Submission

by

THE NEW ZEALAND INITIATIVE

to the Health Select Committee

on

the Misuse of Drugs (Pseudoephedrine) Amendment Bill

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1 INTRODUCTION AND SUMMARY

1.1 This submission on the Misuse of Drugs (Pseudoephedrine) Amendment Bill[1] is made by The New Zealand Initiative (the **Initiative**), a Wellington-based think tank supported primarily by major New Zealand businesses. In combination, our members employ more than 150,000 people.

1.2 The Initiative undertakes research that contributes to the development of sound public policies in New Zealand and the creation of a competitive, open and dynamic economy and a free, prosperous, fair and cohesive society.

1.3 The Initiative's members span the breadth of the New Zealand economy; their diversity strengthens our independence. The views expressed in this submission are the views of the author, not those of our members.

1.4 In summary, we submit:

(a) The ban on pseudoephedrine has failed in its stated purpose. It has not reduced the availability of methamphetamine;

(b) The legislation here is straightforward, correcting Parliament's earlier mistake;

(c) Reinstating pharmacy access will not require any pharmacy to supply pseudoephedrine. Nor will it require anyone to use it. It will simply make it available for those suffering from cold and flu symptoms;

(d) The coalition agreements between National and New Zealand First and National and the ACT Party also called for the automatic Medsafe approval of drugs already approved by at least two trusted overseas drug approval agencies. More precise timelines may be needed for this potential policy lest it unnecessarily and unintentionally impede access to working cold medicine. The government could consider trialling the "Rule of Two" with pseudoephedrine-based cold medicines approved elsewhere for use.

2 ENABLING ACCESS TO EFFECTIVE COLD MEDICINE IS A GOOD IDEA

2.1 The prior National-led government blocked access to the most effective cold and flu medicine because it was being diverted into the production of methamphetamine.

2.2 It was a mistake to believe that the rules around pseudoephedrine would have any non-trivial effect on methamphetamine supply. Work published in the American Economic Review in 2009 showed that the largest and most successful interdiction effort against methamphetamine in America's history to that point had only a temporary effect on methamphetamine availability. Prices returned to their pre-intervention level within four months, and everything else returned to baseline within eighteen months. Criminal organisations innovate around these kinds of supply chain interventions.

2.3 While National's 2010 policy was not informed by appropriate evidence, it at least set an evaluation framework for assessing the policy's success. The Department of Prime Minister and Cabinet published six-monthly reports evaluating progress from October 2009 through October 2014. After that, DPMC reported that reports "will be provided on an annual basis going forward."[2] Over the period, the reports showed increasing availability of

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[1] Misuse of Drugs (Pseudoephedrine) Amendment Bill. 2024. Available at https://www.legislation.govt.nz/bill/government/2024/0021/latest/whole.html#LMS938415

[2] "Tackling Methamphetamine." Available at https://www.dpmc.govt.nz/our-programmes/special-programmes/historical-programmes/tackling-methamphetamine

methamphetamine and slow decreases in the price of methamphetamine – the opposite of what would be expected of a successful anti-methamphetamine policy.

2.4 A 2011 systematic review published in *Addiction* suggested that regulation targeting methamphetamine precursors are undermined by alternative sources of precursor chemicals and by imported methamphetamine.[3] New Zealand's experience is not surprising.

2.5 When the reports showed the policy's failures, the government did not abandon the policy. Instead, it abandoned reporting on the policy's failures. The last indicators and progress report was published in October 2015, rather than continuing on an annual basis as had been expected. Massey University's Illicit Drug Monitoring System reports became the main source of information on supply.

2.6 The policy was such a colossal failure that, had methamphetamine been included in the Consumer Price Index, it could have helped the Reserve Bank remain within its Remit. From 2009 to 2023, the price of everything in the CPI increased by 38%. Over that same period, methamphetamine *dropped* in nominal price by more than 40%.[4]

2.7 Blocking access to pseudoephedrine made little sense to begin with; it had little chance of substantially hindering access to methamphetamine because other ways of more cost-effectively producing methamphetamine are available and because pseudoephedrine from pharmacies was only ever a very small proportion of local methamphetamine supply – as noted in the Regulatory Impact Statement for today's legislation.

2.8 Reversing the ban is unlikely to have more than trivial effects on the market for methamphetamine but will provide relief for those suffering from colds and flus, and perhaps for those isolating at home with Covid.

2.9 Some concerns have been raised about whether pharmacies may experience more break-ins and theft if they stock pseudoephedrine. The image below is a snapshot I took at a Costco on Vancouver Island in December 2023. There, bottles containing 102 tablets of ibuprofen and pseudoephedrine are easily available to consumers on an ordinary aisle in the pharmacy section, with no security guards obviously standing watch, for $8.49 per bottle: the equivalent of about $0.10 New Zealand per tablet. It was far more expensive at community pharmacies than at Costco, as would also be expected in New Zealand.

[3] McKetin, R, R Sutherland et al. 2011. "A systematic review of methamphetamine precursor regulations." *Addiction*. 106:11 (November), pp 1911-24. Available at https://doi.org/10.1111/j.1360-0443.2011.03582.x

[4] See discussion and sources in Crampton, E. 2023. "Pseudoregulation: the failure to stop meth production." *Newsroom*. Available at https://newsroom.co.nz/2023/09/26/pseudoregulation-the-failure-to-stop-meth-production/

2.10 We also note that legalising on-the-shelf sale at pharmacies does not compel its sale. Any pharmacy worried about local crime can choose not to stock it, or to keep it in a locked cabinet, or to take other precautions that it views may be necessary.

2.11 I did not notice anyone ram-raiding Costco to steal cold medicine while there, nor did I read any reports of ram-raiding Costco to steal cold medicine over the period of my visit.

3 A POTENTIAL WORRY - AND OPPORTUNITY

3.1 The Regulatory Impact Statement notes that would-be suppliers of pseudoephedrine-based cold medicines will need to seek Medsafe approval and that suppliers will likely make those applications.

3.2 The government and Medsafe should consider automatically and proactively approving any pseudoephedrine-based cold medicines that are currently approved in Canada, Australia, or the UK.

3.3 The government's coalition agreements have signalled that Medsafe will soon be required to automatically approve any medicine already approved by two trustworthy drug approval agencies overseas: a Rule of Two. We wholeheartedly support the government's signalled legislative intention in that area. But it poses a potential transitional issue.

3.4 If a pharmaceutical supplier expects that its products will soon be automatically approved without the need for application and associated fees, it may prefer to wait for automatic approval rather than pursue Medsafe certification. Indeed, given the speed at which Medsafe operates, Medsafe approval may still be in process by the time legislation precludes the need for applications.

3.5 If it takes some time before "Rule of Two" provisions are in effect, the government should signal timelines so that pharmaceutical companies bother applying for Medsafe approval for pseudoephedrine-based cold medicines rather than waiting for the legislative change.

3.6 Directing automatic approval for any product already approved for sale in comparable jurisdictions would help test the proposed Rule of Two while expediting access to effective cold medicine.

4 CONCLUSION

4.1 The best time to reverse a bad law is before enacting it. The second-best time to reverse a bad law is when the evidence shows the law has failed. Both of those ships have long since sailed. The next best time is now. We thank the government for this legislation. While we do not look forward to our next colds, we view them with slightly less dread.