# Smoking-Cessation Treatment Utilization

## The Need for a Consumer Perspective

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**Abstract:** In the U.S., almost half of all smokers try to quit each year. Yet two thirds of those who try to quit do so without the benefit of effective treatments that are now available. To optimize the contribution to public health of treatment, a consumer-centered approach is needed. This involves understanding and addressing smokers' needs and concerns regarding treatment, and communicating effectively with smokers about the nature and value of available treatments. Consumer-oriented treatment offerings would also recognize the diversity of smokers and match it with diverse approaches to quitting. Increasing use of treatment is important to increasing quit rates.
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## Introduction

Smoking has been killing hundreds of thousands of Americans a year for many decades. In the middle of the 20th century, when the deadly consequences of smoking became clear, the challenge was to convince smokers that their behavior would kill them. In the U.S., that battle is largely won: More than 80% of smokers acknowledge that smoking is very harmful.[1] Moreover, 70% of smokers say they want to quit,[2] and almost half try to quit each year.[3] Yet, only 3% to 5% of those attempts succeed.[2,4] Having won the battle to convince smokers that smoking is harmful, and having gotten many motivated to make the effort to quit, we are stalled in the perhaps bigger struggle to **help** them quit.

This is not for lack of scientific focus and activity: A literature search turns up over 10,000 scientific papers on smoking-cessation treatment. This work has been productive: In the last 25 years, more than half a dozen medications have been proven safe and effective and accordingly approved for use in smoking cessation. Numerous trials have demonstrated the effectiveness of varied behavioral methods to help people quit smoking. While there is ample room for improvement in outcome, we now have multiple proven efficacious treatments that help people quit.[5,6]

But the availability of effective treatments has revealed the next frontier: the gap in treatment utilization. No treatment, no matter how effective, can help a smoker who does not use it. This makes increased treatment utilization an essential goal. Two thirds of quit attempts still proceed without treatment[3]; fewer than one third of quitters use medication, less than 10% use a behavioral treatment, and less than 6% combine pharmacologic and behavioral treatments,[7] even though this dual approach is universally recommended by experts.[5] Having efficacious treatments is essential, but if we could double the utilization of current treatments we would double the population quitting just as surely as doubling the efficacy of treatment—and this might be accomplished more easily.

As we have worked to develop cessation treatments, we have implicitly assumed that *If we build it, they will come*—that the need for effective treatment is so evident, and the pent-up demand surely so high, that we need only to create an effective treatment, and smokers will beat a path to our door. Now we have built it, but not many have come. Put another way, we have created a supply of treatments, but failed to generate matching demand from consumers.

The use of marketing language is deliberate. Generating consumer interest in and demand for cessation treatment is essentially a marketing task—identifying customer needs and wants and creating, positioning, promoting, and delivering products or services to match those needs. From this perspective, the technical characteristics of the products themselves (the efficacy of the treatments) are only one part of the equation. Communicating about the treatment, positioning it appealingly, promoting it, and so on, are critical to successfully developing interest and driving demand.

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As emphasized by the Consumer Demand Roundtable,[8] one key aspect of a marketing approach is the emphasis on understanding smokers and looking at treatment from their perspective. This is the only viable way to understand why they do or do not avail themselves of the offering. Thinking this way, one encounters some fundamental barriers to adoption of treatment. For starters, smoking cessation itself has been framed as something that smokers ought to be able to accomplish on their own, and terms like "quitting" may suggest a simple voluntary act. Indeed, even though smokers have accepted that smoking is an addiction, there is still an expectation that "willpower" should be enough to enable quitting. Widely cited statistics noting that the majority of smokers quit on their own (without noting that these self-quitters also represent a disproportionate share of the failures) reinforce this attitude. When we promote the idea that quitting without help is the norm, we help make treatment seem not only superfluous, but shameful—an admission of one's lack of character. Imagine if we applied the same attitude to infections and antibiotics.

We also need to ask how the "customers" perceive our offerings. Although nicotine replacement therapy (NRT) has been proven quite safe,[6] only a minority of smokers (and far too few doctors[9]) believe that NRT is safer than smoking.[10] This misperception is surely fed by the fact that cigarette packs carry 10–20 words of health warnings, while NRT packages carry 200–300 words of health warnings! It likely doesn't help that "nicotine" is often used, misleadingly, as a code word for the entire tobacco problem—for example, a report that attributed all tobacco-related deaths to "nicotine poisoning."[11] From this perspective, it's no wonder that NRT is under-utilized. How smokers see therapeutic nicotine has to be reframed for it to be widely accepted and adopted.

Nor do smokers always understand what the offering is or how it might help them. How could a medication help them stop doing a behavior they like? How could such a drug work? (Many smokers believe that therapeutic nicotine works like Antabuse[12]—triggering an aversive physical reaction if one smokes and uses the medicine at the same time[13]). And what goes on in counseling, anyway—a lecture about how bad smoking is? A discussion of childhood traumas? In any case, what could a counselor I don't even know tell me that I don't already know? It's hard to sell treatment without having explained what it is and how it will address smokers' needs.

A core marketing principle is that people are diverse—they differ in what they need and want, and thus need to be addressed by different products and appeals. Yet, such market segmentation is almost absent from smoking-cessation offerings. To take just one example, research suggests that about half of all smokers prefer to approach quitting by gradually reducing how much they smoke, rather than quitting abruptly.[14,15] Yet, most programs focus exclusively on abrupt quitting. Medications all offer essentially the same proposition—taking medication to help get through the first few months of quitting, and then being left on your own to maintain abstinence. Perhaps the most important underserved market segment consists of smokers who are not yet committed to quitting right now; could an outreach offering or a trial pack help get them to the point of commitment?

In some domains (computers come to mind), product capabilities and technical specifications dominate the conversation with consumers. But in many domains, other, softer factors weigh in—some products are positioned as masculine or feminine, modern or old fashioned, and some are just plain "cool" (think iPod and iPhone). In the smoking-cessation domain, all the offerings occupy a single position: rational, clinical, medicinal. It's intriguing to think what a cessation product/program designed by Apple would look like.

In summary, the consumer-focused approach to smoking-cessation treatment promulgated/promoted by the National Tobacco Cessation Collaborative and its Consumer Demand Roundtable is sorely needed. To help more smokers quit successfully, we need to be attuned to what smokers want and need in cessation treatment and to address the range of their needs with a spectrum of products and programs that are not only effective, but also appealing, convenient, and yes, even cool. We need to communicate to segments of smokers how these offerings match their needs. Public health can benefit as much or more from increasing utilization of existing treatments as from development of new treatments. We need to create and promote consumer demand for treatment. The papers in this special issue show us the way.

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