Pills, Polices, and Predicaments: The Unintended Consequences of a Health Care System’s Policy toward Opioids

Prescription drug abuse has escalated to a crisis in the United States. According to the Office of National Drug Control Policy, young people abuse prescription drugs second only to marijuana, and one-third of people who start using illicit drugs begin with prescription drugs [1]. Moreover, prescription analgesics were associated with more than 16,000 deaths, with frequent contributions from other medications, including benzodiazepines (involved in 30% of opioid-related deaths), anticonvulsants (13%), antidepressants (close to 7%) and antipsychotics/neuroleptics (almost 5%) [2]. In many cases, the problem is too outsized for the federal policies in place to be effective. To address the prescription drug crisis directly and effectively, five public health initiatives are imperatives.

First, we must aggressively disseminate information through far-reaching public and patient educational programs about the dangers of overusing prescription medications. States and localities that have initiated successful public and patient education programs can serve as models. Utah’s “Use Only As Directed” campaign is a good example of successful public education that, when combined with provider education, coincided with a reduction in overdose deaths in the state [3].

Second, we must create the right incentives to facilitate the research and development of safer, abuse-deterrent formulations for treating chronic pain. Eventually, the opioids being prescribed today must be replaced either by new mu agonists with less potential for serious adverse effects or with non-mu molecules that have highly effective analgesic properties and no rewarding properties. Accomplishing such lofty scientific research goals, however, will require that we nurture useful collaborations and facilitate a variety of public and private partnerships. One such effort is the launch of the Interagency Pain Research Coordinating Committee, which comprises a diverse and expert membership from the federal government, advocacy organizations, and the scientific research community.

Third, the insurance payer system must be overhauled to require adequate coverage and reimbursement for evidence-based alternatives for chronic pain (e.g., cognitive-behavioral therapy, interdisciplinary pain programs) and to require parity in mental-health and substance-abuse treatment. Sadly, according to an analysis by Michael Schatman, PhD, published by the International Association for the Study of Pain, the United States now has only one interdisciplinary program for every 670,000 patients with chronic pain [4]. This stands in contrast with other industrialized nations where the availability of such programs is growing. Moreover, the correlation between mental illness and prescription drug abuse is well established in patients who are prescribed opioids for chronic pain [5,6]. America’s recent history of imprisoning the mentally ill is unsustainable, both economically and in terms of human misery [7]. As physicians, shouldn’t we raise a collective voice for humane and medically appropriate treatments for people who suffer physically and mentally?

One additional change to our health insurance system is needed. For the sake of patient safety, public and private insurance payers should never include methadone, a low-cost prescription, as a preferred drug. According to the Centers for Disease Control and Prevention, methadone is involved in about one-third of unintentional opioid-related overdose deaths while representing only about 2% of all opioids prescribed [8]. To encourage prescribing of methadone because of its lower cost invites tragedy in light of the considerable evidence that methadone is riskier than other opioids and that extreme caution is called for in both prescribing and consuming it.

Fourth, we must lobby the American Board of Medical Specialties and its members to recognize pain medicine as a specialty, as was called for in a position paper published by the American Academy of Pain Medicine [9]. Until we have a true recognized medical specialty—such as exists for anesthesiology, pediatrics, and preventative medicine—that can speak for pain medicine, standards of care will be elusive, research will be fragmented, and advances in the field will stall, threatening patient well-being.

Fifth, the country needs a new national focus on pain to eliminate pain as the no. 1 health care problem in the United States. To be clear, we are calling for a “cultural transformation” as described by the Institute of Medicine in its 2011 report on the state of pain [10]. This transformation—this change in mindset—would serve to acknowledge the failures of a public policy that addresses only enforcement—ignoring the importance of education—in seeking to halt the spread of prescription drug abuse. It is past time to pool greater resources for research and education to address both the pain problem...
and the prescription drug crisis in the United States. Without that transformation at the cultural and societal level in our attitudes toward pain, the unacceptable status quo will remain.

This raises the question of who is qualified to speak to all Americans in language they will take to their hearts and thus open the way forward to a more compassionate health care system armed to battle pain as a disease and not just a symptom. As so often happens, lessons from the past have import for the current struggle as detailed in The Emperor of All Maladies, a cogent history of all aspects of cancer, including its public image [11]. In 1948, cancer was rarely mentioned in polite society, a state of affairs that also marginalized the research needed to advance treatments. Into this setting, organizers launched the Children’s Cancer Research Fund to further research and advocacy. The stroke of genius lay in putting a sympathetic face to a problem that had lacked a public image. They found a child with a rare intestinal form of lymphoma, who also happened to be a baseball fan, and introduced him to the country on the Truth or Consequences radio program. The public response to “Jimmy” and the call for “quarters, dollars, and tens of dollars” for the fund was overwhelming. The organizers of the fund had set a goal of $200,000 that—if reached—would get “Jimmy” his television set on which to watch his revered Boston Braves. The Jimmy Fund raised $231,000—which the author points out—was a drop in the bucket compared with what the Manhattan Project had once spent every month ($100 million) or to what Americans spent on Coca-Cola that year ($126 million). But what the effort did do was raise cancer “from its basement into the glaring light of publicity,” forever changing the public conversation on cancer [11].

In the area of pain research and advocacy, we have a similar problem. Our national spending priorities are no less skewed than they were in 1948, and chronic pain languishes “in the basement” as a feared, misunderstood, and easily dismissed topic of conversation. This state of affairs must not continue. Stopping the harm from prescription drug abuse requires public education, adequate funding for novel new non-addictive analgesics, reimbursement for alternative care and substance abuse treatment, recognizing pain medicine as a specialty, and changing the mindset to one that says law enforcement is not the only answer. We must examine the original problem of persistent pain with compassion and clarity, seeking answers that raise pain patients into the light of compassion and good science.

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References


