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Cessation coverage in Argentina: A qualitative study about its barriers and facilitating factors

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Summary
Objective: To identify barriers and facilitating factors for the inclusion of tobacco cessation treatment coverage in the Argentine health system and to outline priority health policies for the development of smoking cessation programs.
Methods: A qualitative methodology was used based on in-depth interviews conducted with key informants from the State, NGOs and the health insurance sector.
Results: Nine barriers were identified: tobacco consumption is not appreciated as an addiction or illness; lack of a culture of prevention in the health system; lack of agreement on the relevance of coverage in all clinical cases; mistrust about policy-making decisions made under pressure from various lobbies; lack of agreement about the importance of the different components of cessation; fear of overloading the health system with additional expenses; prioritization of other tobacco control interventions as being more effective; health professionals not completely trained to deliver cessation treatment. Four main facilitating factors were recognized: consensus about the necessity of cessation treatment coverage; magnitude of the problem of tobacco use; pressure from a more informed society for the inclusion of coverage; the emergence of new paradigms for the inclusion of health public policies.
Conclusions: The barriers create a vicious circle: members of the health care system do not fully appreciate the issues related to smoking, which leads to an inappropriate set of priorities resulting in a lack of preventive policies and insufficient health practices and interventions to curb the problem. However, this situation is changing since the facilitating factors are gaining strength, an observation supported by the changes witnessed in Argentina over the last few years.
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Introduction

There is a consensus today among researchers and tobacco control policy makers about the *addiction* or *disease* status

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of tobacco consumption. However, not many countries cover, within their health care systems, comprehensive cessation treatments. Argentina is one of those countries.

In Argentina every year, tobacco consumption causes 40,000 deaths [1], the health consequences are valuated at almost $7000 million (invested only in medical care [2]) and more than three out of 10 adults smoke [3]. Notwithstanding this situation, scarce attention is paid in academic and public policy circles except by tobacco control specialists. The magnitude of the problem seems to be invisible or at best ignored.

It is necessary to emphasize that the problems of smoking in general and cessation and treatment coverage in particular, are becoming compelling topics in public health. While many countries are developing laws for the Framework Convention for Tobacco Control (FCTC) adequacy requirements, and several important laboratories are investing in the development of drugs and vaccines against tobacco addiction, not much is being done to promote cessation at the population level [4], even less to offer treatment covered by the health care system. Some of the countries which cover cessation are England, USA (through Medicare), and Brazil. But even that which is defined as covered treatment is different in each case.

Why do differences exist? Considering that most smokers want to quit [5], that cessation has an outstanding positive impact on individual and public health, and the importance of a health basket to guarantee health equity and health access for the population [6], it is necessary to address the following questions: why is cessation not covered in spite of the available data? How is *tobacco consumption* understood by policy makers, medical practitioners and those responsible for health insurance?

The aim of this research was to identify barriers and facilitating factors for the inclusion of tobacco cessation treatment coverage in the *Programa Médico Obligatorio* (PMO), and to indicate priorities for the development of cessation programs in Argentine health policies. The observations and conclusions about the Argentine situation in this paper may not be very different from those in other countries where smoking cessation interventions are still embryonic.

Background

Argentina has a particular health care system with two main characteristics:

(1) It is fragmented into three domains, each covering medical needs: public care (state expenses), private care (out of pocket expenses) and health insurance — the so-called *obras sociales* (OS) [7].
(2) This fragmentation according to levels of financial resources results in access to different levels of quality of care and consequently health inequality.

During the 1990s, social security and private health insurance became regulated by law, defining the basic coverage each should guarantee in order to control differences in access to health care. In Argentina, the PMO is the *health basket*, which is a public health tool to regulate and guarantee minimum health coverage for its citizens.

It is worth observing that in spite of the importance of such an instrument, little research or evaluation has been carried out over the last few years about the selection of practices included in a basket [8]. There is a particular lack of studies about the impact of coverage for cessation treatment in any health care system. Apart from contributions from international organizations such as WHO and from the Mayo Clinic, most studies pertaining to cessation deal with effectiveness or economic assessments of pharmacological treatments.

Implementation of cessation policies for those who want to quit is strongly endorsed by all international organizations that work for tobacco control, appreciating that quitting is the most effective intervention to reduce tobacco related mortality in the short term [4].

Methods

Data collection

The research consisted of a descriptive and analytical case study of a public policy. Data were collected using a qualitative methodology with in-depth interviews. Initially, two groups of key informants were identified:

A. Stakeholders involved in developing the general criteria for the definition and inclusion of benefits/coverage in the PMO.
B. Tobacco control specialists and activists who worked during the time period 1996—2007, in order to ascertain their views on tobacco cessation coverage in the PMO.

Informants in these two groups were identified from four sectors:

1. Government — Ministry of Health: three from the National Tobacco Control Program (NTCP) and two from the Superintendent of Social Services (SSS).[1]
2. Health Insurance: two representatives, one each from the two biggest OS in Argentina.
3. Private sector: one from the pharmaceutical industry.
4. Civil Society: three cessation specialists and leaders, one from each of the three largest Argentine NGOs working for the elimination of tobacco use.

None of the eleven informants identified and contacted refused participation in the interviews. After defining a list of variables relevant to the research subject, a questionnaire was developed translating variables into dimensions and dimensions into questions. Semi-structured guidelines were defined for each informant. Individual interviews were carried out by the researcher between December 2007 and June 2008. Interviewees were asked about reasons why cessation is not covered today, any initiatives undertaken by their institutions to achieve cessation coverage, reasons

[1] The Superintendent of Health Services of the Ministry of Health (SSS) is responsible for oversight of the social insurance plan's compliance with the Compulsory Medical Plan (PMO), guaranteeing system quality and coverage. Is Also has de power to define its changes (inclusions or exclusions from the health basket).

why these initiatives were or were not adopted and finally, their beliefs about coverage for cessation treatment. Questions were open-ended to allow the interviewees to freely express their opinions about the topic and provide any relevant facts.

Data analysis

All the interviews were recorded and transcribed. Barriers and facilitating factors were identified by using a grounded theory-based approach [9] to capture emergent concepts. As a first step, every text was read to identify key segments. Each segment was given an independent code. Second, after the codification of each interview, codes of similar content were gathered, generating concepts, opening a wider concept when necessary. Finally, the barriers and facilitating factors resulted from the identification of categories — a broad group of similar concepts.

All analyses were carried out by the researcher, without resorting to any special software, as there were only eleven interviews to process.

Results

Barriers and facilitating factors were classified into nine and four categories, respectively. Some were explicitly mentioned by the interviewees; others were identified by the investigator upon analysis of the data. Considering that cessation is not a part of the health basket, it is easily understandable that more barriers than facilitating factors were identified.

Barriers

Tobacco consumption not understood as an addiction or illness: this was the main reason offered by the majority of those interviewed. This is not only a characteristic of society, but also and more importantly, of the health professionals and policy makers who defined the health basket. There seems to be an underestimation of the consequences of tobacco consumption on health and a lack of professional knowledge about smoking, which is defined simply as a ''bad habit''. It is not surprising therefore, that 30% of Argentine physicians smoke [10].

Health professionals not adequately trained to deliver cessation treatment: this category was the second comment most often provided, with four of the interviewees making explicit references to this problem. The interviewed informants agreed on the need for nationwide training before offering coverage for pharmacological interventions.

Lack of a culture of prevention in the health care system: health promotion and prevention of diseases are not a priority with Social Security. There is a belief that an investment in these areas does not lead to long term savings due to the mobility of the subjects from one OS to another. Notably, PMO was created with cost saving as an objective. During the 1990s, health expenditure had to decrease and this basket would constrain that expenditure by selecting only a *decent minimum* of coverage (World Bank 2003).

Fear of overloading the health care system with expenses: while some OS on their own have come to recognize the importance of prevention and even cessation, the reason given to avoid compulsory coverage is the fear to burden the health care system with extra expenses.

Lack of involvement of NGOs: this is considered an important missed opportunity. The NGOs against tobacco have been working mainly in the development of smoke-free environments, ratification of the FCTC, and putting the issues on public and governmental agendas. Even in 2006, when varenicline was introduced in Argentina, and tobacco cessation became more popular, NGOs failed to ask the authorities for the inclusion of comprehensive treatment coverage.

Prioritization of other interventions as more effective: OS, tobacco specialists and the SSS uniformly consider other interventions to be more cost effective than cessation treatment, e.g. smoke-free places. Something similar occurred within government. Since the creation of the Tobacco Control National Policy (TCNP) in 2003, priorities have included: ensuring that the issue is put on the agenda of government, increasing public awareness about the health effects of active and passive smoking, and ratification of the FCTC. The TCNP presented a proposal for coverage of a comprehensive smoking cessation treatment, which was debated but never approved by the SSS. On the other hand, a quit line and dissemination of the National Cessation Guideline were approved and adopted.

Lack of agreement about the importance of the different components of cessation: some tobacco specialists and the TCNP acknowledge that educational intervention is the key to quitting smoking — drugs only help the process. In fact, the National Cessation Guide does not recommend pharmacological interventions without a cognitive approach as well. This belief deserves attention and raises the question: why is only partial treatment guaranteed? Today, smoking is not named in the PMO, however, anyone who wants treatment to stop smoking has the right to coverage for visits with a professional (either a physician or a psychologist) — not explicitly for cessation treatment but for a professional consultation. This situation does not help the cause for coverage of both a comprehensive and integrated cognitive and pharmacological therapy.

Lack of agreement on the relevance of coverage in all cases: two of the interviewed participants expressed doubt about the relevance of 100% coverage for any cessation treatment. It is believed that commitment to addiction treatment is stronger if there is at least partial payment by the subject.

Suspicion about policy decisions made under pressure from lobbies: a basket definition is a difficult yet important task for any health care system. It involves economic, social and ethical decisions. At times those decisions may be influenced by stakeholders. In this case there is the tobacco industry, which has always worked against tobacco control policies, and the health insurance enterprise, denying coverage to different practices, drugs or treatments out of consideration for their profit margins. This hypothesis was stated by two interviewees who referred to health insurance pressures against the inclusion of cessation treatment in the PMO.

Facilitating factors

Consensus about the necessity of coverage of cessation treatment: all those interviewed, whether involved or not

in tobacco control policies, acknowledged the need for some kind of assistance with cessation for smokers. This raises the ethical dimension of access to health care.

Magnitude of the problem of tobacco use: all those interviewed agreed that the high prevalence and the important health consequences of tobacco consumption will lead inevitably to a greater social awareness and inclusion of cessation coverage in the Argentine health basket.

Pressure from society for inclusion as it becomes more informed: one of the health insurance representatives highlighted the importance of client or beneficiary pressures over the definition of the health basket. As their claims grow stronger, they become stakeholders themselves and demand inclusion.

Presence of new paradigms about health public policies: after the 1990s and the 2001 crisis, the Argentine health care system created a new scenario to expand preventive policies and not just deal with the curative and saving approach. The benefits of health promotion and disease prevention started to appear at different levels in the health care system. The Ministry of Health as well as some of the OS developed prevention tools. All this is happening while the demand for tobacco control is growing stronger on the public health scene.

Conclusions

In this study nine barriers were identified (some of them similar to those enumerated by the WHO [4]) as well as four facilitating factors. Nine arguments explain why there is no treatment today, but four other ones show why cessation coverage seems closer. This means that some of the old foundations are changing rapidly: tobacco consumption is being seen as a disease and preventive practices are considered a worthy investment to diminish its adverse consequences on health.

When the PMO was defined in 1996, tobacco consumption was not understood as a disease or addiction by the policy makers. Ten years later, coverage for cessation was about to be added to the PMO but the failure of this initiative reveals the power struggle reflected by the barriers and facilitating factors. Several studies have pointed out the role of political decisions in the technical definition of a health basket [6,11,12], and the Argentine case is no exception.

There is a broad consensus about the need to appreciate that smoking is an addiction or illness, and to add tobacco dependence to the PMO as any other addiction. However, not all informants reflected this reasoning. When considering the inclusion of cessation coverage, counter-arguments are put forth, in particular that there are more important, more effective and cheaper policies to control the tobacco epidemic, e.g. tobacco free places.

While it is true that a health system must be sustainable, health is an undeniable right, and access to health care helps achieve equity. There is a strong belief within the social security circle that investment in preventive actions is not worthwhile, but at the same time some OS and private insurance enterprises have already begun to provide full coverage for treatment or give discounts on premiums to members who do not smoke.

Though not all the interviewees see the magnitude of the problem as a facilitating factor, a growing group of well informed smokers may emerge as a new stakeholder demanding coverage of treatment for their addiction.

Finally, one of the most important barriers pointed out by most informants was the lack of training of health care providers. Argentine physicians need to receive proper training particularly about the Argentine guidelines on cessation therapies and how to implement them. That is the most important requirement in order to ensure that there will not be ''*Only bupropion everywhere*'' (NGO interviewee, author's translation).

In Argentina there are an estimated half a million smokers who want to quit. There is an ethical imperative given that a proportion of smokers need pharmacological assistance in order to quit successfully. There must be an affordable and accessible option for those who have more difficulty dealing with their addiction. Treatment must not be a privilege limited to those who can afford medication [13].

Considering that between 1996 and 2008, important changes have taken place in Argentina with new tobacco control policies including creation of the National Tobacco Control Program, two new NGOs working with professionals and society at large, and with debates among different leaders, including SSS to include cessation, the conclusion that best summarizes this analysis is ''*iťs just a matter of time*'' (Ministry of Health representative, author's translation).

Implications for tobacco control

It would be very simple to conclude that all evidence based treatment should be covered by PMO (or any health basket), however there are concerns about system sustainability, which cannot be ignored. There is a need to conduct studies on the cost effectiveness of cessation at the national level. Experiences within Argentina, where some provinces cover cessation therapy as well as those of other countries should be compared and analyzed. National and provincial Health Ministries as well as scientific societies or NGOs involved with tobacco control should pursue or at least support this kind of research. There is also a need for local research about cessation including the attitudes and knowledge about cessation of health professionals. The National Cessation Guideline needs an update and wider implementation among private and public health professionals including pediatricians and gynecologists.

Professional colleges and universities as well as national and provincial ministries of health have a key role and responsibility to train health teams on how to incorporate brief interventions into primary care practice. In fact, NTCP has already started a training schedule to form cessation teams in every province. The challenge now is to reach the local level, working with professional and scientific organizations.

To make decision makers aware of the consequences of tobacco consumption is the most important yet difficult objective. These consequences not only affect the health of the population, but they also generate burdensome expenses to treat tobacco related diseases, result in lost

production due to disabilities, illnesses, etc. Decision makers and the general public need to be informed about local successes with tobacco control legislation and cessation coverage, which do exist in Argentina. Considering that Argentina has not yet ratified the FCTC (the national parliament is a stubborn stakeholder), there is still a long road ahead.

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