

Deadly trends: Medicare Benefits Schedule nicotine and smoking cessation items, 2021–23

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Background and objective

Comprehensive nicotine and smoking cessation interventions can be crucial for successful and sustained cessation, but require adequate time, training and experience. This study aimed to quantify uptake of the temporary Medicare Benefits Schedule (MBS) smoking cessation services from July 2021 to December 2023.

Methods

MBS nicotine and smoking cessation claims processed for face-to-face and telehealth services from July 2021 to December 2023 were examined. Quarterly rates of claims and 95% confidence intervals per 1000 people who smoke were calculated.

Results

Overall, 188,904 claims were processed during this period. The national trends in the rate of face-to-face ($P<0.001$) and telephone ($P<0.001$) services increased significantly. The quarterly rate of claims processed for face-to-face services increased by 16-fold, from a rate of 1 to 16 per 1000 people who smoke.

Discussion

This study highlights that the temporary MBS smoking cessation services were increasingly used, but that changes to this service might deter smoking cessation efforts.

IN JULY 2021, the Australian Government added new items to the Medicare Benefits Schedule (MBS) to allow for face-to-face and telehealth (video and telephone) consults for nicotine and smoking cessation counselling provided by general practitioners (GPs) and other medical practitioners (OMPs).¹ There were approximately 35,000 registered GPs providing the services;² however, unlike other telehealth items, the temporary items did not require a patient to have an established relationship with the GP. The introduction of these items aligned with the rescheduling of e-cigarettes to a Schedule 4 drug (ie the supply of nicotine-containing e-cigarettes only with a valid medical prescription) in October of the same year, with the aim of stopping people who do not smoke from taking up nicotine e-cigarettes while facilitating access for people who currently smoke to products for smoking cessation on their doctor's advice.^{3,4} The development of these MBS items was intended to prevent an elevated demand for access to nicotine vaping products via the routing medical access pathway. This could potentially occur as a result of such changes. The MBS items were planned to run through to 30 June 2022 and were time limited in order to address barriers to limited-service provision and to raise awareness about the regulatory and guideline changes.⁵ The expectation was that the temporary MBS items would facilitate the incorporation of the new regulations and guidelines for nicotine addiction into routine practice.⁵ Ultimately, the temporary

MBS items, which were launched during the COVID-19 pandemic, were extended until 31 December 2023.

The use of commercially produced tobacco is a leading cause of preventable morbidity and mortality. In 2018, commercial tobacco use was estimated to have killed approximately 20,500 people in Australia,⁶ and, in 2021, was reported to account for 37% of all Aboriginal and Torres Strait Islander deaths.⁷ As part of a comprehensive approach to tobacco control, preventing uptake and providing cessation support are essential to reducing tobacco-related harms.⁸ The World Health Organization's Framework Convention on Tobacco Control⁹ and the Australian National Tobacco Strategy 2023–2030¹⁰ reflect the important role of cessation supports in reducing nicotine and tobacco use, as well as improving health outcomes.

Australia offers a range of programs to support people to quit and the important role of general practice in supporting quit attempts has long been established.¹¹ However, in the Australian context, the routine and consistent provision of smoking cessation has not occurred in healthcare settings.¹² Some of the identified barriers to the provision of this service include time, cost and practitioner knowledge.^{11,13,14} The implementation of the temporary MBS item numbers, which allowed for longer, focused consults, together with the launch of The Royal Australian College of General Practitioners (RACGP) Guidance on Smoking Cessation should have addressed some of these concerns.¹⁵

Using MBS data reported by Services Australia, this study aimed to describe the uptake of the temporary MBS items and identify the most used items by analysing the claims processed for MBS smoking and nicotine cessation counselling services from their introduction in July 2021 until they lapsed in December 2023.

Methods

Data

This paper draws on national MBS data to report smoking and nicotine cessation claims processed by Services Australia between July 2021 and December 2023. These MBS items were made temporarily accessible for the provision of nicotine and smoking cessation counselling across Australia by registered providers (GPs and OMPs) via face-to-face and telehealth (videoconferencing and telephone) services.¹

Outcome

The use of the 18 temporary MBS nicotine and smoking cessation items processed between July 2021 and December 2023 was examined.

Statistical analysis

Descriptive analyses were used to calculate frequencies and percentages of claims processed for services provided face to face, by videoconferencing and by telephone separately.

A small number of claims processed for patients aged <14 years were excluded from each item. Quarterly (from Quarter [Q] 3 in 2021 through to Q4 in 2023) rates of claims processed for nicotine and smoking cessation services per 1000 people who smoke were calculated. The change over time (quarterly) in the rate of claims processed was tested and *P*-values were used to show the statistical significance of the observed differences. The number of people who smoked was estimated based on 2023 Australian Bureau of Statistics data for national, state and territory populations¹⁵ and smoking prevalence reported by the Australian Institute of Health and Welfare.¹⁶ In addition, 95% confidence intervals (CIs) were calculated for rates in each quarter for national services offered via face-to-face, videoconferencing and telephone consults.

Analyses were performed using STATA/MP version 18 (StataCorp LLC, College Station, TX, USA) and Excel for Microsoft 365 MSO (V2401; Microsoft Corporation, Redmond, WA, USA).

Results

Overall, 188,904 nicotine and smoking cessation counselling services claims were

processed between July 2021 and December 2023, of which, 139,667, 37,649 and 11,588 were offered via face-to-face, telephone and videoconferencing consults, respectively. Most of the claims in the face-to-face and telephone services were made by GPs in an appointment under 20 minutes duration (*n*=127,780 [91%] and *n*=30,515 [81%], respectively; Table 1).

Figure 1 presents national rates of claims (with 95% CIs) processed for nicotine and

Table 1. Number of nicotine and smoking cessation counselling-related Medicare Benefit Schedule (MBS) claims processed from July 2021 to December 2023

	n	%
Face-to-face		
GP for <20 minutes (93680)	127,780	91.5
GP for ≥20 minutes (93683)	9116	6.5
MP for <20 minutes (93681)	1119	0.8
MP for ≥20 minutes (93684)	200	0.1
MP in an eligible area for <20 minutes (93682)	1322	0.9
MP in an eligible area for ≥20 minutes (93685)	130	0.1
Total claim	139,667	
Videoconferencing		
GP for <20 minutes (93690)	6463	55.8
GP for ≥20 minutes (93693)	1194	10.3
MP for <20 minutes (93691)	63	0.5
MP for ≥20 minutes (93694)	11	0.1
MP in an eligible area for <20 minutes (93692)	195	1.7
MP in an eligible area for ≥20 minutes (93695)	3662	31.6
Total claim	11,588	
Telephone		
GP for <20 minutes (93700)	30,515	81.1
GP for ≥20 minutes (93703)	6958	18.5
MP for <20 minutes (93701)	83	0.2
MP for ≥20 minutes (93704)	40	0.1
MP in an eligible area for <20 minutes (93702)	43	0.1
MP in an eligible area for ≥20 minutes (93705)	10	0.0
Total claim	37,649	

GP, general practitioner; MP, medical practitioner; n, number of claims. Numbers in parentheses are MBS item numbers.

smoking cessation counselling services provided via face-to-face, telephone and videoconferencing consults. Between July 2021 and December 2023, national rates of claims processed for services delivered via face-to-face and telephone consults increased consistently. The rates of claims processed for face-to-face services increased 16-fold, from a rate of 1 to 16 per 1000 people who smoke between 2021 (21Q3) to 2023 (23Q4). The over time increase in the quarterly rate of claims processed for face-to-face services was statistically significant ($P<0.001$). The rate of claims processed for telephone services increased from approximately no service to 2 per 1000 people who smoke during the same time ($P<0.001$), whereas rates for services delivered via videoconferencing across this period were varied and the changes over time were not significant ($P=0.39$).

Quarterly rates of claims processed for nicotine and smoking cessation counselling services provided via face-to-face consults increased consistently in all jurisdictions (Figure 2). The rate of claims processed for face-to-face services ranged by jurisdiction, from approximately 10 per 1000 people who smoke in South Australia to 22 per 1000 smokers in Tasmania. For telephone-based services, the rates of claims processed ranged from approximately 1 per 1000 people who smoke in the Australian Capital Territory to 4 per 1000 people who smoke in the Northern Territory. In all jurisdictions, the rates of claims processed for services delivered via videoconferencing were lower than for the other two modes of delivery (Figure 2).

The rate of claims processed for the services provided via face-to-face increased from 0.74 to 16.59 per 1000 ($P<0.001$) for

females and from 0.71 to 15.28 per 1000 ($P<0.001$) for males between Q3 in 2021 to Q4 in 2023. The rate of claims processed for the services provided via telephone increased from 0.15 to 2.81 per 1000 ($P=0.001$) for females and from 0.15 to 2.04 per 1000 ($P=0.02$) for males during the same period. The rate of claims processed for services delivered via videoconference across this period was not significant for both genders. We found that a greater number of claims were processed for services provided to patients aged between 35 and 64 years for all modes of service delivery (results not shown).

Discussion

Claims for the temporary MBS nicotine and smoking cessation counselling items processed by Services Australia between July 2021 and December 2023 were quantified.

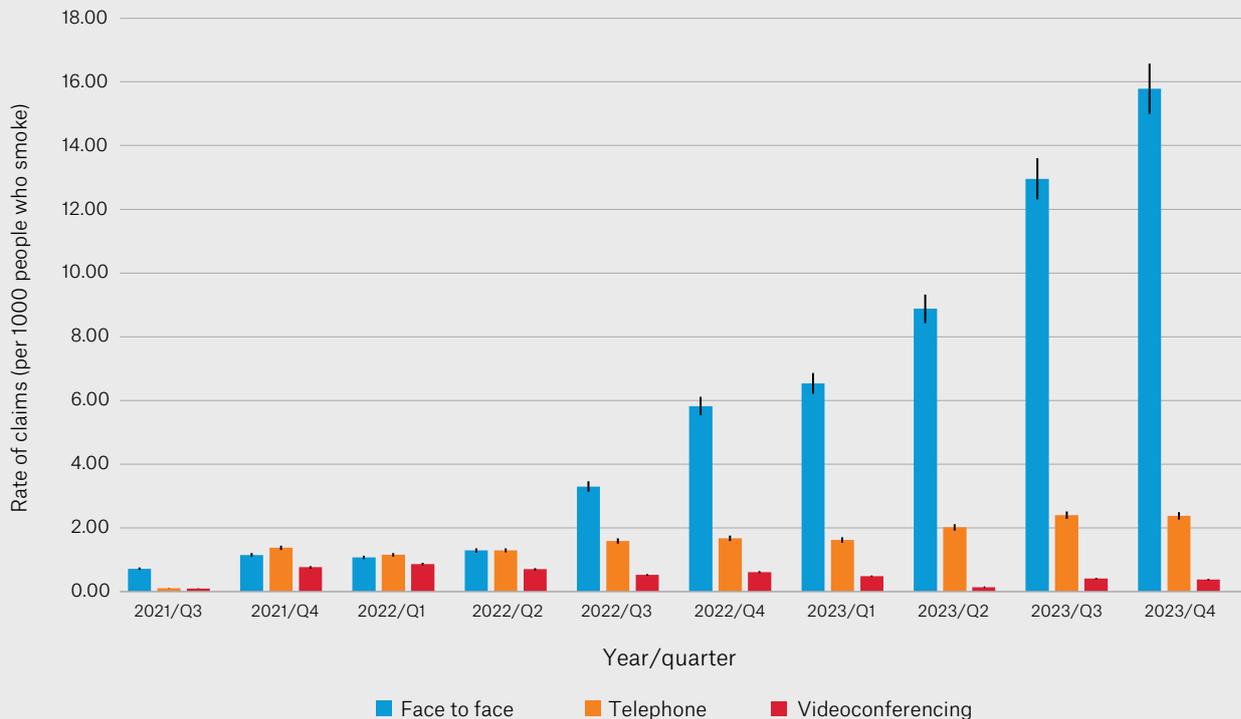


Figure 1. National quarterly rates of claims processed for nicotine and smoking cessation counselling services per 1000 people who smoke provided face to face or via telephone or videoconferencing consults from quarter (Q) 3 in 2021 to Q4 in 2023. Error bars indicate 95% confidence intervals.

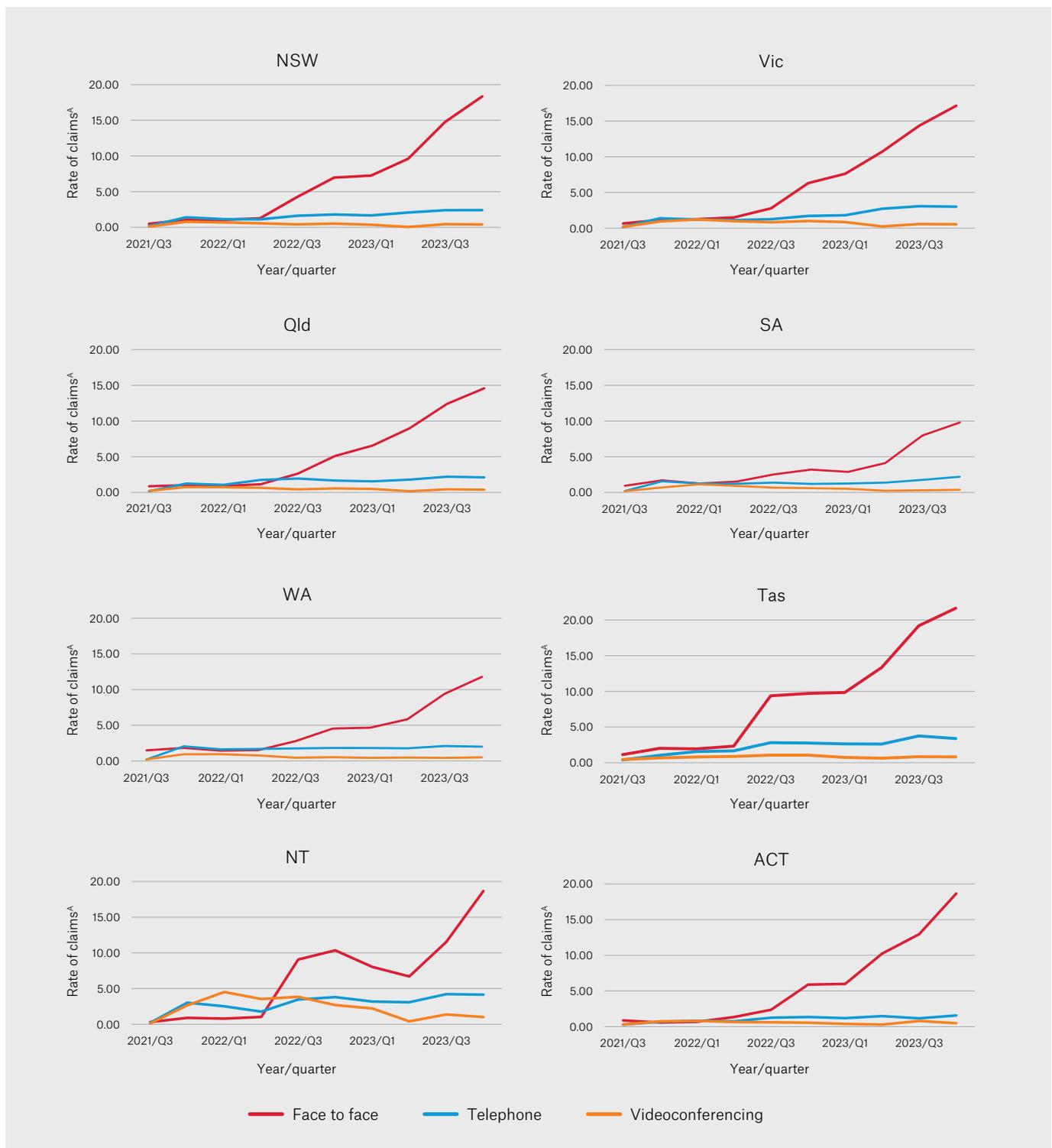


Figure 2. Rates of claims processed per 1000 people who smoke for nicotine and smoking cessation counselling services provided face to face or via telephone or videoconferencing consults from quarter (Q) 3 in 2021 to Q4 in 2023 for states and territories separately.

^APer 1000 people who smoke.

ACT, Australian Capital Territory; NSW, New South Wales; NT, Northern Territory; Qld, Queensland; SA, South Australia; Tas, Tasmania; Vic, Victoria; WA, Western Australia.

The results show that the temporary items were all increasingly used over the period, and trends in the quarterly rates of claims processed for face-to-face and telephone-based services increased significantly nationally and in all jurisdictions separately.

Reducing smoking prevalence remains an urgent health priority, with approximately 2.6 million Australians aged 18 years and over smoking daily,¹⁷ the vast majority of whom want to quit.¹⁸ In addition, the number of people vaping is increasing rapidly,^{19,20} as is the number of people wanting to quit vaping.^{21,22} The results of the present study demonstrate that the temporary MBS nicotine and smoking cessation counselling services were increasingly used across the study period, with the vast majority of items claimed for face-to-face services. Despite the significant increase in uptake, these MBS items ceased on 31 December 2023, with the provision of smoking and nicotine cessation assumed to now be embedded in routine practice.²³

One of the frequently reported barriers to the delivery of smoking cessation support in clinical settings is a lack of time.¹⁴ The observed increase in the claims processed for the temporary MBS nicotine and smoking cessation items could be due to the allocation of adequate time and payment to provide cessation support under these temporarily introduced items. The most important finding was the high and continual increase in the rate of claims processed for services provided face to face, which might suggest that the majority of services were conducted and claimed by the patients' usual practices. The cessation of these services might have had a regressive impact on people seeking quitting support from their GP at a time when many changes were occurring in respect of nicotine and tobacco control measures.

Although the MBS items were increasingly used, it is possible that uptake was not as significant as it could have been. There are various possible reasons for this, including a lack of item awareness, compliance concerns, clinical concerns relating to the exemption for an existing relationship with the patient and the RACGP's assertion that further MBS item numbers fragmented care and were not necessary.⁵ For example, the RACGP reports that 16% of GPs limit the services they provide to avoid the consequences of

non-compliance and that 42% of GPs have not claimed certain Medicare items despite providing services due to fear of compliance ramifications.²⁴ The item descriptors required prescribers to complete 'an assessment of the patient's nicotine dependence, including where clinically appropriate a basic physical examination'.²⁵ A physical examination on telehealth can be quite challenging and may have deterred GPs due to fear of compliance ramifications.

The telehealth provision included an exemption on the requirement to have an established relationship with the patient. GPs raised concerns about this exemption, a concern that appears to have been justified because websites promising prescriptions for vaping scripts (in contradiction of the RACGP guidance relating to front-line treatments) appeared in Australia.^{25–27}

The introduction of the temporary MBS items and their increasing utilisation across the period suggest that they might have raised providers' awareness of smoking and nicotine cessation support and warranted incentives, but that uptake was likely tempered by compliance and clinical concerns. The telehealth MBS items provided an increasingly used alternative to face-to-face consultations where the latter could not be provided due to accessibility issues. People in rural and remote Australia who smoke found telehealth-based counselling for cessation acceptable and helpful,²⁸ with the potential to increase cessation rates.²⁹ The effect of removing these MBS items on rural and regional Australians, where smoking rates remain higher³⁰ and there are challenges in accessing face-to-face consults, should be considered.

Strengths and limitations

This study has several strengths. To our knowledge, it is among the first to evaluate the level of access to the temporary MBS nicotine and smoking cessation items. Trends in the quarterly rates of claims were calculated and changes in the quarterly rates over time were tested for significance. In addition to the national analysis, the results presented by jurisdictions, sex and age provide useful insights into service delivery. Understanding the use of this temporary MBS nicotine and smoking cessation service might help in the evaluation of routine cessation supports.¹⁵ The study is limited by the lack of information

on the determinants of service provision and utilisation, mainly due to the absence of data. However, assessing the efficacy of nicotine and smoking cessation services and factors affecting service provision and utilisation was beyond the scope of this work.

Conclusion

Commercial tobacco use remains the leading cause of preventable morbidity and mortality. Nicotine and smoking cessation support should be available for people who smoke and/or vape to manage nicotine withdrawal, promote cessation and improve health outcomes. This study provides an understanding of nicotine and smoking cessation counselling service uptake based on the temporary MBS nicotine and smoking cessation items. Embedding smoking and nicotine cessation in routine care is essential, and the present study identified that claims processed for face-to-face services (which could be provided by a patient's usual practice) increased from a rate of 1 to 16 per 1000 people who smoke between 2021 and 2023. The monitoring and evaluation of smoking and nicotine cessation as part of routine care are required to help ensure that appropriate supports and ongoing culturally safe best practice are implemented and maintained. General practice has a crucial role to play in supporting people to quit smoking and/or vaping with or without dedicated MBS item numbers.

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