UCSF
WHO Tobacco Control Papers

Title
Effective Access to Tobacco Dependence Treatment, New Zealand

Permalink
https://escholarship.org/uc/item/31w8798d

Author
World Health Organization

Publication Date
2003

eScholarship.org Powered by the California Digital Library
University of California

New Zealand: Effective Access to Tobacco Dependence Treatment

Liz Price and Matthew Allen

Allen & Clarke Policy and Regulatory Specialists Limited



World Health Organization

Tobacco Free Initiative Headquarters would like to thank the Regional Offices for their contribution to this project.

WHO Regional Office for Africa (AFRO)

Cite du Djoue
Boîte postale 6
Brazzaville
Congo
Telephone: +(1-321) 95 39 100/+242 839100

WHO Regional Office for the Americas / Pan American Health Organization (AMRO/PAHO)

525, 23rd Street, N.W.
Washington, DC 20037
U.S.A.
Telephone: +1 (202) 974-3000

WHO Regional Office for the Eastern Mediterranean (EMRO)

WHO Post Office
Abdul Razzak Al Sanhouri Street, (opposite Children's Library)
Nasr City, Cairo 11371
Egypt
Telephone: +202 670 2535

WHO Regional Office for Europe (EURO)

8, Scherfigsvej
DK-2100 Copenhagen
Denmark
Telephone: +(45) 39 17 17 17

WHO Regional Office for South-East Asia (SEARO)

World Health House, Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India
Telephone: +(91) 11 337 0804 or 11 337 8805

WHO Regional Office for the Western Pacific (WPRO)

P.O. Box 2932
1000 Manila
Philippines
Telephone: (00632) 528.80.01

Introduction

At the beginning of 1998 New Zealand lacked tobacco dependence treatments. Only a small amount of Government funding was committed to smoking cessation programmes and it was difficult for many people to find help in quitting. Most of the cessation programmes available were offered by the private sector. These programmes were few in number, often expensive and tended to target white, middle-class smokers. There was little help available for Maori – New Zealand's indigenous population – 50% of whom smoke.

In addition, broader tobacco control measures that would indirectly support smoking cessation were lacking. Health warnings were weak, smoke-free environments largely confined to offices and public transport, and there had not been a significant increase in tobacco excise since 1991.

For several years the tobacco control community in New Zealand lobbied for a smoking cessation media campaign and the provision of help for individuals. The Government listened. In 2003, New Zealand has one of the most advanced mixes of population-level smoking cessation initiatives in the world. In five years it has gone from almost zero Government funding of smoking cessation programmes, to funding of around NZ$ 13 million per annum. This is nearly 50% of the total New Zealand tobacco control budget.[1] The initiatives include a national Quitline, subsidized nicotine replacement therapy (NRT), Maori-focused quit services including quit support and NRT for Maori women and their whanau (families), and a hospital-based quit service for inpatients and their families.

Broader measures supporting smoking cessation are also in place or planned, including stronger health warnings, a ban on point-of-sale advertising, legislation that proposes to ban or severely restrict smoking in workplaces, and significant excise increases in 1998 and 2000.

Description of the policy interventions

New Zealand's smoking cessation landscape is made up of a number of varied initiatives, targeting different groups. It includes Government-funded organizations such as the Quit Group and private-sector services that receive no Government funding. Other services may be partially Government funded.

The Quit Group

The Quit Group is contracted to provide Government-funded whole-population smoking cessation services in New Zealand. Programmes it manages include the Quitline, the Quit Campaign (which includes the *Every cigarette is doing you damage*, and *It's about whanau* multimedia campaigns), the Health Provider NRT Exchange Card Programme, and the *Quit for our kids* programme.

The Quit Campaign

The Quit Campaign is a mass communications campaign and a national telephone Quitline. The Quitline was first piloted in the Waikato/Bay of Plenty region between September 1998 and April 1999 by a partnership of three organizations: the Health Sponsorship Council, Cancer Society of New Zealand and Te Hotu Manawa Maori. The region chosen for the pilot had a smoker population base of around 100000, approximately 30% of whom were Maori. 'Threat appeal' television commercials adapted from the Australian National Tobacco Campaign were screened. These commercials showed the consequences of smoking in graphic detail – images of fatty aortas and rotting lungs, for example. Smokers were given the freephone Quitline number and urged to call for help and advice. Nine thousand calls were received during the six-month pilot.

In 1999, Government funding was secured for the Quitline, and it was launched nationally in May that year. A multimedia campaign promoting the service was launched two months later. The Australian television campaign *Every cigarette is doing you damage* was continued, and an empathetic Quitline advertisement was also shown.

The campaign was particularly designed to be effective for New Zealand's Maori population. A number of Maori quit advisers were employed, and culturally appropriate Quitline services and quit materials were developed.

The Quitline and the multimedia campaigns now receive around NZ$ 3 million annually.

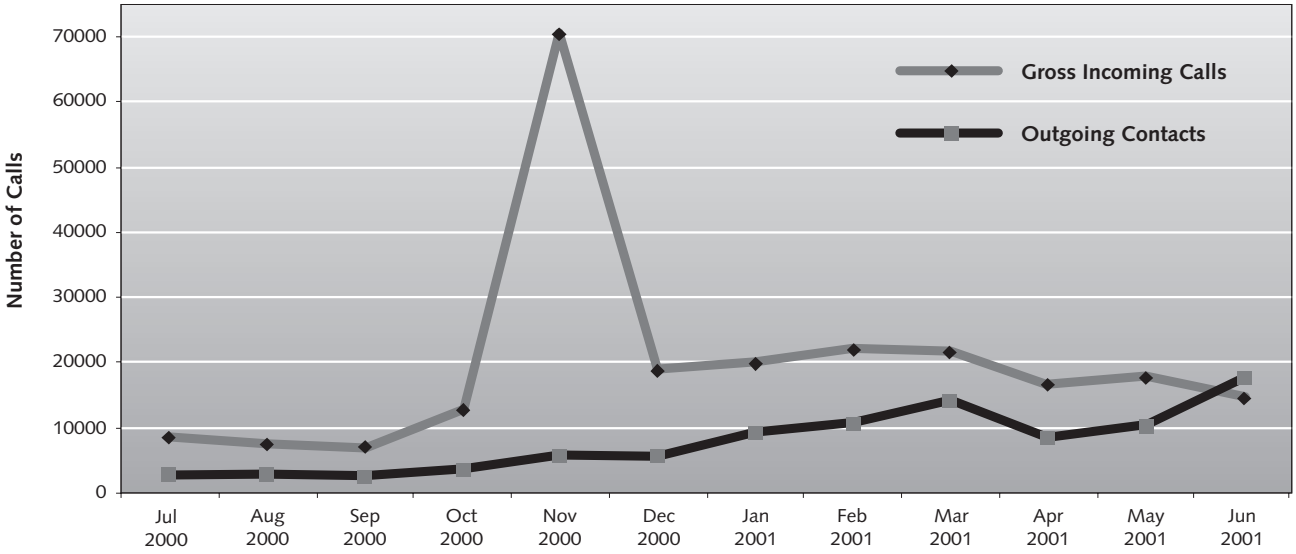
Subsidized NRT

In November 2000, the cessation landscape in New Zealand changed significantly with the introduction

[1] Personal communication, Candace Bagnall (Ministry of Health, Public Health Portfolio Manager, Auckland Locality), August 2002.

Figure 1

Incoming and Outgoing Quitline Calls – July 2000 to June 2001



of Government-subsidized nicotine patches and gum. Government funding of NZ$ 6.18 million per annum had been allocated to this project earlier in the year. This meant that the price of nicotine patches or gum for smokers could be greatly reduced – from a maximum of around NZ$ 136 to NZ$ 10 for a four-week supply. Since then, the price of subsidized patches and gum has been further reduced to NZ$ 5 for the first month and NZ$ 10 for the second month.

When callers contact the Quitline they are connected to a call centre. An operator offers the caller a choice of receiving a pack of quit information or being put through to a quit adviser. Callers who meet specific criteria are issued with a nicotine patches or gum 'exchange card' which they can redeem at participating pharmacies (see below). Research shows that heavier smokers are more responsive to NRT, and therefore as a general rule only those who smoke more than 10 cigarettes a day are eligible for the subsidized patches and gum. Pregnant or breastfeeding smokers, and those who have angina, palpitations or who have suffered a heart attack are asked to talk to their general practitioner (GP) about their suitability for nicotine patches and gum *(1)*.

Around 55 000 people a year have registered with the Quitline since subsidized NRT was made available in 2000.[2] This represents 7% of the smoker population in New Zealand registering each year.

Initially public demand was overwhelming, peaking at 70 000 calls to the Quitline in the first month.[3] A number of major changes to the Quitline were required to cater for the huge numbers. These included moving to bigger premises, increasing staff numbers, and greatly reducing advertising and public relations activity over several months until call levels dropped. Quitline advisers also make outgoing calls (known as call-backs) offering ongoing support and advice to people undertaking a quit attempt. Call-backs had to be reduced for a time after the introduction of the subsidized patches and gum owing to the volume of incoming calls.

Health Provider Exchange Card Programme

Another initiative, the NRT Health Provider Exchange Card Programme, allows individuals and groups with an interest in smoking cessation to distribute exchange cards directly to their clients. Exchange card recipients can then redeem the cards at participating pharmacies and receive subsidized

[2] Personal communication, the Quit group, August 2002.

[3] This figure includes 'hang-ups' and also those people calling more than once while the Quitline initially struggled to cope with the number of people calling.

[4] Personal communication, Steeve Cook, Coordinator of the Health Provider Exchange Card Programme, the Quitline, August 2002.

Type of NRT	Distribution	Price, subsidized (on presentation of Exchange Card)[a]	Approximate price unsubsidized
Patches	General sales medicine (can be obtained from any outlet)	NZ$ 5 for four-week supply (5 mg, 10 mg and 15 mg)	NZ$ 71.20 for four-week supply (10 mg)
Gum	General sales medicine	NZ$ 5 for four-week supply (2 mg and 4 mg)	NZ$ 136.80 for four-week supply (4 mg)
Nasal spray	Prescription medicine (can only be obtained on a doctor's prescription)	Not subsidized	NZ$ 43.71 (10 mg/ml) for one- to two-week supply
Nicotine inhaler	Pharmacist-only medicine (can only be obtained from a pharmacist, but a prescription is not needed)	Not subsidized	NZ$ 43.37 (10 mg starter pack and refills) for two- to four-day supply

[a] Source: National Health Committee *(5)*.

nicotine patches and gum. All providers who wish to be part of this programme must be registered with The Quit Group, which oversees the programme. As of August 2002, around 250 health providers were registered with the service.[4] They included independent practitioner associations representing several hundred GPs, individual GPs, mainstream cessation providers (serving the general population rather than a specific population or ethnic group), and Maori health providers. more Than 40000 exchange cards have now been issued through the programme.

To guide the programme, The Quit Group has established an advisory committee consisting of professionals from relevant fields, to assist with policy decisions.

It's about whanau

A media initiative designed by Maori to appeal to Maori smokers, the *It's about whanau* campaign was launched in August 2001. The campaign aims to motivate Maori smokers to see the benefits of quitting, not only for themselves but also for their family and friends. Maori are the priority group for the campaign because of the disproportionately high number who smoke and their high rates of smoking-related disease.

The campaign uses Maori role models to give a positive message about the benefits of quitting. It includes national television commercials and magazine and radio advertising, supported by public relations activities.

Quit for our kids programme

Quit for our kids is a national programme for hospital patients, established in 2000. It aims to help parents and caregivers of children who are having hospital treatment to quit smoking. The programme operates in nine hospitals in New Zealand, with a focus on areas with a high need for smoking cessation services. The quit coaches working in each hospital provide advice, support and NRT to those parents and caregivers who want to quit. Quit coaches are also able to distribute nicotine patches and gum as part of the treatment plan. The programme will be promoted in five new hospitals in 2002. The Quit Group coordinates this programme, provides training and manages the programme evaluation.

Aukati Kai Paipa

Aukati Kai Paipa is currently delivered by over 30 Maori health providers. The programme offers Maori women and their whanau free cessation services. Those referred are assessed for their readiness to quit *(2)*. Participants initially undertake an intensive eight-week programme using NRT and motivational counselling delivered through a minimum of seven follow-up visits. After the initial eight-week period, participants receive further follow-up visits at intervals of three, six and 12 months.

The programme has a focus on holistic health. Te Hotu Manawa Maori coordinates, trains, assists and advises the network of Aukati Kai Paipa services.

Guidelines for smoking cessation

The Government-funded *Guidelines for smoking cessation* document was developed by a team of smoking cessation experts in 1999 and updated in 2002. The guidelines are designed for smoking cessation providers in assisting clients with smoking cessation. The document is based on comprehensive literature reviews and background information on smoking cessation.

Training in smoking cessation, following the steps set out in the guidelines, is available from several nongovernmental organizations (NGOs).

NRT reclassified as general sales medicine

Nicotine patches and gum were reclassified as general sales medicine (able to be sold 'over the counter') in August 2000. Previously only pharmacies or smoking cessation clinics run by a health professional could sell the products *(3)*.

Nicotine nasal sprays remain a prescription medicine, while nicotine inhalers are a pharmacist-only medicine *(4)*. Nasal sprays and nicotine inhalers were not made available over the counter as it was felt that these products had a greater potential for abuse than patches and gum. It was also felt that sprays and inhalers were better suited to those who were more severely addicted and would benefit from a greater input from a medical professional.

Quit & Win

A *Quit & Win* smoking cessation competition was piloted in 2001, and extended to five health regions in 2002. The Government-funded competition requires entrants to stop smoking for the month of May to be eligible for local, national and international prizes.

Quit and Win is coordinated by the Health Sponsorship Council, a Government agency. Nearly 1800 people entered the 2002 competition, representing 1.8% of the *Quit & Win* region's smoking population. This result was well in excess of the 1.25% international participation rate. The competition is currently being evaluated to determine quit rates.[5]

Smoking cessation services for pregnant women

Specific cessation services are available to pregnant women. These services are often associated with maternity hospitals, and can be accessed through maternity carers, for example GPs, midwives etc. Smoking cessation training for health professionals working with pregnant women is also available. New Zealand's smoking cessation guidelines *(6)* advise that NRT should be considered when a pregnant/lactating woman is unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of NRT and potential continued smoking.

Smoking cessation services offered by GPs and GP groups

An increasing number of GPs offer smoking cessation services to their patients, often in conjunction with subsidized nicotine patches and gum.

Other smoking cessation programmes

Smoking cessation services are also offered by a number of other individuals and groups. Cessation help can be provided in a number of ways – from group-support sessions, counselling and the provision of nicotine replacement therapy, to hypnotherapy and acupuncture. Many of these services are offered by the private sector, although some may be partially Government funded. In addition, some of these services deliver subsidized NRT through the Health Provider Exchange Card Programme administered by The Quit Group.

Bupropion (Zyban) and nortriptyline

Bupropion and nortriptyline are available on a doctor's prescription. Following the recording of over 200 adverse reactions to bupropion in New Zealand, the Medicines' Adverse Reactions Committee advised in September 2001 that it be prescribed only after a person has unsuccessfully tried other stop smoking treatments *(7)*. Bupropion is not publicly subsidized and a seven-week course will cost around NZ$ 300 *(8)*.

[5] Personal communication, Jeremy Lambert, Health Sponsorship Council, July 2002. Also in Health Sponsorship Council Chat Sheet, March 2002.

Nortriptyline is not registered in New Zealand for use as a smoking cessation aid, but can be prescribed for this purpose. It is fully subsidized and as such the New Zealand Smoking cessation guidelines recommend that it be considered after a person has unsuccessfully tried other treatments, in particular for people who cannot afford bupropion.

Other tobacco control initiatives undertaken during this period

The period 1998–2002 was a busy one for tobacco control in New Zealand. Smoking cessation initiatives included:

Steps of implementation

In 1997 New Zealand's inaugural National Smokefree Conference was held, bringing together for the first time a large number of tobacco control workers. The conference endorsed a strong call to Government for the provision of smoking cessation services. In the same year a national Auahi Kore (smoke-free) conference was held for Maori tobacco control workers. Maori advocacy group Apaarangi Tautoko Auahi Kore (ATAK) was established as a result of the conference. Maori had a coordinated voice, and were calling for funding to help their people stop smoking.

Ongoing	Promotion of smoke-free environments in a variety of settings by the Government agency, the Health Sponsorship Council.
Ongoing	Enforcement of the Smoke-free Environments Act 1990, and promotion of smoke-free messages by Government-funded public health services.
May 1998	Tobacco excise increase of 50 cents plus tax on a pack of 20 cigarettes, and equivalent for other tobacco products.
June 1998	Cessation of the requirement for replacement sponsorship by the government of previously tobacco-industry sponsored events.
June 1998	National conference: *Smokefree Towards 2000*.
December 1998	Tobacco advertising at point of sale ceases.
July 1999	Smoke-free Environments (Enhanced Protection) Amendment Bill introduced to Parliament. Proposals include a ban on smoking in educational institutions except tertiary, further restrictions on the display of tobacco products, further restrictions on smoking in workplaces, and strengthening of penalties for retailers convicted of selling tobacco to minors.
September 1999	Auahi Kore conference.
January 2000	Stronger health warnings and constituent information on tobacco packets.
April 2000	National Smokefree Conference.
May 2000	Tobacco tax increases of NZ$ 1 on pack of 20 cigarettes, and equivalent for other tobacco products.
May 2001	World Smokefree Day focus is *Let's Clear the Air*. Television commercials promoting smoke-free homes and bars are aired.
June 2001	Supplementary Order Paper to the Smoke-free Environments (Enhanced Protection) Amendment Bill introduced to Parliament. Proposals include further restrictions on smoking in restaurants, clubs and casinos, and restrictions on smoking in bars, a ban on the supply of tobacco products to minors, and a ban on self-service vending machines. Health groups push for total ban on smoking in restaurants, bars, clubs and casinos.
October 2001	Auahi Kore conference.
June 2001	Consultation on the draft Tobacco Control Research Strategy initiated.
May 2002	New Zealand's World Smokefree Day focus is again *Let's Clear the Air*.
June 2002	Invercargill woman Janice Pou initiates legal action against British American Tobacco and W D & H O Wills claiming that they continued to manufacture, supply and advertise cigarettes that were addictive and gave her cancer.
August 2002	*Let's Clear the Air* television campaign re-launched by The Quit Group.
September 2002	National Smoke-free Conference.

In 1999, the Minister of Health announced the first major funding of a national smoking cessation initiative – the freephone Quitline. Funding of the Quitline was prompted by the success of the Quitline pilot scheme which had been funded by two NGOs and one Government-funded agency. Aukati Kai Paipa, offering quit services to Maori women, was launched in the same year.

Late 1999 saw the election of a Labour-led coalition government. The previous Labour Government had enacted New Zealand's then world-leading Smoke-free Environments Act in 1990 and was traditionally supportive of tobacco control initiatives. The outgoing National Government, having in the past contributed minimal funding to smoking cessation, was starting to redirect funding in this direction. The new Labour Government built on this base.

Aware of the new Government's support for tobacco control, advocates continued their calls for smoking cessation services, drawing politicians' attention to high Maori smoking rates (50%), and high rates of youth uptake (in 1999, 19% of male students aged 14 to 15 years and 25% of female students were at least weekly smokers) *(9)*. They were backed in their calls by tobacco control analysts based in the Ministry of Health, who provided advice to Government that stressed the need for smoking cessation initiatives.

In 2000 there was a significant rise in tobacco tax of NZ$ 1 per pack of 20 cigarettes. Evidence shows that higher tobacco prices reduce consumption, even in the absence of cessation support. However, there were outcries from smokers who cited the limited support available for people forced to quit by the increase. Tobacco control advocates also challenged the Government to use the increased tax take to benefit tobacco control. There were strong calls for the Government to subsidize NRT, which was something governments had avoided in the past, usually arguing that if smokers could afford to buy cigarettes, they could afford to buy NRT. However, in June 2000, supported by lobbying by the tobacco control community, the Government announced the allocation of NZ$ 6.18 million for the subsidized supply of NRT through the national Quitline. Later that year the programme was extended to include other health providers.

ATAK and other Maori tobacco control groups continued to advocate strongly for more cessation support for Maori. The Quitline, while having a heavy focus on Maori, was still seen primarily as a mainstream initiative. Advocates argued that it did not properly address Maori smoking rates, which were twice those of non-Maori rates. In its May budget the Government announced NZ$ 5 million per year of additional funding for Maori smoking cessation initiatives.

Continued strong advocacy has seen ongoing Government funding of cessation services as well as the introduction of some new initiatives. These include the *It's about whanau* campaign and *Quit and Win*.

Major players

New Zealand has a strong and committed tobacco control community, which includes both government organizations and NGOs. Agencies with a key role in securing increased funding for cessation services included Te Hotu Manawa Maori, the Cancer Society, the Health Sponsorship Council, The Quit Group, the National Heart Foundation, the Asthma and Respiratory Foundation, Action on Smoking and Health (ASH), workers in public health services, and the Ministry of Health. Tobacco control organisations have gathered their efforts into two advocacy groups, Apaarangi Tautoko Auahi Kore, which represents Maori groups, and the Smokefree Coalition which is made up of mainstream (general population) groups. ASH also plays a leading role in advocacy.

The Government's role in providing either full or partial funding for several advocacy groups was also vital. The funding enabled such groups to have a high political and media profile, and to coordinate and mobilize the tobacco control community to advocate widely and vocally for cessation funding.

There were few barriers to the initiatives. Government organizations and NGOs agreed that New Zealand's smoking cessation programme needed to be strengthened. Traditional opponents of tobacco control initiatives – such as the tobacco industry, the hospitality industry, and some Members of Parliament – tended to direct their energy towards responding to calls by health groups for a ban on smoking in bars and restaurants. The new smoking cessation initiatives were largely unchallenged.

Success of the interventions

In the three years since the introduction of a variety of national smoking cessation initiatives, New Zealand's smoking prevalence has changed little, while consumption has dropped significantly. Prevalence of cigarette smoking

for those aged 15 years and over was 26% in 1998 and 25% in 2001 *(10)*.

Maori smoking prevalence has remained static over this time, hovering at 49–51%. This is unacceptably high when compared with a non-Maori smoking rate of 21%. The lack of change may be because Maori-focused tobacco control programmes have only been delivered over the past few years, while mainstream programmes (although not necessarily quit programmes) have been available for decades. Maori smoking rates over the next five years will be a telling indication of whether the new, targeted cessation initiatives are having an effect.

Tobacco consumption decreased from 1377 cigarettes per adult in 1998 to 1139 cigarettes per adult in 2001. Over the past 10 years, the average number of cigarettes consumed per adult has decreased by more than one-third *(11)*. The accelerated rate of decline in consumption in 2000–2001 is likely to be mainly attributable to the tobacco excise increase of NZ$ 1 in May 2000.

A comparison with other OECD countries suggests that the New Zealand adult smoking rate is in the medium to low category *(12)*, while New Zealand has one of the lowest tobacco product consumption rates of any OECD country *(13)*.

Many of New Zealand's cessation initiatives began relatively recently and are still being evaluated. Some interim results are available from the subsidized NRT and Aukati Kai Paipa programmes.

Subsidized NRT	Quit rate after three months: around 44%[6]
Aukati Kai Paipa	Quit rate appears to be significantly higher at 12 months (23%)[7] than the rate for those not on the programme (12.5%)

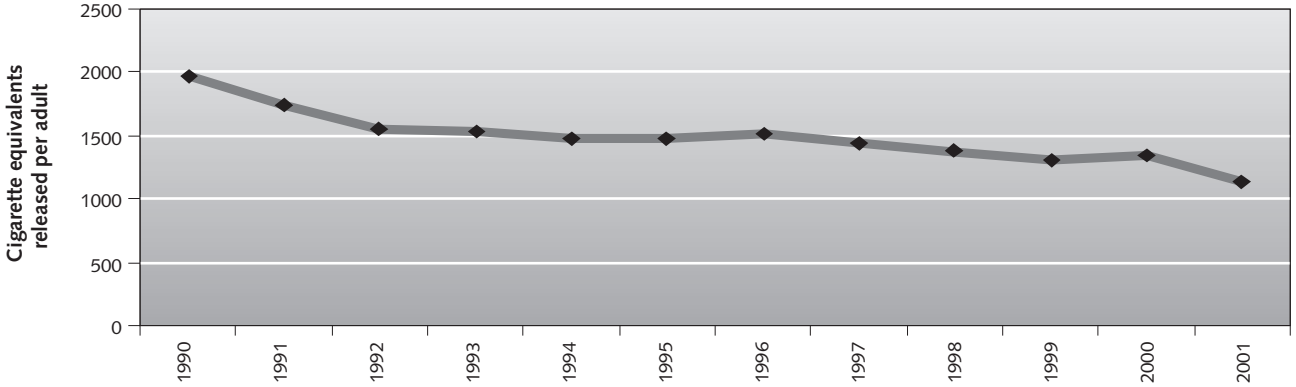
Biological correlates of self-reported quit rates have not been undertaken in the subsidized NRT and Aukati Kai Paipa programmes. A literature review into the value of validation of self-reported smoking status was carried out recently by The Quit Group. Many of the papers reviewed found that self-response of smoking status is a good indicator of actual smoking status. Where underreporting does occur, there is no statistically significant difference between self-reported and validated smoking status, meaning that the overall conclusions of the studies are not affected *(14)*.

[6] This is a conservative measure. A simpler measure of 'Quit = not smoked for two days but may have had occasional puffs', would give a point prevalence quit rate of 58% after three months.

[7] This is also a conservative measure. The simpler measure of 'Quit = not smoked for two days but may have had occasional puffs', would give a point prevalence quit rate of 30% after 12 months.

Figure 2

Tobacco Products Released for Consumption



Youth smoking rates

Smoking among New Zealand fourth-form students (14 and 15 year-olds) rose steeply from 1992, but began to level off in the late 1990s. In 2001, smoking rates for both males and females had returned to levels comparable with 1992. In 2001, 16.3% of males and 22% of females 14 to 15 years of age smoked at least weekly *(15)*.

Other impacts of the intervention

Budget pressure

The NZ$ 6.18 million allocated to subsidized nicotine patches and gum initially appeared to be in danger of being exceeded, because of huge demand. However, this did not turn out to be the case, and the budget appears to match demand well.

Rise in cessation advertising

Advertising of cessation services and products has increased over the past three years. Some providers of smoking cessation services promoted subsidized NRT, while others used the increased profile of NRT to promote non-subsidized and in some cases non-nicotine-based products. The various cessation initiatives resulted in tobacco dependence treatment becoming a much more prominent health issue than previously.

Impact on pharmacies

The subsidized NRT initiative has had a significant effect on pharmacies, as they are the point of redemption for exchange cards. Despite initial plans to consider other outlets, such as supermarkets and service stations, as possible redemption points, pharmacies remain the only type of outlet involved.

Initially pharmacies also had the ability to be exchange card providers themselves. They could distribute as well as redeem the cards, provided they met certain criteria. Around 80 pharmacies joined the scheme as exchange card providers.

However, in September 2001, the Ministry of Health withdrew this right from pharmacies, citing possible conflict of interest issues. The Ministry stated that pharmacies, as suppliers of NRT products, potentially stood "to make a small financial gain when they exchange cards for the product" *(16)*. Many pharmacists were critical of the ministry's decision, believing that the system was working well. Pharmacies are now involved in the programme as dispensers of NRT only.

Impact on pharmaceutical companies

It was no surprise that the subsidized NRT programme significantly altered market forces with respect to the sale of stop smoking products. Sales of the subsidized products rose, while sales of non-subsidized products fell. An exception occurred soon after the introduction of the subsidized Government programme, when the Quitline was having difficulty coping with demand. Sales of some non-subsidized stop smoking products were relatively high, as people motivated to quit by the publicity around the subsidized programme purchased full-price products. A general increase in awareness of smoking cessation issues also contributed.

Volumes of all NRT products dispensed – subsidized and unsubsidized – peaked in May 2001, and have since declined. Unsubsidized stop smoking products are still selling, but at lower levels. Interestingly, most impact has been on sales of nicotine patches – nicotine gum sales have not been affected to the same extent.[8]

Conclusion

Several key factors contributed to New Zealand's transformation from a country that offered little in the way of smoking cessation help to one that has a comprehensive mix of initiatives. Central to the change was strong and persistent advocacy from the tobacco control community. Other key factors were proactive policy analysts and a supportive government. Tax increases also played a part in motivating smokers to call for cessation help. Their message to the Government was that it was unfair to increase the price of tobacco products without providing cessation help. This message was picked up and amplified by health groups.

New Zealand can be proud of its activities. First, the wide reach and variety offered by its cessation initiatives. The national Quitline, for example, has offered quit advice and support to nearly 140 000 New Zealanders over the past four years, making it one of the busiest Quitlines in the world. Nearly 190 000 exchange cards have been distributed. While the results of a comprehensive evaluation of the

[8] Personal communications with New Zealand pharmaceutical companies, August 2002.

Quitline and subsidized NRT are not yet available, early figures are promising. For those who prefer an individual or small-group approach, subsidized nicotine patches and gum, along with quit support and advice, can be obtained from health providers spread throughout the country.

Second, New Zealand's cessation initiatives are targeted at groups with higher smoking rates, particularly Maori. The Aukati Kai Paipa, and *It's about whanau* initiatives, for example, have been developed by Maori for Maori. Even the mainstream initiatives, such as the Quitline, have Maori as a primary audience.

These cessation initiatives have been complemented by New Zealand's other tobacco control programmes. Tobacco tax increases, smoke-free environments, and health promotion initiatives have all created a demand for stop smoking services.

One lesson learnt was the unanticipated demand for subsidized NRT. The Quitline was overwhelmed, and delivery of exchange cards was slow for several months. More time to establish this initiative would have enabled demand to be better gauged and catered for. The demand, however, proves that many smokers are motivated to quit, and the availability of reduced-cost NRT can act as a catalyst.

There is no apparent reason why New Zealand's programme could not be adapted to other countries if sufficient funding was available. Strong advocacy is needed to put pressure on governments to provide this funding. Once the funding is available, care should be taken to target initiatives at those with the highest smoking rates. Services and resources should be developed with the input of those in the target audience, to ensure that they are appropriate for that group. Initiatives should also be carefully evaluated to ensure that they are reaching objectives and represent value for money. Positive results from carefully researched, developed, tested and evaluated cessation initiatives in one country enable tobacco control advocates internationally to argue for similar programmes.

References

1. *Guidelines for smoking cessation*. Wellington, National Health Committee, 2002.
2. Ibid.
3. Quit smoking products on shop shelves soon. Ministry of Health media release of 25 August 2000, available at web site *http://www.ndp.govt.nz/media/moh25aug2000.html*.
4. *Guidelines for smoking cessation*. Wellington, National Health Committee, 2002.
5. Ibid.
6. Ibid.
7. Changes to the way Zyban is prescribed. Ministry of Health media release of 26 September 2001, available at web site *http://www.ndp.govt.nz/media/moh26sept2001.html*.
8. Figures from GlaxoSmithKline web site, available at *http://gsk.co.nz/Zyban/thefacts/cost-html.asp?productID=6*
9. Tobacco facts. Public health intelligence occasional report no 2. Wellington, Ministry of Health, 2002 (available at web site *http://www.moh.govt.nz/moh.nsf/wpg_Index/Publications-Index)*.
10. Ibid.
11. Ibid.
12. Ibid.
13. *Tobacco Statistics 2000*. Wellington, Cancer Society of New Zealand, 2000.
14. Woodward Z. Validation of self-reported smoking status. Literature review for the Quitline, December 2002.
15. *Tobacco facts. Public health intelligence occasional report no. 2*. Wellington, Ministry of Health, 2002.
16. NRT programme: pharmacists no longer required. *Pharmacy Today,* September 2001.

Acknowledgements

The author would like to thank the following people for providing information for, and comments on, this paper:

Iain Potter – Health Sponsorship Council

Shane Bradbrook – ATAK

Teresa Taylor and Sue Taylor – Te Hotu Manawa Maori

Helen Glasgow, Jane Mills, Belinda McLean, Michele Grigg and Ben Weston – The Quit Group

Chas McCarthy, Chris Laurenson, John Stribling, Kate Rockpool, Candace Bagnall – Ministry of Health

Anne Dowden – Business Research Centre