REPORT

Opioid Inaccessibility and Its Human Consequences: Reports From the Field

Eric L. Krakauer, Roberto Wenk, Rosa Buitrago, Philip Jenkins, and Willem Scholten

ABSTRACT

Strong opioids such as morphine are rarely accessible in low- and middle-income countries, even for patients with the most severe pain. The three cases reported here from three diverse countries provide examples of the terrible and unnecessary suffering that occurs everyday when this essential, inexpensive, and safe medication is not adequately accessible by patients in pain. The reasons for this lack of accessibility are explored, and ways to resolve the problem are proposed.

KEYWORDS AIDS, cancer, human rights, opioid, pain, palliative care, world

INTRODUCTION

Opium probably was one of the first medicines known to humankind. Obtained from the opium poppy, its derivatives, such as morphine, remain contemporary medicine’s principle means of relieving moderate and severe pain. Yet most of the world’s population does not have access to this proven, inexpensive, and safe medication when it is needed to treat their pain or dyspnea. As a result of this inaccessibility, people all over the world, especially in low- and middle-income countries, suffer everyday unspeakably and unnecessarily from pain and terminal dyspnea. The following three cases, one from a low-income country in Southeast Asia, one from Argentina, and one from Panama, illustrate this major public health problem.

HOW THE POOR DIE AT THE DAWN OF THE TWENTY-FIRST CENTURY

Mr. A was a 28-year-old unmarried laborer who lived in a large city in Asia. He probably became infected with the human immunodeficiency virus (HIV) in his early twenties when he occasionally used intravenous heroin and had sex with sex workers. Not until he saw a doctor 3 years ago, due to fever, cough, and a weight loss of 8 kg, did he learn that he had both tuberculosis and acquired immunodeficiency syndrome (AIDS). With treatment for tuberculosis, he felt better and regained some weight. A three-drug antiretroviral (ARV) regimen was prescribed for him, but he had to buy the medications, and effective adherence support was not available. As a result, he took the medication only intermittently. One year later, he developed progressive fatigue and weakness, began to lose weight again, and soon could no longer work.
Thus, he could no longer afford to pay for his treatment and stopped taking it completely.

Last year he began taking an ARV regimen provided free of charge, but neither his condition nor his CD4 count improved. No effective alternative ARV regimen was available. Two months ago he developed fever, progressive cachexia, and abdominal pain and was admitted to hospital. However, the expensive antimicrobials he was given there did not help and consumed his elderly parents’ meager savings. When he also became increasingly short of breath, the doctors said that “there was nothing more they could do.” It never occurred to them to treat Mr. A’s symptoms with a strong opioid such as morphine. In their country, as in many others in the region, strong opioid analgesics are used almost exclusively for hospitalized cancer patients and are not readily available even for them. The doctors instructed Mr. A’s parents to give their son paracetamol for his pain and fever, and they took him home.

At home, Mr. A suffered from constant, severe abdominal pain, diarrhea, daily fever and sweating, and worsening dyspnea. Paracetamol provided no relief, and paracetamol with codeine also had little effect on the pain, dyspnea, and diarrhea. Mr. A’s father had heard that heroin could relieve pain and dyspnea and, as his son’s condition worsened, he struggled with his deep moral revulsion toward illicit drugs and with his fear both of the police and of the drug-dependent people in the park where heroin could be obtained. Finally, in desperation, he went one night to find a drug dealer. Using money that he and his wife had obtained, he bought heroin and clumsily injected it into his son’s arm. Minutes later, Mr. A’s breathing became less labored, his taut face relaxed, and he fell asleep.

Over the next week, Mr. A’s father borrowed money to buy more heroin. It seemed to relieve his son’s suffering, but only for a few hours. Grieving, exhausted, ashamed of patronizing criminals, and now deeply in debt, the elderly couple watched their only child die grimacing and gasping, despite their best efforts to comfort him.

Case submitted by Eric L. Krakauer.

THE LONG BUMPY ROAD TO PAIN RELIEF

Mrs. C was 37 years old and had two young children. At the National Institute of Oncology in Panama City, she was told bluntly by a doctor: “You have advanced cervical cancer and no medicine or surgery can cure you. All I can do is send you to the Palliative Care Unit (PCU) so they can help you control the symptoms that will come as your illness progresses.”

At the PCU she was told that if she felt pain she should come back to the Unit. The physician sympathetically explained to her that pain is frequent with cervical cancer, but that there are medicines to control it.

The laws that govern opioid availability were designed primarily to prevent illicit use of these medicines. They did not allow the rural poor who lived far from the only PCU in Panama, people like Mrs. C, adequate access to the pain relief they deserve. General practitioners were allowed to prescribe oral morphine only for 48 hours. Only oncologists...
and anesthesiologists were authorized to prescribe parenteral morphine, and the maximum allowable length of their opioid prescriptions was 10 days. In addition, oral morphine and transdermal fentanyl could be obtained only at the National Institute of Oncology, and there was no oncologist or anesthesiologist near Mrs. C’s home. Therefore, weak and in pain, she had to leave her children and travel for hours on bad roads to Panama City every 10 days to get her medication. A family caregiver could make the trip for her, but transport cost 7 US dollars each time, whereas Mrs. C’s family income was only 10 US dollars per day.

Because cancer is one of the most common causes of death in Panama, cases such as Mrs. C’s were very common. For this reason, it was crucial for clinicians to be allowed more flexibility to help these patients, who continue to die in terrible pain. The Patients’ Rights Law, approved in 2003, states that palliative care should be available at every primary health care unit. But for years it was not enforced, and patients continued to suffer from untreated cancer pain.

Finally, within the past year, Panama’s opioid regulation was changed. The maximum number of days for which general practitioners can prescribe parenteral opioids increased from 48 hours to 5 days, and the permissible duration of their prescriptions for oral opioids increased from 5 to 15 days. Oncologists and anesthesiologists as well as pain and palliative care specialists may now prescribe parenteral opioids for up to 15 days and oral opioids for up to 30 days. Our hope is that these new regulations will be followed and that patients who suffer from cancer pain now will be able to obtain relief and to live comfortably and with dignity until they die.

Case submitted by Rosa Buitrago.

**DISCUSSION**

Opioids are essential medications for pain relief. This simple fact is not in dispute. Oral and injection morphine are on the World Health Organization (WHO) Model List of Essential Medicines (1). In its treatment guideline Cancer Pain Relief, the WHO reports that its simple method for relief of cancer pain, based on a small number of inexpensive medicines including morphine, has proven to be effective in most cancer patients (2). The principal international treaty regulating opioid availability, the 1961 Single Convention on Narcotic Drugs, as Amended by the 1972 Protocol, states, “that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes” (3). Yet opioids are not available to the great majority of the world’s people, especially those in low- and middle-income countries like the three mentioned in our case reports. According to the international drug control body, the International Narcotics Control Board (INCB), in 2003 “just six high income countries accounted for 79 percent of global morphine consumption,” and “developing countries combined (with about 80 percent of the world population) accounted for just 6 percent.”(4) More recent data from the INCB and the Pain & Policy Studies Group (PPSG) at the University of Wisconsin indicate that this situation has not changed much (5). The result is the sort of suffering described in the cases, but on a massive scale.

The reasons for the inaccessibility of opioids are many. An overriding problem is widespread opioophobia: unfounded fear of opioids. These fears include the mistaken belief that opioid therapy frequently causes psychological dependence. Mr. B’s care team could not disabuse his family of this myth. Many people fear opioids because they associate them with criminal activity, gang violence, destroyed lives, even terrorism (6). Many fear that taking opioids, even in a medical setting, carries with it a significant risk of death. Patients may decline opioid therapy for fear that an opioid prescription signifies the terminal stage of their disease and impending death. But physicians, nurses, and health care officials also harbor many such misconceptions and fears.

Although these fears may be misguided, they often are understandable. Throughout the 19th century, the British cultivated opium in India and forced it literally down the throats of the Chinese in return for hard currency and tea. As Booth notes, “the Chinese regarded opium as an agent of foreign aggression, debasing Confucian ethics and encouraging selfish idleness.” “It was estimated that 1 percent of the population was addicted, usually men between the ages of 20 and 55,” as many as 12 million people (7). When the Chinese had the audacity to resist, the British launched the two Opium Wars. Both resulted in still worse humiliation of the Chinese, including deeper incursions by the British into China, the ceding of Hong Kong to Britain in perpetuity, and intensification of the coerced opium trade (8). The French brutalized the people of their Indochinese colonies in a similar fashion. In light of this sordid history, antipathy toward opioids in Asia is not surprising. In the last few decades, illicit heroin dependence has reached epidemic proportions in some developing countries and much of the developed world and has contributed to the HIV/AIDS epidemic. The demand for illicit heroin has generated widespread and often violent criminal activity that has wreaked havoc in many
regions and communities. These events have reinforced opiophobia throughout the world.

Opiophobia has congealed into national opioid policies and regulations around the world that are highly restrictive and imbalanced: they focus on interdicting illicit opioid trafficking and use without also providing for adequate availability and accessibility of opioids for medical uses (9). As a result, few low- and middle-income countries produce or import much opioid. Because little opioid is available and laws and regulations discourage its use, a vicious circle is established. Low availability of opioid leads to little use. The low use is reported to Ministries of Health, which then base estimated need for the following year on the low use in the previous year. These low estimates of projected need are passed to the INCB, which then allocates opioid accordingly. As a result, availability of opioid remains low. The problem is perpetuated also by the inadequate training of most pharmacists, nurses, and physicians in low- and middle-income countries in pain relief and palliative care. Clinicians inadequately trained in handling and prescribing opioids may harbor fears and misconceptions about them and may be reluctant to use them. Many countries also lack a secure distribution system for medicines that may be diverted for illicit purposes.

To address these problems, the WHO formulated a public health strategy for developing national palliative care programs (10). It also established in 2005 the Access to Controlled Medications Programme. The Programme, which “aims at improving access to opioid analgesics,” divides the causes of underuse of opioids and other controlled substances into three categories: regulatory impediments, attitude and knowledge impediments, and economic and procurement impediments, and recommends ways to overcome each of these (11). Its recommendations are reflected by those of Human Rights Watch, an international nongovernmental organization that has taken on opioid inaccessibility as a human rights issue (12). Governments should establish a working
group on pain relief and palliative care to assess the need for pain relief and palliative care in their countries and to develop an action plan to meet the need. The working group then should direct specific activities, including reviewing and revising overly restrictive national opioid control policies, developing clinical guidelines for pain relief and palliative care, and creating systems for accurately estimating opioid need and for secure opioid distribution. The International Pain Policy Fellowship of the PPSG, funded by the International Palliative Care Initiative of the Open Society Institute, is designed specifically to assist low- and middle-income countries to review and revise their national opioid policies. Training for clinicians in pain relief and palliative care must be provided and timed to coincide with an increased availability of opioid analgesics, obtained either through scale-up of domestic production or via import. To make this possible, donor countries and agencies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President’s Emergency Plan for AIDS Relief should require that pain relief and palliative care be a part of the treatment packages they support. In a number of countries where some or all of these recommendations have been followed, progress has been made toward making pain relief and palliative care more accessible (13–15).

CONCLUSION

Most of the world’s people, especially those living in low- and middle-income countries, have either inadequate or no access to treatment for moderate and severe pain and for terminal dyspnea. This is due primarily to the inaccessibility of opioid medications. A pervasive opiodiphobia with historical and social roots has given rise to regulations that severely restrict opioid accessibility. In response, the WHO and several nongovernmental organizations have developed strategies and recommendations for overcoming the barriers to effective pain relief and palliative care. More funding for this work is needed if the world’s enormous burden of unnecessary suffering from pain is to be reduced.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

REFERENCES


RECEIVED: 16 January 2010
REVISED: 13 March 2010
ACCEPTED: 2 June 2010

© 2010 Informa Healthcare USA, Inc.