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POSTMARKET REVIEW OF PHARMACEUTICAL BENEFITS SCHEME MEDICINES USED TO TREAT ASTHMA IN CHILDREN

Thank you for the opportunity to comment on this review of medicines used to treat asthma in children

The AMA reiterates the views and advice it provided to the Drugs Utilisation Subcommittee (DUSC) of PBAC in its letter of 12 October 2011.

Feedback from our general practice members suggests that the combination steroid/long-acting b-agonist is so effective that medical practitioners have been inclined to use it early for treating recurrent asthma in children.

This approach tends to improve compliance with medication because it: involves only one product; requires one prescription and is therefore cheaper for parents; requires only twice daily administration; and reduces the use of oral steroids. AMA members also note that if parents are resistant to giving their children 'drugs', when medication is necessary, the fewer the agents the better.

AMA members advise that FDC use results in children able to return to day care or school more quickly as well as parents back to work faster. It also appears to reduce hospital admissions.

Staff in day care and schools are trained in using inhalers, and episodes are quicker and easier for staff to manage if there is only one inhaler required.

We note the findings of the DUSC review that there appeared to be no reported or measurable adverse outcomes based on current practice. Our members have also reported that they have seen no instances of side effects, and in fact, their experience is that it reduces morbidity.

There is therefore a view that the protocols and guidelines should be updated to reflect current experience. The guidelines are now quite dated – based on 2005 and 2008 evidence.

In addition, while general practitioners are aware of the current guidelines, the guidelines are largely developed by experts in asthma treatment and, while medically and scientifically correct, don't necessarily reflect appropriate use in the community by all patients.

General practitioners see the vast majority of asthma cases, while hospitals, respiratory physicians and paediatricians see the minority. Typically these latter experts give less weight to 'real life' general practice experience.

It is also important to note that the DUSC review stated that its analyses of current practice 'need to be interpreted carefully' owing to limitations in the data analysis and that 'the reasons for high rate of single prescriptions and low continuation may be complex' (last and first paragraph, pages 31-32).

Our members agree with the reservations in this paragraph. For example, bronchodilators (Ventolin) is an over the counter item, so parents have already been 'self-prescribing' for their children prior to presenting to their general practitioners.

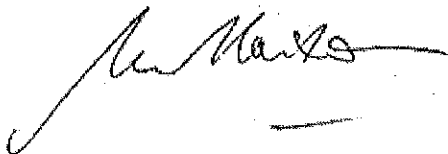
In addition, asthma diagnosis has replaced bronchitis as an acceptable diagnosis in children (perhaps more accurately 'wheezy bronchitis'). The significance of this is that the bronchoconstriction and the inflammatory response are treated with an FDC. However, this increased use should be viewed in light of decreased antibiotic prescriptions.

In conclusion, our members do not support increased restrictions on prescribing FDCs. They would prefer to see:

- removal of the current restrictions/requirements and
- updated guidelines that include general practice input to reflect the compliance and community attitudes experienced in 'real life' and the way these impact on the science and evidence base.

If you have questions or seek further information, please contact in the first instance

Yours sincerely



Dr Brian Morton
Chair
AMA General Practice Council

12 March 2013

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