Sales of over-the-counter products containing codeine in 31 countries,

2 **2013-2019:** a retrospective observational study

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ABSTRACT Introduction Opioid prescribing trends have been investigated in many countries. However, the patterns of over-the-counter purchases of opioids without a prescription, such as codeine combinations, are mostly unknown. **Objective** We aimed to assess national sales and expenditure of over-the-counter codeinecontaining products purchased in 31 countries over six years. Methods We conducted a retrospective observational study using electronic point-of-sales data from the human data science company, IQVIA, for Argentina, Belgium, Brazil, Bulgaria, Canada, Croatia, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Japan, Latvia, Lithuania, Mexico, The Netherlands, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, South Africa, Spain, Switzerland, Thailand, the UK, and the USA. We calculated annual mean sales (units per 1000 of the population) and public expenditure (GBP, £ per 1000) for each country between April 2013 and March 2019. We quantified changes over time and the types of products sold. **Results** 31.5 billion units of codeine, costing £2.55 billion, were sold over-the-counter in 31 countries between April 2013 and March 2019. Total sales increased by 3% (3025) units/1000 in 2013 to 3111 in 2019) and public expenditure doubled (£196/1000 in

56 2013 to £301/1000 in 2019). Sales were not equally distributed; South Africa sold the 57 most (31 units/person), followed by Ireland (24 units/person), France (16 units/person), 58 Latvia (15 units/person), and the UK (11 units/person). The types of products (n=569) 59 and formulations (n=12) sold varied. 60 61 **Conclusion and Relevance** In many parts of the world, substantial numbers of people may be purchasing and 62 63 consuming codeine from over-the-counter products. Clinicians should ask patients 64 about their use of over-the-counter products and public health measures are required to 65 improve the collection of sales data and safety of such products. 66 67 Study protocol pre-registration: https://osf.io/ay4mc 68 **Key points** 69 70 Total sales and public expenditure of over-the-counter products containing 71 codeine increased from April 2013 to March 2019 in line with increased trends 72 of global opioid use. 73 There was substantial variation in mean sales of over-the-counter codeine 74 between countries. 75 In countries with access to over-the-counter codeine, these sales data should be 76 reviewed to informed regulatory decisions and requirements for public health 77 measures to ensure safety. 78 79

1 Introduction

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Prescribing patterns of opioids are documented in many countries [1–7]. However, opioids such as analgesic combinations containing codeine can be purchased over-thecounter (OTC) without a prescription or consultation with a doctor or prescriber in most countries. As access to granular data on OTC sales has been limited, previous research on the use of non-prescribed codeine has relied on case reports [8–10], self-reported questionnaires [11–18], qualitative studies [19–22], and data from poisons centres, hospital admissions, or coronial systems [23–27]. It is therefore unknown whether OTC sales of codeine have followed trends similar to the use of prescribed opioids. Codeine (3-methylmorphine) is used for its analgesic, antidiarrheal, and antitussive effects [28–30]. It is often combined with other analgesics, such as paracetamol, and non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen. These combinations have greater efficacy than codeine alone [28,31,32]. But most clinical trials testing the efficacy of codeine have used high doses (25–90 mg), which are not available OTC [31–33]. A Cochrane overview of systematic reviews on oral OTC analgesics for acute pain found no studies or data that could be extracted on combinations of analysesics containing low doses of codeine [33]. A systematic review of the efficacy and safety of low-dose (≤30 mg) codeine included ten RCTs [34]. It reported low- to moderate-quality evidence that combination products of low-dose codeine provided little to moderate pain relief for acute and chronic pain conditions in the short term [34]. In observational studies products containing codeine have been associated with dependence, misuse, death, and collateral toxicity from combinations with paracetamol and ibuprofen [9,25].

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Access to codeine without a prescription can bolster the perception of safety, and in some settings abuse of OTC codeine is normalised and encouraged. Mixing codeine cough syrup with alcohol and or soft drinks has been popularised in rap music and by American athletes, who make a drink called "purple drank" from codeine syrup and soda [35]. OTC codeine has been used to manufacture illicit morphine and heroin and to create a cheap heroin substitute called "krokodil" [36,37]. The use of "Krok" has been reported in Russia, Europe, the UK, and North America, and its adverse effects from intravenous use include damage to blood vessels, skin, muscles, and bones, multiorgan failure, and death [36,38]. Thus, the growing opioid problem is incomplete without evaluation of OTC sales of codeine. Regulation of codeine-containing products varies across the world, making it difficult to estimate how much they are used [39]. Under the 1961 Single Convention on Narcotic Drugs, codeine is a Schedule III drug [40]. Drugs in this Schedule reportedly "are not liable to abuse and cannot produce ill effects", and thus it is not mandatory to report data on their consumption to the International Narcotics Control Board (INCB). In a report presented at the WHO's Expert Committee on Drug Dependence in October 2019, reviewing codeine formulations listed in Schedule III, the INCB reported a 64% increase in demand for codeine in the last decade [39]. However, governments can also mandate regulation of codeine. Minnesota (July 2013), Manitoba (February 2016), France (July 2017), and Australia (February 2018) have reclassified codeine to prescription-only [41–44]. A review of OTC codeine regulations

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in the European Union showed that more than half of member countries did not permit OTC sale of codeine as of March–August 2014 [45]. Despite variation in codeine's regulatory status, studies have analysed consumption of OTC cough syrup containing codeine in Taiwan [46] and the impact of rescheduling codeine to prescription-only in Australia [47,48]. We aimed to assess national sales and public expenditure on OTC codeine-containing products purchased in countries with available data. 2 Methods 2.1 Design and data source We conducted a retrospective observational study using consumer health sales data from IQVIA [49], which has previously been used in observational research on a range of medications [46–48,50–53]. The data included products containing codeine in the adult pain relief category, which were collected using scan track barcodes from electronic point-of-sale (EPoS) store data in all countries that provided data, including Argentina, Belgium, Brazil, Bulgaria, Canada, Croatia, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Japan, Latvia, Lithuania, Mexico, The Netherlands, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, South Africa, Spain, Switzerland, Thailand, the UK, and the USA. *IQVIA* extracted the data on 16 September 2019 and provided quarterly sales from 1 April 2013 to 31 March 2019. IQVIA's sample of data is based on audits and covers a median of 73% (IQR: 58–86%) of pharmaceutical markets (Table S1 in Supplement 1). Annual population statistics in calendar years (2013 to 2018) were sourced from the World Bank [54]. 2.2 Data analysis

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We extracted details from the pack information and used descriptive statistics to determine the numbers and types of products sold across the 31 countries. Data on dosages were missing from the pack information for most countries, so we used IQVIA's standard units to account for liquid and solid dosage forms. We calculated the total units sold over the study period and the totals for each year (e.g. from quarter two in 2013 to quarter one in 2014). We also calculated the mean number of units sold over six years, adjusted for population. We created an annual rate of units sold per 1000 of each year's population for each country to examine trends over time. For expenditure, IOVIA converted sales to pounds sterling (GBP, £) for each country on the date of data extraction (16 September 2019). We calculated annual totals, mean public expenditure for each country, adjusted for population, and a rate of GBP per 1000 to assess changes over time. 2.3 Software and data sharing We used Stata v16 and Python v3 in Jupyter Notebooks with pandas [55], seaborn [56], and matplotlib [57] libraries for analysis and figures. The commercial information we used requires a fee to access. Thus, we cannot openly share the data, owing to contractual agreements with IQVIA. However, we have openly shared our statistical code at GitHub [58], preregistered [59] and published [60] our study protocol, and shared all our study materials via the Open Science Framework (OSF) [61]. 3 Results

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31.5 billion units containing codeine were sold across 31 countries over the study period (April 2013 to March 2019). Total sales increased by 2.8%, from 3025 units/1000 in 2013–14 to 3111 units/1000 in 2018–19. However, the distribution of sales between countries was not uniform. Five countries represented 90% of all OTC codeine sales. South Africa accounted for the greatest volume of sales (34%), followed by France (20%), Japan (16.5%), the UK (14.5%), and Poland (5%). South Africa sold the most (mean of 31 units/person, see Figure 1), followed by Ireland (24 units/person), France (16 units/person), Latvia (15 units/person), and the UK (12 units/person). [Figure 1 near here] In the most recent year (April 2018–March 2019), South Africa sold the most (38 units/person), followed by Ireland (23 units/person), Latvia (16 units/person), the UK (11 units/person), and Japan (10.7 units/person) (Table S2 in Supplement 1). Over time, 48% of countries (15/31) had increased OTC codeine sales. For countries in the top quartile of sales (Figure 2A), trends increased in South Africa (30%), Ireland (8%), Latvia (11%), and Poland (19%), and sales fell in France (99%), the UK (7%), Serbia (4%), and Croatia (17%). For countries in the second-largest quartile of sales (Figure 2B), trends increased in Japan (1219%), Estonia (65%), Romania (10%), and Bulgaria (18%), and sales fell in Switzerland (50%), Finland (22%), The Netherlands (16%), and Slovenia (16%). Trends for countries in the bottom two quartiles are in Figure S1 and S2 in Supplement 1.

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[Figure 2 (Figure 2A and Figure 2B) near here] The public spent £2.55 billion on OTC codeine-containing products in 31 countries over six years; expenditure increased by 54%, from £196/1000 in 2013–14 to £301/1000 in 2018–19. Ireland had the largest mean public expenditure of £5.70 per person, followed by the UK (mean of £1.60/person), South Africa (£1.26/person), Croatia (£1.25/person), and Estonia (£1/person) (Figure 3). In April 2018 to March 2019, Ireland continued to have the largest public expenditure (£6.60/person), followed by South Africa (£1.64/person), the UK (£1.64/person), Japan (£1.47/person), and Estonia (£1.41) (Table S2 in Supplement 1). [Figure 3 near here] Most countries (58%, 18/31) had increased public expenditure over time. There were simultaneous increases (45%, 14/31) and decreases (39%, 12/31) in both sales and expenditure in most countries, while other countries (16%, 5/31) had a discordance in the direction of their sales and expenditure (Figure 4). [Figure 4 near here] There were 569 products and 12 formulations sold across 31 countries. Tablets were the most common formulations sold, followed by syrups, soluble tablets, and coated tablets (Figure S3 in Supplement 1). Products contained a median of three substances per combination (IOR: 2-4, range: 1-16). Limited details were available in the pack

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information: the dosages of codeine were available in 17% of products (98 of 569) in 15 countries. 4 Discussion Many people are purchasing non-prescribed codeine in several parts of the world. Total sales and public expenditure of OTC codeine products increased over time in line with previous trends of global opioid use. However, sales were not equally distributed across the 31 countries. According to IQVIA's data, South Africa consistently sold the greatest volume of OTC codeine each year. In a study of opioid dependence in South Africa 5–8% of people in addiction treatment facilities reported problems with OTC codeine medications and cough mixtures as their primary or secondary drug of choice [62]. The availability of non-prescribed codeine may also have ramifications for neighbouring countries that restrict access. For example, there were reports in Zimbabwe that codeine-containing cough syrup was being illegally smuggled in from South Africa and sold on the streets after being outlawed in 2015 [63]. However, there are limited data in many countries on the prevalence of such activities and the extent of codeine use and misuse. Abuse of OTC codeine products has been encouraged and normalised on social media and in hip-hop music [64–66], which is a growing public health concern. A scoping review of the non-medical use of pharmaceuticals identified several ways in which codeine was reportedly being abused, including mixtures with alcohol or soft drinks (e.g. "purple drank") and in the production of home-made opiates (e.g. "krokodil") [67].

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Public health interventions are needed to prevent abuse, misuse, and pharmacy shopping of OTC codeine products, particularly in young adults. The hip-hop song titled "1-800-273-8255", from the US suicide prevention lifeline, significantly increased public awareness of and calls to the hotline [68]. Thus, hip-hop music can also be used as a tool to tailor public health messages to young adults and counteract the glamourisation of codeine misuse. The growing recognition of codeine abuse and misuse has led governments in Minnesota, Manitoba, France, and Australia to reclassify codeine to prescription-only [41–44]. In South Africa, Canada, Switzerland, Ireland, and the UK, governments are proposing or considering plans to reclassify codeine-containing products to prescription-only [69–72]. Studies assessing the effect of rescheduling codeine to prescription-only in Australia showed a reduction in all codeine-related poisonings and no change in calls to poisons centres or sales of high-strength (>15 mg) prescribed codeine after reclassification [47,73]. The success of Australia's rescheduling questions whether governments worldwide should make codeine prescription-only. But since many low- and middle-income countries experience barriers to accessing opioids [74– 76], the WHO recommends that codeine should not be upscheduled and for codeine to be included in essential medicines lists [77]. If a consensus on the status of OTC codeine products cannot be reached, data should be collected globally to monitor its use and harms. Changes to regulations of OTC codeine and differences in trade exemptions and disclosures of commercial interests at the country level may explain some of the

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variation in sales [39]. For example, in France, sales fell considerably after codeine became prescription-only. In countries such as Canada, Germany, and the USA, which had high rates of prescribed opioids [76], mean sales of OTC codeine products were lower than countries without similar access to prescribed opioids. However, our figures depended on coverage of data from IQVIA during this time. Thus, it is hard to determine whether the variation in sales represents real differences between countries. Strengths and limitations We used IQVIA's standard units to measure sales, which allows liquid and solid dosage forms to be combined. The figures represent population-level sales and expenditure of OTC codeine in 31 countries, providing the best available proxy for actual use. Sales represented adult pain relief, although we calculated rates using population statistics for all age groups, including children. Codeine-containing products may also be purchased in large quantities from online pharmacies or the black market [78], not captured in these data. IQVIA's coverage and the completeness of data may have also affected sales trends; they provided percentages on data coverage and converted expenditure to GBP at single time points, which may not accurately represent changes to such metrics over time. Better access to OTC sales data is required. Amendments to medicines legislation in the UK show how such data could be collected. The Misuse of Drugs Regulation 2001, the Medicines for Human Use (Administration and Sale or Supply) (Miscellaneous Amendments) Order 2007, and the Medicines (Sale or Supply) (Miscellaneous Provisions Amendment Regulations 2007) were updated to require pharmacies to

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submit counts of private prescriptions for Schedule 2 and Schedule 3 controlled drugs to the National Health Service (NHS) Prescription Services for analysis, audit, and monitoring [79,80]. A similar system could be enforced through a public health organisation such as the WHO or the International Narcotics Control Board (INCB), which already collects governments' annual drug statistics on opioids [81]. Such data could then be used by governments and researchers to monitor sales of OTC codeine and measure the impact of regulatory changes. **Conclusions** Codeine is one of the most widely accessible and used opioids worldwide. However, monitoring its use and preventing its misuse as an OTC product is a public health challenge. Healthcare professionals should ask their patients about their use of OTC products. Public health measures are needed to identify and prevent codeine misuse and increase awareness and education of the harms of codeine, particularly in young adults. Governments should review policies to improve the collection of sales data and safety of products sold OTC containing codeine.

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Supplementary material Supplement 1: Supplementary tables and figures Supplement 2: STROBE reporting checklist **Declarations Funding** This research was supported by the Primary Care Research Trust of Birmingham and Midlands Research Practices Consortium who provided the funding to purchase the sales data from IQVIA. **Competing interests** GCR was financially supported by the National Institute for Health Research (NIHR) School for Primary Care Research (SPCR), the Naji Foundation, and the Rotary Foundation to study for a Doctor of Philosophy (2017-2020), but no longer has any financial COIs. GCR is an Associate Editor of BMJ Evidence Based Medicine. JKA has published articles and edited textbooks on adverse drug reactions and interactions and has often given medicolegal advice, including appearances as an expert witness in coroners' courts, often dealing with the adverse effects of opioids. BM works for NHS England as a pharmacist adviser. BG has received research funding from the Laura and John Arnold Foundation, the NIHR, the NIHR SPCR, the NIHR Oxford Biomedical Research Centre, the Mohn-Westlake Foundation, NIHR Applied Research Collaboration Oxford and Thames Valley, the Wellcome Trust, the Good Thinking Foundation, Health Data Research UK (HDRUK), the Health Foundation, and the World Health Organisation (WHO); he also receives personal income from speaking

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and writing for lay audiences on the misuse of science. FDRH acknowledges part support from the NIHR SPCR, the NIHR Applied Research Collaboration (ARC) Oxford Thames Valley, and the NIHR Oxford OUH BRC. CH is an NIHR Senior Investigator and has received expenses and fees for his media work, received expenses from the WHO, FDA, and holds grant funding from the NIHR SPCR and the NIHR SPCR Evidence Synthesis Working Group [Project 380], the NIHR BRC Oxford and the WHO. On occasion, CH receives expenses for teaching EBM and is also paid for his GP work in NHS out of hours (contract with Oxford Health NHS Foundation Trust). CH is the Director of the CEBM. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care. Availability of data and material Study materials are available on an open repository [61] (https://osf.io/yt6bf/). We cannot openly share the data owing to contractual agreements with IQVIA, but the data can be accessed directly from IQVIA, which will require a fee. Code availability Our statistical code is openly available at GitHub [58] (https://github.com/georgiarichards/otc_codeine). **Authors' contributions** GCR devised the research question, designed the methods, wrote the protocol, conducted a literature search, sourced the data, cleaned, managed, and analysed the data, created the figures, and wrote the first draft of the manuscript. JKA and CH

reviewed the protocol and preliminary findings and provided supervisory support.

FDRH reviewed the protocol and facilitated the grant application. BM reviewed preliminary findings and contributed to the interpretation of data. BG provided supervisory support.

Ethics approval

Not applicable

Consent to participate

Not applicable

Consent to publication

All authors read and approved the final manuscript and consent to submit the manuscript for publication.

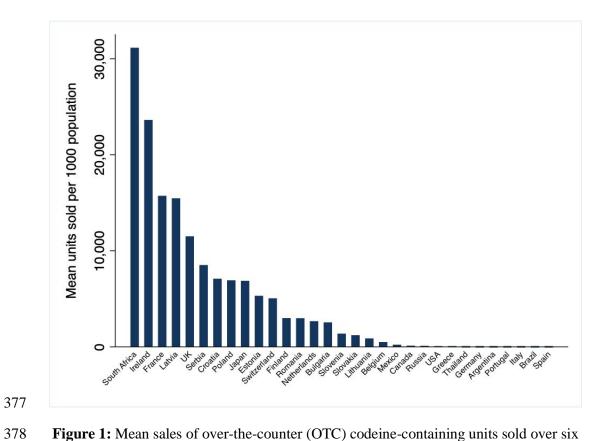


Figure 1: Mean sales of over-the-counter (OTC) codeine-containing units sold over six years in 31 countries with data in descending order

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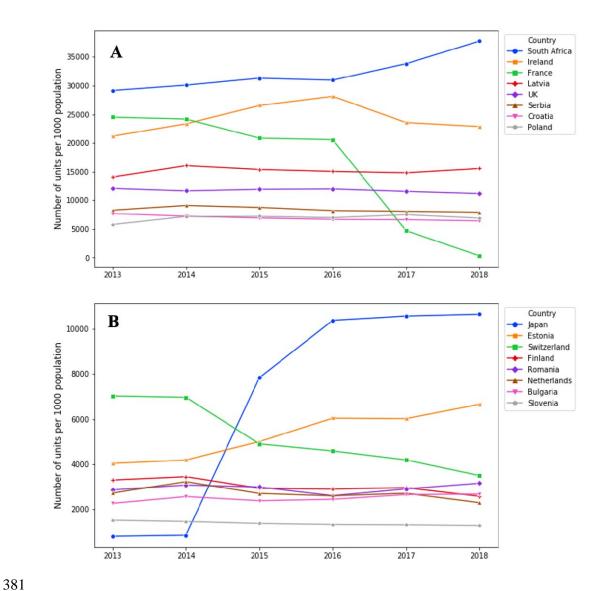


Figure 2: Sales of over-the-counter (OTC) products containing codeine per 1000 of the population starting in April 2013 to March 2014, and ending in April 2018 to March 2019, for countries in the top quartile (A) and second quartile (B) of sales

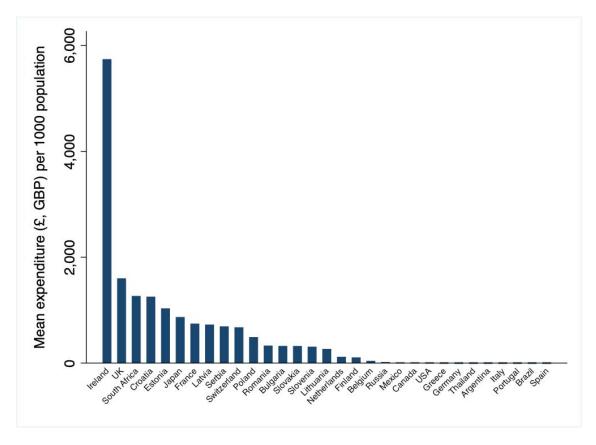


Figure 3: Public expenditure on over-the-counter (OTC) codeine-containing units sold over six years in 31 countries with data in descending order

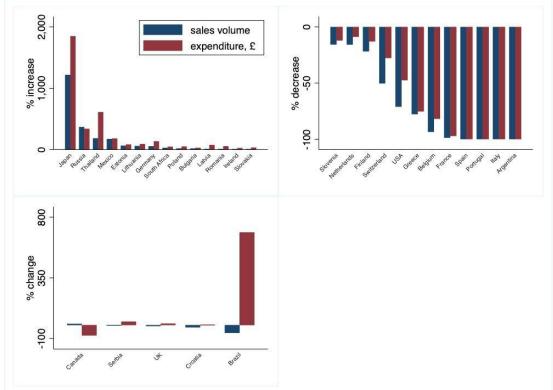


Figure 4: Percentage changes in sales (units sold per 1000 of the population) and public expenditure (£ per 1000) on products containing codeine sold over-the-counter (OTC) in 31 countries between April 2013 and March 2019

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