

Correction

Re: “A financial case to enable state health jurisdictions to invest in tobacco control”, by Seham T Girgis and Jeanette E Ward in the 17 November 2003 issue of the Journal (*Med J Aust* 2003; 179: 539-542).

Statistical errors occurred in this article as follows.

In Box 1 (*page 540*):

- The aetiological fraction for “cardiac dysrhythmias” for men aged less than 65 years was incorrectly cited as 0.538. It should read 0.358. The correct value was used in calculations.
- ICD-9 codes for “premature rupture of membranes” were used in calculations as given by Ridolfo and Stevenson (Ref 23, page 83). These were incorrectly cited as “658.1–658.2, 761.1”, but should read “658.1, 658.2, 761.1”. The correct ICD codes were used in calculations.
- The aetiological fraction for “ischaemic heart disease, cardiac dysrhythmias and heart failure” conditions for women aged 65 years and over was incorrectly cited and incorrectly used in calculations as 0.027. It should read 0.059.

In Box 2 (*page 541*):

- The aetiological fraction for “oesophageal cancer” for women was incorrectly used in calculations as 1.324. Using the correct aetiological fraction (0.324), as correctly cited in Box 1 (*page 540*), reduces the number of hospitalisations for cancer by 3% and 2% in NSW and SWS women, respectively.
- “Heart failure” conditions for NSW were incorrectly calculated. Using the correct value, the number of hospitalisations in the “other” category for NSW men is reduced by 356 hospitalisations.

These errors do not introduce substantive changes in our findings. However, the following changes should be made to the text:

In the Abstract (*page 539*), replace the third and fourth bullet points with:

- Tobacco was responsible for 43 350 hospitalisations in New South Wales in 1999–2000 alone, incurring \$176 096 323 in hospital costs (\$482 456 per day).

- If the equivalent of a specified percentage of expenditure as calculated for one year were “invested” in tobacco control in the next year, then commitments to a substantive suite of health promotion programs could be made. For example, using our formula, a contribution of 3% would secure an annual tobacco control budget of \$5 282 890 in NSW.

In the case studies (*pages 540–541*), replace the state example with the following text:

State example

As calculated for the 1999–2000 financial year, tobacco directly contributed to an estimated 43 350 hospitalisations in NSW (Box 2) constituting 3.1% and 1.5% of all hospitalisations for men and women, respectively. Tobacco-attributed hospitalisations accounted for 295 960 hospital bed-days, representing 3.5% of all bed-days in NSW (total, 8 337 286 bed-days). As the average bed-day cost in NSW hospitals for that period was reported as \$595 per day,²⁵ tobacco-attributed hospitalisation cost \$176 096 323 in that 1 year alone (\$482 456 every day).

In NSW, major contributors to tobacco-related hospitalisations for men included ischaemic heart disease (28%) and cancer (20%). For women, the major contributor to tobacco-related hospitalisations was chronic obstructive pulmonary disease (29%). Lung cancer contributed to 4027 (2961 men; 1067 women) hospital separations attributed to tobacco use. This represented 54% and 57% of the cancer-related hospitalisations attributed to tobacco use in men and women, respectively.

A proportional levy of 3%, as would be typically imposed upon public-sector organisations as an annual productivity saving, would secure an annual budget of \$5 282 890 for NSW. Five per cent would secure an annual budget of \$8 804 816.