Pharmacoeconomics of COPD and Smoking Cessation

To the Editor:

In the November issue of CHEST, Hilleman et al1 published valuable information on the direct financial costs of providing care for patients with COPD. Although the authors provide the valuable information that the annual health-care cost of stage III COPD is much higher ($10,812) than stage I COPD ($1,681), and itemize direct costs, there is important information in their article that goes without comment.

For example, although 26% of patients with stage I COPD are current smokers, there is no mention of costs for nicotine replacement, bupropion, or smoking-cessation counseling. Presumably, the data accurately reflect the fact that COPD patients were not helped with smoking-cessation interventions proven effective in prospective randomized clinical trials. This is not surprising given the current schizophrenic state of the art.

Although the National Institutes of Health, Agency for Healthcare Policy and Research guidelines clearly mandate that all smokers should have nicotine replacement or bupropion prescribed, neither Medicare, nor Medicaid, nor private insurers pay for such treatment.2 The data of Hilleman et al1 suggest that this is a costly frugality. Spending $250 to $500 for nicotine replacement and/or bupropion in stage I COPD patients might reasonably be expected to achieve smoking cessation in 30 to 40%. We know from the results of the Lung Health Study that decrements in pulmonary function parallel those in nonsmokers following smoking cessation.3 It is therefore possible that spending a few dollars on smoking cessation in early stage COPD may prevent or delay progression to advanced COPD, with enormous potential cost savings.

It is time to quit paying “lip service” to preventive medicine, and to provide funding for effective smoking-cessation interventions that will prevent morbidity, mortality, and expense secondary to COPD, cardiovascular disease, neoplasms, and other diseases caused by tobacco products. The money to pay for these treatments is already available in the > $280 billion Tobacco Master Settlement Agreement, the lion’s share of which is now allocated by politicians to such mundane purposes as paving the sidewalks of Los Angeles. More financing can be obtained through a United States Department of Justice lawsuit against the tobacco industry to recover > $22 billion annual Medicare costs attributable to diseases caused by tobacco products.3

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To the Editor:

We wholeheartedly agree with the recommendations offered by Dr. Grannis. Smoking cessation is clearly a cost-effective approach to reducing the medical consequences and costs of COPD as well as a host of other disease states. Smoking-cessation efforts are underutilized not only in patients with COPD but in other high-risk patient groups, such as those with myocardial infarction.1 Following Agency for Health Care Policy and Research recommendations to fund smoking-cessation treatment programs and reimbursing providers who offer smoking-cessation treatments should go a long way to stimulate more widespread use of these treatments.

Specific to our study, we clearly were not able to document what percentage of patients had treatment for smoking cessation and, hence, could not identify the costs or cost-effectiveness of such interventions. The most commonly used forms of nicotine replacement therapy (patch and gum) are available over the counter, which limited our ability to capture utilization rates for these products. In addition, bupropion was not generally used for smoking cessation until 1997–1998. Our data collection period extended from 1993-1994 through 1997-1998. This may be the reason we were unable to document use of this product.

We concur with Dr. Grannis that a significant percentage of the tobacco settlement dollars be used to cover the medical expenses of patients suffering from smoking-related illnesses and for the implementation of both preventive treatment and smoking-cessation interventions.

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