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EDITORIAL

Asthma action plans: use it or lose it

When it comes to the delivery of asthma care, we know a lot about what to do but not enough about how to do it, especially in primary care. We know that standard doses of inhaled corticosteroids, often in combination with a long acting beta-2 agonist, can control symptoms and exacerbations. We know that education programmes that teach early recognition and treatment of deteriorating asthma can effectively minimise hospitalisation and emergency visits for asthma [1]. These messages can be encapsulated as a written action plan [2] and possession of a written action plan is probably a good marker that a treatment review and education has taken place.

The structure of a written action plan is also now well defined [3]. The first section describes maintenance treatment for use when well. This serves as a reminder to patients to reinforce adherence with daily asthma therapy. The next section details the early management of an asthma exacerbation. There are four key components of this section. They are instruction about when to increase treatment, how to increase treatment, how long to stay on the increased medication, and instruction on when to seek help. Early exacerbation management is generally divided into an action plan for a mild exacerbation and instructions on managing a severe episode. Written action plans can be presented in a variety of ways to suit the needs of the doctor and the patient [2].

After 10 years of harping on about written action plans, only one in five people with asthma have one. This is a consistent finding in both the UK and Australia [4], and clearly indicates that the problem is not what to do, but how to do it. The delivery of this aspect of asthma care falls short of guidelines. Asthma is common and most often mild in severity. It is a disease of primary care, and so the solutions to this problem must involve primary care. The relevant variables that need to be considered in this process are the doctor, the patient, the doctor—patient interaction, and the health care delivery system.

The Living and Breathing study [5] gives some insight into the patient's perspective of these issues. This study used qualitative research methodology to define relevant issues in asthma care from the patients perspective, and then tested these out in a more structured way by surveying people form a variety of settings. The study identified that patients would be receptive to written action plans. In fact, many people with asthma were already changing their medication as a matter of course (with or without medical advice) and many said that they would find a written action plan useful. Some of these patients were getting verbal advice about how to change treatment but it was not systematised in the form of an adherence aiding device such as a written action plan. There are other studies that also give insight into what patient's think about written action plans [6,7]. A consistent message is that they need to be individualised to the patient's situation, and unless this happens the patient is likely to reject the plan [6].

General practioners do not seem enthusiastic about written action plans. When asked [7], they said there were considerable barriers in the current practice structure to implementing these plans. Some aspects of the health care system no doubt could be modified to facilitate this process. For example, in Australia the GP Asthma Group have modified the Australian Asthma Management Plan for use in primary care and developed the ''3+ visit plan'' [8]. This process effectively improves asthma management in children [10]. The health care system has also been modified to provide a financial incentive to GPs when patients complete the 3+ plus visit plan. It will be necessary to review the delivery of asthma care in each primary care setting in order to identify areas were system changes would facilitate better care delivery.

GPs have questioned the place of action plans in promoting 'dependency' among patients or diminishing their patients autonomy [7]. When you ask patients about this they have differing views [9]. Adams et al. assessed patients preferences for autonomy in decision making about the management of asthma exacerbations. They found that patients wanted to share decisions with their doctor about changing medication during a moderate exacerbation of asthma.

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So we have a problem. In written action plans we have a treatment approach of proven value, but there is a fundamental mismatch between the views of primary care physicians and patients regarding the relevance and importance of this approach. While this may explain why things are as they are, it does not go a long way to delivering effective asthma care to the right people. Haughey et al. propose task substitution as a solution. This has several guises. Basically it means getting someone else to deliver the written action plan and the education that goes along with it. It has been promoted previously with practice nurses, and is now being trialled with pharmacists. It is a pragmatic solution, whose long-term success will depend on the extent to which GPs and patients see it as offering effective multidisciplinary care rather than further fragmentation of medical care.

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