

Bupropion and NRT to promote smoking cessation

Action on Smoking and Health

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Attending

- Clive Bates, Director, Action on Smoking and Health
- Martin Jarvis, Professor of Health Psychology, University College London and Principal Scientist, Imperial Cancer Research Fund. Professor Jarvis is a member of the board of ASH.

Summary points

A full submission was provided in July and contains a fully referenced account of our views ¹. The headings below outline what we consider to be the main points for discussion in formulating a view on the therapies for smoking cessation.

Central importance of smoking cessation to individual smokers and to the NHS

Helping smokers to quit is one of the most important strategies available to the NHS and for the health of individual smokers. It contributes directly to achieving official targets for cancer and heart disease, and will play an important role in meeting the objectives to reduce health inequalities. There are numerous benefits outside the framework of NHS targets:

- Smoking causes around 50 diseases and smoking cessation is a highly effective and cost-effective means of 'treating' these diseases in advance of their development;
- Smoking complicates treatment for other conditions;
- It is highly addictive, difficult to control and intrusive in life;
- It costs a substantial proportion of the disposable income of poor people
- There are serious impacts arising from passive smoking – especially to children;
- Given that parental or role model smoking is one of the most significant predictors of adolescent smoking, adult smoking cessation is one of the most important strategies in reducing uptake among children.

Smoking cessation is probably the single most effective 'holistic' health intervention possible and should be encouraged at every tier in the NHS, primary care and beyond.

The patient's perspective: the nature of smoking

The Royal College of Physicians report: *Nicotine Addiction in Britain* concludes that cigarettes are as addictive as drugs such as heroin or cocaine. At the same time we know that most smokers begin as adolescents, and that as adults most smokers (71%) say they would like to quit and over three quarters have tried. The American tobacco giant, Philip Morris, described the *modus operandi* of the business as follows:

“Smoking a cigarette for the beginner is a symbolic act. I am no longer my mother's child, I'm tough, I am an adventurer, I'm not square. [...] As the force from the psychological symbolism subsides, the pharmacological effect takes over to sustain the habit ².”

The common experience of the smoker is a youthful flirtation with perceived glamour and rebellion of smoking followed by steadily consolidating addiction. The process is fuelled by marketing and the extent to which smoking is 'normalised' in a person's life experience.

Smokers are not to blame for their 'addicted' condition and many will need considerable reserves of will power to quit whatever support they have.

¹ This is available on the ASH web site at: <http://www.ash.org.uk/html/cessation/niceSubmission.html>

² T. Osdene, Philip Morris Co. “Why one smokes” 1969 Minnesota Trial Exhibit 3681

The patient's perspective: trying to quit smoking

Over time, smokers become concerned about their smoking and wish to quit. Some 71% of adults would like to quit and at least a quarter make an attempt in any given year. However, unaided quit attempts have very low probability of success (1-2%). Increasing the intensity of behavioural support and the use of pharmacotherapies increase the odds of a successful quit, but even with the best treatment, counselling and high motivation, it is hard to achieve quit rates greater than 30%. However, this does suggest that cessation interventions greatly increase the chances of successful quitting.

The idea that smokers can afford to pay for their own treatment if they can afford to smoke has been one of the most serious long-term mistakes in British public health policy – and would not be used in any other area of health care. A rational smoker knows that the chance of success in any quit attempt is low, and therefore that they might have to pay for both the treatment and continued smoking. Most smokers do not even make such a calculation – they do not regard these expenditures as interchangeable.

Given the value to the individual and to the NHS, smokers should expect the best treatment available to help them raise the odds of making a successful quit from the otherwise pitifully low level associated with unaided quit attempts.

Excellent cost-effectiveness

Smoking cessation interventions are extremely cost-effective. Recent analysis suggests that the NHS smoking cessation services have cost-effectiveness of better than £800 per life year saved. It has been reported that NICE health technology assessments are converging on a threshold of £30,000 per QALY for acceptable NHS expenditure – suggesting smoking cessation is some 40 times better than this benchmark. Even allowing for differences in calculation methodology, this represents amazing value for NHS money.

We also showed that in an area where direct choices might be made, the NHS was spending far more on treatments with greatly inferior cost effectiveness: around ten times as much will be spent on statins with one thirteenth the cost effectiveness of smoking cessation drugs. Over 80% of patients prescribed statins would fall below the risk threshold (3% annual risk of heart attack) for these drugs if they stopped smoking – 87% of those prescribed statins are smokers. This suggests that smoking cessation could generate considerable additional savings in other areas of the drugs budget.

Smoking cessation is extremely cost-effective and its health economics are superior to many common treatments widely prescribed in the NHS.

Prescribing

We do not believe that any limitation should be placed on which patients should receive smoking cessation pharmacotherapies. The physician should assess motivation and then *always* recommend treatment and *always* include pharmacotherapy in the treatment – unless there is an obvious reason not to use it. There is no case at all for 'grey listing' or somehow regarding smoking cessation interventions to be outside the responsibility of general practitioners.

For reasons of flexibility in prescribing, we believe the products should be made available from the manufacturers in one-week units. For reasons of economy, we favour prescribing according to an abstinent-contingent protocol, in which the product is usually prescribed in two-week batches. We do not think it is right to class bupropion as a second line therapy.

Patients motivated to quit should have ready access to pharmacotherapies, but physicians should have the flexibility to prescribe in units of as little of one week, with two weeks being the norm.

Behavioural support for smoking cessation

The best outcomes in smoking cessation are achieved when pharmacotherapy is combined with intensive behavioural support. While it is desirable for smokers to attend clinics or receive other structured support, this should never become a *requirement*. Smokers obtain support from a variety of sources but still benefit from pharmacotherapy, which should not be denied to them if they choose not to attend a specialist clinic. Lower intensity support interventions (eg. GP advice) have lower efficacy, but their cost effectiveness is comparable or superior and the reach is significantly greater.

The smoker should be encouraged but not compelled to take the most intensive support available, but should have access to pharmacotherapies whatever they intend to use for support.

Unwarranted restrictions on NRT

We believe the regulatory system fails smokers by its over-caution in the application of NRT products. This caution serves to protect regulators and medical professionals but leaves smokers exposed to the greater risk of continued smoking if they do not use NRT. This applies to restrictions or cautions on the use of NRT for young smokers, pregnant smokers and smokers with heart disease. We also believe that smokers should have access to such products to control their smoking – for example to facilitate abstinence on flights, at work, in the presence of children, or simply to reduce the amount of tobacco smoked.

The regulation of NRT products should be changed to put the health of the smoker first.

Safety scares about bupropion (Zyban)

We regard Zyban as a particularly important drug, with clear evidence of efficacy from available clinical trials. We consider this drug should be widely prescribed and promoted. However, there have been a number of safety scare stories about Zyban, mostly based on a simple misunderstanding of the surveillance process for new drugs. Fifty sudden deaths have been recorded in patients using Zyban, but this has been mistakenly reported as deaths *caused* by Zyban. This has led to mounting public concern and even calls for its withdrawal. However, it has been used by over 8 million people world wide, and its risks are tens of thousands of times lower than those arising from continued smoking. Like other anti-depressants, it is not risk-free: there is a seizure risk, numerous drug interactions and contraindications for Zyban, but this is a reason for careful prescribing, not a rejection of the product.

At a time when a newspaper has mounted a highly misleading campaign against a vital and cost-effective drug, it is important that as much official reassurance as possible – consistent with truthful risk communication – is offered to the public.

Medical negligence

We believe that failure to treat smoking should be regarded in much the same way as failure to detect and treat pneumonia or other obvious life-threatening conditions. For the NHS, smoking should be seen as equivalent to the major diseases that develop from it. To ignore these cannot be acceptable.

Practitioners in the NHS who do not offer treatment for tobacco dependence to those in their care are acting negligently.