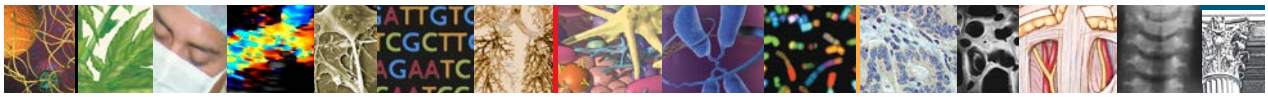

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Perspective

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Is It Time for a Tobacco-free Military?

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Secretary of the Navy Ray Mabus recently announced that he wanted to end tobacco sales on all Navy installations. Secretary of Defense Chuck Hagel, citing both financial costs and tobacco's harmful effects on readiness, added that military tobacco policy in general should be reviewed, including the possibility of ending tobacco sales and establishing smoke-free military installations. Currently, a Department of Defense review of the tobacco issue is under way, 5 years after the Institute of Medicine called for a tobacco-free military.[1]

Military personnel are required to pass fitness tests, undergo periodic drug tests, and meet weight and body-composition standards or face disciplinary action, including possible discharge. Yet despite the underlying expectations for superlative fitness — and despite the availability of state-of-the-art tobacco-cessation programs — many military personnel still use tobacco, and its use remains accepted, accommodated, and promoted in the armed forces. Why?

One reason is that tobacco use for military personnel is still too frequently characterized as a right, a necessity, or a benefit. Achieving a tobacco-free military requires rethinking these perceptions and unmasking the forces perpetuating them.

The belief that members of the armed forces have a right to use tobacco is widespread.[2] However, such a right has never been established by the courts. The military frequently regulates the sale and use of legal products that it deems harmful to health, discipline, or public perception, and personnel must abide by regulations in order to maintain discipline, fitness, and morale. Prohibiting tobacco use would be entirely consistent with other requirements regarding weight, fitness, and cardiovascular health.

Military personnel are sometimes said to need tobacco for stress relief; however, tobacco users in the military report higher levels of stress than do nonusers,[3] so perhaps the stress being relieved actually derives from nicotine withdrawal. Most military personnel are not tobacco users, and smoking prevalence is substantially lower among officers than in the civilian population — a fact that undermines the notion that military life somehow necessitates tobacco use. The argument that tobacco is a necessity for military service members

devalues their long-term quality of life and ignores the military's obligation to provide healthy, effective means of stress relief to service members.

The availability of convenient, cheap tobacco products is sometimes described as a benefit to service members. Tobacco prices in military commissaries and exchanges are supposed to be set within 5% of the lowest local price. Recent studies, however, have shown that this policy is frequently unenforced and that prices can be as much as 73% lower than those at the local Walmart.[4] But we would argue that cheap tobacco is not a benefit unless disease and addiction are regarded as downstream benefits.

Efforts to remove tobacco from military stores have been met with the argument — stressed by the tobacco industry and its allies — that such a policy would establish a "slippery slope" ultimately leading to the elimination of commissaries. But many tobacco-control policies, such as clean-indoor-air laws and cigarette taxes, have been similarly characterized as harbingers of government intrusiveness that would lead to bans on dairy products, baked goods, and more, yet none of these dire results have come to pass. In any case, deciding to end sales of a particularly harmful product is entirely different from deciding to close military stores.

Profits from exchanges support Morale, Welfare, and Recreation activities on military installations. The argument is sometimes made that eliminating tobacco sales at exchanges would reduce funding for such activities. If tobacco products were removed from military stores without other policy changes, it is possible that some financial loss would occur, but if tobacco use by military personnel were prohibited, disposable income previously spent on tobacco products would probably be spent for other items. Numerous individual stores and some large retail chains have stopped selling tobacco without long-term financial damage. Surely a means can be found to subsidize Morale, Welfare, and Recreation activities better than selling deadly and addictive products to service members.

Some observers may believe that a tobacco-free military would be ideal but that trying to institute such a change might lead to problems with discipline, recruitment, or retention. We believe these outcomes are unlikely, given existing standards of military discipline. For example, the submarine fleet established a smoke-free policy in 2010 without notable negative consequences. The Air Force has lower rates of smoking than the civilian population; among officers, smoking prevalence is in the single digits. A plan for a tobacco-free military that started in the Air Force could model norm change, gradually recharacterizing tobacco use as "unmilitary." The current practice of tobacco-free basic training also provides a starting point; preventing subsequent initiation or relapse, while offering cessation support to current smokers, would be unlikely to cause disruption.

Moreover, the argument that banning tobacco use would be excessively disruptive ignores the serious disruptions that tobacco use itself causes in the military. Tobacco use is associated with premature discharge during the initial year of military service,[1] which suggests that recruiting only nonusers could increase retention. (Such a rule is unlikely to negatively affect the ability of the military to recruit qualified personnel. Because basic training is tobacco-free now, recruits are compelled to quit immediately on enlistment. The current drawdown in military personnel means that recruitment standards are already becoming more stringent; being tobacco-free could be among the new requirements.) Although service members' breaks are officially limited to two per day, many informants suggest that smokers take breaks as frequently as once per hour; eliminating smoking breaks could increase efficiency and productivity. In combat zones, the light and odor of a cigarette can give away troop locations. Tobacco use by military personnel is also associated with reduced physical fitness, increased risk of injury, retarded wound healing, higher rates of mental health disorders, and greater financial strain for junior enlisted personnel.[1]

So why, given these arguments, don't we already have a tobacco-free military? The real reasons, we believe, are a lack of strong civilian advocacy, a powerful tobacco-industry lobby, and congressional representatives who continue to protect industry profits at the expense of our service members' health and the fitness of our forces.

Until recently, civilian tobacco-control advocates have been reluctant to take up the issue. Public health leaders too frequently subscribe to the myths described above.[2] Historically, military tobacco-control efforts have been halted repeatedly by tobacco-industry allies on the House and

Senate Armed Services Committees.[5] Congressional interference has prevented the military from acting at local command levels to address tobacco use. For example, a smoke-free policy set at an Army installation and a campaign to motivate cessation at an Air Force Strategic Air Command unit[5] were rescinded after tobacco-industry allies in Congress intervened. In fact, in response to the latest announcement from the secretary of the Navy, the House Armed Services Committee has already included language in the new defense-authorization bill that could force the military to continue cheap tobacco sales. As of late June, the language was not included in the Senate bill.

Tobacco use harms military personnel, impairs readiness, and incurs unnecessary costs to individual service members and the military as a whole. Military service should not be a risk factor for tobacco initiation: many young people who join start to use tobacco only after enlisting. We propose that Congress quit doing the tobacco industry's bidding, citizens quit subsidizing cheap military tobacco sales, and civilian public health organizations and military supporters stand shoulder to shoulder with Secretaries Hagel and Mabus in moving toward a stronger, healthier, tobacco-free U.S. military.

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Adverse Effects of Prohibiting Narrow Provider Networks

David H. Howard, Ph.D.

The nominal goals of the Patient Protection and Affordable Care Act (ACA) — protecting patients and making insurance affordable — are often contradictory: policies that promote access often increase costs. If health insurance is unaffordable, fewer consumers will buy insurance on the exchanges, and the federal government will have to spend more on subsidies for those who do. Faced with ACA-based limitations on their ability to trim benefits and increase cost-sharing levels, many exchange insurers have opted to control costs by offering plans with narrow provider networks.

According to a recent analysis of exchange plans by the consulting firm McKinsey and Company, about 40% of plan networks were classified as "ultranarrow" or "narrow," meaning that they contracted with less than 30% or 70%, respectively, of the hospitals in the plan rating area.[1] The situation is fluid. Some plans' networks may expand as the exchange market matures. Other plans may shrink their networks so that they can match the premiums of their narrow-network competitors. Some plans exclude nearby "name-brand" providers such as M.D. Anderson in Houston or Cedars–Sinai in Los Angeles. Less than half of ultranarrow network plans contract with an academic medical center.[1]

These developments have caught ACA supporters off guard and challenged the veracity of President Barack Obama's oft-repeated claim that "If you like the doctor you have, you can keep your doctor."[2] Not coincidently, the Centers for Medicare and Medicaid Services (CMS) recently proposed new regulations to promote network adequacy. These regulations promise to expand plans' networks, but regulators should not assume that a pro-provider stance is inherently pro-consumer or even pro-patient.

The ACA requires qualified health plans to maintain adequate provider networks. Initially, CMS took a hands-off approach to enforcement, but in February, the