General reliance restriction

This report is only for the use of the Pharmacy Guild of Australia. It was prepared for the purpose of understanding the fiscal impact of proposed changes to prescription requirements for medicines containing codeine. You should not use the advice for any other purpose. This report should not be used or relied upon by anyone else and we accept no duty of care to any other person or entity. Due to the uncertain nature of economic data and the information available, Cadence Economics does not warrant the completeness or accuracy of the estimates provided in this report.

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Glossary

Codeine proposal A proposal to require a prescription for low-dose codeine medicines (currently available without a prescription, but after talking to the pharmacist)

ABS Australian Bureau of Statistics
CACC Combination Analgesics Containing Codeine
CPA Community Pharmacy Agreement
GP General Practitioner
MBS Medicare Benefits Scheme
OTC Over the counter
PBS Pharmaceutical Benefits Scheme
PGA Pharmacy Guild of Australia
RIS Regulation Impact Statement
SN Safety Net
S2 Schedule 2 – Pharmacy Only Medicine
S3 Schedule 3 – Pharmacist Only Medicine
S4 Schedule 4 – Prescription Only Medicine
TGA Therapeutic Goods Administration
1 Introduction

The Pharmacy Guild of Australia engaged Cadence Economics to undertake an analysis of the fiscal impacts (and related issues) of all medicines containing codeine to require a prescription.

Currently, low dosage codeine medicines are available without a prescription. Medicines containing codeine are mainly for pain relief (eg codeine with paracetamol or ibuprofen) or cold and flu preparations (codeine with pseudoephedrine or phenylephrine, and paracetamol).

This report provides estimates of the fiscal impact of the proposal only, it does not consider any wider economic impacts or public health implications of the policy changes. Due to the uncertainty of these estimates, a range of possible impacts are provided. Guidance is provided for additional data or information that would assist in producing more precise estimates. References to ‘Panadeine’ or ‘Panadeine Forte’ also refer to medicines with equivalent active ingredients.

1.1 Policy proposal

Currently, lower-dose codeine medicines – up to 12mg anhydrous codeine, equivalent to 15mg of codeine phosphate, in Schedule 3 (Pharmacist Only), and up to 10mg in Schedule 2 (Pharmacy Only) – are available for purchase from a pharmacy without a prescription. The supply of Schedule 3 medications is subject to the mandatory oversight of a pharmacist and these medicines must be stored in an area of the pharmacy that is not directly accessible to the public. Medicines containing codeine that are indicated for pain relief are Schedule 3 medicines. These codeine medicines must be combined with an analgesic (such as paracetamol, ibuprofen and aspirin). Medicines indicated for cold and flu symptoms that contain pseudoephedrine and codeine are also in Schedule 3. Cold and flu medicines containing phenylephrine and codeine are Schedule 2 medicines. As a result of changes made in 2010, codeine medicines indicated for pain relief were rescheduled to Schedule 3 medicines. In addition, the maximum pack size for codeine medicines was reduced to 6 days’ supply for Schedule 2 medicines and 5 days’ supply for Schedule 3 medicines.

Despite these changes, there are still concerns regarding a small proportion of consumers becoming dependent on these medicines which is leading to inappropriate use of these medicines. Unlike pseudoephedrine, there is no mandatory requirement for the sales of codeine medicines to be recorded by the pharmacy. In addition, there is currently no nationally linked real-time recording system that is suitable for recording codeine medicines (the Project STOP system is designed to record sales of medicines containing pseudoephedrine).

Consequently, a consumer who has codeine dependency can conceivably obtain multiple packs of codeine medicines from several pharmacies, as pharmacists have no mechanism of determining if a consumer is obtaining these medicines to an extent that is inconsistent with genuine therapeutic need.

The Therapeutic Goods Administration (TGA) Advisory Committee on Medicines Scheduling is considering a proposal that all (currently) OTC low-dose codeine medicines will require a doctor’s prescription. That is, the proposal, if accepted, would reclassify these medicines as Schedule 4 – Prescription Medicine. This proposal would, therefore, capture not only the combination analgesics
containing codeine (CACC), i.e., for pain relief, but also the cold and flu medications that include codeine (for example, Codral Cold & Flu which contains 9.5mg of codeine phosphate per tablet).

The proposal to restrict the availability of codeine to Schedule 4 medicine is based on concerns about dependency and misuse of these medicines. That is, some consumers develop a codeine dependency leading to an over-consumption of CACC medicines (in some cases, 80-100 tablets per day) which leads to complications usually associated with the excessive consumption of the analgesic contained in the medicine (mainly ibuprofen and paracetamol). Therefore, while the codeine causes the dependency and overconsumption, it is the analgesic that causes the adverse outcome (the specific adverse outcome will vary depending on the analgesic).

The availability of low-dose codeine as Schedule 3 or Schedule 2 medicines benefits large numbers of Australians and saves taxpayers in terms of avoided subsidised GP visits. So, although there are health costs related to accidental overdose, the Commonwealth Government should consider the net costs and benefits of any proposal to reclassify Schedule 3 codeine-based medicines, especially when there appears to be (i) significant potential fiscal costs from increased GP consultations, and (ii) obvious lower-cost alternatives to addressing the health issue (such as instituting a register of OTC codeine medicines).

This chapter sets out the potential fiscal costs (i.e., the additional Commonwealth outlays through the MBS) from this proposed measure. While there may potentially be additional costs to the PBS, these costs are briefly discussed, but have not been quantified for the purposes of this analysis.

1.2 Current demand for OTC codeine medicines

The starting point is to consider the number of codeine-based medicines currently dispensed as:

- Schedule 2 – Pharmacy Only Medicine; and
- Schedule 3 – Pharmacist Only Medicine

That is, both those currently dispensed as OTC medicines. According to IMS Health (2014) data, the current annual OTC consumption of codeine medicines is as follows:

**Table 1: Purchases of OTC codeine-based medicines, 2014**

<table>
<thead>
<tr>
<th>Medicine type</th>
<th>Number of ‘units’ dispensed per year*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics that include codeine (i.e., for pain relief)</td>
<td>16.4 million</td>
</tr>
<tr>
<td>Cold and flu medication that includes codeine</td>
<td>5.2 million</td>
</tr>
</tbody>
</table>

Note: *A ‘unit’ is defined as a packet of the medicine, which ranges from 12 to 40 tablets per pack, but more commonly available in packets of 24 tablets. Schedule 2 medicines cannot contain more than 6 days’ supply and Schedule 3 medicines cannot contain more than 5 days’ supply. The number of tablets contained in an individual unit will vary depending on the amount of codeine contained in the medicine (which generally range between 8-15mg of codeine phosphate). The Pharmacy Board stipulates that only one proprietary pack of Schedule 2 and Schedule 3 Medicines is to be supplied at a time, unless there are exceptional circumstances clearly demonstrable by the customer, additional documentation of which should be kept. The Board considers that the sale of multiple packs of Schedule 2 or Schedule 3 medicines, and failure to comply with local jurisdiction regulations applying to Schedule and Schedule 3 medicines and Board guidelines may be considered as unprofessional conduct.*
2 Estimating the cost of the codeine proposal

Because the ‘policy change’ scenario (where codeine is classified as S4) is different to current practice (the ‘business as usual’ scenario), there are a number of variables or parameters that need to be estimated or assumed to arrive at a fiscal impact estimate for this policy proposal. This section sets out the available data and underlying assumptions. Where little information is available to inform the analysis, an estimated range is provided rather than a point estimate of the fiscal costs.

2.1 Number of additional GP visits to fill codeine-based prescriptions

In Australia, 16.4 million units of S2 and S3 codeine is sold for pain relief and a further 5.2 million units of S2 and S3 codeine is sold as cold and flu medication\(^1\). Reclassifying codeine as an S4 – Prescription Medicine, will require consumers to (i) obtain a prescription from their GP, and (ii) fill that prescription at their local pharmacy.

The requirement to visit the doctor and then the pharmacist to fill a prescription clearly involves a cost additional to just going to the nearest pharmacy to purchase a low-dose codeine medicine OTC. It is therefore reasonable to assume that a certain proportion of those people currently getting their low-dose codeine OTC, will switch to a less-effective (but still convenient) OTC alternative (such as paracetamol or ibuprofen or a combination ibuprofen/paracetamol medicine)\(^2\). Taking this option will save the consumer the time and financial cost to visit a GP, which can be considerable for full-time and/or middle to high-income workers\(^3\). That is, there would be ‘marginal’ consumers whereby the additional pain (whether in length or severity) is worth bearing relative to the time and financial cost of seeing a GP to get a prescription for a codeine medicine.

A survey undertaken by The Macquarie Centre for the Health Economy (2014) found that 63% of respondents said they would see a GP to obtain codeine-based medication as an analgesic (ie for pain relief) if they could no longer get that medication at a pharmacy (Figure 1)\(^4\).

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1 IMS Health data (2014)

2 There may be an increased health risk from consumers taking higher doses of paracetamol to compensate for the lack of codeine. This factor is not considered in this analysis.

3 It could also be potentially very costly for full-time carers (such as mothers with young children) in terms of the inconvenience involved in seeing a GP. Additionally, a relatively sudden and significant increase in GP visits (demand) would place considerable strain on the GP-gatekeeper system given the relatively fixed supply of GPs, potentially leading to longer waiting times and increased prices for non-bulk-billed visits. We have not modelled the GP workforce capacity (supply-side constraints) to handle the increased GP visits.

4 The research was undertaken by Professor Scott Koslow and funded by The Australian Self Medication Industry and a research grant from Macquarie University.
Figure 1: Response to survey regarding OTC medication being withdrawn


The same 2014 survey found that, for cold and flu medication (precisely: ‘Cough & Cold’ and ‘Allergy & Sinus’), the proportion electing to visit a GP would be 52% and 66% respectively. This lower proportion makes intuitive sense, given that codeine is only one active ingredient (and not the key ingredient) in cold and flu medications.

These survey results are taken to be around the upper-limit to consumers’ preparedness to see a GP in order to obtain a medicine containing codeine. There are two main reasons for the reported survey figure of 63% saying they would see a GP to obtain codeine-based medication as an analgesic to be lower:

1. The possibility that some of those formerly OTC consumers seeking codeine-based medicines for *one-off cases* just happen to be seeing their GP that day or the next day; or
2. The possibility that those formerly *regular users* of OTC codeine are likely to be seeing their GP on a regular enough basis that they would not generally need an additional GP visit to obtain their codeine-based prescription.

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For the subset of the population that have developed a codeine addiction, the behavioural response could be unpredictable – without access to OTC codeine these people may substitute to other addictive substances to counteract the withdrawal effects of codeine. This paper does not analyse the complex issues surrounding addiction, nor whether this policy change will be effective at reducing addiction. Rather, the focus of this paper is on the fiscal impacts related to people with a genuine clinical need for codeine products, and not the fiscal costs associated with addiction.
These are difficult permutations to consider without more precisely relevant survey evidence or evidence from other countries. Nonetheless, these factors are taken into consideration.

2.2 Those seeing their GP on a regular basis

Those that are most likely to undertake additional GP visits are doing so in response to one-off (sudden and severe) pain episodes requiring a strong analgesic (Case 1 above). The evidence does not seem to support a hypothesis that the overwhelming majority of OTC codeine users are self-medicating for long-term chronic pain, as these patients are likely to be already seeing a GP on a regular basis.

Figure 2 suggests that OTC CACC purchases are predominantly for short-term ailments such as headache/migraine, back or muscular pain.

Figure 2: Reason for using OTC codeine-based medicine

Consider the case where someone with long-term or chronic pain chose to self-medicate. First, given the relatively low financial cost of seeing a GP (for instance, over 70% of GP visits are bulk billed), it would make more sense that this person suffering chronic pain or more complex medical conditions would choose to be managed by a GP rather than relying only on pharmacy-only or pharmacist-only medicine.

Second, given the tight restrictions around dispensing S3 codeine-based medicines, it would be difficult and costly for this person to choose to self-medicate relative to being managed by a GP.
Another possibility is that a significant proportion of OTC codeine consumers are genuinely addicted to codeine and shopping at multiple pharmacies to satisfy that addiction, resulting in an accidental overdose of paracetamol. To the extent that there are persons with codeine addictions shopping OTC, given the scheduling restrictions, it would be reasonable to expect an equivalent number of GP visits (and pharmacy visits) are already occurring to satisfy that addiction. That is, while the human cost of addiction is an issue, it is likely there may be no behavioural change or fiscal impact as a result of this policy change, relating to those with addiction, as they are probably (mostly) already getting prescriptions for higher-dose medicines.

Finally, we considered the impact of people already receiving a regular prescription that might already want to use a low dose codeine medicine, and whether that could be prescribed at the same GP visit. However, many long-term medications only require two visits to a GP per year to obtain a 1-month prescription and 5 repeats. Because codeine repeats are not allowed, and so GP visits are required more frequently, patients are not able to fulfil all their codeine requirements at the same time as seeing a GP for repeats of their other long term medications, so the impact of this factor is expected to be negligible.

Thus, the estimates are based on people taking S2 and S3 codeine medicines and their likely GP visiting behaviour in response to the policy change are, in the main, short-term or ‘one-off’ users.

2.3 Those who would have seen their GP when pain struck

The next step, therefore, is to work out the chances that a person needing codeine was, by coincidence, also seeing a doctor on the day sudden and severe pain struck.

Medicare and ABS data indicates that there is a wide dispersion around the average number of doctor visits per year – with age cohorts and degree of ‘rurality’ being significant determining factors. And the data is further complicated by how those visits are defined – the number of visits being far higher if we include allied health visits.

According the MBS statistics for 2014-15, non-refferred attendances to a GP were 6.1 per patient. We have used this figure as our base case assumption for the number of patient visits to a GP per year. We therefore assume that there is only a 1.7% chance (6.1 visits / 365 days) that a person seeking a codeine-based medicine was already planning to see a doctor that day.

However, the above argument relies on several assumptions and the evidence is scant. We have therefore taken a conservative approach to our estimations, and assumed that 10 percentage points of those 63% saying that they would visit a GP when pain strikes would already be seeing their GP within the next 24 hours or so, or have been able to obtain a prescription from a previous visit.

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7 The GP may conduct other interventions such as a liver function test if concerned about paracetamol over use, but no allowance for additional referrals or tests is included.
This brings our base case assumption from 63% of all current OTC codeine purchases seeing a GP down to 53%.

2.4 Treatment of cold and flu medication

In relation to cold and flu medication containing codeine, a conservative approach is taken by assuming that none of those 5.2 million cold and flu purchasers would seek to have a prescription written for a codeine-based cold and flu medicine. Instead, these people would opt for another OTC cold and flu medication that did not contain codeine. There is an upside risk to the fiscal estimates that a number of people with cold and flu symptoms, and not able to purchase codeine-based cold and flu medicines, decide to visit a GP (where they could be prescribed other PBS medicines other than codeine-based cold and flu medicines).

2.5 Summary

The table below reports the base case estimate from the policy change: an additional 8.7 million GP visits per annum as a result of moving the availability of codeine medicines from S2 and S3, to S4.

Table 2: Additional GP visits due to codeine not available OTC

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of visits to the GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine medicine for pain no longer available OTC</td>
<td>53% of 16.4 million = 8.7 million GP visits</td>
</tr>
<tr>
<td>Codeine cold and flu medicine no longer available OTC</td>
<td>Zero by assumption</td>
</tr>
<tr>
<td>Total</td>
<td>8.7 million additional GP visits</td>
</tr>
</tbody>
</table>

Source: The Macquarie Centre for the Health Economy (2014) and Cadence Economics estimates.

2.6 Cost of additional GP consultations (Commonwealth MBS cost)

The Commonwealth Government would subsidise these additional 8.7 million visits according to the length of the consultation and complexity of the patients’ symptoms.

For cases where patients were formerly self-medicating with low-dose codeine medicines for pain relief we have assumed that the two most likely consultation levels would be Level A and Level B visits (i.e. generally not lengthy or complex visits). The current per-visit costs to the Commonwealth Government of these consultation levels are as follows:
### Table 3: GP visit costs

<table>
<thead>
<tr>
<th>Level of Consultation</th>
<th>Cost to the Commonwealth per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level A:</strong></td>
<td></td>
</tr>
<tr>
<td>Obvious and straightforward cases that should be reflected in the practitioner’s records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken. Generally, Level A is a less than 10-minute consultation – perhaps to fill an existing/long-standing prescription.</td>
<td>$16.95</td>
</tr>
<tr>
<td><strong>Level B:</strong></td>
<td></td>
</tr>
<tr>
<td>For cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner’s record. Generally, Level B is a 10-20 minute consultation.</td>
<td>$37.05</td>
</tr>
</tbody>
</table>

*Source: Australian Government.*

We have not found published evidence on the level of GP consultation most often used to write prescriptions for temporary or chronic pain relief, although undoubtedly there would be a distribution of levels depending upon the severity of the cases presented. That said, the group of people in question are those that were formerly self-medicating on low-dose codeine OTC medicines, so these would generally probably not be highly critical or emergency cases that would require longer than a Level B consultation.

The Department of Human Services publishes data on the number of GP consultations by Level. In the 2014-15 financial year, there were:

- Around 3 million Level A consultations
- Around 90 million Level B consultations
- Around 15 million Level C consultations
- Around 1.3 million Level D consultations

The statistics indicate that Level A consultations account for 2.7% of all consultations whereas Level B accounts for 82.3% of all consultations. Given the simplifying assumption that people will not require longer consultations, the above statistics indicate the proportion of Level A and B consultations:

- Level A = 3m ÷ 93m = 3.2%
- Level B = 90m ÷ 93m = 96.8%

The weighted average fiscal cost of a GP visit is thus $36.41 and the fiscal cost (MBS outlay) of the additional GP visits is estimated to be $316.44 million per year.

We have not accounted for any side-benefits from the GP visit (such as the GP identifying and preventing a more complex underlying problem or addiction, or counselling the patient to use an alternative, more effective medicine). Nor have we included any additional costs of further diagnostic/specialist investigations flowing from the additional GP visits. As a necessary simplification, the additional GP visit is treated as purely a costly procedural task that is required to be undertaken to obtain low-dose codeine. This is likely to be the case for many adults who, with the advice of their pharmacist, are capable of safely self-medicating.
Table 4: Annual fiscal cost of additional GP visits

<table>
<thead>
<tr>
<th>Type of GP visit</th>
<th>Cost to the Commonwealth Government (per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional GP visits</td>
<td>8.7 million</td>
</tr>
<tr>
<td>Weighted average cost</td>
<td>$36.41</td>
</tr>
<tr>
<td>GP visit for pain medication</td>
<td>$316.44 million</td>
</tr>
<tr>
<td>GP visit for cold and flu medication</td>
<td>Zero by assumption</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$316.44 million</strong></td>
</tr>
</tbody>
</table>

*Source: Cadence Economics estimates, numbers may not multiply exactly due to rounding.*

### 2.7 Cost of prescribed PBS medication (PBS cost to government)

There may be an additional fiscal cost – increased PBS outlays – related to a possible increase in PBS-subsidised prescriptions, from so-called ‘up-scaling’ of patients to higher dose medicines that attract a PBS subsidy. As noted above, our central modelling assumption is that an additional 8.7 million people will visit a GP to obtain a prescription.⁸

The patients most likely to be those generating ‘new’ GP visits are those that are otherwise relatively healthy, and not already seeing a GP on a regular basis. Those households on the SN are likely to have complex medical conditions and already seeing a GP regularly, so are unlikely to be in the cohort generating the additional GP visits. As such, many of these new GP visits are likely to be from non-SN patients.

For patients that obtain a prescription for the same medicines they are currently using (Panadeine or Panadeine Extra, or equivalents), these are expected to be private scripts that are not eligible for a PBS subsidy, so no cost to the PBS. If some of these patients are up-scaled to Panadeine Forte, this could increase the cost to government for some non-SN concessional patients (even for these patients, the government cost is relatively low, at around $5 per script). For general non-SN households, the cost of a medicine such as Panadeine Forte will be under the PBS co-payment.

Overall, we consider the likely PBS impact from any ‘up-scaling’ to be in the order of a few million dollars per annum. Given this is modest compared to the fiscal impact of the additional GP visits, we have not included it in the estimate, but note there may be a small upside risk to PBS outlays from up-scaling non-SN patients as a result of this policy change.

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⁸ For this analysis, we have not explicitly modeled the capacity of the MBS ‘gatekeeper’ system to absorb an additional 8.7 million GP visits per year. According to the published MBS Statistics 2014-15, the total number of GP-patient interactions in 2014-15 was just over 123 million. The additional 8.7 million GP visits would therefore represent a 7% increase annually, which would need to be absorbed by the existing GP workforce and/or might induce more GPs into the system, but there would be limits on how quickly new GPs could enter the system. Some GPs might also elect to manage the demand for their services by lifting their consultation prices.
2.8 Total estimated cost over forward estimates

The estimated base case MBS cost (ignoring any impacts to the PBS, which are likely to be modest) of the proposed policy change to require a prescription for all codeine-based medicines that are currently available OTC is \$316.4 million per year. Over the forward estimates (a 4 year period), this would amount to a fiscal cost of \$1.27 billion, not allowing for either (i) population growth, or (ii) the indexation of the MBS subsidy.

3 Fiscal impact range (sensitivity analysis)

Given the limited information available around the key assumptions, a range of estimates are provided of the fiscal cost to the Commonwealth Government of the proposed change to the dispensing of low-dose codeine medicines.

3.1 Number of additional GP visits

Given the uncertainty over the proportion of OTC codeine ‘units’ that would translate to GP visits, a range around the survey result is estimated of 45%, 53% and 55%, assuming that not many more than the 63% surveyed who said they would visit to a doctor would indeed take the time and expense to visit a doctor.

3.2 Cost of GP consultations

The cost of the GP consultation depends on the level of that consultation. As discussed above, the Level A/B split is estimated based on MBS consultation data where 96.8% of consultations are Level B.

Scenarios of a 95% lower bound and 100% upper bound for Level B visits are estimated, reflecting the high propensity to use Level B consultations.

Table 5: Sensitivities for fiscal costs of the codeine policy change

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Base case assumption</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of additional GP visits – pain relief medication</td>
<td>8.692 million</td>
<td>7.380 million (45%)</td>
</tr>
<tr>
<td></td>
<td>53% of total OTC codeine units</td>
<td>9.020 million (55%)</td>
</tr>
<tr>
<td>Number of additional GP visits – cold and flu medication</td>
<td>Zero by assumption</td>
<td>Zero by assumption</td>
</tr>
<tr>
<td>Cost of GP consultation – pain relief medication</td>
<td>3.22% Level A / 96.88% Level B</td>
<td>5% Level A / 95% Level B</td>
</tr>
<tr>
<td></td>
<td>0% Level A / 100% Level B</td>
<td></td>
</tr>
<tr>
<td>Cost of GP consultation – cold and flu medication</td>
<td>Zero by assumption</td>
<td>Zero by assumption</td>
</tr>
</tbody>
</table>

These scenarios result in lower and upper bound fiscal cost estimates in Table 6.
Table 6: Fiscal impact scenarios ($m, per annum)

<table>
<thead>
<tr>
<th>Range of Scenarios</th>
<th>Additional cost to Commonwealth per year ($m)</th>
<th>Key assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOWER BOUND</td>
<td>266.0</td>
<td>45% of OTC ‘pain’ customers visit a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% of OTC ‘cold and flu’ customers visit a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5%/95% split between Levels A &amp; B consultations</td>
</tr>
<tr>
<td>BASE CASE</td>
<td>316.4</td>
<td>53% of OTC ‘pain’ customers visit a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% of OTC ‘cold and flu’ customers visit a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2%/96.8% split between Levels A &amp; B consultations</td>
</tr>
<tr>
<td>UPPER BOUND</td>
<td>334.2</td>
<td>55% of OTC ‘pain’ customers visits a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% of OTC ‘cold and flu’ customers visit a GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% of GP consultations are Level B</td>
</tr>
</tbody>
</table>

Source: Cadence Economics estimates.

4 Other (non-fiscal) costs and impacts

We have not estimated the other potential (non-fiscal) costs of the policy proposal, such as any adverse impacts on health (net of any health benefits) as well as the financial and time cost to patients. The personal cost to patients, assuming for instance an hour out of their day to visit the GP is potentially very high.

In its research, The Macquarie Centre for the Health Economy found the following:

“If Pharmacist Only analgesics were up-scheduled to prescription only the cost to the system would be considerable. Currently, these medicines make up 22 per cent of the volume of analgesics sold in pharmacies, so the decision to up-schedule would cost $675 million. Of this, almost $170 million is the direct cost to Medicare for additional doctors’ visits, $25 million is borne by insurance companies and $70 million will be paid by individual consumers. The indirect costs of lost productivity and delayed treatment are over $400 million [emphasis added].

Faced with the scenario of their S3 Pharmacist Only cold and flu medicines no longer being available over-the-counter at their local pharmacy, most respondents (58 per cent) would opt to visit a doctor in order to obtain their preferred medications.

For S3 Pharmacist Only cold and flu medicines, up-scheduling would result in additional costs of almost $550 million. Of this amount, Medicare would have to reimburse $115 million for doctors’ visits; almost $20 million would be health insurance payouts; while individual consumers would have to pay close to $50 million — all just for a visit to the doctor. If the indirect costs of lost productivity are included, these total an additional $370 million in costs” [That is, an additional 370-(50+20+115)=$185 million]. (Macquarie 2014, p.6).

In summary, the Macquarie study finds an additional $585 million in lost productivity costs per year.
5 References

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