It is my pleasure to work with John Pinney and with so many of you assembled at this conference, to continue to forge new models for comprehensive nicotine addiction treatment for all Americans. I want to join Mr. Pinney and Neal Benowitz in thanking and welcoming all of you, and in thanking the planning committee, the presenters, and the many other sponsors of this conference: the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health, the National Cancer Institute (NCI), the Agency for Health Care Policy and Research (AHCPR), and the Society for Research on Nicotine and Tobacco (SRNT). It is our partnership that gives us power. I also want to thank Buxness Communications for their efforts to publicize this conference and bring media attention to us today. Finally, let me applaud Pinney Associates for their superb work planning, organizing, and publicizing this event.

The Robert Wood Johnson Foundation is encouraged by the wide interest in this conference and in the AHCPR smoking cessation guideline. We have taken a number of steps recently to promote the wide application of the AHCPR guideline, including giving small dissemination grants to organizations and professional societies such as the American Medical Association, the Visiting Nurses Association, and even the AFL-CIO (American Federation of Labor and Congress of Industrial Organization).

We are also funding efforts to form a tobacco treatment policy group to continue to identify barriers to wide treatment access for American smokers and tobacco users, and we support efforts to create tobacco control performance measures for health plan report cards. As you may know, the mission of the Robert Wood Johnson Foundation is to improve health and healthcare for all Americans. Statistics make reducing the harm caused by tobacco a priority.

We are all aware that over 25% of adult Americans continue to smoke or use spit-tobacco products. Adult smoking prevalence has been fairly level since 1991, and new signs show increases among young adult smokers. At the same time, smoking among teens is at its highest level in 16 years, with smoking among 13-14 year olds up 34% over the most recent five-year period. Nearly 3000 young Americans become smokers every day. If this trend continues, smoking prevalence among adolescents will also rise.

We are all too familiar with the toll tobacco takes—more than 400,000 premature deaths each year, lifetime medical expenses that are 1.2 to 1.3 times higher for smokers than non-smokers, and direct medical costs alone of $50 billion each year. This makes tobacco the single greatest threat to the national public health.

Most of you in this room are also familiar with these disappointing statistics: although over 70% of American smokers see a doctor each year, only 37% report receiving medical advice about or assistance with quitting. Few quitters—as few as 10 to 15%—report ever having used a formal treatment. The barriers to making tobacco intervention a routine part of healthcare are formidable, and the incentives have been few. Barriers have included the lack of authoritative clinical practice guidelines, the lack of reimbursement for smoking cessation advice and assistance, the lack of routine training in tobacco intervention for doctors, nurses, physicians, pharmacists, and other key primary-care providers, and most importantly, the lack of system-level changes that will integrate prevention into a culture of healthcare organized to provide acute care.

The AHCPR smoking cessation guideline may represent America's best hope to reverse these trends. The guideline emphasises brief treatments that are strongly evidence-based, highly cost effective, and easily incorporated into routine primary care. Not only is the guideline especially strong, but it comes at a time when our healthcare system should be especially receptive to it. The emergence of managed care as the dominant form of healthcare in America has created new incentives and new tools to assure wide implementation of this guideline.

Managed healthcare plans not only have a powerful new stake in keeping the populations and communities they serve healthy, but they also have unprecedented access to defined populations of providers and defined populations of smokers and tobacco users, giving rise to new possibilities for population-based prevention and tobacco control.

As further motivation, new tobacco control performance measures proposed for the nation's leading accrediting organisations, the Foundation for Accountability (FACT), and the National Committee on Quality Assurance will hold health plans accountable for the first time for how consistently they intervene to prevent and treat tobacco use.

Promising treatment technologies, including over-the-counter (OTC) nicotine gum and patches, prescription nasal spray, and model programmes that use personally tailored communications and treatment geared to smokers in all stages of readiness to change—give us the capabilities to individualise treatment for a wide spectrum of smokers enrolled in today's health plans, both public and private.

Finally, issues of tobacco addiction and treatment are receiving unprecedented national attention both in the political arena and through wide advertising of new OTC nicotine replacement products. In many ways, we are now poised to make the same inroads to cessation that President Clinton's proposed FDA Executive Order could make to smoking prevention. All of us working to plan this conference have shared a sense of excitement about that, and a sense of new possibility. We have a long way to go before the treatment of tobacco dependence is given the priority and resources that its toll demands, but we have every reason to be optimistic. The outstanding guideline that the AHCPR panel has forged sets the course for a new era of tobacco control. The purpose of this conference is to highlight new models and tools for putting this guideline into practice and to identify areas where the challenges are greatest.

As we all know that even the best guidelines don't implement themselves, it is our hope to foster the development of new teams and networks of clinicians, scientists, policy makers, and health plan administrators committed to implementing the guideline and moving us closer to an America where all smokers have access to effective cessation treatments. Let me close by saluting the outstanding effort and work of the AHCPR and the entire smoking cessation guideline panel, and by introducing Dr Doug Kamerow. Doug is the director of the Office of the Forum for Quality and Effectiveness in Health Care within the Agency for Health Care Policy and Research. It is his office that is responsible for the development of evidence-based clinical practice guidelines, and we are certainly the beneficiaries of his and his colleagues' superb efforts.

C. Tracy Orleans

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