Statement by

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TESTIMONY OF
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Mr. Chairman and members of the Committee, my name is Michael C. Fiore. I am a physician trained in internal medicine and preventive medicine and am an Associate Professor of Medicine and Director for the Center for Tobacco Research and Intervention at the University of Wisconsin Medical School in Madison, Wisconsin. Recently, I served as Chair of the Agency of Health Care Policy and Research (AHCPR) *Clinical Practice Guideline Panel on Smoking Cessation.* This panel of smoking cessation experts reviewed the last 20 years of research on nicotine addiction and, based on those findings, provided practicing physicians and other clinicians with evidence-based recommendations regarding what will help smokers, young and old, to quit successfully.

I would like to commend the Senate for addressing the enormous health and economic burden that results from nicotine addiction. As a result of your actions, I believe this extraordinary burden on our society may be eliminated or greatly reduced.

Mr. Chairman, your committee is investigating ways to prevent another generation of young Americans from becoming addicted to tobacco. I am convinced that one of the most effective ways to achieve this goal is to focus on the 50 million Americans currently addicted to tobacco. In my view, we have not sufficiently addressed providing effective clinical treatments to those Americans who already suffer the health and economic costs of nicotine addiction. In essence my remarks echo those of Dr. Koop, "Don't Forget the Smokers."

There are a number of reasons why helping adults to quit is one of the most effective means of helping children. First, children of parents who smoke have twice the risk of becoming smokers that children of nonsmokers have. By helping parents to quit, the risk of their children becoming smokers is reduced. Children also benefit from reduced exposure to environmental tobacco smoke in the home. Children exposed to ETS in the home have increased risk of asthma and other lung diseases. During the initial years of a comprehensive legislative settlement, no other initiative offers the nation a more cost-effective or measurable public health benefit.

I would like to make three points this afternoon- first, most smokers want to quit; second, effective clinical treatments exist; and, third, these effective treatments are underutilized by physicians and smokers alike.

In 1998, most smokers want to quit. The United States Office on Smoking and Health, Centers for Disease Control and Prevention, has documented the statistics regarding quitting in America. Among the approximately 50 million current smokers, more than 70% have already tried unsuccessfully to quit and about one-third, almost 20 million, try to quit *each year.*

Sadly, only about 7% of those who try to quit succeed. These tragic findings -- most smokers wanting to quit while few beat nicotine addiction -- have motivated me to devote my career to identifying effective clinical treatments for nicotine addiction.

In my view, one of the reasons that smokers are not successful is that they have not been offered effective treatments such as those identified by the AHCPR Smoking Cessation Clinical Practice Guideline. In fact, national statistics report that up to 90% of those trying to quit do so on their own, usually taking a

"cold-turkey" approach. This contributes to their low success rates. Our recent research shows that about 70% of smokers will enter cessation programs if they are readily available in their health care setting. I want to be clear in acknowledging that clinical treatment is only part of the solution. Many of my public health colleagues have identified a variety of strategies necessary for a comprehensive approach to reducing tobacco addiction in our society. Appropriately, many of these strategies focus on preventing children and adolescents from ever becoming addicted. But, I am struck by the underemphasis on helping those already addicted to nicotine to stop - and this includes both adolescents and adults, particularly those who are poor and less educated -- groups experiencing some of the highest rates of smoking in our society. This is particularly important for women and girls who are experiencing some of the greatest increases in smoking rates. Today, more women are killed by lung cancer caused by smoking than by breast cancer.

This brings me to my second point -- new and effective clinical treatments exist and these would have an enormous impact if they could achieve greater implementation. As part of the AHCPR Smoking Cessation Clinical Practice Guideline process, we reviewed all of the scientific research on quitting -- what helps and what doesn't. The findings were quite striking. First, clinicians have a powerful impact in motivating their patients who smoke to try to quit. Second, as little as three minutes of a physician's time can about double the rate of quitting among his/her patients and the more time spent with smokers, the higher their quit rates. Third, one simple, essentially no-cost, intervention -- expanding the vital signs to include smoking status -- markedly enhances the rate at which physicians then go on to help their patients quit. Fourth, every patient who wants to quit should be offered effective treatments including social support, simple advice on how to quit successfully, and pharmacotherapies that have been demonstrated to increase the likelihood that smoker will beat tobacco addiction -- nicotine replacement therapies (the patch, gum, nasal spray and inhaler) as well as the new non-nicotine medicine, Zyban.

But why haven't effective cessation programs become an intrinsic part of every smoker's health care in the U.S.? One reason is that both physicians and patients are often discouraged by a paradox of the current reimbursement system -- in virtually all instances, insurers pay for the very expensive outcomes of nicotine addiction - whether it be a heart attack or cancer or stroke -- but, in only about 50% of cases, do they pay for the less expensive smoking cessation counseling and/or medications that would prevent those illnesses. Reimbursement must be made available for smoking cessation treatment just as it is for other preventive interventions such as mammography screening. In fact, we recently completed a cost-benefit analysis of implementing the AHCPR Smoking Cessation Guideline nationwide and found that smoking cessation was the most cost effect adult prevention intervention -- one-twentieth the cost of mammography screening. These results were reported in December, 1997 in the Journal of the American Medical Association.

Some have said, "why provide smokers with treatment - nothing works!" This statement is not supported by the current research findings. Moreover, it appears to be based on a "magic bullet" standard -- a demand that smoking cessation treatments guarantee a 50%, or 70%, or 90% successful quit rate.

This demand reflects a lack of understanding of the powerful nature of nicotine addiction. When I talk to my physician colleagues, I urge them to change the way they think about nicotine addiction - to stop viewing it as an acute illness like a strep throat that can be cured with a brief course of penicillin. Rather, I urge them to think about it for what it is - a chronic disease similar to hypertension, or hyperlipidemia, or diabetes with periods of relapse and remission as part of the disease. This requires primary care physicians to treat patients over time and frequently, try a series of interventions.

While very similar to other chronic diseases, nicotine addiction differs in one important respect -- three to five minutes of a physician's time combined with a two to three month course of nicotine replacement therapy or Zyban can lead 15% to 30% of patients each year into long term remission from tobacco.

There is not another chronic disease where physicians can have such a powerful impact with such a modest investment.

Think about the potential public health impact if clinicians nationwide provided the brief, effective treatments outlined in the AHCPR Guidelines. The rates of quitting among those who try would increase from the background, "cold-turkey" rate of 7% to at least 15% each year. This would result in more than *one million* additional ex-smokers per year -- ex-smokers who are healthier, who are more productive citizens, and who utilize fewer health care resources. Moreover, the children of those ex-smokers are less likely themselves to become addicted to tobacco. Having a parent who smokes increases children's risk of smoking for a variety of reasons. For instance, one simple reason is that cigarettes become much more available to the child. Second, powerful modeling influences equate smoking with maturity and adulthood. Third, it makes smoking appear safe because of its familiarity. For all of these reasons, and more, increasing smoking cessation rates among adults may be the best single way to help kids.

The final point I would like to emphasize is that these effective treatments -- both counseling and medications -- are terribly underutilized. While 70% of smokers see a physician each year, only about half are urged to quit by their clinician and less than 20% are provided with specific assistance -- counseling and medications -- that can increase the likelihood they will successfully quit.

What can be done? I would suggest a number of specific steps:

1) Include as part of any comprehensive tobacco legislation sufficient resources to treat the majority of American smokers who want to quit. Since smokers will pay for the settlement, shouldn't we offer them effective treatments to help them quit?
2) Establish an evidence-based Guideline, such as the AHCPR Guideline, updated with the new FDA-approved medications, as the standard of care for reimbursable smoking cessation treatment.
3) Train clinicians to provide effective smoking cessation treatment.
4) Regularly update the AHCPR Smoking Cessation Guideline to provide clinicians with the most current, effective treatments. Include the new FDA-approved medications in these updates.
5) Designate research dollars to better understand the basic science of nicotine addiction as well as applied research to identify effective treatments to help people quit.
6) Ensure that managed care organizations and other insurers take their appropriate role as partners in this effort including the provision of smoking cessation treatment (both counseling and pharmacotherapy) as a covered service for patients who smoke.

I am convinced that we now have the potential to improve the public health in a powerful way -- to eliminate nicotine addiction and its devastating burden of illness, death and economic cost from our society. In my view, we will only achieve this goal if we bring to focus more of our attention, more of our resources, on the 50 million adult Americans addicted to nicotine. By aiding these individuals to quit, we can take the most effective steps available to prevent our young people from ever becoming addicted to this dangerous drug.
Thank you very much.