Case Statement

Chronic Obstructive Pulmonary Disease (COPD)

Australia and New Zealand
I am pleased to present to you The Australian Lung Foundation's Case Statement on Chronic Obstructive Pulmonary Disease (COPD) in Australia and New Zealand.

COPD is Australia's most burdensome respiratory disease. It is associated with ageing so its burden will only escalate as our population ages.

COPD has been an afterthought for decades, largely neglected by pharmaceutical companies, researchers and governments with healthcare dollars to spend. Doctors have been frustrated by the lack of availability of effective treatments. Many sufferers have felt guilty and isolated by their disease because it carries the stigma of being self-inflicted.

There is renewed interest in COPD in the medical and scientific worlds which we need to capitalise on to improve disease management and health outcomes.

The Australian Lung Foundation will be the health organisation leading the charge to reduce the enormous burden of COPD in our community. We will communicate with consumers, government and health professionals about why COPD management is in desperate need of improvement, and how this can be achieved. Our efforts will be backed by The Thoracic Society of Australia and New Zealand, the peak scientific and medical authority on COPD.

I am delighted that our New Zealand counterparts, The Asthma and Respiratory Foundation, will link with us in implementing major COPD initiatives across the Tasman.

I urge you to recognise the serious attention and effort Australia and New Zealand's burgeoning COPD problem requires and assist by spreading the message or taking an active role in projects being developed by The Australian Lung Foundation.

Dr Robert Edwards FRACP
National Chairman
The Australian Lung Foundation
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is a short-hand term for Chronic Obstructive Pulmonary Disease, which includes chronic bronchitis and emphysema. People with chronic asthma and bronchiectasis are also sometimes given this diagnostic label. In general, the conditions are progressive, disabling and all too common. The cost for sufferers, their carers, governments and society is substantial. Yet expenditure and consistency of management are well below ideal.

Smoking is the major risk factor, but more research is needed into what disease processes actually take place which cause some (but not all) smokers to develop COPD. We need to know more about how common and burdensome COPD is in both indigenous and non-indigenous Australians and New Zealanders.

Perceptions abound that COPD is unattractive and unrewarding to treat, that it is self-inflicted, and that there are no effective remedies. Current medical evidence can strongly refute these perceptions. Greater knowledge about cause, diagnosis and management would allow earlier diagnosis and better outcomes. Further inroads on the uptake of smoking by our young people would lead to progressive decline in the prevalence of COPD (and several other important health problems). Wider use of more effective smoking cessation regimens would slow progression of impaired lung function and development of disability. Treatments that have been shown to help people with COPD need to be more accessible to the many thousands of Australians and New Zealanders with established COPD, through committed expenditure.

Limited knowledge and a lack of public information have kept COPD an “orphan disease” and its management largely ineffectual. The Australian Lung Foundation’s Case Statement is one step towards drawing the attention of the public, governments, researchers and health professionals to COPD. We hope this will encourage better focussing of research and treatment efforts, rationalisation of expenditure, effective self-care partnerships between patients and the medical profession, and improved well-being for the half-million or more sufferers and their carers.

Above all, this information is aimed to create an environment of optimism and collaboration to empower coordinated action nationally.

Dr Peter Frith FRACP
Chairman
The Australian Lung Foundation Chronic Airflow Limitation Consultative Group
# Chronic Obstructive Pulmonary Disease - 2001
(also referred to as emphysema, chronic bronchitis, COAD and CAL)

## A Growing Problem Worldwide

In 1990 COPD ranked 12th in the Global Burden of Disease Study and it is projected to rank 5th in 2020.

## High Cost
- Highest hospital cost of any respiratory disease
- Enormous indirect costs, including absenteeism, early retirement and burden on carers
- Fourth leading cause of mortality in Australia
- Leading cause of death among indigenous Australians
- Estimated direct and indirect costs, $800m pa

## Low Awareness and Understanding
- Low community awareness, despite its burden on society
- Prevalence data is desperately needed to plan for better management
- Available data indicates COPD could affect 1 in 10 people aged over 45
- Inconsistent definitions and descriptions continue, even amongst health professionals

## Low Severity and Burden
- Third leading cause of burden of disease in Australia
- Increasing rapidly amongst women
- Not reversible
- Co-morbidities often exist, of which depression is a significant one
- Creates significant emotional and physical impairment and is a health state perceived on par with paraplegia and AIDS
- Australia's most burdensome respiratory disease

## Low Attention
- Often undiagnosed or misdiagnosed
- Limited and disproportionate attention from health professionals or Government
- Causal links with smoking create some stigma
WHAT IS COPD?

Chronic Obstructive Pulmonary Disease (COPD) was recently defined by an international working party as:

“A disease state characterised by progressive development of airflow limitation that is not fully reversible. The airflow limitation is usually both progressive and associated with an abnormal inflammatory response of the lungs to noxious particles or gases.”

(Global Initiative for Chronic Obstructive Lung Disease International Working Party)

COPD is commonly known as emphysema and chronic bronchitis. Both are long term diseases that cause shortness of breath. Each condition can occur on its own, but many people have a combination of the two problems.

In emphysema, the alveoli or air sacs in the lungs are gradually destroyed so it is difficult to absorb enough oxygen. The bronchi become floppy and narrow so that it becomes harder to breathe in and out. In chronic bronchitis, excessive mucus is produced which makes people cough up sputum (or phlegm). Coughing and breathlessness can occur for months and sometimes years.

THE SIZE OF THE PROBLEM

a) Burden of Disease

Recent data has documented for the first time what the lung health community has long suspected - COPD is the third leading cause of ‘burden of disease’ in Australia behind ischaemic heart disease and stroke.

Burden of disease data is based on a new summary measure of population health, the Disability Adjusted Life Year (DALY). This measure combines information on the impact of premature death and of disability, and other non-fatal health outcomes.

COPD is the largest contributor to the burden of disease associated with all lung diseases and conditions (including asthma), three times the burden of acute respiratory infections and more than four times the burden of other chronic respiratory diseases.

The burden of COPD will escalate worldwide as the population ages. The 1996 Global Burden of Disease Study compared the leading causes of disability in 1990 and 2020 (projected). In 1990 COPD was ranked 12, and it is projected to rank 5 in 2020, behind ischaemic heart disease, major depression, traffic accidents and cerebrovascular disease.

b) Mortality

COPD is less prevalent in the population than asthma, but it is responsible for many more deaths. It is the fourth leading cause of death in Australia, accounting for 5,532 deaths in 1998. This figure is slightly higher than the average for ‘developed regions’ which places COPD as the fifth leading cause of death.

COPD is the 4th most common cause of death in males, and the sixth most common cause in females. The male death rate has been declining from a peak of 75 per 100,000 in 1982 to a low of 38 per 100,000 in 1998. In contrast, the female death rate is increasing (to 17 per 100,000 in 1998). It is expected that death rates amongst females will overtake men in around 2005.

In the 15 years from 1981 to 1996, the per capita mortality burden for COPD decreased by 16% in males, but increased by 70% in females.

c) Prevalence

The Australian Institute of Health and Welfare (AIHW) estimates there were almost 300,000 persons with COPD in 1996, with more than 20,000 new cases being diagnosed every year.

A population based assessment model developed by Boehringer Ingelheim has been used by the World Health Organisation to estimate the prevalence of COPD in developing countries. When Australian population data is applied to this model, the estimated cases of moderate to severe COPD in the year 2000 is 474,000.
In a recent postal survey completed by the Monash Medical School and Alfred Hospital in Melbourne, 12.4% of adult respondents aged between 45 and 70 self-reported chronic bronchitis or emphysema. This survey did not include an objective measurement of lung function, but its findings confirm the incidence of COPD in Australia could be greatly underestimated.

Obtaining reliable prevalence data for COPD is a worldwide problem. It is complicated by differences in the way the condition is labelled (bronchitis, emphysema, COPD, COAD and CAL are all used). Some overlap with chronic asthma adds a further difficulty.

Studies collecting data on physician-diagnosed COPD have shown prevalence rates between 11% and 17% in UK and USA, while population surveys that examine self-reported diagnosis suggest lower rates. Larger population-based studies that include lung function measurements produce higher figures and confirm substantial under-diagnosis.

The international Global Initiative for Chronic Obstructive Lung Disease Workshop concluded that available prevalence and morbidity data on COPD are likely to greatly underestimate the total burden of disease, because COPD is usually not recognised and diagnosed until it is having a significant impact on a person’s lifestyle, and is moderately advanced.

d) COPD in Indigenous Australians

Indigenous Australians suffer a significant health disadvantage with higher infant mortality, higher rates of infectious disease, much lower life expectancy, and higher standardised mortality and morbidity rates, compared with non-indigenous Australians.

There is a dearth of good quality lung health statistics for Australia’s indigenous population. It is known that chronic lung disease is a major cause of morbidity and eventual premature mortality in Aboriginal Australians. Lung disease (uncategorised) is the third leading cause of death among indigenous people behind cardiovascular disease and injury. It is known that deaths from these causes occurred at greater rates in Aborigines than among other Australians, and respiratory disease accounts for 12% of admission to hospitals in males, and 9% in females. While pneumonia was the main contributor, there was over five-fold greater morbidity from COPD than expected for non-indigenous Australians.

A study of self-perceived health issues among 15,700 indigenous Australians has shown that 56.1% of males and 48.3% of females smoke cigarettes. Higher rates are seen in rural male Aborigines, especially aged 25-44, and are associated with smoking, poor education, alcohol consumption, housing and employment status. More than 15% of males and 22% of females reported asthma and other chest conditions. Cigarette smoking was associated with substantially higher rates of reporting poor health in both males and females, and poor general health was reported more frequently by indigenous people with long-term respiratory conditions than those without.

e) COPD in the context of Tobacco Related Diseases

Tobacco smoking is the risk factor associated with the greatest burden of disease in Australia, responsible for an estimated 10% of total disease burden, 12% in males and 7% in females. The burden of smoking-related diseases has decreased in males, but increased substantially in females.

Over 18,000 deaths and 150,000 hospital admissions each year in Australia are attributable to smoking. COPD accounts for almost one third of these (40,000 hospital separations).
The health system costs of COPD are $300 million per annum. These are direct costs only.

COPD has other significant costs, such as absenteeism, and change in physical capacity at work, leading to early retirement from the workforce.

Two costs which are unquantified but important are depression and the huge burden of this disease on carers.

COST TO THE COMMUNITY

a) Direct Costs
Each year, approximately 40,000 public and private hospital separations have the principal diagnosis of COPD, with an average length of stay of 5.3 days.

Anecdotal reports suggest that COPD will consume about 75% of the resources of a Respiratory Unit/Department in a major teaching hospital.

Lung diseases (including COPD, asthma and respiratory infections) are the sixth most costly disease group accounting for $2.5 billion, or 8.0% of total health system costs. The AIHW estimates that the health system costs of COPD on its own in 1993 - 94 were $300 million.

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>$112 million</td>
</tr>
<tr>
<td>Medical</td>
<td>$61 million</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>$66 million</td>
</tr>
<tr>
<td>Other</td>
<td>$61 million</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$300 million</td>
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</tbody>
</table>

COPD costs the health system almost three times as much as lung cancer ($107 million). The major costs relate to hospital and medical care reflecting chronic symptom severity and inadequate treatment strategies.

b) Indirect Costs

Costs to the healthcare system don’t reflect the total cost of COPD to the community. COPD has other significant economic impacts, such as absenteeism, productivity losses and change of duties leading to early retirement from the workforce. Studies have shown that within 7 to 8 years of initial diagnosis, most people with COPD are no longer capable of productive work.

Two important cost impacts which are unquantified, but should not be overlooked are depression (studies have shown that between 30% and 96% of patients with COPD display anxiety, depression, panic, confusion or neurosis), and the substantial economic and emotional burden on carers.

The Australian Lung Foundation’s Chronic Airflow Limitation Consultative Group attempted in 1998 to determine a figure for the total direct and indirect costs of COPD to the community, by extrapolating US statistics. The figure they arrived at was almost $800 million per annum.

WHO DEVELOPS COPD?

a) Risk Factors

Smoking is the most well known and widely studied risk factor for developing COPD, but it is not the only one. Because of the variable natural history of the disease and the lack of evidence on disease progression, current understanding of risk factors for COPD is still incomplete. Risk factors for COPD fall into two categories - host factors (or inherent factors) and environmental exposures. Some of these risk factors are known to cause COPD, while others, when combined with other risk factors, may increase an individual’s risk and speed the progression of COPD.
Our understanding of COPD risk factors is incomplete. Some risk factors cause COPD, while others may increase risk and speed the progression of COPD.

### Table: COPD Risk Factors

<table>
<thead>
<tr>
<th>Inherent Factors [e.g. individuals makeup]</th>
<th>Factor</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genes [e.g. hereditary deficiency of alpha-1-antitrypsin]</td>
<td>Causal</td>
<td></td>
</tr>
<tr>
<td>Airway Hyperresponsiveness</td>
<td>Additive</td>
<td></td>
</tr>
<tr>
<td>Lung Growth</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental Factors</th>
<th>Factor</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette Smoking</td>
<td>Causal</td>
<td></td>
</tr>
<tr>
<td>Occupational Dusts &amp; Fumes</td>
<td>Causal [if heavy]</td>
<td></td>
</tr>
<tr>
<td>Indoor/Outdoor Air Pollution</td>
<td>Causal [if heavy]</td>
<td></td>
</tr>
<tr>
<td>(including biomass fuels for cooking and heating)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td>Additive</td>
<td></td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>Additive</td>
<td></td>
</tr>
</tbody>
</table>

Most people with COPD have smoked over 20 pack-years (20 per day for 20 years), and smoking contributes about 85% of the risk of developing COPD.

A widely quoted statistic is that 15 - 20% of smokers develop COPD. This statistic is still being debated, as a much higher proportion of smokers will develop abnormal lung function and experience the symptoms of COPD, but depending on the variable natural history of their disease, may not die as a result of COPD.

**b) Susceptibility**

It is not known whether ethnicity or gender make an individual more susceptible to COPD risk factors.

COPD appears to occur more commonly in older individuals who have multiple chronic conditions that contribute to overall disability.

### IMPACT ON THE INDIVIDUAL

The characteristic symptoms of COPD are cough, sputum and breathlessness upon exertion. At first the symptoms are minimal. The individual will often ignore mild symptoms, believing they are associated with ageing and not an underlying health problem.

The ideal diagnostic tool for COPD is spirometry, a measure used to determine the volume of air inhaled and exhaled.

The natural rate of decline of lung function (Forced Expiratory Volume or FEV₁) after 25 years of age is 15 - 30 mL per year. In ‘susceptible’ smokers who continue to smoke, the decline averages 60 mL per year and may be as great as 150 - 200 mL per year in some individuals. Susceptible individuals who stop smoking during their 40’s still have a greater rate of decline than non-smokers.

The natural history of COPD is variable and will depend on continued exposure to risk factors.

As the disease progresses and impairments advance, other organ systems are threatened and a multi-system complex develops. Furthermore, the major risk factor, smoking, can lead to other concurrent morbidities. Common complications include depression, anxiety, panic disorder, social effects, cor pulmonale, polycythaemia, osteoporosis, proximal and ventilatory myopathies, upper airway obstruction and altered ventilatory control. Concurrent conditions commonly seen in patients with COPD include coronary artery disease, chronic cardiac failure, peripheral vascular disease, diabetes, cerebrovascular disease, dementia and degenerative joint disease.

As a health state, severe COPD has the third highest perceived ‘severity’ rating, on a par with paraplegia and first-stage AIDS.

Carers provide the bulk of long term care for COPD patients, which results in physical and emotional health problems. There is a link between a carer’s psychological health and the quality of care received by the patient.
COPD has been an ‘orphan disease’ for decades but global interest is reawakening, slowly.

There are significant variations in COPD management in Australia.

Less than 1% of patients with moderate to severe COPD undergo pulmonary rehabilitation per annum.

There is an urgent need to increase access to effective management strategies for early and established disease.

WHAT IS BEING DONE ABOUT COPD?

a) Global Response

Despite the escalating problem, COPD has been an ‘orphan disease’ over the past two decades, worldwide and in Australia. This can be attributed to a variety of factors:

- Lack of knowledge about the disease
- Negative attitude towards the disease (because of its mainly self-inflicted nature)
- Perceived lack of effective drug treatments
- Limited success with prevention

The global burden of COPD is finally being recognised, and interest in the disease is reawakening, albeit slowly.

The Global Initiative for Obstructive Lung Disease (GOLD) is a collaborative project of the World Health Organisation and the National Heart, Lung and Blood Institute (USA). Its goals are to increase awareness of COPD and decrease morbidity and mortality from this disease. It aims to improve the ‘public image’ of COPD as a self-inflicted disease, to improve prevention and management of COPD, and to encourage renewed research interest in the disease.

GOLD will release later this year, its Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease.

The strategy is likely to advocate that early diagnosis and appropriate management are the key to effective outcomes. Management of mild to moderate COPD is based on the avoidance of risk factors and symptomatic pharmacotherapy. More advanced disease will require integration of different disciplines, a variety of treatment approaches and a commitment to continued support of the individual as the disease progresses.

b) Local Response

The Thoracic Society of Australia and New Zealand and The Australian Lung Foundation (ALF) believe the significant variations in the management of COPD identified worldwide are reflected in Australia. There is a lack of appreciation of the scale of health burden of COPD. Understanding of new and emerging treatments and of methods for early diagnosis are also lacking. Despite the burden of the disease, promising non-drug treatments such as pulmonary rehabilitation are only being funded through the goodwill of some public and private hospitals and community health organisations.

Comprehensive pulmonary rehabilitation has been shown to improve quality of life, reduce emotional morbidity, improve exercise performance, improve functionality and confidence and reduce both primary admissions and readmissions to hospital17,18. Despite this, recent data collected by the ALF reveals that fewer than 1% of patients with moderate to severe COPD are receiving pulmonary rehabilitation per annum (approximately 1 in 200)19.

Tobacco control is the major primary preventive strategy for reducing our burgeoning public health problem, but given the time lag between behaviour change and any influence on disease development, improvements from such strategies are at least a generation away. The need to improve access to effective management strategies for early and established disease is pressing.

c) What is the Government’s current view of COPD?

In 2000, the ALF made initial contact with the State and Federal Government Health Ministers, to gather information on how policy makers view the COPD problem.

Most Health Ministers acknowledge that COPD is a significant cost to the health system, and measures need to be taken to address the problem. The National Health and Medical Research Council Health Advisory Committee acknowledged that “COPD is a major public health issue, requiring serious attention”. The Federal Government acknowledged that “the need to improve access to effective management strategies for early and established disease is pressing.”
Most States indicated that they hoped their investment in preventive (smoking cessation) programs would have an indirect benefit on the reduction of COPD in the future.

Integrated Chronic Disease Management is becoming an increasingly important health policy focus for State and Federal Governments. COPD could be targeted for future strategies.

The challenges facing COPD sufferers in rural, remote and indigenous populations were of particular concern for some States.

Several States would welcome the opportunity to collaborate with other States and combine knowledge and experiences, to strengthen the response to COPD.

WHAT ISSUES DO THE LUNG HEALTH COMMUNITY BELIEVE TO BE IMPORTANT?

The Australian Lung Foundation has consulted medical and allied health professionals with a special interest in COPD, on issues which need to be investigated in a national effort to improve COPD management.

Prevention & Screening
- Need for improved smoking cessation strategies
- The role of screening - who, when and what to do with results

Risk Factors and Epidemiology
- Risk factors for COPD other than tobacco as preventative targets
- Better data on COPD prevalence, incidence, mortality, burden on patients and carers.
- Need to learn more about genetic and/or immunologic factors encouraging development of COPD
- Exploring the role of COPD in indigenous Australians

Management
- Assessment of severity in the community
- Strategies for improved community management (including exacerbations), and transition from hospital to community care
- Factors related to admission in COPD & objective criteria for admission and readmission
- Recommended models for integrated/co-ordinated care, outreach/home care
- Role of Lung Volume Reduction Surgery (LVRS)
- Role of Home Oxygen Therapy
- Improving community access to pulmonary rehabilitation
- Producing guides for health professionals on how to establish rehabilitation programs
- National outcome measures for pulmonary rehabilitation
- Patient education and support programs
Communication with key groups:

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Message</th>
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<tbody>
<tr>
<td>People with COPD</td>
<td>“Something can be done”</td>
</tr>
<tr>
<td>People with COPD who don’t know it</td>
<td>“Take control now before it becomes a problem”</td>
</tr>
<tr>
<td>General Public (candidates for COPD)</td>
<td>“Smoking causes COPD”</td>
</tr>
<tr>
<td>Health Professionals</td>
<td>“Things have changed in COPD”</td>
</tr>
<tr>
<td>Government</td>
<td>“COPD is a major health problem”</td>
</tr>
</tbody>
</table>

THE AUSTRALIAN LUNG FOUNDATION’S ACTION SO FAR

The Australian Lung Foundation has a key focus on COPD, with major initiatives already underway.

- Development of a co-ordinated National Strategy for action on COPD
- Chronic Airflow Limitation Consultative Group (established 1997) - a multidisciplinary group assisting the ALF with the development of COPD related projects.
- LungNet (established 1997) - an information service and network of lung support groups (currently 70 nationwide). Services include a toll free 1800 number for information and referrals to support groups and pulmonary rehabilitation programs, assistance with establishment of support groups, state based education seminars and a quarterly self-help newsletter for patients and carers.
- Pulmonary Rehabilitation - in February 2000 the ALF surveyed 53 program coordinators to gain a picture on the current status of Pulmonary Rehabilitation in Australia. A blueprint of the essential elements, costs and benefits of Pulmonary Rehabilitation is currently being developed.
- Development of a handbook for General Practitioners on diagnosing and treating COPD
- Development of education information and self management plans for patients and carers
- Development of Australian and New Zealand Guidelines for the Management of COPD. This will be a joint project of the Thoracic Society of Australia and New Zealand and The Australian Lung Foundation to be undertaken in 2001. The aim is to develop evidence based guidelines presented in user friendly formats for the range of health professionals who are involved in COPD management, patients and carers.
COPD - WHERE DO WE WANT TO GO?

Despite the size of the problem and its predicted escalating burden, there has been no State or National co-ordinated effort to address Australia’s COPD problem to date.

To achieve better lung health in our community and arrest the escalating problem of COPD the following broad gains need to be made:

- An accurate profile and statistical analysis of COPD in Australia
- Improved knowledge of causation and optimal prevention and treatment methods
- Improved quality of life for COPD patients through education, self-management and improved access to optimal treatment methods
- A measured reduction in causal behaviours by at-risk groups
- A significant increase in early diagnosis, treatment and rehabilitation activity, leading to proportionally lower patient/community/economic cost
- A level of awareness that reflects the burden of COPD and the gains which must be made
- Declining incidence of COPD
- Reducing the burden of COPD

For more information or to become involved please contact:

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COPD IN NEW ZEALAND

In New Zealand, COPD is the second most important chronic disease in adults, second only to stroke.

New Zealand currently has the 5th-highest death rate for COPD in the world. It is the 3rd most common reason for death in males and the 4th most common reason in females.

It is among the top 4 major causes of avoidable hospitalisation for New Zealanders aged 45 and over. In 1998/9 there were 7,450 admissions to public hospitals for COPD with an average length of stay of 6.2 days and total cost of $16.4 M.

The costs of COPD to the health system are proportionally similar in New Zealand to the Australian figure of $300 million per annum.

In New Zealand, the Ministry of Health has identified COPD as requiring significant attention. The Government has targeted smoking cessation as a vital health initiative for 2001 and beyond as a way of preventing COPD, particularly among the Maori population.

The Asthma and Respiratory Foundation of New Zealand has selected COPD for its awareness week activity in 2001 and as the focus for community education for the year.

The Asthma and Respiratory Foundation of New Zealand will link with the New Zealand Branch of the Thoracic Society of Australia and New Zealand (TSANZ) to work with the Ministry of Health to develop a health strategy to deal with the growing problem of COPD.

Evidence based guidelines being developed by the TSANZ and The Australian Lung Foundation could be readily adapted for use in New Zealand.
REFERENCES

5 Boehringer Ingelheim GmbH 1999
7 Draft Executive Summary: Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease. NHLBI, WHO, September 2000
8 Cunningham J, Paradis Y. Occasional Paper: Mortality of Aboriginal and Torres Strait Islander Australians. ABS cat. no. 3315.0, ABS, Canberra, 2000
19 The Australian Lung Foundation National Survey of Pulmonary Rehabilitation, March 2000

ACKNOWLEDGEMENTS

This COPD Case Statement was collated and reviewed with the assistance of:
Members of The Australian Lung Foundation’s Chronic Airflow Limitation Consultative Group: Dr Peter Frith (Chair)
Ms Jenny Alison
Dr Jonathan Burdon
Associate Professor David McKenzie
Dr James Markos
Dr Matthew Peters
Professor Robert Pierce
Associate Professor Robyn Richmond
Dr Greg Snell
Mr Pieter Walker
Associate Professor Iven Young

Associate Professor Alan Crockett
Ms Joan Cunningham
Dr Graeme Maguire
Professor Ian Town

The ALF acknowledges the support of Boehringer Ingelheim for allowing use of its population based assessment model for COPD, and supporting the meetings of The Chronic Airflow Limitation Consultative Group.
THE AUSTRALIAN LUNG (ALF)
FOUNDATION AND COPD

The Australian Lung Foundation's mission is to reduce the burden of chronic lung disease in Australia and promote lung health, through research, education, advocacy and patient support.

The ALF was established in 1990. Its National Office is in Brisbane and it has a Committee in every State. It is linked to The Thoracic Society of Australia and New Zealand, which is the peak professional body for medical and scientific knowledge on respiratory disease.

How can the ALF help people with COPD?

By calling the ALF's toll free number (1800 654 301), COPD patients and carers will be offered:

1) COPD Information

Publications available:

- LungNet News (free quarterly magazine for patients and carers)
- Education Leaflets including:
  - Chronic Bronchitis & Emphysema
  - Home Oxygen Therapy
  - The Lungs (an overview of how they work)
  - Steroid Therapy in Respiratory Disorders
  - Better Living with COPD

2) Support Groups

The ALF co-ordinates LungNet, a national network of lung support groups. There are currently 70 groups throughout metropolitan, regional and rural Australia.

3) Pulmonary Rehabilitation Program Details

The ALF maintains a database of all the pulmonary rehabilitation programs currently operating throughout Australia and can provide contact details of program co-ordinators.

TOLL FREE 1800 654 301
http://www.lungnet.com.au
enquiries@lungnet.com.au