



Refresh of the National Strategic Framework for Chronic Conditions

Asthma Australia Survey Response, April 2024

ABOUT ASTHMA AUSTRALIA

Asthma is a respiratory condition that affects just under 2.8 million Australians, with children being the most impacted. Asthma is responsible for at least one Australian death every day, making it a serious health concern. Around 39,000 people are hospitalised each year due to asthma, yet at least 80% of these hospitalisations are considered potentially avoidable.

Despite the prevalence of asthma, it is often misunderstood, causing fear and anxiety for those living with the condition. Asthma Australia has been the leading charity for people with asthma and their communities for over 60 years.

The challenges of climate change, unhealthy air, and health inequity make it more important than ever for people with asthma to have a voice. We search for new and progressive approaches to challenge the status quo. Our work is grounded in evidence and centred on the experiences of people affected by asthma. We believe by listening to those living with asthma, designing solutions with them, and influencing change, people with asthma can live freely, unrestricted by their asthma.



OUR ONLINE SURVEY RESPONSE

This is Asthma Australia’s response to the online survey of the consultation on the Refresh of the National Strategic Framework for Chronic Conditions. The consultation document can be found [here](#).

Q1. Which stakeholder group best describes you?

National not for profit non-government organisation

Q2. Have you engaged with and used the Framework, and if so, how? Please tick all that apply.

To guide our organisation’s funding models and initiatives, and

Other

There is also the option to include any other information about your engagement with the Framework in the ‘Other’ open-text response box.

The National Asthma Strategy 2018 was aligned to the Framework, which was developed in partnership by Asthma Australia with the National Asthma Council, among other stakeholders.¹

In addition, following a short survey based on these survey questions with members of Asthma Australia’s Consumer Advisory Council (CAC), Asthma Champion program and Professional Advisory Council (PAC), we found that some consumers had accessed the Framework:

- To improve their understanding of the health care system,
- In discussion with a healthcare professional,
- Out of personal interest, and
- Through an organisation they are engaged with (e.g. Asthma Australia).

Many consumers who responded to the survey (23 out of 44 respondents) were not previously aware of the Framework prior to this consultation.

One member of the PAC said they had used the Framework to inform their clinical practice.

1. Commonwealth of Australia (Department of Health) 2018 (2017) National Asthma Strategy 2018. Available from: <https://www.nationalasthma.org.au/living-with-asthma/resources/health-professionals/reports-and-statistics/national-asthma-strategy-2018>



Q3. The Vision of the Framework (Vision) is: “All Australians live healthier lives through effective prevention and management of chronic conditions.”

To what extent do you agree the Vision is still relevant?

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

Please provide further comments about your response, including any suggested amendments to the Vision.

The Vision is a broad statement that captures the ongoing and principal objectives of the Framework. It could be improved by:

- Recognising the importance of **equitable outcomes** in effective prevention and management policies and interventions.
- Reflecting the importance of a **holistic approach** to the effective prevention and management of chronic conditions.
- Recognising that many people with chronic conditions may not become ‘healthier’ in relation to the absence of disease but may instead become **happier, experience a better quality of life and be able to participate more fully** in education, employment, social and physical activities.
- Using language that is **more inclusive** such as ‘everyone living in Australia’ or ‘people’ rather than ‘all Australians’ to reflect that there are around 1.6M temporary residents living in Australia.¹

1. Australian Bureau of Statistics (2021). [Temporary visa holders in Australia](https://www.abs.gov.au/statistics/people/people-and-communities/temporary-visa-holders-australia/latest-release#:~:text=In%202021%20there%20was%201%2C614%2C000,the%20remainder%20were%20secondary%20applicants). ABS Website. Available from: <https://www.abs.gov.au/statistics/people/people-and-communities/temporary-visa-holders-australia/latest-release#:~:text=In%202021%20there%20was%201%2C614%2C000,the%20remainder%20were%20secondary%20applicants>



Q4. There are 7 enablers to achieving the Vision included in the Framework. Each of these enablers are shown below.

Please provide a score from 0-10 to demonstrate how important you think each of the enablers are (with 0 being not at all important and 10 being very important).

- Governance and leadership — supports evidence-based shared decision-making and encourages collaboration to enhance health system performance.
- Health workforce — a suitably trained, resourced and distributed workforce is supported to work to its full scope of practice and is responsive to change.
- Health literacy — people are supported to understand information about health and health care and appropriate health care settings, to apply that information to their lives and to use it to make decisions and take actions relating to their health.
- Research — quality health research accompanied by the translation of research into practice and knowledge exchange strengthens the evidence base and improves health outcomes.
- Data and information — the use of consistent, quality data and real-time data sharing enables monitoring and quality improvement to achieve better health outcomes.
- Technology — supports more effective and accessible prevention and management strategies and offers avenues for new and improved technologically driven initiatives.
- Resources — adequate allocation, appropriate distribution and efficient use of resources, including funding, to address identified health needs over the long-term.

Are there any other enablers you think should be included in the Framework?

We have identified consumer engagement and regulation as important enablers that should be added to the Framework and set out why below.

- **Consumer engagement**

The insight, feedback, behaviour or lived experience of consumers is invaluable to informing and improving prevention and management strategies and services, including in relation to every enabler listed above. Consumer input can help to develop more sustainable and effective interventions and services by ensuring that consumer needs and experiences are appropriately accommodated in their design, implementation and delivery.

In addition, many chronic conditions, such as asthma, are primarily self-managed by the individual or their carer. This role is a powerful enabler role and should be recognised in this way in the Framework, with consideration as to how other key stakeholders and parts of the system support and enhance self-management.



• Regulation

Regulation is another critical enabler that is required to achieve the Vision of this Framework and implement actions to meet its objectives. Regulation has been responsible for some of Australia's most significant gains in public health and preventive health, including in tobacco and e-cigarette control,¹ exposure to ultraviolet radiation,² water quality,³ and food safety.⁴ Conversely, the lack of regulation of food and alcohol marketing and labelling has limited public health improvements.⁵ While regulation has led to notable public health successes relating to air quality, such as reduced exposure to lead and asbestos exposure,⁶ the lack of regulation of other avoidable sources of air pollution, including wood heaters and internal combustion engine vehicles, continues to harm health outcomes.⁷

Regulation is an important enabler as many causes of chronic conditions are either outside the direct control of the individual or compromise the individual's ability to make informed and healthy choices. Supported by appropriate evidence and engagement with Australian communities, and free from influence from vested interest, regulation can significantly progress positive health outcomes in relatively short timeframes. Regulation is particularly important to this Framework since many chronic conditions share common environmental risk factors that contribute to their development and exacerbation. Risk factors for which regulation could have notable impact include air quality and climate change, where regulation is needed, for example, to reduce the number of wood heaters in residential areas and accelerate emission reduction. Additionally, introducing and strengthening standards to ensure homes provide healthy living environments would support outcomes across a range of chronic conditions.

1. Australian Institute of Health and Welfare (AIHW, 2022) Health promotion and health protection. AIHW Website. Available from: <https://www.aihw.gov.au/reports/australias-health/health-promotion>
2. Prichard I, Dobbins S, Wilson C, Hutchinson AD, Rayner J, Makin J. Perceptions of the solarium ban in Australia: Fake it, don't bake it. *Health Promot J Austr.* 2015 Aug;26(2):154-158. doi: 10.1071/HE15002. PMID: 26169388..
3. E.g. National Health and Medical Research Council (NHMRC, 2017). Information paper – Water fluoridation: dental and other human health outcomes, report prepared by the Clinical Trials Centre at University of Sydney, NHMRC; Canberra
4. E.g. Australian Government Department of Health and Aged Care (2024). Website. Available from: <https://www.health.gov.au/topics/food-and-nutrition/what-were-doing#legislation>
5. E.g. Royal Australian College of General Practitioners (2023). Web news article. Available from: <https://www1.racgp.org.au/newsgp/racgp/racgp-backs-proposed-crackdown-on-harmful-marketin>
6. https://phidu.torrens.edu.au/pdf/2010-2014/public-health-successes-2013/advocacy_action_public_health_full.pdf
7. Office of the Commissioner for Sustainability and the Environment (2023). Can Canberra 'Burn Right Tonight' or is there 'no safe level of air pollution'? An Investigation into wood heater policy in the ACT. <https://envcomm.act.gov.au/wp-content/uploads/2022/08/OCSE-Wood-Heaters-Report-A40588031.pdf>
8. E.g. Climate and Health Alliance (CAHA, 2023). Web news article. Available from: https://www.caha.org.au/mr_240223#:~:text='Like%20smoking%2C%20vehicle%20emissions%20contribute,from%20exposure%20to%20vehicle%20emissions.



Q5. The Framework identifies determinants of health that influence the prevention, treatment and management of chronic conditions. Several are listed below. These are commonly referred to as the social, cultural, environmental and economic or commercial determinants of health.

- Employment
- Income level
- Living in a rural/ regional/remote location
- Education
- Language and writing skills
- Refugee or migration status
- Housing
- Living with a disability
- Promotion of unhealthy products
- Social connection
- Racism and discrimination
- Air and water quality
- Climate change
- Opportunities to take part in physical activity
- Weight related stigma
- Access to safe, nutritious and culturally appropriate food

Please discuss which, if any, of the above determinants of health impact have most significantly impacted you or the work of your organisation.

The list above is comprehensive and each determinant significantly impacts chronic conditions either at the broad population level or for priority populations for whom additional support is needed to increase health equity. Many of these determinants contribute to the exacerbation of asthma in people with the condition; some also increase the risk of developing the condition. This means that addressing these determinants will support primary and tertiary asthma prevention.

Asthma Australia strongly welcomes the inclusion of air quality, climate change and housing in the listed determinants of health, noting the absence of any of air quality and climate change in the current Framework. In our experience, the impacts of air quality and climate change on health are often underprioritised while housing policy developments rarely address the contribution of poor housing condition to chronic conditions. Air quality, climate change and housing are key determinants for people with asthma, and those at risk of developing asthma. They also contribute to a range of other chronic health conditions and increase health inequities.

The National Preventive Health Strategy (NPHS) failed to include climate change and air quality as focus areas and missed a significant opportunity to make progress on pressing contemporary public health issues. The NPHS listed climate change as a “wider” determinant of health “outside of the direct control of the health system” that is outside the scope of the NPHS.¹ This is an inadequate excuse for neglecting to prioritise the most significant public health threat of the current century,² particularly when the NPHS commits to a range of policies outside the direct control of the health system across its focus areas. Examples include tobacco excise taxes, restricting retailers from promoting unhealthy food and drink, using urban design to increase physical activity, and regulating marketing and promotion of alcohol.³

The absence of climate change and air quality in the current Framework should be rectified in this Refresh given the influence of these determinants on a range of chronic conditions. We briefly set



out how air quality, climate change and housing cause inequities in asthma and for people with asthma below.

1. Commonwealth of Australia (Department of Health). 2021. National Preventive Health Strategy 2021–2030. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf
2. Commonwealth of Australia (Department of Health and Aged Care). 2023. National Health and Climate Strategy. <https://www.health.gov.au/sites/default/files/2023-12/national-health-and-climate-strategy.pdf>
3. Commonwealth of Australia (Department of Health). 2021. National Preventive Health Strategy 2021–2030. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf

- **Air quality**

There is no safe level of air pollution, which means that health impacts can occur at relatively low levels of pollution.¹ The UN has deemed air pollution as ‘the most important environmental health risk of our time’, with it being responsible for 1 in 9 deaths globally.² Notable sources of air pollution in Australia are industrial processes and power generation using fossil fuels, combustion in vehicle engines and domestic wood heaters, the latter being the largest source of winter air pollution in many Australian communities.³

For people with asthma, air pollution is a notable concern since certain air pollutants can trigger asthma symptoms and exacerbations and increase the risk of developing asthma. Pollutants that are harmful to health include particulate matter (PM), nitrogen oxides (NO_x) and sulphur dioxide (SO₂) and all can harm respiratory health.^{4/5/6} The exposure to fine particulate matter (PM_{2.5}) is of greatest concern as the tiny particles can penetrate deep into the lungs and directly pass into the bloodstream, causing systemic health impacts. People who have asthma and other respiratory conditions are particularly vulnerable to the negative impacts of PM_{2.5} exposure, as are people with cardiovascular disease and diabetes, pregnant people, infants, children and older people.⁷

1. Centre for Air Pollution, Energy and Health Research (CAR, 2021). No level of air pollution is safe’: Commitment to continuous emissions reduction through an alternative model for the AAQ NEPM. A brief from the Centre for Air pollution, energy and health Research.
2. United Nations Environment Programme website. Available online: <https://www.unep.org/explore-topics/air>
3. Australian Government Department of Climate Change, Energy, the Environment and Water. Wood heaters and wood smoke. <https://www.dcceew.gov.au/environment/protection/air-quality/woodheaters-and-woodsmoke>
4. Centre for Air pollution, energy and health Research-CAR (2022). Bushfire smoke: what are the health impacts and what can we do to minimise exposure? Located online: <https://www.car-cre.org.au/bushfire-smoke-factsheet>
5. New South Wales Health (2023). Air Quality. Website. Available from: Nitrogen Dioxide (nsw.gov.au)
6. New South Wales Health (2023) Air Quality. Website. Available from: Sulphur Dioxide (SO₂) (nsw.gov.au)
7. Centre for Air pollution, energy and health Research-CAR (2022). Bushfire smoke: what are the health impacts and what can we do to minimise exposure? Located online: <https://www.car-cre.org.au/bushfire-smoke-factsheet>

- **Climate Change**

Many effects of climate change involve unhealthy air, including prolonged bushfire smoke, thunderstorm asthma events, increased ground level ozone and airborne infectious diseases. Findings from Asthma Australia’s survey on the 2019-20 bushfire crisis showed people with asthma reported higher rates of serious health outcomes than people without asthma, including attending the emergency department, hospitalisation and requiring oral or injected corticosteroid medication.¹

In addition to extreme weather events, global warming is causing pollen seasons to start earlier and to last longer and increased levels of carbon dioxide in the air stimulates plants to increase pollen production.² Hay fever is the most common type of allergy that overlaps with asthma and at least 75% of people with asthma also have it.³ While the symptoms of hay fever can be severe and disrupt



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quality of life, uncontrolled hay fever can also trigger asthma symptoms and reduce asthma control. Furthermore, extreme climate-change driven weather events typically have unhealthy impacts on housing (see more below). As climate change progresses, its detrimental effects on air quality will also limit the physical activity levels of people across the nation as well as their ability to socialise, which can harm the physical and mental health of everyone, and particularly people managing chronic conditions.

1. Asthma Australia. 2020. Bushfire Smoke Impact Survey: https://asthma.org.au/wp-content/uploads/Resources/AA6_Smoke-Impact-Survey-1920_Revised.pdf
2. Chan, T.H. (2023). Allergies are getting worse with climate change. Harvard School of Public Health News. (11 April 2023). Available online: <https://www.hsph.harvard.edu/news/hsph-in-the-news/allergies-are-getting-worse-with-climate-change/#:~:text=Since%20warmer%20weather%20signals%20plants,production%20and%20release%20of%20pollen>
3. National Asthma Council Australia. Brochure on Hay fever (allergic rhinitis) and your asthma. Available online: [Hay fever allergic rhinitis and your asthma - National Asthma Council Australia](#)

• Housing

Housing is a key social determinant of health, and particularly important for asthma as **housing conditions can influence an individual's asthma control and risk of developing asthma**. With climate change increasing the presence of asthma triggers and occurrence of extreme weather events, the health of our homes is becoming more important. People will increasingly seek refuge in their homes from climate-driven events, yet conditions within homes can quickly become unhealthy from bushfire smoke entering poorly sealed homes, extreme heat, or mould. These impacts are exacerbated by the absence of good housing design, construction and maintenance.

Many features of a home can influence health, including their ability to provide shelter, security, privacy and space, access to fuel and electricity and protection from hazards. Poorly designed and maintained homes can present significant health risks as they can:

- **Harbour indoor triggers** - substances to which people with asthma and allergies are sensitive - such as mould, dust mites and pest infestations.
- Be **poorly sealed** against outside pollutants such as smoke, dust and pollen; all common triggers for asthma flare-ups and potential contributors to its development.
- Be **inadequately ventilated** to remove accumulated air pollutants and harmful substances.
- Be fuelled by **harmful energy sources** such as gas cooktops and gas and woodfire heaters, which emit pollutants such as nitrogen dioxide and fine particulate matter that can trigger and cause asthma symptoms. Cooking with gas is estimated to be responsible for up to 12% of the childhood asthma burden in Australia.¹

1. Knibbs, W., Marks, C. (2018). Damp housing, gas stoves and the burden of childhood asthma in Australia. MJA.208(7):299–302.

Additionally, are there any other determinants of health that you think the Framework should focus on? If yes, please note them.

We would like to see **gender and sex-related determinants of health** included in the Framework's focus areas. For too long, issues relating to women's health have been underfunded, poorly researched and not given the attention that they deserve. Yet, on average women experience



chronic health conditions at higher rates than men, while their sex-related health needs change over their lives and can also exacerbate these conditions.¹

Globally, women experience a greater burden of asthma compared to men. They are more likely to have asthma, experience severe asthma symptoms and die from asthma.² In 2022, our counterparts in the UK, Asthma + Lung UK, developed a report that synthesised what is known about the impact of asthma on women and its causes.² They found that:

- Sex differences in asthma may occur through many mechanisms, including through:
 - **The role of female hormone oestrogen in stimulating type 2 inflammation**, a type of allergic response that exacerbates asthma. Oestrogen appears to enhance allergic airway inflammation, while blocking oestrogen has been found to improve lung function.
 - **A collective role in female sex hormones in up-regulating inflammation.**
 - **The role of male androgen hormones (e.g. testosterone) in down-regulating type 2 inflammation.** Males have increased androgen receptor expressions that are beneficial in asthma, while the loss of androgen receptors is associated with increased risk of airway inflammation and bronchoconstriction.
 - **Sex-specific genetic differences in asthma risk.**
 - A link between obesity and the development of late-onset asthma in women.
- The effects of sex hormones on asthma symptoms and its progression are **complex** and are **poorly understood**. More research is needed.

However, despite these differences, women are broadly treated for their asthma in the same way as men and can encounter barriers to their care, including the lack of knowledge of healthcare professionals about sex-related differences and in spite of what female consumers may tell them about the connection to, for example, being premenstrual and experiencing worse asthma symptoms.³ Transgender, intersex and non-binary people may also be affected by these female sex differences and may experience additional, more complex or different barriers to access asthma care, including a lack of inclusive health services and health services tailored to their needs.

In addition to sex-related drivers of health inequities, there are also gender-related health inequities relating to chronic condition care. For women, these include having poorer health outcomes due to systemic issues in healthcare delivery (e.g. delayed diagnosis, overprescribing and a failure to properly investigate symptoms), clinical research as well as the intersection of other social determinants.¹ Similar issues disproportionately affect First Nations women as well as transgender, intersex and non-binary people.¹

Factoring in gender and sex-related health determinants is critical to achieving health equity through the Framework given the scale of the issues and how many people's lives they affect.

1. Australian Department of the Prime Minister and Cabinet. National Strategy to Achieve Gender Equality: Discussion paper. Available from: [National Strategy to Achieve Gender Equality - Discussion Paper | PM&C \(pmc.gov.au\)](#)

2. Asthma + Lung UK (2022). *Asthma is Worse for Women*.

3. Ibid.



Q6. One of the aspirational outcomes of Objective 2 of the Framework is that people with chronic conditions have equitable access to quality health care. Pages 35-36 of the Framework discuss this in further detail.

To what extent do you agree with the following statements?

a. Australians with chronic conditions can easily access primary care services, including regular care with a GP and/or allied health providers.

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

b. Australians with chronic conditions can easily access specialty healthcare services when required.

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

Please provide further comments about any of your responses to the previous statements.

While there is a good provision of and access to primary and specialist healthcare services for many people in Australia, there are some notable equity issues that mean accessing these services for some people, including many people with chronic conditions and priority groups can be challenging. These equity issues are set out below.

- **GP access**

Australia had the **highest rate of primary care consultations skipped due to cost** (14% of people aged 16 years and over) in the OCED in 2021.¹ Many people with asthma identify the cost of healthcare as a significant barrier to accessing healthcare, including GPs. The lack of bulk billing GPs or practices in an area is a key issue alongside waiting times to access them where they are available. Data from 2022 evidenced that the highest average out of pocket costs for a GP consultation were in some of the most disadvantaged electorate,² where affordable care is often most needed due to the correlation between higher prevalence of chronic conditions amongst people from lower socioeconomic groups. This inverse care law in primary care has been found to arise from providers finding it less profitable and having less workforce capability in areas of high socioeconomic disadvantage.³ Consequently, some practices provide shorter GP consultations to manage this workload or ask patients to make copayments.



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For people with asthma, waiting to see a GP is not an option when they experience a flare up of their asthma symptoms as they may need to access urgently additional medications (e.g. oral corticosteroids) or advice on how to gain control of their symptoms. In addition, if the cost of accessing a GP is prohibitive or a deterrent, people with asthma may simply try to manage escalating symptoms through using their reliever or short-acting reliever inhalers (Short-acting beta-agonists, SABAs) when other treatment options would be more beneficial (e.g. optimisation of preventer use). Overuse of SABAs is common among people with asthma. While for most people with asthma, relievers are an important medicine to temporarily relieve asthma symptoms and help gain control of asthma, their overuse increases the risk of an asthma attack, and is a risk factor for hospitalisation and death for people with asthma.⁴ Evidence suggests that using just three or more SABA inhalers a year increases flare-ups, and 6 or more increases the risk of death.⁵

Asthma Champions who responded to our survey on this consultation noted that they can end up having to go to emergency to manage an exacerbation due to not being able to see a GP promptly. One Asthma Champion said they have to pay for their GP appointment using a credit card due to being a pensioner and having little income.

[The] cost of seeing a doctor is really high. There are no bulk billing options where I live at all. Also, the wait list is long. I have to book 2-3 days ahead to see a doctor. I can't access one same day where I live. So if I have any kind of serious asthma episode, I have to go straight to ER since I can't see a GP. And often it might be mild, but by the time I can see a doctor I'm at the point I need to go to hospital anyway. My doctor says I need to see him at a frequency of 6-10 weeks and I can only get appointments every 3 months because of the demand and lack of availability of appointments.

Asthma Champion, April 2024

1. AIHW (2023) OECD health care quality and outcomes indicators, Australia 2022-23. Web Report. Available from: <https://www.aihw.gov.au/reports/international-comparisons/oecd-health-care-indicators-2022-23/contents/primary-care-avoidable-hospital-admissions>
2. Visontay E., Evershed, N. (2022) Calls for GP funding boost as figures reveal how Medicare gap hits some of Australia's poorest areas. The Guardian. Available from: [Calls for GP funding boost as figures reveal how Medicare gap hits some of Australia's poorest areas | Health | The Guardian](#)
3. Harris E, Harris MF (2023). An exploration of the inverse care law and market forces in Australian primary health care. Aust J Prim Health. 2023 Apr;29(2):137-141. doi: 10.1071/PY22160. PMID: 36403292.
4. National Asthma Council Australia (2022). Australian Asthma Handbook, Version 2.2. Melbourne: National Asthma Council Australia. Available online: <https://www.astmahandbook.org.au/>
5. Loh ZC, Hussain R, Balan S, Saini B, Muneshwarao J, Ong SC, Babar ZU (2023). Perceptions, attitudes, and behaviors of asthma patients towards the use of short-acting β_2 -agonists: A systematic review. PLoS One.

- **Specialist access**

Accessing a specialist can also be difficult for many people with asthma due to long waiting lists for specialists through the public and private systems, the high costs of seeing a specialist privately and the lack of specialist services, particularly in rural, remote and regional areas. Asthma Champions in our survey on this consultation advised that wait lists to see a public respiratory specialist can be around 6-12 months.

Specialists are difficult to access in the public system, and particularly for people who live in rural, remote and regional areas. But generally [there are] long waiting lists to see a specialist in the public sector, which forces people to go private.

Asthma Champion, April 2024



The wait lists for specialist healthcare in the public system are very long and the threshold for accepting referrals is quite high - which can leave patients falling through the gaps.

Asthma Champion, April 2024

Yet accessing specialists is critical for many people with asthma, particularly for people with severe asthma, who cannot control their asthma despite taking preventer inhalers regularly. This is because it is only through a specialist that people with asthma can access potentially more effective treatments for their condition (e.g. biologics) and thereby remove or minimise the need for regularly taking oral corticosteroids to ease their asthma symptoms, which have harmful systemic side effects. The eligibility criteria for biologics require attending a specialist for 6 months and hence a long wait list to see a specialist further impedes consumers from accessing the care and treatment they need.

- **Diagnosis**

Diagnosis is a critical tool in the secondary prevention of asthma. Effective diagnosis can help:

- Ensure people with asthma can access appropriate treatment and effectively manage their symptoms and prevent exacerbations,
- Ensure those who do not have asthma can access appropriate diagnosis and treatment for their symptoms,
- Prevent the deterioration of asthma and conditions with similar symptoms,
- Optimise the use of health care services and medicines, and minimise unnecessary expenditure and waste, and
- Optimise the use of consumer resources (e.g. time, agency and income) in their care journey and minimise their waste.

There are many diagnostic tests that can be undertaken to help diagnose asthma accurately, however, **they are not widely available to the general population**. This includes spirometry, which in 2019, received a higher rebated MBS item from the Medical Services Advisory Committee (MSAC) to encourage its use in general practice. This followed MSAC's acknowledgement of its importance in confirming the diagnosis of asthma and chronic obstructive pulmonary disease (COPD) and recognition that these conditions are both under and over-diagnosed with resulting, detrimental health outcomes. However, the rebate increase was not adequate and the implementation and uptake of spirometry in primary healthcare has declined.¹ To increase spirometry testing, rebates for spirometry must accurately reflect the costs in delivering the service, including the time and expertise required to complete high quality tests, consumables and maintenance of equipment.

There are also a range of diagnostic services (e.g. fractional exhaled nitric oxide (FeNO) tests, Forced Oscillation Testing (FOT) and electrical impedance tomography (EIT)) that can help accurately diagnose and monitor asthma, particularly for people with severe or difficult to control asthma. They each have their advantages such as speed and ease of use and provide clinicians with unique information useful to make critical clinical decisions and more effectively distinguish and diagnose comorbid conditions. In addition, there are a number of portable and home-based diagnostic and monitoring technologies, with high quality evidence around their efficacy. However, while **equitable access to these services would improve the treatment and control of asthma** (and other respiratory



conditions) and reduce the burden of these conditions on the healthcare system, they are far from the mainstream. This reality prevents precision diagnosis and consequently can prevent people with asthma from accessing appropriate treatment, with fewer side effects (e.g. biologics in preference to oral corticosteroid use, which have serious systemic side effects).

1. Gibson, PG (2023). Spirometry, you have an image problem! *Respirology*. 2023; 28(6): 577.

Q7. Another of the aspirational outcomes of Objective 2 of the Framework is effective sharing of information and data. Pages 37-38 of the Framework discuss this in further detail.

To what extent do you agree with the following statement?

I have access to health information and data, and use this to help make decisions regarding the prevention, diagnosis, treatment and management of chronic conditions.

- Agree
- Somewhat agree
- Neither agree nor disagree
- **Somewhat disagree**
- Disagree
- Not applicable

Please provide further comments about your response, and if appropriate, provide examples of ways you have or have not used information and data.

We identify below some gaps in health information and data in the current system that impede the optimisation of the consumer care journey and experience for people with asthma within the health care system, and that prevent the undertaking of timely actions to protect health and prevent deterioration of symptoms for people with asthma in the community more broadly.

- **Consumer records**

My Health Record has significant potential to help improve the quality of the care journey and experience that consumers have in the healthcare system (while noting that some consumers choose not to have a record). This includes by:

- Providing consumers with **easy access** to all their clinical history (including GP visits, dispensed medicines, diagnostic and pathology test results, hospital admissions and surgery) **in one place, despite changes in healthcare practitioners or providers.**
- **Empowering consumers** about their own health through providing access to information about their health.
- **Reducing the burden on consumers** of remembering details about their health, repeating their story, keeping or chasing copies of their results and taking them to appointments.
- **Optimising every interaction consumers have with the healthcare system** by ensuring that healthcare professionals are aware of, and can build on, their clinical history.



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- **Improving consumers' experience** of engaging with healthcare professionals and their healthcare journey through improving their confidence in the system and enabling a more seamless care experience.
- **Improving health outcomes** through providing healthcare professionals with a better understanding of consumers' health issues so they can better treat and manage their needs.
- **Facilitating better quality use of medicine and stewardship of medicines** (such as oral corticosteroids and reliever inhalers) by providing a central record of dispensed medicines.

In addition, My Health Record has the potential to support chronic conditions in specific ways. For people with asthma this includes in relation to having better visibility over whether consumers are optimising their treatment and asthma control, having their device technique regularly assessed or attending a 6 monthly or annual asthma review. It could help ensure that consumers have an asthma action plan and host a centralised record of their dispensed medicines to ensure, for example, that they are not overusing reliever inhalers or oral corticosteroids. My Health Record has yet to fulfill its potential as currently healthcare professionals and consumers do not use it optimally but through working with organisations like Asthma Australia, ways can be found to extend its reach and use.

- **Air quality**

The lack of infrastructure and data needed to measure air quality, inform communities, or monitor health outcomes is a major barrier to protecting the health of people with asthma. The 2021 State of the Environment report found that better information could reduce the impact of poor air quality and recognised that communities need real-time, local air quality information during periods of poor air quality.¹ However, many communities in Australia do not have access to local air quality information. Regional and rural populations commonly lack local air quality monitoring facilities, which is particularly problematic when these communities are affected by smoke from nearby bushfires and grass fires. Even in metropolitan areas, air quality monitoring stations span many suburbs, meaning localised variations in air pollution can be undetected. Low-cost air quality sensors can help to fill the gaps in air quality monitoring networks as they are affordable and easy to install.

Additionally, despite recommendations from inquiries into the 2019-20 bushfire smoke crisis, governments have not invested in a public education campaign around air quality. To address this need, Asthma Australia developed and piloted the AirSmart public education campaign and mobile app under the guidance of an expert advisory committee, which included representatives of the Australian and NSW environment departments, with funding from the NSW Government for a pilot campaign in 2022. Evaluation of the pilot strongly indicated that consumers want access to local, responsive air quality information and tools with the campaign having, for example, over 16,000 app downloads and 23,000 website views in six weeks. However, despite this demand and the identified need for improved air quality public education, Asthma Australia has not secured funding for a national AirSmart campaign.

1. Commonwealth of Australia. (2021). Australia State of the Environment Report. 2021. Available from: <https://soe.dceew.gov.au/air-quality/introduction>



- **Climate Change**

Asthma can be used as a helpful indicator to monitor and record as a range of climate change-driven conditions affects the condition and certain outcomes are evident during or immediately after an event, such as emergency department presentations and hospitalisations. Trends in the sale of inhaler medicines can also indicate short term respiratory health impacts. The Australian Institute of Health and Welfare considered a variety of short-term health outcomes occurred during the 2019-20 bushfire crisis that could help inform the development of measurements for this outcome.¹ Medium- and long-term health outcomes could also be measured, as climate change impacts can impact the incidence of conditions such as asthma. Data on the relative burden of disease from different conditions should be monitored, noting the rising burden of asthma over the past two decades has coincided with increasing exposure to hazards associated with the condition.²

1. AIHW (2020). Australian bushfires 2019–20: Exploring the short-term health impacts. <https://www.aihw.gov.au/reports/environment-and-health/short-term-health-impacts-2019-20-bushfires/contents>

2. AIHW (2021). Australian Burden of Disease Study 2018—Key Findings; AIHW. 2021. Australian Burden of Disease Study 2018; AIHW. 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015.

Q8. The Framework aims to act as a broad overarching guidance document that is inclusive of the full spectrum of chronic conditions.

To what extent do you agree with the following statements?

Australians living with chronic conditions, including myself, friends/family, patients, or members of the organisation I represent if applicable, are recognised in the Framework.

- Agree
- **Somewhat agree**
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

The Framework is representative of the diversity of population groups in Australia.

- **Agree**
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable



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The Framework recognises the individual needs of the many different groups in Australia.

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

The Framework provides guidance about how the prevention and management of chronic conditions can be tailored to the needs of different population groups.

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Not applicable

Please provide further comments about any of your responses to the previous statements.

We responded 'somewhat agree' to the statement relating to the Framework's recognition of everyone living with chronic conditions as children should be recognised as a priority population with specific needs and challenges in the Framework (for more detail on this please see our response to question 9).

We responded 'somewhat disagree' and 'disagree' respectively to the statements relating to recognition of the needs of the many different groups in Australia and to whether the Framework provides guidance tailored to their needs as the Framework does not provide this level of detail. As per the consultation document's suggestion, we support an approach whereby the refreshed Framework provides more detail on individual needs in relation to common issues that affect people with chronic conditions, leaving the expansion of detail in relation to issues that are condition-specific to the individual Action Plans and Strategies.



Q9. The Framework includes the following list of priority populations, but notes this list is not exhaustive.

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse backgrounds
- Older Australians
- Carers of people with chronic conditions
- People experiencing socio-economic disadvantage
- People living in remote, or rural and regional locations
- People with disability
- People with mental illness
- People who are, or have been incarcerated

Please provide information known to you on the experiences of people with chronic conditions in the above, or additional, priority population groups including any challenges and barriers in accessing prevention and/or treatment services that you think may be of relevance to the refresh of the Framework.

We welcome the identification of the above priority groups, noting that the following populations experience a higher prevalence of asthma in Australia:

- Aboriginal and Torres Strait Islander people,¹
- Older Australians,²
- People experiencing socio-economic disadvantage,³
- People living in remote, or rural and regional locations,⁴ and
- People with disability.⁵

Some groups also experience higher death rates due to asthma (for example, Aboriginal and Torres Strait Islander people and people experiencing socio-economic disadvantage⁶) and higher hospitalisations due to their asthma (for example, Aboriginal and Torres Strait Islander people⁷).

It is important to note that older women experience higher prevalence of asthma most notably. For example, 14.8% of females aged 55-64 years had asthma compared to 10.4% of males from the same age group in 2017-18.⁸ The higher burden of asthma for all women, as set out fully in our response to question 5, means that they should be a priority population in the Framework. There is a significant need for greater research to understand this inequity and to deliver services and treatment better designed to the needs of women with asthma.

Asthma prevalence amongst people from culturally and linguistically diverse backgrounds (CALD) increases the longer people stay in Australia, in relation to people born overseas compared to people born in Australia.⁹ CALD communities require greater support in relation to health education and promotion about conditions like asthma, as well as accessible care and support to treat them.

There is a link between poor mental health and asthma outcomes,¹⁰ and people with asthma have twice the rate of mental illness than people who do not have asthma.¹¹ While the relationship is not fully understood, anxiety and depression negatively impact asthma control, resulting in increased asthma symptoms, severity and health use.¹²

In addition, children and people from the LGBTQI+ community should be added to the list of priority populations and we set out why below.



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1. Australian Institute of Health and Welfare (2023). First Nations people with asthma [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2024 Jan. 2]. Available from: <https://www.aihw.gov.au/reports/chronic-respiratory-conditions/first-nations-people-with-asthma>
2. Australian Bureau of Statistics (ABS, 2023). National Health Survey 2022: Asthma [Internet]. Canberra: ABS. [cited 2024 January 5]. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release>
3. Ibid.
4. AIHW (2023). Chronic respiratory conditions: asthma. Web article. Available from: [Chronic respiratory conditions, Asthma - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma)
5. World Health Organisation (2023) Fact sheet. Available from: <https://www.who.int/news-room/fact-sheets/detail/disability-and-health#:~:text=Persons%20with%20disabilities%20have%20twice,obesity%20or%20poor%20oral%20health>.
6. AIHW (2020). Asthma. 25 Aug 2020 update. Cat. no. ACM 33. Canberra: AIHW. <https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma>
7. AIHW (2023). First Nations people with asthma [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2024 Jan. 2]. Available from: <https://www.aihw.gov.au/reports/chronic-respiratory-conditions/first-nations-people-with-asthma>
8. ABS (2023). National Health Survey 2022: Asthma [Internet]. Canberra: ABS. [cited 2024 January 5]. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release>
9. AIHW (2023). Chronic health conditions among culturally and linguistically diverse Australians, 2021. <https://www.aihw.gov.au/reports/cald-australians/chronic-conditions-cald-2021>
10. Australian Government Productivity Commission (2024). Report on Government Services 2024. 10 Primary and Community health data tables. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services/2024/health/primary-and-community-health>
11. The University of Newcastle (2018) Severe Asthma Toolkit. Available from: <https://toolkit.severeasthma.org.au/living-severe-asthma/mental-emotional-health/>
12. Ibid.

• Children

Children with asthma in Australia bear a disproportionate burden of the disease. Asthma is the leading cause of burden of disease for people aged 5-14 years.¹ An estimated 8.2% (around 386,000) children aged 0-14 had asthma in Australia in 2022.² This represents 12.8% of the total disease burden for boys 5-14, and 11.1% for girls.³ Children are much more likely than adults to be hospitalised for asthma, with 10,000 children with asthma aged under 15 years hospitalised in 2021-22 (42% of all hospitalisations).⁴ As a result, asthma is a key reason for missing school due to chronic illness,⁵ and 42% of children aged 0-14 had to take time off school in 2014/15 due to their asthma.⁶ Research undertaken in New South Wales shows that educational attainment is worse for young people (under 18 years old) hospitalised with asthma compared to matched peers.⁷

While the exact reason behind the development of asthma is unknown,⁸ researchers have found that it can run in families,⁹ as well as be linked to many other factors relating to:

- **Maternal exposures** during pregnancy (e.g., smoking,¹⁰ a high maternal pregestational body mass index and traffic-related air pollution during pregnancy¹¹),
- **Birth** (e.g., premature births, low birth weights and caesareans¹²),
- **Reduced exposure to diversity of beneficial, environmental and human micro-organisms due to modern day living** (e.g., cleanliness, chemical exposure, antibiotics use, nutrition and reduced biodiversity¹³),
- **Severe respiratory infection in early childhood** (e.g. RSV¹⁴),
- **Environmental exposure to air pollution** (e.g., bushfires, mould and second-hand cigarette smoke¹⁵),
- **Adverse childhood experiences resulting in toxic stress in the first 1,000 days changing the body's stress response**,¹⁶
- **Lower socio-economic background**,¹⁷ and
- **Homelessness**.¹⁸

In addition, children's lungs are not fully developed until they are three years old and infants have much smaller airways, meaning any swelling of the lining and/or tightening of the airways, or



increased amounts of mucus, can make breathing extremely difficult. Hence, Asthma Australia strongly supports the design and delivery of earlier and better supports for children and families during the first 1,000 day period in relation to their healthy development. The first 1,000 days covers the period of development from their conception until children are 2 years old, and hence must include services and interventions targeting people during their pregnancy or those who are trying to conceive. Focusing on children is particularly important for asthma as it can cause non-reversible airflow limitation, especially during early childhood, while early life development can influence lung function in adulthood and subsequent respiratory morbidity.¹⁸ This fact alongside the significant potential for instilling good protective and preventive health behaviour and knowledge early amongst children and their parents highlights why children must be a focus for the Framework.

1. AIHW (2023). Australian Burden of Disease Study 2023 [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2024 Jan. 5]. Available from: <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2023>
2. ABS (2023). National Health Survey 2022: Asthma [Internet]. Canberra: ABS. [cited 2024 January 5]. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release>
3. AIHW (2023). Australian Burden of Disease Study 2023 [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2024 Jan. 5]. Available from: <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2023>
4. AIHW (2023). Principal diagnosis data cubes [Internet]. Separation statistics by principle diagnosis (ICD-10-AM 11th edition), Australia 2021-22. Canberra: Australian AIHW, 2023 [cited 12 Jul 2023]. Available from: <https://www.aihw.gov.au/reports/hospitals/principal-diagnosis-data-cubes/contents/data-cubes>
5. Australian Government Productivity Commission (2020), Report on Government Services.
6. ABS (2017). Health Service Usage and Health Related Actions Australia 2014-15. Canberra: ABS
7. Mitchell RJ, McMaugh A, Homaira N, Lystad RP, Badgery-Parker T, Cameron CM (2022). The impact of childhood asthma on academic performance: A matched population-based cohort study. *Clin Exp Allergy*. 2022 Feb;52(2):286-296. doi: 10.1111/cea.14022. Epub 2021 Oct 2. PMID: 34564913
8. John Hopkins Medicine. Website. Available online: <https://www.hopkinsmedicine.org/health/conditions-and-diseases/asthma/asthma-in-children>
9. Thomsen, F. S. (2015). Genetics of asthma: an introduction for the clinician. *European Clinical Respiratory Journal*. 2: 10.3402/ecrj.v2.24643.
10. Nascimento, J.X.P.T., Ribeiro, C.C.C., Batista, R.F.L. et al (2017). The First 1000 Days of Life Factors Associated with “Childhood Asthma Symptoms”: Brisa Cohort, Brazil. *Sci Rep* 7, 16028.
11. Bettiol, A., Gelain, E., Milanese, E. et al (2021). The first 1000 days of life: traffic-related air pollution and development of wheezing and asthma in childhood. A systematic review of birth cohort studies. *Environ Health* 20, 46.
12. Nascimento, J.X.P.T., Ribeiro, C.C.C., Batista, R.F.L. et al (2017). The First 1000 Days of Life Factors Associated with “Childhood Asthma Symptoms”: Brisa Cohort, Brazil. *Sci Rep* 7, 16028.
13. Moore, T.G., Arefadib, N., Deery, A., & West, S. (2017). *The First Thousand Days: An Evidence Paper*. Parkville, Victoria; Centre for Community Child Health, Murdoch Children’s Research Institute.
14. National Asthma Council Australia 2022. *Australian Asthma Handbook, Primary Prevention of asthma*. Version 2.2. Melbourne: National Asthma Council Australia. Available online: <https://www.astmahandbook.org.au/prevention/primary>
15. Moore, T.G., Arefadib, N., Deery, A., & West, S. (2017). *The First Thousand Days: An Evidence Paper*. Parkville, Victoria; Centre for Community Child Health, Murdoch Children’s Research Institute.
16. Ibid.
17. Ibid.
18. E.g. Martinez FD (2016). Early-Life Origins of Chronic Obstructive Pulmonary Disease. *N Engl J Med*. 2016 Sep 1;375(9):871-8. doi: 10.1056/NEJMra1603287. PMID: 27579637.

- **LGBTIQ+ community**

Importantly, lesbian, gay, bisexual, transgender/gender diverse, intersex, queer, asexual and people of other diverse sexualities and genders not captured in this acronym should be identified in the Framework as a priority population. People from the LGBTIQ+ community experience persistent health inequities in a range of different ways, depending on their personal circumstances and the intersectionality of other determinants of health (e.g. ethnicity¹ and socioeconomic background) and risk factors (e.g. tobacco use²). These health inequities include, for example, increased risk of lung conditions³ and higher risks of asthma in lesbian, gay and bisexual people compared to heterosexual people.⁴ They also encounter significant stigma and discrimination in accessing health care and lack services and support tailored to their needs.⁵



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1. E.g. Job, S., Kaniuka, A.R., Reeves, K., Brooks, B.D. (2023) Interactions of Sexual Orientation and Gender Identity with Race/Ethnicity in Prevalence of Lifetime and Current Asthma Diagnosis. Available from: <https://www.researchgate.net/publication/369451565> [Interactions of Sexual Orientation and Gender Identity with Race/Ethnicity in Prevalence of Lifetime and Current Asthma Diagnosis](#)
2. AIHW (2024) National Drug Strategy Household Survey 2022-2023: LGBT people's use of alcohol, tobacco, e-cigarettes and other drugs. Available from: [National Drug Strategy Household Survey 2022-2023: LGBT people's use of alcohol, tobacco, e-cigarettes and other drugs - Australian Institute of Health and Welfare \(aihw.gov.au\)](#)
3. Lung Foundation Australia (2023) LGBTIQ+ Lung Health Community of Practice. Fact sheet. Available from: [LGBTIQ+ community-factsheet.pdf \(lungfoundation.com.au\)](#)
4. Veldhuis CB, George M, Everett BG, Liu J, Hughes TL, Bruzzese JM (2021). The Association of Asthma, Sexual Identity, and Inhaled Substance Use among U.S. Adolescents. *Ann Am Thorac Soc*. 2021 Feb;18(2):273-280. doi: 10.1513/AnnalsATS.202001-062OC.
5. AIHW. LGBTIQ+ communities. Available from: [LGBTIQ+ communities Overview - Australian Institute of Health and Welfare \(aihw.gov.au\)](#)

Q10. Potential barriers for people with chronic conditions are shown below.

Which of these barriers do you believe significantly impact Australians living with chronic conditions (including yourself if applicable)? Please select all that apply.

- Difficulty in finding an appropriate healthcare provider or facility
- Long wait lists
- Lack of coordinated care and communication between health professionals
- Lack of information sharing and exchange between healthcare providers
- Financial cost of healthcare
- Limited awareness and understanding of chronic conditions and/or prevention by patients and/or carers
- Limited understanding of the healthcare system by patients and/or carers
- Limited knowledge of some chronic conditions by healthcare professionals
- Stigma associated with chronic conditions and risk factors
- Stigma of accessing healthcare
- Not being able to attend appointments due to geographical location/transport
- Difficulty using technology to receive or navigate healthcare services
- Lack of health promotion education and prevention activities
- Low English proficiency and other language challenges
- Limited availability of publicly funded health programs
- Lack of access to research and data
- Lack of culturally safe healthcare



Are there any other barriers that you would like to draw attention to?

The health workforce can be a barrier for people with asthma. People with asthma commonly tell us that the healthcare professionals lack knowledge about asthma. For example, in the survey we undertook for this consultation, Asthma Champions and CAC members noted that healthcare professionals commonly lack education about asthma symptoms, triggers, risk factors and effective treatment.

Common complaints from patients are that they can't get into their GP or when they do, they are given inappropriate advice or medications.

Asthma Champion, April 2024

Emergency doctors are taught basic treatment for asthma and all seem to follow the same protocol. Too much emphasis is on whether they can hear a wheeze. I rarely have a wheeze and present with a cough and the effort breathing burst blood vessels in my face and neck, so they treat me for allergic reaction. Then when I crash very quickly they find out I'm asthmatic. They need to listen to the patient. If they say asthma, treat asthma first. Being intubated is not nice and they rarely wait for you to go under before pushing the tube down when You crash. I can't react at this point as I'm out of it, but I still feel it.

Asthma Champion, April 2024

In addition, Asthma Champions stated that their healthcare professionals do not take asthma seriously, particularly when asthma is present with other chronic conditions.

My whole life I feel that my asthma has not been taken seriously, despite being the chronic condition that actually has life threatening consequences.

Asthma Champion, April 2024

There is also evidence of health professionals' non-adherence to the Australian Asthma Guidelines in relation to asthma.¹ For example:

1. **Australian data shows that less than 20% of consumers are being dispensed preventer medicine at a rate consistent with therapeutic use.**² Regular inhaled preventer medication is the most important medication intervention in asthma, which reduces the risk of asthma attacks and the need for emergency care and improves overall health and quality of life.³
2. **Up to 90% of people with asthma do not use their inhaler correctly and hence will deliver little to none of the medicine to their lungs.**⁴ Inhaled asthma medicines are only effective if they are used properly. However, inhaler devices can be challenging to use and require instruction and review to ensure that they are being used correctly. This high margin for error in asthma medicine administration is unique and is too often overlooked by healthcare professionals, many of whom do not know how to teach correct inhaler device technique.⁵
3. **There is an over-reliance on reliever medicine to the detriment to consumers' health.** Reliance on short-acting reliever inhalers (Short-acting beta-agonists, SABAs) is common among people with asthma. While for most people with asthma, relievers are an important medicine to temporarily relieve asthma symptoms and help gain control of asthma, their overuse increases the risk of an asthma attack, and is a risk factor for hospitalisation and death for people with



asthma.⁶ Evidence suggests that using just three or more SABA inhalers a year increases flare-ups, and 6 or more increases the risk of death.⁷

4. **Only 33% of people with asthma have a written asthma action plan.**⁸ An asthma action plan is one of the most effective interventions to support people with asthma by guiding their actions in response to a change in their asthma control and condition.⁹ All healthcare professionals should be aware of the importance of asthma action plans.

To help address these issues, Asthma Australia supports:

- **Increased professional development opportunities for healthcare professionals on asthma care and treatment as per Australian guidelines.**
 - Since 2020, Asthma Australia partnered with Reed Medical to provide free, accredited asthma education for GPs and other health professionals via ThinkGP. Since its introduction, the program has nearly 10,000 unique enrolments with a 60% completion rate and continues to exceed targets year on year. Of the participants, 82.5% are doctors, with excellent representation from other healthcare providers.
 - We are part of the Lung Learning Partnership delivering the Quality Use of Medicines (QUM) in CAD Program in response to the Health Care Professional Education grant from the Quality Use of Diagnostics, Therapeutics and Pathology Program. The program aims to deliver national education to primary care healthcare professionals to improve QUM and diagnosis and management of chronic airways disease, including asthma and COPD. We are using a human-centred design process to ensure that lived experience informs program design and implementation.
 - While these programs are on their way to reaching the 30,000 GPs in Australia, many other healthcare professionals including hospital and emergency staff, practice nurses, allied health and pharmacists would also benefit from professional development opportunities focused on their role in asthma management.
- **The development of a clinical care standard¹⁰ for asthma.** A clinical care standard aims to deliver a nationally consistent approach to care, focusing on key areas of clinical practice where variation has been observed. The following and monitoring of a clinical care standard for asthma would help to provide people with asthma with safe, high quality appropriate care more effectively than relying only on healthcare professionals to remain up-to-date with, be knowledgeable of and adhere to expert-informed guidelines.
- **Enabling primary healthcare professionals to work at their scope of practice.** To this end, the primary care workforce must have the capacity and skills to undertake elements of asthma management. In addition, there must be financial support to enable primary healthcare professionals to have the time and resources to undertake appropriate needs assessment, education and review with the consumers for optimal asthma management (e.g. through an Asthma Cycle of Care MBS item with appropriate rebate to ensure uptake).

1. Australian Government as represented by the Department of Health and Aged Care (2017). National Asthma Strategy; [Assessing appropriateness of paediatric asthma management: a population-based sample survey — Macquarie University \(mq.edu.au\)](#)

2. Reddel HK, Lembke K, Zwar NJ (2018). The cost of asthma medicines. *Aust Prescriber*, 2018;41:346. <https://doi.org/10.18773/austprescr.2018.011>

3. National Asthma Council Australia (2022). Australian Asthma Handbook, Version 2.2. Melbourne: National Asthma Council Australia. Available online: <https://www.asthmahandbook.org.au/>

4. Basheti IA, Armour CL, Bosnic-Anticevich SZ, Reddel HK (2008). Evaluation of a novel educational strategy, including inhaler-based reminder labels, to improve asthma inhaler technique. *Patient Educ Couns* 2008; 72: 26-33.

5. Fink JB, Rubin BK (2005). Problems with inhaler use: a call for improved clinician and patient education. *Respir Care*. 2005 Oct;50(10):1360-74; discussion 1374-5. PMID: 16185371.



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6. National Asthma Council Australia (2022). Australian Asthma Handbook, Version 2.2. Melbourne: National Asthma Council Australia. Available online: <https://www.astmahandbook.org.au/>
7. Loh ZC, Hussain R, Balan S, Saini B, Muneshwarao J, Ong SC, Babar ZU (2023). Perceptions, attitudes, and behaviors of asthma patients towards the use of short-acting β 2-agonists: A systematic review. PLoS One. 2023 Apr 20;18(4):e0283876. doi: 10.1371/journal.pone.0283876. PMID: 37079594; PMCID: PMC10118161.
8. ABS (2023) Asthma. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release>
9. E.g. [Asthma Action Plan - Asthma Australia](#)
10. Australian Commission on Safety and Quality in Health Care. Clinical Care Standards. Available from: <https://www.safetyandquality.gov.au/standards/clinical-care-standards>

Q11. As part of the refresh of the Framework, condition-specific Action Plans and Strategies will be reviewed to ensure that the documents are complementary to, and build on, the Framework.

Do you support this description of the inter-relationship between the Framework and condition specific Action Plans and Strategies?

- Yes
- No
- Not applicable

Please elaborate on your response.

Asthma Australia and the National Asthma Council were partners in the development of the National Asthma Strategy 2018 (the Strategy). It identifies a number of critical actions that need to be taken in key areas to optimise the prevention and management of asthma.¹ Some of these actions have been completed, including Asthma Australia’s development of a consumer-focused national asthma research agenda in 2023 designed to coordinate and translate quality health research evidence.² However, many of the actions are ongoing and require a cross-departmental, multidisciplinary and health in all policies approach to achieve them. In addition, while the Strategy consolidated optimal thinking at the time, its pillars need connecting through a greater focus on the patient journey. Implementation of any actions of a refreshed Strategy will require funding and incentives to drive collaboration among stakeholders to achieve outcomes. Government should identify funding for the implementation of Actions Plans and Strategies in this Refresh. Asthma Australia has begun the process of identifying how to update the Strategy and looks forward to working with the Government and other stakeholders in the review process.

1. Australian Government as represented by the Department of Health and Aged Care (2017). National Asthma Strategy; [Assessing appropriateness of paediatric asthma management: a population-based sample survey — Macquarie University \(mq.edu.au\)](#)
2. [National Asthma Research Agenda Project - Asthma Australia](#)



Q12. The condition-specific Action Plans and Strategies include a number of commonalities in priorities and actions.

It is proposed to embed these common priorities and actions in the refreshed Framework. Therefore, any condition-specific guidance would be focussed on tailored actions for that condition, where the need exists.

Do you support this approach?

- Yes
- No
- Not applicable

Please elaborate on your response.

Air pollution, climate change and housing are examples of key risk factors for many chronic conditions, which could be embedded in the refreshed Framework to leave condition-specific guidance to be focused on condition-specific areas.

Q13. Many common issues and challenges can be found in the prevention, treatment and management of different chronic conditions. Several of these issues are listed below.

- Multi-disciplinary care
- Managing multimorbidity
- Continuity of care across life stages
- Transitions of care as a patient moves across and through the health system
- Enhanced and targeted support for priority populations
- Health promotion and education
- Self-management
- Life stage transitions
- Embedding prevention in the continuum of care

Do you believe a focus on these common issues is relevant, accurate and appropriate for Australians living with a chronic condition?

- Yes
- No
- Not applicable

Please elaborate on your response and/or include any other common issues across chronic conditions that you would like to note.

People with asthma commonly experience many of the issues and challenges listed above in the health care system. They **regularly interact with many different healthcare professionals**, including GPs, nurses, nurse practitioners, respiratory and allergy specialists, allied health professionals, hospital and emergency staff and pharmacists. This often means that their care journey is disjointed



and that they are required to repeat their story and clinical history multiple times. It also means that opportunities to optimise their care experiences and outcomes are missed as healthcare professionals do not or cannot join up and apply their medical history to inform their provision of support and treatment. This can have serious impacts on consumer health. Improving the use and uptake of My Health Record, as we note in our response to question 7, would help multidisciplinary providers of care deliver continuity of care, seamless transitions of care across the system and embed prevention in the continuum of care by ensuring all stakeholders are aware of, for example, an individual's asthma triggers and personal circumstances. For example, consumers could keep their health story (e.g. first episode of ill health, triggers and personal circumstances) on My Health Record, or a condition-specific app, to avoid having to continuously repeat them to healthcare professionals.

Comorbidity is a particular concern for people with asthma. The chance of developing chronic conditions increases with age, and since asthma often starts early in life, people with asthma are likely to develop another chronic condition during their lifespan. In 2020–21, 78% of people with asthma aged 45 and over, had at least one other chronic condition, with the top three comorbidities for asthma being arthritis (42%), back problems (33%) and heart, stroke and vascular disease (31%).¹ Other chronic conditions that are commonly found in people with asthma, and that can impact on asthma control, include mental illness, obesity, chronic obstructive pulmonary disease (COPD), allergic rhinitis, obstructive sleep apnoea, nasal polyps and gastro-oesophageal reflux disease. Management of comorbid conditions often also supports asthma control as obesity, mental illness, allergic rhinitis and obstructive sleep apnoea detrimentally affect asthma control and the risk of flare-ups.² It is also critical that healthcare professionals do not overlook the seriousness of asthma when other conditions are also present.

I've certainly found that asthma is taken less seriously when in conjunction with other chronic conditions.

Asthma Champion, April 2024

The current Framework has **person-centred approaches** as one of its eight guiding principles. Person-centred approaches are essential in the prevention and management of chronic conditions and, if applied effectively, would help overcome many of the issues listed above. For people with asthma, person-centred approaches are important as asthma is a unique and complex condition that affects each person differently. Causes for its development and triggers for its symptoms and flare-ups are wide-ranging, individualised and can be unknown. Asthma triggers are frequently linked to the social, environmental, cultural and commercial determinants of health. They also include viral respiratory infections, hormonal changes, some medications, exposure to tobacco smoke, strong odours and chemicals, physical exercise and mental health issues. Risk factors for developing asthma include genetics, exposures in utero and birth outcomes, the absence and presence of certain environmental exposures and socio-economic background. Both asthma risk factors and asthma triggers can be found in indoor and outdoor environments. This complexity can make asthma development and symptom prevention and symptom management challenging and requires **holistic needs assessment and treatment of the condition**.

Additionally, a holistic approach would help to address the social determinants of health that affect people with asthma and other chronic conditions. To this end, **social prescribing is needed in the treatment of asthma**, whereby consumers are connected to a range of non-clinical support to improve their health and wellbeing, which can help to reduce triggers and risk factors non-medically.



Such support could include accessing green space, exercise, singing and activities designed to enhance social inclusion.³ Taking part in these activities has been found to reduce the need for medications among people with asthma and to help many common issues affecting chronic conditions such as mental health, psychosocial and lifestyle factors.^{4/5}

Finally, **asthma is primarily self-managed** by the individual or their carer using medicines and devices, under the guidance of a healthcare professional. Asthma medicines include relievers for the rapid relief of asthma symptoms as they occur, preventers used every day to prevent symptoms and reduce the likelihood of exacerbations, combinations of preventer and reliever medicines, and add-on therapies used for severe asthma. Inhaled medicines are the mainstay of asthma treatment and control but can be difficult to administer, while children and many adults using inhalers are also advised to use spacers and masks with them to support effective administration. Self-managing and administering this complex array of medication and devices can be challenging, particularly for priority populations and groups with low health literacy. Asthma Australia undertakes a significant amount of health promotion and education amongst consumers and focuses on delivering universally appropriate resources, using plain language and appropriate reader level content to help ensure people with asthma are optimising their asthma control through, for example, using medicines and devices appropriately. Our free Asthma Educator service (1800 ASTHMA) also provides people with asthma with essential support about their individual asthma control.

In addition, Asthma Australia works with a range of community healthcare professionals and provide education on asthma control and connect them with high priority groups in their community. For example, we recently partnered with the World Wellness Group and One Health Organisation to deliver the Culture Well Pilot in Brisbane and Adelaide. Funded by the Australian Department of Health the pilot's aim was to work with three communities (Arabic, Samoan and Vietnamese-speaking) to better understand their perspectives on health and wellbeing, identify barriers and enablers to their engagement with local health services and test interventions to support good health.⁵ Results of the co-design research process with members of the three communities demonstrated the need for **two-way community and healthcare professional training** – e.g. the community educates healthcare professionals about their unique needs, experiences and barriers to support, and healthcare professionals educate the community about their role in supporting them within the healthcare system. Community-based projects such as Culture Well can help deliver equitable outcomes for people with asthma by **empowering priority population groups** to access the care and support they need.

1. AIHW (2023) Chronic respiratory conditions: Asthma. Available from: <https://www.aihw.gov.au/reports/chronic-respiratory-conditions/chronic-respiratory-conditions/contents/asthma>

2. National Asthma Council Australia 2019. Australian Asthma Handbook, Version 2.0. Melbourne: National Asthma Council Australia.

3. Kuhn, A.L.R., Rariden, C.A. (2024). Social prescribing: healing people through community. The Journal of Nurse Practitioners, Volume 20, Issue 2, February 2024. Available from: [Social Prescribing: Healing People Through Community - The Journal for Nurse Practitioners \(npjjournal.org\)](https://doi.org/10.1016/j.npr.2024.02.001)

4. Personnel Today (2023) Social prescribing can reduce need for some medications. Available from: <https://www.personneltoday.com/hr/social-prescribing-study-urban-living/>

5. Primary Care Respiratory Society (2022) Primary Care Respiratory Update. Available from: <https://www.pcrs-uk.org/sites/default/files/2022-December-PCRU-Breathchamps.pdf>

6. Saini B., Komaric, N., Phillips, J., and David, M. (2022). Culture Well: Community pharmacists and Arabic speaking Australians – communicating capably to build health partnerships. Australian Pharmacists, Vol 41, No 3, May 2022.



Q14. A large number of resources, training modules, tools and guidelines have been developed to support the prevention, treatment and management of chronic conditions. There is an opportunity for digitisation to reduce duplication, improve effectiveness of support and enhance impact. Use of emerging digital technologies provide opportunities for enhanced chronic conditions management into the future. This will be a key consideration for the refresh of the Framework.

Please provide information on any opportunities for digitisation to enhance the prevention, treatment and management of chronic conditions.

Digital technologies can play a pivotal role in providing health support. As was seen during the COVID-19 pandemic, for example, digital resources and support can help to bridge gaps and challenges in access and has notable value for a country as large as Australia and with widespread rural and remote communities. The digital world can provide services and support remotely and virtually, and depending on the nature of the support, whenever consumers need them (e.g. 24/7).

Asthma Australia supports greater investment in technology, and particularly to support self-management of conditions like asthma at scale. In the asthma context, such investment could deliver consumer-specific resources designed to support the prevention and management of chronic conditions. Asthma Australia's current work in the digital area includes building an integrated suite of digital platforms that will enable people with asthma and their carers to store, engage and track information about their asthma health. They will build on the work of our retiring Kiss myAsthma App. The functionalities will include:

- Input of key health information (e.g., triggers, symptoms, medication type and tracking, reminders)
- Digitisation of Asthma Action Plans (AAPs, which are a key tool for improving asthma control that are developed through consultation between a consumer and their healthcare professional).
- Integration of Bluetooth enabled devices, allowing for accurate tracking of inhaler device technique, for example, and medication adherence.
- Air quality data to flag poor air quality events/days and what actions to take as a result.
- Correlation of data to provide warnings about increasing asthma symptoms and information about next step actions as well as about worsening asthma symptoms and poor air quality.
- General information and resources about common asthma triggers, risk factors and the optimum approaches to prevention and management of symptoms.
- Mood logging and the integration of other health apps.

With consumer consent, we also aim to enable the sharing of this information with third parties such as carers, healthcare professionals, schools and community groups to provide centralised access to, and understanding of, personalised, asthma data.

While noting the potential of digitisation in healthcare, **it is important that it does not become another area where priority population groups are left behind.** Given the digital divide, there is a risk that technology and its use in healthcare could further increase health inequities rather than reducing them by enabling consumers who already engage and benefit from health services to do so more conveniently or affordably while leaving consumers who lack access to digital devices or stable and secure internet without the same access. The needs and experiences of priority population groups should instead be used to guide the development and implementation of digital interventions and services so that everyone may benefit from them.



Q15. COVID-19 has had significant impacts on the Australian healthcare system, including the prevention, treatment and management of chronic conditions.

Please describe any impacts (positive or negative) of COVID-19 that you would like to highlight.

The pandemic and the public health measures taken to keep people from catching COVID-19 (e.g. masks, hand hygiene, limited travel, social distancing, staying at home if sick) resulted in reduced rates of asthma hospitalisations and deaths in 2020-21,^{1/2} with rates rebounding in the subsequent year. This evidences the effectiveness of promoting basic public health measures to help protect everyone's health more generally, noting that they must also be supported by high levels of acceptability (e.g. hand hygiene and staying at home if sick) when used during

The pandemic also strongly evidenced how agile and responsive consumer organisations like Asthma Australia can be in a public health crisis and highlighted the invaluable role we play as a partner to consumers, government and communities. For example, given COVID-19 is an infectious respiratory disease, Asthma Australia immediately recognised that COVID-19 would have a significant impact on the lives of people with asthma. As the scale of the pandemic unfolded, we were quick to ensure that we had the resources in place to support the increasing numbers of consumers concerned about their vulnerability to COVID-19, the use of masks and its impact on their asthma and ongoing access to asthma medications and healthcare services.

To ensure that we fully captured the concerns and experiences of people with asthma, we developed an extensive consultation approach with consumers. This included undertaking three standalone surveys (with nearly 2,000 people with asthma or their carers) and a fortnightly pulse survey with 200-500 respondents for six months. This comprehensive approach to consumer engagement enabled us to:

- **Ensure people with asthma had a voice** and felt listened to during this period of uncertainty.
- **Raise awareness and advocate for the needs and concerns of people with asthma to governments and other stakeholders.** This included raising the difficulties people with asthma were having in accessing healthcare services and attending their regular check-ups with GPs since the symptoms of asthma overlap with COVID-19, flagging the need to prioritise the implementation of telehealth at this time. Our advice also related to governments messaging on mandatory facemasks since some people with asthma were unable to wear them as masks trigger their symptoms, and so felt isolated, misunderstood and at times vilified as a result.
- **Develop resources to support people with asthma in direct response to their concerns and needs.** We provided support through our website COVID-19 hub (there have been 164,524 pageviews of COVID-19 pages since 2020), newsletters, blogs and social media posts as well as access to experts through Facebook live sessions – all informed by and responding to our survey findings. In view of consumer concerns, we also commissioned a systematic review of the evidence to determine the risk of COVID to people with asthma. Thanks to this research, we were able to alleviate concerns in the community and advise governments and healthcare and services professionals accordingly, at the same time as reinforcing key messages around reducing risk and remaining vigilant.
- **Use these established communication channels to share information from government** about medicines availability and public health messages.

1. AIHW. *Principal diagnosis data cubes*. Separation statistics by principal diagnosis, 2016-17 to 2021-22. www.aihw.gov.au

2. ABS (2022). *Causes of Death, Australia: Data downloads* [Internet]. Canberra: ABS; 2022 [cited 2023 December 5]. Available from: <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-downloads>;



Q16. Which of the following statements are most important to you in terms of how the Australian Government enhances and uses the Framework in the future? Please select up to 5 options.

- Greater promotion of the Framework to peak bodies to increase awareness
- Greater promotion of the Framework to health professionals and researchers to increase awareness
- Greater promotion of the Framework to consumers and the general public to increase awareness
- Increased focus on how organisations can work together to improve the management of chronic conditions
- Improve the collaboration between state and territory governments and the federal government
- Refresh the content of the Framework to be better aligned with other state and territory, national and international policies, strategies and plans
- Refresh the content of the Framework to focus on emerging risks and issues (e.g., the use of e-cigarettes)
- Refresh the content of the Framework so it reflects the post COVID-19 health landscape
- Increased focus on the importance of lived experience in the Framework
- Greater emphasis on the needs of priority populations

Q17. In 1000 words (6000 characters) or less, please provide any additional feedback on the Framework including any other opportunities to improve the Framework.

Policy frameworks can be useful in providing overarching objectives to guide the strategies, policies and activities of stakeholders who will work to achieve them. This Framework has significant potential to help drive change, notably given the common risk factors of chronic conditions, and as a tool to focus the policy and interventions of the many stakeholders from diverse policy areas including health, housing and the environment that are needed to achieve its objectives. If positioned and promoted appropriately amongst the range of actors that should be responsible for its implementation – including, for example, government representatives working a range of different government departments, professionals from multi-disciplines and community organisations representing a range of different issues and consumers – it could help drive transformational change across the policy landscape.

However, the current Framework does not attempt to do this. Its reference to ‘Partners’ notes the ‘public and private health sectors, including all health care providers and private health insurers’ and a range of other partners but who all come from the health care system. To ensure that the Framework can guide the work of all the stakeholders required to meet its objectives, it must be clear that it is **taking a health in all policies (HIAP) approach** and that this means that **the Framework’s partners must include representatives from different policy sectors**. A HIAP approach is critical if the Framework is to be used to inform the work of all policy areas and levels of



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government and thereby better prevent chronic conditions development and exacerbation. Failing to do take this approach would reduce the potential of the Framework, and like the National Preventive Health Strategy did in relation to air quality, unhelpfully delineate people's lives into policy areas that cannot meet their needs holistically. To this end, **the Framework needs to be developed meaningfully with these necessary partners so they feel ownership of its content and energised about its implementation.** This essential step would also help ensure that the Framework is not just a means for Australia to meet its international commitment under the WHO'S Global Action Plan on noncommunicable diseases but is also a galvanising focus for action.

