Public Policy to Maximize Tobacco Cessation

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Abstract: Tobacco use kills more than 400,000 Americans every year. For smokers, quitting is the biggest step they can take to improve their health, but it is a difficult step. Fortunately, policy-based interventions can both encourage smokers to quit and help them succeed. Evidence shows that tobacco tax increases encourage smokers to quit—recent state and federal increases have created dramatic surges in calls to quitlines. Similarly, smokefree workplace laws not only protect workers and patrons from secondhand smoke but also encourage smokers to quit, help them succeed, and create a social environment less conducive to smoking. The impact of policy changes can be amplified by promoting quitting around the date they are implemented. Outreach to health practitioners can alert them to encourage their patients to quit. Earned and paid media can also be used to motivate smokers to quit when policy changes are put into effect. Although these policies and efforts regarding them can generate great demand for evidence-based cessation services such as counseling and medication, it is important to make these resources available for those wanting to quit. Public and private health insurance plans should provide coverage for cessation services, and states should invest tobacco tax and/or tobacco settlement dollars in smoking-cessation programs as recommended by the CDC. Finally, the Family Smoking Prevention and Tobacco Control Act has given the U.S. Food and Drug Administration new authority to regulate tobacco products and marketing, and to prevent tobacco companies from deceptively marketing new products that discourage smokers from quitting and keep them addicted.

(Am J Prev Med 2010;38(3S):S327–S332)

Introduction

Although preventing kids from starting to smoke produces enormous health benefits and cost savings in the future, the most immediate health and healthcare cost gains accrue from getting current smokers to quit. The immediate and long-term benefits of quitting smoking are well-documented. For example, a smoker's excess risk of cardiovascular disease may be cut in half within 1 year of quitting.[1,2] It is also known that fewer adult smokers means fewer youth smokers, as children of nonsmokers are less likely to become smokers themselves.[3–6]

To maximize quit attempts and success by smokers, interventions are necessary that encourage them to quit and help them succeed and that limit efforts by tobacco companies to encourage them to smoke and/or discourage quitting. Fortunately, a set of policy-based solutions is available to help achieve these objectives. Unfortunately, many of solution approaches have not been put in place by policymakers to the extent necessary.

Harnessing Public Policies That Encourage Smokers to Quit and Help Them Succeed

Although a number of individual-level interventions (e.g., counseling, medications) have been proven to help smokers quit, resources have to be available to provide them, and smokers have to demand them. Policy solutions such as tobacco taxes and smokefree laws not only boost the number of smokers who quit, but also have the added advantages of affecting virtually all smokers and costing little, if anything. In the case of tobacco taxes, they actually produce large amounts of new revenue despite consumption declines.

The Consumer Demand Roundtable, a group of experts (research, marketing, tobacco control) working to increase demand for cessation services, has taken steps to more effectively harness the cessation effects of tobacco tax increases and comprehensive smokefree air laws. New York City's success at raising demand for cessation services after passing several tobacco control policies serves as a model for states and other cities. The combination of

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0749-3797/00/$17.00

doi: 10.1016/j.amepre.2009.11.017

a large tobacco tax increase, a comprehensive smokefree law, and programs to encourage smokers to quit and help them do so through the citywide information line (311), including the provision of nicotine replacement therapy (NRT), led to a 14.4% decline in adult smoking in 2 years, after years of stagnant smoking rates.[7]

Tobacco tax increases are major opportunities to reach smokers and encourage them to quit, especially low-income smokers who are more price-sensitive and thus most affected by tax increases. Because more lower-income smokers than higher-income smokers will quit or cut back because of cigarette tax increases, cigarette tax rate increases will also end up increasing the portion of the total cigarette tax revenues that is paid for by higher-income smokers and reducing the portion paid by lower-income smokers.[8,9] A 10% increase in price is expected to bring about a 2% decrease in adult smoking prevalence and about a 4% decrease in consumption (total pack sales).[10,11] However, this effect could be even greater with better promotion and use of free and effective services, such as telephone quitlines ("Michigan's quit smoking hotline flooded with calls—why the sudden urge to quit?" 9&10 News 2009, Mar 13. www.9and10news.com/category/story/?id=150612; "Stop smoking programs boom after Idaho tax increase," KTVB 2009, Apr 20).[12–14]

The recent $0.61 increase in the federal tobacco tax resulted in a dramatic surge around the country in calls to state quitlines, owing to the price increase itself but also to outreach efforts taken by the states relating to the price increase. In anticipation of the federal tax increase, the Campaign for Tobacco-Free Kids and the Office on Smoking and Health at the CDC convened a webinar with representatives from state tobacco prevention and cessation programs, quitlines, and the American Legacy Foundation's EX campaign to provide ideas and resources to the states for promoting quitting around the tax increase. These materials included earned media ideas, letters to health providers to encourage them to counsel patients to quit at the time of the price increase, and tips on how to deal with surges in calls to quitlines. These materials were provided to all the states and are available from the Campaign for Tobacco-Free Kids. The media relating to the tax increase and the fact that the tobacco companies actually increased prices 1 month or so prior to the effective date of the tax resulted in a doubling in the volume of calls to the national quitline number (1-800-QUIT-NOW) from February to March compared to those same months the year before. As other states consider tobacco tax increases, these same tools can be used to maximize the impact of state tax increases.

Similarly, when workplaces go smokefree, not only are nonsmokers protected from secondhand smoke, but workers in those newly smokefree environments are encouraged to quit by making smoking more difficult, and they are more likely to succeed because of reduced chances to relapse and greater social support for nonsmoking. The Surgeon General's 2006 report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke,* concluded that "workplace smoking restrictions lead to less smoking among covered workers." The report cited numerous studies that found "an association between workplace smoking policies, particularly more restrictive policies, and decreases in the number of cigarettes smoked per day, increases in attempts to stop smoking, and increases in smoking-cessation rates."[15] Again, this is an effect that could be more fully and systematically harnessed.

Just as with tobacco taxes, the impact of smokefree laws on quitting can be enhanced by ensuring that the quitting message is incorporated into policy implementation efforts. Opportunities include earned and paid media relating to the implementation, as well as sending the materials to hospitality venues to educate them about implementation of the law. Ideas for incorporating smoking cessation into smokefree implementation efforts are included in the toolkit for implementing smokefree laws at www.GoingSmokeFree.org. More than half of the states have now passed strong smokefree laws, including South Dakota, North Carolina, and Wisconsin this year. The momentum is sure to continue as several, including Texas and Michigan, address the issue in the coming session.

Policy changes and accompanying efforts to promote cessation will continue to encourage more smokers to try to quit, generating increased demand for evidence-based smoking-cessation services. Unfortunately, too many public and private health insurance plans do not provide comprehensive coverage for these life- and money-saving interventions, and few states fund efforts to encourage and help smokers to quit at anywhere near the level recommended by the CDC.[16] Policies (appropriations) that provide resources for comprehensive tobacco-prevention and -cessation programs and for public health plan coverage of evidence-based smoking-cessation interventions are therefore critical to helping meet the demand stimulated by tobacco taxes and smokefree laws.

The CDC's *Best Practices for Comprehensive Tobacco Control Programs* details three primary components of these programs—state and community-based interventions; health communications interventions; and cessation interventions.[17] The first two parts reach smokers where they live, work, play, and worship, as well as through the media, to change knowledge and attitudes about smoking, alter social norms, motivate smokers to quit, and educate them about the best ways to do so and the available help. The cessation component provides direct assistance to smokers through telephone quitlines, medications, and other interventions to help them succeed

in their quit attempts. Studies have shown that these individual elements, especially when combined with one another, work to reduce smoking among both youth and adults.[18–24]

Even with the evidence base for these programs, and the billions of dollars the states and federal government collect from their tobacco settlement payments and tobacco taxes, policymakers have simply been unwilling to use the resources to fund tobacco prevention and cessation efforts. Despite ongoing efforts of advocates around the country since the tobacco settlement, it remains difficult to get even a minimal proportion of these funds allocated for tobacco prevention and cessation. The Campaign for Tobacco-Free Kids' 2009 report on state spending revealed that although states collect more than $25 billion each year in settlement revenue and tobacco taxes, together they spend only about $567 million on tobacco prevention and cessation.[16] It would take less than 15% of state tobacco revenues for every state to fund these programs at the level recommended by the CDC. Although this may be a large figure, it is dwarfed by the substantial amount that tobacco companies spend to market and promote their products, as well as the annual healthcare costs accrued by tobacco use.[25–27] Research has demonstrated a clear relationship between tobacco prevention and cessation program spending and declines in both youth and adult smoking.[22–24] Still, policymakers have not exercised the political will to provide the necessary funding for these life- and cost-saving programs.

Approximately 15% of current adult smokers are covered by Medicaid or Medicare, whereas more than 55% are covered by private health insurance,[28] but only six state Medicaid programs currently cover all of the evidence-based smoking-cessation interventions—counseling as well as FDA-approved cessation medications—for all smokers, while Medicaid programs in 39 states and Washington DC cover some form of tobacco-cessation treatment, and five state Medicaid programs do not provide any coverage for cessation treatment.[29] However, even if cessation treatment is available through the state Medicaid program, there are often still many barriers that make it difficult for smokers to receive the help they need and want, such as copayments, limits on medication and/or counseling duration, and prior authorization for medications.[29,30] In addition, these benefits are seldom promoted either to smokers or their providers.[31]

Similarly, not all health plans cover all effective treatments,[32] and when they do, they may not promote them, resulting in lack of awareness of the benefits among enrollees. Many private insurance plans also do not cover the full range of services despite the fact that smoking cessation is one of the most cost-effective health interventions available.[33–35] Employees who smoke cost businesses, not only in higher healthcare premiums, but also in productivity losses from more absences, lower productivity levels, lower concentration levels, and smoking breaks.[36–43]

State legislatures can require private insurance companies to meet certain standards that would cover cessation treatments, as in Rhode Island, which passed a law in 2006 requiring all insurance plans in the state to cover nicotine replacement therapy and cessation counseling for all beneficiaries.[29,44] Although it is ultimately in their self-interest to cover cessation treatment for employees, many employers argue that employees may leave the company before the employer recoups any cost savings from offering treatment. However, mandating that all employers must cover cessation treatment will eliminate that argument. Several of the Health Reform bills currently being debated in Congress include such a mandate.

Strengthening Policies to Reduce the Impact of Tobacco Company Marketing

According to the latest figures from the Federal Trade Commission (FTC), the major American tobacco companies spend more than $12 billion each year to market their products.[25,26] Their efforts to entice children to smoke have been well documented, even in their own documents. However, their marketing and their product design strategies also work to encourage smokers to smoke more, discourage them from quitting, and undermine quit attempts.[45]

The new authority by the U.S. Food and Drug Administration (FDA) to regulate tobacco products and marketing under the Family Smoking Prevention and Tobacco Control Act (FSPTCA), which was enacted on June 22, 2009, will change the way tobacco companies do business. The FDA now has the authority to regulate the sale, marketing, and manufacture of all tobacco products, including the authority to, among other things:

- Restrict tobacco company marketing that targets children or misleads consumers;
- Enforce limits on sales to minors;
- Require larger warning labels on tobacco products and possibly include a quitline number;
- Review any new products or changes to existing products for their impact on public health;
- Review any claims regarding reduced risk to ensure that they are not only technically accurate, but also actually improve public health, taking into account the impact not only on the individual smoker, but also on encouraging initiation and discouraging cessation; and
- Require changes in new and existing products to make them less harmful if the agency believes this will improve public health.

Historically, the companies have made changes to the product that make it more addictive and more harmful, with no regard to public health. These changes include manipulating nicotine levels and smoke particle size, as well as adding flavors and other additives that make it easier for kids to smoke or for smokers to inhale more deeply.[45–50] The FDA has recently banned the sale of flavored cigarettes that attract youth and has indicated it will explore the possibility of banning other flavored tobacco products as well.

Tobacco companies have also introduced new products designed to get health-concerned smokers to switch to brands that are marketed as less harmful, when in fact they are not.[51] The marketing of light and low-tar cigarettes convinced untold numbers of smokers to use these products rather than quit, which has taken an incalculable toll on public health. Even today, many smokers still consider these cigarettes to be less harmful.[52] One provision of the FSPTCA bans the use of the terms "light" and "low-tar." To prevent additional misperceptions and a repeat of the light and low-tar public health debacle, the FDA will require tobacco companies to scientifically prove any reduction in risk before making any such claims in marketing and promotional materials.

The companies have also introduced new smokeless products that help smokers maintain their addiction during those times they cannot smoke. Products are marketed with messages such as "Anytime, Anywhere" and "No Smoking? No problem." With the major cigarette companies now making and marketing smokeless tobacco, they are likely to use these new smokeless products to discourage quitting smoking.

Other companies have introduced nontobacco nicotine delivery products, such as the e-cigarette, which is not proven to be safe or effective. Before such products are endorsed as smoking-cessation devices, as many of the companies implicitly do, these products should undergo rigorous product testing, like that required for every other drug delivery device. Such testing will ensure that, even if the products are not harmful, they are, in fact, effective and do not steer smokers who want to quit away from interventions that are evidenced-based and FDA-approved, thus resulting in fewer successful quit attempts.

All of these actions undermine cessation. However, now that the FDA has oversight of product changes, new products, and their marketing, including health claims, the companies' ability to dissuade smokers from quitting can be made more difficult.

The FDA could also examine evidence regarding the impact of making FDA-approved smoking-cessation products more affordable and accessible to smokers, such as by allowing sale in daily doses, even though this is not currently a responsibility of the FDA. The FDA can also exercise its existing authority over non–tobacco containing nicotine products to take action on non–FDA approved cessation devices.

Summary

In short, the ideal policy environment for cessation will decrease the positive cues for tobacco use, increase the negative cues, and increase the incentives, cues, and supports for quitting and never starting. It will also better align efforts to promote and increase the use of effective and cost-effective cessation services with broader public health tobacco control policies, bridging the gap between public policy and cessation efforts.

The Campaign for Tobacco-Free Kids receives a small portion of its budget from providers of cessation products and services for general use.

No other financial disclosures were reported by the authors of this paper.

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