Improving Smoking Cessation Interventions
in the Clinical Setting

A proposal to NSW Health

NSW Agency for Clinical Innovation (ACI)

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Developed by the ACI Respiratory Network

Network Co-Chairs: A/Professor David McKenzie, A/Professor Jenny Alison

Airways Diseases Working Group Co-Chairs: Prof Peter Van Asperen, Mr Ken Langbridge

Smoking Cessation Sub-Group Members

A/Prof Renee Bittoun Director, Smoker's Clinics SWSAHS
Ms Karen For Respiratory Specialist Liaison Nurse Liverpool Hospital
Ms Donna Harrison CNC, Smoking Cessation SWAHS
A/Prof Guy Marks Consultant Physician, Respiratory Medicine Liverpool Hospital
Ms Merylese Mercieca CNC Respiratory Medicine Nepean Hospital
Ms Elayne Mitchell Senior Policy Analyst, Cessation Tobacco & Health Branch, NSW Health
A/Prof Matthew Peters Consultant Physician, Respiratory Medicine Concord Hospital
Dr Sue Towns Consultant Physician, Respiratory Medicine Children's Hospital Westmead
Prof Peter Van Asperen Consultant Physician, Respiratory Medicine Children's Hospital Westmead
Mr Nick Wilcox Manager, Respiratory Network ACI

Authors: Mr Nick Wilcox, A/Prof Matthew Peters, Prof Peter Van Asperen, Ms Donna Harrison, A/Prof Renee Bittoun
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PROPOSAL ENDORSEMENTS

This proposal has been endorsed (see Appendix C: Letters of Endorsement) by the following organisations:

- Asthma Foundation NSW
- Australian Lung Foundation
- Clinical Excellence Commission
- Clinical Oncological Society of Australia
- Diabetes Australia - NSW
- Justice Health NSW
- Mental Health Coordinating Council NSW
- Stroke Foundation
- National Asthma Council Australia
- The Cancer Council NSW (in-principle agreement)
- Thoracic Society of Australia and New Zealand
- ACI Cardiology Network
- ACI Diabetes Network
- ACI State-wide Ophthalmology Service
- ACI Stroke Services Network
- ACI Transition Care Network

STATEMENT OF DISCLOSURE

A/Prof Renee Bittoun receives funding for research and education from various pharmaceutical companies that manufacture products used to treat nicotine dependence.
1. **EXECUTIVE SUMMARY**

This proposal links with the *NSW State Plan* which outlines priorities and targets for improved health, through reduced smoking rates by delivering better services to NSW, and aligns with Strategic Direction 1 of the *NSW State Health Plan* to “make prevention everyone’s business”. The proposal builds on the *NSW Tobacco Action Plan 2005-2009* which outlines the “NSW Government’s commitment to the prevention and reduction of tobacco-related harm” in which smoking cessation was identified as one of six key focus areas.

Further, the proposal is aligned with the *National Tobacco Strategy 2004-2009*, with particular reference to its aim for improved services and treatments for smokers, and with the *World Health Organisation’s Evidence Based Recommendations on the Treatment of Tobacco Dependence*, which state that “purchasing treatment for tobacco dependence represents an extremely cost effective way of reducing ill health and prolonging life”.

Moreover, the recommendations in this proposal concur with the report of the *NSW Joint Parliamentary Select Committee’s Inquiry into Tobacco Smoking in NSW (June 2006)* regarding the need for resource enhancement for smoking clinics and/or smoking cessation therapists within area health services. To this end ACI proposes a pathway for action in accordance with the *NSW Government Response to the Select Committee Inquiry*.

The introduction section of this proposal explains that, notwithstanding a decrease in the prevalence of tobacco smoking in Australia over the last 25 years, there is universal consensus on the continuing burden of tobacco smoking, and the benefits of reducing smoking prevalence. Tobacco smoking remains the single largest preventable cause of mortality and morbidity in Australia, and in NSW alone there are over 6,600 deaths and 55,000 hospitalisations attributable to tobacco related disease each year.

Aside from the enormous costs to NSW in general ($6.6 billion per annum), and the costs to NSW Health in direct health care ($477 million per annum), many of the personal costs are borne by the most disadvantaged members of the population.

About half of Australia’s smokers make at least one serious quit attempt in a twelve month period. However, 95 percent of quit attempts made in the absence of medication or support, fail.

Public health approaches, including television advertising and public education campaigns, have demonstrated acceptable quit rates in smokers with mid- to low-level nicotine dependence. Quitline NSW provides telephone support to the general smoking population and has been an important component of the stop smoking campaign in NSW. However, notwithstanding the on-going importance of the role of the Quitline, smokers accessing the healthcare system as patients have failed, at least to that point, public awareness campaigns and Quitline.
Furthermore, nicotine dependence is classified as a relapsing chronic disease, which often requires ongoing medical treatment, as do all other diseases, medical disorders and drug dependencies. Many smokers, therefore, will only be able to cease smoking and maintain long term abstinence on receiving clinical treatment and management of their nicotine dependence.

The effectiveness of smoking cessation interventions, including intensive individual counselling, pharmacotherapy and extended follow-up is well established. Although brief advice to patients on quitting has been found to be effective, an individual’s chances of success in quitting can be roughly doubled by the use of established tobacco dependence treatments including intensive counselling, Nicotine Replacement Therapy (NRT) and extended follow-up. The evidence suggests that more complete assistance of this type should be provided to patients to increase the likelihood of a successful smoking cessation attempt. Additionally, it should be remembered that there is a strong dose-response relationship between intensity of treatment of tobacco dependence (dosage of medications and frequency of visits) and long term clinical outcomes (abstinence rates).

The cost-effectiveness of smoking cessation interventions is also well documented. In England, clinical treatment services for addicted smokers are now provided through the National Health Service (NHS). Successful services have also been established in France and New Zealand.

In NSW, however, clinical smoking cessation interventions are provided on an ad-hoc basis and in limited capacity. Most clinicians believe it is important to ask patients about smoking and to provide advice on how to quit. However, evidence suggests that even after undergoing smoking cessation training, only half of the clinical population actually identify smokers in their practice and even fewer assist with brief interventions for smoking cessation. Clinician training alone is unlikely to represent a useful investment of resources.

Organisational change and clinical resource enhancements, including greater investment in the provision of nicotine replacement therapy, are required to facilitate an effective range of intervention practices and, thus, cessation outcomes.

Treating tobacco dependence produces a strong return on investment. ACI proposes a clinical Smoking Cessation Program (SCP) consisting of three key initiatives which will have a synergistic impact on smokers with a chronic dependence on nicotine. The Smoking Cessation Program, if implemented, has the potential to substantially reduce the cost burden of tobacco dependence on the NSW health system.
2. **SUMMARY OF KEY RECOMMENDATIONS**

**Recommendation 1: Population Approach**  
**Smoking Cessation Coordinators (Area-based)**

That funding be made available to employ twelve ‘Smoking Cessation Coordinators’; one in each Area Health Service in NSW, and one dedicated coordinator for each of four specific target groups: aboriginal health, mental health, paediatrics, and Justice Health.

The job of Smoking Cessation Coordinators will be to coordinate the implementation of ‘Focus Area 1: Smoking Cessation’ of the NSW Tobacco Action Plan 2005-2009. The key outcomes of this focus area will be achieved by taking a population approach to promote, coordinate and facilitate smoking cessation services, to foster clinical smoking cessation networks across the hospital and community/primary care settings, and to develop a variety of other smoking cessation initiatives.

**Recommendation 2: Clinical Services**

**Smoking Cessation Clinicians (Facility-based)**

That funding be made available to employ hospital-based ‘Smoking Cessation Clinicians’ according to the needs of individual facilities.

These new clinical positions would be dedicated to the delivery of evidence based, specialised smoking cessation interventions in hospital and community settings to nicotine-dependent patients across all medical specialties. Interventions would be delivered to specifically targeted patient populations (see sections 5.1.1 and 5.1.2) using strict referral criteria (see section 5.2.1).

The key outcome of substantially increased client quit rates, through the provision of specialist tobacco dependence treatment services (including behavioural counselling, pharmacotherapy, and on-going management and support), is strongly supported by the evidence.

**Recommendation 3: Pharmacotherapy**

**Free / Heavily Subsidised Nicotine Replacement Therapy**

That current Nicotine Replacement Therapy (NRT) subsidisation be extended to facilitate the provision of free / heavily subsidised, full course NRT (for the duration of individual therapeutic requirements), for high risk smokers.
3. BACKGROUND

3.1 NSW State Plan

This proposal links directly with the NSW State Plan which outlines priorities and targets for improved health through reduced smoking rates by delivering better services to NSW\(^{(1)}\):

<table>
<thead>
<tr>
<th>Delivering Better Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our Goals</strong></td>
</tr>
<tr>
<td>Healthy Communities</td>
</tr>
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<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

[Adapted from: ‘NSW State Plan 2006’]

3.2 NSW State Health Plan

Additionally, this proposal aligns with Strategic Direction 1 of the NSW State Health Plan to:

‘Make Prevention Everyone’s Business’

The Plan states that this will be achieved by:

“…continuing to implement social marketing campaigns, tobacco legislation, smoking cessation programs and other tobacco control measures particularly aimed at disadvantaged groups”\(^{(2)}\).

3.3 NSW Tobacco Action Plan 2005-2009

The recommendations contained in this proposal build on the *NSW Tobacco Action Plan 2005-2009* outlining the “NSW Government’s commitment to the prevention and reduction of tobacco-related harm” in which smoking cessation was one of six identified focus areas\(^{(3)}\). Specifically, the recommendations augment the following activity areas detailed in the Plan:

- Implementation of the *Guide for the Management of Nicotine Dependent Inpatients* including the routine use of Nicotine Replacement Therapy (NRT), patient education and Quitline referral post-discharge.
- Education and training for healthcare workers on smoking cessation initiatives/interventions for patients.
- Data collection
- Specific focus on target groups including:
  - Aboriginal and Torres Strait Islander peoples
  - Young adult smokers aged 16-29 years
  - Smokers from the lower socioeconomic groups
  - Heavily dependent smokers
  - Mental health clients
  - Culturally and Linguistically Diverse (CALD) population groups with high smoking rates
  - Pregnant women, their partners and families and those planning a pregnancy
  - Parents and carers of babies and children
  - Inmates and detainees in correctional settings
  - Health Services staff
3.4 National Tobacco Strategy 2004-2009

Additionally, the recommendations align with the *National Tobacco Strategy 2004-2009*, with particular reference to its aim for improved services and treatments for smokers:

“To improve the quality and acceptability of services to assist smokers to quit and to ensure that any new treatments that are significantly more cost-effective are available and affordable to all Australian smokers by:

- Interlinking policies and programs to encourage greater involvement by general practitioners and other health professionals in smoking cessation;
- Improving the quality of use of pharmacotherapies;
- Increasing the use of behavioural support services; and
- Ensuring that effective treatment for tobacco dependence is offered wherever possible in people’s interactions with the health care system”.

3.5 World Health Organisation Recommendations for Healthcare Purchasers

The *World Health Organisation’s Evidence Based Recommendations on the Treatment of Tobacco Dependence* state that “purchasing treatment for tobacco dependence represents an extremely cost effective way of reducing ill health and prolonging life”.

Specific recommendations for healthcare purchasers included:

- Health care purchasers should purchase tobacco dependence treatments, choosing a blend of interventions relevant to local circumstances but emphasising those interventions which have the strongest evidence base.
- Because tobacco dependence treatment is so cost effective, it should be provided by public and private health care systems.
- Access to both behavioural and pharmaceutical treatments should be as wide as possible with due regard to local regulatory frameworks and other circumstances.
- Mechanisms should be found to increase the availability of treatment to low income smokers, including at a reduced cost or free of charge.
- Health professionals should be trained to advise and help smokers stop smoking, and health care purchasers should ensure the provision of adequate training budgets and training program.
- Education and training for the different types of interventions should be provided not only at the postgraduate and clinical level, but should start at under-graduate and basic level, in medical and nursing schools and other relevant training institutions.
- Telephone help lines can be effective and are very popular with smokers and should be made available where possible.
3.6 NSW Parliamentary Select Committee Inquiry on Tobacco Smoking in NSW (June 2006)

Moreover, this proposal concurs with the report of the NSW Parliamentary Select Committee on Tobacco Smoking in NSW (June 2006)\(^6\) regarding the need for resource enhancement for smoking clinics and/or smoking cessation therapists within area health services. Specifically, we endorse Recommendations 9 and 10 of the Parliamentary Committee’s report:

**Recommendation 9**

*That NSW Health give consideration to ways of ensuring that area health services deliver antismoking programs, with specific reference to ensuring access by the full range of disadvantaged groups.*

**Recommendation 10**

*That NSW Health increase resources for smoking clinics and/or professional smoking cessation therapists in every area health service.*

**Recommendation 11**

*That the NSW Government and the Cancer Institute NSW initiate discussions with the Commonwealth Government focussing on the need to make nicotine replacement therapy accessible and affordable for all smokers.*

3.7 NSW Government Response to the Select Committee’s Inquiry on Tobacco Smoking

ACI proposes a pathway for action, a Smoking Cessation Program (SCP), in accordance with the NSW Government Response to the Select Committee Inquiry\(^7\), with particular reference to the Government’s response to the following recommendations:

**Recommendation 10:**

“The NSW Government notes this recommendation and will give consideration to the provision of a smoking cessation therapist in every Area Health Service”\(^7\)

**Recommendation 11**

“NSW Health will continue to advocate to the Commonwealth Government for increased accessibility and affordability of NRT for quitting smokers.”

“…A proposed program for the distribution of free nicotine patches… should be based on the New Zealand model, with Quitline staff assessing nicotine dependence of callers and their suitability for using NRT to quit and issuing redeemable vouchers in exchange for NRT through pharmacies.”\(^7\)
4. **INTRODUCTION**

4.1 **Burden of Tobacco Smoking**

There is universal consensus\(^{(3, 4, 5, 6, 8, 9)}\) on the burden of tobacco smoking and the benefits of reducing smoking prevalence.

Tobacco smoking is a behaviour which accounts for the single largest preventable cause of mortality and morbidity in Australia\(^{(10)}\). Diseases and conditions that are known\(^{(6)}\) to be caused by tobacco smoking are listed in Table 1.

Table 1: Mortality and morbidity causally associated with the consumption of tobacco

<table>
<thead>
<tr>
<th>Oropharyngeal cancer</th>
<th>Oesophageal cancer</th>
<th>Stomach cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal cancer</td>
<td>Pancreatic cancer</td>
<td>Laryngeal cancer</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Endometrial cancer</td>
<td>Cervical cancer</td>
</tr>
<tr>
<td>Vulvar cancer</td>
<td>Penile cancer</td>
<td>Bladder cancer</td>
</tr>
<tr>
<td>Renal parenchymal cancer</td>
<td>Renal pelvic cancer</td>
<td>Respiratory carcinoma <em>in situ</em></td>
</tr>
<tr>
<td>Tobacco abuse</td>
<td>Parkinson’s disease*</td>
<td>Ischaemic heart disease</td>
</tr>
<tr>
<td>Pulmonary circulatory disease</td>
<td>Cardiac dysrhythmias</td>
<td>Heart failure</td>
</tr>
<tr>
<td>Stroke</td>
<td>Atherosclerosis</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Peptic ulcer</td>
<td>Chronic obstructive pulmonary disease</td>
<td>Ectopic pregnancy</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td>Ulcerative colitis*</td>
<td>Hypertension in pregnancy*</td>
</tr>
<tr>
<td>Spontaneous abortion</td>
<td>Antepartum haemorrhage</td>
<td>SIDS (and smoking during pregnancy)</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>Premature rupture of membranes</td>
<td>Fire injuries</td>
</tr>
<tr>
<td>Asthma (under 15 years)</td>
<td>Lower respiratory illness (&lt;18 yrs)</td>
<td>SIDS (and post-natal smoking)</td>
</tr>
<tr>
<td>Lung cancer (passive)</td>
<td>Ischaemic heart disease (passive)</td>
<td>Eye Disease (AMD and Cataract)</td>
</tr>
</tbody>
</table>

* Indicates negative association


In NSW there are over 6,600 deaths and 55,000 hospitalisations attributable to tobacco related disease each year\(^{(3)}\).

Aside from the enormous costs to NSW in general ($6.6 billion per annum)\(^{(8)}\), and the costs to NSW Health in direct health care ($477 million per annum)\(^{(6)}\), many of the personal costs are borne by the most disadvantaged members of the population\(^{(3)}\).
4.2 Prevalence of Tobacco Smoking

The prevalence of tobacco smoking in Australia has fallen substantially over the last 25 years (see Table 2 below)\(^6,\,11\).

<table>
<thead>
<tr>
<th>Year</th>
<th>Tobacco Smoking Prevalence (% Population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945</td>
<td>45</td>
</tr>
<tr>
<td>1992</td>
<td>26</td>
</tr>
<tr>
<td>2001</td>
<td>19</td>
</tr>
<tr>
<td>2006</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 2: The Changing Prevalence of Tobacco Smoking in Australia\(^6,\,11\)

This decline has been largely attributed to population based approaches to smoking cessation. Public health approaches, including television advertising and public education campaigns, have demonstrated acceptable quit rates in smokers with relatively low-level nicotine dependence. However, smokers are not a homogenous group\(^13\). There is a wide range of nicotine dependence as measured by multiple factors including nicotine plasma levels and urine cotinine concentrations. Further, the precise picture of dependence may change from person to person and from time to time\(^13\).

In NSW the prevalence of tobacco smoking has fallen from 36 percent in 1977 to 20.1 percent (22.6% of males and 17.5% of females) in 2005\(^14\) (Table 3).

Table 3: Smoking status by sex, persons aged 16 years and over, NSW 1977 to 2005\(^14\)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>Males 23</td>
<td>35.9</td>
<td>41.1</td>
<td>35.55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 10.7</td>
<td>59.3</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>Males 28.7</td>
<td>36.8</td>
<td>34.5</td>
<td>30.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 15.3</td>
<td>58.6</td>
<td>26.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989/90</td>
<td>Males 28.2</td>
<td>39.5</td>
<td>32.3</td>
<td>28.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 17.3</td>
<td>57.4</td>
<td>25.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>Males 33</td>
<td>41</td>
<td>26</td>
<td>24.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 24</td>
<td>53</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>Males 31.4</td>
<td>41.6</td>
<td>27</td>
<td>23.35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 20.5</td>
<td>59.8</td>
<td>19.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997/98</td>
<td>Males 28.4</td>
<td>44.6</td>
<td>26.9</td>
<td>24.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 21.2</td>
<td>57.6</td>
<td>21.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Males 27.7</td>
<td>47.3</td>
<td>25</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 21.7</td>
<td>58.3</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Males 25.5</td>
<td>51.9</td>
<td>22.6</td>
<td>20.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Females 20.6</td>
<td>61.9</td>
<td>17.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[From: NSW Health Public Health Division, Report of the Chief Health Officer, 2006.]
4.3 Tobacco Dependence as a Disease

It is well established that the driving force behind tobacco smoking is the body’s requirement to establish and maintain nicotine blood and brain levels for normal daily functioning (nicotine dependence).

Nicotine dependence is classified as a chronic relapsing disorder\(^4\) which, for many smokers, requires ongoing medical treatment as do all other diseases, medical disorders and drug dependencies\(^4, 15\).

On attempting smoking cessation, smoking behaviour often involves periods of remission and relapse mainly due to re-stimulation of nicotine receptors via environmental exposure to nicotine, stress hormone release and cue conditioning\(^15\).

Without assistance, around 95% of quitters will fail on any single attempt\(^4\). Most people make multiple attempts before they quit\(^4\), and many people never succeed despite a strong preference not to smoke\(^4\).

4.4 Treatment of Nicotine Dependence

Many smokers will only be able to cease smoking and maintain long term abstinence on receiving assistance to quit\(^4\). Such assistance should include the availability of evidence based treatment and management of nicotine dependence\(^4, 16\).

Further, as nicotine dependence is a chronic condition, with periods of remission and relapse, it is important that a treatment and management model for nicotine dependence is performed within a chronic framework as opposed to an acute one\(^12\).

An individual’s chances of success in quitting smoking can be roughly doubled by the use of known tobacco dependence treatments such as face-to-face (or intense telephone) counselling, and the use of pharmacotherapies\(^10, 17\).

Further, the effects of pharmacological and non-pharmacological treatments are additive, and success rates are maximised when treatment is comprehensive. Motivated patients undertaking comprehensive treatment including both behavioural and pharmacological approaches have more than a one in three chance of succeeding\(^10, 17\).

4.4.1 Effectiveness of Smoking Cessation Interventions

The effectiveness of smoking cessation interventions is also well established\(^10, 18 - 26\).

A review\(^10\) of evidence for best practice smoking cessation interventions in healthcare settings demonstrated effectiveness in the following interventions:

1. Brief interventions consisting of cessation advice and referral from health care providers delivered opportunistically during routine consultations to smokers whether or not they are seeking advice on stopping smoking. Each session usually lasts three to five minutes and follows a stepped process described as the 4A’s (UK, NZ) or 5A’s (US) approach (Appendix 4); Ask, Advise, Assess, Assist, Arrange.

2. Individual consultation including:
   a. More intensive treatment by usual carers (eg doctors, nurses) particularly if combined with follow-up visits and telephone consultations.
   b. Treatment by a specialised tobacco dependence clinician

3. Medications including combination therapeutic nicotine, anti-depressant medication (bupropion hydrochloride, nortriptyline hydrochloride) and varenicline (particularly when administered via an evidence based treatment programme).

There is a dose response relationship between intensity of treatment (dosage of medications and frequency of visits) of tobacco dependence and long term clinical outcomes (abstinence rates)\(^4, 10, 12, 27\).
4.4.1 Cessation Interventions in the Hospital Setting

A 2007 Cochrane review(20) examining the effectiveness of smoking cessation interventions in the hospital setting found that “high intensity behavioural interventions that begin during a hospital stay, and include at least one month of supportive contact after discharge, promote smoking cessation among hospitalised patients. These interventions are effective regardless of the patient’s admitting diagnosis. Interventions of lower intensity or shorter duration have not been shown to be effective in this setting”. The authors stated that “the evidence of benefit for NRT has strengthened and the point estimates are compatible with research in other settings showing that NRT and bupropion are effective”(20).

4.4.1.2 Peri-operative Smoking Cessation Programs

Evidence demonstrates that short-term preoperative cessation of smoking does not reduce the risk of complicated tissue and wound healing or other complications following surgery(28). Conversely, effective intervention resulting in cessation of smoking in the longer term prior to surgery significantly reduces postoperative morbidity and length of stay in hospital(29). Moller et al 2002 demonstrate a fifty percent reduction in postoperative wound-related and cardiovascular complications and a two-day reduction in length of stay in hospital as a result of well timed preoperative cessation interventions in orthopaedic patients(29). If these results were replicated in NSW at half the success rate observed in this study, the cost savings would be substantial.

4.4.2 Current Clinical Practice

Freund et al (2009) describe hospitals as “key settings for the provision of smoking cessation care”, providing a variety of opportunities for delivering cessation interventions at a time when patients are receptive to such care. However, a review(30) of the prevalence of smoking cessation interventions in hospitals suggests the prevalence of smoking care remains inadequate and/or low, despite the existence of guidelines recommending such care.

The review provides both patient-reported and clinician-reported prevalence:

<table>
<thead>
<tr>
<th></th>
<th>patient reported (%)</th>
<th>clinician reported (%)</th>
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</thead>
<tbody>
<tr>
<td>Patients assessed for smoking status</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Patients advised or counselled to quit</td>
<td>42</td>
<td>70</td>
</tr>
<tr>
<td>Provision / advice on NRT</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Referral / follow-up</td>
<td>12</td>
<td>39</td>
</tr>
</tbody>
</table>

The results suggest that, although the proportion of patients assessed for smoking status was relatively high (between 60% and 80%), it remains inadequate with between 20 to 40 percent of patients not receiving assessment of smoking status, an obvious barrier to recommended care.

Levels of care regarding provision or advice on NRT and follow-up or referral to further quitting assistance were particularly low. Given the potential of NRT to improve cessation rates(19, 17) the low levels of its provision is of particular concern, as is the low prevalence of provision of discharge NRT, service referral and follow-up.

The central theme of this proposal is the augmentation of resources in hospitals and clinical community settings to improve patient access to comprehensive evidence-based cessation interventions.
4.4.3 Limitations of Brief Intervention in the Clinical Setting

Although brief advice to patients on quitting has been found to be effective\(^{(10, 18, 31)}\), evidence suggests that more complete assistance should be provided to patients to increase the likelihood of a successful smoking cessation attempt\(^{(20)}\). The provision of intensive counselling, NRT and extended follow-up are recommended as requirements to support such an attempt\(^{(20)}\).

A 2006 study\(^{(32)}\) of the self-reported practice of fifty seven paediatricians in brief interventions for adolescents who smoke was conducted at The Children’s Hospital at Westmead. The study demonstrated that although 96% of paediatricians believed it is important to ask about smoking and advise adolescents to quit smoking, only half (54%) actually identify adolescent smokers in their practice and even fewer assist with brief interventions for smoking cessation\(^{(32)}\).

The study also described clinicians’ confidence in providing brief smoking cessation interventions. Not surprisingly clinicians who were more confident in brief intervention skills, motivational interviewing and relapse prevention were significantly more likely to use the 5A’s intervention strategy. Additionally training was found to increase clinician’s confidence in brief intervention skills and knowledge of nicotine replacement therapy\(^{(32)}\).

However, there was no statistically significant change in clinical practice one month post training\(^{(32)}\). To this end the authors cite Lancaster et al. who state that training alone is unlikely to represent a useful investment of resources unless it is linked to organisational changes that facilitate the intervention\(^{(33)}\). Milne and Towns suggest that “a cultural change within an institution is required in order to see a greater change in clinicians’ practice of providing smoking interventions for teenagers”.

An important component of the role of smoking cessation coordinators as outlined in this proposal would be to facilitate such change.

4.4.4 Cost Effectiveness of Smoking Cessation Interventions

The cost effectiveness of smoking cessation interventions is well documented\(^{(18, 34-38)}\), comparing very favourably with other medical interventions\(^{(36)}\). Parrott and Godfrey (2004) illustrated the cost-effectiveness of a range of intensities of smoking cessation interventions in the United Kingdom compared with that of routine strategies for preventing myocardial infarction (Figure 2).

\[\text{Figure 2: Cost-effectiveness of a range of intensities of smoking cessation interventions in the United}
\]
\[\text{Kingdom compared with that of routine strategies for preventing myocardial infarction (From Parrott and Godfrey (2004))}\]

The most cost effective intervention was brief advice alone (cost £159 per life year saved), although the most intensive, and most effective\(^{(10)}\), clinical interventions represent good value for money at £1002 per life year saved\(^{(34)}\).
In Canada, Popova et al (2009) assessed the impact of four effective interventions, focusing on individual behavioural change and aimed at reducing tobacco-attributable morbidity with respect to effects on reducing prevalence rates of cigarette smoking, population-attributable fractions, reductions of disease-specific morbidity and its cost(22). Results revealed that an implementation of a combination of four tobacco policy interventions would result in a savings of 33,307 acute care hospital days, which translates to a cost savings of about $37 million per year in Canada(22). Assuming 40% coverage rate for all individually based interventions, the most effective interventions, in terms of avoidable burden due to morbidity, were nicotine replacement therapy and physicians' advice, followed by individual behavioural counselling and increasing taxes by 10%(22).

4.4.5 The Target Population is Harder to Treat

There is emerging evidence(39 - 42) that the current population of smokers has become harder to treat with overall higher nicotine dependence scores, increasing number of attempts at quitting and the existence of complex psychiatric co-morbidities(43).

As the tobacco dependence level rises, a more intensive approach is required to treatment(44), including tailored treatment with a combination of evidence based medications, higher medication dosing and more frequent clinic visits. This concept is shown in Figure 1 below.

**Figure 1: Hierarchy of Smoking Cessation Interventions**

![Smoking Cessation Pyramid](image)


At the bottom of the pyramid are the broader strategies that may help smokers quit spontaneously while at the top are the more intensive approaches that may be required for the more heavily dependent smoker.
4.4.6 Specialist Smoking Cessation Services in England

In England, treatment services for addicted smokers are now provided through the National Health Service (NHS). Services are paid for out of general taxation and are free at the point of use.

After four years these services existed in every local health area in the country and were working at full capacity. In the fourth year almost 235,000 people attended treatment and set a quit date\(^{(36)}\).

Evaluations\(^{(35-37)}\) of the English specialist smoking cessation services reported a biologically validated (expired carbon monoxide measuring less than 6 ppm) 4-week abstinence rate of 53%, a validated 52-week abstinence rate of 14.6%, and a relapse rate from 4 to 52 weeks of 75%\(^{(35)}\). There was no sex difference in cessation rates at long-term follow-up. The cessation results and relapse rate from weeks 4 to 52 were consistent with results from published studies, including clinical trials.

In terms of cost effectiveness the services provided effective treatment well below the cost effective benchmark of £20,000 per quality adjusted life-year saved (QALY) that is used by the National Institute for Clinical Excellence in the United Kingdom to recommend new health care interventions. Using an up-to-date estimate for health gain accrued by stopping smoking, the average cost per life year gained was £684, falling to £438 when savings in future health-care costs were counted. With the worst case assumptions, the estimate of cost-effectiveness rose to £2693 per life-year saved and fell to £227 under the most favourable assumptions\(^{(36)}\).

The cost-effectiveness results confirm that treating dependent smokers is extremely cost-effective and represents excellent value for money compared with many other health care interventions. Raw M et al (2005) state that “treatment of dependent smokers is one of the most cost-effective of any intervention provided by the English health care system and, on these figures, by a long way. The figure from the government monitoring data of an average cost per treated smoker of around £200 also shows that helping smokers stop is a remarkably low-cost intervention. Thus treatment for dependent smokers is excellent value for health care systems”\(^{(36,37)}\).

The services also succeeded in reaching socio-economically disadvantaged smokers\(^{(45)}\).

Raw M et al (2005) in ‘Lessons from the English Smoking Treatment Services’ make the following recommendations to other health care systems considering initiatives of this kind:

1. Set training standards and increase training capacity \textit{before} launching the services;
2. Standardise the provision of pharmaceutical treatments and make them as accessible as possible \textit{before} launching the services;
3. Give the services at least 5 years of central funding to allow them to become well established.

Monitoring is extremely important but should not be so much of a burden that it detracts from developing a quality service and, although cessation targets can be helpful, care needs to be taken that they are reasonable and do not promote throughput at the expense of quality.
4.5 Smoking Cessation Services in NSW

The provision of smoking cessation services in NSW is inadequate\(^{(46, 47)}\).

Clinical smoking cessation interventions in NSW are provided by a range of medical, nursing and allied health clinicians in hospital and community settings. With the notable exception of one dedicated service in the respiratory department of a principal metropolitan hospital (RPAH), such interventions are usually provided in an ad-hoc, untimely fashion and on a short-term basis.

Moreover, the type of interventions provided in the clinical setting in NSW extend only to partial-course NRT and/or brief advice to patients. When these interventions are provided they are delivered by busy clinicians in addition to their substantive patient care roles and responsibilities. They are not delivered by specialist smoking cessation clinicians.

4.5.1 Drug and Alcohol Services in NSW

Limited services are provided by existing drug and alcohol services\(^{(47)}\). However, drug and alcohol services are principally concerned with the treatment of alcohol, opioid, amphetamine and cannabis dependence\(^{(47)}\). An average of only 1.2 percent (2005-06) of total treatment episodes in NSW are devoted to the provision of cessation services to smokers\(^{(47)}\) (see table below).

### Closed treatment episodes\(^{(a)}\) by principal drug of concern, New South Wales and Australia, 2001–02 to 2005–06 (per cent) for Drug and Alcohol Services in Australia\(^{(48)}\)

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>42.7</td>
<td>42.1</td>
<td>41.2</td>
<td>41.5</td>
<td>43.0</td>
<td>38.7</td>
<td>56,076</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>10.7</td>
<td>10.9</td>
<td>10.9</td>
<td>11.3</td>
<td>11.2</td>
<td>11.0</td>
<td>15,935</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>2.7</td>
<td>2.4</td>
<td>2.5</td>
<td>2.1</td>
<td>2.2</td>
<td>1.8</td>
<td>2,583</td>
</tr>
<tr>
<td>Cannabis</td>
<td>14.3</td>
<td>15.4</td>
<td>16.1</td>
<td>17.4</td>
<td>20.2</td>
<td>24.6</td>
<td>35,636</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.8</td>
<td>0.5</td>
<td>0.4</td>
<td>0.6</td>
<td>0.6</td>
<td>0.3</td>
<td>434</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>—</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.6</td>
<td>897</td>
</tr>
<tr>
<td>Nicotine</td>
<td>1.9</td>
<td>1.2</td>
<td>1.3</td>
<td>1.3</td>
<td>1.2</td>
<td>1.8</td>
<td>2,618</td>
</tr>
<tr>
<td>Opioids</td>
<td>23.7</td>
<td>25.4</td>
<td>25.5</td>
<td>24.5</td>
<td>20.2</td>
<td>17.1</td>
<td>24,816</td>
</tr>
<tr>
<td>All other drugs(^{(b)})</td>
<td>2.2</td>
<td>0.5</td>
<td>0.4</td>
<td>1.1</td>
<td>1.0</td>
<td>4.1</td>
<td>5,968</td>
</tr>
<tr>
<td>Total not stated</td>
<td>—</td>
<td>1.3</td>
<td>1.4</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total (per cent)</td>
<td>100</td>
<td>100</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>..</td>
</tr>
<tr>
<td>Total (number)</td>
<td>38,111</td>
<td>40,002</td>
<td>41,426</td>
<td>41,789</td>
<td>42,589</td>
<td>..</td>
<td>144,963</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Excludes treatment episodes for clients seeking treatment for the drug use of others.
\(^{(b)}\) Includes balance of principal drugs of concern coded according to the Australian Standard Classification of Drugs of Concern.


4.5.2 Quitline NSW

Quitline NSW provides telephone support to the general smoking population and has been an important component of the stop smoking campaign in NSW. Specific information on quit rates and the number of callers to the NSW Quitline are not available. However, a national evaluation (1997 data) of state Quitline services demonstrated caller quit rates of 14% at 6 months and 6% at 12 months\(^{(28)}\). Callers to the national Quitline network during that 12 month period numbered 123,600 representing 3.6% of all adult smokers\(^{(49)}\).

However, notwithstanding the on-going importance of the role of the NSW Quitline, smokers accessing the healthcare system as patients have failed, at least to that point, public awareness campaigns and Quitline.
4.5.3 ACI Survey* of smoking cessation services in NSW Hospitals (2007)

The hospital setting provides a natural, educational opportunity to highlight to patients and parents the health risks of smoking to them and their children, the benefits of quitting, and to deliver effective smoking cessation interventions.

However, a ACI survey (2007) of hospitals (46) in greater metropolitan NSW (n = 27, including 11 principal referring hospitals, 13 major hospitals and 3 district hospitals) revealed the following data on smoking cessation services provided in those facilities:

- 59% (16) have a smoking cessation service / clinic / program in operation**
- 41% (11) have a policy on smoking cessation
- 33% (9) have access to specialist counselling services
- 26% (7) collect data on smoking cessation activity

Nicotine replacement therapy (NRT)
- NRT is subsidised to varying degrees by NSW hospitals. In general, inpatients are given access to free NRT for the duration of their hospital stay.
- Upon discharge patients are usually provided with between 3 and 7 days of free on-going NRT.
- Subsidised NRT is not generally available to outpatients or community patients.
- Subsidised NRT is not available to patient’s live-in relatives / co-habitants.

These figures highlight the urgent need to augment and better co-ordinate smoking cessation services in line with our recommendations.

* ACI survey data available on request. [Contact: Respiratory Network Manager nwilcox@nsccahs.health.nsw.gov.au ]

** The existing ‘smoking cessation services’ identified by our survey can not be compared to substantive services, such as those in England, provided by dedicated staff. The existing smoking cessation services in NSW are provided by a range of medical, nursing and allied health clinicians with varied position descriptions. In addition to providing routine medical, nursing and allied health care, these clinicians deliver a range of ad-hoc smoking cessation interventions, usually brief advice, to patients.

4.5.4 Controlled Trial of a Smoking Cessation Intervention in NSW

A controlled trial (50) in NSW demonstrated the effectiveness of a multi-strategic intervention in increasing the provision of smoking cessation care practices to nicotine dependent patients by hospital health professionals.

The quasi-experimental study, involving two intervention and two control hospitals, investigated whether a 12-month multi-strategic intervention increased smoking care provision to nicotine dependent patients in intervention versus control hospitals. The study included regional acute care hospitals with more than 5000 admissions in NSW, Australia.

Intervention strategies included local consensus and adaptation, linking into existing structures and processes, training, compliance monitoring, prompts and reminders, management support and communication. Smoking care outcome data were collected at baseline and follow-up using patient surveys, medical records audits and health professional surveys.

Significantly (50) greater increases in the intervention group compared to the control group were found for:
- Offers and provision of Nicotine Replacement Therapy (NRT)
- Discussions of smoking management
- Provision of written resources
- Advice regarding post-discharge support
4.5.5 A Randomised Controlled Trial in NSW

The efficacy of a comprehensive smoking cessation program for smokers scheduled for surgery was assessed in major teaching and referral hospital in NSW. Non-cardiac elective surgery patients were randomised to receive either a comprehensive smoking cessation program or usual care. The level of program intervention was modified according to individual dependence and included interactive computer counselling, tailored self-help material, telephone counselling, nicotine replacement therapy and advice on quitting from a nurse. Results of the study demonstrated that dependent smokers who received the intervention were significantly more likely to have been abstinent pre-operatively and at 3 months post intervention.

The findings suggest that the provision of smoking cessation programs in the pre-operative setting have the potential to significantly improve patients’ smoking behaviour. The provision of such programs therefore has the potential to reduce the risk of surgical complications, improve access to surgery, reduce demand on hospital beds and healthcare resources, and may assist patient abstinence over the longer-term.

Wolfenden et al (2007) state that “despite this opportunity, and cessation advice being a recommended component of pre-operative care, research in Australia indicates that only 17% of smokers receive cessation advice from their GP or specialist prior to their pre-operative clinic visit and 47% and 39% receive cessation advice from pre-operative clinic nursing and anaesthetist staff respectively.”

4.5.6 The Smoking Cessation Clinic at Royal Prince Alfred Hospital, Sydney

An independent review of the Smoking Cessation Clinic at Royal Prince Alfred Hospital for patients with Chronic Obstructive Pulmonary Disease (COPD) has shown that the treatment of tobacco dependence in this treatment resistant category of smokers significantly increased rates of abstinence. The biologically validated (expired CO measure) results presented in Figure 3 show abstinence rates after attendance at the clinic of 60 percent of patients at three months, 51 percent at six months and 32 percent at 12 months.

Figure 3: Proportion of COPD patients who were abstinent after 3, 6 and 12 months after attending the RPAH Smoking Cessation Clinic
[From: Holt et al 2004]
4.6 Nicotine Replacement Therapy

About half of Australia’s smokers make at least one serious quit attempt in a 12 month period\textsuperscript{48}. Ninety five percent of quit attempts made in the absence of medication or support fail\textsuperscript{4}.

Pharmacotherapies including combination nicotine replacement therapy (particularly when combined with behavioural intervention), anti-depressant therapy, and some other pharmacological aids, are an important component in the treatment and management of tobacco dependence\textsuperscript{10}.

However, evidence shows that smokers are more willing to take up smoking cessation interventions if they are provided by their insurance scheme or health service, than if they have to pay for it themselves\textsuperscript{34}.

It has often been argued that NRT is a similar cost to cigarettes, and that the savings made by stopping smoking should enable the purchase of NRT. This is true for a 2.5 - 3 pack per week smoker who pays approximately $10 for each pack of cigarettes per week or, alternatively, outlays a similar amount for one week’s supply of high dose (21mg) NRT patches ($25 - $32). However, for those who smoke less than 2.5 – 3 packs per week the NRT option is more costly.

“\textit{The whole point of medical insurance is to share these sorts of risks among the whole community, rather than allowing the most disadvantaged groups to curtail their use of life-saving treatments. The argument “if they can afford to smoke, they can afford treatment” would be completely unacceptable in the treatment of alcohol or illicit drug dependence. It represents an unprecedented and anomalous form of “means testing” for offering medical or pharmaceutical treatment and is discriminatory towards some of the poorest smokers in the community, many of whom are in the most urgent need of treatment for tobacco dependence.}” -\textsuperscript{16}

Currently, nicotine replacement therapy (NRT) is subsidised to varying degrees by NSW hospitals. In general, inpatients are given access to free NRT for the duration of their hospital stay\textsuperscript{46}. Upon discharge patients are usually provided with between 3 and 7 days of free on-going NRT\textsuperscript{46}.

In the community there is inconsistency in the current financing arrangements for bupropion and varenicline compared with NRT. NRT products are, at worst, only slightly less efficacious than the prescription drug bupropion\textsuperscript{17}. However, unlike NRT (an over-the-counter medication), bupropion and varenicline enjoy heavy subsidisation on the Pharmaceutical Benefits Scheme (PBS) and may be accessed by the consumer at substantially lower cost.

There are many people - including many disadvantaged people - for whom bupropion is contraindicated, who find it difficult to purchase NRT, which has a much lower risk profile\textsuperscript{17}. We submit that these people should have access to NRT at a price comparable to bupropion and varenicline, and under comparable conditions – that is, where they are also undertaking supportive behavioural counselling. After all, NRT provided in conjunction with counselling is more efficacious than bupropion alone\textsuperscript{17} and contact with a counsellor around the time of the quit date greatly increases success rates\textsuperscript{17}. Where people do relapse, contact with a counsellor often prompts a further quit attempt, which is more likely to succeed\textsuperscript{17}.

Hospital and health care staff wishing to quit smoking have access to four weeks supply of NRT patches for free, plus an additional four weeks supply at cost price\textsuperscript{56}. This is available once per year to each staff member\textsuperscript{56}. In addition staff wishing to quit smoking can purchase any type of NRT, for an unlimited period, held in pharmacy stock at cost price\textsuperscript{56}.

Subsidised NRT is not generally available to outpatients or community patients\textsuperscript{46}.

Subsidised NRT is not available to patient’s live-in relatives / co-habitants\textsuperscript{46}.
4.6.1 95% Subsidisation of Nicotine Replacement Therapy: The New Zealand Experience

**Voucher System**

In 2000 the program of subsidised NRT provision was expanded using a voucher system. The program was capped to a ceiling of vouchers for 66,000 smokers per year\(^{(57)}\).

The cost subsidy amounted to approximately 95\%\(^{(57)}\) of the retail price of NRT (user fee = $NZ 5.00 or $US 3.45 for 4 weeks supply).

**Program Description**

Callers to the free phone Quitline are assessed for eligibility for NRT. Callers are mailed a voucher redeemable at any pharmacy for a 4-week supply of NRT patches or gum. A further 4-week voucher is then provided\(^{(57)}\).

Free on-going telephone counselling is provided via trained Quit advisors (average = 3 support calls)\(^{(57)}\).

Vouchers can also be accessed through health providers registered with the program (20\% of total)\(^{(57)}\).

Cost of NRT provided through this program = $3.3 million / year\(^{(57)}\).

**Program Uptake**

In the 2004 the NZ Quitline offered support, advice and NRT to 58,000 callers\(^{(58)}\).

Of the total smoking population in NZ 1.3\% register with the Quitline every 6-month period (2003-05 data); an average of 30,000 to 33,000 per year\(^{(57)}\). Of these, an average of seventeen percent of callers (n = 5,100 – 5,600) are sent an initial voucher for four-week’s supply of NRT\(^{(55)}\). A second voucher for a further four weeks supply is usually sent\(^{(57)}\).

**Effectiveness**

A 2002-2003 evaluation demonstrated:

- 12-month self-reported quit rate of 18\%\(^{(57)}\)
- 6-month self-reported quit rates of 17\% for Māori populations and 22\% for non-Māori populations\(^{(57)}\)

**Cost-Effectiveness**

Including counselling + NRT costs:

[Conservative assumptions ignoring short-term health gains, work productivity etc]

- Cost per smoker who quit for a year: $NZ 2099 - 4272 ($US 1448 - 2948)\(^{(57)}\)
- Cost / lifetime quitter: $NZ 3198 – 7120 \(^{(57)}\)
- Cost / QALY gained: $NZ 2449 – 6794 \(^{(57)}\)

**Conclusion**

“Mass subsidisation of NRT and Quitline distribution is a successful public health intervention in NZ”. \(^{(57)}\)
5. PROPOSAL FOR A SMOKING CESSATION PROGRAM

This proposal has been developed in conjunction with the Tobacco Health Branch, NSW Health.

In accordance with the NSW Government Response to the Select Committee Inquiry on Tobacco Smoking, ACI proposes the implementation of the following recommendations, as part of a state-wide Smoking Cessation Program, to improve the treatment and management of tobacco dependence in NSW.

**Recommendation 1: Population Approach**

**Smoking Cessation Coordinators (Area-based)**

That funding be made available to employ twelve ‘Smoking Cessation Coordinators’; one in each Area Health Service in NSW, and one dedicated coordinator for each of four specific target groups: aboriginal health, mental health, paediatrics, and Justice Health.

The job of Smoking Cessation Coordinators will be to coordinate the implementation of ‘Focus Area 1: Smoking Cessation’ of the NSW Tobacco Action Plan 2005-2009. The key outcomes of this focus area will be achieved by taking a population approach to promote, coordinate and facilitate smoking cessation services, to foster clinical smoking cessation networks across the hospital and community/primary care settings, and to develop a variety of other smoking cessation initiatives.

**Recommendation 2: Clinical Services**

**Smoking Cessation Clinicians (Facility-based)**

That funding be made available to employ hospital-based ‘Smoking Cessation Clinicians’ according to the needs of individual facilities.

These new clinical positions would be dedicated to the delivery of evidence based, specialised smoking cessation interventions in hospital and community settings to nicotine-dependent patients across all medical specialties. Interventions would be delivered to specifically targeted patient populations (see sections 5.1.1 and 5.1.2) using strict referral criteria (see section 5.2.1).

The key outcome of substantially increased client quit rates, through the provision of specialist tobacco dependence treatment services (including behavioural counselling, pharmacotherapy, and on-going management and support), is strongly supported by the evidence.

**Recommendation 3: Pharmacotherapy**

**Free / Heavily Subsidised Nicotine Replacement Therapy**

That current Nicotine Replacement Therapy (NRT) subsidisation be extended to facilitate the provision of free / heavily subsidised, full course NRT (for the duration of individual therapeutic requirements), for high risk smokers.
5.1 RECOMMENDATION 1: POPULATION APPROACH

SMOKING CESSATION COORDINATORS

Smoking Cessation Coordinators (Area-wide, senior position) would be installed in each Area Health Service in NSW, plus one coordinator for each of the following four specific target groups:

- Indigenous people
- Mental health clients
- Adolescents (aged 12-18 years), and smoking parents of children admitted to tertiary paediatric hospitals (with further rollout of developed resources through the Paediatric Networks)
- Inmates and detainees in correctional settings

The roles and responsibilities (see Position Description Appendix A) of these new positions will be to promote, coordinate and facilitate smoking cessation services, to foster clinical smoking cessation networks across the hospital and community/primary care settings, and to develop a variety of other smoking cessation initiatives within their Area Health Service / target setting.

The broad aim of Smoking Cessation Coordinators will be to coordinate the implementation of ‘Focus Area 1: Smoking Cessation’ of the NSW Tobacco Action Plan 2005-2009, the key outcomes of which include:

- Decrease in adult smoking prevalence by 1% per annum between 2005-2009 moving from 19% to 14%.
- Decrease in smoking rates across various population groups.
- Increase in people’s understanding about the health consequences of smoking.
- Increase in the utilisation of quit smoking services, products and resources in NSW.
- Increase in the provision of effective smoking cessation interventions by a range of practitioners and other people in NSW.
- Increase the number people of making a successful quit attempt.

Smoking Cessation Coordinators will not directly deliver smoking cessation interventions to patients. The high prevalence of patients who are smokers, and the geographical distances involved in Area Health Services prohibits the notion that the addition of one extra clinician to each Area Health Service / target group would be sufficient to meet current capacity requirements for the provision of smoking cessation services directly to patients. Instead new smoking cessation initiatives, facilitated by smoking cessation coordinators, will be conducted by new and existing clinicians and incorporated into new and existing clinics.

Additionally the Smoking Cessation Coordinator will:

- act as an educational resource provider
- promote training opportunities to healthcare workers in hospital and community settings
- facilitate links with established tobacco control activities such as the NSW Quitline
5.1.1 Critical and Disadvantaged Target Populations

Particular attention will be directed toward delivering effective smoking cessation interventions to the following critical and disadvantaged target populations:

- Indigenous people
- Adolescents (aged 12-18 years)
- Young adults (aged 16-29 years)
- Pregnant smokers, their partners and families, and those planning a pregnancy
- Mental health clients
- Inmates and detainees in correctional settings

The roles and responsibilities of Smoking Cessation Coordinators will be to identify and liaise routinely with Aboriginal Health and Medical Services, ante-natal services, adolescent/youth services, mental health services, and correctional health services to maximise the delivery of evidence-based smoking cessation services as part of routine clinical practise.

5.1.2 Other Target Populations

Attention will also be directed toward delivering effective smoking cessation interventions to the following target groups:

- Smoking parents
- Hospital and healthcare staff
- Smokers in the pre-admission setting (eg between Pre-Admission Clinic and surgery)

5.1.3 Cost of Coordinators

Table 4: Cost per Smoking Cessation Coordinator

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary (1.0 FTE CNC2 or HSM3 @ $85,093 + 18% on-costs)</td>
<td>100,410</td>
</tr>
<tr>
<td>Car lease</td>
<td>20,000</td>
</tr>
<tr>
<td>Computer</td>
<td>2,000</td>
</tr>
<tr>
<td>Mobile Phone</td>
<td>300</td>
</tr>
<tr>
<td>Consumables</td>
<td>200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>122,910</strong></td>
</tr>
</tbody>
</table>

Table 5: Total Cost of Coordinators to NSW Health

<table>
<thead>
<tr>
<th>Area Health Service / Target Population</th>
<th>No. Coordinators</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Southern</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Greater Western</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Hunter / New England</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>North Coast</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>North Sydney Central Coast</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>South Eastern Sydney / Illawarra</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Sydney South West</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Sydney West</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Paediatric Health</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Indigenous Health</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td>Justice Health</td>
<td>1</td>
<td>122,910</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>12</strong></td>
<td><strong>1,474,920</strong></td>
</tr>
</tbody>
</table>
5.2 RECOMMENDATION 2: CLINICAL SERVICES

SMOKING CESSATION CLINICIANS

High-level facility-based ‘Smoking Cessation Clinician’ positions would be made available at full time equivalent rates according to the needs of individual facilities (see Table 6).

These new clinical positions would be dedicated to the delivery of specialised smoking cessation interventions in hospital and community settings to nicotine-dependent patients across all medical specialties. Additionally, Smoking Cessation Clinicians will facilitate strong links with general practice and with established tobacco control initiatives and services such as the NSW Quitline.

Interventions would be delivered to specifically targeted patient populations (see sections 5.1.1 and 5.1.2) using strict referral criteria (see section 5.2.1).

Smoking Cessation Clinicians may have clinical backgrounds in either nursing or allied health (see position description, Appendix B).

The minimum standard of smoking cessation training required for smoking cessation clinicians would be the successful completion of a course in smoking cessation, nicotine addiction and evidence-based smoking cessation techniques, of equivalent standard and substance to the University of Sydney’s three day training program (section 5.2.3). In addition, clinicians will be required to complete a period of clinical supervision.

5.2.1 Referral Criteria for Smoking Cessation Clinicians

All smokers identified in the following clinical settings should be referred to a smoking cessation clinician:

- Adult and adolescent inpatients
- Adult and adolescent outpatients
- Adult and adolescent community patients
- Patients attending pre-admission clinics prior to surgery
- Patients placed on public hospital operative waiting lists by (private) surgeons with visiting appointments
- Smoking parents of children or adolescents
- Co-habitants / live-in relatives
- Hospital and healthcare staff requesting help with smoking cessation

The exceptions to referral are as follows:

- After initial advice, the smoker does not wish to engage in a quit attempt or have any further consultation in relation to the issue
- The patient prefers to attempt to quit unassisted
- The patient prefers to use the services of a GP or the QuitLine rather than hospital services
### 5.2.2 Cost of Proposed Smoking Cessation Clinicians

Table 6: Distribution of proposed clinical positions by facility, staffing FTEs and cost

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>High Need</th>
<th>Smoking Cessation Clinicians (FTE)</th>
<th>COST (CNC2 or HSM3 @ $100K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bankstown / Lidcombe Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Concord Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Gosford Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>John Hunter Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Liverpool Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Nepean Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Prince of Wales Group</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Royal North Shore Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Royal Prince Alfred Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>St George Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>St Vincent’s Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Sydney Children’s Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>The Children’s Hospital at Westmead</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Westmead Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Wollongong Hospital</td>
<td>1.0</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Auburn Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Blacktown</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Campbelltown Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Canterbury Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Fairfield Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Hornsby and Ku-Ring-Gai Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Manly District Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Mona Vale and District Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Mount Druitt</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Newcastle Mater Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Royal Hospital for Women</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Royal Newcastle Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Ryde Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Sutherland Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Sydney/Sydney Eye Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Wyong Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Albury Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Coffs Harbour Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Dubbo Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Lismore Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Maitland Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Manning Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Orange Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Port Macquarie Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Shoalhaven Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Tamworth Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>The Tweed Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Wagga Wagga Base Hospital</td>
<td>0.6</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>Armidale Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Bathurst Base Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Bega District Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Belmont Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Blue Mountains District</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Bowral Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Broken Hill Base Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Camden Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Goulburn Base Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Grafton Base Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Griffith Base Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Hawkesbury Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Kempsey Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Murwillumbah District Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Shellharbour Hospital</td>
<td>0.4</td>
<td>40,000</td>
<td></td>
</tr>
</tbody>
</table>

Total: 34.8 $3,480,000

* Hospitals identified as ‘high need’ were those situated in geographical areas of high smoking prevalence.
5.2.3 Workforce Training

NSW Health 2 Unit Training Package

As part of the national Vocational Education and Training (VET) Population Health Training Package, NSW Health has made available two units of competency in tobacco use and treatment of nicotine dependence to all NSW clinicians via videoconferencing and online modalities.

Recently more than 300 health professionals around the state have been trained in smoking cessation interventions using this educational program.

Plans are underway to introduce an accreditation scheme for health workers trained in smoking cessation best practice who have achieved competency in the two units.

This training course is suitable for health promotion health professionals and for clinicians to perform brief interventions only.

University of Sydney 3 Day Training Course

The Smoking Research Unit of the Brain Mind Research Institute, University of Sydney, offers a three day training course for anyone with an interest in smoking cessation, nicotine addiction and evidence based smoking cessation techniques, with particular focus on causes, consequences, treatment, and research.

The course is run on a quarterly basis and is applicable to all healthcare clinicians and others with a legitimate interest.

All clinicians intending to engage in intensive tobacco dependence treatment must have completed this course, or other comparable, as a minimum requirement. The University of Sydney (BMI) recognises that a clinical supervision system with accreditation needs to be developed.
5.3 **RECOMMENDATION 3: PHARMACOTHERAPY**

**SUBSIDISATION OF NICOTINE REPLACEMENT THERAPY (NRT)**

Current Nicotine Replacement Therapy (NRT) subsidisation would be extended to facilitate the provision of free/heavily subsidised, full course NRT (for the duration of individual therapeutic requirements), for high risk smokers.

Patient compliance with therapy - thus treatment effectiveness and program effectiveness - will be maximised if all forms of NRT, including patches, lozenges, and gum are made available.

5.3.1 **Method of NRT Provision**

Following clinical assessment (and the fulfilment of eligibility criteria - section 5.3.2), free / heavily subsidised NRT would be prescribed in conjunction, where appropriate, with referral for on-going counselling, to:

- A specialist smoking cessation clinician (section 5.2)
- Quitline
- General Practitioner
- Other clinicians registered with the program

Consultations with specialist smoking cessation clinicians may take place in a hospital or community setting.

Written prescriptions would be redeemable from public hospital pharmacies rather than via vouchers redeemable at private pharmacies in the community. Provision of NRT in accordance with existing hospital formularies and processes will restrict consumer medication costs to $13.85 per pack of seven (ie 7 days prescription). By comparison the cost of a seven day prescription from private community pharmacy ranges from $25.00 to $32.00.

In addition, an in-hospital approach will obviate the requirement for new administration infrastructure and for price negotiation between individual hospitals and private pharmacies.

The initial prescription would stipulate four weeks supply of government contract brand NRT (high dose 21mg). A further four weeks supply would be available upon demonstration of program compliance (ie pharmacotherapy and counselling). Compliance will be determined by the clinician providing on-going counselling.

5.3.2 **Eligibility Criteria for Access to Free / Heavily Subsidised NRT**

To be eligible for access to free / heavily subsidised NRT smokers must:

- Obtain referral to, and maintain on-going counselling with, a smoking cessation clinician, a Quitline counsellor, general practitioner, or other program-registered clinician
- Establish their intention to quit smoking
- Demonstrate compliance with their therapeutic program (ie pharmacotherapy and counselling)
- For cohabitants of patients: documental proof (eg driver’s licence etc) of co-habitation status
- For hospital / healthcare staff proof of current employment (eg staff ID card)
5.3.3 Potential Cost of a Program of Free / Heavily Subsidised NRT in NSW

Two methods have been used to estimate the potential demand for free/heavily subsidised NRT, and thus the potential cost, of a NSW program.

5.3.3.1 Method 1: Extrapolation using Total New Zealand (NZ) Program Cost

Since the introduction of the heavily subsidised NRT voucher program in New Zealand in 2003, The Quit Group (NZ) conducted an economic evaluation\(^{(32)}\) of the program estimating the monthly cost of NZ Quitline activities with and without NRT.

By using the total annual costs of the NZ program, and by estimating the size of the population eligible for the program (see below), the demand for the NZ program can be approximated. Extrapolating this demand to an estimated eligible program population in NSW, the annual cost of a similar program in NSW has been approximated.

Cost of Subsidised NRT Program in NZ

Table 7: Monthly cost for NZ Quitline activities with and without NRT\(^{(58)}\)

<table>
<thead>
<tr>
<th>Variant</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitline service pre-NRT (March-November 2000)</td>
<td>$96,672</td>
<td>$149,017</td>
<td>$212,994</td>
</tr>
<tr>
<td>Quitline service post-NRT (Year to 30 June 2002)</td>
<td>$152,371</td>
<td>$252,660</td>
<td>$375,236</td>
</tr>
<tr>
<td>Quitline service + subsidised NRT products &amp; materials (Year to 30 June 2002)</td>
<td>$389,855</td>
<td>$490,145</td>
<td>$612,721</td>
</tr>
</tbody>
</table>

The cost for NRT products and materials only can be estimated by subtracting total Quitline service post-NRT costs from the total cost of the Quitline service with subsidised NRT:

From Table 7:
Cost (medium variant) for NRT products and materials only:
= $490,145 – $252,660
= $237,485 per month
= $NZ2.9 million per year

Approximation of Eligible Program Population (NZ)

An estimation of the eligible population for the NZ Quitline program can be made as follows:

4,255,188 \times 78.5\% \times 23.5\% \times 61\% \approx 478,835

NZ Service Uptake / Financial Demand for Subsidised NRT

The total financial demand for the NRT products component of the NZ Quitline program is $2.9 million per year for an eligible program population of 478,835.

Expressed as a ratio, the financial demand for the total eligible NZ population = $NZ6.06 per person ($NZ2.9 million / 478,835 people).
Approximation of Eligible Program Population for NSW

Based on population composition, smoking prevalence figures for NSW, and rates of intention to quit, a maximum eligible program population can be approximated as follows:

\[
6,827,700 \times 81\% \times 21\% \times 61\% = 708,448 \text{ people}
\]

Extrapolation of NZ Demand and Cost to Potential NSW Program

Assuming a similar service uptake / demand, an extrapolation of the cost of the NZ program to the eligible program population in NSW (708,448 people) gives an estimate annual cost of implementing a similar program (that is, provision of vouchers through private pharmacies) in NSW:

At the current currency exchange rate of $1.2 NZ dollars = 1 Australian dollar, the demand cost per person $NZ6.06 = $AU5.01

\[
708,448 \text{ people} \times 5.01 = $3.5 \text{ million per year (private pharmacy cost)}
\]

The unit cost to redeem an NRT subscription from a private pharmacy in NSW is approximately double that from a public hospital pharmacy (see below).

<table>
<thead>
<tr>
<th>Total Annual Cost Estimation (Method 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total annual cost of a program of free / heavily subsidised NRT provided through public hospital pharmacies is therefore estimated at $3.5 million /2 = $1.75 million.</td>
</tr>
</tbody>
</table>

* NZ Quitline employs television advertising to stimulate demand for Quitline services including the NRT voucher program. In the absence of similar promotional activity in NSW the demand for NRT in NSW is therefore likely to be substantially less than that in NZ.

5.3.3.2 Method 2: Extrapolation using NZ Program Voucher Redemption Rates

In 2006, 15,916 smokers registered with the NZ Quit program were issued with NRT vouchers. The rate of redemption of those vouchers was measured at 81 percent (12,891 people).

Service Uptake / Demand for Subsidised NRT in NZ

The total demand for NRT products component of the NZ Quitline program is being generated by a total of 12,891 smokers.

This represents 2.3 percent of the eligible NZ program population of 478,835 smokers.

NRT Cost per Person in NSW

Government contract-brand high dose (21mg) NRT patches cost = $13.85 per pack of seven ie 7 days prescription.

Eight weeks supply of government contract brand NRT patches
= $13.85 /person /week
x 8 weeks (maximum duration of prescription)
= Cost of NRT per person = $110.80
Potential Annual Cost of Free / Heavily Subsidised NRT in NSW

Assuming a similar service uptake / demand, an extrapolation of the population demand for the NZ program to the eligible program population in NSW using a NSW unit cost, gives an estimate cost of implementing a similar program in NSW:

From above: the eligible program population in NSW = 708,448 people.

2.3% of 708,448 = 16,294 smokers

16,294 x $110.80 (unit cost, NSW) = $1.8 million

Total Annual Cost Estimation (Method 2)
The total annual cost of a program of free / heavily subsidised NRT in NSW is therefore estimated at $1.8 million.

5.3.3.3 Summary of Approximate Cost of a Potential NRT Program in NSW

The cost of a program of free / heavily subsidised NRT in NSW was estimated using two separate methods. Both methods used independent data from the Quitline New Zealand program to extrapolate to the NSW market.

<table>
<thead>
<tr>
<th>Method</th>
<th>Extrapolation</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method 1</td>
<td>Extrapolation using Total New Zealand (NZ) Program Cost</td>
<td>$1.75 million</td>
</tr>
<tr>
<td>Method 2</td>
<td>Extrapolation using NZ Program Voucher Redemption Rates</td>
<td>$1.8 million</td>
</tr>
</tbody>
</table>

There is a $50,000 difference between the two cost estimations.

5.3.3.4 Variables Impacting on Demand for NRT

The cost estimations above do not include an estimate of the impact, in the Australian market, of other tobacco dependence medications available at heavily subsidised prices via the Pharmaceutical Benefits Scheme, such as bupropion and varenicline. The availability of these drugs (with similar efficacy to NRT) at heavily subsidised prices to the Australian consumer will reduce the demand for over-the-counter NRT.

Conversely, the calculation of demand for free/heavily subsidised NRT does not include an estimate of the number of co-habitants / live-in relatives of patients who will access the service. An estimation of the size, and potential demand, from this population has not been determined.

In addition, demand for NRT will be by affected by the following variables:

- Increase in the number of quitters: Annual demand will reduce with successful quit rates (18 – 32 percent at 12 months).
- Decreasing smoking prevalence: Yearly demand will decrease with the continued trend in prevalence reduction (approximately -0.5% per annum\(^{14}\)).
5.3.3.5 Estimated Impact of NRT Program on Hospital Pharmacies

A program of free/heavily subsidised NRT will place some additional demand on public hospital pharmacy. An estimation of the size of that demand is provided below.

The total annual demand for NRT will be generated by approximately 16,294 smokers per year (from section 5.3.3.2). To estimate the potential additional demand on hospital pharmacies, the total annual number of smokers was divided by a demand weight€ according to the size of individual hospitals and the commensurate staffing level at which smoking cessation clinicians were apportioned to those facilities in section 5.2.2 of this proposal (see Table 6, page 24).

Table 8: Estimated Increase in Annual NRT Demand in NSW Public Hospitals

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Demand Weight € (%)</th>
<th>Estimated Increase in Annual NRT Demand (No. Smokers)</th>
<th>Estimated Increase in Daily NRT Demand (No. Smokers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Referral Hospital</td>
<td>2.8735632</td>
<td>468</td>
<td>1.80</td>
</tr>
<tr>
<td>Major Metropolitan Hospital ('High Need')</td>
<td>1.7241379</td>
<td>281</td>
<td>1.08</td>
</tr>
<tr>
<td>Major Metropolitan Hospital</td>
<td>1.1494253</td>
<td>187</td>
<td>0.72</td>
</tr>
<tr>
<td>Major Non-Metropolitan Hospital</td>
<td>1.7241379</td>
<td>281</td>
<td>1.08</td>
</tr>
<tr>
<td>District Group 1 Hospital</td>
<td>1.1494253</td>
<td>187</td>
<td>0.72</td>
</tr>
</tbody>
</table>

* Hospitals identified as ‘high need’ were those situated in geographical areas of high smoking prevalence.

€ From Table 3 (section 5.2.2) demand weight was calculated using smoking cessation clinician staffing levels as a surrogate:

\[ \text{Demand Weight (\%)} = \frac{\text{Clinician FTE per facility}}{\text{Total NSW FTE}} \times 100 \]

This proposal does not draw conclusions regarding the capacity of existing pharmacy workforce to absorb this increased demand. Recommendations, therefore, on potential requirements for increased staffing resources to appropriately service this demand have not been made.
5.4 PROGRAM MEASUREMENT AND EVALUATION

5.4.1 Performance Indicators

The absence of baseline data makes the performance / impact of any future smoking cessation program difficult to quantify.

We therefore recommend the collection of baseline data for the following indicators at the commencement of the program to facilitate ongoing review.

- **Number of dedicated, specialised smoking cessation clinics**
  
  KPI: Increase in the number of dedicated, specialised smoking cessation clinics
  
  [baseline: __ target: __ (include ___% increase)]

- **Number of other clinics employing routine smoking cessation activities (brief intervention therapy)**
  
  KPI: Increase in the number of other clinics employing routine, brief smoking cessation interventions
  
  [baseline: __ target: __ (include ___% increase)]

- **Number of high risk smokers receiving specialised smoking cessation interventions**
  
  KPI: Increase in the number of high risk smokers receiving specialised smoking cessation interventions
  
  [baseline: __ target: __ (include ___% increase)]

- **Number of high risk smokers receiving other/brief smoking cessation interventions**
  
  KPI: Increase in the number of high risk smokers receiving other/brief smoking cessation interventions
  
  [baseline: __ target: __ (include ___% increase)]

- **Proportion of the population of clinicians who have attended smoking cessation training**
  
  KPI: Percentage increase in the number of clinicians who have attended smoking cessation training
  
  [baseline: __ target: __ (include ___% increase)]

- **Biologically verified (expired CO measure or urine cotinine assay) abstinence rates at 3, 6 and 12 months post commencement of treatment.**

- **Harm minimisation measures including:**
  
  - expired CO measures decreasing compared to baseline
  
  - time to first cigarette increasing compared to baseline
  
  - cigarette numbers decreasing compared to baseline

5.4.2 Information Systems, Data Collection and Reporting

It is important that the data collection and reporting process for this program is uniform across the state. Of equal importance is that data collection occurs in each service as a matter of routine.

We therefore recommend the provision of a standardised electronic information system. The system would provide comprehensive patient management software incorporating a minimum data set. The system would have the facility to produce standardised and ad-hoc reports. It would be accessible to all staff involved in the program including coordinators, clinicians and pharmacists.

The system would be accessible via laptop computer to support outreach patient management and effective data collection in the community setting. In this regard data that is entered into a laptop computer that is not connected to the network at the time of entry (eg in the community setting) will require the addition of a user-friendly function to facilitate delayed transfer/upload of this data to the database when the computer is connected to the network. This will ensure efficient data transfer from the laptop’s local drive to the common repository without data entry duplication.
5.5 **FINANCIAL SUMMARY**

<table>
<thead>
<tr>
<th>Program Item</th>
<th>Number</th>
<th>Cost Estimate per annum ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinators</td>
<td>12.0 FTE (CNC2 or HSM3)</td>
<td>1,474,920</td>
</tr>
<tr>
<td>Clinicians</td>
<td>34.8 FTE (CNC2 or HSM3)</td>
<td>3,480,000</td>
</tr>
<tr>
<td>Clinician Training</td>
<td>34.8 clinicians (@ $1150.00 per clinician)</td>
<td>40,020</td>
</tr>
<tr>
<td>Free / Heavily Subsidised NRT</td>
<td>See calculations Section 5.3.3</td>
<td>1,800,000</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td></td>
<td><strong>6,794,940</strong></td>
</tr>
</tbody>
</table>

6. **CONCLUSION**

The clinical setting provides a ‘teachable moment’; an opportunity in which patients are receptive to the health risks of smoking, the benefits of quitting and cessation intervention.

Moreover, treating tobacco dependence produces a strong return on investment\(^{22, 37}\). Further investment of this kind is needed in NSW to augment successful public health approaches and brief intervention practices that are provided to patients - often diligently but in an ad-hoc fashion and ‘on-the-run’ - by busy clinicians.

We draw the reader’s attention to the most recent systematic review of clinical smoking cessation interventions conducted by Ranney L et al (Annals of Internal Medicine, 2006). The review ‘Smoking Cessation Intervention Strategies for Adults and Adults in Special Populations’ draws the following conclusion: “Although self-help strategies alone marginally affect quit rates, individual and combined pharmacotherapy’s and counselling, either alone or in combination, can significantly increase cessation. Using effective smoking treatments is strongly encouraged for all populations, especially those with high and heavy rates of smoking…\(^{(16)}\)”.

An outlay of under $7 million for the Smoking Cessation Program detailed in this proposal will substantially reduce the higher costs of treating cardiovascular diseases, cancers, chronic respiratory diseases and other conditions caused by smoking\(^{(37)}\), currently costing $477 million per annum in direct health care and $6.6 billion per annum to NSW in total\(^{(6)}\).

Other positive effects of implementing smoking cessation services include reducing employees’ time off work\(^{(40)}\) and reducing the number of young people taking up smoking as a result of copying their parents\(^{(37)}\).

An enhancement of workforce capacity, through the introduction of Area Smoking Cessation Coordinators and specialised facility-based Smoking Cessation Clinicians, will considerably improve the development of smoking cessation services across NSW. Combined with an enhancement of NRT subsidisation these initiatives, if implemented as a state-wide Smoking Cessation Program, will have a synergistic impact on smokers with a chronic dependence on nicotine, and on the cost burden to the NSW health system.
7. REFERENCES

7. NSW Department of Health 2007. NSW Government Response to the Joint Select Committee’s Inquiry on Tobacco Smoking (June 2006)


25 Lancaster T and Stead LF. Individual behavioural counselling for smoking cessation. Cochrane Database of Systematic Reviews, 2005(2).


45 Chesterman J, Judge K, Bauld L, Ferguson J. How effective are the English smoking treatment services in reaching disadvantaged smokers? Addiction. 100 Suppl 2:36-45, 2005 Apr.


48 Department of General Practice, Flinders University, Adelaide. Review of the Literature into Smoking Cessation Services and NRT.

49 Miller CL, Wakefield M and Roberts L. Uptake and effectiveness of the Australian telephone Quitline service in the context of a mass media campaign. Tobacco Control 2003;12;53-58


54 Wolfenden L, Wiggers J, Knight J and Elizabeth Campbell. Smoking and surgery: an opportunity for health improvement. Australian and New Zealand Journal of Public Health 2007 vol. 31 no. 4


57 www.quit.org.nz. Wilson N (Otago University, Wellington, NZ), Grigg M (The Quit Group, Wellington, NZ), Bullen C (Auckland University, Auckland, NZ). Mass Distribution of Heavily Subsidised NRT: the New Zealand Experience


APPENDIX A: POSITION DESCRIPTION, SMOKING CESSATION COORDINATOR

POSITION DETAILS

Position No: 
Position Title: Smoking Cessation Coordinator
Award: Health Service Manager, Level 3 (or equivalent)
Reports To: Area Director of Population Health / Health Promotion
Liaise with: Senior Policy Analyst (Cessation) Tobacco and Health Branch, NSW Health Smoking Cessation Clinicians
Location: Area Health Service Coordinators: AHS Population Health Units
Specific Target Group Coordinators:
- Paediatric Coordinator: The Children’s Hospital, Westmead
- Indigenous Coordinator: Centre for Aboriginal Health
- Mental Health Coordinator: Mental Health and Drug and Alcohol Office
- Justice Health Coordinator: Justice Health, Malabar

MAIN PURPOSE OF POSITION

To promote, coordinate and facilitate evidence based smoking cessation services, to foster clinical smoking cessation networks, and to develop a variety of other smoking cessation initiatives within the Area Health Service or specified target setting.

KEY ROLES AND RESPONSIBILITIES

1. Provide support to clinicians in the development of policy and practices relating to cessation interventions, ensuring that cessation interventions are accessible for all sectors within the community

2. Assist with the implementation of the Department’s Smoke Free Workplace Policy and with the implementation of Focus Area 1 of the ‘NSW Tobacco Action Plan 2005-2009’ and the ‘Guide to the Treatment of Nicotine Dependent Inpatients of NSW Health facilities’

3. Assist clinicians and other health professionals (including those outside AHSs) to access smoking cessation training in effective intervention and treatments for nicotine dependence

4. Assist Area Health Services in the implementation of systemic changes necessary to support routine intervention for nicotine dependence

5. Support the implementation of regular smoking cessation clinics within existing services

6. Assist Area Health Services to support staff who are nicotine dependent and reduce staff smoking prevalence (a major barrier to delivery of effective cessation advice)

7. Collect and record baseline data on smoking cessation activities and interventions, maintain an up-to-date database on specified program indicators, and provide quarterly progress reports

8. Foster partnerships with relevant professional associations, tertiary institutions, non-government organisations, government agencies, health advocate organisations and other associated organisations such as the NSW Quitline.
1.2.1 KEY RELATIONSHIPS

<table>
<thead>
<tr>
<th>Contact / Organisation</th>
<th>Purpose of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians (medical, nursing and allied health) including heads of clinical departments</td>
<td>- Main contact group</td>
</tr>
<tr>
<td>NSW Health Department</td>
<td>- To ensure streamlined roll out of coordinator positions.</td>
</tr>
<tr>
<td>• Tobacco &amp; Health Branch</td>
<td>- To maximise collaboration of coordinator activities and networks.</td>
</tr>
<tr>
<td>• Centre for Aboriginal Health</td>
<td>- To minimise duplication the development of resources across the state.</td>
</tr>
<tr>
<td>• Mental Health and Drug and Alcohol Office</td>
<td></td>
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<tr>
<td>• Justice Health</td>
<td></td>
</tr>
<tr>
<td>• Nursing and Midwifery Officer</td>
<td></td>
</tr>
<tr>
<td>• The Cancer Institute</td>
<td></td>
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<tr>
<td>• Quitline NSW</td>
<td></td>
</tr>
<tr>
<td>Area Health Services</td>
<td>- Communicate and collaborate with Area Health Services to</td>
</tr>
<tr>
<td>• Population Health</td>
<td>ensure the delivery of specific policy and strategies</td>
</tr>
<tr>
<td>• Clinical Services</td>
<td>addressing cessation as outlined in the NSW Tobacco Action Plan 2005-2009.</td>
</tr>
<tr>
<td>• Drug and Alcohol staff</td>
<td>- Support Area Health Services in the local implementation of policy initiatives.</td>
</tr>
<tr>
<td>• Workforce Development Units</td>
<td>- Support and assist Area Health Services in the development of local plans.</td>
</tr>
<tr>
<td>Non-Government Organisations including (but not limited to):</td>
<td>- Provide direction and support to forums that address</td>
</tr>
<tr>
<td>• Action on Smoking and Health (ASH)</td>
<td>initiatives for tobacco control</td>
</tr>
<tr>
<td>• Asthma Foundation</td>
<td></td>
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<tr>
<td>• Australian Medical Association</td>
<td></td>
</tr>
<tr>
<td>• The Australasian Professional Society on Alcohol and other Drugs</td>
<td></td>
</tr>
<tr>
<td>• Cardiac Society of Australia and New Zealand</td>
<td></td>
</tr>
<tr>
<td>• Divisions of General Practice</td>
<td>Consult and collaborate with relevant stakeholders in the</td>
</tr>
<tr>
<td>• Heart Foundation NSW</td>
<td>development and implementation of policy and practice.</td>
</tr>
<tr>
<td>• Local Government Associations</td>
<td></td>
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<tr>
<td>• Medical/Surgical Colleges</td>
<td></td>
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<tr>
<td>• NSW Cancer Council</td>
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<tr>
<td>• NSW Nurses Association</td>
<td></td>
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<tr>
<td>• NSW Pharmaceutical Association</td>
<td></td>
</tr>
<tr>
<td>• SIDS Association</td>
<td></td>
</tr>
<tr>
<td>• Thoracic Society of Australia and New Zealand</td>
<td></td>
</tr>
<tr>
<td>• Universities</td>
<td></td>
</tr>
</tbody>
</table>
CHALLENGES

- Providing adequate support on smoking cessation intervention to all relevant clinicians in the Area Health Service / Target Group
- Collecting and recording relevant data on smoking cessation activity for the Area Health Service / Target Group, maintaining the database and providing data reports as required
- Developing and maintaining partnerships with clinicians, Area Health Services and Non-Government organisations and other relevant stakeholders
- Consulting and collaborating with diverse range of groups
- Developing and implementing integrated and comprehensive strategies such as workforce development strategies, organisational development strategies and resource development strategies to improve the capacity of the Area Health Service / Target Group to improve compliance with cessation activities
- Balancing priorities between issues requiring rapid and urgent response and the management of longer time initiatives
- Addressing issues arising out of ad hoc data and information requests

SKILLS, KNOWLEDGE AND EXPERIENCE REQUIRED

Essential

- A tertiary qualification in health science, public health or equivalent
- Two units of competency in smoking cessation from the Population health training package (HLTPOP403B: ‘Provide information on smoking and smoking cessation’ and HLTPOP404B: ‘Provide interventions to clients who are nicotine dependent’) or ability to obtain same
- A complete knowledge of best practice cessation interventions for the treatment of nicotine dependence
- Demonstrated understanding of policies and programs addressing tobacco-related health issues
- Demonstrated understanding of the provision clinical healthcare in the primary, secondary and tertiary settings
- Experience working with senior clinicians and health administrators
- Experience in or demonstrated understanding of policy/program development, implementation, management and evaluation
- Proficient computer skills including use of common MSOffice applications, the internet and email
- Ability to work independently, and to plan and prioritise tasks with little supervision
- NSW driver’s license
- Commitment to EEO and OH&S principles

Desirable

- Experience in coordinating healthcare programs
APPENDIX B:  POSITION DESCRIPTION, SMOKING CESSATION CLINICIAN

POSITION DETAILS

Position No:  
Position Title: Smoking Cessation Clinician  
Award: CNC2 / HSM3 (or equivalent)  
Reports To: Area Director of Medicine  
Liaise with: Area Smoking Cessation Coordinator  
Location: Hospital based position with community clinic requirements / responsibilities

MAIN PURPOSE OF POSITION

To provide evidence based clinical smoking cessation services through the development of new smoking cessation clinics in the hospital and associated/appropriate community settings.

KEY ROLES AND RESPONSIBILITIES

Provide clinical smoking cessation services to inpatients, outpatients, community patients in associated/appropriate community settings, co-habitants/live-in relatives, and hospital / healthcare staff including:
- assessment of tobacco dependence
- treatment initiation and monitoring
- education on relapse prevention
- behavioural counselling
- nicotine replacement therapy
• Provide education on smoking cessation to clients and their carers.
• Provide training for other health professionals on the assessment, treatment and management of tobacco dependence.
• Collect and record baseline data on smoking cessation activities and interventions, maintain an up-to-date computerised database on specified program indicators, and provide quarterly progress reports
• Ensure timely and appropriate communication and collaboration with referring clinicians, specialist physicians, GPs, the NSW Quitline and other members the client’s nominated multi-disciplinary team.
• Raise awareness of the benefits of NRT for smoking patients/clients
• Support frontline health staff with the Nicotine Replacement Therapy program
• Support the Area Health Service smoke-Free Workplace Policy
• In conjunction with the Area Smoking Cessation Coordinator:
  - Develop specialised education resources for client care, to be shared with other health care professionals and family members / carers
  - Contribute to the development and delivery of education programs
  - Engage in promotional activities that support the Smoke Free Workplace Policy
  - Assist with the implementation of the NSW Health Department’s Smoke Free Workplace Policy and with the implementation of Focus Area 1 of the ‘NSW Tobacco Action Plan 2005-2009’ and the ‘Guide to the Treatment of Nicotine Dependent Inpatients of NSW Health facilities’
  - Disseminate the findings of new smoking cessation research
  - Assist Area Health Services in the implementation of systemic changes necessary to support routine intervention for nicotine dependence
  - Foster partnerships with relevant professional associations, tertiary institutions, non-government organisations, government agencies, and health advocate organisations
Other Roles and Responsibilities

• Participate in relevant committees and organisational activities
• Promote and participate in clinical research projects to improve patient outcomes
• Participate/collaborate in the design and conduct of quality improvement initiatives
• Identify future issues and new directions for the service
• Contribute to formal service and strategic planning processes within the organisation
• Provide ongoing comprehensive analysis of current practice and the impact of new directions on the clinical speciality/service
• Initiate, develop, implement and evaluate strategic changes for the clinical speciality/service.
• Provide written reports as required
• Manage financial & environmental resources efficiently
• Communicate efficiently and effectively through electronic networks when appropriate
• Maintain accurate client records
• Develop, implement and evaluate an annual service business plan in collaboration with all relevant personnel
• Comply with Equal Employment Opportunity and OH&S policies and practices
• Undertake an annual performance review
• Report to the Area Director of Medicine any matter that may affect unit management, including all reportable incidents involving the unit
• Adhere to the Anti Discrimination Act in matters relating to relationships with patients, visitors and staff
• Comply with the infection control policies and practices of the hospital.
• Comply with all the policies of the Area Health Service.
• Comply with the AHS Smoke-Free Workplace Policy.

KEY RELATIONSHIPS

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<td>- To maximise communication and coordination of patient care between the client’s nominated multidisciplinary clinical team</td>
</tr>
<tr>
<td>• Quitline NSW</td>
<td></td>
</tr>
<tr>
<td>Area Smoking Cessation Coordinators</td>
<td>- To maximise collaboration of coordinator / clinician activities and networks.</td>
</tr>
<tr>
<td></td>
<td>- To minimise duplication the development of recourses across the Area Health Service.</td>
</tr>
<tr>
<td>Area Health Services</td>
<td>- Communicate and collaborate with Area Health Services to ensure the delivery of specific policy and strategies addressing cessation as outlined in the NSW Tobacco Action Plan 2005-2009.</td>
</tr>
<tr>
<td>• Population Health</td>
<td>- Support Area Health Services in the local implementation of policy initiatives.</td>
</tr>
<tr>
<td>• Clinical Services</td>
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<tr>
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<tr>
<td>• Action on Smoking and Health (ASH)</td>
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<tr>
<td>• Asthma Foundation</td>
<td></td>
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<tr>
<td>• Australian Medical Association</td>
<td></td>
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<tr>
<td>• The Australasian Professional Society on Alcohol and other Drugs</td>
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<tr>
<td>• The Black Dog Foundation &amp; Beyond Blue</td>
<td></td>
</tr>
<tr>
<td>• The Brain &amp; Mind Research Institute</td>
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</table>
Cardiac Society of Australia and New Zealand  
Divisions of General Practice  
Heart Foundation NSW  
Local Government Associations  
Medical/Surgical Colleges  
NSW Cancer Council  
NSW Nurses Association  
NSW Pharmaceutical Association  
SIDS Association  
Thoracic Society of Australia and New Zealand  
Universities

CHALLENGES

- Providing adequate and equitable smoking cessation interventions to all relevant clients in the Area Health Service / Target Group
- Collecting and recording relevant data on smoking cessation activity for the Area Health Service / Target Group, maintaining the database and providing data reports as required
- Developing and maintaining partnerships to develop new smoking cessation clinics in hospital and community settings

SKILLS, KNOWLEDGE AND EXPERIENCE REQUIRED

Essential

- Clinical qualifications in either nursing or allied health including the successful completion of the University of Sydney’s three day training course in smoking cessation, nicotine addiction and evidence-based smoking cessation techniques.
- A complete knowledge of best practice cessation interventions for the treatment of nicotine dependence
- Demonstrated understanding of policies and programs addressing tobacco-related health issues
- Experience working with senior clinicians and health administrators
- Experience in or demonstrated understanding of policy/program development, implementation, management and evaluation
- Excellent interpersonal and communication skills
- Proficient computer skills including use of common MSOffice applications, the internet and email
- Ability to work independently, within a multidisciplinary team, and to plan and prioritise tasks with little supervision
- Demonstrated commitment to quality improvement principles and improved health care outcomes
- NSW driver’s license
- Commitment to EEO and OH&S principles

Desirable

- Relevant postgraduate qualifications in respiratory, cardiac or chronic care
- Competent research skills
APPENDIX C: LETTERS OF ENDORSEMENT

- Asthma Foundation NSW
- Australian Lung Foundation
- Clinical Excellence Commission
- Clinical Oncological Society of Australia
- Diabetes Australia - NSW
- Justice Health NSW
- Mental Health Coordinating Council NSW
- Stroke Foundation
- National Asthma Council Australia
- The Cancer Council NSW (in-principle agreement)
- Thoracic Society of Australia and New Zealand
- ACI Cardiology Network
- ACI Diabetes Network
- ACI State-wide Opthalmology Service
- ACI Stroke Services Network
- ACI Transition Care Network
29 January 2010

Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

To whom it may concern

Asthma Foundation NSW would like to support the Smoking Cessation Program – Improving Smoking Cessation Interventions in Clinical Settings, which has been proposed to NSW Health by the Greater Metropolitan Clinical Taskforce Respiratory Network.

Asthma Foundation NSW believes that the measures outlined in the proposal:

- To fund one smoking cessation support person in each NSW Area Health Service to focus on stopping people smoking via the operation of programs, the promotion of initiatives and the coordination of actions of other NGO's in their Area Health Authority
- To fund Smoking Cessation Clinicians who would deliver evidence-based smoking cessation programs in hospitals and community settings to help to secure a higher quit rate
- To provide free or heavily subsidised nicotine replacement therapy for high-risk smokers
- Will enable NSW Health to exceed its current yearly 1% quit rate.

These measures are particularly important as an estimated 95% of quit attempts fail without support or medication. Dedicated health professionals would be able to refer quitters with complicating medical conditions to NGO's currently funded by NSW Health. Asthma Foundation NSW has a wide range of easily accessible literature on asthma and an Asthma Information Line staffed by health professionals able to offer advice about smoking and asthma.

We have been pleased to see that the NSW Government has adopted a number of smoking proposals we have campaigned for in the past, namely: banning smoking inside pubs, clubs and hotels, in cars carrying children under 16, requiring retailers to remove tobacco products from sight and removing tobacco products from loyalty programs. These measures will help to safeguard the health of non-smokers, particularly those with respiratory and other conditions.
However, Asthma Foundation NSW believes that there is still much work to be done to create a smoke-free environment in NSW. Smoking outdoors in public areas, particularly in pubs and clubs, is still a major issue that needs to be addressed. Research has shown that tobacco smoke does not dissipate outdoors as quickly as might be thought and can still be harmful within a surprisingly large radius and we will be urging the NSW Government to address this in future legislation. Legislation has been proven to be the most effective way to change smoking behaviour.

Smoking affects the health of the 800,000 people in NSW (1:9 children 1:10 adults) who live with asthma in a number of ways.

- People with asthma continue to smoke at least as commonly as people without asthma, despite the known adverse effects. This suggests a lack of awareness amongst asthmatics of how smoking can affect their condition and those around them. This is supported by research into attitudes of asthmatics conducted by Asthma Foundation NSW over the past couple of years.

- Second hand tobacco smoke is a major trigger for asthma.

- An estimated 11% of children with asthma live in homes where smoking occurs inside the home.

- Australian and international research shows that children who are exposed consistently to tobacco smoke will suffer damaged airways and impaired lung function and have more early life wheezing and respiratory infections. They will also require urgent health care more frequently.

- Although a direct causal link between asthma and smoking has yet to be established, children exposed to second hand smoke have a 50% higher chance of developing asthma.

- A recent US study found that teenagers who said they regularly smoked were four times more likely than non-smokers to develop asthma over the next eight years. A large quantitative survey undertaken by Asthma Foundation NSW in 2007 also revealed that people who smoke require twice as much reliever and preventer medication as people who don’t smoke. They have also been shown to have higher morbidity and more poorly controlled asthma.

In conclusion, Asthma Foundation NSW supports The Smoking Cessation Program proposal and urges NSW to adopt the proposals outlined in its proposal document.

Should you require further supporting testimony or require any information on smoking and asthma please feel free to contact us.

Yours sincerely

[Signature]

Greg Smith
Chief Executive Officer
THE AUSTRALIAN LUNG FOUNDATION

15 October 2008

Mr Nick Wilcox
The Respiratory Network Manager
Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

Dear Mr Wilcox,

Thank you for allowing The Australian Lung Foundation the opportunity to comment on Improving Smoking Cessation Interventions in the Clinical Setting.

Smoking is the single leading cause of both Lung Cancer and Chronic Obstructive Pulmonary Disease. Lung Cancer is the third biggest killer of Australians and has the highest mortality rate of all the cancers.

Chronic Obstructive Pulmonary Disease is the fifth leading killer in Australia with an estimated 2 million people currently living with the disease.

The Australian Lung Foundation supports the key recommendations of the GMCT and would further urge the taskforce to consider including spirometry testing in the outlined clinical services.

Thank you for the opportunity and The Australian Lung Foundation wishes you well in this important initiative.

Yours sincerely,

Heather Allan
Director – COPD National Program

For Lung Health & ALF information on the internet visit http://www.lungnet.com.au
28 August 2008

Mr Nick Wilcox
Manager, GMCT Respiratory Network
Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

Dear Mr Wilcox,

Re: GMCT Proposal to NSW Health for a state-wide smoking cessation program:
"Improving Smoking Cessation Interventions in the Clinical Setting"

I am writing in response to the Greater Metropolitan Clinical Taskforce proposal to NSW Health for a state-wide smoking cessation program.

The Clinical Excellence Commission has reviewed the proposal, and is pleased to fully endorse the document and its recommendations for the proposed implementation of this very important program.

Kind regards,

Clifford Hughes AO
Clinical Professor
Chief Executive Officer
8 October 2008

Dr Peter Castledi
Greater Metropolitan Clinical Taskforce (GMCT)
NSW Health
PO Box 6314
NORTH RYDE NSW 2113

Dear Peter,

nwilcox@nsccahs.health.nsw.gov.au

GMCT proposal to NSW Health for a state-wide smoking cessation program: "Improving Smoking Cessation Interventions in the Clinical Setting"

The Clinical Oncological Society of Australia (COSA) is now in receipt of your letter dated 18 April 2006 and apologise for the delay in providing a response on the final draft proposal.

COSA is Australia’s peak multidisciplinary society for health professionals working in cancer research, treatment, rehabilitation or palliative care. Our overarching mission is to develop and maintain high-quality clinical care of cancer patients in Australia. We are allied with, and provide high-level clinical advice to, the Cancer Council Australia.

COSA is pleased to endorse the GMCT proposal to NSW Health for a state-wide smoking cessation program however would offer the following comments.

The document is predicated on smoking cessation being understood to involve public health approaches (including advertising) and also involving a clinical setting. A clinical perspective is a response to nicotine dependence being (as the document argues) a chronic disease.

The first proposal made, lies within the public health approach, while the other two are focused on the clinical setting, and the situation of the individual. The document seeks to establish complementarity with key policies, e.g. makes reference to "NSW Tobacco Action Plan 2005-2009" and similar. However, there is no analysis of how the proposed initiatives will relate to the detail of what’s occurring at present. Such reference might stem from considering current expenditure and how the $6.7m is to relate to it. Better approaches perhaps could begin with current responsibilities and current 'patient' (ie quitters).

Current responsibilities, at least in the public health setting, involve NSW Health, Cancer Institute NSW, Cancer Council NSW, ASH and the Heart Foundation, all coordinated through the Tobacco Network. The interface between public health approaches and individual counselling and management is facilitated by Quitline NSW. Reference to how the present initiatives affect the operation of Quitline (up to, and including - if necessary - the specification that there would be complete independence) would enhance the document.

Thank you for the opportunity to comment on the proposal.

Yours sincerely,

Margaret McJannett
Executive Officer

cc: Mr Nick Wilcox GMCT Respiratory Network Manager

(Affiliated with Cancer Council Australia)
6th May 2008

Mr Nick Wilcox  
The Respiratory Network Manager  
Greater Metropolitan Clinical Taskforce  
PO Box 6314  
North Ryde NSW 2113

Dear Mr. Wilcox,

Thank you and Professor Castaldi for the opportunity to endorse and/or comment on the recommendations in the GMCT Respiratory Network proposal to the New South Wales Health Department.

Diabetes Australia NSW endorses the key recommendations of GMCT Network.

Smoking, as mentioned, is still the single largest preventable cause of mortality and morbidity in Australia, and smoking cessation is certainly a key management issue for people with diabetes.

Cardiovascular and peripheral vascular diseases are complications of diabetes, both Type 1 and Type 2, and smoking increases this morbidity and mortality. Cardiovascular disease is the cause of death in a large number of people with diabetes.

Diabetes Australia NSW also supports the NSW Health Department’s, “Make prevention everyone’s business” campaign, and smoking cessation will prevent morbidity in the Australia population.

Yours sincerely,

Dr Lilian Jackson  
Manager  
Health & Education Division  
Diabetes Australia NSW
Re: GMTC proposal to NSW Health for a state-wide smoking cessation program: “Improving Smoking Cessation Interventions in the Clinical Setting”

Thank you for the opportunity to comment on the above proposal.

As you are aware, smoking prevalence rates in the NSW custodial population (which features several high risk groups including Aboriginal people, illicit drug users and people with mental illness) remain very high. This poses a danger not only to the health of smokers, but also other (non-smoking) inmates and staff when exposed to environmental tobacco smoke (ETS).

In the past twelve months, the Justice Health Executive and Board have prioritised the need to develop a strategic, comprehensive and ongoing response to tobacco smoking in the NSW custodial setting aimed towards a reduction in the rates of smoking and exposure to ETS.

As part of this process, Justice Health has developed a short summary briefing document regarding tobacco smoking in the NSW custodial setting. The document includes an analysis of key issues and options for the future management of tobacco. This document is yet to be circulated and we would be more than happy to provide you with a copy once able to be released.

Whilst Justice Health is supportive of, and endorses in principal, the three key recommendations of the proposal, we request some changes to ensure the smoking cessation needs of the custodial population are met. These are outlined on the next page.

Should you require any further information please do not hesitate to contact Ms Maureen Hanly, Director of Clinical and Nursing Services, on 02 9289 2964 in the first instance.

Yours sincerely,

Julie Babineau
Chief Executive

15 May 2008
Justice Health Response to the GMTC proposal to NSW Health for a state-wide smoking cessation program

Recommendation One: Population Approach – Smoking Cessation Coordinators

Justice Health endorses and supports the need for a Smoking Cessation Coordinator. Currently there are no funded designated smoking positions within Justice Health. The position description in Appendix A would need to be adapted to reflect the requirements of the custodial setting, and Justice Health as a state-wide health service provider to more than thirty correctional facilities and nine Juvenile Detention Centres. The role would involve liaison and negotiation between Justice Health and the Department of Corrective Services as well as Area Health Services and other stakeholders in the development of a range of strategies aimed at reducing smoking prevalence amongst people in custody and on release to their communities.

An over representation of Aboriginal people, illicit drug users and people with mental illness within the custodial population requires a coordinated and integrated response. Cessation Coordinators assigned to those specific target groups would need to work with the Justice Health Coordinator to respond to the needs of Aboriginal people, illicit drug users and people with mental illness in custody (and on release to the community).

Recommendation Two: Clinical Services – Smoking Cessation Clinicians (Facility-based)

The proposal does not include smoking cessation clinicians for Justice Health. Justice Health provides health care to almost 10,000 people in custody at any given time with an annual throughput of 25,000 in 2007. Health care is provided via primary health services and teams in each correctional centre plus a state-wide outpatient facility and new prison and forensic hospital (at Long Bay).

Primary and secondary prevention initiatives are essential for a population at very high risk of (and already exhibiting high rates of) chronic disease, multiple co-morbidities, health inequalities and social disadvantage. The custodial setting offers a stable environment to develop and provide specialist tobacco dependence treatment services for groups who are traditionally hard to reach, who are often excluded from mainstream services and have very high rates of smoking.

Justice Health is therefore well placed to develop and deliver best practice evidence based specialist tobacco dependence treatment services, as it does with other drugs of addiction. This would be central to any smoking cessation service delivery model, staff training and workforce development and to support the role of the Smoking Cessation Coordinator. Justice Health therefore requests its inclusion in the allocation of smoking cessation clinicians.

Recommendation Three: Pharmacotherapy – Heavily Subsidised Nicotine Replacement Therapy

Justice Health fully supports the provision of free/heavily subsidised full course NRT to people in custody. Generally (with few exemptions) people in custody are required to purchase their own NRT and this is more expensive than tobacco. Most inmates have very high levels of nicotine intake. The development of tailored (and heavily subsidised) NRT protocols for people in custody and particularly those on mental health medications would be strongly endorsed and supported.
03 October 2008

Mr Peter Castaldi
Chief Executive
Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

Dear Mr Castaldi

On behalf of the National Asthma Council Australia (NAC) I am writing in support of the Greater Metropolitan Taskforce’s proposal to NSW Health for a state-wide smoking cessation program. Implementation of the recommendations in the proposal would assist many more smokers to stop smoking.

As the peak body for asthma in Australia, it is of great concern to the NAC that:

- The proportion of smokers among people with asthma is similar to the proportion of smokers among people without asthma.
- Among people with asthma, those who are younger and live in localities that are relatively socioeconomically disadvantaged are most likely to smoke.
- Forty-one per cent of children with asthma and 38% of children with asthma live with one or more regular smokers.
- The higher rate of household exposure to smokers among children with asthma is most evident among boys aged 5 to 14 years, girls aged less than 5 years and people living in more socioeconomically disadvantaged areas.

(ACAM, Asthma in Australia 2005, AIHW)

The effects of smoking and passive smoking on asthma are clearly documented and we support your carefully developed proposal to NSW Health. It is important for each Government in Australia to provide systematic and easily available treatment and counselling to chronic smokers to assist them in the difficult task of quitting. The implementation of your proposal would establish NSW Health as the leader in smoking cessation interventions.

Your proposal, if implemented, would provide a systematic approach to smoking cessation and deliver important health outcomes and cost benefits to the community. It has the endorsement of the National Asthma Council Australia.

Yours sincerely

Kamala Whorlow
Chief Executive Officer

National Asthma Council Australia Limited (ABN 61 008 044 034) Suite 104, Lvl 1, 153-161 Park Street, South Melbourne, Vic 3205 Australia
Tel (03) 9128 4333 Fax (03) 9123 4300 Order Line: 1800 032 416 Email: nac@nationalasthma.org.au Website: www.nationalasthma.org.au

Leading the attack against Asthma.
Wednesday 14th May 2008

Respiratory Network Manager
Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

Dear Sir/Madam,

Thank you for the opportunity for the Mental Health Coordinating Council (MHCC) to provide feedback on the GMCT proposal to NSW Health for a state-wide smoking cessation program: ‘Improving Smoking Cessation Interventions in the Clinical Setting’.

MHCC has recently commenced an 18 month joint project with The Cancer Council NSW called ‘breathe easy’ – lifting the burden of smoking, which is aimed at reducing smoke-related harm within NGO services working in mental health. Thus, a proposal for a state-wide smoking cessation program is timely.

In principle MHCC supports the need for more enhanced smoking cessation services, particularly for the mental health sector where smoking rates are higher than in the general population. However, MHCC cannot wholly endorse this proposal without consideration to the following issues.

Recommendation 1 – Smoking Cessation Coordinators

MHCC supports the recommendation for Smoking Cessation Coordinators based in Area Health Services to promote, coordinate and facilitate smoking cessation services within the community. This recommendation ensures a more uniform and coordinated effort in smoking cessation practices and would be a logical point of contact for education and staff training opportunities.

Recommendations 2 – Smoking Cessation Clinicians

MHCC does not support the recommendation for Smoking Cessation Clinicians in the clinical setting. Although the recommendation for Smoking Cessation Clinicians iterates the dire need to address smoking, creating specialised roles may not have the desired effect of a sustained smoking cessation program to reduce smoking.

Smoking cessation may not be as comprehensively addressed as it could be if it is delegated to specific people and programs. Staff may continue to see smoking cessation as someone else’s job rather than addressing it as part of their roles in dealing with patients overall health and well being. This is supported by Johnson and Baum (2001)1 where it was found that health promotion was less sustainable.

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hospitals aimed at being a health promotion setting where health promotion is integrated throughout the organisation and part of all staff roles. The proposed state-wide smoking cessation program would be more effective in clinical settings if Smoking Cessation Clinicians are considered in addition to reorientation of all staff roles to incorporate smoking intervention so that smoking cessation is seen as a priority by all staff. But MHCC believes a more appropriate and more effective approach would be to have Smoking Cessation Coordinators in the clinical setting instead of Smoking Cessation Clinicians.

As proposed in Recommendation 1, the Smoking Cessation Coordinators in the clinical settings would oversee and coordinate the training of all staff in smoking cessation and implementation of smoking cessation programs, thereby facilitating the organisational change of the clinical setting to address smoking as a unified body rather than referring it to one trained clinician.

As smoking is the single, largest preventable cause of mortality and morbidity in Australia contributing to more than 6 500 deaths and 55 000 hospitalisations in NSW alone, is associated with numerous chronic conditions and contributes to further social and financial burdens in disadvantaged people who smoke, it would make sense for all health professionals in the clinical setting to address smoking in all patients as part of their roles.

This approach would also ensure patients, particularly patients from disadvantaged groups who require more intensive support, who do wish to reduce smoking, do not ‘fall through the cracks’ as they are continually referred to the ‘Smoking Cessation Clinician’ who may not always be available for consultation.

In regard to mental health services, integrating and coordinating smoking cessation in services is seen as more appropriate by Campion et al (2008) instead of only referring patients to smoking advisors within the NHS Stop Smoking Services. This too would be appropriate for all clinical settings to see that the smoking cessation program is sustainable.

**Recommendation 3 – Pharmacotherapy**

MHCC strongly supports the proposal for heavily subsidised Nicotine Replacement Therapy (NRT) to be made available to smokers who are ready and willing to reduce or quit smoking. However, MHCC would like to see this recommendation to NSW Health amended to include subsidising NRT to be available to NGOs funded by NSW Health.

As is recognised by GMCT disadvantaged people require greater support in reducing smoking. Allowing for subsidised NRT to be available in the clinical setting and NGO services would mean that it is not only people who interact with hospitals that will benefit; this is particularly important in the mental health setting as not all people with mental illness will enter the clinical setting.

Greater access by NGO services to subsidised NRT would increase the likelihood of capturing smokers from disadvantaged groups who are ready to reduce or quit smoking and will also further the chances of people quitting smoking, as smokers generally make several quit attempts before quitting smoking altogether.

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MHCC Feedback to GMCT proposal for state-wide smoking cessation program
Although it is outside the realm of this proposal MHCC would like to see NRT placed on the Pharmaceutical Benefits Scheme so that disadvantaged people, for whom the cost of NRT is currently prohibitive, can access subsidised NRT.

As mentioned, MHCC is, in principle, supportive of the state-wide proposed smoking cessation program. A more stable program rather than the ad-hoc nature by which smoking is currently addressed in NSW can help with reducing the rate of smoking. Nevertheless, MHCC believes that consideration of the aforementioned issues will ensure the smoking cessation program is more efficient and sustainable in the long-term.

Thank you once again for providing MHCC with this opportunity to respond to GMCT’s proposal to NSW Health. To clarify any points please contact Carla Cowles on 9555 8388 (ext112).

Sincerely,

Jenna Bateman
Executive Officer
Mental Health Coordinating Council
1 September 2008

Nick Wilcox
Manager, GMCT Respiratory Network
PO Box 6314
North Ryde NSW 2113

Dear Mr Wilcox,

It is with pleasure the National Stroke Foundation responds to your correspondence (April 18, 2008) to support the GMCT proposal to NSW Health for a state-wide smoking cessation program.

The National Stroke Foundation recognises the devastating consequences of tobacco use on health and is pleased to offer endorsement and support of the recommendations towards improving smoking cessation interventions in the clinical setting.

In particular, from a population approach we believe Smoking Cessation Coordinators will play a valuable role to help to relieve the burden on GPs who are often a main support for successful smoking cessation.

In addition to supporting your strategies we would reinforce (from a public health perspective) that interventions in the clinical setting need to be supported or coordinated with additional strategies such as social marketing to achieve a greater effect. This will move smokers in the population towards contemplation of quitting and entry into clinical cessation programs.

Please do not hesitate to contact me if you require any further feedback. Thank you for allowing us to be involved in your proposal and we wish you success.

Yours sincerely,

[Signature]

Dr Erin Lalor
Chief Executive Officer
15 May 2008

Mr Peter Castaldi
Chief Executive
Greater Metropolitan Clinical Taskforce
PO Box 6314
North Ryde NSW 2113

Dear Mr Castaldi,

Comments on GMCT Proposed Smoking Cessation Program –
Improving Smoking Cessation Interventions in the Clinical Setting

Thank you for inviting me to comment on the proposal to NSW Health for a state-wide smoking cessation program involving the establishment of twelve Smoking Cessation Co-ordinator positions, smoking cessation clinicians in hospitals, and heavily subsidised NRT for high risk smokers using the clinical cessation services.

The Cancer Council NSW is a strong proponent of potent action on tobacco control, including measures and programs that will assist smokers to quit. We are particularly concerned about high smoking rates amongst the most severely socially disadvantaged groups – people with a mental illness, the homeless, indigenous Australians and others who are dependent on social services – who exhibit a much higher prevalence of smoking than the rest of the population.

We appreciate that the GMCT has turned its attention to the issue of smoking cessation, and is considering options that will contribute to a reduction in smoking rates in NSW. We agree with a number of the fundamental principles underlying the proposal:

- That more still needs to be done to reduce smoking rates, notwithstanding the broad success of our tobacco control efforts
- That smokers are not a homogenous group
- That organisational and cultural change is required to facilitate effective interventions, and provide supportive environments for quit attempts
- That improving access to NRT for price-sensitive smokers is important

The Cancer Council NSW has committed to a five-year strategy to reduce the disproportionate burden of tobacco use amongst the severely socially disadvantaged (Tackling Tobacco). The key focus of the strategy is to engage social service organisations to adopt their policies and practices so that clients of services are more able to resist smoking and more likely to attempt to quit smoking. The strategy is based on the following rationale:

Cancer Council Helpline 13 11 20
That the most effective way of reaching those in need of assistance is through the environments and settings where they already have a relationship

That increasing the frequency with which opportunistic brief interventions are provided in the context of any service provision (including non-health settings) will increase the likelihood of smokers attempting to quit

That increasing the numbers of professionals who provide brief interventions enables a greater reach into priority populations, and maximises the investment in brief intervention training

That increasing quit attempts within the population has a greater impact on prevalence than improving the quality of quit attempts

Our research about smoking amongst highly disadvantaged groups suggests a strong preference amongst smokers to receive cessation assistance through those services they already use rather than from a separate clinical setting, where the requirement to attend appointments, the need to travel and be sufficiently organised to participate may be insurmountable barriers for those smokers most in need of assistance. Furthermore, notwithstanding the high prevalence of smoking among disadvantaged groups, the frequency of their quit attempts appears to be as high as any other groups. This suggests that developing environments that support quitting and prevent relapse is more important than specific clinical services in hospitals.

The Cancer Council NSW recently recommended to the State Government that cessation support be tightly targeted to priority population groups, and assistance provided to government funded community services to play a more active role in providing targeted cessation support to clients. In our submission Budget Initiatives for Cancer Control – NSW State Budget 2008/2009, we recommended:

1. The employment of an additional tobacco cessation trainer as a full-time NSW Health position to promote and implement evidence-based smoking cessation training to government-funded community service agencies, at an approximate cost of $100,000 pa

2. Providing free nicotine replacement therapy to clients of government-funded community service agencies who want to quit smoking. The provision could be administered through the Area Health Services, with eligibility limited to those organisations that had participated in appropriate smoking cessation training. While the quantity of NRT needed would increase each year as the capacity of community services to provide cessation assistance increases, we recommended that a fund of $300,000 for the first year would provide 5,000 courses of NRT (8 weeks supply per person).

This budget provision of $1M would enable the broad adoption of brief intervention practice by workers in regular and close contact with priority population groups with the highest smoking rates and support the creation of organisational culture that recognises the need to address smoking as part of general service provision, in a highly targeted and cost-effective manner.

If the GMCT is interested in discussing our approach and recommendations and its implications for the proposal for Improving Smoking Cessation Interventions in the Clinical Setting, please don’t hesitate to contact me on 9334-1931.

Yours sincerely

Andrew Penman
Chief Executive Officer
5 December 2008

Professor Peter Castaldi
Chief Executive, GMCT
P.O. Box 6314
North Ryde NSW 2113

Dear Professor Castaldi,

Re: GMCT proposal to New South Wales Health for a statewide smoking cessation program

I apologise for the very long delay since you first wrote to the TSANZ seeking our support for this program. It seems this letter arrived and was lost during a change of personnel in the TSANZ office.

The TSANZ Executive has considered the three recommendations, including smoking cessation coordinators, facility-based smoking cessation clinicians and a heavily subsidised program for nicotine replacement therapy. We support this proposal to optimise service delivery to enhance smoking cessation in the area health service context.

As the national organization of respiratory physicians, allied health professionals and scientists, we do not see any reason (other than the habit of history), for the existence of multiple different strategies, interventions and funding mechanisms to enhance smoking cessation in different states in Australia. The TSANZ would encourage the GMCT to consider mechanisms by which other states and jurisdictions could be engaged in a discussion to develop a common approach to optimise smoking cessation interventions in area health services nationally.

Kind regards
Yours sincerely

CHRISTINE JENKINS
President

cc. Mr Nick Wilcox, GMCT Respiratory Network Manager
25th June, 2008

Associate Professor Jenny Alison &
Associate Professor David McKenzie
GMCT Respiratory Network
PO Box 6314
North Ryde
NSW 2113

Dear Professors Alison and McKenzie,

Re: GMCT Respiratory Network Smoking Cessation Program

The GMCT Respiratory Network Smoking Cessation Proposal was distributed for
comment and feedback to cardiac clinicians in May and the document was
also discussed at the cardiac Coordinating Committee meeting which was held
on 12th June, 2008.

On behalf of the GMCT Cardiac Network, we are pleased to endorse the
Smoking Cessation Proposal.

Yours sincerely,

[Signatures]

Professor Peter Fletcher
Co-Chair Cardiac Network
Director Cardiac Services
John Hunter Hospital

Karen Linten
Co-Chair Cardiac Network
CNC Cardiac Services
Liverpool Hospital

Our Ref:

An Advisory Body to the NSW Minister for Health
PO Box 6314, North Ryde NSW 2113 Tel: (02) 9867-5728

NSW HEALTH
Working to be a leader
Fax: (02) 9867-5640
Email: gmct@nhs.health.nsw.gov.au

Page 63 of 68
greater metropolitan clinical taskforce

20 June 2008

Mr Nick Wilcox
Respiratory Network Manager
Greater Metropolitan Clinical Taskforce
PO Box 6314
NORTH RYDE NSW 2113

Dear Mr Wilcox,

Re Smoking Cessation Proposal

Thank you for the opportunity for the GMCT Diabetes Network to review and comment on the recommendations in the GMCT Respiratory Network proposal to NSW Health.

Smoking increases the morbidity and mortality of people with cardiovascular and peripheral vascular complications of diabetes.

The Diabetes Network supports the key recommendations of the Smoking Cessation proposal as improving the management of people with diabetes.

Yours sincerely,

Prof. Stephen Colagiuri
Co-Chair, GMCT Diabetes Network

cc Professor Greg Fulcher
Dr Jeff Flack

Dr David Chipps
Co-Chair, GMCT Diabetes Network

NSW Health
An Advisory Body to the NSW Minister for Health
PO Box 8314, North Ryde NSW 2113
Tel: (02) 9887-6724
Fax: (02) 9887-5945
Email: nswhealth@health.nsw.gov.au
greater metropolitan clinical taskforce

Prof Peter Castaldi
Chief Executive
GMCT
Level 3
51 Wicks Rd
North Ryde NSW 2113

Dear Prof Castaldi

Re: GMCT proposal to NSW Health for a state-wide smoking cessation program: 'Improving Smoking Cessation Interventions in the Clinical Setting'

Thank you very much for the opportunity to comment on the above proposal. The Statewide Ophthalmology Service (SOS) strongly supports the cessation of smoking given the evidence linking smoking to vision impairment.

Mitchell et al (1999)' estimate that smoking is responsible for around 20% of all cases of blindness in Australians over 50 years of age.

Age-related Macular Degeneration (AMD) and cataract are linked to smoking. In 2004 in over 40 year olds AMD was the leading cause of blindness in Australia and responsible for 48% of severe vision loss; 2 cataract was responsible for 12% of blindness. Three major studies have provided overwhelming data about the relationship between smoking and AMD. The Blue Mountains Eye Study (BMES) 3 showed that after controlling for age, sex and other factors current smokers had a 4-fold higher risk of late AMD than never smokers and past smokers had a 3-fold risk of geographic atrophy. 4 The Melbourne Vision Impairment Project 5 noted that smoking is the only modifiable risk factor for Age-related Maculopathy (ARM) and AMD. And the Beaver Dam Eye Study 6 concluded that smoking appears to be related to the long-term incidence and progression of AMD. This has important health care implications because early AMD increases the risk of developing late AMD and smoking behaviour is modifiable.


Our Ref: 07_Ltr to PCastaldi_Inspr smoking cessation_June 2008.doc
A review of the association between smoking and AMD by Thornton et al (2005) noted that in spite of strong association between smoking and AMD there appears to be a lack of awareness about the risks of developing eye disease from smoking among health care professionals and the general public.

The Access Economics Report ‘Investing in Sight’ was commissioned to identify and cost strategic policy interventions that would cost-effectively enhance prevention and treatment of vision impairment including blindness in Australia. Of particular relevance in the ‘awareness, detection and prevention’ group was the intervention ‘to promote the cessation of smoking’ to prevent age-related macular degeneration and cataract. Access Economics modelling based on a successful National Tobacco Campaign Quit program demonstrated that ‘4.5% of the total financial benefits and just under 1% of quality of life gains from quitting smoking are gained from avoiding vision impairment’.

The SOS support the GMCT Respiratory Network’s proposal for a Smoking Cessation Program. The three pronged approach consisting of the employment of Area Health Service (AHS) Smoking Cessation Coordinators, Hospital based Smoking Cessation Clinicians and heavily subsidised Nicotine Replacement Therapy (NRT) will raise the awareness of smoking and the risk of eye disease amongst AHS residents and health care professionals. It will also assist smoking cessation with accessible programs and NRT.

Yours sincerely

Peter McCluskey
NSW SOS
Co-chair

Michael Hennessy
NSW SOS
Co-chair

Cc Kate Needham, Executive Director GMCT
Nick Wilcox, Respiratory Network Manager
Jan Steen, Executive Director, NSW SOS

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Professor Peter Castaldi  
Chief Executive, GMCT  
PO Box 6314  
NORTH RYDE NSW 2113

Re: Proposal for a state-wide clinical smoking cessation program

Dear Professor Castaldi,

Thank you for the opportunity to comment on the smoking cessation proposal developed by the GMCT Respiratory Network.

Smoking is a well-known independent risk factor for ischemic stroke\(^1\)\(^2\), which contributes to a higher likelihood of stroke-related fatality\(^3\).

Additionally, recent smokers with acute ischemic stroke experience a poorer outcome than non-smokers\(^4\).

The Stroke Services Network fully endorses the three key recommendations in this proposal.

Sincerely,

Ms Sue Day  
Co-Chair, Stroke Services NSW

A/Prof Catherine Storey  
Co-Chair, Stroke Services NSW

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greater metropolitan clinical taskforce

Nick Wilcox
GMCT Respiratory Network Manager
PO Box 6314
NORTH RYDE NSW 2113

May 30th 2008

Dear Nick,

Thank you for forwarding a copy of the smoking cessation proposal developed by the GMCT Respiratory Network. This is a clear and focussed document and the proposal provides a considered approach to implementation of the NSW Tobacco Action Plan 2005 -2009 that is in keeping with the State Health Plan and National Tobacco Strategy.

The Transition Network is pleased to see targeting of adolescents and young adults as this is the best opportunity to ensure that lifelong smoking habits are reduced. The addition of a smoking habit to established chronic illness will have an exponential effect on morbidity and mortality.

On behalf of the GMCT Transition Care Executive we are very happy to endorse the proposal's key recommendations and well done!

Yours Sincerely,

Kate Steinbeck
Director Youth Consultancy Service
SSWAHS
Co-chair, GMCT Transition Care Executive

Alison Kingsley
Head of Occupational Therapy
Sydney Children's Hospital
Co-chair, GMCT Transition Care Executive

Our Ref: C:\Documents and Settings\NSAH\Users\My Documents\Correspondence\Kathy Meadey.doc