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Commentary on Willemsen *et al.* Population impact of reimbursement for smoking cessation: a natural experiment in the Netherlands

Cigarette smoking remains a leading cause of preventable morbidity and mortality, claiming more than five million lives annually[1;2] and with enormous costs worldwide. There have been substantial gains in tobacco control efforts over the past few decades, as exemplified by the WHO Tobacco Free Initiative and Framework Convention on Tobacco Control, amongst innumerable international, national, and regional efforts, but there is a considerably long road yet to travel[2]. One aspect of this effort involves reducing demand for tobacco, part of which means increasing demand for effective treatment[3–5]. An ongoing dialogue about possible determinants of demand seems essential. For this reason, the intention of this commentary is to highlight a few sources of demand for treatment suggested by the study by Willemsen and colleagues[6] and elsewhere.

Lack of health insurance coverage is a well-known barrier that limits demand for treatment, and moving to coverage generally results in a surge in treatment initiation[7]. As demonstrated in Willemsen et al.[6], ensured coverage explicitly lowers the bar on costs to drive demand[8]. Importantly, this occurs against a backdrop of individual motivation to quit and decision-making about when (and if) to seek treatment. Some smokers motivated to quit may postpone seeking treatment opting to wait to see if it becomes an insured benefit, potentially producing pent-up demand. For others, treatment coverage itself may drive readiness to quit and increase demand. For example, the observation that decision-makers find quitting smoking and increasing treatment access sufficiently compelling as to devote limited resources to making treatment a covered benefit, possibly postponing or obviating coverage of other pressing health care issues, may heightened public perception of the priority of quitting, drive demand for treatment, and normalize nonsmoking. A similar process likely occurs when smaller entities (employers, healthcare institutions, private insurance companies) make treatment a priority through incentives or other mechanisms. Clearly, efforts targeting cost barriers address a fundamental need.

Expanding treatment options may also drive demand. In Willemsen et al.[7], prior to 2011, the only treatment widely available at no cost seemingly was the National Quitline. In 2011, not only did smoking treatment become a covered benefit, but treatment options were also expanded to include group, face-to-face, and telephone counseling, as well as pharmacotherapy. This underscores the importance of accounting for individual preferences and needs in health care decisions. However, also important are mass media campaigns that make the public aware of accessible, low-cost interventions[9,10]. It is notable that the Dutch study included essentially two campaigns, one coinciding with the start of the reimbursed care program, and another informing the public of its imminent termination[7]. The combination of universal coverage plus wide-reaching communication of treatment options to stakeholders seems to be an essential key to effective broad-based interventions[11].

Policy decisions and political will are also important factors in individual decisions around smoking cessation. For example, in countries that have lists of essential health care, updates occur in cycles. Decision-making about healthcare utilization at the consumer level therefore occurs in the context of shifts in covered benefits that are out of individuals' control. With statutory coverage, while the cyclical nature of coverage may be predictable, less predictable are the contents of future benefits. Much research examines insurance coverage as a static process and utilization during periods without or with coverage and especially in specific populations, but how people behave while anticipating coverage loss is unclear. One possibility is that an uptick in treatment initiation occurs as the end of coverage is anticipated, perhaps indicating a stock piling effect, although the conditions in which this might occur are uncertain[12]. Cyclical and unpredictable aspects of coverage may increase, or may decrease, demand for treatment. Similar processes may occur in private health insurance systems with shifts in coverage not controlled by the consumer. Nonetheless, the reality of a seemingly large pool of demand not being met underscores again the importance of minimizing the need for individuals to postpone seeking smoking treatment, an overwhelmingly cost-effective endeavor[13;14], on the basis of cost alone.

Overall, the study by Willemsen et al.[7] presents the opportunity for further discussion about how to spend limited resources for smoking cessation in ways that will have the greatest public health impact. It does not definitively answer questions about whether increasing benefits for smoking cessation alone results in greater cessation. However, the study spotlights issues related to demand, and punctuates the need to explore further the dimensions of population-based interventions so that we might maximize benefits. Perhaps notably, the 2013 Dutch basic insurance plan re-enlists smoking cessation treatment, presumably in response to demand.

References

1. World Health Organization. WHO global report: mortality attributable to tobacco. Switzerland: World Health Organization; 2012.
2. Eriksen, M.; Mackay, J.; Ross, H. The Tobacco Atlas. Fourth. Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation; 2012. Also available at www.TobaccoAtlas.org
3. World Health Organization. WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2003. (updated reprints 2004, 2005) (http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf, accessed 21 March 2008)
4. World Health Organization. WHO report on the global tobacco epidemic, 2008: the MPOWER package. Geneva: World Health Organization; 2008. http://www.who.int/tobacco/mpower/en/index.html, accessed 30 November 2012
5. Orleans T, Abrams DB, Mabry PL. Increasing Tobacco Cessation in America. A Consumer Demand Perspective. Am J Prev Med. 2010; 38(3):A1–A6.
6. Willemsen MC, Segaar D, van Schayck CP. Population impact of reimbursement for smoking cessation: A natural experiment in the Netherlands. Addiction. this issue.
7. West R, DiMarino ME, Gitchell J, McNeill A. Impact of UK policy initiatives on use of medicines to aid smoking cessation. Tob Control. 2005; 14:166–71. [PubMed: 15923466]
8. Backinger CL, Thornton-Bullock A, Miner C, Orleans CT, Siener K, DiClemente CC, Phillips TM, Rowden JN, Arkin E. Building consumer demand for tobacco-cessation products and services, The National Tobacco Cessation Collaborative's Consumer Demand Roundtable. Am J Prev Med. 2010; 28(3S):S207–S311.

9. Willemsen SC, Simons C, Zeeman G. Impact of the new EU health warnings on the Dutch quit line. Tob Control. 2002; 11:381–2. [PubMed: 12432169]

10. Centers for Disease Control and Prevention. Increases in Quitline calls and smoking cessation website visitors during a national tobacco education campaign – March 19–June 10, 2012. MMWR Morb Mortal Wkly Rep. 2012; 61(34):667–670. [PubMed: 22932300]

11. Hopkins DP, Briss PA, Ricard CJ, Husten CG, Carande-Kulis VG, Fielding JE, Alao MO, McKenna JW, Sharp DJ, Harris JR, Woolery TA, Harris KW, The Task Force on Community Preventive Services. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. Am J Prev Med. 2001; 20(2S):16–66. DOI: 10.1016/S0749-3797(00)00297-X [PubMed: 11173215]

12. Gross, T. Using insurance before you lose it: Health care consumption at the end of coverage. Mailman School of public health, Columbia University; 2010. Downloaded 29 November 2012 http://www.columbia.edu/~tg2370/bte.pdf

13. Cromwell J, Bartosch WJ, Fiore MC, Hasselblad V, Baker T. Cost-effectiveness of the clinical practice recommendations in the AHCPR guideline for smoking cessation. JAMA. 1997; 278(21): 1759–66. DOI: 10.1001/jama.278.21.1759 [PubMed: 9388153]

14. Chevreul K, Cadier B, Durand-Zaleski I, Chan E, Thomas D. Cost-effectiveness of full coverage of the medical management of smoking cessation in France. Tob Control.