Public health benefit of over-the-counter nicotine medications

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Abstract

Objective—To estimate the impact of allowing non-prescription sales of nicotine medications in the United States on increasing the numbers of smokers quitting.

Design—Sales and marketing data were used to compare the use of nicotine medications before and after non-prescription sales, and to estimate the impact of non-prescription sales on quit rates.

Setting—United States.

Measures—Number of quit attempts using nicotine replacement therapy (NRT) products, number of smokers who quit smoking with over-the-counter (OTC) NRT or with NRT still sold by prescription, and incremental quits attributable to OTC NRT.

Results—Since the US Food and Drug Administration approved nicotine medications for OTC sale in 1996, use of the medications has increased by 152% compared with prior prescription use. With increased use of an efficacious treatment, OTC nicotine medications are estimated to yield from 114 000–304 000 new former smokers annually in the United States.

Conclusions—The broader availability and promotion of effective treatments for tobacco dependence, specifically nicotine gum and patch, increase the number of smokers availing themselves of the medications. This increased use is estimated to contribute substantially to the number of former smokers in the United States.

Keywords: nicotine replacement therapy, smoking cessation

Introduction

Even though the United States has made significant progress in reducing the prevalence of cigarette smoking, one out of every four adults continues to smoke. Prevention of initiation of tobacco use among adolescents is an essential element of a comprehensive tobacco control effort although most of the public health benefit of such interventions will not be realised for decades. Promotion of cessation among current smokers offers the promise of more immediate health benefits. Nicotine medications such as the nicotine gum and patch are proven effective therapies to assist smoking cessation. Nicotine replacement therapy (NRT) typically doubles success rates (compared with placebo). In 1984, when nicotine gum was introduced in the United States, and in 1991–1992, when four nicotine patches were introduced, NRT was available by prescription only. Prescription status was deemed appropriate by the US Food and Drug Administration (FDA) because of concerns about the possibilities of abuse and negative consequences of improper use; it was thought that considerable provider assistance was necessary to achieve compliance (especially with nicotine gum, where instruction in chewing technique is helpful). It was also thought that NRT was effective only with considerable behavioural intervention, and labelling required that the medications be used only within a “comprehensive smoking cessation treatment programme”, which was thought to best delivered under a physician’s care. However, clinical experience with millions of prescriptions revealed that NRT treatments were generally safe. It also became clear that physicians rarely could provide the kind of comprehensive counselling called for in the guidelines, and that, in any case, NRT medications were relatively effective even in the absence of intensive intervention. Indeed, smoking cessation guidelines issued by an expert panel of the US Agency for Health Care Policy and Research recommended that NRT be part of standard care for every smoker.

However, the restriction of NRT medications to prescription-only status had become an access barrier to these effective treatments. One survey of smokers showed that 57% were unlikely to see a physician for a medication to help them quit smoking. To increase access to NRT, in 1996 the FDA approved the switch of three NRTs (Nicorette gum, NicoDerm CQ patch, and Nicotrol patch) from prescription-only (R) to over-the-counter (OTC) availability. In the United States, OTC signifies general sale; products are usually stocked on pharmacy and general merchandising shelves, though some are located near staffed counters because of their comparatively high cost. NRT products are restricted for sale to those aged 18 and older.

The fundamental rationale for approving OTC sale of NRT was to improve access to and use of NRT products, which had been used by only 20–30% of smokers before 1996. The underuse of effective treatments is unfortunately characteristic of treatment dynamics in smoking cessation: the most
efficacious treatments have not been widely disseminated or adopted. (A review by Schwartz showed that the least effective methods of quitting were most accessible through outlets such as the Yellow Pages.) Only a small fraction of quit efforts involve the most intensive and efficacious treatments; for example, behavioural cessation therapy is used in only approximately 3–4% of quit efforts. This disparity is even greater among medically underserved populations. Meanwhile, almost all smoking cessation efforts are made without the benefit of formal assistance. The marked dominance of unaided quitting is unfortunate in that it shows that most smokers use the least effective method of quitting.

Increasing the use of an efficacious smoking cessation method could substantially enhance its public health benefit, as long as it remained efficacious for many users. Because NRT has proven efficacy in a wide variety of contexts, including those with little adjunctive intervention, it is well-suited for a role as an OTC medication. Specifically, a placebo-controlled study comparing quit rates for NicoDerm CQ (n = 283) with those for placebo (n = 284) demonstrated that NRT could produce a 171% increase in quit rates in a simulated OTC environment (19% vs 7% 28-day continuous abstinence at six weeks). Studies of each of the NRT’s switched to OTC status also demonstrated that use of NRT under OTC conditions yielded efficacy comparable to that observed in real-world prescription practice (without the intensive intervention characteristic of clinical trials). In these OTC studies (consisting of a total of 9016 smokers followed for six months and 5022 smokers followed for one year), one-year continuous abstinence rates were conservatively estimated at 8%. These figures are likely to underestimate actual success, because they are based on exhaled carbon monoxide-verified complete continuous abstinence—not even a puff allowed—and count all persons lost to follow-up as treatment failures. The latter conventions differentially impact low-contact designs and low-intensity interventions, such as those used in the OTC studies. Thus, this estimate of the quit rate is likely to underestimate systematically real-world success rates. Given that unaided quitting produces one-year success rates of only 2.5–5%, increasing use of NRT medications could yield substantial public health benefit.

Before the OTC switch, the hypothetical benefit of increased use attending an R-to-OTC switch of NRT was estimated by Oster and colleagues, who modelled the potential benefit of switching nicotine gum under a variety of assumptions—for example, quit rates and impact on use of behavioural programmes. They estimated that over a 10-year period, an additional 450,000 smokers might be expected to quit because of the OTC availability of nicotine gum. This finding suggested that OTC held real promise for improving the public health. Oster et al based their analysis on hypothetical projections. This updated communic-
appears for the first time in a household's data, this is counted as a new use. (This underestimates new use because it does not account for the possibility that (a) more than one smoker in a household may quit with NRT, and (b) the same smoker may try to quit on two occasions months or even years apart.) The percentage of unit purchases that represent a new use was computed, and applied to the Nielsen retail volume estimates to project the total number of new NRT users.

To estimate OTC use, we used data from March through May 1997, then projected annual use. This period was the longest stretch marked by an absence of major commercial promotions as well as naturally occurring peaks in smoking cessation, and so reflects a stable OTC market. From mid-August 1996 (when the OTC patches became widely available) through the end of May 1997, the weekly volume of new purchases held to ±10% when promotion periods were excluded. Thus, this period should represent a projectable, but very conservative, estimate of OTC use.

Besides ignoring the effect of specific commercial promotions on NRT use, this estimate of steady-state NRT use also excludes the increased NRT use during naturally occurring periods of peak smoking cessation interest, such as the American Cancer Society's Great American Smokeout in November and the New Year. We separately estimated (from these same sources) the increased use of OTC NRT during these periods, because they represent recurring natural surges of smoking cessation interest and NRT use. These estimates were not used in our basic computations of NRT use, but are discussed below.

Results
In 1995, we estimate that 2.5 million quit attempts were made using NRT products. Projecting from March through May 1997 (112,000 new purchases of OTC NRT per week), we estimate 5.8 million quit attempts per year with OTC NRT—more than double the 2.5 million figure for 1995. In addition to these OTC uses, prescription data suggest that prescription NRT was being used at the rate of 500,000 new prescriptions per year, for a total of 6.3 million quit efforts using NRT, 92% of which were OTC products. Thus 3.8 million (6.3 million minus 2.5 million) annual quit efforts are attributable to OTC availability.

A recent FDA analysis of the three switch applications for the currently marketed OTC products found a 12-month quit rate of 8% when results were pooled across studies. Using this conservative estimate of the quit rate, we estimate that 464,000 smokers per year will succeed in quitting with OTC NRT. An additional 40,000 are estimated to have quit using NRT products still sold by prescription, yielding a total of 504,000 NRT-assisted successful quits per year in the OTC era.

It is hard to estimate how many of these smokers might have attempted to quit had OTC NRT not been so readily available and so effectively promoted. We estimated the number of incremental quits attributable to OTC NRT under a variety of assumptions: first, that all NRT users would have tried to quit anyway; second, that none would have tried to quit without OTC NRT; and third, that half would have tried to quit anyway. We also used two estimates of the success rate of unaided quitting. Cohen et al suggest that 5% of smokers who try to quit on their own remain abstinent for one year. However, Hughes reported that only 3% were abstinent for as long as six months, leading to a one-year estimated quit rate of 2.5%. Accordingly, we modelled unaided quit rates of 2.5% and 5%.

Finally, we computed the incremental number of quits: that is, the number of one-year quits over and above the number estimated for NRT in 1995.

Table 1 shows the number of estimated incremental quits; that is, successful quits that would not have occurred without OTC availability of NRT products. If none of the smokers who used OTC NRT would otherwise have attempted quitting, the number of incremental quits totals 304,000. Conversely, if all NRT users would have tried quitting anyway, and if the unaided quit rate is as high as 5%, then 114,000 incremental quits are attributable to OTC NRT.

The number of incremental 12-month quitters resulting from a year of OTC availability of NRT is conservatively estimated to lie between 114,000 and 304,000. Given the estimate that 1.2 million smokers quit annually in the entire smoking population, this represents a significant contribution to smoking cessation.

Discussion
The magnitude of the apparent benefit of the OTC availability of nicotine medications is striking. Although the conservatively estimated continuous abstinence rates remain low, the comparable rates for NRT users are substantially greater than for unaided quitting, consistent with the finding that NRT generally doubles quit rates. Because the population impact of treatment depends on use as well as absolute efficacy, broad availability and use of NRT medications appear to have had substantial population impact.

We estimate that OTC NRT medications may have increased smoking cessation in the entire American population of smokers by 10% to 25%. This is all the more noteworthy because the figures are likely to underestimate the impact. First, we excluded periods of special commercial promotions from our
estimates (to estimate sustainable volume conservatively). Second, we excluded naturally occurring periods of peak smoking cessation interest, such as the Great American Smokeout and the New Year, which were also associated with promotional efforts. The Great American Smokeout and associated promotions have been demonstrated to increase cessation activity. In fact, these two week-long periods of enhanced use are estimated (by extensions of the methods used here) to boost the impact of OTC NRT by about 7%, accounting for approximately 266,400 new NRT quit attempts and an additional 8,000–21,300 incremental quits. In sum, when the increased cessation activity for these two periods is considered, the total number of annual successful quitters resulting from OTC NRT is estimated at 122,000–325,000.

It is also noteworthy that rates of OTC use have been strikingly stable. As noted, weekly sales have not varied by more than 10%, except during increases related to more intensive promotions. This experience is in sharp contrast to the initial marketing of nicotine patches, when demand surged and then quickly bottomed out. Patches were first promoted widely in March 1992, at which time sales skyrocketed 240% over the first two months of 1992 (based on Walsh America data). Only four months later, sales had fallen back to baseline, and a month later fell below the baseline, never to recover. Although it is impossible to predict future NRT use, OTC sales show no signs of abating, nor of the boom-and-bust cycle that marked the introduction of prescription patches. Based on experience to date, the increased use due to OTC availability appears sustainable.

The ability to sustain smokers’ interest in quitting with NRT may be attributable, in part, to the intensive advertising and promotional campaigns that have characterised the OTC market in NRT. Besides television advertising that is estimated to have reached almost every smoker in the United States, these marketing efforts have included promotion of programmes sponsored by voluntary associations and other activities to promote cessation. Although many promotional activities promote particular products, this marketing and outreach effort also brings smoking cessation messages before the public in unparalleled intensity. This makes it particularly plausible that many of the quit efforts involving OTC NRTs are incremental efforts that would not otherwise have occurred. Although these projections need to be confirmed by direct population studies of prevalence and cessation, the middle–ground estimates of approximately 225,000 incremental quits—an increase of almost 20%—are probably quite realistic.

Although these estimates are heartening, it is likely that even greater population impact could be achieved by further improving access. Currently, the cost of NRT products is one of several potential barriers to access. Only about a fifth of NRT users have household incomes below $20,000; a third describe their financial circumstances as less than “comfortable” (SBCH data on file). Although the daily cost of NRT treatment in the United States is comparable to the cost of smoking a pack a day, some smokers may not have—or may be unwilling to spend the concentrated up-front cost of an NRT purchase—seven days’ worth of therapy at a minimum. Thus, low-income groups—where smoking is increasingly concentrated and where quit rates are low—have the least improved access to effective smoking cessation treatment. Accordingly, access could be improved by partial or complete coverage of NRT products. A 1995 survey of managed-care organisations showed uneven and often restricted coverage of NRT products when they were available only by prescription. Although a comparable survey has not assessed coverage of OTC products, it seems clear that coverage has diminished (health plans [companies providing or paying for health services] rarely cover OTC products and of the plans surveyed in the above study, only 10–14% [depending on patch or gum] believed they would). In this instance, coverage of OTC NRT could potentially have significant public health benefit by increasing cessation.

The demonstration that effective treatment can be made widely available is especially salient given the renewed emphasis on smoking cessation (see resolutions adopted at the 10th World Conference on Tobacco or Health—page 277 of this issue of Tobacco Control)—and the possibility that new resources may be available to support it. The proposed tobacco industry settlement currently underway in the United States contains provisions for funding of smoking cessation treatments. Nicotine replacement is not the sole approach to treatment of tobacco dependence, but our data suggest the possibility that it can make effective treatment widely available.

The benefits of OTC NRT need to be weighed against the realisation of any potential risks associated with broader marketing and availability of NRT. These risks were thought to include use/abuse by teenagers or non-smoking adults, and any harm resulting from use of NRT products (including concern about use beyond the recommended period). At FDA request, companies marketing these products have conducted extensive surveillance activities, including surveys of smokers and non-smokers, interviews with school-based, drug-abuse prevention coordinators, media tracking, and follow-up of efforts of NRT users. The methods and results are too extensive to be described here, but preliminary analyses of some of these data (to be reported in a later publication) do not demonstrate significant indications of misuse of the current OTC NRT medications or of unexpected adverse experiences. Expanded availability was also thought to increase the likelihood that NRT medications would be used by smokers for purposes other than quitting—for example, to reduce smoking, perhaps in situations where smoking is forbidden. Surveillance has not turned up any indication of such use. In any
case, it has been suggested that such use, if it occurred, would not pose a public health risk, but instead would yield a public health benefit compared with continued tobacco use. Thus, there is little realized risk to offset the substantial benefit of increased cessation activity.

These data suggest that OTC availability of NRT medications has resulted in a public health benefit. Of course, further research questions remain. It would be useful to describe how use of NRT medications is distributed across groups of smokers, and to help identify the impact of reimbursement and coverage policies would also be useful. Finally, research may help identify methods of maximizing the benefit of NRT under minimal-intervention OTC conditions, while minimizing any risks associated with it.

Conclusions

The switch to over-the-counter availability for nicotine medications appears to have begun to fulfill its promise of increased access. This paper demonstrates how increased availability of treatment can result in increased use, suggesting the potential for substantial public health benefit. There are likely hundreds of thousands of NRT-assisted continuous quitters in the United States who would not have become former smokers without OTC NRT. The American population could see a benefit in decreased morbidity and mortality in the coming years as a result.

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