observations in other countries, including Hong Kong, Switzerland and the United Kingdom,⁴ the reasons for this rise and subsequent plateau remain unknown. Nevertheless, the observation highlights the value of ongoing surveillance for asthma.

Over the past 5–10 years, rates of general practitioner visits and hospitalisations for asthma have declined substantially. Furthermore, deaths due to asthma have fallen by more than 50% since the early 1990s.

Despite these overall gains, there are important inequalities in the outcomes of asthma among Australians. Aboriginal and Torres Strait Islander people, particularly adults, have more asthma and higher rates of hospitalisation for asthma than other Australians. Adults living in rural or remote areas and people living in the most socioeconomically disadvantaged localities also have higher rates of hospitalisation for asthma. The reasons for these inequalities need exploring.

The burden of GP consultations, emergency department visits and hospitalisations for asthma is highest among children and probably reflects their higher rate of disease exacerbations. At the beginning of school terms, particularly in February, rates of emergency department attendance for asthma are higher than usual and the episodes are more severe than usual among pre- and

primary-school-age children. A similar return-to-school increase has been observed in other countries, and has been attributed to increased transmission of respiratory infections.⁵ This observation highlights the need to develop and test interventions to prevent exacerbations.

Regular use of inhaled corticosteroids can reduce asthma symptoms and prevent severe episodes of worsening asthma.^{6,7} However, *Asthma in Australia 2005* highlights evidence that inhaled corticosteroid therapy, the cornerstone of drug therapy for asthma, is not well targeted. Many people who would benefit from using

Major findings of the *Asthma in Australia 2005* report

Gains

The rising trend in the prevalence of asthma among children during the 1980s and early 1990s has reached a plateau. Currently, 14%–16% of children and 10%–12% of adults have asthma.

In 1990, there were 822 deaths attributed to asthma in Australia (5.6 per 100 000), whereas in 2003 there were 314 deaths (1.5 per 100 000).

Hospitalisation rates for asthma have declined from 920 patient-days per 100 000 in 1993–94 to 419 patient-days per 100 000 in 2003–04.

No gains

Hospitalisation rates for asthma in 2002–03 were higher among:

- Aboriginal and Torres Strait Islander people compared with others in Australia (1003 v 418 patient-days per 100 000);
- Adults in rural and remote areas compared with adults in major cities and regional areas (728 v 331 patient-days per 100 000); and
- People with greater levels of socioeconomic disadvantage (528 patient-days per 100 000 in the most disadvantaged quintile v 309 patient-days per 100 000 in the most advantaged quintile).

Only 34% of people with asthma aged 15 years and over are using inhaled corticosteroids, but 71% of inhaled corticosteroids are supplied in the highest dose formulations.

In South Australia, the proportion of people with asthma who stated that they owned a written asthma action plan declined from 42% in 1995 to 22% in 2001. ♦

them regularly are not doing so. Furthermore, most formulations are prescribed at the highest doses, in spite of evidence that many people with asthma can be well controlled, with fewer side effects, at lower doses of inhaled corticosteroids.⁸ This discrepancy with current evidence is further highlighted by the rapid market penetration of inhaled formulations that combine long-acting β -agonists with corticosteroids, a combination which achieves effective asthma control in most people with moderate to severe asthma with lower doses of inhaled corticosteroids.⁹ These combined formulations accounted for 64% of inhaled corticosteroids distributed in Australia in 2004. Hence, more work is needed to improve appropriate prescribing of inhaled corticosteroid therapy for people with asthma.

The Asthma 3+ Visit Plan is an Australian Government initiative introduced to improve the quality of care for people with moderate to severe asthma by promoting structured care of asthma in general practice. However, it is estimated that only 14.1% of eligible people have used this program since its introduction in 2002. Respondents to a survey of GPs in Sydney indicated that the administrative complexity of the program acted as barrier to its uptake.¹⁰ Another cause for concern is the limited use of written asthma action plans. Despite evidence that these improve the outcomes of asthma,¹¹ their use has decreased in recent years.¹²

Asthma in Australia 2005 shows that the outcomes of asthma in Australia are improving, but there is still a long way to go to ensure access to the best quality care for all Australians. We need to understand more about the barriers to effective care and the basis for inequalities in health outcomes for people with asthma.^{10,13} To investigate these issues, we need more detailed asthma-specific data at a population level, qualitative research in specific populations of health care users and providers, and randomised controlled trials of interventions designed to improve care and outcomes, particularly in disadvantaged groups.

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