SESSION VI DELIVERY ISSUES

Introduction

John M Pinney

Our purpose this morning in this last session is to try to focus on delivery of smoking cessation; all that we talked about yesterday really means very little unless we can find ways to reach people and to deliver what we know will help them. And we have an excellent panel who can bring a number of different perspectives to this issue. Let me introduce the rest of the panel, starting on Dr Davis' right.

Dr Roselyn Epps from the National Cancer Institute.

Dr Jack Hollis, a Senior Investigator for Kaiser Permanente Center for Health Research. He's also Clinical Associate Professor of Public Health and Preventive Medicine at the School of Medicine of Oregon Health Sciences University.

Dr Marc Manley, Acting Chief of the Public Health Applications Research Branch at the National Cancer Institute.

Dr Deborah Ossip-Klein, Associate Professor of Psychology in Community and Preventive Medicine, and Director of the Smoking Research Program at the University of Rochester.

Lastly, Dr Nancy Rigotti who, in addition to being Assistant Professor of Medicine and Preventive Medicine at Harvard Medical School, is launching one of the premier hospital-based smoking cessation programmes at the medical mecca of Massachusetts General Hospital.

Finally, our presenter, Dr Ron Davis, has been the Chief Medical Officer of the Michigan Department of Public Health since April 1991. He's responsible for the medical aspects of the Department's policies and programmes and oversees the Department's chronic and infectious disease activities.

The delivery of smoking cessation services: current status and future needs

Ronald M Davis

What I will try to do is to present a base of information on the extent to which various smoking cessation services and messages are delivered. I will cover the major channels through which such services and messages are delivered, and I will talk about the benefits of each channel. I will also address what I perceive to be the need to enhance the effectiveness or volume of messages and programmes through those channels.

Mass media**BENEFITS**

If we start with the mass media, the benefits include the wide reach and cost-effectiveness – and I use that latter term advisedly. What I refer to here is the likelihood that mass media messages on stopping smoking are more likely to get more people to stop smoking per dollar spent than other smoking cessation programmes and strategies. Ken Warner cited the best example: the anti-smoking public service announcements on television and radio in the late 1960s under the Federal Communications Commission's Fairness Doctrine.¹

Also, the mass media allow us to reach high-risk groups that are difficult to reach through other channels, such as unemployed people. Messages through the mass media augment, reinforce, and tie into other services and programmes, such as telephone hotlines and quit-smoking classes.

CURRENT STATUS

What's the current status of messages being delivered through mass media? Mostly the messages are in the form of public service announcements produced by federal agencies (eg, the Office on Smoking and Health of the Centers for Disease Control and Prevention; the National Cancer Institute; and the National Heart, Lung, and Blood Institute), the voluntary health agencies, and State health departments.^{2,3}

We have, to my knowledge, paid TV or radio messages or paid space on billboards in only three states. California spends about \$16 million a year on a paid media campaign funded through their tobacco tax initiative (Proposition 99).⁴ Minnesota has had \$400 000 to \$700 000 a year allocated to a media

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campaign funded by a tobacco tax as well, which has declined in recent years (personal communication, Kathy Harty, April 1993). I was speaking with Kathy Harty of the Minnesota Department of Health a few days ago, and she said that there's an even greater risk that all of their tobacco money, media and otherwise, will be taken away and diverted to other areas of public health. And in Michigan we have had a paid media campaign funded to the tune of about \$600 000 to \$1 million a year; and that's funded, interestingly enough, through a tax on computer software. It's called the Michigan Health Initiative. It was adopted three or four years ago and raises \$9 million a year, which is earmarked for AIDS and health promotion, and our department has allocated most of the health promotion part of that to tobacco prevention in recent years. I don't know why they put the tax on computer software. They might have just looked around to see who had the weakest lobby and maybe the computer software people didn't have much of a lobby back then.

We have also had occasional low-budget paid ad campaigns by various groups, such as Doctors Ought to Care (DOC), and Smoke-Free Educational Services (Joe Cherner's group up in New York City). The American Medical Association took out a paid ad in the 27 January 1993 issue of the *Washington Post* (page A16) endorsing a tobacco tax increase. The Asian-Pacific Association for the Control of Tobacco, took out a couple of ads in recent years in the *Washington Post* and *Washington Times* on US tobacco trade policies. We occasionally see paid anti-tobacco campaigns by other groups, but certainly nothing consistent. Many of these ads do not address cessation specifically, but may encourage cessation by raising the public profile of smoking as a health concern.

We also have ads in the mass media for other products that may reinforce to people the need to quit smoking or just the notion that smoking does bad things to you. Of course we have the ads for nicotine skin patches. We also have the ads for Wrigley's gum, which is being touted for places where you can't smoke. I don't know whether the Wrigley's ads encourage people to quit, but I doubt that it's been studied. It would be interesting to look at that.

Topol, "the smoker's tooth polish", has been advertised, and it would be interesting to know how things like this contribute to the social milieu that goes against smoking in our society, just reminding people about yellow teeth and bad breath and so on. And then we have a fair amount of advertising from time to time, sometimes on those cable TV stations that some people watch when they can't fall asleep at night, for over-the-counter smoking deterrent products.

But all that being said, I think you have to compare total anti-smoking advertising to the tobacco industry's advertising budget of \$4 billion in 1990,⁵ which comes out to \$127 per second. So whatever mass media communication we have, it doesn't compare at all to the tobacco industry's budget, even though they

don't have access to TV and radio, except, of course, through sponsorship of Virginia Slims tennis tournaments, Marlboro car races, and similar events broadcast on television and radio.⁶

NEEDS

What would it take to increase our advertising messages in the mass media? Given the cost, I think we have to look at earmarked tobacco taxes, as we've seen in California and in Minnesota. Another option is a counter-advertising mandate, a strategy that could be instituted by law that would require tobacco companies to buy an ad for our message for every ad they take out to promote smoking.⁷ I think the Feds and well-funded health groups such as the American Cancer Society (ACS) need to take a serious look at funding paid media campaigns. Obviously, that can bankrupt any sort of budget if it's not done judiciously, so it does need to be done with care.

Also, tobacco has not yet been discovered by celebrities or philanthropists, along the lines of what we have seen with Elizabeth Taylor and AIDS, and Jerry Lewis and muscular dystrophy. I think it's kind of strange that we haven't found a celebrity or a philanthropist that has really put in the money or done the fund-raising to promote this cause. Where is the Ross Perot of tobacco control? You'd think, with all the celebrities who have died of smoking-related diseases, that somebody would have caught on, but it hasn't happened yet.

Health care settings

BENEFITS

Taking a figure from one of Judy Ockene's papers,⁸ at least 70 % of smokers visit health care providers each year, so there's an obvious benefit in focusing on the health-care setting. And many smokers visit health care providers several times a year. Arguably, health care providers carry authority and command respect, so they can be influential in imparting a quit-smoking message. Smokers are very susceptible to messages on smoking when seeking health care, and even minimal interventions increase quit rates, as we've discussed.

CURRENT STATUS (PROVIDERS)

In 1987, 51 % of smokers said that a doctor had ever advised them to quit.⁹ Gilpin *et al.*⁹ looked at how that percentage has changed over time, and found that it has increased, but it's still only about half.

Smokers are less likely to report having been advised to quit by a dentist (22 %), nurse (24 %), or pharmacist (4 %), according to a survey conducted in four states by the ACS, with assistance from the Office on Smoking and Health.¹⁰ And if you ask the providers, you see statistics like these: 52 % of internists and 35 % of dentists reported counselling more than 75 % of their smoking patients about cessation in 1986.¹¹ So whether you talk to the smokers or to the providers, you certainly have a lot of room for improvement.

CURRENT STATUS (FACILITIES)

Of 2165 hospitals accredited by the Joint Commission on Accreditation of HealthCare Organisations that responded to a survey in 1988, 60 %, 51 %, and 37 % had 'an ongoing or regularly available' quit-smoking programme for staff, the general public, and patients, respectively.¹² That's 37 % for patients, which is awfully low. And as that survey only had a 44 % response rate, I think these numbers might be artificially high because of nonresponse bias.

So certainly facilities have a long way to go, hospitals in particular. Fewer than a dozen hospitals offer in-patient treatment for nicotine dependence, the type of dependence that hasn't been treated successfully by less intensive interventions. (Dr John Slade has a list of facilities that offer in-patient treatment, one of which is the Mayo Clinic¹³.) Obviously, lack of third-party payment is a factor affecting the availability of in-patient treatment.

I'm not aware of any information on what health maintenance organisations (HMOs) and medical clinics and other health care settings are doing in the area of smoking cessation. So that's an area for future research.

NEEDS

To improve smoking cessation services in health care facilities, we need better training of health care providers, including undergraduate and graduate medical education and continuing medical education (CME). The main target for postgraduate medical education and CME should be primary care providers, but I would also argue that we shouldn't ignore specialists. I'm not talking about pulmonologists and cardiologists, but, for example, ophthalmologists. Two papers published recently associated smoking with cataracts,^{14,15} and an accompanying editorial estimated that about 20 % of cataracts may be attributable to smoking,¹⁶ so why shouldn't ophthalmologists counsel their patients to quit smoking? And certainly gastroenterologists, with the link between smoking and ulcers, ought to be talking with their patients about quitting, and we can go on down the line, with smoking affecting nearly every major organ system.

John Hughes threw out a suggestion yesterday that I thought was worth repeating, and that is putting questions on smoking cessation on Board certification examinations. That would tie into the issue of training physicians in smoking cessation.

I think we should have a smoking cessation consulting service in every hospital, perhaps following the Mayo Clinic model.

Third-party payment for smoking cessation services has been discussed already, and I await with interest the results of the Agency for Health Care Policy Research study on the effectiveness of various smoking cessation interventions. I think that's what we will need to persuade third-party payers to cover smoking cessation treatment, because they're worried about how far coverage might go. Do you include hypnosis, acupuncture, and so on?

I should mention that the Department of

Health and Human Services has endorsed third-party payment for effective smoking cessation services, at least to the extent to which treatment of alcoholism and illicit drug addiction is covered.¹⁷ There's no reason to have a double standard between treatment of alcoholism and illicit drug addiction on the one hand and nicotine addiction on the other.

Inclusion of smoking cessation services in a basic benefits package under health care reform will be very important, and Dr McGinnis talked about that over lunch yesterday.

And I'll mention a proposal by Dr Mike Fiore just to make a point. He suggested that smoking status become part of the routine vital signs that physicians and nurses report, along with heart rate, blood pressure, and temperature.¹⁸ I personally don't think that's ever going to happen, but it's worth mentioning because it demonstrates the fundamental change we need in how the medical profession looks at this problem before we're really going to tap its full potential.

And a final need is to achieve the following 'Healthy People 2000' goal: 'Increase to at least 75 % the proportion of primary care and oral health care providers who routinely advise cessation and provide assistance and follow-up for all of their tobacco-using patients.'¹¹

Worksites

BENEFITS

There are several benefits in providing smoking cessation services in the workplace. We're dealing with a large captive population. It's probably the best setting to reach blue-collar workers, who have a much higher smoking rate than white-collar workers.¹⁹ Funding is often available for worksite interventions from employers concerned about the costs of smoking. And these programmes are reinforced by worksite smoking bans and restrictions. In fact, they are often offered to complement a new policy banning or restricting smoking in the workplace.

CURRENT STATUS

A survey done by Dr McGinnis's office (the Office of Disease Prevention and Health Promotion) found that 36 % of worksites with 50 or more employees offered some kind of smoking cessation programme in 1985.²⁰ That figure increased slightly to 40 % in a 1992 survey done by the same office.²¹

The Bureau of National Affairs conducted a survey in 1991, to which 833 companies responded.²² The survey found that companies provided the following assistance: distributed literature, 49 %; sponsored employee wellness programmes, 36 %; reimbursed workers for outside quit-smoking programmes, 32 %; sponsored an event, such as the Great American Smokeout, 30 %; offered an in-house quit-smoking programme in company time (30 %) or out of company time (26 %); gave cash awards (6 %) or non-cash awards (3 %) to workers who quit; and gave lower insurance rates to non-smokers, 6 %.

NEEDS

We need to educate employers about the costs of smoking to motivate them to promote cessation. We need to push worksite smoking bans through laws, regulations, LITIGATION, and voluntary policies, which may be the most effective way to drive smoking cessation programmes at the worksite. And I put 'litigation' in upper-case letters because I think that is probably the most powerful incentive for companies to move toward a smoke-free workplace, which will usually bring with it the availability of smoking cessation services for employees.

At lunch yesterday, I asked a couple of people who run smoking cessation programmes how their business has been since the Environmental Protection Agency's (EPA's) report on passive smoking²³ came out, and their response was that business has increased significantly. Employers are concerned about litigation because of the EPA report, and are therefore more likely to ban smoking and to offer quit-smoking programmes.

We need to do a much better job of reaching out to unions. Companies should offer smoking cessation support to make smoking bans more acceptable. Unions ordinarily have a negative or passive reaction to smoking bans, usually because many of their members smoke. But if you can offer employees as much help as they want if they try to quit, then that makes unions more likely to go along with a smoking ban.

And finally, it's a good idea to give small seed grants for worksite wellness programmes, as we have seen in Michigan. We've spent about \$2.5 million a year through the Michigan Health Initiative, which I mentioned earlier, on a programme giving small seed grants (\$2000 to \$3000 each) to worksites to run wellness programmes. That doesn't sound like a lot of money, but it's usually enough to get them interested in doing something. It gets companies to run a programme for a couple of years, and when we cut off the funding – we say it's only for two or three years – by that time employees enjoy and are committed to the programme and they often get management to continue it on corporate money.

The public health system

BENEFITS

A major benefit of providing smoking cessation services through the public health system is that it reaches high-risk populations. In addition, its delivery network extends to most communities throughout the country, through primary care clinics, WIC clinics, substance abuse clinics, and so on. So there are multiple settings in the public health system at the community level through which to deliver services.

CURRENT STATUS

According to a survey conducted by the Association of State and Territorial Health Officials in 1991, 26 state health departments

said they offered smoking cessation programmes to members of the community.²⁴

The National Association of County Health Officials conducted a survey of local health departments in 1990, and found that, of 2263 local health departments responding to their survey, 74 % reported being active in health education and 69 % in chronic disease control.²⁵ They didn't specifically ask about smoking cessation, but I would hope that health education and chronic disease control would include smoking cessation. However, only 37 % had a full- or part-time health educator on staff. Because it's hard to do a whole lot unless you have paid staff to do it, I am doubtful about how much they're really doing.

NEEDS

The greatest need, in my opinion, is to build up the public health infrastructure for chronic disease prevention and control. Most local health departments are not going to do much (if anything) on smoking unless they're given resources, and I would cite as an example the recent programme sponsored by Lederle Laboratories donating two million Prostep nicotine skin patches free of charge to state health departments for use in low-income people. Michigan is participating, and we're getting enough Prostep patches to treat about 2100 smokers. We put out a notice to local health departments in our state, and very few had any capacity to deal with this (the programme offered no funding for administrative support). Normally we'd give them vaccines, or antibiotics for treatment of sexually transmitted diseases, and they would have no problem using those products, but if you offer them a smoking cessation product, most do not have the infrastructure or the setup to use it. We hope that some will develop the infrastructure soon (as we have begun to see in Michigan), but that's a major impediment to getting local health departments to work on smoking cessation.

Earmarking tobacco taxes are one way to fund infrastructure in local health departments, and we're seeing that in California where local health departments have received some of the Proposition 99 money.⁴

Coverage under Medicaid for smoking cessation would certainly help. As of 28 April 1992, only 25 states and the District of Columbia included transdermal nicotine patches on their lists of pharmaceuticals covered under Medicaid (written communication, Beth Worden, CIBA-Geigy Pharmaceuticals, 4 May 1992).

Also, we need to increase the capacity of community and migrant health centres to deliver smoking cessation services. Those health centres deliver the bulk of primary care to indigent populations, and smoking cessation ought to be a part of that care. My impression is that they are not doing much in smoking cessation, although I haven't seen relevant data.

Schools

Schools are another channel through which

smoking cessation – in addition to smoking prevention – can be supported.

BENEFITS

The benefits are that we would reach adolescent smokers before their tobacco dependence has achieved its full strength. We would also reinforce prevention messages and programmes where they occur in schools.

CURRENT STATUS

Currently these programmes are rarely offered, and when they are, it's usually as part of a research protocol. The research that's been done to date shows generally poor results for cessation programmes targeted to youth, and there's been particular difficulty in recruiting youth to cessation programmes. This research will be reviewed in the 1993 Surgeon General's report (scheduled for release in late 1993), which will focus on tobacco use among young people.

NEEDS

The need for more smoking cessation services targeted to youth was mentioned in the 1989 Surgeon General's report (p 12)¹⁹:

'Whereas past smoking control efforts targeting children and adolescents focused exclusively on prevention of smoking, the smoking control community has identified the need to develop cessation programs for children and adolescents addicted to nicotine.'

But as the 1993 report will indicate, we need more research to determine what works and how to recruit smokers into these programmes. Ideally, we would have a smoking-cessation instructor in every school, or at least someone with responsibility for both prevention and cessation of smoking. School prevention and cessation programmes should not exist independently of each other; they should be integrated with each other at each school and within each school curriculum.

Once again, I come back to earmarked tobacco taxes as a source of revenue to fund smoking cessation (and prevention) activities in schools. It's going to be hard for schools to add tobacco control counsellors when they don't have new money to do so.

Another source of revenue to fund school tobacco programmes would be licence fees imposed on tobacco retailers (similar to those imposed on alcohol retailers). Collecting a \$300 licence fee from tobacco retailers, which is what the Department of Health and Human Services has recommended for retailers with at least \$5000 in annual tobacco sales,²⁶ would bring in a lot of money. And part of that money might be earmarked for school smoking cessation and prevention programmes.

The Federal Drug-Free Schools money ought to be applied to tobacco. This programme is administered by the US Department of Education, and the programme's fiscal year 1993 budget is \$600 million. A few years ago Senator Bill Bradley of New Jersey tried to amend the appropriations bill which funded this programme in order to mandate that states

use some of the money for tobacco prevention, but that amendment did not pass. Nevertheless, given that tobacco use may be the most common form of drug addiction among youth, and given the role of tobacco as a 'gateway drug', we should continue to pursue this funding strategy.

And one last point about school smoking cessation counsellors: my understanding is that many if not most schools have counsellors who deal with substance abuse. If that's true, it's a precedent that ought to be followed for tobacco, as I mentioned earlier. Or at the very least, substance abuse counsellors ought to be trained to intervene in the area of tobacco prevention and cessation.

Community

At the outset, I should define what I mean by 'community'. For the purpose of this discussion, it refers to delivery channels that don't fall into the previous categories. These community channels include: voluntary health agencies (eg, the ACS, the American Heart Association, and the American Lung Association); churches, such as the Seventh Day Adventist churches, which have been very active in smoking cessation; and for-profit vendors (eg, Smoke Stoppers and SmokEnders). They provide a wide variety of services and materials such as quit-smoking classes, self-help materials, over-the-counter (OTC) products, hypnosis, telephone hotlines, and acupuncture; and they sponsor special events such as the Great American Smokeout.

BENEFITS

Having these programmes in the community increases the accessibility of smoking cessation services. They allow us to reach some people who are difficult to reach through the other channels I've discussed. They also reinforce messages and services that are delivered in institutions, so that people who do avail themselves of those messages and services will receive a 'booster dose' in the community.

CURRENT STATUS

1993 data from Marketdata Enterprises²⁷ give us an idea of the extent to which some of these services and products are used in the community. The following figures are for services and products that, for the most part, don't fall into the channels I discussed previously: OTC products, \$99 million; hypnosis, \$58 million; cessation clinics (commercial and non-profit), \$39 million; and acupuncture, \$36 million. The nicotine patch and gum are prescribed through many of the different channels I discussed previously, but for the sake of comparison, I'll give you the 1993 estimated sales figures for those products: \$575 million and \$82 million, respectively.²⁷

The category of cessation clinics breaks down as follows: Smoke Stoppers, \$10.2 million; 7th Day Adventists, \$9.4 million; SmokEnders, \$6.5 million; Smokless, \$6.3 million; Addiction Management Systems, \$3.4 million; American Lung Association, \$3.0

million; and the American Cancer Society, \$0.6 million.²⁷

Here are a few other interesting facts: 1) more than 600 000 smokers have completed the SmokEnders programme since it was established in 1969¹⁹; and 2) hypnotists accounted for 31% of all smoking cessation services listed in the telephone yellow pages in 47 US cities.²⁸

And some statistics for the 1991 Great American Smokeout: about one-third of all smokers participated in the event, with 7.1 million smokers (14.2% of smokers) reporting having quit for the day and another 10.6 million (21.3%) reducing the number of cigarettes consumed on that day.²⁹ One to three days after the Great American Smokeout, 5.8 million of the smokers who quit that day (82%) were still abstinent. Gritz and colleagues reported one-year follow-up data on a cohort of smokers who quit on the Great American Smokeout day.³⁰

NEEDS

The needs for delivering more smoking cessation in the community include research on the efficacy and effectiveness of these different products and services. Many of these services have been evaluated in controlled clinical trials, but how effective are they when delivered in the community?

We need research on the accessibility of services that smokers desire. How accessible are these services geographically, culturally, and financially? We also need research on consumer satisfaction with these services. It's incredible to me that with all the evaluation research that has been done, the research community has paid little attention to these issues.

We need to seriously consider the development of standards for smoking cessation. Yesterday Neal Benowitz talked about clinical guidelines, and that's the sort of thing that I'm referring to here. Should someone accredit smoking cessation programmes? Should we certify smoking cessation counsellors? Tracy Orleans mentioned certified addiction counsellors yesterday; along the same lines, we need to look at the feasibility and desirability of developing a voluntary certification process for smoking cessation counsellors nationwide. Certification may be driven by third-party payment. Insurance companies may not pay for these services and may not pay providers for delivering these services unless we have some sort of quality control in place, as we've seen in other parts of the health care sector.

And finally, we need strict regulation of OTC products, which I brought up yesterday with the FDA representative, Dr Spyker. The draft monograph I mentioned yesterday (which the FDA called a 'tentative final monograph') was published by the FDA in 1985, and proposed to 'grandfather in' all products that were already on the market.³¹ So Cigarrest and Nikoban and other products would have been grandfathered in, but the introduction of new products containing lobeline or silver acetate, for example, was to be

prohibited until such products were shown to be safe and effective. Dr Spyker's answer to my question yesterday implied that *all* these products would be taken off the market when the monograph is finalised. Maybe they've changed the monograph since 1985, but as it existed then, it would have grandfathered in all of the existing products.

[A post-conference note: On 2 June 1993, the FDA announced a ban on all OTC smoking deterrent products. Individual products will not be allowed to be introduced or re-introduced into the marketplace unless and until they are shown to be safe and effective. The policy prohibits new shipments after 1 December 1993, but allows the products to be sold until existing supplies are exhausted.³²]

So that's an overview of the extent to which various smoking cessation services, products, and messages are delivered through the major health communication channels. A lot is going on, but we have a long way to go in order to make effective smoking cessation services available to all smokers. Our goal for education on smoking cessation should be to achieve for the country what the State of California has been able to achieve through Proposition 99-funded programmes, media campaigns, and research.

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