



Financing Smoking Cessation Treatment Through National Health Systems May Improve Success

To the Editor: There is currently no doubt regarding the cost-effectiveness of the treatments available to aid smoking cessation—treatments that should be used by all smokers who wish to quit (evidence Grade A).¹ It is incomprehensible that in a national health system like that of Spain, which is based on equity, quality, solidarity, and cohesion and has a range of services whose objective is to guarantee the basic common conditions for comprehensive, ongoing healthcare at the appropriate level, does not finance smoking cessation treatment, considering that tobacco use disorder is recognized as a chronic disease. The question is, therefore, whether we have any scientific evidence that financing smoking cessation treatment through national health systems improves final abstinence rates.

Some recent studies have evaluated this aspect of smoking cessation treatment. In a metaanalysis aimed at assessing the effect on final abstinence of treatment financed through a national health system, Kaper et al² found evidence that full and direct financing can increase smokers' abstinence rates, at a relatively low cost, compared to partial financing or no financing at all. The same authors³ carried out a randomized controlled trial in which smokers were assigned to a treatment group offered reimbursement for

treatment (replacement therapy, bupropion, and behavioral psychotherapy) or a control group who were not reimbursed. The trial found that financing smoking cessation treatment appeared to be effective based on increased use and 6-month abstinence rates that were twice as high as high. Further, rigorous studies are required to confirm these findings, however. West et al⁴ analyzed the impact of healthcare measures that facilitated smokers' access to pharmacological smoking cessation treatment and included reimbursement of the cost of the medication by the British National Health Service and sale of the medication in outside pharmacies. The authors found that refunding the cost of the replacement therapy and of the bupropion increased their use to twice previous rates (from 8%-9% in 1999 to 17% in 2002). This could have a considerable impact on public health. Petersen et al⁵ carried out a study to evaluate whether different levels of services to aid smoking cessation provided to pregnant women influenced cessation rates during and after pregnancy. The different levels were full service (including pharmacological and psychological treatment), partial service (pharmacological or psychological treatment), and no service. The authors found that high levels of healthcare coverage were associated with improved abstinence rates during pregnancy and with maintaining abstinence after giving birth. The likelihood of stopping smoking was 1.6 times greater both during and after pregnancy. Finally, Cummings et al⁶ evaluated the effectiveness of a program that included providing free replacement therapy to a group of smokers. The authors observed higher final abstinence rates in these smokers than in those of the control group and thus concluded that providing medication to aid smoking cessation is cost-effective because it increases the number of smokers who try to stop smoking and who succeed.

There is, therefore, scientific evidence currently available that shows that financing treatment for tobacco use disorder could increase abstinence rates. National studies should be designed to confirm the data reviewed here and to make the health authorities aware that financing smoking cessation treatment may improve success.

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