

Parallel opioid crises: brakes on sustainable development?

Katherine Pettus  and Lukas Radbruch

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Abstract: This Review perspective analyzes the parallel ‘opioid crises’ – one of access, the other of excess – affecting different demographic groups in distinct regions of the world, in terms of a knowledge gap between the founding 20th-century regulatory frameworks around ‘drugs’, including opioids, and evolving 21st-century clinical developments in public health, palliative care, addiction medicine, and regulatory sciences. Identifying the parallel crises as such is a positive step that can enable governance and science to catch up to one another and realign. As it is now, the opioid crises are acting as brakes on development as defined by the United Nations (UN) 2030 Agenda for Sustainable Development (SDGs). Both crises affect UN member states’ ability to reach the Goal 3 ‘Ensure healthy lives and promote well-being for all at all ages’ of the Sustainable Development Goals (SDGs). Among the nine targets for Goal 3, the two opioid crises affect progress toward Target 3.5, on strengthening the prevention and treatment of substance abuse, including narcotic drug abuse, and Target 3.8, providing Universal Health Coverage (UHC), and adequate access to essential medicines. The parallel opioid crises, which both represent misalignment between anachronistic governance structures and epistemic developments, have several things in common beyond the opioid molecules themselves: regulatory and health system deficits that interact pathologically with baked in cultural stigma around psychoactive substances, stigma evident in the designation of these substances in international law as ‘narcotic drugs’. Community regeneration, educational development, and governance reforms can now replace politicized rather than evidence-based and public health-promoting drug policies that block progress toward both SDG 3 targets in different countries for different reasons. Quantification of serious health-related suffering (SHS) pertaining to a range of health conditions and demographic groups now provides the epidemiological evidence to legitimate such a timely paradigm shift.

Keywords: harm reduction, opioid crises, palliative care, sustainable development

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Introduction: the two crises

Academic experts have described the unavailability of medical opioids in more than two-thirds of the world as a ‘pain pandemic’ and the crisis of excess availability in North America as an ‘opioid overdose epidemic’.¹ The different prefixes (*pan-* and *epi-*) indicate the difference between the population-level impacts of the two related public health problems. The World Health Organization (WHO) defines pandemics, epidemics, and endemic diseases based on a disease’s rate of spread. Thus, the difference between an epidemic and a pandemic is not in the severity of the

disease, but the degree to which it has spread.² Both opioid crises – one being *inadequate* access to medical opioids affecting more than 80% of the world, largely low- and middle-income countries (LMICs), and the other being *excess* exposure to medical and non-medical opioids – stem from educational, regulatory, and health system deficits, which we conceptualize in terms of knowledge gaps or deficits.

The knowledge gaps that limit our awareness of the twin opioid crises derive from more than a century of stigmatizing legal and political

Correspondence to:
Katherine Pettus
International Association
for Hospice and Palliative
Care, 5535 Memorial
Drive, Suite F, 509,
Houston, TX 77007, USA.
kpettus@iahpc.com
Lukas Radbruch
University Hospital Bonn,
Bonn, Germany

discourse, conceived during the twilight of the colonial era, and consolidated during the current era of neoliberal globalization. Reducing either or both contextually distinct public health crises to the word ‘opioids’ reduces the underlying socio-historical dynamics to the substances themselves – and by ignoring the associated knowledge deficits, blocks the path to rational regulatory reforms and public health strategies that could constructively address each crisis on its own terms.

The current access crisis describes the situation in what the World Bank calls LMICs, also known as ‘the majority world’, wherein providers and patients have no or inadequate access to opioid medications for palliative care, pain relief, and treatment of substance use disorder, among other things. Individuals and their caregivers in those countries experience serious health-related suffering (SHS)³ due to untreated, preventable pain and dependence issues, which *Lancet* editor Richard Horton has dubbed ‘the most disfiguring inequity in health care today’.⁴ UN experts identify barriers to access as lack of clinical education for health providers to prescribe opioids correctly (workforce), unduly restrictive regulations and policies (governance), and deeply rooted cultural attitudes regarding addiction, among other things, (socio-historical).^{4,5}

The excess crisis, also known as the overdose epidemic, describes the situation in a minority of largely upper-income countries where both patients and recreational users have, until recently, had more access to both prescribed and illicitly trafficked opioids than is strictly necessary for rational medical use. Most observers agree that illicitly manufactured fentanyl and heroin, not legally prescribed opioids, are fueling current morbidity and mortality rates in the United States and Canada.⁶ An extensive epidemiological 2019 study of the history of the ongoing North American opioid crisis concluded that ‘the current overdose crisis is rooted in the intersection of long-term psychosocial and cultural trends with the lucrative opportunities offered by drug prohibition’.⁷ People with substance use disorder and their families, as well as patients with clinical pathologies whose pain is now under-treated as a result of over-zealous application of federal pain guidelines issued in 2016, just updated in November 2022, are experiencing serious health-related suffering as a result of the bureaucratic weaknesses and oversight failures that precipitated the North American epidemic. Financial

stress from pressure on opioid-related emergency, police, social, and health services is negatively impacting local economies, municipalities, and communities affected by overdoses and deaths of workers, parents and students.⁸

The two stubborn and concurrent public health crises of access and excess persist and are in fact worsening at the time of writing, even though the WHO includes pharmaceutical opioids for the treatment of severe pain, symptoms, and dependence treatment on the WHO Model List, and international law identifies them as ‘indispensable’ for the relief of suffering. Palliative care and harm reduction advocates have raised the profile of the topic at international, regional, and national fora; the Human Rights Council recently approved a report denouncing lack of access to internationally controlled essential medicines in many parts of the world. Evidence-based policies and practices regulating the rational consumption of opioids for medical purposes are found in only a handful of health systems where palliative care and harm reduction services are integrated into primary care under universal coverage. This means that few health professionals are adequately trained to prescribe medical opioids, and regulations guarding against diversion and harmful non-medical use, when not unduly restrictive, are inconsistent or non-existent. Such governance environments give the pharmaceutical industry more than enough room to maneuver for its own benefit.⁹ Recommendations addressing these shortcomings are at the heart of the Report of the 2022 Stanford *Lancet* Commission on the North American Opioid Crisis and the 2018 Report of the *Lancet* Commission on Palliative Care and Pain Relief.^{10,11}

The exception proves the rule: if at least one country, in this case the Federal Republic of Germany,^{12–14} can achieve balanced policy around opioids, others can too, with financial and technical assistance from the international system as well as the active participation of global civil society. Sadly, although the WHO, the UN Office of Drugs and Crime, and the International Narcotics Control Board (the three international agencies most implicated in this global health issue) have produced guidelines, resolutions, and helpful joint declarations urging member states to address the issue,^{1,15–17} there is little or no funding to move things along at the national level, where the level dial is stuck in the red zone of severe, and mostly preventable, health-related suffering. The following sections describe the genesis of the

excess and access crises in terms of the knowledge gap and suggest a way forward to help governments achieve SDG3.

The knowledge gap

The roots of both the excess and access crises reach back to the East India Company's, and then the British government's commodification of opium, a traditional indigenous medicine, to support its empire throughout the 18th and 19th centuries. Moral entrepreneurs in the United States and the United Kingdom led the subsequent mid-20th century backlash to bring what was then the extremely profitable *licit* global opium trade, under global control, limiting population level access, which was to be controlled by national governments, exclusively to highly regulated medical and scientific use. The emerging international law governing 'drugs' defined everything but such use as 'illicit' and encoded the whole new 'machinery' as the drafters called it then, in a complex global regulatory system aligned with the capacities of the advanced bureaucratic systems of what were then the 'Great Powers'.¹⁸ Chronologically speaking, the institution of drug regulatory systems in every national government that was a party to the Single Convention on Narcotic Drugs, including the newly independent nations, pre-dated both modern, evidence-based palliative care and addiction medicine. The body of international 'drug control' law and norms that developed through the mid-20th century relied largely on *national* governments, convened by UN organs such as the Commission on Narcotic Drugs, to enact and implement policies that outlaw the cultivation, manufacture, and supply of 'substances containing narcotic drugs', except for medical and scientific purposes.

Few national laws direct state parties to the Single Convention to ensure adequate access to those substances for needed medical and scientific purposes. Only in the last decade have the technical secretariats for the WHO in Geneva and the Commission on Narcotic Drugs (CND) in Vienna published evidence-based reports and guidances urging national governments to ensure access. Uptake has been slow but steady, and in 2022 the Ambassador for Belgium, the Honorable Ghislain D'Hoop promoted a campaign putting the topic of 'access and availability' at the center of the agenda for the 65th Session of the CNDs.

The international drug control system has fostered an arranged marriage between the CND and the WHO. Many substances under international control that are essential for medical purposes – those at the heart of the access crisis as well as those used to treat people with opioid use disorder (OUD) – are included in the WHO Model List of Essential Medicines, which is updated every 2 years. This list contains the medications considered to be most effective and safe to satisfy the primary health care needs of the population.

The Model List, which includes medical opioids, is based on evidence regarding the comparative effectiveness, safety, and cost-effectiveness of the medicines. Governments, especially of LMICs, often use the Model List to develop their own national lists of essential medicines. Not until 2013 did the WHO Model List categorize medications for the management of severe pain, symptoms, and palliative care in a separate Section 2. This development, half a century after the adoption of the Single Convention, along with other UN guidelines drafted more recently, provides health systems with the normative and technical tools to overcome the knowledge gap. When the model list is supplemented with the Lancet Commission algorithm to determine SHS at country level,¹⁹ procurement agencies working with clinician leaders and civil society organizations can take the necessary steps to correctly estimate need from the community to the tertiary levels to ensure public availability of the medications used by properly trained clinicians to manage severe pain and OUD, among other conditions.

To overcome the knowledge gap set up by the original drug control system, health systems all over the world can utilize the recently released Lancet Commission on Pain and Palliative Care algorithm for measuring serious health-related suffering (SHS) across 20 life-limiting and life-threatening conditions and 15 symptoms most associated with a need for palliative care. Quantifying the staggering global burden of SHS for the first time, the Commission reported that more than 61 million people each year experience SHS that could be affordably ameliorated by palliative care and pain relief. The aggregate suffering is at least 6 billion physical and psychological symptom days each year. Over 80% of this SHS burden occurs in LMICs where access to palliative care, and more specifically to oral

immediate-release morphine for pain relief, is extremely limited.²⁰ A large proportion of the current SHS burden is associated with non-communicable chronic diseases (NCDs) such as cancer, dementia, cerebrovascular disease, and lung disease, and this will only increase as populations age. Globally, approximately 15 million cancer patients experience untreated SHS every year.²¹ Untreated SHS is not just an ethical issue, it is also an economic issue that sabotages sustainable development, undermining community health, resilience, and social capital.

International civil society organizations such as the International Association for Hospice and Palliative Care (IAHPC) are working through the United Nations system to promote these tools and assist member states aspiring to comply with their treaty obligations under international law by overcoming the knowledge gap. As a civil society organization in consultative status with the UN Economic and Social Council, the IAHPC can participate on the margins of multilateral meetings such as the World Health Assembly and regular sessions of the CNDs. Civil society advocacy provides testimony and evidence about policy options that strengthen health systems attenuated by the access opioid crisis and promote sustainable development at the same time.

As the Lancet Commission on Palliative Care and Pain Relief and the Stanford Lancet Commission on the North American Opioid Crisis have demonstrated, academic institutions are critical civil society allies in the process of overcoming the knowledge gaps underpinning opioid governance. The Stanford Commission analyzed the multiple factors underlying the failure of US supply control policies that led to the devastating public health debacle afflicting hundreds of thousands of individuals, and families today, concluding that

The North American crisis emerged when insufficient regulation of the pharmaceutical and health-care industries enabled a profit-driven quadrupling of opioid prescribing. This prescribing involved a departure from long-established practice norms that prevailed before the mid-1990s – particularly in the expanded prescribing of extremely potent opioids for a broad range of chronic, non-cancer pain conditions.¹⁰

The inadequate ‘drug’ regulatory architecture, meticulously tracked in the United States by investigative reporters and researchers,²² stemmed

from official rejection of international developments in harm reduction and addiction medicine in a context of growing private sector domination of the public, or governmental sector. This has been more than adequately documented in the literature of many academic disciplines as well as in popular non-fiction books such as *Empire of Pain* and *Dopesick*, among other bestsellers.^{23,24}

From the knowledge gap perspective, the lack of affordable and accessible harm reduction and treatment services for people with OUD has exacerbated the governance failures that precipitated the excess crisis in North America. The cumulative impact of the public sector’s *failure to provide evidence-based prevention and treatment for people with, or at risk of, OUD* damages individuals, their families, and communities. Related workforce, education, health, and legal system impacts²⁵ are all brakes on sustainable development. Evidence regarding inequity in access to services and medications for historically marginalized and impacted communities, including those in rural areas,²⁶ compounded with social stigma that has attached to opioids and a clinical profile of ‘addiction’ (the word itself a source of stigma), can inform constructive opportunities to craft robust, community driven, governance solutions that reject the limited 20th-century imaginary regarding drugs and effective drug policies.

More sophisticated community-level strategies than those available from law enforcement or the courts can counterbalance the harms the pharmaceutical industry set in motion with its virtually unregulated release of branded opioids such as OxyContin in the 1990s. The current opioid epidemic in the United States has been characterized as having three waves: prescription opioid use, followed by heroin use, and then the use of synthetic opioids (e.g. fentanyl). Persons with OUD provide an attractive parallel market for (completely unregulated by definition) global traffickers. Observers attribute the ‘fourth wave’ of the opioid crisis to illicitly trafficked synthetic fentanyl, heroin, and stimulants, with mental illness co-morbidities being more evident than in the past.^{27,28}

The way forward

The 2030 Agenda urges governments aiming to meet the SDG targets to demonstrate progress toward long-term solutions by convening dialogues with impacted populations such as patients

and families, health care practitioners, civil servants, faith leaders, and the academy, among others. The Vatican promoted Synod is an interesting model. Community-level ‘conventions’ bring neighbors, colleagues, and persons working in similar fields together to identify barriers to prevention and care for those suffering from both the excess and access crises. The overall vision is to chart sustainable ways forward. Sub-national units of government that foster such public goods as healthy and compassionate communities and cities, already taking root in some parts of the world,²⁹ can drive the process to overcome knowledge gaps in both evidence and praxis, promoting equity and sustainability along the way.

The legitimacy of such a course is found in social contract theory, which holds that government’s job is to protect the public good, which includes *public health*, from the harms generated by unfettered exercise of private interest. The theory proposes that governments upholding their side of the contract protect their citizens from living lives that are ‘solitary, poor, nasty, brutish and short’, in Thomas Hobbes’ pithy phrase. The overdose epidemic, which is also related to the epidemic of loneliness, epitomizes official failure to keep this contractual bargain, as US life expectancy has dropped for the second year in a row and overdose deaths continue to rise. Since the public interest is clearly in tension with the goals of the private sector, whose ‘end’ is to maximize profits, it is to be expected that ‘big pharma’ will attempt to create global demand for their supply of non-generic commodities such as designer opioids *even when doing so is harmful to public health*. Ideally, in a realistic utopia,³⁰ well-governed polities overseen by active citizens supported by robust regulatory systems can balance the harm these entities can be expected to inflict. Indeed, the last recommendation of the Stanford Lancet Commission, which can simultaneously begin to address both the excess *and* access crises, is that

Developed nations should prevent their opioid manufacturers from promoting overprescribing in other countries. Developed nations should also provide generic morphine to low-income nations to ensure adequate pain and palliative care.¹⁰

The evidence academic experts are generating to overcome the knowledge gaps can help the public sector overhaul anachronistic regulatory systems and build better ‘fences’ to prevent diversion and

harmful non-medical use while supporting adequate access for medical purposes. Locally friendly supply chains that allow for affordable pooled procurement of generics, and a focus on oral morphine instead of more expensive opioid formulations, can mitigate big pharma’s pernicious influence on public health. Shifting to patient-centered rather than substance-centered modes of health and criminal-legal system governance can also ensure the availability, affordability, and accessibility of such basic public health services as evidence-based prevention and treatment for people with OUD, palliative and geriatric care, appropriate clinical education for students and professionals, and integration of palliative care and substance use disorder treatment into primary health care.

In sum, the necessary and sufficient conditions for governments to achieve *both* Targets 3.5 and 3.8 of the 2030 Agenda for Sustainable Development are that they act as a single payer to procure medical opioids *and* commit publicly to adequate availability of generic controlled essential medicines for palliative care and treatment of substance use disorder. This is a ‘both/and’, not an ‘either/or’ prescription. Public procurement of generics minimizes the risks of diversion of prescribed medicines to the illicit market, as does proper training of physicians, nurses, pharmacists, and other health care professionals in the adequate use of opioids, with proper indication and monitoring of initiation and maintenance of opioid therapies. Governments that procure generic oral morphine and methadone in bulk as the staple medicines of choice in the public health system can use stigma to their advantage, getting a bargain on efficacious and essential controlled substances that are also unattractive to the black and gray markets.

The solution goes beyond governance though. Aspiring to sustainable development entails committing to a cultural shift that in Theodore Adorno’s words, ‘lends a voice to suffering as the condition of all truth’.³¹ Asking policymakers to heed the ‘critical voice of pain’³² of the individuals and affected populations experiencing serious health-related suffering, and to work with their constituents to overcome the knowledge gap, is one way to develop authentic, community-based strategies to solve both the access and excess crises. Just as pain in the body can be an opportunity to re-evaluate personal habits and patterns, pain in the politic body signals a need for collective reflection and public re-commitment to common

values whose neglect can be cumulative and pathological at system levels.

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Consent for publication

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Katherine Pettus: Conceptualization, Resources.

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ORCID iD

Katherine Pettus  <https://orcid.org/0000-0002-3952-9644>

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