SESSION III TRENDS AND ISSUES IN FINANCING

Introduction

John M Pinney

It gives me a great deal of pleasure to introduce Dr Michael McGinnis. He and I go back a number of years. Dr McGinnis is Assistant Surgeon General and Deputy Assistant Secretary for Health of the US Department of Health and Human Services. He chaired the 1977-78 Secretary's Task Force on Smoking and Health. Among his many contributions to disease prevention is the landmark Surgeon General's report on prevention, *Healthy People*. He and I shared the experience of developing reports under Mr Califano, who was Secretary at the time, and both of us, I think, can relate stories about being awakened late and early by Mr Califano or some of his minions wanting to know whether or not we

were doing the job we were expected to do.

I think it's appropriate that the topic is the financing issues around smoking cessation. Dr McGinnis has been working for many years to integrate preventive services into all categories and channels of health care delivery, and I think we're at a very important moment in the health care reform effort. Decisions will soon be made about how health care will be structured and paid for and delivered, and clearly smoking cessation, at least most of us believe, has a rightful place in that scenario.

So it gives me great pleasure to introduce Dr Michael McGinnis to talk about financing issues. Thank you.

Trends and issues in financing: payment for smoking cessation services

J Michael McGinnis

Impressive progress has been made in moving the tobacco issue to greater prominence on the health policy agenda. We are seeing renewed emphasis on tobacco education, greater commitment and tougher efforts to reduce access of minors to tobacco, more focus on the possible use of higher tobacco excise taxes, the classification this year by the US Environmental Protection Agency of environmental tobacco smoke as a Group A (known human) carcinogen, and the banning of smoking on the White House premises. These are welcome developments and hopeful harbingers of the prospects for future gains.

Nonetheless, smoking remains the leading cause of preventable death in the US.¹ Despite gains that have been made since the release of the landmark Surgeon General's Report on Tobacco and Health in 1964, one in every five deaths is still attributable to tobacco, and even today tobacco use is practiced by more than one of every four adults.² Moreover, trends show that increasing numbers of adolescents are beginning to smoke, with females and minorities disproportionately represented in these increases.³

Not only is the human cost of smoking high, but the economic costs of tobacco use are staggering. It has been estimated that the

health consequences of tobacco use cost our country between \$68 and \$72 billion each year.^{4,5} While the national burden of tobacco use is so large as to be difficult to grasp, a more tangible way to look at the economic impact is through the fact that it averages out to a cost per smoker of approximately \$3-4 per day. Ironically, the groups for whom the least progress is being made in the campaign against smoking - women and African-Americans - include those who can least afford the economic consequences.

Related to both individual and national costs of smoking are the trends and issues concerned with financing smoking cessation within our health care system. As of 1993, health care represents 14% of the gross domestic product - \$3600 on average for every man, woman, and child in the US. Provision of health care services to all Americans necessitates a sharper look at which services are truly effective, as well as at what mechanisms are available to deliver these services most efficiently. Consequently, to improve the efficiency with which health care is delivered, the pressure is tremendous for close scrutiny of services and their costs.

Despite the mandate for constraints on health care spending, there are positive signals

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for services that have provided solid evidence of effectiveness in preventing downstream illness. Prevention, on both a population and an individual basis, will be an integral part of a reformed health care system. In the clinical setting, the science base reviewed by the US Preventive Services Task Force (USPSTF) has provided key recommendations for those services likely to be included for coverage in a core benefits package. The USPSTF, a non-Federal panel of experts representing clinical medicine, prevention, epidemiology and health services research has constructed an evidence-based methodology to review the scientific literature regarding specific screening, immunisation, counselling, and chemo-prophylaxis. Formed in 1984, the Task Force reviewed approximately 2500 articles in the literature related to various clinical preventive interventions to produce the age-, gender-, and risk-factor-specific recommendations contained within the 1989 Guide to Clinical Preventive Services.⁶

Reflecting the Task Force view of the validity and importance of clinician involvement in addressing smoking within the clinical encounter, the Guide recommended that: 'Tobacco cessation counseling should be offered on a regular basis to all patients who smoke... The prescription of nicotine... may be an appropriate adjunct for some patients.' (p289). The Task Force, however, also noted the level of uncertainty concerning the effectiveness of the average clinician's advice on smoking cessation, a fact that may have implications for the inclusion of smoking cessation services in a core benefits package.

Ultimately, evaluation of clinical smoking cessation interventions, or any intervention for that matter, as a candidate benefit under health care reform will most likely revolve around four dimensions:

- evidence on the efficacy of a given intervention
- evidence on the efficiency of a given intervention (the health return for a dollar investment)
- likelihood that using the clinical setting to offer an intervention is necessary or unusually advantageous
- likelihood that the clinical setting offers special access for targeting high risk populations.

How do clinically based smoking cessation programmes measure against each of these four concerns? With respect to efficacy, the picture is unclear. The one-year success rates for smoking cessation programmes have been reported in the range of 10 to 40 %, with group programmes faring better than physician's advice alone.⁷ The combination of nicotine therapy and counselling appears to be synergistic.⁸ Most of the current findings on efficacy need affirmation in view of the fact that the people who enter smoking cessation programmes are already a selected group who are more interested than non-enrollees in stopping smoking.

On the efficiency issue, Cummings and co-authors⁹ have provided some evidence in

favour of the cost-effectiveness of smoking cessation advice in a clinical setting compared with other types of preventive interventions. Physician counselling on tobacco use is estimated to cost some \$700 to \$2100 per life year saved,⁹ and when combined with nicotine treatment, the cost is estimated at between \$1000 and \$9000 per year of life saved.^{8,9} While not inexpensive, this cost compares favourably with estimates for the treatment of high blood pressure and hypercholesterolemia, which range between \$11 000 and \$100 000 per year of life saved, depending on the analysis involved.⁹

An important issue in this regard is the dichotomous application of decision rules for treatment versus preventive interventions. That is, we have in our society what has been described as a 'rescue mentality'¹⁰ which leads us to devote resources rather uncritically to problems presenting in various states of crisis, independent of the anticipated health returns for a given dollar investment, while requiring elaborate analyses of cost impact for those that seem more elective. One can identify strong reasons on emotional grounds for this bifurcated set of standards, but from the perspective of rational allocation of social resources, and from the perspective of those of us interested in tobacco control, this presents a special challenge.

On the likelihood that offering smoking cessation interventions in clinical settings is technically advantageous, there is also uncertainty. While the use of prescription preparations, such as nicotine, as adjuncts in smoking cessation needs to be clinically supervised, it is a fact that many elements of smoking cessation can and are being offered outside clinical settings. Indeed, 85 % of the population succeeds in stopping smoking without involvement in any outside programme.⁸ In addition, nearly three-quarters of the Fortune 500 companies offer some sort of smoking cessation assistance to their employees. This decision is linked to evidence of improved employee health, productivity, and rates of absenteeism when smoking is less prevalent in the workforce.¹¹ Community clinics as well as many proprietary programmes are also available to those who seek related services. Hence, many alternative delivery vehicles are already available, and this will certainly factor into the deliberations about a benefits package.

The final issue relates to whether special advantage is gained in using the clinical setting to reach those most at risk. When one thinks of the population most in need of smoking cessation services, the focus shifts rapidly to adolescents, low income, and low education groups. These are populations who have traditionally had poorer access to primary care settings.¹² While a reformed health care delivery system is likely to mitigate against financial problems of access, outreach to higher risk populations through community-based efforts will be looked upon to improve uptake of education and services. For adolescents, school-based programmes are likely to take on increasing importance. For workforce mem-

bers, the worksite will continue to offer important opportunities.

We can feel confident that health care reform will contain incentives for a larger clinical focus on tobacco use. But because of the uncertainties in each of the dimensions noted above, the probability that smoking cessation services will be included as part of the core benefits package is not clear at this time, and the debate will surely continue. As of Spring 1993, the following developments seem most likely:

First, health advice, including advice to stop smoking, will be part of a basic set of preventive services. The inclusion of more elaborate smoking cessation procedures will most likely await the results of more definitive proof of the effectiveness of various intervention models. Short of that, such services are not likely to be one of the first elements included in what is intended to be a fairly tight benefits package.

Second, if prescription drugs are included under health care reform, as is now under discussion, the fact that nicotine gum and patches seem in most studies to be more effective than advice alone bodes well for their inclusion as reimbursable items, assuming that negotiation reduces the obstacle presented by the currently high price for a course of treatment.

Third, prepaid medical plans may well decide to cover smoking cessation programmes over which they have local oversight. That, however, is likely to be a plan-specific decision at this juncture.

In the final analysis, perhaps the largest anti-tobacco contribution that could be made through health care reform would be a hefty boost in the tax on tobacco products to help finance the reform. Particularly among younger groups, the demand for tobacco appears elastic with respect to price, and a large price increase might be most useful in reducing demand.

With a problem as compelling as that represented by the health consequences of tobacco use, all the levers of public policy must be engaged – education, services, incentives, regulations, statutes – in a multifaceted attack on the issue. Payment for smoking cessation services has a role in this regard, but represents only one component of a comprehensive and aggressive public health programme to blunt the impact of tobacco on the vitality of the citizenry. The Public Health Service is committed to the support of such a programme.

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