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Costs Associated with Operating a Quitline

Overview

As noted earlier, most quitlines operate not as stand-alone clinical services, but as part of a comprehensive tobacco control program. Thus, estimating costs for a quitline depends partly on the role that it is expected to play in the larger program. For example, is it designed to augment the mass media campaign's cessation messages by providing a low-cost service to a large number of callers? Or is it intended to provide more intensive, comprehensive counseling to a smaller number of callers? Is it meant to provide comprehensive treatment to any smoker desiring assistance, or a safety net for those unable to access the health care system? The answers to these types of questions have great bearing on cost calculations because they define the service structure of the quitline, which in turn affects costs.

This chapter examines the costs of quitlines from two perspectives. The first focuses on the internal structure of a quitline budget, that is, the percentage of funds dedicated to various key activities within the organization. The second focuses on the cost of a quitline in relation to the costs of other activities within the tobacco control program.

Estimating Annual Costs by Key Activities

A quitline generally engages in three key activities:

- ◆ Intake (handling incoming calls from new program participants and mailing self-help materials).
- ◆ Counseling.
- ◆ Evaluation.

In addition, there are important support activities. One is coordination with promotional efforts. (Since mass media promotion is generally handled by a separate agency, a separate media budget must be developed.) Other activities include providing administrative

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support for the project as a whole; providing technical support for telephone, database, and computing facilities; managing clearing-house services; and conducting training.

Most states can expect to spend between 65% and 80% of their operational budgets on intake and counseling. If the primary objective of a new quitline is to provide comprehensive, proactive counseling (which is the model followed by most U.S. quitlines), intake can be expected to require about 10% to 15% of the budget, counseling about 55% to 65%, and evaluation about 10%. The remaining funds will go toward staff training, development of materials, and in-house promotional activities (assuming that the bulk of media promotion is handled by a separate organization, as is usually the case). The costs of providing administrative and technical support are subsumed within each category.

If, on the other hand, the primary objective of a quitline is to provide brief, reactive counseling to a larger number of callers (in the manner of a hotline), the line between intake and counseling blurs. However, the total proportion of the budget dedicated to both activities will probably remain between 65% and 80%, which differs little from a quitline operating under a proactive counseling model.

Many states have allocated about 10% of their quitline budgets to evaluation. As discussed in Chapter 7, evaluation is critical for the overall health of the program, and funding for this activity should be considered a key component of a responsible quitline budget. In conceptualizing the scope of evaluation, it is helpful to try to foresee what information would be needed if one had to justify the quitline's continued existence.

A question that frequently arises with respect to the calculation of quitline costs is how much it costs to counsel a single tobacco user (McAlister et al. 2004). The answer depends on several factors, including the cost of living in the area where the quitline is located, the educational background of the staff providing the service, whether medications are provided, and operational efficiency. But the key variable is the relative comprehensiveness of the counseling provided.

There is no generally applicable calculation of cost per person counseled because the counseling protocols of existing quitlines vary widely in length and intensity. For proactive counseling protocols, which usually aim to provide four to six calls per person, the total cost per person counseled ranges from \$175 to \$230, although these

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calculations sometimes include the cost of evaluating a sample of callers. For reactive counseling protocols, a per-person figure is not available; however, it obviously costs less to provide brief, reactive counseling sessions than to provide more intensive, proactive sessions.

Another important question for a state quitline is what amount represents a minimum acceptable level of funding. Reasonable funding for a state quitline ensures that the operation is staffed at a level sufficient to allow it to serve as a meaningful component of the state's comprehensive tobacco control program. A quitline has many advantages that make it particularly well suited to play an important role in a state's comprehensive tobacco control program. For example, it provides a very convenient cessation service. However, if a statewide quitline is insufficiently promoted or insufficiently staffed, its fitness for that role is diminished.

In 2001, the median annual budget for U.S. quitlines was \$600,000 (Zhu 2002a), not including the cost of promotion. The amount of funding required in a given state depends in large part on the size of the state's tobacco-using population. A crude method of calculating a minimum funding level is to assume that 2% of the state's adult tobacco users will call the quitline each year, and then to multiply that number by \$130. (The figure \$130, given in 2004 dollars, comes from multiplying the lowest cost per caller estimate [\$175] by about 75%, assuming that 25% of callers will not use counseling.) When this method of calculation is used to compare states that currently have quitlines, it shows that states with larger populations are generally spending less money on their quitlines (per tobacco user in the state) than states with smaller populations.

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Assessing the Cost of a Quitline in Relation to Other Tobacco Control Costs

A new statewide quitline is usually highly dependent on mass media promotion to inform smokers of its existence (see Chapter 9). Therefore, the advertising budget is closely linked to the budget for operations. Because media spots for the quitline are often purchased with other anti-smoking media spots, it can be difficult to separate the exact amount spent to promote the quitline. Still, a rough estimate can help to set an operating budget for the quitline. For a new quitline, a rule of thumb is to allocate one dollar for quitline operations for every dollar spent on promotion.

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When considering the costs of quitline operation in relation to those of other anti-smoking activities, the following observations regarding promotion are relevant. First, given the same promotional efforts, smokers are more likely to use a quitline than to use face-to-face clinical services. In a recent survey, smokers were several times more likely to say they would prefer using a quitline to attending a group clinic when the availability of both services was simultaneously made known to them and both were free of charge (McAfee 2002). This suggests that it is significantly less costly to recruit the same number of tobacco users into quitline counseling than to recruit them into traditional cessation clinics.

Second, there may be periods when quitline promotion must be curtailed to keep the number of callers from overwhelming the staff. The “problem” of having too many tobacco users calling for service contrasts with the experience of many traditional cessation group programs, which often have more trained facilitators than needed because of the low number of tobacco users attending.

These observations suggest that, in most cases, there is the potential to increase the size of quitline operations, since additional promotion of quitlines is likely to result in large numbers of smokers using the service. Of course, operational expansion of the quitline requires increased funding. The amount allocated for a quitline often represents a large portion of a state’s funding for cessation. However, the amount allocated for cessation usually represents only a small portion of a state’s total funding for tobacco control. In other words, states provide little money for cessation, but much of what they do provide for this purpose is entrusted to quitlines.

If a state needs to give its media campaign wider exposure or needs to reach more tobacco users through the quitline, but increased funding for quitline expansion is not feasible, it has the option of making quitline counseling protocols less intensive, so that counseling can be provided to more smokers. The lower-intensity counseling in such a setting probably produces less effect per caller than higher-intensity counseling. However, the total impact on the smoking population may be significant if the lower-intensity counseling protocol allows the program to handle more calls. The total direct effect of a quitline is the product of the number of people who use it and the average effect per person, so the impact of a quitline could theoretically be maintained even with lower-intensity counseling.

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Over the long term, however, there will be more quitline callers who relapse in their quit attempts when a lower-intensity intervention is used, which may damage the quitline's credibility as an effective cessation strategy. Therefore if additional funding becomes available, a more desirable option for increasing the impact of the quitline might be to maintain the counseling protocol at a high level of intensity and to increase the program's capacity to serve callers. This approach allays justifiable concerns that abbreviating the protocols may compromise program effectiveness.

Most existing quitlines employ a mixture of reactive and proactive counseling and other services of varying costs in an attempt to use funding as efficiently as possible. Efficient use of funding is an evolving issue even for states with extensive experience with quitlines. It would be a mistake to compare programs on the basis of simple numbers such as cost per call without first carefully examining the whole service protocol and the rationale for each component. Moreover, the smoking population and the makeup of quitline callers change over time, so even states with well-established quitlines should periodically assess their services and associated cost structures in the context of the larger tobacco control agenda.

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Recommendations

- ◆ Use the following guidelines to establish a minimum budget for a state quitline:
 - For a new quitline, the operating budget should equal the amount being allocated for the promotion component of the quitline.
 - A crude method of calculating a minimum funding level for operations is to assume that 2% of the state's adult smokers will call the quitline each year, and then to multiply that number by \$130.
 - Currently, the median annual budget for state quitlines is about \$600,000.
 - The cost per smoker using an evidence-based proactive counseling protocol has been reported to range from \$175 to \$230.

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- ◆ Allocate operational funding for the key activities of quitlines as follows:
 - Intake, 10% to 15%.
 - Counseling, 55% to 65%.
 - Evaluation, 10%.
 - Other, 10% to 25%.
 - Include adequate funding for evaluation in the budget calculation, as the evaluation component is critical to a quitline's success.
- ◆ Consider the following to determine how the cost of a quitline will fit into the budget for the overall tobacco control program:
 - Recruiting smokers into quitline services is likely to be substantially less expensive than recruiting them into face-to-face counseling because smokers, by a wide margin, prefer to use quitlines.
 - Increasing a quitline's budget can help meet the untapped demand for quitline services and can increase the reach of the quitline. Most statewide quitlines have, at times, experienced a greater demand for service than their staffing levels could meet.
 - In contrast, group programs often have more trained facilitators than needed for the small number of smokers attending the programs.