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*Visies op Financiering van
Ondersteuning bij Stoppen
met roken (Perceptions on a
Reimbursement Scheme for
Quitting Smoking Support)*

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*Prepared for the
Dutch Health Care Insurance Board*

RAND Europe

The research described in this report was prepared for the Dutch Health Care Insurance Board.

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Published 2004 by the RAND Corporation
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Executive summary

In the Netherlands, one out of three people smokes. Amongst teenagers the percentage is even higher (44%). Smoking is a lifestyle factor with serious health consequences. A recent Dutch study established that between 1950 and 1999 about 13% of all deaths could be attributed to smoking. On average Dutch smokers live 5 years shorter than non-smokers. This makes smoking the largest avoidable cause of death in the Netherlands. The term avoidable should however be nuanced as smoking is a serious addiction and many smokers have trouble quitting even though they are motivated to do so. Almost 20% of all health costs for men and about 10% of health costs for women can be attributed to smoking related illnesses and treatments. Smoking thus results in substantial health and financial costs.¹ It is therefore important to decrease the number of smokers through either prevention or increasing the number of smokers who stop permanently.

Initiatives aimed at helping smokers to quit mostly focus on providing information on how to stop and where to get help. Most smokers stop without seeking help, even though scientific evidence shows that getting support – for example nicotine replacement medication or counselling – increases the success rate considerably. The Dutch Ministry of Health is considering implementing a reimbursement scheme to support smokers financially when they attempt to quit smoking and asked the Dutch Health Care Insurance Board, or CVZ for its equivalent in Dutch, to investigate the options and the costs regarding such a scheme. The results of an earlier CVZ-study on this issue were used in the design of the current study. This study gave an overview of the scientific evidence on different types of quitting smoking support available in the Netherlands, but did not involve the smoker and his/her view on the matter. The latter was the focus of our study. The main research question of the current study was:

How would a reimbursement scheme aimed at supporting smokers need to be set up, considering the needs and wishes of the future users of this scheme, the smokers?

This question was rephrased into a set of more concrete sub questions regarding:

- Adequacy of information provision on quitting smoking support;
- Types of quitting smoking support to be included in the reimbursement scheme;
- Financial implementation of the reimbursement scheme;
- Acceptability of certain restrictions on eligibility for reimbursement;

- Ways in which reimbursement could best be given; and
- Willingness to participate in an evaluation study as condition for the scheme.

The current study was aimed at gaining an insight in the perceptions, ideas and needs that smokers have regarding a reimbursement scheme for quitting smoking support. A tested method to collect such information is through focus groups. When using more or less homogeneous focus groups it is possible to establish the degree of consensus on a given subject within a group. By organising a number of focus groups it is possible to establish the similarities and differences between groups. In this study reaching consensus within or between groups was not the issue, but rather establishing the range of opinions, needs and ideas that smokers from different backgrounds have regarding this particular reimbursement scheme. The protocol designed for the focus groups was used as a checklist, discussion was encouraged and questions were introduced as the opportunity arose from the interaction within the groups.

In consultation with CVZ, the perceptions of three important target groups of quitting smoking policy were included in the study, namely:

1. people from lower socio-economic classes;
2. people from ethnic minority groups; and
3. people suffering from medical conditions aggravated by smoking.

The respondents were recruited by registered agencies specialised in recruiting participants for focus groups. All focus groups consisted of 11 or 12 respondents, with spread in gender, age, and employment status. Participants were selected on the basis of their smoking history and their interest in quitting smoking. For the focus groups, we selected people that considered to quit smoking, that tried to quit smoking but were not successful, and people that recently stopped smoking. Smokers that are not considering to quit were not selected. The group with people from ethnic minority groups consisted mostly of respondents from the Netherlands Antilles, Surinam, Turkey, and Morocco. All spoke Dutch well. The group with people from lower socio-economic classes mainly consisted of men and women with relatively low education levels. Most of them were working, but had a relatively low income. The group with people suffering from medical conditions that require them to quit smoking consisted of people with coronary and vascular conditions, diabetes or long conditions. The focus groups were organised in the early evenings in three different large or medium-sized cities (Amsterdam, Rotterdam and Amersfoort). At the time of the focus groups, most respondents (31 or 91%) were smoking.

¹ ZonMw (2003) PrePost, Jaargang 5, Nr .13, p.4.

Smoking and how to quit are subjects of great interest to the respondents. In all the groups the discussion was lively, with active participation of all respondents. Almost all participants indicated they had had an interesting evening and wished to be informed of the results of the study. The discussions resulted in the following conclusions and recommendations:

INFORMATION PROVISION

In general, provision of information on how to quit smoking is well

organised: The respondents indicate that they have little trouble finding information about methods and help, they were well aware of most of the options available in the Netherlands. The group with people from lower socio-economic classes was in favour of setting up a central information point, where they would be able to get information and personal advice.

A number of avenues for dissemination of information can be improved: Some respondents indicated that information points (e.g. Postbus 51) and health insurers are at times difficult to reach and that the information they get is not always what they expect. Also only very few were aware of the role that an addiction expert can play, meaning this specific issue needs improvement.

Health insurers are the appropriate party to disseminate information about the reimbursement scheme

QUITTING SMOKING SUPPORT

Information about how to quit smoking must be person specific: Many respondents indicated that although information is readily available, it often is of a very general nature and thus not motivating. The participants believed that different people might benefit from different methods, and indicated that quitting smoking support should be more person specific in order to increase its effectiveness. The respondents suggested that more research might be needed to gain an insight in which methods are beneficial for which types of person.

More study is needed regarding the role of the general practitioner in this issue: A general practitioner can play an important role in supporting smokers who are attempting to stop. However, not many respondents had considered asking their general practitioner for advice. A few respondents indicated that they felt the quality

of care from their general practitioner with regard to quitting to smoke was lower than could be expected.

It is important to take account of the social environment of the smoker: In the focus groups it was often mentioned that it is extra difficult to abstain from smoking when family and friends continue smoking. This needs to be taken into account when designing new approaches for quitting smoking support.

It is important to provide smokers trying to stop with information on a healthy diet and weight: In several discussions respondents mentioned that they would appreciate information on and support with trying not to gain weight after stopping. Slimming and information from dieticians should possibly be added to quitting smoking support.

IMPLEMENTATION OF THE REIMBURSEMENT SCHEME

Introducing a reimbursement scheme for quitting smoking support was generally believed to be a good idea: Most respondents were in favour of financial support, in particular because this would stimulate people to try to quit. This will eventually lead to a reduction in the number of smokers.

Establishing the reimbursement scheme means recognition of smoking as an addiction: The respondents emphasised several times that smoking is a 'real' addiction but is not being recognised as such. Recognition would lead to a more equal treatment of all addictions.

The implementation of the scheme needs careful considerations to ensure low threshold for usage together with little opportunity for fraud: How to design a system that is available for all smokers alike, but without resulting in misuse by less motivated smokers taking advantage of the system? Some respondents believed it would be a good idea to ask participants to the scheme to do a motivation test before considering reimbursement.

Total reimbursement is not considered optimal: The majority of the respondents believed that smokers wishing to quit should pay a part of the cost. The reasoning for this was that this will discourage 'free riding' participants not seriously motivated.

A clear maximum to the reimbursement is necessary, but there is discussion on what or how high this maximum should be: To keep control of costs, all

respondents agree that a maximum reimbursement is necessary. However, there is no consensus on how to implement this. The options discussed range from a maximum on the total amount or the total number of attempts. The latter is subject of heated discussion. On the one hand respondents think that reimbursing only one attempt will select only really motivated smokers. On the other hand it is known that most smokers need multiple attempts to succeed.

A reimbursement scheme with increasing individual contributions seems to be preferred: The previous discussions lead to the conclusion that a reimbursement scheme would need to combine the option of multiple attempts with decreasing reimbursement – and thus increasing individual contribution. Such a system has a low threshold, thus encouraging people to seek help, while the chance of misuse is decreased because people are asked to make a financial contribution. It also encourages continued abstinence, because the individual's contribution to each subsequent attempt will increase.

The reimbursement scheme needs to be available for all smokers: If sufficiently motivated, all smokers should be eligible to make use of the reimbursement scheme. If this is not possible for financial reasons, smokers with medical problems aggravated by smoking should get preference. A different suggestion made on various occasions is to make the reimbursement scheme income dependent.

CONDITIONS FOR REIMBURSEMENT

All methods to support attempts at stopping need to be included: As different people benefit from different methods, reimbursing only specific methods is unacceptable to most participants. Two of the three groups did not object to counselling as a necessary condition for reimbursement. In the group with people from ethnic minority groups intrinsic motivation was seen as the dominant success factor in an effort to quit smoking, and therefore they felt that counselling would not seriously increase the rate of success and would not be an acceptable condition.

It is acceptable to make reimbursement conditional to participation in an evaluation study: All groups agreed that participation in an evaluation study to determine the effects of the reimbursement scheme would not be a reason to decline the opportunity of reimbursement. On the contrary, a number of respondents thought this would be desirable. The evaluation study was seen as a form of after care and a way to motivate participants to persevere.