Special report: asthma care in the UK

Improving outcomes and experiences
**BY THE NUMBERS**

**Asthma in the UK**

1 in 20

people with asthma have a severe case of the disease

39%

of people with asthma were prescribed excessive reliever medication (blue inhalers) in the year before their asthma-related death

5.4m

people living with asthma in the UK

3+

blue (reliever) canisters per year are associated with a two-fold increase in risk of severe asthma attacks

130,000

people with asthma take three or more courses of oral corticosteroids (OCS) per year, which can have life-changing side effects

3.24m

people with asthma do not receive the basic level of care, which includes an annual asthma review, written action plan and an inhaler technique check

72

months is the average time to diagnosis of severe asthma from the original asthma diagnosis

75,000

hospital admissions per year due to severe attacks in the UK

~1,000,000

severe asthma attacks in the UK every year

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i) Excessive prescribing of blue inhalers is described as more than 12 reliever inhalers in one year.  
ii) Reliever/rescue inhalers (Short-action beta-agonist (SABA)) – commonly referred to as the “blue inhaler” can provide immediate symptom relief but do not treat the underlying inflammation of asthma. 
iii) Basic level of care is defined as an annual asthma review, a written action plan and an inhaler technique check with a healthcare professional.
Zero tolerance for asthma attacks

Asthma outcomes in the UK are amongst the poorest in Europe11 – now is the time for zero tolerance for asthma attacks, says Dr Alexander de Giorgio-Miller, vice president for medical and scientific affairs at AstraZeneca.

With 5.4 million people in the UK living with asthma3, you may suffer from it personally or know someone who has it. Our familiarity with asthma means that many refer to it as “just asthma”. However, asthma is a serious, inflammatory disease requiring regular inhaled anti-inflammatory treatment to reduce symptoms and prevent severe asthma attacks. In the UK, it is estimated that someone with asthma suffers an attack every ten seconds3. Any severe attack is a terrifying event and can be life-threatening. With approximately 75,000 people hospitalised for severe attacks each year4, rates of hospital admission and mortality in the UK are amongst the worst in Europe5.

Fundamentally, asthma is an inflammatory disease and therefore the foundation of care is inhaled corticosteroid (ICS) treatment5. ICS-containing “preventer inhalers” (typically brown but come in many colours) reduce inflammation in the airways, preventing symptoms from worsening and reducing the risk of an attack. One of the biggest contributors to the growing burden of asthma attacks is a systematic over-reliance on “rescue” therapies – in particular, the “blue inhaler”.

Despite numerous effective preventer inhalers available, people with asthma instead primarily seek quick relief from their asthma symptoms by using their blue inhaler4. Evidence suggests that people who use blue inhalers excessively are at a greater risk of having an asthma attack5. Indeed, the use of three or more blue inhalers in a single year is associated with a two-fold increase in the risk of having a severe attack5. Disappointingly, in the UK, we dispense 15.5 million blue inhalers to asthma patients each year (~three per person on average), which is amongst the highest in the world16 and suggests a large number of people may be sub-optimally treated. Used alone, blue inhalers possess no anti-inflammatory properties and therefore do not address the cause of the disease, the inflammation4,57.

Another consequence of the over-reliance on blue inhalers beyond the associated attacks, is the over-prescribing of steroid tablets to treat them. Oral corticosteroids (OCS) may be used in short bursts as a life-saving treatment for attacks but frequent use of OCS courses may be an indicator of sub-optimal asthma care5,18. OCS tablets are associated with significant side effects5, and even short courses can have a significant impact on patients59. Side effects can include weight gain, mood changes, and the increased risk of osteoporosis, hypertension, heart attack, and stroke, amongst others58.

Furthermore, people with severe asthma, a significant form of the disease that is not controlled with high doses of inhaled medication, are frequently treated with OCS6. In light of the side-effects associated with OCS and despite numerous “precision” medicines now available to treat severe asthma, only a small proportion of approximately 200,000 people living with severe disease in the UK today are given access to these medicines3.

The over-reliance on rescue treatments in the UK is contributing to poor national asthma outcomes and is increasing the risk of asthma attacks. Furthermore a reliance on frequent OCS courses may be causing unnecessary harm to people with asthma. Given the extraordinary circumstances of recent months and the heightened need to keep high risk people out of hospital, now is the time to seek better outcomes for all people living with asthma.

It is more critical than ever that we all adopt a mindset of zero tolerance for asthma attacks – people with asthma must come to understand the cause of their disease and use the appropriate anti-inflammatory medicines to treat it. Only then, will asthma ever be “just asthma”.●
Asthma is a chronic inflammatory condition, affecting 5.4 million people in the UK – one of the highest prevalence rates in the world.

Asthma outcomes – it’s time for change

Introduction
Despite over 50 years of campaigning for change22,23,24,25,26,27, people with asthma in the UK continue to face significant challenges in the management and treatment of their condition28. Between the early 1990s and 2006, progress was made globally in reducing deaths from asthma, but improvements plateaued by 201229. At this time, the UK lagged behind most of its main European counterparts, recording the second highest rates of deaths and hospital admissions (see table)-, and recent evidence demonstrates that improvements against these key outcomes have stalled over the past ten years30.

For people with asthma, the goal of treatment is to achieve good asthma control by minimising the risk of asthma attacks and reducing the burden of their symptoms31. Uncontrolled asthma is debilitating for people living with the condition, impacting every area of their lives32. On average, three people die from an asthma attack every day in the UK33. In 2017, 1,484 people died from an asthma attack in the UK (latest data available), almost equalling the 1,793 UK road deaths in the same year34.

The Royal College of Physicians’ (RCP) report, The National Review of Asthma Deaths (NRAD), published six years ago, analysed circumstances surrounding deaths from asthma in 193 people in the UK between February 2012 and January 2013. The Review found that about two-thirds of deaths from asthma are potentially preventable in the UK. The report made 19 recommendations to support an improvement in outcomes and a reduction in death35. However, despite acknowledgement of the findings by charities and professional organisations36,37, development of materials to help translate the guidance into clinical practice38, only one recommendation has seen implementation so far – the National Asthma and COPD Audit Programme launched in 2018, designed to audit services from across the care pathway to present a vision for improved patient care39,40.

Asthma UK, the largest asthma patient organisation34, commissioned a paper in the same year, a paper from asthma care, which includes an asthma review, a written action plan and an inhaler technique check with a healthcare professional41. In 2018, Asthma UK found that despite system improvements across all areas of basic care, 60 per cent of people with asthma are “still not receiving the most basic asthma care”, which includes an asthma review, a written action plan and an inhaler technique check with a healthcare professional42,43. In the same year, a paper commissioned by The Lancet reported that people with asthma are still at risk of preventable asthma attacks across all disease severities, with the authors calling for “zero tolerance for asthma attacks”44. In severe asthma – a distinct condition affecting up to 0.4 per cent of asthmatics requiring high intensity treatment – especially, Asthma UK has identified there is a “significant unmet need for referral to specialist care45”. Furthermore, in England, health services for adults with severe asthma are currently commissioned based on modelled data for an estimated 7,000 people with severe asthma. This is much lower than the estimated real-life population of 200,000 suggesting that services, as they are currently configured, do not have the capacity to effectively treat everyone with severe asthma.

Positive steps are being taken to improve asthma outcomes; respiratory disease is included as an area of clinical focus in a number of NHS strategy initiatives, including NHS RightCare46, the Long Term Plan47, and Getting It Right First Time (GIRFT)48. Additionally, UK clinical groups are working to put the management of asthma in the spotlight, such as the Primary Care Respiratory Society’s “Asthma Right Care” social movement, which is exploring how to challenge the current status quo in asthma outcomes49.

But more must be done, and national leadership is key to this. With exacerbating factors such as rising pollution putting people with asthma at higher risk50, it is possible that the care and treatment needs of people with asthma will continue to increase, as will the pressures on the health system.

To reverse the stagnation in UK asthma outcomes we must raise awareness of the issues in asthma treatment and care across the public, healthcare professional, and policymaker communities, as well as improve environmental factors. The

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<th>Country</th>
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HOSPITAL ADMISSION (2012) AND MORTALITY RATES (2011) OF ASTHMA IN ADULTS ACROSS THE “BIG FIVE” EUROPEAN COUNTRIES

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HOSPITAL ADMISSION (2012) AND MORTALITY RATES (2011) OF ASTHMA IN ADULTS ACROSS THE “BIG FIVE” EUROPEAN COUNTRIES

There must be zero tolerance for asthma attacks

Asthma explained
- Asthma is a chronic inflammatory disease with fluctuating levels of inflammation and episodic symptoms.
- Difficult asthma is often the result of poor adherence to treatment, other co-morbidities and/or the wrong diagnosis.
- Severe asthma is a distinct condition, classed as requiring high-intensity treatment to keep it under control.

On average, three people die every day from asthma

Basic level of care is defined as an annual asthma review, a written action plan and an inhaler technique check with a healthcare professional.

In the United Kingdom, 77.74 cases of asthma in 100,000 people with asthma are currently configured, do not have the capacity to effectively treat everyone with severe asthma.

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Asthma care in the UK

Diagnosis

Asthma is primarily diagnosed and treated in primary care, although there is no universally recognised standard for diagnosis.3 This is because of accurate diagnostic testing coupled with limited specialist knowledge can result in incorrect and/or delayed diagnosis thus impacting patient outcomes4. This is especially the case for those with severe asthma, as accurate diagnosis is usually only possible via referral to specialist-led centres which have the appropriate expertise and equipment.5 Unfortunately, due to the limited awareness of severe asthma within non-specialist clinical communities and inadequate data sharing between primary and secondary care, people can experience long delays (median 72 months from original asthma diagnosis) for their severe asthma diagnosis. The UK and Global guideline bodies all state that symptoms alone should not be enough to diagnose asthma, and recommend capturing a clinical history supported by objective measurements.6 In primary care, a number of methods and assessments, such as lung function tests, are available to determine the likelihood of asthma but normal results do not necessarily rule out asthma and abnormal results do not always mean it is asthma.7 There is a further optional test, measuring FeNO in exhaled air, which is used where diagnosis is uncertain, but there are concerns over its cost-effectiveness8. In 2021, Asthma UK called for investment into the development of a low-cost, accurate diagnostic test that improves diagnosis in primary care and identification of new biomarkers.

Asthma treatment and management in primary care

There are several issues facing the asthma patient and healthcare professional in the primary care setting – we explore three common issues.

Basic asthma care

Asthma UK defines basic asthma care as an annual asthma review, a written personalised asthma action plan (PAAP) and an inhaler technique check with a healthcare professional.9 An annual asthma review aims to achieve optimal outcomes for people with asthma and address any issues with treatment, adherence or symptoms.10 Monitoring of adherence to preventer treatment (such as a brown inhaler) is particularly important, yet studies have found that average adherence to preventer treatment in asthma varies from 22-63 per cent.11 In 2014, the National Review of Asthma Deaths (NRAD) identified that non-adherence is associated with increased patient hospitalisation and mortality of those who died, 77 per cent did not have a PAAP, an essential component of supported patient self-management, and 43 per cent had not received an annual asthma review.12 In 2014, NRAD recommended implementation of basic care for every person with asthma, assessment of asthma control, self-management and education, and monitoring of adherence to preventer medication which is advocated by NICE, BTS/SIGN, PCRS and GINA.13,54 NICE also recommends the use of a validated questionnaire such as The Asthma Control Test which measures symptoms, quality of life and reliever use.14,15 Despite this, Asthma UK’s 2018 survey findings demonstrate that up to the end of 2016, only around three fifths of people, approximately 3 million people, are “still not receiving this most basic level of care”, highlighting that implementing the recommended basic care in clinical practice is proving difficult.16 There is also significant variation in asthma care across the UK, which has been a trend since the Asthma UK surveys began, with the 2018 results showing Wales has the lowest level (32 per cent) of people with asthma receiving basic care.17 In the 2018 paper commissioned by The Lancet, the authors recommended a move to preventer treatment as first-line treatment.18,19 NICE has also published new indicators that have been added to the Quality and Outcomes Framework from 2020/21, which includes, in the annual review, a record of the number of asthma attacks.20

Reliever therapy overreliance

Asthma is a variable, inflammatory disease – blue inhalers (reliever) do not treat the underlying inflammation, so the use of brown inhalers (preventer) is crucial to treat the inflammatory component of the condition and to achieve optimal patient outcomes.21,22 However, people with asthma learn that immediate symptom relief is best achieved with their blue inhaler. This may lead to non-adherence to their preventer treatment, leaving them at risk of preventable attacks.23,24 Additionally, using three or more blue inhalers a year is associated with increased A&E visits or hospitalisations and is more with an increased risk of death.25 Overreliance on blue inhalers also leads over time to bronchial hyperresponsiveness (characterised by easily triggered contraction of the airways) and tolerance (people with asthma experience less relief from the original dose).26 In 2014, NRAD identified excessive prescribing of blue inhalers in 39 per cent of the 195 deaths analysed, with brown inhalers in 58 per cent of death and no brown inhalers prescripted in 14 per cent of deaths.27

Multiple Coroner’s reports following deaths the death of a 13-year-old girl, who had been admitted both primary and urgent care services 47 times for her asthma over four years.28 A 2018 paper commissioned by The Lancet advocates for asthma attacks to be considered a trigger event that should prompt a thorough re-evaluation

Systemic corticosteroids use

Those with difficult or severe asthma, either identified or unidentified, can often be prescribed oral corticosteroids (OCS) to control symptoms and prevent risk of future asthma attacks.29 However, long-term use of OCS is associated with a risk of debilitating side effects, such as weight gain, bone weakening and mood changes.30 In 2014, NRAD recommended people with asthma to be referred to a specialist asthma service if they have required more than six courses of oral systemic corticosteroids in the previous 12 months31 which GINA endorses.32 Despite this, Asthma UK’s 2019 report on severe asthma identifies over 150,000 people with asthma on three or more OCS courses per year with only 23.4 per of these people being referred.33 This is likely a result of the lack of OCS recommendations in UK national guidelines, as the BTS/SGIN guidelines do not provide a threshold of OCS courses, but recommend frequent or continuous use of oral corticosteroids should be under the care of a specialist asthma service with no mention of frequent or continuous use of OCS use in the NICE guidelines.34

Emergency admissions

Unfortunately, due to the high prevalence of those with difficult and severe asthma, asthma attacks require emergency care, and hospital admissions.35 Asthma UK estimates that on average, 185 people are admitted to hospital because of asthma attacks every day in the UK.36 Too often, this is a revolving door; some people have multiple hospitalisations for life threatening asthma attacks which are not viewed collectively, and not flagged for urgent review.37 This was tragically demonstrated in the Coroners’ report on the death of a 37-year-old girl, who had attended both primary and urgent care services 47 times for her asthma over four years.38

A 2018 paper commissioned by The Lancet advocates for asthma attacks to be considered a trigger event that should prompt a thorough re-evaluation

Surviving life-threatening asthma attacks

Reliever therapy overreliance in asthma has been proven further in clinical practice – asthma experts in both primary and secondary care were interviewed and defined their clinical practice strategies, such as collecting variables including A&E attendance, number of reliever (blue inhaler) prescriptions and poor symptom control, which could be built into a routine review to reduce risk of an asthma death.39 NICE has also published new indicators that have been added to the Quality and Outcomes Framework from 2020/21, which includes, in the annual review, a record of the number of asthma attacks.40

The Lancet

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Thus impacting patient outcomes47. This diagnostic testing coupled with limited specialist-led centres which have the ability to achieve economies of scale and improve the practicability of implementing the recommendations.48

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48. In 2017, Asthma UK called for national leadership, as we’ve seen with diabetes.5

literature and real-world experience demonstrates the repeated issues in the treatment and management of asthma, and the challenge of implementing clinical guidelines into practice has been widely documented45-47. Asthma UK states “a condition of this scale demands national leadership, as we’ve seen with diabetes”.48 This is true, and a significant issue facing people with asthma and the various recommendations which have been made to address these.
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Secondary care and specialist centres

Accurate diagnosis of severe asthma is crucial for possible following referral to specialist centres which have the appropriate expertise and equipment. Across the asthma treatment pathway there are multiple opportunities for a person to be referred to specialist care if they are predicted to have severe asthma.

However, people with asthma are often not being referred at the right time, or sometimes not referred at all, from primary care. Asthma UK suggesting this is the case for 82 per cent of people with difficult and severe asthma. Furthermore, three-quarters of people with severe asthma and difficult courses of OCS have not had an appointment with an asthma specialist. This means that these people with multiple asthma attacks but have still not been referred according to the guidelines.

Potentially one of the most significant reasons for the variable care received is misaligned referral criteria. Currently, there are no statutory guidelines on the transmission of people with difficult and severe asthma, and there is variance in recommendations. BTS/SIGN guidelines state over prescription of inhaled and/or oral steroids and symptoms of acute severe or life-threatening asthma as a criterion for referral, while in 2014, NICE recommended people with asthma should be referred to a specialist asthma service if they have required more than two courses of systemic corticosteroids in the previous 12 months. This has contributed to confusion among clinicians about the referral threshold, previous research carried out by Asthma UK of 17 difficult/severe asthma patients from across the UK shows clinician uncertainty about which people should be referred, ranging from two courses of OCS (1 per cent of responses) to continuous courses (15 per cent of responses) being the criteria for referral. Compounding this, there is variation in primary care understanding of the wider services offered in secondary/tertiary care, and the importance of these for severe asthma.

NICE, SIGN and BTS are collaborating to produce UK-wide Joint Guidelines on Chronic Asthma to be published in 2020, which provides an important opportunity to provide clarity and subsequently increase appropriate and timely referrals. However, key stakeholders such as Asthma UK and The Taskforce for Lung Health have highlighted concerns that the criteria under which specialist services are commissioned is based on modelling that does not reflect the real-life patient population. There is a risk that some hospitals may not have capacity for an increased number of patients with difficult and severe asthma.

Asthma care in the UK

Ambitions for UK asthma outcomes

There are a plethora of guidelines, strategies and reports calling for different actions in the specialist and management and management of asthma. However, asthma outcomes in the UK are stagnating and action must be taken to improve outcomes for people with asthma.

The summarised evidence points to clear areas for improvement within the current asthma treatment pathway. For every person with asthma receives basic care, clearer referral criteria for primary and secondary care are required, better asthma monitoring and support for those over-relying on blue inhalers, and increased communication between primary and secondary care.

Contradictory advice and recommendations must be streamlined, all the necessary specialist services should be properly resourced. All stakeholders, both in the healthcare and policy community, must focus on and act to improve the key challenges experienced by people with asthma along their treatment and care pathway, underpinning the steps to improve these outcomes.
Asthma care in the UK

At an event in Westminster, sponsored by AstraZeneca and the All-Party Parliamentary Group on Respiratory Health (APPG), experts and policy influencers gathered to discuss asthma awareness and care strategies.

Poppy Hadkinson, a television presenter and nutritional therapist, has suffered from severe asthma since she was a child. Her condition has caused her to be hospitalised on numerous occasions, to experience hypoxic fits (convulsions caused by the body’s reduced access to oxygen), to be intubated (where airways are supported with a ventilator), and to be medicated with oral steroids for much of her life.

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This is the “stark reality” of severe asthma, she told the audience at a parliamentary reception event earlier this year, sponsored by AstraZeneca and the All-Party Parliamentary Group on Respiratory Health (APPG). Too often, she said in the company of around 50 guests in Westminster, including a range of clinicians and industry experts, her struggle was still being underestimated. “A phrase you’ll often hear as an asthmatic is that it’s ‘only asthma’, ” Hadkinson lamented, before offering in retort: “Is it ‘only breathing’?”

The host of the reception, Jim Shannon, the DUP Member of Parliament for Strangford and the chair of the APPG, agreed that the “mindset around asthma has to change”. At the end of its inquiry, Shannon said, the APPG wants to have clear recommendations for standards and more uniformity across asthma care, from diagnosis through to treatment, and outpatient support. “The economic argument,” Shannon said, “is in helping people with asthma to enter and stay in the workforce.”

More important than that, however, the MP added, is the “social argument that we need to look at... We have to ensure that everyone has a right to breathe, and to a better quality of life.”

The scale of asthma prevalence and cost is significant. According to Asthma UK, around 5.4 million people in this country are currently receiving treatment for the condition, comprising 1.1 million children (one in 11) and 4.3 million adults (one in 12), at a cost of roughly £1bn a year to the NHS. Every ten seconds someone in the UK has a potentially life-threatening asthma attack, and on average, three people die from asthma every day. Of all asthma cases in the UK, approximately 200,000 are classed as severe – the most debilitating form of the condition, which may not respond to usual treatments, and can have a staggering ripple effect across the wider economy and society.

As much as it being a personal issue for those affected, Hadkinson highlighted that asthma also represents a “productivity” issue, in that asthma cases comprise 2% of all deaths from asthma in the UK. The Royal College of Physicians’ National Review of Asthma Deaths (NRAD) report estimated that about two-thirds of all deaths from asthma in the UK could be classed as preventable.

Also speaking at the reception was Professor Andrew Menzies-Gow, who serves as the director of the lung division at Royal Brompton Hospital. Using a short clip from a documentary produced by AstraZeneca, Breathless – The story of life with severe asthma, he underscored the importance of early diagnosis, and avoiding a “pile-up in primary care”. He, too, raised the issue of the lack of awareness around asthma, not just in terms of public perception, but even within the medical community. While
Menzies-Gow did not dispute the role that corticosteroid tablets had to play in treating asthma – indeed, he noted their capacity to provide valued relief to particularly uncomfortable symptoms – he stressed that they should not be too readily given out as a “sticking plaster”, and that greater consideration must be afforded to their potential side effects. For Menzies-Gow, while steroid-based treatments can help to alleviate symptoms, the focus within the medical science community should be on more advanced treatments that actually address the underlying causes of asthma.

Across the board, he said, the health service had to be more alert to the condition. Menzies-Gow called for a more efficient referral process, empowered and streamlined by data, that could help get people with asthma to the specialist knowledge and expertise they need more quickly. “Many life-changing treatments and services do exist now, I am proud to say, but the fact is, at the moment, we aren’t getting people to them quickly enough. We are trying very hard, though, and it’s a very clear focus for the severe asthma community.”

Although Menzies-Gow admitted that specialist asthma hubs were not as widely in place as some may have hoped, he did point out the progress that has been made in the past ten years: “I think if we look back to a decade ago, we had about four centres – one in London, one in Birmingham, one in Manchester, and one covering the Leicestershire area. That’s all there was, and people were travelling from Truro – that’s about six hours away – to come and see me in London. We are now up to 12 [specialist asthma] centres and England is becoming better covered geographically.”

Also on display at the reception were asthma “heat maps” – digitised databases to chart and analyse variance in prevalence and outcomes of asthma across the UK, in addition to prescribing data and referral patterns. Funded by AstraZeneca, and developed by the NHS South Central and West Commissioning Support Unit, it is hoped these maps will help identify potential outlying performance to prioritise efforts to tackle unwarranted local variation throughout England.

Ultimately, the event in Westminster was confirmation that, as Poppy Hadkinson put it, it’s “never only asthma”. The energy for change within the asthma patient community must be matched by proactive policymaking. Asthma is not an issue to be swept under the carpet; it is a serious condition that has profound effects on people’s physical and mental wellbeing, as well as a knock-on impact on the UK economy.
My life with asthma

Gabriella Perry, a student at the University of South Wales, shares her experiences of living with severe asthma

What has it been like to live with severe asthma?
I was diagnosed with asthma when I was two years old, and with severe asthma when I was seven. By the age of ten, I was being seen by a consultant at a children’s hospital, and by 11 or 12, my asthma had become extremely difficult to manage.

In many ways, asthma has been life-limiting for me, because having been an initially energetic child, I suddenly became less capable of joining in with sports and other activities. I had to give up dancing and playing rugby. My attendance at school was patchy, because of constant hospital appointments. I was even kicked out of Sixth Form at one point because of my attendance and that was heartbreaking.

I’ve also found it hard to get work placements that can accommodate my condition – which often leaves me fatigued or short of breath. While I enjoy studying where I am, going to university in London or another busy city was never an option for me, because the air pollution would make things worse.

What has been extremely frustrating throughout my life has been the lack of awareness attached to asthma, both among the general public, and even within clinical settings. Too often, I’ve found, asthma is used as an umbrella term that covers all respiratory difficulties. The reality is that each case is unique, and some are very serious, but people don’t seem to appreciate that. During one hospital stay, a paediatrician suggested that he would have to stop dealing with me in order to tend to “actually sick children”.

What are your views on the current state of asthma medicine and care in the UK?
While things are better now than when I was diagnosed, we still have a long way to go in terms of the level of pastoral support shown to patients. In the early stages of my diagnosis, I was never really told exactly what was wrong with me. That made me feel very vulnerable.

There is a tendency, in my experience, to over-medicate asthma patients. While oral corticosteroids can provide short-term relief to severe asthma’s more uncomfortable symptoms, they also carry some adverse side effects, including weight gain and mood swings, that are not always fully articulated to patients. It’s a Catch-22, because I am grateful for the relief they provide, but I’ve been stuck on them for over ten years.

What are your hopes for the future of asthma care, in terms of treatment and perception?
Asthma care in the UK could definitely stand to be more coordinated. Various doctors and healthcare staff having access to the same patient information, in real time, would be a good place to start.

I’ve had a pretty disjointed experience between the doctors I see closer to home and those that I see when at university. I would also encourage further research into the expansion of biologics [precision treatments that target a specific antibody or cell involved in asthma and are usually delivered by parenteral injection].

As for improving people’s perception, that can only come through training and education. Asthma isn’t “just asthma”; it is a serious respiratory condition that affects millions of people’s lives.
Radical change in asthma policy requires a shift in public perception, says Monica Fletcher, honorary research fellow at The Usher Institute, University of Edinburgh, and knowledge exchange lead at the Asthma UK Centre for Applied Research

Understanding asthma as a social issue

There are many reasons why asthma may not be treated as seriously as it should be by healthcare professionals and often by patients themselves. This is not helped by current national and international guidelines, that according to the methods they use, classify the majority (between 50-75 per cent) of asthma cases as mild. Evidence shows us that patients are many advances in the way asthma can be diagnosed and treated over recent decades. There is a greater understanding of the underlying mechanisms of the disease, improvements in diagnosis and we have a range of therapies to treat asthma across the disease severity spectrum. So why have outcomes not improved, and has complacency set in and what can be done? It is probably time to rethink our approach and to wholesale shift mindsets. We need to move away from concentrating on individual practitioners and patients and their behaviours, and on to whole systems thinking.

It is only when we do this that we will see game-changing improvements in asthma care and patient outcomes. For such a change to occur a political drive to treat asthma as a priority health and wider social issue is needed. This prioritisation is necessary at both a national and local level. A review of seven national European asthma programmes aimed at reducing asthma mortality and morbidity, concluded that national- or regional-wide programmes are more effective than conventional treatment guidelines. The authors also suggested that the success of these programmes relies on the commitment of stakeholders at all levels.

One of the most well-known and successful national programmes in Europe is the Finnish National Asthma Programme, the results from which are certainly impressive showing reductions in morbidity, mortality and treatment costs. Not only did the Ministry of Social Affairs and Health in Finland recognise asthma as an important public health issue, it has, it designed – with a whole range of experts and patients – a national programme for the prevention and alleviation of asthma-related problems.

So why was the programme successful and what can we learn? At the heart of their strategy was the acceptance that asthma was a community problem – a public health issue – and therefore to achieve a broad commitment and reallocation of resources, government action was essential. Central to the success of the Finnish Programme was the recognition that primary care practitioners – physicians, nurses and pharmacists – were pivotal and investment was needed in capacity building, including a national training programme for front-line generalists. So national steer is vital, but so is the recognition that no one single intervention will make the changes that are necessary.

Poor health outcomes in patients with asthma have been attributed to gaps between evidence-based recommendations and practice, particularly in primary care, where most asthma patients are seen. The use of evidence-based clinical guidelines to guide healthcare professionals in their day to day practice are known to be helpful, particularly to those working in primary care. In the UK the British Thoracic Society’s national guidelines are respected and updated. We also know, according to the National Review of Asthma Deaths in the UK, that patients with ostensibly mild cases can die. It is also important to recognise that about 200,000 of the 5.4 million people with asthma in the UK live with a severe life-threatening and disabling disease, on a daily basis.

On a positive note, there have been many advances in the way asthma can be diagnosed and treated over recent decades. There is a greater understanding of the underlying mechanisms of the disease, improvements in diagnosis and we have a range of therapies to treat asthma across the disease severity spectrum. So why have outcomes not improved, and has complacency set in and what can be done? It is probably time to rethink our approach and to wholesale shift mindsets. We need to move away from concentrating on individual practitioners and patients and their behaviours, and on to whole systems thinking.

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