NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

Submission:

Post-market review of medicines for smoking cessation

Australian Government Department of Health,

Pharmaceutical Benefits Advisory Committee

April 2020

About NACCHO

NACCHO is the national peak body representing 143 Aboriginal Community Controlled Health Organisations (ACCHOs) Australia wide on Aboriginal and Torres Strait Islander health and wellbeing issues. NACCHO's work is focussed on liaising with governments, its membership, and other organisations on health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

Our members provide about three million episodes of care per year for about 350,000 people across Australia, which includes about one million episodes of care in very remote regions.

Sector Support Organisations, also known as affiliates, are State based and also represent ACCHOs offering a wide range of support services and Aboriginal and Torres Strait Islander health programs to their members including advocacy, governance and the delivery of State, Territory and national primary health care policies.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal Health Workers/Practitioners and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive holistic primary health care, and by integrating and coordinating care and services. Many provide home and site visits; provision of medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and providing help with income support.

Collectively, we employ about 6,000 staff, 56 per cent of whom are Indigenous, which makes us the single largest employer of Indigenous people in the country.

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Summary

NACCHO welcomes the opportunity to provide input at this stage of the *Post-market review of medicines for smoking cessation* conducted by The Commonwealth Government. Rates of smoking for Aboriginal and Torres Strait Islander populations are demonstrably higher compared to other Australians. Optimal use and access to smoking cessation pharmacotherapy is an essential strategy to address this healthcare disparity that ultimately worsens the health inequities that Aboriginal and Torres Strait Islander people face. While strategies and programs exist that enhance the support Aboriginal and Torres Strait Islander people may receive to quit smoking, some gaps persist and more needs to be done. Therefore, NACCHO is proposing three key recommendations to improve how the PBS supports smoking cessation for Aboriginal and Torres Strait Islander people. These enhancements are based on clinical evidence, guidelines, stakeholder expertise and current practice across Australia and overseas. Universal access is an essential tenet of the PBS. We propose that such enhancements at this Commonwealth level provide equity for all Aboriginal and Torres Strait Islander people and program comprehensibility for clinicians and the health sector.

NACCHO's recommendations:

- Expand the number and scope of smoking cessation PBS listings for Aboriginal and Torres Strait Islander people, so that all evidence-based smoking cessation medications available in Australia are more readily accessible for this target population. This includes fast acting nicotine replacement in various dose forms, gum, lozenge, inhaler and sprays.
- Current restrictions on the duration of therapy for medications to assist smoking cessation for Aboriginal and Torres Strait Islander patients should be lifted.
- Current restrictions that varenicline, bupropion, nicotine patch, gum or lozenge "must be the sole PBS-subsidised therapy for this condition" should be lifted for Aboriginal and Torres Strait Islander people.

Below we explore the demographics related to smoking in Aboriginal and Torres Strait Islander populations; the features and limitations of current Australian smoking cessation therapies, guidelines, measures and programs; and the costs associated with these measures and programs. We have collated support for NACCHO's recommendations from some member organisations in this submission, responding primarily to the second and fourth Terms of Reference[1]. These relate specifically to utilisation of PBS-listed medicines for smoking cessation and costs respectively:

> *2) Review the utilisation of PBS-listed medicines for smoking cessation including but not limited to patient demographics, time on treatment, and the proportion using PBS subsidised combination treatment*
>
> *4) Subject to the findings of Terms of Reference 1, 2 and 3, review the cost-effectiveness of medicines for smoking cessation*

We have consulted with a range of stakeholders including representatives of member ACCHOs through the joint NACCHO and Pharmaceutical Society of Australia ACCHO Pharmacist Leadership Group, at meetings last year and our most recent meeting on the 27th of April 2020. In response to feedback from stakeholders and subject matter experts, there is a focus on expanding the use of combination therapy, which we propose is a key area to be addressed in this review, particularly for vulnerable populations. Further PBS support for combination therapy stands to have a large impact on reducing smoking rates in Aboriginal and Torres Strait Islander populations and thus improving health outcomes.

[1] Available at http://www.pbs.gov.au/info/reviews/post-market-review-of-medicines-for-smoking-cessation

Demographics and access

Aboriginal and Torres Strait Islander peoples make up around 3% of the Australian population,[2] but are disproportionately represented in smoking rates and affected by smoking related illnesses at a significantly higher rate than other Australians. The smoking rate for Aboriginal and Torres Strait Islander Australians in 2019 was 37%, compared to a national average of 13.8%.[2] In remote areas, this figure may be as high as 61-85%.[3] In consideration of these stark statistics, smoking is recognised as a major contributor to the mortality gap between Aboriginal and Torres Strait Islander people and other Australians.

Aboriginal and Torres Strait Islander patients may access support to quit smoking through a variety of state-based or federal programs, such as the national Tackling Indigenous Smoking program (TIS).[4] The most recent review of this program references the need to improve access to Nicotine Replacement Therapy (NRT). The high cost of specific NRTs that are not available on the Pharmaceutical Benefits Scheme was noted as a significant barrier to NRT access for Aboriginal and Torres Strait Islander people. In remote areas, limited inventory of NRT was noted as another barrier to access. Several TIS grant recipients disclosed that not being able to provide NRT or samples of NRT to clients has reduced community engagement for their local TIS program. NRT is still viewed by grant recipients as central to a continuum of care for community members, who felt it was problematic to suggest combination therapy to clients without supplying NRT.

"We are starting to have a lot of disengagement due to people knowing the message and options [NRTs] but not being able to access these resources through the TIS team". TIS Grant recipient, rural 2017

To ensure clients still have access to NRT and to attract potential clients into local TIS Programs, some grant recipients are seeking funding elsewhere to supply community members with NRT. Disparate jurisdictional measures to support NRT access may lead to variable and inequitable outcomes between regions.

A study referenced by the Tackling Indigenous Smoking (TIS) program shows that Aboriginal and Torres Strait Islander smokers were less likely to use nicotine replacement and medicines to stop smoking (37%) compared to the general population (58.5%), and that cost is a barrier to using pharmacological aids.[5] A study of three remote Aboriginal communities in the Northern Territory found that 35% of smokers expressing a desire to quit didn't know about cessation pharmacotherapies. Only 16% of participants had used them with the main therapy used being NRT patches and gum. Around 2% had been prescribed varenicline but had not used it due to lack of knowledge and confidence to use it.[3]

Cost of medicines is an established barrier for Aboriginal and Torres Strait Islander people accessing medicines. The national *Closing The Gap* prescription measure (CTG) was developed to address this barrier. CTG allows many Aboriginal and Torres Strait Islander people to access PBS medicines at a co-payment cost that is further reduced from standard Australian PBS-subsidised co-payment rates. For example, concession card holders with a CTG script can receive their PBS medicines at no cost. Therefore, the cost of even modestly priced over-the-counter NRT products may be a barrier a client's access, as it can be significantly different to the cost of their other medicines listed on the PBS. Similarly, the s100 Remote Area Aboriginal Health Service measure allows Aboriginal and Torres Strait Islander people in remote communities to access most PBS medicines at no cost. This excludes some NRT and therapeutic options that are outside current PBS restrictions (e.g.

combination therapy). Furthermore, consumers purchasing over-the-counter NRT may be limited by lower access to community pharmacy in remote areas.

Anecdotal reports regarding access to smoking cessation pharmacotherapies suggest a long history of poor uptake, especially for those in remote areas, which has contributed to a therapeutic inertia in health professionals. The review of the TIS program described several tobacco workers as feeling frustrated by being unable to supply or recommend NRT. Costs are currently often met by patients, health services or other programs. Poor accessibility of pharmacotherapies adds a level of complexity and uncertainty to a quit smoking consultation that is counter to TIS aims. The review of TIS reinforced the focus on "community education and multi-component tobacco control strategies, using and promoting best practice approaches to tobacco control, use of population health and place-based approaches, and building partnerships and collaborations to support innovation, capacity-building and behaviour change". Pharmacotherapies are an evidence-based aid to assist smoking cessation and thus should be available to Aboriginal and Torres Strait Islander people in conjunction with community based support programs.[4]

Time on treatment

Medications currently listed on the PBS to assist smoking cessation include varenicline, bupropion, nicotine gum, lozenge and patches. These medications have various time restrictions limiting their use within a 12-month period. Below, we present the current PBS restrictions according to the PBS website.

- *Nicotine products*
    - *Only 2 courses of PBS-subsidised nicotine replacement therapy may be prescribed per 12-month period.*
- *Bupropion*
    - *Patient must not receive more than 9 weeks of PBS-subsidised treatment with this drug per 12-month period*
- *Varenicline*
    - *Completion of a short-term (24 weeks) course of treatment. Patient must have ceased smoking in the process of completing an initial 12-weeks or ceased smoking following an initial 12-weeks of PBS-subsidised treatment with this drug in the current course of treatment.*

These restrictions create another impediment for patients who want to begin a second quit attempt within the year or for those that have successfully cut down but not completely quit. Removing the PBS restrictions related to treatment time frames would facilitate high-risk patients continuing to attempt quitting. The additional cost of lifting these restrictions specifically for Aboriginal and Torres Strait Islander people is minimal when considering the overall cost to the Commonwealth of smoking cessation measures and programs. If these restrictions are removed, the risk of ongoing supply of PBS scripts which are then not used by the patient is low and the additional cost of supporting motivated quitters past the current duration restrictions would be offset by downstream savings to the health system.

Feedback from some ACCHO members strongly supports removing time restrictions. A pharmacist working with Galambila Aboriginal Health Service in Coffs Harbour states:

> "The 12-week timeframe on PBS supply is not consistent with successful cessation. NRT can help reduce smoking, which can increase chances of successfully quitting at a later time; hence it can be used with the strategy of first reducing then quitting, which will take longer than 12 weeks. We also know that some people require longer than 12 weeks to successfully remain abstinent, as well as with more attempts the success rates increase. If we are reducing attempts to only one/year, we are not enabling clients to empower themselves to continue to try to improve their health."

Combination treatments

Some current clinical guidelines used in the ACCHO sector include:

- The Royal Australian College of General Practitioners. Supporting smoking cessation: A guide for health professionals. 2nd edition [6]
- Medicines to help Aboriginal and Torres Strait Islander people stop smoking: a guide for health workers [7]

These guidelines recommend various combinations of medicines to support smoking cessation. Removing the restrictions for Aboriginal and Torres Strait Islander people that varenicline, bupropion, nicotine patch, gum or lozenge "must be the sole PBS-subsidised therapy for this condition" would allow combinations of therapy to be used as per current clinical guidelines and practice. This generally accepted combination involves adding a quick acting nicotine product (such as gum, lozenge, inhaler or spray) to a long acting product (such as an NRT patch, varenicline or bupropion). The PBS currently restricts patients to only using one type of treatment at a time, which prevents patients from maximising their chance of success as advised in the guidelines.

To maximise the patient's chances of quitting, many health services try to facilitate access to combination treatment. This is done in a variety of innovative, but potentially unsustainable ways, such as using ACCHO core funding, applying for other local grants, state-based schemes and even taking compassionate donations of short dated stock from community pharmacies and pharmaceutical companies. During the consultation, some large ACCHOs have advised NACCHO that they purchase quick acting nicotine products to provide to patients out of internal revenue, which displaces other important clinical activity. This creates an inequitable environment where Aboriginal and Torres Strait Islander patients in other parts of Australia may miss out on this treatment. Some members have expressed strong support for combination therapy being available on the PBS

> "Combination NRT is well known to be best practice for smoking cessation and it is an absolute travesty that this is not available on the PBS for Aboriginal and Torres Strait Islander people. Having to purchase NRT over the counter can be financially unattainable for some of our Community, which means they are not able to receive best practice therapy. Galambila has been able to access small amounts of NRT through grant money, however we are only able to supply a limited quantity to clients (i.e. 7 days), which is unable to meet the required clinical timeframe to effectively remain abstinent. Having smoking cessation discussions with clients can be really challenging, as the recommendations made can't always be adhered to, which doesn't align to the critically important motivational interviewing techniques required" Pharmacist, Galambila Aboriginal Health Service

We understand that there may be more opportunities to respond to this review and we welcome the opportunity to further consult and elaborate on these issues in subsequent iterations of this review process.

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