Helping Smokers Quit: Understanding the Barriers to Utilization of Smoking Cessation Services

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Context: Counseling smokers to quit smoking and providing them with pharmaceutical cessation aides are among the most beneficial and cost-effective interventions that clinicians can offer patients. Yet assistance with quitting is not universally covered by health plans or offered by all clinicians. Analysis of stakeholders' perspectives and interests can identify the barriers to more widespread provision of cessation services and suggest strategies for the public policy agenda to advance smoking cessation.

Methods: Review of literature and discussions with representatives of stakeholders.

Findings: All stakeholders—health plans, employers, clinicians, smokers, and the government—face barriers to broader smoking cessation activities. These range from health plans' perceiving that covering counseling and pharmacotherapy will increase costs without producing commensurate health care savings, to clinicians' feeling unprepared and uncompensated for counseling. Like other preventive measures aimed at behavior, efforts directed at smoking cessation have marginal status among health care interventions. State governments can help correct this status by increasing Medicaid coverage of treatment and expanding coverage for state employees. The federal government can promote the adoption of six initiatives recommended by a government subcommittee on cessation: set up a national quit line, develop a media campaign to encourage

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cessation, include cessation benefits in all federally funded insurance plans, create a research infrastructure to improve cessation rates, develop a clinician training agenda, and create a fund to increase cessation activities through a new \$2 per pack cigarette excise tax. Both the federal and state governments can increase cessation by adopting policies such as the higher cigarette tax and laws prohibiting smoking in workplaces and public places.

Conclusions: Public policy efforts should assume greater social responsibility for smoking cessation, including more aggressive leadership at the state and federal levels, as well as through advocacy, public health, and clinician organizations.

Keywords: Smoking, cessation, insurance coverage, policy.

DESPITE GREAT STRIDES IN TOBACCO CONTROL, CIGARETTE smoking remains the leading preventable contributor to morbidity and mortality in the United States. Smoking and exposure to tobacco smoke cause 438,000 premature deaths and more than \$167 billion in health care costs and lost productivity every year (CDC 2005a). In 2006, nearly 21 percent of U.S. adults (45.3 million) currently were smokers (CDC 2007). The two latest Surgeon General's reports on smoking underscore the persistence of smoking as a major public health problem, concluding that smoking harms nearly every organ of the body and that involuntary smoke exposure has numerous adverse effects on otherwise healthy children and adults (U.S. DHHS 2004, 2006).

The remaining burden notwithstanding, the strides in tobacco control have been impressive indeed. Since the release of the landmark 1964 Surgeon General's report on smoking and health (Public Health Service 1964), half of all Americans who have ever smoked have quit, the vast majority on their own (i.e., without the assistance of formal programs or pharmacotherapies) (CDC 2005b). Furthermore, an estimated 3 million-plus have gained an average of fifteen years of life each as a result of their antismoking campaign-induced decisions to quit or to not start to smoke in the first place (Warner 2006). But quitting smoking is difficult. Only approximately 2.5 million of the nation's 45 million smokers succeed each year, out of more than 30 million who try. On surveys, fully 70 percent of smokers indicate that they would like to quit (U.S. DHHS 2000).

In recent years, larger proportions of successful quitters have relied on professional counseling and pharmaceutical aides, a reflection of both the greater availability of products and services and the higher level of addiction to nicotine in the nation's remaining smokers (Hughes and Burns 2003). Professional and pharmaceutical assistance with quitting is both effective and cost-effective. The 2008 update of the Public Health Service's (PHS) clinical practice guideline for smoking cessation concludes that a variety of interventions double or triple the odds of quitting without assistance, the latter being about 10 percent for motivated smokers who enter cessation trials, and less for average smokers attempting to quit on their own (Fiore et al. 2008). (See the guideline update for detailed data on estimates by type of intervention.) The guideline's review of the evidence also concludes that "tobacco dependence treatments are . . . highly cost-effective relative to interventions for other clinical disorders." One of the guideline's major findings is that "providing coverage for [tobacco dependence] treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in this Guideline as covered benefits" (Fiore et al. 2008).

Given the magnitude of the problem and the potential benefits of quitting smoking, advising and assisting patients to quit smoking is the most important intervention that clinicians can offer patients who smoke (Schroeder 2005). Interventions that increase quit rates include simply asking patients if they smoke and advising them to quit, referring them to cessation resources (e.g., telephone quit lines), providing behavioral counseling, and offering nicotine replacement therapy (NRT) or other pharmacotherapy (i.e., the antidepressant bupropion or the partial nicotine agonist varenicline) (Fiore et al. 2008; Lancaster and Stead 2004, 2005; Ranney et al. 2006; Schroeder and Sox 2006). Cessation has both immediate and long-term benefits for the health and quality of life of smokers of any age (Lightwood and Glantz 1997; Lightwood, Phibbs, and Glantz 1999; Taylor et al. 2002; U.S. DHHS 1990). The PHS clinical guideline recommends that all health plans implement tobacco-user identification systems; give education, resources and feedback to clinicians; and, as noted earlier, provide coverage for smoking cessation treatments (both counseling and pharmacotherapy) (Fiore et al. 2008). Moreover, the Institute of Medicine recently recommended that all insurance plans cover smoking cessation programs as a lifetime benefit (IOM 2007).

Considering both the tremendous impact of quitting smoking on smokers' health and quality of life and the demonstrated effectiveness and cost-effectiveness of medical assistance with cessation, one might expect that smoking cessation benefits would be included in all health plans already, so as to make treatments accessible and affordable to every insured smoker. While most health plans do provide coverage for some form of pharmacotherapy, fewer (less than half of managed care plans surveyed in one study) also provide coverage for some form of counseling (McPhillips-Tangum et al. 2006), a combination that is more effective than either strategy alone (Fiore et al. 2008). Moreover, clinicians do not consistently advise their patients who smoke to quit or refer them for treatment, even those practicing in plans with good cessation coverage (Ferketich, Khan, and Wewers 2006; Stevens et al. 2005). The 2006 National Institutes of Health State-of-the-Science Conference Statement suggested that more research was needed to understand why cessation treatments were not universally available and how to increase smokers' demand for treatment (NIH 2006).

In this article, we discuss what underlies the gap between best practice and the status quo. We consider the roles of each stakeholder involved in smoking cessation, describe the barriers that each faces, hypothesize reasons for the gap, and suggest several specific strategies to advance smoking cessation on the public health policy agenda. In so doing, we draw from a large number of sources and direct the reader to several recent influential publications on these issues (see, e.g., Curry et al. 2008; IOM 2007; Orleans 2007). Note that this article is not intended to be a meta-analysis of the literature. (For a comprehensive summary of the literature to date on advancing smoking cessation in the health care sector, we recommend the new review by Curry and colleagues [2008].) Rather, we highlight the significant progress that has been made in smoking cessation and indicate areas where improvements are needed, providing the most inclusive synthesis to date across all stakeholders who have the potential to make progress, from smokers to the health care system to the government. Our recommendations focus on public policy, particularly because other recent articles outline innovative health care-sector approaches to improving access to and delivery of smoking cessation services (see, e.g., Curry et al. 2008; Fiore, Keller, and Curry 2007).

A Social Perspective

The use of smoking cessation treatments is a socially cost-effective way to reduce smoking-produced morbidity and mortality (Cromwell et al. 1997; Fiore et al. 2008; Warner 1997). The National Commission on Prevention Priorities ranked tobacco use screening and intervention (brief counseling and the offer of pharmacotherapy) as its top preventive intervention because of its clinically preventable burden and favorable cost-effectiveness (Maciosek et al. 2006). Published estimates of smoking cessation programs' cost per life year saved range from about \$2,300 to \$4,200 (Warner, Mendez, and Smith 2004), which compares favorably with other common preventive interventions. For instance, hypertension screening and treatment with antihypertensive medications cost \$14,000 to \$35,000 per quality-adjusted life year (QALY) saved, while screening adults (older than thirty-five for men and older than forty-five for women) for high cholesterol and treatment to lower lipid levels ranges from \$35,000 to \$165,000 per QALY (Maciosek et al. 2006). The cost per life year saved of smoking cessation puts it among the most socially cost-effective interventions in all of health care (Tengs et al. 1995). Yet cost-effectiveness evidence alone is unlikely to motivate stakeholders to increase the availability of smoking cessation services. Neither health plans nor physicians routinely incorporate cost-effectiveness analyses in their coverage or treatment decisions, due to a lack of will or interest or misunderstanding (Neumann 2005; Prosser et al. 2000; Ubel et al. 2003).

Another compelling social reason to emphasize smoking cessation is to reduce health disparities. In 2005, 46 percent of adults who had earned their GED diploma currently were smokers, compared with 10 percent of those with a bachelor's degree (CDC 2007). Reducing smoking in populations with lower socioeconomic status would thus reduce disparities in mortality, since the top contributors to mortality are smoking-related diseases (Wong et al. 2002). Making cessation services more affordable and widely available would increase access for the subpopulations with the highest current smoking rates—people of lower socioeconomic status, Native Americans, and those with psychiatric illnesses. Achieving the twin goals of cost-effective health improvement and disparity reduction requires the participation of health plans, employers, clinicians, smokers and their families, and the government, but each group faces

substantial barriers to actively contributing to the desirable social goal of smoking cessation.

Stakeholders' Roles and Barriers

Insurers and Health Plans

Health plans can promote smoking cessation by covering cessation treatments to make them more accessible and encouraging clinicians to follow guidelines (Curry et al. 2008; Manley et al. 2003). Coverage increases the likelihood that smokers will quit and is a cost-effective investment from the health plan's perspective (Kaper et al. 2005). Yet plans have several reasons for not providing these benefits. First and foremost, adding a smoking cessation benefit would increase the immediate costs for health plans, albeit minimally, and plans may believe that the benefits of smoking cessation will accrue only far in the future. (Warner, Mendez, and Smith [2004] estimate that adding a coverage benefit would cost health plans approximately \$0.41 per member per month.) Since patients and employers change their health plans frequently (Schlesinger, Druss, and Thomas 1999), there is no guarantee that the long-term health or economic benefits of smoking cessation would be realized by any plan providing the cessation service rather than the plan's competitors. In addition, plans may also fear adverse selection—attracting supposedly high-cost smokers to plans with cessation coverage—even despite the lack of evidence that a smoking cessation benefit is a major factor in people's choice of health plans (Chernew and Scanlon 1998; Schaefer and Reschovsky 2002). Without sufficient demand from payers and their enrollees, insurers will not feel pressure to provide this service, regardless of how relatively inexpensive or cost-effective it is. (For a similar perspective with regard to treatment of alcohol and drug abuse, see Harris and Sturm 2002.)

Second, in addition to the financial concerns, health plans may have philosophical grounds for opposing the coverage of smoking cessation services. These services violate the theoretical principle that insurance should cover rare, high-cost events that are not affected by possessing the insurance (e.g., homeowner's fire insurance). Smoking is common; use of cessation services is predictable; treatments are relatively inexpensive; and having insurance increases the likelihood of use of treatments (Curry

et al. 1998). In general, preventive services are especially sensitive to price and are used more frequently when they are available for free than with cost-sharing (Lurie et al. 1987), and studies have shown that more patients take advantage of cessation services when they are available at lower cost (Kaper et al. 2005). Insurance for cessation services may be viewed as a direct subsidy for smokers rather than an equally distributed benefit. As a result, some might argue that because smoking cessation treatment is relatively inexpensive, smokers should pay out of pocket. Even though the daily cost of a cessation pharmaceutical is roughly equivalent to the cost of smoking, smokers usually pay for their cigarettes by the pack. But the pharmaceuticals typically come in expensive weekly or monthly supplies, making paying out of pocket financially difficult for many low-income smokers. For example, whereas a pack of cigarettes costs from \$3 to \$5 (more in certain locations, like New York City), Nicorette gum comes in packages costing more than \$30 for forty pieces to more than \$70 for packages of two hundred pieces. The recommended daily usage during the first several weeks of a quit attempt is approximately eight to nine pieces, with twelve weeks a common course of treatment. And many smokers are prescribed two or more cessation drugs, such as a nicotine patch and gum or bupropion and the patch, which increases the cost commensurately.

The criticism that smoking violates this insurance principle applies to many services covered by health insurance, including the prescription of antihypertensive medications for high blood pressure (also relatively inexpensive and predictable). Moreover, insurance plans commonly cover services for which not every person is at risk (e.g., mammography). Singling out smoking as an exception indicates there is more to the hesitation to cover smokers than the insurance companies' usual objections.

Indeed, reluctance by health plans to cover smoking cessation therapy may reflect value judgments embedded in benefit decisions. Titlow and colleagues (2000) found, for example, that far fewer managed care organizations covered the cessation drug bupropion than prescription drugs for other purposes (i.e., not related to smoking cessation), suggesting that judgments about the value of smokers and smoking may be involved. One health plan benefit manager even stated that they "only cover pharmaceuticals needed to treat an illness and we do not consider smoking to be an illness" (Titlow et al. 2000, p. 246). Such attitudes, likely extending to other behavioral health issues such as obesity (Tsai,

Asch, and Wadden 2006) and substance abuse (McFarland et al. 2003), may well pose a significant barrier to wider coverage.

Employers

For insurers to include smoking cessation as a benefit and overcome these barriers, they must be demanded by employers. Smoking cessation services are cost-effective (in some studies, cost-saving) for employers relative to other employee health investments (Burns, Rosenberg, and Fiore 2007; Javitz et al. 2004; Levy 2006; Nielsen and Fiore 2000; Warner et al. 1996). But 54.5 percent of plans completing a survey by the Addressing Tobacco in Managed Care project reported a lack of purchaser demand (McPhillips-Tangum et al. 2006). Employers may worry that the benefits from cessation treatments would accrue to employers' competitors when their employees change jobs (Levy 2006). Yet the evidence indicates significant economic payoffs for employers, many of which may be realized in the short term, including on-the-job productivity gains, reduced absenteeism, lower health care costs, and reductions in life insurance payments (Fitch, Iwasaki, and Pyenson 2006; Warner et al. 1996). One barrier to a greater demand by employers is that studies too rarely translate the costs and benefits of cessation into terms that are meaningful for employers, so they may find it difficult to compare smoking cessation with other investments in employees (Javitz et al. 2004).

Even if employers understand the benefits of smoking cessation, they may worry about unintended consequences. Like health plans, employers may be concerned about adverse selection, attracting more employees who smoke and thus raising the costs of providing the benefit. But a study of alcohol treatment benefits—more costly per case than tobacco cessation services—found no evidence that employees choose plans with more generous benefits (Harris and Sturm 2002).

Clinicians

The "gold standard" in dealing with smoking is for clinicians to provide the "five As" to patients: Ask about smoking, Advise smokers to quit, Assess readiness to quit, Assist patients to quit, and Arrange follow-up (Fiore, Bailey, and Cohen 2000). Recent data suggest that while a

majority of clinicians asked patients if they smoked, far fewer (20 percent or fewer) provided assistance to quit (AAMC 2007; Ferketich, Khan, and Wewers 2006). Other data indicate that fewer than 40 percent of adult smokers in health plans received even a brief discussion of cessation strategies in 2005 (NCQA 2006). According to Stange and colleagues (2000), preventive interventions, especially those associated with behavioral health (e.g., obesity and other substance abuse, in addition to smoking), often receive short shrift in clinicians' offices.

Clinicians' still-sluggish performance in this area may reflect a lack of financial incentives to provide smoking cessation treatments or referrals, as they are rarely paid for these efforts. Ultimately, however, there could be a strong financial and legal incentive to provide cessation services: clinicians might be held legally accountable for not providing cessation services in accordance with the PHS guideline. Given the clarity of the guideline, the importance of smoking in health, and the effectiveness and cost-effectiveness of medical intervention with smokers, physicians' failure to determine the smoking status of their smoking patients and to offer them assistance with quitting might be deemed malpractice. Patients sickened by smoking, or their families, could bring a negligence tort action against their physicians (Torrijos and Glantz 2006).

Clinicians may believe they lack the counseling expertise required to discuss smoking cessation with their patients. They may lack the knowledge of the availability of nationwide telephone quit lines, relevant practice guidelines, or their health plans' specific coverage policies (Schroeder 2005). Clinicians may also hold misconceptions about drugs, for example, that NRT can be harmful, that make them reluctant to prescribe them (Borrelli and Novak 2007).

Clinicians' negative attitudes likely pose an additional major barrier to their promoting cessation services for their patients (Meredith et al. 2005). Clinicians may believe that offering cessation services is too time-consuming or that discussions with their patients about quitting smoking are unpleasant, uninteresting, or unproductive (Vogt, Hall, and Marteau 2005). (However, asking about tobacco use, advising patients to quit, and referring them to a counselor or quit line would take less than one minute.) Or, clinicians may feel discouraged by previous patients' experiences, as low quit rates could engender a fatalistic belief that their patients cannot, or will not, quit. Indeed, the factor that physicians cited most frequently as a barrier to providing cessation services was the lack of patient motivation (AAMC 2007).

Physicians are more likely to offer cessation information to sicker than to healthier patients, even though all patients who smoke can benefit from advice to quit (Houston et al. 2005). They also may be less likely to advise patients with less education and of ethnic minority status, thereby perpetuating disparities (Houston et al. 2005). Accustomed to writing prescriptions but not necessarily providing counseling, physicians might be more comfortable with pharmacotherapy. Indeed, smokers who try to quit use pharmacotherapy more often than behavioral counseling (Cokkinides et al. 2005). While the medicalization of smoking cessation services likely has encouraged more clinicians to discuss cessation, overemphasizing pharmacotherapy could distract from behavioral or psychosocial approaches that for many smokers are an important component of effective therapy (Fiore et al. 2008).

Clinicians other than physicians can also help smokers quit. For instance, the American Dental Hygienists' Association has an intervention program encouraging referrals to quit lines and other cessation resources (ADHA 2006). By providing both inpatient and outpatient services, mental health professionals could also encourage patients to quit smoking (Williams 2008). Even though mentally ill persons are more likely to smoke than are those without mental illness (Lasser et al. 2000), a recent study found that psychiatrists offered cessation counseling in only 12 percent of visits with patients who, they knew, smoked (Himelhoch and Daumit 2003). More work is needed to address the public health burden of tobacco dependence among the mentally ill and educate mental health providers about the importance of smoking cessation (Williams 2008; Ziedonis et al. 2005).

Smokers

Forty-three percent of the managed care plans in the Addressing Tobacco in Managed Care (ATMC) survey cited "lack of patient demand" as a barrier to providing cessation services (McPhillips-Tangum et al. 2006). In 2000, of all smokers who attempted to quit in the previous year, only 22 percent used any type of cessation treatment (counseling or pharmacotherapy) (Cokkinides et al. 2005). A recent article argued that creating consumer and market demand for these treatments is critical to increasing the delivery and impact of cessation services (Orleans 2007).

Smokers avoid cessation services for many reasons. They may not believe they are effective, or they may prefer to quit on their own.

Quitting smoking is difficult, unpleasant, and takes time and effort, and smokers differ in their readiness and motivation to quit (DiClemente et al. 1991). Some smokers might not believe that treatments are effective or safe (Bansal et al. 2004). Smokers with a lower socioeconomic status have higher smoking rates, are less likely to try to quit, and achieve lower abstinence rates when they do (Levy, Romano, and Mumford 2005). These smokers are likely to be more sensitive to price; hence they are less willing to pay co-insurance payments for cessation services, and they may consider smoking cessation to be discretionary (Warner 2006).

In addition, some smokers have co-morbid mental illness or substance abuse disorders that complicate their uptake of or compliance with cessation (Grant et al. 2004; Lasser et al. 2000). In fact, much of the high mortality of people with substance abuse disorders can be attributed to smoking (Hurt et al. 1996). Contrary to conventional wisdom in the mental health and substance abuse fields—which tend not to prioritize smoking cessation—smokers with mental illness who try to stop have only marginally lower quit rates than those without mental illness, and there is little evidence to suggest that smoking cessation interferes with substance abuse treatment (El-Guebaly et al. 2002; Lasser et al. 2000; Lemon, Friedmann, and Stein 2003). In fact, emerging data show that alcohol relapse rates may be lower if the patient also stops smoking (Grant et al. 2007).

Despite these reasons why smokers may be reluctant to use smoking cessation services, a majority of primary care patients have said they would participate in cessation programs if offered the opportunity (Fiore et al. 2004b). Studies have shown that high proportions of smokers would like their physicians to address smoking often (Stevens et al. 2005) and would be interested in participating in a smoking cessation treatment program (especially when it is free) (Fiore et al. 2004b). Free coverage of cessation services—and informing smokers about the effectiveness of treatments and of the existence of their coverage—could go a long way toward improving acceptance of treatment (McMenamin, Halpin, and Bellows 2006). Of course, this strategy will not reach the many uninsured smokers, including subpopulations with very high smoking rates (including the homeless and the mentally ill). Yet it is important to note that even homeless smokers can be motivated to use smoking cessation treatments to quit smoking (Okuyemi et al. 2006). Telephone quit lines, mass media campaigns, and the provision of cessation services

at safety net health centers and in homeless facilities would raise quit rates in these populations (Fiore et al. 2004a).

Government

Governments also encounter barriers to promoting smoking cessation. Tight state and federal budgets limit the potential to add new benefits or programs, especially those that government officials may not be convinced are effective or that lack a vocal constituency. Encouraging smoking cessation also has a financial downside for the federal government, as it would increase Social Security expenditures (Shoven, Sundberg, and Bunker 1989). Although the government might benefit from modest net savings in Medicare expenditures from reduced smoking (Warner, Hodgson, and Carroll 1999), any such savings would be dwarfed by the additional Social Security obligations.

Government can and does support some cessation efforts. Given the high prevalence of smoking among Medicaid recipients (Lethbridge-Cejku, Rose, and Vickerie 2006), Medicaid coverage of smoking cessation treatments is highly desirable. A recent report suggests that if all current Medicaid beneficiaries who smoke were to quit, Medicaid expenditures would be reduced, on average, by nearly 6 percent after five years (American Legacy Foundation 2007). Yet tobacco-dependence treatment is not a core Medicaid benefit in all states; in 2005, thirty-eight state Medicaid programs provided coverage for at least one PHS guideline-recommended tobacco-dependence treatment, but only seven covered all recommended medications and at least one type of counseling (Halpin et al. 2006). While the increases in voluntary state coverage in recent years are promising, quit rates among the poorest Americans would improve if Congress added cessation treatment as a core Medicaid benefit (Halpin, Bellows, and McMenamin 2006).

States can also provide cessation benefits for their employees. In 2003, twenty-nine of the forty-five states surveyed had insurance coverage for their employees for at least one treatment recommended by the PHS guideline (Burns, Bosworth, and Fiore 2004).

On the federal side, Medicare now covers limited smoking cessation counseling (up to a total of eight sessions for two quit attempts in one year) for beneficiaries with tobacco-related illnesses or those who take medications adversely affected by tobacco, but not for healthy smokers

simply wishing to quit. Medicare Part D covers physician-prescribed pharmacotherapy (CMS 2005). The U.S. Department of Veterans Affairs health care system supports cessation strategies through its policies, programs, and practice guidelines, serving about 5 million veterans (Isaacs, Schroeder, and Simon 2005).

Finally, in considering the role of governments in cessation, we should not overlook policies and programs that affect cessation while not directly involving the provision or coverage of treatment services. Some of these policies are related to treatment, the most notable example being the federal government's funding of research on behavioral and pharmaceutical interventions, cost-effectiveness studies, and demonstration projects of coverage initiatives (e.g., the Medicare Stop Smoking Program) (Arday et al. 2002). Other governmental policies may be highly effective in encouraging cessation, though without addressing treatment *per se*. The most important of these is an increase in the cigarette excise tax. The impact of taxation on cessation and on smokers' seeking professional help with quitting is discussed later.

Why Does the Gap Persist?

Systematic barriers to the promotion or use of smoking cessation services, apparent for all stakeholders, reveal broader contextual issues that might explain the gap between best practice and the status quo. Preventive services appear to have a marginal status compared with other health care interventions. Society places great value on saving the desperately ill and alleviating suffering (Hadorn 1991). Yet, this understandable emphasis accompanies an undervaluation of prevention, as prevention efforts are dramatically underfunded relative to their contributions to health (Foege 1983; McGinnis, Williams-Russo, and Knickman 2002). Moreover, therapeutic and preventive interventions are held to different standards. As Foege (1983) contended, surgical procedures are provided and reimbursed when deemed safe; pharmaceuticals must be proven safe and effective; yet many preventive interventions have to overcome a higher barrier—they must be safe, effective, and exhibit a positive cost-effectiveness (or even cost savings).

The emphasis on cost savings for mental health and substance abuse services, rather than their value to health and well-being, may suggest prejudice against the services and their users (Goldman 1999; Sturm

2001). Indeed, new evidence found that smokers are becoming increasingly socially marginalized (Christakis and Fowler 2008; Schroeder 2008). Negative attitudes toward tobacco users may well influence the provision of services. That is, tobacco use is viewed as a voluntary behavior of smokers who have abundant knowledge of its harm and therefore exhibit poor, even antisocial judgment (Frieden and Blakeman 2005). To many, smokers willfully perpetuate their own bad health and should be held personally responsible for quitting. The public holds higher levels of social stigma and blame, and exhibits less pity, for people with diseases perceived to be under their control (Wiener, Perry, and Magnusson 1988). This attitude discounts the addictive nature of tobacco, the fact that most smokers become addicted as teens, and the broader structural influences on smokers, including stress, unhealthy workplaces, and tobacco marketing.

Perhaps most important, most smokers (and their families) represent a segment of society with little voice in politics or active representation by advocacy groups (Schroeder 2007). As emphasized earlier, smokers today are disproportionately poor and disproportionately burdened by psychiatric illness. These groups are portrayed unfavorably and associated with negative stereotypes, which indicates they are unlikely to receive sympathetic policy attention (Schneider and Ingram 1993). Unlike women activists advocating for breast cancer research or gay activists seeking new HIV treatments in the 1980s, smokers are neither affluent nor politically sophisticated. In general, very few organized interest groups support health promotion interventions in the political arena (McGinnis, Williams-Russo, and Knickman 2002). In contrast, the tobacco industry is a great commercial power and wields that power to promote smoking both publicly and in the formerly smoke-filled rooms of legislators. In fact, the tobacco industry has often tried to prevent the implementation of policies to reduce the impact of smoking (Advocacy Institute 1998), recently even working to avert price increases for cigarettes in the U.S. military (Smith, Blackman, and Malone 2007).

Approaches to Improving the Use of Cessation Services

Since others have recently focused on the important role of health care systems in increasing the delivery of smoking cessation services (Curry

et al. 2006, 2008; Fiore, Keller, and Curry 2007), we direct our recommendations to the public policy realm. To be sure, state and local governments have made great progress in advancing policies to reduce smoking, such as establishing clean indoor air laws, raising cigarette taxes, and expanding Medicaid coverage for cessation services. Moreover, smoking cessation is receiving more policy attention, as evidenced at the federal level by the National Commission on Prevention Priorities, the U.S. Interagency Committee on Smoking and Health (ICSH) Subcommittee on Cessation (Fiore et al. 2004a), the National Institutes of Health Conference Statement on Tobacco Use (NIH 2006), the recent Surgeon General's reports (U.S. DHHS 2004, 2006), and the Institute of Medicine report (IOM 2007). This recent flurry of national and scholarly attention to smoking cessation is very encouraging. Still, there is room for improvement. Given the continuing magnitude of the problem, the federal government should promote cessation, relying on visible political, cultural, and public health leaders for support; tracking quit rates and progress; and leading in the creation of an agenda for other stakeholders.

For smoking cessation to achieve such a position on the policy agenda, however, smokers must develop more vocal support. Even though smokers have little political power, diverse interest groups that represent the disenfranchised might mobilize to increase access and the availability of smoking cessation treatments. For instance, behavioral and mental health groups, advocacy groups for the homeless, and groups who advocate for minority rights and minority health all should consider smoking an issue central to their missions. Such a consensus has begun to form with the recent creation of the National Mental Health Partnership for Wellness and Smoking Cessation (National Mental Health Partnership 2007), but this effort is in its infancy and requires continued support from diverse groups to grow strong.

The existence of the ICSH Subcommittee on Cessation, initially convened in 2002, suggests that nonpartisan political attention at the federal level to smoking cessation has potential. This group recommended six federal initiatives to promote cessation: (1) set up a national quit line, (2) develop a media campaign to encourage cessation, (3) include cessation benefits in all federally funded insurance plans, (4) create a research infrastructure to improve cessation rates, (5) develop a training agenda to educate clinicians, and (6) create a smokers' health fund to increase

cessation activities through a new \$2 per pack federal excise tax on cigarettes (Fiore et al. 2004a). Each of these recommendations warrants attention.

In particular, the excise tax recommendation could make a substantial contribution to cessation, which is why the Institute of Medicine named higher tobacco excise taxes as one of its main recommendations (IOM 2007). Higher cigarette prices would encourage smokers to quit. Research indicates that for every 10 percent increase in cigarette price, the demand for cigarettes declines by 3 to 4 percent, with approximately half the decline reflecting decisions to quit smoking (and the other half reflecting continuing smokers' reduction of their daily cigarette consumption) (Chaloupka et al. 2000). As tax-induced price increases raise the desire of smokers to quit, they also expand the demand for cessation services. In addition, as the ICSH subcommittee recommended, revenues from such a tax increase could support other cessation efforts, including providing treatments to poor smokers (Fiore et al. 2004a). We strongly endorse directing a significant portion of new tobacco tax revenues to assisting poor smokers to quit, given that the burden of increased taxation will fall especially heavily on the poor (who will also derive the greatest benefits from cessation, as they are more likely to respond to higher prices by quitting or reducing daily cigarette consumption).

Such an increase in the excise tax on cigarettes may be a political possibility, as reflected in the recent congressional debate on the expansion of the State Children's Health Insurance Program (SCHIP), linked to an increase in the cigarette tax of 61 cents, from 39 cents to \$1 per pack. This political mobilization suggests that raising the excise tax is a credible policy option for many politicians. Indeed, a \$2 increase in the excise tax (as recommended by the ICSH) would fund such a SCHIP expansion, with the remainder going a long way toward helping impoverished smokers quit. While passing such an excise tax has not yet received sufficient political support, in a different political environment it could well have majority support. Surveys find that the public is largely in favor of raising tobacco excise taxes, especially when their proceeds are earmarked for tobacco control or other health-related purposes (Hamilton, Biener, and Rodger 2005).

If federal legislators do take seriously the notion of a large increase in the federal cigarette excise tax, they will have to address a negative "side effect": precisely because a sizable increase in the federal tax will reduce

smoking, state governments will lose revenues from their own cigarette taxes. Indeed, state governors and their representatives in Congress have opposed federal cigarette tax increases for this reason. The solution is either encouraging states to increase their own tax rates simultaneously or the federal legislation's earmarking a portion of revenues from a new federal tax to replenish the states' coffers.

In addition, more government-funded research is needed on how to improve the long-term effectiveness of cessation interventions, especially identifying which approaches and products work best for diverse types of smokers, as the NIH State-of-the-Science Conference stated as one of its key priorities (NIH 2006). In particular, research should attend to the social and biological factors associated with higher smoking rates for people with mental illness and substance abuse disorders and should devise effective cessation strategies for this population. Providers of mental health services have tended not to make smoking cessation a top priority for their patients, perhaps because people with mental illness commonly smoke to alleviate their anxiety or distress, reduce boredom, and improve concentration (Ziedonis et al. 2005). Yet these potential benefits of smoking are overshadowed by the immense disease burden associated with the behavior. More research funds also should be devoted to finding effective cessation strategies for uninsured smokers who have little access to covered treatments.

State and local governments can and should continue to push legislation on smoking cessation. State governments can continue to wield their purchasing power, adding smoking cessation as a covered benefit for both Medicaid beneficiaries and state employees. They can use their legislative power to mandate cessation coverage for all health plans in the state, or they can influence state insurance commissioners to require coverage as a condition of licensing.

Finally, federal and state governments should continue striving to create an environment that encourages smokers to quit—through smoke-free air laws, tobacco taxes, aggressive media social marketing campaigns, and new FDA regulation of tobacco products (a prospect that looks possible in a new political environment) (see also IOM 2007, which also argues for continuing aggressive public policy initiatives in addition to changing the regulatory environment). A new mass media campaign, *Become an Ex* (www.becomeanex.com), a partnership across multiple states, nonprofit organizations, companies, and foundations, has great promise. These actions would send a strong message to all

stakeholders that the government is serious about its responsibility to help reduce the public health burden of smoking. With that kind of leadership—creating a supportive environment for quitting—an increase in consumer, employer, and health plan demand for cessation services should follow (Orleans 2007).

Conclusion

The barriers to increasing the use of smoking cessation services are considerable, and reconciling the tensions across stakeholders will not be easy. Yet increasing smoking cessation should be viewed as a great opportunity for yet-unrealized policies to improve the population's health (Schroeder 2007). Public policy efforts should be taken to assume greater social responsibility for smoking cessation, including more aggressive leadership at the state and federal levels, as well as by advocacy, public health, and clinician organizations. Reducing smoking in the United States was one of the great achievements of public health in the twentieth century (CDC 1999; Eriksen et al. 2007). With some effort, as we have outlined here, reducing smoking could stand out as a hallmark achievement of the twenty-first century as well.

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