

**MPHA Policy Resolution**  
**Asthma**  
**May 2006**

WHEREAS, asthma is a major public health issue, resulting in excess hospitalizations, school and work absenteeism, lost productivity, disability, and increased health care costs; and

WHEREAS, asthma is a serious, chronic disease of the respiratory system, the lungs and the system of air tubes that lead to the lungs; and

WHEREAS, asthma occurs when the tiny air passageways in the lungs (bronchioles) become narrowed when they react to an irritant or an allergen in the environment; and

WHEREAS, numerous studies have demonstrated an association between air pollutants and respiratory diseases, including childhood asthma<sup>1,2,3</sup>; and

WHEREAS, asthma symptoms are exacerbated by several factors such as colds/flu, cold air, exercise; environmental triggers including irritants (e.g. tobacco smoke, perfumes/paints, ambient air pollution from auto exhaust and industrial emissions) and allergens (e.g. pollens, animal dander, cockroaches, dust mites, foods); and,

WHEREAS, asthma affects 300 million people worldwide;<sup>4</sup> about 20 million people in the U.S., including over 6 million children (2003)<sup>5</sup>; and

WHEREAS, 10.5% of adults in Minnesota have had asthma at some point in their life and 6.8% currently have asthma, with the highest rates in the Twin Cities Metro Area<sup>6</sup>; and

WHEREAS, various asthma data sources show differences for adults across racial and ethnic groups as presented in a recent study (2002,Hennepin County), rates varied, with U.S. born Black (12.5%); American Indian (10.1%); Hispanic/Latino (5.0%); White (7.7%)<sup>6</sup>; and

WHEREAS, asthma ranks nationally within the top ten prevalent conditions causing limitation of activity that resulted in 12.8 million lost school days in children and 24.5 million lost work days in adults<sup>5</sup>; and

WHEREAS, asthma is costly, annually contributing \$16.1 billion in health care costs in the US, with prescription drugs as the largest single direct medical expenditure at \$5 billion<sup>5</sup>; and

WHEREAS, asthma resulted in 484,000 discharges from the hospital; 12.7 million physician office visits; 1.2 million hospital outpatient visits; and 1.9 million emergency visits in the U.S. in 2002<sup>7</sup>; and 4,500 hospitalizations of Minnesotans in 2003<sup>6</sup>; and

WHEREAS, the initial onset of asthma cannot yet be prevented and asthma cannot be cured<sup>7</sup>; asthma can be managed through early detection and identification, avoidance of triggers, such as second-hand smoke, and using appropriate medications;

WHEREAS, stakeholders throughout the public health community have developed a strategic plan to address asthma in Minnesota.<sup>8</sup>

**Therefore, be it resolved that the Minnesota Public Health Association:**

1. Supports implementation of the strategic plan for addressing asthma in Minnesota, including policies which:
  - Promote good coordination between health care and public health systems;

- Promote the use of evidence-based guidelines by Minnesota providers, such as the National Institute of Health (NIH)/National Heart, Lung, and Blood Institute (NHLBI) and Institute of Clinic Systems Improvement (ICSI);
  - Promote the use of asthma action plans by Minnesota health care providers;
  - Promote asthma education for students in schools;
  - Promote coordination among all organizations and systems that work with people with asthma;
  - Promote training and education for professions who provide care for people with asthma, such as physicians, nurses, school nurses, and pharmacists;
  - Promote training and education for those who interact with people with asthma such as families, teachers, day care providers, and coaches;
  - Include asthma in state and local initiatives focused on reducing health disparities.
2. Promotes the enhancement of the existing statewide asthma surveillance system for collecting, analyzing and reporting health outcomes and risk factor data.
  3. Supports actions, legislation, and regulations that will ensure people with asthma have access to healthy environments that are free of secondhand smoke and other asthma triggers, especially those that reduce air pollutants.
  4. Raises public awareness about the identification and reduction of asthma triggers for people with asthma.
  5. Promotes the effective evaluation of existing prevention and intervention strategies to determine and advance the most effective population-based approaches.

## **References**

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- <sup>1</sup>Tolbert P, Mulholland J, MacIntosh D, Xu F, Daniels D, Devine OJ, Carlin BP, Klein M, Dorley J, Butler AJ, Nordenberg DF, Frumkin H, Ryan PB, White MC. Air quality and pediatric emergency room visits for asthma in Atlanta. *American Journal of Epidemiology*. 151(8): 798-810. April 15, 2000.
  - <sup>2</sup>Gent JF, Triche EW, Holford TR, Belanger K, Bracken MB, Beckett WS, Leaderer BP. Association of low-level ozone and fine particles with respiratory symptoms in children with asthma. *Journal of the American Medical Association*. 290(14): 1859-67. October 8, 2003.
  - <sup>3</sup>McConnell R, Berhane K, Gilliland F, London SJ, Islam T, Gauderman WJ, Avol E, Margolis HG, Peters JM. Asthma in exercising children exposed to ozone: a cohort study. *The Lancet*. 359(9304): 386-91. February 2, 2002.
  - <sup>4</sup>Global Burden of Asthma. Global Initiative for Asthma. May 2004.  
<http://www.ginasthma.com/ReportItem.asp?I1=2&I2=2&intId=94>
  - <sup>5</sup>Trends in Asthma Morbidity and Mortality. American Lung Association. May 2005.  
<http://www.lungusa.org/atf/cf/{7A8D42C2-FCCA-4604-8ADE-7F5D5E762256}/ASTHMA1.PDF>
  - <sup>6</sup>Minnesota Department of Health. Asthma in Minnesota: 2005 Epidemiology Report. September 2005.\
  - <sup>7</sup>Centers for Disease Control, National Asthma Control Program, "2005 at a Glance."  
<http://www.cdc.gov/asthma/aag05.htm>
  - <sup>8</sup>Minnesota Department of Health. A Strategic Plan for Addressing Asthma in Minnesota.  
<http://www.health.state.mn.us/asthma/documents/AsthmaPlan.pdf>