

## Is it time to stop subsidising nicotine replacement therapies?

Written by The Conversation

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Nicotine replacement therapy (NRT) became available in Australia in 1984 (gum) and 1993 (patches), first as prescription-only items. From 1988, they started becoming available as an over-the-counter item, with patches available without prescription from 1997. Today, some forms of NRT can even be bought in supermarkets.

If prescribed, NRT attracts a government subsidy. In the 17 months from July 2013 to Dec 2014, data provided by the Department of Health show 199,818 NRT scripts cost the government A\$8,617,804.

But 31 years later, what should governments do if data show that NRT is little better, or even a good deal worse, at helping smokers quit than if they try to do it cold turkey?

Globally, the pharmaceutical industry understandably wants to convince quitters to use their products as much as possible. The smoking cessation field has long been [dominated](#) by research and promotional activity on how to deter smokers from ever attempting to quit without pharmacological or behavioural assistance, despite this being the way that most smokers have always quit.

Claims have abounded for years that NRT can significantly increase a smoker's chance of quitting compared to placebo. These claims have overwhelmingly derived from clinical trials. But clinical trials differ markedly from real world use of NRT:

- clinical trials [exclude](#) many people who might purchase NRT, such as those with any mental illness
- there are major problems with [blindness integrity](#) (unsurprisingly, many smokers pickled in nicotine for years can guess if they have been allocated to the placebo arm of the trial)
- trialists are contacted an average of [7.6 times](#) by eager and supportive research staff trained to maximise retention of participants in the study
- trialists are often paid for their participation
- the drugs participants get are always free.

All this combines to produce an unreal situation and where trial participants do not represent all smokers and can be highly motivated to complete the trial to "please" the researchers.

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So 31 years on, how does NRT perform away from clinical trials in the real world?

One of the world's most rigorous and important data sets on smoking cessation comes from the [Smoking in England](#) study. A recent paper from that project casts a pall over any impact of NRT, other than generating more expensive urine in most of those who use it.

The [paper](#) reported on 1,560 English smokers who had made at least one recent and serious quit attempt. At six months, 23% were not smoking on the day they completed the questionnaire.

Several things stand out from this important study. First, smokers who used NRT obtained over the counter had by far the worst quit rate (15.4%) of any of the methods used. Even quitting unassisted (without using any medication or professional support), much denigrated by the makers of NRT and many smoking-cessation professionals, saw 24.2% taking this approach quit: a rate 57% higher than in those using NRT obtained over the counter.

The authors of the paper speculate that this low rate of success for NRT-users may be explained by “inappropriate usage and low adherence in the real world”.

Over the past three decades, NRT has been massively promoted via advertising and by pharmacists and doctors who have been heavily targeted by visiting sales reps. Doctors have been deluged with reprints of scientific articles on the virtues of NRT, and many have attended often lavishly catered educational meetings. Today, undying optimists still flying a flag for NRT still think there is hope that its users might one day start using NRT properly. Meanwhile, most who buy it keep smoking.

Second, the “most effective” method of quitting was also by far the least popular and acceptable. Using a prescribed medication (including NRT) and receiving specialised support for “at least six sessions” from one of England's dedicated smoking cessation services saw 38.7% quit. But while the authors emphasised this throughout the paper, they were silent on how this best rate multiplied by the relatively small numbers availing themselves of these services would make much impression on the national goal of significantly boosting England's quit rate at the population level. Any “most effective” way of quitting radically reduces in

importance if few people are prepared to use it.

Only 4.8% of people attempting to quit were prepared to avail themselves of the “full monty” specialist cessation centres. These, even with the best success rate, contributed just 29 of the 359 who had quit using any method (8% of all quitters). This compared with 168 who had quit unassisted (a rate of 24.2%), yielding in this study nearly six times as many quitters as the specialist centres.

Third, having doctors write prescriptions for NRT or other prescribed cessation medications, and offering brief advice on quitting, produced a success rate only marginally higher than unassisted cessation (27.8% v 24.2%).

The fourth stand out message is what was *not* emphasised in the paper. If over-the-counter NRT (as it is mostly used), produces a far worse quit rate than smokers going cold turkey, where is the chorus of smoking cessation experts telegraphing this message to the community? How much worse would the data have to be before cessation experts declare its use-by date has arrived?

If the focus is on methods that yield high numbers of quitters throughout a population, this paper shows – as have many others – that cold turkey produced nearly 90% as many quitters (168) than from all other methods combined (191). Yet cold turkey is denigrated in pharmaceutical industry messaging like Pfizer’s “[Don’t go cold turkey](#)”.

The [neglect](#) of serious study of the way most smokers actually quit may be keeping us from gaining important insights that could be useful in campaign messaging.

Important questions also need to be asked about whether continuing the substantial government investment in subsidised-NRT is sensible. In the six months July to December 2012 (latest available data), the Commonwealth spent [A\\$8.7m](#) in media placement of anti-smoking messages trying to stimulate smokers to make quit attempts. How many more attempts might have been made had that figure been able to draw on the money being allocated to subsidised NRT?

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Two [studies](#) of various Australian policies and programs' impact on declining smoking prevalence between 1995 and 2011 found [no evidence](#) of impact of NRT sales or advertising volume.

**Editor's note: please ensure your comments are [courteous and on-topic](#) .**

*Simon Chapman does not work for, consult to, own shares in or receive funding from any company or organisation that would benefit from this article, and has no relevant affiliations.*

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