Asthma Australia submission to the Therapeutic Goods Administration: Proposed amendments to the Poisons Standard - ACMS, ACCS and Joint ACMS/ACCS meetings, November 2020

Item 1.4 Budesonide + formoterol

PART A: Item 1.4 - budesonide + formoterol

Asthma Australia does not support the proposed amendment regarding budesonide in combination with formoterol.

PART B

Introduction

Asthma Australia works to support the one in nine Australians with asthma to breathe better and live freely. For over 50 years Asthma Australia and the Asthma Foundations have been leaders in asthma health care, education, research and advocacy.

Asthma Australia delivers evidence-based preventive health strategies through our information provision, phone line and asthma community projects and programs. The organisation also provides education and training to promote best practice asthma care and first aid training to health professionals, schools, childcare centres, workplaces and sporting and recreational settings to ensure asthma is managed according to best practice.

Asthma Australia supports research that contributes to national and international understandings of asthma and how best to manage the disease. The organisation engages in advocacy on the issues that are important to people with asthma, to ensure policies are in place to support people with asthma achieve optimal health.

Through this work, we reach more than 500,000 Australians each year.

Method

Asthma Australia undertook extensive consultation with health clinicians and professionals and with consumers via a number of methods to stimulate discussion, debate and exchange of ideas related to this significant policy issue affecting many Australians with asthma.

This consultation included a survey of consumers, discussions at meetings of Asthma Australia's Board appointed Consumer Advisory Council and Professional Advisory Council and a targeted survey of consumer and professional council representatives and key staff.

Asthma Australia also facilitated a joint meeting of consumer and professional experts with AAL professional staff.

Asthma in Australia

Asthma is one of the most common chronic illnesses in Australia, affecting one in nine people. It is the most common chronic illness among children and the leading burden of disease for this age group.[1]

People with asthma can experience mild, moderate and severe disease and this is typically defined by the amount of medication required to gain control of symptoms and to avoid asthma attacks or flare-ups. People with severe disease need high doses of potent combination inhaled medications and often rely of frequent courses of systemic corticosteroids to control their disease. People with mild asthma experience mild and infrequent symptoms and can often control these with low doses of simple preventer medication.

Approximately 40,000 people with asthma are admitted to hospital each year due to a severe asthma attack and it is considered by the AIHW that over 80% of these admissions are avoidable with **appropriate delivery of preventative and disease management interventions in primary care and community settings**.[2] It is in this context and the indicators reflecting this view provided below that the risks and benefits of this application need to be considered.

Indicators reflecting the quality of appropriate health interventions currently in Australia include:

- Only 30% of people with asthma have an asthma action plan despite the recommendation that all people with asthma should have one
- Only 15-30% of people prescribed a regular preventer use them at a rate consistent with recommended or therapeutic use
- Up to 80% of people don't use their inhaler device correctly
- The vast majority of general practice encounters for asthma are urgent visits despite evidence supporting the effectiveness of routine, planned follow up consultations[3,4].

Best practice asthma management

The Australian Asthma Handbook[5], Australia's evidence-based reference for primary health care health providers, considers the following as minimum requirements in treatment planning for people with asthma:

[1] https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/overview
[2] https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview
[3] https://www.mja.com.au/journal/2005/183/2/general-practitioner-views-barriers-and-facilitators-implementation-asthma-3
[4] https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma/contents/treatment-management
[5] https://www.asthmahandbook.org.au/

- Confirming the diagnosis
- Assessing asthma control (recent asthma symptom control and risk factors)
- Identifying management goals in collaboration with the patient choosing initial treatment appropriate to recent asthma symptom control, risk factors and patient preference
- Reviewing and adjusting drug treatment periodically
- Providing information, skills and tools for self-management, including:
  - Training in correct inhaler technique
  - Information and support to maximise adherence
  - A written asthma action plan
  - Information about avoiding triggers, where appropriate
- Managing flare-ups when they occur
- Managing comorbid conditions that affect asthma or contribute to respiratory symptoms
- Providing advice about smoking, healthy eating, physical activity, healthy weight and immunisation.

Asthma Australia advocates strongly on behalf of people with asthma that quality asthma care is delivered according to this framework and the principles of person-centredness. It is a minimum requirement to individualise care and achieve asthma control, reduce risk of flare-ups, improve quality of life and overall safety and wellness.

Asthma medicines

The goal of asthma medication therapy is to prevent symptoms, prevent asthma attacks and maximise quality of life. For the majority of people with asthma, this takes the form of inhaled medicines which are described by the two commonly recognised classes; *relievers* and *preventers.*

Relievers
These medicines should be used only when breakthrough symptoms occur and should only be used as infrequently as possible. Until recently they were known as 'blue/grey' relievers and included Salbutamol and Terbutaline-based products. The last few years have seen Budesonide/Formoterol (B/F) in fixed dose combination (FDC) added to the list of relievers for use in 'maintenance and reliever' treatment (MART) protocols for people with moderate to severe asthma (see below). Since 2019 B/F FDC has been registered and approved for use on an as-needed basis for people with mild asthma without concomitant regular preventer therapy.

Relievers work by relaxing the muscles within the airways – bronchodilation. The B/F FDC promise an added benefit of reducing the risk of flare-ups due to their anti-inflammatory action.

Preventers (also known as 'maintenance' or 'controller' therapy)
Preventers are recommended, registered and approved for regular use in asthma and work to suppress the inflammation, hyperresponsiveness and mucus production within the airways of a person with asthma. Inhaled corticosteroids are considered the most effective among the preventer class of medicines and are required daily or twice daily to be effective at dampening airway inflammatory processes and preventing symptoms. Like most other medicines to control chronic illness, they need to be used all the time, irrespective of the presence or perception of symptoms.

Preventers also include inhaled corticosteroid/long-acting beta-agonist (ICS/LABA) combination medicines like B/F FDC. There are also non-steroidal inhaled preventers and non-steroidal preventers taken in tablet form.

Asthma is a relatively unique chronic illness in terms of its reliance on therapy delivered by inhalation. This has the advantage of working in the area of the body where the inflammation is present, avoiding unwanted side effects through use of systemic medicines.

However, people with asthma often associate their condition with symptoms and face challenges adhering to their prescribed preventer regimen. Asthma Australia and key collaborators over many years have worked hard to reinforce the importance of regular preventer treatment and equally dismantle misconceptions around the appropriateness and safety of symptom driven patterns of treatment.

Maintenance and reliever therapy (MART)
This is a form of treatment which uses the same ICS/LABA combination product on a regular basis, twice daily, to *prevent* symptoms as is used to *treat* any breakthrough symptoms. The effectiveness of this regime is predicated on the rapid onset of the LABA (formoterol) component of the product and several studies have demonstrated the superiority of MART against other preventer and reliever (ICS/LABA plus as-needed SABA) regimens.[6]

Budesonide/Formoterol for use is mild asthma 'as-needed' in Australia

Budesonide/Formoterol in fixed dose combination form (DuoResp Spiromax 200/6, Symbicort Rapihaler 100/3, Symbicort Turbuhaler 200/6 - herein referred to as B/F FDC) was included on the Australian Register for Therapeutic Goods (ARTG) for use 'as-needed' by people with mild asthma in 2019. In June 2020, it was announced by the Department of Health that B/F FDC was added to the Pharmaceutical Benefits Scheme (PBS) list of medicines eligible for subsidy when prescribed appropriately. An 'Authority Required (Streamlined)' classification is applied which requires that the prescriber needs to validate:

Mild asthma -

- Patient must have asthma and require anti-inflammatory reliever therapy
- Patient must not be using single agent concomitant long-acting beta agonist (LABA)
- Patient must be aged 12 years or older.

On September 2, 2020, the Australian Asthma Handbook (AAH V2.1, National Asthma Council, Australia) was updated to include this option for treatment of mild asthma. **The 'as-needed' use of B/F FDC without concomitant use of an inhaled corticosteroid (ICS)-based preventer is extremely new in Australia and marks a very significant change in asthma management guidelines**. Asthma Australia aims to monitor closely how prescribers and consumers respond to this change, which we hope will be positive, result in appropriate treatment planning, positive health outcomes for people with asthma and is assimilated into their overall health seeking behaviour effectively. An Authority Required classification on the PBS is in place for this medicine to ensure it is prescribed for the right patients, for the right reasons and to avoid misuse and avoidable harm. To move from Authority Required to unrestrained access over the counter is a leap too far too quickly.

[6] https://onlinelibrary.wiley.com/doi/full/10.1111/resp.13804

It is important to note also that B/F FDC is indicated also for use in moderate and severe asthma and similarly has an Authority Required (Streamlined) classification attached to these applications. Patients qualifying for subsidy under the PBS for these prescriptions:

Must have asthma, and –

- Experience frequent episodes of asthma while receiving oral corticosteroid or optimised inhaled corticosteroid treatment
- Experience frequent episodes of asthma while receiving oral corticosteroid or optimised inhaled corticosteroid treatment and require single maintenance and reliever therapy
- Experience frequent asthma symptoms whilst receiving treatment with an ICS/LABA
- Must be 12 years or over
- Cannot be initiated on this therapy
- Adherence and device technique should be checked at each clinical visit and before 'stepping up to this therapy

The appropriate prescription and dispensing of this medicine for the right patient according to a supervised asthma management plan is a complex thing and the availability of B/F FDC over the counter in this context risks the potential that people with complex asthma accessing it without recommended medical supervision.

Asthma Australia's position on the Budesonide/Formoterol rescheduling application

The availability of OTC B/F FDC has great potential to reduce preventable harm, but the application cannot be supported by Asthma Australia in its present state. Asthma Australia acknowledges the drivers of the proposed rescheduling, in particular the option of a safer alternative to short-acting beta agonists over the counter for consumers who prefer to access their asthma medicines in this way, Asthma Australia asserts there are too many unanswered questions and not enough real world evidence of structures in place to support the successful implementation of this change.
Asthma Australia cannot see the down-scheduling of B/F FDC as-needed to be available as a pharmacy only medication as one consistent with the planks of the National Medicines Policy (NMP) and in particular, the Quality Use of Medicines.

International context

Budesonide and Formoterol are available only by prescription in countries including New Zealand, the United Kingdom, Canada and the United States. It is understood that SABA has been available over the counter (OTC) as a schedule 3 pharmacy-only medicine for approximately 30 years in Australia. Australia is unique among NZ and the US markets in making SABA available OTC.

Asthma Australia's review of the evidence

SABA over-reliance/over-use

Research studies over decades have demonstrated the risk to people with asthma associated with excessive use of SABA. Over-use of SABA is associated with a significant increase in the risk of asthma attacks and death.[7,8] Evidence suggests that even short term, regular use of SABA can be risky in not only reducing responsiveness to SABA in asthma emergency situations but also causing of asthma symptoms, from airway hyper-responsiveness and increasing inflammation.[2] In hospital database studies, patients found to have a lower ICS to SABA ratio were more likely to be hospitalised whereas those with a higher ratio were less likely to experience life-threatening asthma attacks requiring hospitalisation.[2] There is a strong case for addressing the public health challenge of SABA over-use and Asthma Australia recognises the need to address this challenge.

Budesonide/Formoterol as-needed to treat symptoms in mild asthma

The role of B/F used in an 'as-needed' regimen is based on a substantial body of international research which investigated the head to head benefits of B/F as needed against SABA as-needed and against regular B/F plus SABA as needed. The findings of these studies are summarised here (indicators are comparing the interventions along the top row): [9,10,11,12]

	Regular B/F plus SABA as-needed	**B/F as-needed**	**SABA only as-needed**
Risk of severe exacerbations	Superior	Superior	Inferior
Symptom control	Superior	Inferior	Most inferior
Lung function	Superior	Inferior	Most inferior
Inflammatory markers	Superior	Inferior	Most inferior
Exposure to corticosteroid	Greater	Less	N/A

Asthma Australia acknowledges the significant body of evidence demonstrating:

- B/F FDC is superior to SABA alone to prevent exacerbations when used as-needed
- B/F FDC as- needed is equal to regular Budesonide plus as-needed SABA in preventing exacerbations
- Regular budesonide plus as-needed SABA is superior to B/F FDC as-needed for asthma control
- B/F FDC as-needed superiority to SABA as-needed for asthma control did not meet the criteria for clinical significance
- Lung function is most effectively preserved with regular budesonide plus SABA as-needed compared with B/F FDC as-needed which is more effective than SABA as-needed
- Regular budesonide plus SABA as-needed is more effective at reducing inflammatory markers than B/F FDC as-needed. B/F FDC was superior to SABA as-needed for this metric.

However, that evidence is limited to people with symptoms fewer than twice per week and more frequently than twice per month.[13] For this group of patients the use of B/F FDC as-needed would be

[7] https://pubmed.ncbi.nlm.nih.gov/11208619/
[8] https://erj.ersjournals.com/content/53/6/1901046#ref-3
[9] https://www.nejm.org/doi/full/10.1056/NEJMoa1715274
[10] https://www.nejm.org/doi/full/10.1056/nejmoa1715275
[11] https://www.nejm.org/doi/full/10.1056/NEJMoa1901963
[12] https://www.thelancet.com/article/S0140-6736(19)31948-8/fulltext
[13] https://www.asthmahandbook.org.au/management/adults/initial-treatment/relievers

a consideration alongside the regular use of a preventer (ICS or other). This is a scenario that needs to be discussed with a doctor and not taken without professional medical consultation.

It is also noted that B/F FDC as-needed is not as effective as regular Budesonide plus as-needed SABA at improving asthma control and compared with SABA does not improve asthma symptom control sufficient to be considered clinically significant. Where consumers express preference to achieve symptom control, they should be supported appropriately to understand their options against their goals of care and the evidence.

Given the complexity of the research findings presented above, the availability of this treatment would need to be supported by appropriate safeguard structures and complemented by meaningful education and information to enable consumers to make the best informed decision for their choice of asthma treatment. **Asthma Australia is unaware of any other chronic disease where the opportunities for planned management are removed in favour of ad hoc over the counter management.**

Beyond the evidence supporting the use of as-needed B/F FDC for mild asthma against as-needed SABA only, we are not aware of evidence existing regarding the effectiveness of pharmacy-only medicines in asthma chronic disease management (not including use in emergency situations)– none of the studies were designed to provide B/F FDC as-needed simulating an OTC transaction. On the contrary, we are aware of evidence which suggests that asthma treatments available over the counter may be dangerous or associated with sub-optimal health care.[14,15] This includes a recent study of people who access their SABA over the counter in Australia.[16] This study revealed that:

1. 70% of people who access SABA in this way are over-users
2. Over-users are more likely to have uncontrolled asthma
3. Almost 20% report not having a medical diagnosis of asthma.

Over-users need to be supported by qualified and skilled primary health care professionals and inappropriate access to over the counter medicines enable the opposite.

Over-users with poor asthma control may not benefit from B/F FDC as-needed over the counter given the lack of clinical significance demonstrated in the aforementioned studies (summarised in the table above).

We should not facilitate access to asthma treatments without a medical diagnosis of asthma.

With these findings in mind, and without strong reassurance that there will be controls and guardrails in place beyond those listed in the application, Asthma Australia does not support a policy change which is likely to further deter access to structured health care.

Asthma Australia's review of the reasons put forward by the applicant

[14] https://uwe-repository.worktribe.com/output/817751/why-asthma-still-kills-the-national-review-of-asthma-deaths-nrad

[15] https://www.bmj.com/content/306/6891/1514?ijkey=7b661eedf2442dca51d9b14b88d79be99f3c858a&keytype2=tf_ipsecsha

[16] https://bmjopen.bmj.com/content/9/8/e028995

In their application, the sponsor refers to a number of factors in support of the re-scheduling. Asthma Australia has considered the available evidence around these factors carefully:

Statement	Review of evidence
Budesonide/formoterol FDC 'as needed' provides a more effective anti-inflammatory reliever alternative to the current OTC reliever	SABA alone is over-used (75% don't use ICS preventer) Effective at reducing risk of exacerbations compared with SABA alone (by 60%) Regular Budesonide plus as-needed SABA was more effective at **achieving asthma control** than B/F FDC as needed
B/F being available OTC as an alternative to the current OTC reliever will help reshape behaviour	No evidence that we are aware of - studies weren't designed to and didn't reveal behaviour change in context of OTC provision Post market review of the current as-needed treatment option listed this year on the PBS will be needed to help understand this better
Will help avoid early reliance on SABA for recently diagnosed patients	Intuitive, for people who can afford and access the option, but no evidence that we're aware of and concern that fewer people return to GP for follow up after initiation of treatment
B/F will provide patients with early anti-inflammatory therapy	Evidence of clinical benefit suggestive of anti-inflammatory action and improvement in inflammatory biomarkers However, early anti-inflammatory based treatment can be obtained via prescription of same product also
Adherence to ICS won't be an issue with B/F as budesonide is provided in combination with the reliever	This will be true for consumers who access and use B/F FDC as-needed for symptom control in mild asthma However, there is potential for B/F FDC OTC to be accessed by consumers who have been prescribed regular preventer but for whom this option appeals and is available which has the potential to cause regression in control, risk and quality of life
Fewer people over-relying on SABA and more people using ICS-based treatment will result in less people with uncontrolled asthma, less urgent health care use, potentially less asthma related deaths and overall less risk and cost to community	Evidence doesn't support clinically significant impact on asthma control. Evidence supports significant reduction in risk of severe flare-ups which would otherwise have resulted in urgent health care use However, evidence was limited to prescribed provision of B/F FDC, not OTC
Pharmacist/patient interaction **will orient towards anti-inflammatory treatment** which will benefit all people with asthma	No evidence that we're aware of in case of asthma and role of anti-inflammatory reliever Some evidence around potential for role of health education delivered during medicine dispensing which improves health promotion behaviours among consumers when supported by appropriate structures and incentives
Pharmacist/patient interaction will orient towards anti-inflammatory treatment **which will benefit all people with asthma**	There is no clear evidence that we're aware of about likelihood that conversations around anti-inflammatory role of B/F FDC will result in similar conversations with other severities of asthma. A population effect like this would require a whole of system approach not limited to an access to medicines policy.

Compliance with dispensing regulations will facilitate best practice collaboration and communication between pharmacy and GP about patient's ongoing asthma management	No evidence that we're aware of No compliance framework suggested in application that compels and obliges this interaction

Asthma Australia's review on how Appendix M can support the safe implementation of this change

The sponsor proposes that Appendix M provides a suitable framework for the safe implementation of B/F FDC in schedule 3, as follows

> *BUDESONIDE when combined with formoterol, where the pharmacist providing professional advice:*
> - *Demonstrates competencies as outlined in the Pharmaceutical Society of Australia competency-based education framework relevant to the supply of budesonide/formoterol as a Pharmacist Only medicine; and*
> - *Complies in all respects with the relevant professional practice standards, and the Pharmaceutical Society of Australia professional practice guidance for supply of budesonide/formoterol as a Pharmacist Only medicine; and*
> - *Confirms the patient has a medical diagnosis of asthma; and*
> - *Documents the supply of budesonide/formoterol in a clinical information system in accordance with professional practice guidance.*

As far as Asthma Australia is aware, there is no monitoring by regulators or evaluation protocol built into Appendix M which would ensure that the largely voluntary terms above are complied with. With regard to the important criterion of confirming the patient has a diagnosis of asthma, how will this be confirmed? While we acknowledge that there are many community pharmacies who look forward to offering these services and indeed have expressed interest to see B/F FDC down scheduled to pharmacy-only medication,[17] there are many pharmacies in Australia where the business model does not support the kind of interaction being described by Appendix M and where people with asthma will miss out on the important structured interaction to determine their individual needs and assess risk.

Indeed the Therapeutic Goods Administration in the *Poisons Standard February 2019* describes Appendix M as an instrument to *facilitate the down-scheduling of substances from Schedule 4 to Schedule 3 where, for example, there is community need for access to a medicine… but where it is considered additional controls and oversight… are needed, in the interests of protecting public health (because) these medicines carry additional risk to public safety that exceed the level considered acceptable for substances in Schedule 3.* [18] Currently**, B/F FDC is needed** by the community and until proven otherwise, it is effective and safe when prescribed by, **and with the support of, a professional health care provider** to manage risk and maximise benefit and safety.

Appendix M provides a level of comfort around the likelihood that dispensing essential medicines will be done conscientiously but medicine dispensing is just one method to achieve the aim of good quality asthma management, which requires substantially more effort.

[17] https://ajp.com.au/wp-content/uploads/2019/04/Appendix-M-Paper-FINAL.pdf
[18] https://www.legislation.gov.au/Details/F2019L00032/Explanatory%20Statement/Text

Asthma Australia's analysis of risks vs benefits

Risks

This application may be unusual because whether the benefits outweigh the risks depends significantly on the eventuality of the interaction between pharmacist and consumer. Asthma Australia recognises that significant potential benefits could result from this application being approved if pharmacists perform according to the applicant's expectations and consumers proceed to access a general practitioner following an interaction with a pharmacist when required.
The assumption behind this theoretical opportunity is also problematic – the SABA overuse and population/individual health risk faced by people with asthma is in part a function of the unstructured and unlimited dispensing of SABA over the counter to Australians with or without a medical diagnosis of asthma. Notwithstanding Appendix M, the concern is that not enough has changed to suggest this transactional way to access medicine will be any different with B/F FDC on the market.

Asthma Australia is concerned about the potential for this policy to result in regressive health choices. Will people prescribed and adherent to regular preventer medicine which is superior at preventing symptoms and flare-ups in the majority of people with asthma be tempted by the ease of access of this medicine? Although the likelihood of this risk is unclear, and we don't have evidence of how this happened in Australia when SABA was made available over the counter, the potential consequences can be severe, including loss of asthma control and increased risk of asthma attack.[19] Consumer-centred care and consumer preference is important but it needs to occur in a safe and supported environment.

Asthma Australia is also concerned about the potential to result in regressive health service delivery. How will the pharmacist know the patient has asthma? How will the pharmacist know the severity of asthma? How will we avoid people who need a different treatment option not getting what they need and people without asthma not being dispensed this medicine inappropriately?

Asthma Australia is advised by paediatric and adolescent respiratory specialists that the use of B/F FDC as-needed in adolescents is an area of concern. Although registered by the TGA and listed on the PBS for use by adolescents aged 12 years and over, based on subgroup analyses of the efficacy of the as-needed protocol in this population[20,21,22] **Asthma Australia considers it an unacceptable risk to make this medicine available for use by adolescents over the counter.** Adolescents experience unique challenges in the context of their unique neurobehavioural and physical developmental experiences and unmonitored use of B/F FDC by this population could be hazardous. Studies designed by paediatric specialists, researchers and adolescent consumers evaluating outcomes in adolescents are required to clearly demonstrate the appropriateness and success parameters of this health intervention for adolescents with asthma.

The complexity of the research supporting B/F FDC suggests that the point of treatment decision is not just a matter of one or the other but must be taken with full understanding of the benefits and risks, strengths and weaknesses of the various choices. An unstructured OTC classification doesn't allow for this currently.

[19] https://pubmed.ncbi.nlm.nih.gov/23321206/
[20] https://www.nejm.org/doi/full/10.1056/nejmoa1715275
[21] https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/PICMI?OpenForm&t=&q=budesonide
[22] https://www.pbs.gov.au/medicine/item/8625y-8750m-8796y

Consumers should be supported appropriately to understand their diagnosis, be presented with their options against their goals of care and the evidence and be given opportunities for follow up and monitoring of their therapy.

Asthma Australia understands that one of the products containing these medicines (Symbicort Rapihaler) may have a short expiry date of 3 months once opened and removed from its foil packaging. This is an area of great concern for consumers trying to manage their supply and access to their critical reliever medicines. What are the implications of using the product past its expiry date? Will the medicine still be effective at relieving symptoms past its expiry date? Could a simple exacerbation escalate into a severe exacerbation if an expired medicine is used?

Another significant issue raised by consumers, which is not a new issue in asthma, is around the cost of this treatment option. Although at the time of writing this submission we are unclear about what the purchase price will be of the packaged medicines. We anticipate it costing approximately twice that of the conventional reliever medicine currently available. Although consumers will ideally have a choice when they present to pharmacy to purchase their reliever, they have shared their views on likely fear and confusion incited by:

- Cost of regularly replacing expired medicines, especially if using a product with a 90 day expiry date
- Cost of having more than one type of reliever in case maximum dose of the B/F FDC is reached in one 'occasion'
- Cost of having ready access to a reliever at home and in other settings, like school, work, parents, partners' houses
- Even though the long-term cost of health care might be reduced or unchanged, the point of sale price is likely to be a factor in consumer decision making
- Concern about the deterrent nature of pricing signals and the eventuality that consumers won't be able to access tailored health care due to these signals
- Concern about the unconscious incentive built into the cost and profit margin of this medicine in commercial pharmacy.

In asthma there is a plethora of treatments and devices. Up to 80% of people with asthma already use devices incorrectly, and the chances of using this medication incorrectly are similarly high. It is recommended that at each health care visit, device technique is checked, and correct instructions reinforced. This requires time and resources. Aside from the importance of correct device use, every person with asthma needs a written asthma action plan which provides clear instructions on what to do when circumstances change. They also need their asthma control and risk reviewed periodically, as well as consideration of their overall condition, other co-morbidities and external environmental determinants of their health. The risk faced by people with asthma if this policy disincentivises best practice provision of health care can be significant and include misuse and misunderstanding of treatment, unmonitored deterioration in condition, accumulation of side effects, increasing cost of health care and consequences related to this.

Benefits

Asthma Australia acknowledges the potential benefits of this change if people with mild asthma, at risk of severe exacerbations, are persuaded to switch from their SABA-only therapy to B/F FDC as-needed. Ideally people with infrequent and mild symptoms, who have a medical review once per year and who understand their options and why they are appropriate for them will access this medicine and use it infrequently in place of their SABA in order to reduce their risk of life-

threatening flare-up by up to 60%.[23] Extrapolating from an epidemiological working group report on mild asthma, up to 20% of deaths in asthma are among people with mild disease[24] – if translatable to Australia, it is important to imagine reducing the risk for the cohort of people with mild asthma who would access this treatment more readily and more effectively, within a conscientious treatment plan.

Although the B/F FDC as-needed treatment idea for use in mild asthma is new in Australia and we don't have significant data about the unintended consequences of its use, we acknowledge that unsupervised use of this treatment option is likely to be a safer or less risky option for people with asthma than unsupervised use of SABA as-needed alone due to the likely therapeutic benefit of the anti-inflammatory (budesonide) component.

We note that population health trends for asthma over the past decade have stagnated with deaths and hospitalisations not improving. Asthma Australia acknowledges the disruptive nature of this policy change and its potential to appeal to the right consumer, whose condition is amenable, to access anti-inflammatory-based treatment. Even though Australia stands out among comparable countries in terms of OTC access and now access to B/F FDC as-needed, this might be a positive, demonstrating strategic policy design to change intractable public and population health challenges.

Summary of the critical issues and unanswered questions:

- How can we ensure that all people with asthma have their asthma diagnosed, managed and monitored appropriately?
- How can patients' wellbeing be safeguarded with the arrival of this treatment over the counter?
- What other options exist within the Poisons Act to address the dangers of SABA over-use which encourage constructive health service engagement?
- How can we reduce the confusion and dilemmas faced by consumers regarding cost of access, management of expiry dates, storage and access to spare reliever medicines?
- How can we be sure that consumers with more severe forms of asthma won't access and use this medicine in place of their regular prescription?
- What are the influences of the pharmacist/GP collaboration based on evidence which can be addressed to make this treatment option relevant and safe?
- What will the medicine cost?
- What are the electronic medical record systems that are integral to safe provision of this medicine and how will they work in practice?
- What is the community pharmacy business model that gives us confidence in conscientious provision of asthma medicine over the counter to consumers?
- What impact will down-scheduling have on the accessibility of B/F FDC for people who appropriately rely on this medicine for their asthma management and for whom it is affordable only if subsidised on the PBS?

[23] https://www.nejm.org/doi/full/10.1056/NEJMoa1715274
[24]

Conditions that would need to be in place if it does go ahead:

Ref section 52e of the Therapeutic Goods Act:
(f): any other matters that the Secretary considers necessary to protect public health.

1. Post-market analysis of use and impact on population of as-needed B/F treatment published in treatment guidelines in 2020
   We need to understand better how B/F FDC is being used, accessed and is impacting the population since its introduction in the guidelines in September this year ideally before making it available to consumers in an unsupervised way.
2. Separate and discrete treatment guidelines for adolescents with asthma, excluding this population in roll out plans
   We need to look deeper at the safety, efficacy, translation and impact of the B/F FDC as-needed treatment option among adolescents before making it available to them without supervision.
3. Ensure medicines are affordable
   Affordability is one of the highest order priorities for consumers and it's not appropriate that individual preference is influenced by pricing signals or profit margins.
4. B/F FDC remains available and subsidised under the PBS for people who need the medicine for their asthma management
   Down-scheduling should not result in disadvantageous access to people who face financial hardship
5. Dispensing records are captured and centralised in shared electronic medical record systems so dispensing pharmacists are alerted when dispensing rate is deemed in excess of safe use and good asthma control.
   Unsupervised use should be contained through a monitoring mechanism which flags excessive dispensing and provides relevant signposts for pharmacist and consumers when thresholds of consumption are reached.
6. Structured and comprehensive package of education and training:
   a. Public multi-channel awareness campaign
   b. Adjacent mandatory online HP training attached to continuous professional development
   c. Clear, nationally consistent guidelines on when OTC B/F FDC is applicable
   d. Standardised, national consistent process to confirm diagnosis of asthma
   e. Consent and anonymous information recorded on national registry
   f. Nationally standardised verbal, written and video advice be mandated for consumers before accessing B/F FDC OTC
   g. Signposts to asthma resources regarding 'what good care looks like'

Conclusion

Asthma Australia acknowledges the significant effort over the past decade to unpack treatment guidelines for people with mild asthma and to address the dangers evident in SABA over-reliance. As a complex, chronic and heterogeneous condition, asthma is a difficult challenge to overcome in terms of making inroads on a population health level. As-needed use of anti-inflammatory

containing medicines among people who have mild and infrequent symptoms, exhibit good health seeking behaviour and demonstrate competence to monitor their health and take appropriate action, for example consulting with their health professional, may be a very useful population health level intervention.

However, we believe that it is too early to move from the introduction of as-needed B/F FDC by prescription, which was only implemented very recently, to the availability of this treatment option unsupervised over the counter. Given we aim to manage asthma as a chronic condition, then it's unlikely that efforts to remove people from appropriate chronic disease management will be successful. The risk of entrenched counterproductive and unsafe health care access, the potential for regressive behaviours and choices and its potentially disastrous implementation among adolescents are irreconcilable for Asthma Australia under current circumstances. Add to these risks logistic and practical concerns raised by consumers around cost, education and support around device use and product expiry and we believe there are too many unanswered questions and unresolved issues for safe and effective implementation at this stage.

As a result of our assessment of the concerns, risks, conditions and assumptions upon which this application seems based, Asthma Australia does not support this application to reschedule B/F FDC to pharmacy-only, schedule 3.

However, should this proposal be approved for implementation, Asthma Australia will contribute to further work in this area to develop the support structures, implementation mechanisms and evidence required to ensure the effective and safe change in this major public health policy.