VERSION 2.0

POPULATIONS

Aboriginal and Torres Strait Islander peoples

This PDF is a print-friendly reproduction of the content included in the Populations – Aboriginal and Torres Strait Islander Peoples section of the Australian Asthma Handbook at asthmahandbook.org.au/populations/indigenous-people

Please note the content of this PDF reflects the Australian Asthma Handbook at publication of Version 2.0 (March 2019). For the most up-to-date content, please visit asthmahandbook.org.au

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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>CFC</td>
<td>chlorofluorocarbon</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>COX</td>
<td>cyclo-oxygenase</td>
</tr>
<tr>
<td>DXA</td>
<td>dual-energy X-ray absorptiometry</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>EIB</td>
<td>exercise-induced bronchoconstriction</td>
</tr>
<tr>
<td>FEV₁</td>
<td>forced expiratory volume over one second</td>
</tr>
<tr>
<td>FEV₆</td>
<td>forced expiratory volume over six seconds</td>
</tr>
<tr>
<td>FSANZ</td>
<td>Food Standards Australia and New Zealand</td>
</tr>
<tr>
<td>FVC</td>
<td>forced vital capacity</td>
</tr>
<tr>
<td>GORD</td>
<td>gastro-oesophageal reflux disease</td>
</tr>
<tr>
<td>HFA</td>
<td>formulated with hydrofluoroalkane propellant</td>
</tr>
<tr>
<td>ICS</td>
<td>inhaled corticosteroid</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
</tr>
<tr>
<td>IgE</td>
<td>Immunoglobulin E</td>
</tr>
<tr>
<td>IL</td>
<td>interleukin</td>
</tr>
<tr>
<td>IU</td>
<td>international units</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>LABA</td>
<td>long-acting beta₂-adrenergic receptor agonist</td>
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<tr>
<td>LAMA</td>
<td>long-acting muscarinic antagonist</td>
</tr>
<tr>
<td>LTRA</td>
<td>leukotriene receptor antagonist</td>
</tr>
<tr>
<td>MBS</td>
<td>Medical Benefits Scheme</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NIPPV</td>
<td>non-invasive positive pressure ventilation</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>nonsteroidal anti-inflammatory drugs</td>
</tr>
<tr>
<td>OCS</td>
<td>oral corticosteroids</td>
</tr>
<tr>
<td>OSA</td>
<td>obstructive sleep apnoea</td>
</tr>
<tr>
<td>PaCO₂</td>
<td>carbon dioxide partial pressure on blood gas analysis</td>
</tr>
<tr>
<td>PaO₂</td>
<td>oxygen partial pressure on blood gas analysis</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PEF</td>
<td>peak expiratory flow</td>
</tr>
<tr>
<td>pMDI</td>
<td>pressurised metered-dose inhaler or 'puffer'</td>
</tr>
<tr>
<td>PPE</td>
<td>personal protective equipment</td>
</tr>
<tr>
<td>SABA</td>
<td>short-acting beta₂-adrenergic receptor agonist</td>
</tr>
<tr>
<td>SAMA</td>
<td>short-acting muscarinic antagonist</td>
</tr>
<tr>
<td>SaO₂</td>
<td>oxygen saturation</td>
</tr>
<tr>
<td>SpO₂</td>
<td>peripheral capillary oxygen saturation measured by pulse oximetry</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
</tbody>
</table>

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Asthma in Aboriginal and Torres Strait Islander peoples

In this section

<table>
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<tr>
<th>Cultural considerations</th>
<th>Cultural and psychosocial considerations when providing care for Aboriginal and Torres Strait Islander people</th>
</tr>
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<table>
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<tr>
<th>Diagnosis and assessment</th>
<th>Considerations for diagnosis and assessment in Aboriginal and Torres Strait Islander people</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Management</th>
<th>Caring for Aboriginal or Torres Strait Islander people, including cultural considerations and considerations for diagnosis, assessment and management</th>
</tr>
</thead>
</table>
Recommendations

Health professionals should ensure that they and their staff have information and training on how to provide culturally secure care to Aboriginal and Torres Strait Islander people.

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available).

Where appropriate and possible, work with an interpreter who speaks the person's first language.

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available).

More information

Culturally secure asthma care for Aboriginal and Torres Strait Islander people
Primary care services can aim to deliver healthcare that is culturally secure. However, only the Aboriginal or Torres Strait Islander person themselves can determine whether their care is culturally safe or respectful. Making the healthcare system a secure environment for Aboriginal and Torres Strait Islander peoples involves cultural respect, which involves not only respecting cultural difference but recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples. Cultural awareness (or ‘cultural sensitivity’) among individual health professionals involves sensitivity to the similarities and differences between different cultures to enable effective communication with members of another cultural group. Training in cultural awareness and ‘cultural safety’ is available for non-Indigenous health professionals who provide healthcare for Aboriginal and Torres Strait Islander people. An education program (three sessions) conducted by Aboriginal and Torres Strait Islander health workers in primary health care in the Torres Strait region reduced the number of school days missed due to wheezing among school-aged children, and increased carers’ knowledge of asthma, the contents of the child’s written asthma action plan, and where the written asthma action plan was kept. However, it did not reduce the rate of asthma flare-ups, compared with children whose families did not participate. Aboriginal and Torres Strait Islander health workers and practitioners can provide health care services that are reimbursable through

Involvement of Aboriginal and/or Torres Strait Islander health workers and health practitioners in asthma care
Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners can provide self-management education for people with asthma and parents of children with asthma. Culture-specific programs may be more appropriate than mainstream programs for Aboriginal and Torres Strait Islander people. An education program (three sessions) conducted by Aboriginal and Torres Strait Islander health workers in primary health care in the Torres Strait region reduced the number of school days missed due to wheezing among school-aged children, and increased carers’ knowledge of asthma, the contents of the child’s written asthma action plan, and where the written asthma action plan was kept. However, it did not reduce the rate of asthma flare-ups, compared with children whose families did not participate. Aboriginal and Torres Strait Islander health workers and practitioners can provide health care services that are reimbursable through
References


Diagnosing and assessing asthma in Aboriginal and Torres Strait Islander people

Recommendations

Ask all patients whether they smoke or are exposed to other people's tobacco smoke.

How this recommendation was developed
Adapted from existing guidance
Based on reliable clinical practice guideline(s) or position statement(s):
- Zwar et al. 2011

For all Aboriginal and Torres Strait Islander adults and children, take a comprehensive respiratory health history.

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available), with particular reference to the following source(s):
- Chang et al. 2010

For Aboriginal and Torres Strait Islander children and adults, routinely ask about coughing (frequency and type), and carefully observe for cough, even if parents or carers do not mention cough.

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available), with particular reference to the following source(s):
- Morey et al. 2013

When cough is present (especially wet or productive cough), consider the possibility of other chronic lung disease (e.g. bronchiectasis, chronic suppurative lung disease and COPD) as an alternative or coexisting diagnosis in Aboriginal and Torres Strait Islander adults and children with respiratory symptoms.

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available), with particular reference to the following source(s):
- Chang et al. 2003
- Chang et al. 2008
- Chang et al. 2012
- Craven and Everard, 2013
In Aboriginal and Torres Strait Islander adults in whom bronchiectasis cannot be ruled out, arrange high-resolution computed tomography and offer referral to a specialist if possible.

How this recommendation was developed
Adapted from existing guidance
Based on reliable clinical practice guideline(s) or position statement(s):
• Chang et al. 2008

In children with symptoms and signs that suggest chronic suppurative lung disease, offer referral to a specialist if possible.

How this recommendation was developed
Adapted from existing guidance
Based on reliable clinical practice guideline(s) or position statement(s):
• Chang et al. 2008

Consider and investigate any other comorbid conditions (e.g. diabetes, cardiovascular disease, kidney disease, ear problems).

How this recommendation was developed
Consensus
Based on clinical experience and expert opinion (informed by evidence, where available), with particular reference to the following source(s):
• Australian Institute of Health and Welfare, 2013

Include a thorough respiratory check-up when performing a Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715).

Go to: National Aboriginal Community Controlled Health Organisation and Royal Australian College of General Practitioners’ National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people

How this recommendation was developed
Adapted from existing guidance
Based on reliable clinical practice guideline(s) or position statement(s):
• National Aboriginal Community Controlled Health Organisation and Royal Australian College of General Practitioners, 2012

More information

Culturally secure asthma care for Aboriginal and Torres Strait Islander people
Primary care services can aim to deliver healthcare that is culturally secure. However, only the Aboriginal or Torres Strait Islander person themselves can determine whether their care is culturally safe or respectful.

Making the healthcare system a secure environment for Aboriginal and Torres Strait Islander peoples involves cultural respect, which involves not only respecting cultural difference but recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples.

Cultural awareness (or ‘cultural sensitivity’) among individual health professionals involves sensitivity to the similarities and differences between different cultures to enable effective communication with members of another cultural group.

Training in cultural awareness and ‘cultural safety’ is available for non-Indigenous health professionals who provide healthcare for...
Aboriginal and Torres Strait Islander people.

Go to: Australian College of Rural and Remote Medicine’s Cultural awareness module for PIP Indigenous Health Incentive
Go to: RACGP’s Cultural awareness and cultural safety training

**Involvement of Aboriginal and/or Torres Strait Islander health workers and health practitioners in asthma care**

Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners can provide self-management education for people with asthma and parents of children with asthma. Culture-specific programs may be more appropriate than mainstream programs for Aboriginal and Torres Strait Islander people.\(^{13}\)

An education program (three sessions) conducted by Aboriginal and Torres Strait Islander health workers in primary health care in the Torres Strait region reduced the number of school days missed due to wheezing among school-aged children, and increased carers’ knowledge of asthma, the contents of the child’s written asthma action plan, and where the written asthma action plan was kept.\(^{14}\) However, it did not reduce the rate of asthma flare-ups, compared with children whose families did not participate.\(^{14}\)

Aboriginal and Torres Strait Islander health workers and practitioners can provide health care services that are reimbursable through Medicare.\(^{15, 16}\)

**Asthma prevalence in Aboriginal and Torres Strait Islander people**

Asthma prevalence is higher among Aboriginal and Torres Strait Islander people than non-Indigenous Australians, based on the findings of various surveys.\(^{8, 17, 18, 19}\)

Based on data from the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey and the Australian Centre for Asthma Monitoring:

- The estimated overall asthma prevalence in Aboriginal and Torres Strait Islander people is 16.5%, compared with 10.2% among non-Indigenous Australians.\(^{19}\)
- The estimated asthma prevalence in Aboriginal and Torres Strait Islander adults (aged 18 years and over) is 17.5%, compared with 9.8% among non-Indigenous adults.\(^{19}\)
- The estimated asthma prevalence rates are similar in Aboriginal and Torres Strait Islander children (13.5%) and non-Indigenous children (11.2%).\(^{19}\)

Fewer Aboriginal and Torres Strait Islander people living in remote areas (9%) report that they have asthma than those living in non-remote areas (17%).\(^{17}\) Torres Strait Islander people living in the Torres Strait Island region report a relatively low prevalence of asthma (5%).\(^{17}\)

The rate of hospitalisation for asthma is approximately twice as high among Aboriginal and Torres Strait Islander people, compared with other Australians.\(^{20}\)

**Risk factors for asthma in Aboriginal and Torres Strait Islander people**

Compared with the whole Australian population, Aboriginal and Torres Strait Islander people have higher rates of some risk factors for developing asthma or for poor asthma control.

See: [Primary prevention of asthma](#)
See: [Preventive healthcare in people with asthma](#)

**Smoking and smoke**

Rates of tobacco smoking are high among Aboriginal and Torres Strait Islander people.\(^{8, 21, 22, 23}\)

- Approximately 45% of Aboriginal and Torres Strait Islander people aged 15 years and over smoke daily (more than twice the rate among non-Indigenous Australians).
- Approximately half of Aboriginal and Torres Strait Islander mothers smoked during pregnancy (3.7 times the rate among non-Indigenous mothers).
- Approximately 65% of Aboriginal and Torres Strait Islander children live households with someone who smokes daily (approximately twice the rate among non-Indigenous children).

See: [Smoking and asthma](#)

Many Aboriginal people are also frequently exposed to smoke from outdoor vegetation fires and cooking fires, particularly in remote regions.

**Allergies**
Limited available data suggest that sensitisation to house dust mite is increasing among rural and remote Aboriginal communities, correlating with adoption of urban lifestyles.\(^{24}\)

Factors contributing to an increase in allergic disease may include dietary changes and reductions in parasitic infestation and exposure to some bacteria.\(^{24}\)

► See: [Allergies and asthma](#)

### Dietary factors

Low fruit and vegetables intakes are more common among Aboriginal and Torres Strait Islander people than non-Indigenous Australians.\(^{8}\)

Increasing intake of pro-inflammatory fats and low intake of antioxidant-rich fruits and vegetables may be contributing to an increase in allergic asthma among Aboriginal and Torres Strait Islander people.\(^{24}\)

► See: [Healthy eating for asthma](#)

### Obesity

The rate of obesity among Aboriginal and Torres Strait Islander adults (approximately 34%) is almost twice the rate in non-Indigenous adults (approximately 18%).\(^{8}\)

Among Aboriginal and Torres Strait Islander people aged 18 years and over living in non-remote areas, rates of overweight and obesity increased between 1995 (51%) and 2004–05 (60%).\(^{8}\)

► See: [Obesity and asthma](#)

### Socioeconomic risk factors

Traditional markers of socioeconomic status (e.g. education, income and employment status) are not strongly associated with asthma risk among Aboriginal and Torres Strait Islander peoples,\(^{18}\) unlike the associations between socioeconomic status and asthma risk in non-Indigenous Australians, and the risk of other chronic diseases such as diabetes and kidney disease in Aboriginal and Torres Strait Islander people.\(^{18}\)

In the 2000–2002 Western Australian Aboriginal Child Health Survey, Aboriginal children aged 0–17 years living in areas with highest socioeconomic status were more than nine times more likely to have ever had asthma than those living in the lowest socioeconomic status areas.\(^{25}\) However, when socioeconomic status was measured by parental, family and household indicators rather than by area, it was less strongly association with asthma.\(^{25}\)

### Respiratory disease in Aboriginal and Torres Strait Islander peoples

Morbidity and mortality from respiratory diseases among Aboriginal and Torres Strait Islander people is higher than among non-Indigenous Australians across all age groups and regions.\(^{26}\) Among Aboriginal and Torres Strait Islander people living in remote areas, the rate of hospitalisation for respiratory disease is approximately three times the rate among Aboriginal and Torres Strait Islander people living in major cities.\(^{17}\) However, from 1997 to 2010 there was a 39% reduction in deaths due to respiratory disease among Aboriginal and Torres Strait Islander people.\(^{8}\)

Detection, diagnosis and management of asthma may be complicated by increased rate of respiratory infections and chronic lung disease in rural remote Aboriginal and Torres Strait Islander communities.

- Approximately 30% of Aboriginal and Torres Strait Islander people report respiratory problems.\(^{5}\)
- Chronic cough in Aboriginal and Torres Strait Islander children may be under-reported because it is so common that is considered normal by parents and caregivers.\(^{3}\)
- Pneumonia and COPD are the most common causes of hospitalisation for respiratory disease among Aboriginal and Torres Strait Islander people.\(^{17}\) The prevalence of COPD among Aboriginal and Torres Strait Islander people cannot be accurately estimated.\(^{27}\) Aboriginal and Torres Strait Islander people are more than 2.5 times more likely than non-indigenous Australians to die from chronic lower respiratory disease (includes asthma, bronchitis, bronchiectasis, emphysema, and other COPD).\(^{28}\)
- The prevalence of bronchiectasis is disproportionately high in remote Aboriginal communities, particularly in Central Australia, but is underdiagnosed.\(^{5, 4}\) High-resolution computed tomography of the chest is necessary to diagnose bronchiectasis in adults.\(^{5}\) In Aboriginal and Torres Strait Islander adults, it may be difficult to distinguish between asthma, COPD and bronchiectasis.\(^{27}\)
- Bronchiectasis is associated with relatively rapid decline in lung function.\(^{5}\)
- Chronic suppurative lung disease is highly prevalent among Aboriginal and Torres Strait Islander children in remote communities.\(^{5}\) The diagnosis of chronic suppurative lung disease is made in children who have symptoms and signs of bronchiectasis without radiographic features of bronchiectasis.\(^{5}\) In Aboriginal and Torres Strait Islander children, it may be difficult to distinguish between asthma and bronchiectasis or chronic suppurative lung disease.\(^{27}\)
- Protracted bacterial bronchitis is often misdiagnosed as asthma,\(^{7, 29}\) but can also co-occur with asthma.\(^{29}\) Protracted bacterial
Bronchitis might precede chronic suppurative lung disease, but this is not yet well understood. Inadequate treatment of protracted bacterial bronchitis might put Aboriginal and Torres Strait Islander children at risk for chronic suppurative lung disease. Recurrent episodes of protracted bacterial bronchitis that does not resolve after treatment (e.g. a 14-day course of antibiotics) require investigation for chronic suppurative lung disease, bronchiectasis and aspiration.

Notes
† Chronic suppurative lung disease is defined as a clinical syndrome of respiratory symptoms and signs due to chronic endobronchial suppuration, including continuous, wet or productive cough > 8 weeks, with or without other features (e.g. exertional dyspnoea, symptoms of reactive airway disease, recurrent chest infections, growth failure, clubbing, hyperinflation or chest wall deformity).
‡ Bronchiectasis is diagnosed in patients with both chronic suppurative lung disease and the presence of radiological features on a chest high-resolution computed tomography scan.

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Non-respiratory comorbidity among Aboriginal and Torres Strait Islander peoples
Aboriginal and Torres Strait Islander peoples have a high burden of chronic diseases that may affect asthma control and management, including:
- diabetes
- cardiovascular disease
- kidney disease
- ear disease
- mental health problems.

Australian government health initiatives for Aboriginal and Torres Strait Islander people
Asthma Spacer Ordering System
The Asthma Spacer Ordering System provides Aboriginal and Torres Strait Islander health services with access to low cost asthma spacers for their clients.

Health Assessment Medicare items
The MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) reimburses health professionals for health assessments for (any of): Aboriginal and Torres Strait Islander children (< 15 years), Aboriginal and Torres Strait Islander adults (≥ 15 years and < 55 years), Aboriginal and Torres Strait Islander older people (≥ 55 years).

This item is linked to follow-on item numbers to support follow-up care by allied health professionals and Aboriginal/Torres Strait health workers and practitioners to manage asthma and comorbid conditions.

The Indigenous Chronic Disease Package
The Indigenous Chronic Disease Package provides a range of supports to Aboriginal and Torres Strait Islander people with chronic disease or at risk of chronic disease. The package includes:
- subsidy of PBS medicines (reduced copayments for Aboriginal and Torres Strait Islander people with chronic disease)
- orientation and training for Aboriginal and Torres Strait Islander Outreach Workers in Aboriginal community-controlled general practices
- professional development scholarships and clinical placement scholarships for nurses working in Community Controlled Aboriginal/Torres Strait Island Health Services
- general practitioner registrar training posts for Aboriginal Medical Services
- Practice Incentives Program Indigenous Health Incentive to support general practices and Indigenous health services to provide...
care for people with chronic disease
- increased access to specialist medical and allied health care
- GPs can access these services to overcome barriers to health care for Aboriginal and Torres Strait Islander people.

Go to: [Closing the Gap Indigenous Chronic Disease Package](#)

### National immunisation program

Additional vaccinations are recommended and reimbursed for Aboriginal and Torres Strait Islander people. Refer to national guidelines.

Go to: [Australian Immunisation Handbook](#)

### Other resources

Go to: Australian College of Nursing’s [Australian Government scholarships](#) web page
Go to: [General Practice Education and Training Limited](#)

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**Asthma–COPD overlap**

Distinguishing between typical allergic asthma (childhood-onset allergic asthma) and typical COPD (emphysema in a heavy smoker) is straightforward. However, it can be difficult to distinguish COPD from asthma in adults who have features of both conditions. These people are described as having asthma–COPD overlap.

Asthma–COPD overlap is not a single, well-defined disease entity, but includes a range of airway disease phenotypes with different causal mechanisms.

- people with current asthma (allergic or non-allergic) who have had significant exposure to tobacco smoke
- people with longstanding asthma or late-onset asthma who have become persistently short of breath over time
- people significant smoking history and symptoms consistent with COPD who also have a history of childhood asthma
- people who present in middle age or later with shortness of breath, with a history of childhood asthma but no or few symptoms in between, and little smoking history.

**Figure. Development of asthma, COPD and asthma–COPD overlap**


People with asthma–COPD overlap often have poor disease outcomes, including:

- high need for healthcare services
- worse quality of life, more wheezing, dyspnoea, cough and sputum production, and more frequent and severe respiratory exacerbations and hospitalisations, than people with COPD or asthma alone
- worse lung function demonstrated by spirometry than those with COPD alone, despite lower average exposure to tobacco smoke.

**Features of asthma, COPD and asthma–COPD overlap**

If several features of both asthma and COPD are present and neither condition is strongly favoured, respiratory disease should be managed according to recommendations for asthma–COPD overlap.

<table>
<thead>
<tr>
<th>Clinical feature (if measured/relevant)</th>
<th>Asthma more likely</th>
<th>COPD more likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of onset</td>
<td>Before 20</td>
<td>After 40</td>
</tr>
<tr>
<td><strong>Pattern of symptoms</strong></td>
<td>Variation in respiratory symptoms:</td>
<td>Persistence of respiratory symptoms despite treatment</td>
</tr>
<tr>
<td></td>
<td>- changes over minutes, hours or days</td>
<td>Symptoms every day, including exertional dyspnoea</td>
</tr>
<tr>
<td></td>
<td>- worse at night or early morning</td>
<td>History of chronic cough and sputum</td>
</tr>
<tr>
<td></td>
<td>- triggered by exercise, emotions,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>airborne pollutants or allergens</td>
<td></td>
</tr>
<tr>
<td>Clinical feature (if measured/relevant)</td>
<td>Asthma more likely</td>
<td>COPD more likely</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unrelated to specific triggers, before onset of dyspnoea</td>
</tr>
<tr>
<td><strong>Lung function</strong></td>
<td>Expiratory airflow limitation* is variable#</td>
<td>Expiratory airflow limitation* is persistent†</td>
</tr>
<tr>
<td></td>
<td>Lung function normal between symptoms</td>
<td>Lung function abnormal between symptoms</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td>Previous diagnosis of asthma</td>
<td>Previous diagnosis of COPD, chronic bronchitis or emphysema</td>
</tr>
<tr>
<td></td>
<td>Family history of asthma and allergies§</td>
<td>Heavy exposure to tobacco smoke or biomass fuels</td>
</tr>
<tr>
<td></td>
<td>(allergic rhinitis or eczema)</td>
<td></td>
</tr>
<tr>
<td><strong>Long-term disease trajectory</strong></td>
<td>Seasonal or yearly variation in symptoms</td>
<td>Slowly worsens over years</td>
</tr>
<tr>
<td></td>
<td>Improvements (spontaneously or in response to medication) last for weeks</td>
<td>Relief in response to medication is limited and short term</td>
</tr>
<tr>
<td><strong>Chest X-ray</strong></td>
<td>Normal</td>
<td>Severe hyperinflation‡</td>
</tr>
</tbody>
</table>

Features that, when present, increase the probability of either typical asthma or typical COPD. None of these features is essential to make the diagnosis of asthma or COPD, with the exception of persistent airflow limitation for making the diagnosis of COPD.

* Expiratory airflow limitation: indicated by a reduced ratio of forced expiratory volume in one second (FEV₁) to forced vital capacity (FVC) on spirometry (FEV₁/FVC less than the lower limit of normal (i.e. less than the 5th percentile of normal population). Typical FEV₁/FVC values derived from population studies are > 0.75 in people aged 40–59 years and > 0.70 in people aged 60–80 years.

# Variable expiratory airflow limitation: variation beyond the range seen in healthy populations. It is indicated in adults by any of the following:

- a clinically important increase in FEV₁ (change in FEV₁ of at least 200 mL and 12% from baseline) 10–15 minutes after administration of bronchodilator
- clinically important variation in lung function (at least 20% change in FEV₁) when measured repeatedly over time (e.g. spirometry on separate visits)
- a clinically important increase in lung function (at least 200 mL and 12% from baseline) after ≥ 4 weeks’ treatment trial with an ICS
- clinically important variation in peak expiratory flow (diurnal variability of more than 10%, calculated over 1–2 weeks as the average of daily amplitude per cent mean)
- a clinically important reduction in lung function (decrease in FEV₁ of at least 200 mL and 12% from baseline on spirometry, or decrease in peak expiratory flow rate by at least 20%) after exercise (formal laboratory-based exercise challenge testing uses different criteria for exercise-induced bronchoconstriction)
- a clinically important reduction in lung function (15–20%, depending on the test) during a test for airway hyperresponsiveness (exercise challenge test or bronchial provocation test) measured by a respiratory function laboratory.

The greater the variations, or the more occasions excess variation is seen, the more confidently the diagnosis of variable expiratory airflow limitation consistent with asthma can be made.

† Persistent expiratory airflow limitation is indicated by reduced post-bronchodilator FEV₁/FVC*

§ Lack of history of atopy does not exclude non-allergic asthma.

‡ Chest X-ray may be normal in a patient with COPD

* Adapted from Global Initiative for Asthma, Global Initiative for Obstructive Lung Disease. Diagnosis and initial treatment of asthma, COPD and asthma-COPD overlap. Updated April 2017. Global Initiative for Asthma and Global Initiative for Obstructive Lung Disease; 2017.
# Table. Spirometry findings in asthma, COPD and asthma–COPD overlap

<table>
<thead>
<tr>
<th>Finding</th>
<th>Consistent with</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td><strong>COPD</strong></td>
</tr>
<tr>
<td>Normal FEV₁/FVC before of after bronchodilator</td>
<td>Yes</td>
</tr>
<tr>
<td>Abnormal lung function</td>
<td>Yes #</td>
</tr>
<tr>
<td>(post-bronchodilator reduced FEV₁/FVC and FEV₁ &lt; lower limit of normal)</td>
<td></td>
</tr>
<tr>
<td>Airflow limitation with greater bronchodilator reversibility than in healthy population (post-bronchodilator FEV₁ increase ≥ 12% and 200mL from baseline)</td>
<td>Yes ‡</td>
</tr>
<tr>
<td>Marked bronchodilator reversibility (FEV₁ increase ≥ 12% and 400mL from baseline)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**FEV₁/FVC:** ratio of forced expiratory volume in one second (FEV₁) to forced vital capacity (FVC), either before or after bronchodilator

* Normal FEV₁/FVC is not consistent with COPD unless there is other evidence of chronic non-reversible expiratory airflow limitation.

# This finding is consistent with asthma that is poorly controlled or measured during a flare-up, or can be seen in some patients with longstanding asthma.

‡ The greater the variation, and the more times variation is seen, the more likely the diagnosis of asthma. However, some patients with longstanding asthma may develop persistent airflow limitation.

† Marked reversibility strongly favours asthma and is generally inconsistent with COPD, but does not rule out asthma–COPD overlap.

§ This finding may be seen in patients with asthma–COPD overlap, or occasionally in COPD, especially when FEV₁ is low.

**Sources**


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**Treatment for patients with asthma–COPD overlap**

Inhaled corticosteroid treatment at low–moderate doses is essential to reduce the risk of potentially life-threatening flare-ups, even if...
asthma symptoms appear mild or infrequent.32, 43
Most patients also need treatment with a long-acting bronchodilator (either long-acting beta2 agonist or long-acting muscarinic antagonist) in addition to an inhaled corticosteroid. Long-acting beta2 agonists and long-acting muscarinic antagonists should not be used by people with asthma or asthma–COPD overlap unless they are also taking an inhaled corticosteroid (either in combination or separately).

Table. Long-acting bronchodilators for asthma–COPD overlap

<table>
<thead>
<tr>
<th>Class</th>
<th>Dosing frequency</th>
<th>Agent</th>
<th>Brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS–LABA combinations</td>
<td></td>
<td>Fluticasone furoate + vilanterol</td>
<td>Breo Ellipta 100/25 microg†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Do not prescribe 200/25 microg formulation#</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td>Budesonide + formoterol</td>
<td>Symbicort Rapihaler</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Fluticasone propionate + formoterol</td>
<td>Symbicort Turbuhaler</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Fluticasone propionate + salmeterol</td>
<td>Fluticasone and Salmeterol Cipla</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td></td>
<td>Seretide Accuhaler</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Seretide MDI</td>
</tr>
<tr>
<td>LABAs*</td>
<td></td>
<td>Indacaterol</td>
<td>Onbrez Breezhaler</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Formoterol</td>
<td>Oxis</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Salmeterol</td>
<td>Foradile</td>
</tr>
<tr>
<td>LAMAs*</td>
<td></td>
<td>Glycopyrronium</td>
<td>Seebri Breezhaler</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td>Tiotropium</td>
<td>Spiriva</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td></td>
<td>Spiriva Respimat</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td>Umeclidinium</td>
<td>Incruse Ellipta†</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Aclidinium</td>
<td>Bretaris Genuair</td>
</tr>
<tr>
<td>LABA–LAMA combinations*</td>
<td></td>
<td>Indacaterol + glycopyrronium</td>
<td>Ultibro Breezhaler</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td>Olodaterol + tiotropium</td>
<td>Spiolto Respimat</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td>Vilanterol + umeclidinium</td>
<td>Anoro Ellipta†</td>
</tr>
<tr>
<td>Class</td>
<td>Dosing frequency</td>
<td>Agent</td>
<td>Brand name</td>
</tr>
<tr>
<td>-------</td>
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<td>------------</td>
</tr>
<tr>
<td></td>
<td>Twice daily</td>
<td>Formoterol + aclidinium</td>
<td>Brimica Genuair</td>
</tr>
</tbody>
</table>

- * Ensure that patient is also using regular long-term ICS. LABAs and LAMAs should not be used by people with asthma or asthma–COPD overlap unless they are also taking an ICS, in combination or separately.

- Advise patients/carers that inhalers should be stored below 30°C and should not be left in cars.

† The inhaler must be discarded 1 month after opening the package and removing device from tray. When first opened, patients should write the discard date on the label in the space provided. If stored in the refrigerator, inhaler should be taken out and allowed to return to room temperature for at least an hour before use.

‡ The inhaler must be discarded 6 weeks after opening after removing device from tray. When first opened, patients should write the discard date on the label in the space provided. If stored in the refrigerator, inhaler should be taken out and allowed to return to room temperature for at least an hour before use.

# Only the 100/25 microg dose of fluticasone furoate/vilanterol is TGA-approved for treatment of COPD. The higher dose (200/25 microg) is not TGA-approved for the treatment of COPD, so it should not be used in people with asthma–COPD overlap.

High doses of ICS (alone or in combination) are not recommended in patients with COPD and should therefore be used with caution in patients with asthma-COPD overlap, because of the risk of pneumonia.

Refer to PBS status before prescribing.

Management should also include smoking cessation, treatment of comorbid conditions, physical activity, pulmonary rehabilitation, vaccinations, self-management (including a regularly updated action plan) and regular follow-up.32

Go to: Asthma action plans
Go to: COPD action plans

Respiratory tract infections should be monitored carefully because people with asthma–COPD overlap have high morbidity rates and because ICS treatment is associated with increased risk of non-fatal pneumonia in people with COPD.44 Most of the available evidence is from patients treated with fluticasone propionate, particularly at higher doses. Increased pneumonia rates have also been observed in studies of patients with COPD using fluticasone furoate/vilanterol. The higher dose of fluticasone furoate/vilanterol (Breo Ellipta 200/25 microg) is not approved for patients with COPD, so it should also not be used in patients with asthma–COPD overlap.

Specialist referral should be considered for patients with atypical symptoms or symptoms that suggest an alternative diagnosis, persistent symptoms or flare-ups despite treatment, or complex comorbidities.

Go to: National Asthma Council Australia's Asthma–COPD overlap information paper

For information on diagnosis and management of COPD, refer to the COPD-X Concise Guide for Primary Care.45

Go to: Lung Foundation Australia’s COPD-X Concise Guide for Primary Care

References


34. Gibson PG, Simpson JS. The overlap syndrome of asthma and COPD: what are its features and how important is it?. Thorax. 2009; 64: 728-735. Available from: http://thorax.bmj.com/content/64/8/728.full


Managing asthma in Aboriginal and Torres Strait Islander people

Recommendations

Consider whether the person has any comorbid conditions that may affect asthma management or be affected by asthma medicines.

*How this recommendation was developed*

Consensus

Based on clinical experience and expert opinion (informed by evidence, where available).

Consider using and providing asthma self-management resources that have been designed specifically for Aboriginal and Torres Strait Islander people, where appropriate.

*How this recommendation was developed*

Consensus

Based on clinical experience and expert opinion (informed by evidence, where available).

Keep influenza and pneumococcal vaccination up to date, following immunisation guidelines for Aboriginal and Torres Strait Islander children and adults.

Go to: The Australian Immunisation Handbook

*How this recommendation was developed*

Consensus

Based on reliable clinical guidance:


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Provide a written asthma action plan that is culturally appropriate for each patient.

*How this recommendation was developed*

Consensus

Based on clinical experience and expert opinion (informed by evidence, where available).

Where possible, involve Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners in Team Care Arrangements and Multidisciplinary Care Plans.

*How this recommendation was developed*

Consensus

Based on clinical experience and expert opinion (informed by evidence, where available).
Culturally secure asthma care for Aboriginal and Torres Strait Islander people

Primary care services can aim to deliver healthcare that is culturally secure. However, only the Aboriginal or Torres Strait Islander person themselves can determine whether their care is culturally safe or respectful. Making the healthcare system a secure environment for Aboriginal and Torres Strait Islander peoples involves cultural respect, which involves not only respecting cultural difference but recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples. Cultural awareness (or ‘cultural sensitivity’) among individual health professionals involves sensitivity to the similarities and differences between different cultures to enable effective communication with members of another cultural group.

Training in cultural awareness and ‘cultural safety’ is available for non-Indigenous health professionals who provide healthcare for Aboriginal and Torres Strait Islander people. Go to: Australian College of Rural and Remote Medicine’s [Cultural awareness module for PIP Indigenous Health Incentive](#)

Go to: RACGP’s [Cultural awareness and cultural safety training](#)

Involvement of Aboriginal and/or Torres Strait Islander health workers and health practitioners in asthma care

Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners can provide self-management education for people with asthma and parents of children with asthma. Culture-specific programs may be more appropriate than mainstream programs for Aboriginal and Torres Strait Islander people.

An education program (three sessions) conducted by Aboriginal and Torres Strait Islander health workers in primary health care in the Torres Strait region reduced the number of school days missed due to wheezing among school-aged children, and increased carers’ knowledge of asthma, the contents of the child’s written asthma action plan, and where the written asthma action plan was kept. However, it did not reduce the rate of asthma flare-ups, compared with children whose families did not participate.

Aboriginal and Torres Strait Islander health workers and practitioners can provide health care services that are reimbursable through Medicare.

Risk factors for asthma in Aboriginal and Torres Strait Islander people

Compared with the whole Australian population, Aboriginal and Torres Strait Islander people have higher rates of some risk factors for developing asthma or for poor asthma control.

See: [Primary prevention of asthma](#)

See: [Preventive healthcare in people with asthma](#)

Smoking and smoke

Rates of tobacco smoking are high among Aboriginal and Torres Strait Islander people. Approximately 45% of Aboriginal and Torres Strait Islander people aged 15 years and over smoke daily (more than twice the rate among non-Indigenous Australians).

Approximately half of Aboriginal and Torres Strait Islander mothers smoked during pregnancy (3.7 times the rate among non-Indigenous mothers).

Approximately 65% of Aboriginal and Torres Strait Islander children live households with someone who smokes daily (approximately twice the rate among non-Indigenous children).

See: [Smoking and asthma](#)

Many Aboriginal people are also frequently exposed to smoke from outdoor vegetation fires and cooking fires, particularly in remote regions.

Allergies

Limited available data suggest that sensitisation to house dust mite is increasing among rural and remote Aboriginal communities, correlating with adoption of urban lifestyles.

Factors contributing to an increase in allergic disease may include dietary changes and reductions in parasitic infestation and exposure to some bacteria.

See: [Allergies and asthma](#)
Dietary factors

Low fruit and vegetables intakes are more common among Aboriginal and Torres Strait Islander people than non-Indigenous Australians.\(^9\)

Increasing intake of pro-inflammatory fats and low intake of antioxidant-rich fruits and vegetables may be contributing to an increase in allergic asthma among Aboriginal and Torres Strait Islander people.\(^{13}\)

► See: [Healthy eating for asthma](#)

Obesity

The rate of obesity among Aboriginal and Torres Strait Islander adults (approximately 34%) is almost twice the rate in non-Indigenous adults (approximately 18%).\(^9\)

Among Aboriginal and Torres Strait Islander people aged 18 years and over living in non-remote areas, rates of overweight and obesity increased between 1995 (51%) and 2004–05 (60%).\(^9\)

► See: [Obesity and asthma](#)

Socioeconomic risk factors

Traditional markers of socioeconomic status (e.g. education, income and employment status) are not strongly associated with asthma risk among Aboriginal and Torres Strait Islander peoples,\(^{14}\) unlike the associations between socioeconomic status and asthma risk in non-Indigenous Australians, and the risk of other chronic diseases such as diabetes and kidney disease in Aboriginal and Torres Strait Islander people.\(^{14}\)

In the 2000–2002 Western Australian Aboriginal Child Health Survey, Aboriginal children aged 0–17 years living in areas with highest socioeconomic status were more than nine times more likely to have ever had asthma than those living in the lowest socioeconomic status areas.\(^{15}\) However, when socioeconomic status was measured by parental, family and household indicators rather than by area, it was less strongly association with asthma.\(^{15}\)

Asthma morbidity and mortality in Aboriginal and Torres Strait Islander people

Among Australians aged 5 years and over, the rate of hospitalisation due to asthma is higher for Aboriginal and Torres Strait Islander people than non-Indigenous people.\(^{16}\)

Among Aboriginal and Torres Strait Islander people, asthma is the reason for approximately 11% of all hospitalisations.\(^9\)

The rate of deaths due to asthma is approximately 2.5 times higher among Aboriginal and Torres Strait Islander people than non-Indigenous Australians.\(^{16}\)

Respiratory disease in Aboriginal and Torres Strait Islander peoples

Morbidity and mortality from respiratory diseases among Aboriginal and Torres Strait Islander people is higher than among non-Indigenous Australians across all age groups and regions.\(^{17}\)

Detection, diagnosis and management of asthma may be complicated by increased rate of respiratory infections and chronic lung disease in rural remote Aboriginal and Torres Strait Islander communities.

- Approximately 30% of Aboriginal and Torres Strait Islander people report respiratory problems.\(^{19}\)
- Chronic cough in Aboriginal and Torres Strait Islander children may be under-reported because it is so common that it is considered normal by parents and caregivers.\(^{20}\)
- Pneumonia and COPD are the most common causes of hospitalisation for respiratory disease among Aboriginal and Torres Strait Islander people.\(^{18}\) The prevalence of COPD among Aboriginal and Torres Strait Islander people cannot be accurately estimated.\(^{21}\)
- Aboriginal and Torres Straight Islander people are more than 2.5 times more likely than non-indigenous Australians to die from chronic lower respiratory disease (includes asthma, bronchitis, bronchiectasis, emphysema, and other COPD).\(^{22}\)
- The prevalence of bronchiectasis is disproportionately high in remote Aboriginal communities, particularly in Central Australia, but is underdiagnosed.\(^{19, 23}\) High-resolution computed tomography of the chest is necessary to diagnose bronchiectasis in adults.\(^{19}\)
- In Aboriginal and Torres Strait Islander adults, it may be difficult to distinguish between asthma, COPD and bronchiectasis.\(^{21}\)
- Bronchiectasis is associated with relatively rapid decline in lung function.\(^{19}\)
- Chronic suppurative lung disease is highly prevalent among Aboriginal and Torres Strait Islander children in remote communities.\(^{19}\)
- The diagnosis of chronic suppurative lung disease is made in children who have symptoms and signs of bronchiectasis without radiographic features of bronchiectasis.\(^{19}\)
- In Aboriginal and Torres Strait Islander children, it may be difficult to distinguish between
asthma and bronchiectasis or chronic suppurative lung disease. Protracted bacterial bronchitis is often misdiagnosed as asthma, but can also co-occur with asthma. Protracted bacterial bronchitis might precede chronic suppurative lung disease, but this is not yet well understood. Inadequate treatment of protracted bacterial bronchitis might put Aboriginal and Torres Strait Islander children at risk for chronic suppurative lung disease. Recurrent episodes of protracted bacterial bronchitis that does not resolve after treatment (e.g. a 14-day course of antibiotics) require investigation for chronic suppurative lung disease, bronchiectasis and aspiration.

Notes
† Chronic suppurative lung disease is defined as a clinical syndrome of respiratory symptoms and signs due to chronic endobronchial suppuration, including continuous, wet or productive cough > 8 weeks, with or without other features (e.g. exertional dyspnoea, symptoms of reactive airway disease, recurrent chest infections, growth failure, clubbing, hyperinflation or chest wall deformity). Bronchiectasis is diagnosed in patients with both chronic suppurative lung disease and the presence of radiological features on a chest high-resolution computed tomography scan.

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Non-respiratory comorbidity among Aboriginal and Torres Strait Islander peoples
Aboriginal and Torres Strait Islander peoples have a high burden of chronic diseases that may affect asthma control and management, including:

- diabetes
- cardiovascular disease
- kidney disease
- ear disease
- mental health problems.

See: Comorbid conditions and asthma

Written asthma action plans for adults
Every person with asthma should have their own written asthma action plan.

When provided with appropriate self-management education, self-monitoring and medical review, individualised written action plans consistently improve asthma health outcomes if they include two to four action points, and provide instructions for use of both inhaled corticosteroid and oral corticosteroids for treatment of flare-ups. Written asthma action plans are effective if based on symptoms or personal best peak expiratory flow (not on percentage predicted).

How to develop and review a written asthma action plan
A written asthma action plan should include all the following:

- a list of the person’s usual medicines (names of medicines, doses, when to take each dose) – including treatment for related conditions such as allergic rhinitis
- clear instructions on how to change medication (including when and how to start a course of oral corticosteroids) in all the following situations:
  - when asthma is getting worse (e.g. when needing more reliever than usual, waking up with asthma, more symptoms than usual, asthma is interfering with usual activities)
  - when asthma symptoms get substantially worse (e.g. when needing reliever again within 3 hours, experiencing increasing difficulty breathing, waking often at night with asthma symptoms)
  - when peak flow falls below an agreed rate (for those monitoring peak flow each day)
  - during an asthma emergency.
- instructions on when and how to get medical care (including contact telephone numbers)
- the name of the person writing the action plan, and the date it was issued.

Table. Options for adjusting medicines in a written asthma action plan for adults

Please view and print this figure separately: http://www.asthmahandbook.org.au/table/show/42
Table. Checklist for reviewing a written asthma action plan

- Ask if the person (or parent) knows where their written asthma action plan is.
- Ask if they have used their written asthma action plan because of worsening asthma.
- Ask if the person (or parent) has had any problems using their written asthma action plan, or has any comments about whether they find it suitable and effective.
- Check that the medication recommendations are appropriate to the person's current treatment.
- Check that all action points are appropriate to the person's level of recent asthma symptom control.
- Check that the person (or parent) understands and is satisfied with the action points.
- If the written asthma action plan has been used because of worsening asthma more than once in the past 12 months: review the person's usual asthma treatment, adherence, inhaler technique, and exposure to avoidable trigger factors.
- Check that the contact details for medical care and acute care are up to date.

Templates for written asthma action plans

Templates are available from National Asthma Council Australia:

- National Asthma Council Australia colour-coded plan, available as a printed handout that folds to wallet size and as the Asthma Buddy mobile site
- Asthma Cycle of Care asthma action plan
- A plan designed for patients using budesonide/formoterol combination as maintenance and reliever therapy
- Remote Indigenous Australian Asthma Action Plan
- Every Day Asthma Action Plan (designed for remote Indigenous Australians who do not use written English – may also be useful for others for whom written English is inappropriate).

Some written asthma action plans are available in community languages.

Software for developing electronic pictorial asthma action plans\(^{29,30}\) is available online.

- Go to: National Asthma Council Australia's Asthma Action Plan Library
- Download: Imperial College London's Electronic Asthma Action Plan

Asthma self-management resources for Aboriginal and Torres Strait Islander people

Templates for written asthma action plans have been specifically designed for Aboriginal and Torres Strait Islander people. These include:

- Remote Indigenous Australian Asthma Action Plan
- Every Day Asthma Action Plan (designed for remote Aboriginal Australians who do not use written English).

- Go to: National Asthma Council Australia's Library of written asthma action plan templates

Short wind resources (booklets and flip chart) developed by Asthma Foundation Northern Territory explain:

- how asthma medicines are used
- how to take asthma medicine
- how to use puffers and spacers.

- Go to: Asthma Foundation Northern Territory Short wind resources

An online library of health promotion resources designed for Aboriginal and Torres Strait Islander people is available through LungInfoNet. LungInfoNet is the respiratory health stream of the Australian Indigenous HealthInfoNet from Edith Cowan University.

- Go to: LungInfoNet

Australian government health initiatives for Aboriginal and Torres Strait Islander people

Asthma Spacer Ordering System

The Asthma Spacer Ordering System provides Aboriginal and Torres Strait Islander health services with access to low cost asthma spacers for their clients.

- Go to: Asthma Australia's Asthma Spacer Ordering System page
Health Assessment Medicare items

The MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) reimburses health professionals for health assessments for (any of):⁸

- Aboriginal and Torres Strait Islander children (<15 years)
- Aboriginal and Torres Strait Islander adults (≥15 years and < 55 years)
- Aboriginal and Torres Strait Islander older people (≥ 55 years).

This item is linked to follow-on item numbers to support follow-up care by allied health professionals and Aboriginal/Torres Strait health workers and practitioners to manage asthma and comorbid conditions.

Go to: Medicare Health Assessment for Aboriginal and Torres Strait Islander People

The Indigenous Chronic Disease Package

The Indigenous Chronic Disease Package provides a range of supports to Aboriginal and Torres Strait Islander people with chronic disease or at risk of chronic disease. The package includes:³¹

- subsidy of PBS medicines (reduced copayments for Aboriginal and Torres Strait Islander people with chronic disease)
- orientation and training for Aboriginal and Torres Strait Islander Outreach Workers in Aboriginal community-controlled general practices
- professional development scholarships and clinical placement scholarships for nurses working in Community Controlled Aboriginal/Torres Strait Island Health Services
- general practitioner registrar training posts for Aboriginal Medical Services
- Practice Incentives Program Indigenous Health Incentive to support general practices and Indigenous health services to provide care for people with chronic disease
- increased access to specialist medical and allied health care
- GPs can access these services to overcome barriers to health care for Aboriginal and Torres Strait Islander people.

Go to: Closing the Gap Indigenous Chronic Disease Package

National immunisation program

Additional vaccinations are recommended and reimbursed for Aboriginal and Torres Strait Islander people. Refer to national guidelines.

Go to: Australian Immunisation Handbook

Other resources

Go to: Australian College of Nursing's Australian Government scholarships web page
Go to: General Practice Education and Training Limited

Health system initiatives that support asthma care

Chronic Disease Management Medicare items

Patients with asthma are eligible for Chronic Disease Management Medicare items.⁷ These include:

- Preparation of a GP Management Plan (Item 721)
- Review of a GP Management Plan (Item 732)
- Coordination of Team Care Arrangements (Item 723) for patients who need ongoing care from a multidisciplinary team of at least three health or care providers
- Coordination of a Review of Team Care Arrangements (Item 732)
- Contribution to a multidisciplinary care plan being prepared by another health or care provider (Item 729)
- Contribution to a multidisciplinary care plan being prepared for a resident of an aged care facility (Item 731).

GPs can be assisted by practice nurses, Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers and other health professionals.⁷

Go to: Australian Government Department of Health's Chronic Disease Management (CDM) Medicare Items webpage

Asthma cycle of care

The Asthma cycle of care is an Australian Government initiative to support primary care health professionals (GPs, other medical practitioners and trainees) to provide asthma care. It is implemented through the Practice Incentives Program (PIP) Asthma Incentive and applies to the clinical care of people with moderate-to-severe asthma, generally defined as people with (any of):³²

- symptoms on most days
• use of preventative medication
• bronchodilator use at least three times per week
• hospital attendance or admission following an acute asthma flare-up.

The Asthma cycle of care involves at least two asthma-related consultations within 12 months for a patient with moderate-to-severe asthma, of which at least one visit is a planned asthma review. Each consultation includes:

• documenting the diagnosis, assessing asthma severity and assessing level of recent asthma symptom control
• reviewing the patient’s use of and access to asthma medicines and inhaler devices
• providing a written asthma action plan (or documented alternative, if the patient is unable to use a written action plan)
• providing asthma self-management education
• reviewing the written or documented asthma action plan.

The Personally Controlled eHealth Record System

The eHealth record is an electronic record for a patient that contains a summary of their health information. Patients can choose to register for an eHealth record. Authorised healthcare professionals can access a patient’s record and upload information to the record if their healthcare organisation has registered for the eHealth record system.

Health system initiatives for Aboriginal and Torres Strait Islander people

Health system initiatives to support the care of Aboriginal and Torres Strait Islander people include:

• Health Assessment Medicare items
• The Indigenous Chronic Disease Package
• The Asthma Spacer Ordering System.

References


11. Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Health Survey 2004-05*. Cat. no. 4715.0. Australian