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McMillan, Mark; Davis, Joshua

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The increasing burden of ADEs on the Australian health system has been clearly documented, and it is argued that we need new systems to deal with the reality that only limited numbers of highly selected patients are studied before a drug is marketed, and such systems must have the capacity to detect early signals of potential ADEs in large populations.³

The risk identification model using clinical trial data and linked administrative health data, as described above, can provide that level of prediction.

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Correspondence to:

Dr Margaret Whitstock, PO Box 4264, Melbourne University, Victoria 3052. E-mail: whitstock@inet.net.au.

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Acute hospital admission for sepsis: an important but under-utilised opportunity for smoking cessation interventions

Mark McMillan

Menzies School of Health Research, International Health Division, Northern Territory

Joshua S. Davis

Menzies School of Health Research, International Health Division / Department of Health and Families, Northern Territory Government

Although an integrated health promotion approach is the keystone of effective tobacco control, acute care hospitals do have a specific role to play in the individual screening, risk assessment, and education of patients about smoking cessation.¹⁻² A systematic review of hospital-based interventions estimated that counselling about smoking cessation commenced during hospitalisation and continued for at least one month following discharge increases the odds by 65% that person remains a non-smoker at 6-12 months.² Clearly, the first step in any hospital-based intervention aimed at smoking cessation is to identify smokers. Asking patients about tobacco smoking is considered a routine part of medical history taking, as is documentation of this information in the patient's medical record.

In 2007/08 we performed a 12-month prospective epidemiological study of community-acquired sepsis at Royal Darwin Hospital. Demographic and clinical information was prospectively collected from medical records and hospital databases. All adult patients admitted with a suspected or proven infection along with two or more criteria for the systemic inflammatory response syndrome (SIRS)³ were enrolled. A total of 1,191 admissions were included in the study, of whom 604 (50.7%) were Indigenous and 624 (52.4%) were male. Of these 1,191 acute hospital admissions, 391 (31.9%) had no documentation of smoking status. Of the remaining 800, 413 patients (51.6%) were documented as current smokers, 380 (47.5%) as non-smokers, and seven had missing data due to lack of access to the patient's medical record. This smoking prevalence of 51.6% is substantially higher than the NT age-adjusted prevalence of 35.3% ($p < 0.001$),⁴ suggesting that smoking may be a risk factor for sepsis-related hospitalisation. Smoking was more common in males (63.2%) than females (51.2%) and in Indigenous (66.5%) than non-Indigenous (49.1%) patients (Table 1).

We also examined predictors of a lack of documentation of smoking status. Smoking status was documented in 60.1% of those admitted under a surgical team compared with 74.3% of patients under a medical team ($p < 0.001$). In a multivariate model controlling for comorbidities, age, gender, severity of sepsis and homelessness the admitting team remained a statistically significant predictor of a lack of documentation of smoking status (odds ratio of 2.30 [95% CI 1.71-3.08] for surgery versus medicine). Documentation of smoking status was also less likely ($p < 0.05$) in females, those reporting hazardous alcohol use, and those with dementia, but not in those with more severe sepsis. Being admitted under a surgical team and hazardous alcohol use were the only significant predictors of a lack of documented smoking status in our multivariate model. A potential limitation of this data is that a lack of documentation does not prove that smoking status was not discussed. However, it is more likely that the admitting team or alcohol use are associated with failure to discuss smoking status rather than simply a failure to document such a discussion.

Acute care smoking assessment and intervention is only one part of the overall integrated approach to tobacco control. However, the potential benefits are likely to be significant, with tobacco control being an extremely cost effective intervention.¹ There are many reasons that smoking cessation interventions are overlooked in acute hospital admissions such as lack of time or resources, and poor systems. The alarmingly high rates of smoking in this cohort, particularly among Indigenous people, strengthens the case for improving acute care smoking assessment and

Table 1: Crude prevalence of smoking by Indigenous status and sex.

Crude prevalence%	Male	Female	Total
Indigenous	71.4 (n=130/182)	62.4 (n=136/218)	66.5
Non-Indigenous	57.4 (n=147/256)	33.6 (n=46/137)	49.1
Combined	63.2 (n=277/438)	51.2 (n=182/355)	52.0

cessation management, with a particular focus on improving the assessment of surgical patients. For many people, especially the most vulnerable, hospitals are often the first if not the only point of contact they have with the health system. It is time that acute care hospitals stop wasting this important opportunity.

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Correspondence to:

Dr Joshua S. Davis, John Mathews building (Building 58), Royal Darwin Hospital, Rocklands Drive, Casuarina, NT 0810, E-mail: Joshua.davis@menzies.edu.au

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Monitoring the cost of healthy food

Nathan Givoni, Claire Palermo

Department of Nutrition and Dietetics, Monash University, Victoria

The cost and availability of healthy food is a major determinant of food and nutrition security.¹ The link between food insecurity and poor health and social outcomes are well established.² Recent data showing the increasing cost of food, particularly for those in rural and remote areas,³ is of concern. Monitoring the affordability of healthy food is important to consider in addressing food insecurity and can assist in influencing public health nutrition policy and practice.

The Mornington Peninsula and Frankston Local Government Areas (LGAs) are to the south of Melbourne with a combined population of almost 250,000 (Frankston, 116,199; Mornington Peninsula, 131,631). These LGAs have been monitoring the cost of healthy food, in the absence of a state or national monitoring system, over the past three years using the Victorian Healthy Food Basket (VHFB) described previously.⁴ A complete sample of supermarkets in Frankston and Mornington Peninsula were identified through directories and from Health License Registrations from local councils. The VHFB data was collected on a standardised collection sheet with accompanying detailed instructions. Data collection was carried out during winter (May-August) in 2007-09 by trained data collectors. Stores that had

greater than 90% of the items in the basket were included in the analysis. The cost of the basket was compared with the fortnightly government unemployment benefits received by each different family type. This income was determined using government Centrelink data from years 2007-09.⁵ It was assumed that no family members were employed. Socioeconomic Index For Areas (SEIFA) for suburbs within the LGA were obtained from Australian Bureau of Statistics.⁶ Data was analysed using PASW Statistics v18.0 for Windows (SPSS Inc; Chicago, IL, US). Significance was taken as $p < 0.05$.

The number of eligible stores increased from 2007 (26 supermarkets on Mornington Peninsula and 14 in Frankston City) to 2009 (29 in Mornington Peninsula and 16 in Frankston City). The cost of the VHFB for a typical family in 2009 (\$425.32) was significantly higher than in 2007 (\$400.43) ($p=0.000$) (Table 1).

The cost of the VHFB for a typical family was 34% (IQR = 1.56) of fortnightly income slightly higher than a single parent family (30% of estimated fortnightly income) and single man (29% of estimated fortnightly income), and higher than an elderly woman (18% of estimated fortnightly income) ($p=0.000$) (Table 2). The total cost of a VHFB as a percentage of fortnightly income for a typical family in 2009 was 34%, significantly lower than 40% in 2007 ($p=0.000$) and 38% in 2008 ($p=0.000$).

Table 1: The total cost of a VHFB for a typical family, and the cost of a VHFB as a percentage of estimated fortnightly income for a typical family in Mornington Peninsula and Frankston City in 2007, 2008 and 2009.

	Median Cost (IQR)		
	Median Percentage of Income (IQR) (n=number of stores surveyed)		
	2007	2008	2009
Frankston City	\$418.71 (18.11) 41.85% (1.81) (n=14)	\$403.99 (12.04) 40.38% (1.20) (n=14)	\$427.03 (17.22) 33.79% (1.36) (n=16)
Mornington Peninsula	\$391.60 (28.94) 39.00% (2.82) (n=26)	\$391.38 (35.48) 35.75% (3.25) (n=27)	\$425.32 (28.80) 34.10% (3.97) (n=29)
Combined (Mornington Peninsula and Frankston City)	\$400.43 (33.60) 39.86% (3.51) (n=40)	\$400.10 (23.39) 37.78% (5.28) (n=41)	\$425.32 (19.74) 33.66% (1.56) (n=45)

Table 2: The median total cost of the VHFB in Mornington Peninsula and Frankston City as a percentage of estimated fortnightly income for a typical family, single parent family, elderly woman and single man 2007-09.

	2007	2008	2009
Total cost of VHFB	Median	Median	Median
	(% of income)	(% of income)	(% of income)
Typical family	\$400.43 (40%)	\$400.10 (37%)	\$425.32 (34%)
Single parent family	\$275.37 (36%)	\$275.14 (32%)	\$292.49 (30%)
Elderly woman	\$96.10 (18%)	\$96.02 (18%)	\$102.16 (18%)
Single man	\$125.73 (29%)	\$125.63 (29%)	\$133.34 (29%)