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People Lack Treatment for Pain for Narcotics Prohibition

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Introduction

Paradoxically, 80% are mostly in poorer countries, and their need for pain relief is heightened by a relative absence of curative care such as surgery, or treatment for both communicable and non-communicable diseases causing pain. There are many reasons for this disturbing health inequity, but the fundamental, often overlooked reason is the cumbersome, restrictive drug laws and policies that exist at international, national, and local levels [1]. We call the legal barriers fundamental because where laws forbid access to pain relief, that prohibition trumps all other reasons for the inequity. Two treaties contain the foundation for many national drug control laws, the 1961 United Nations Single Convention on Narcotic Drugs, and the 1971 Convention on Psychotropic Substances. Both these international laws are overseen by the International Narcotics Control Board, whose mandate is split awkwardly between promoting and controlling narcotic and psychotropic drugs and precursor chemicals [2]. On the one hand, International Narcotics Control Board is responsible to ensure that adequate supplies of drugs are available for medical and scientific uses, but on the other hand, it is supposed to identify weaknesses in national and international control systems and to muster pressure on governments to stanch illicit uses of these same drugs. The International Narcotics Control Board is basically in the conflicted position of both promoting and throttling the drugs it regulates [3]. Last year, the president of International Narcotics Control Board admitted that the two sides of his legal mandate are out of balance: while much attention goes to prohibiting the production, supply, and use of illicit controlled substances, equal emphasis has not been placed on the other fundamental objective of the treaties of ensuring that controlled substances are available for medical and scientific purposes [4]. Credit must be given to International Narcotics Control Board for recognizing this problem, but it also cannot be overlooked that the imbalance is largely the International Narcotics Control Boards own fault. A system of annual estimates administered by the International Narcotics Control Board imposes legal limits on the amount of controlled substances that countries can lawfully import. Thus, while International Narcotics Control Board con cedes that the global consumption of licit narcotics for therapeutic purposes is inadequate, actually its own legal regime is implicated as a cause. The Estimated World Requirements for Narcotic Drugs published by International Narcotics Control Board provides a chilling illustration of how this institution entrenches health inequities, while ostensibly fighting illicit drugs [5]. Under Single Convention, International Narcotics Control Board estimates are legally binding and tantamount to quotas for each controlled substance that a country may possess. These estimates are based on the country's own prediction of its pain treatment needs for the projected year, frequently using data on the number of treatments consumed in the previous year [6]. Thus, a country that consumed low amounts of drugs in previous years can become trapped in a cycle of reduced access in subsequent years, divorced from any epidemiological measure of actual clinical need [7]. Common sense holds that such large per capita differences between rich and poor countries cannot correspond accurately to the epidemiological prevalence of clinical pain. We twice wrote International Narcotics Control Board requesting it explain the methods used in deriving and ensuring the quality of its annual estimates, but received no reply [8]. Some argue that the International Narcotics Control Board system of estimates should not be blamed for causing any health inequity, because the Single Convention allows countries to revise and supplement their annual estimates of controlled narcotics when needed. That argument, however, lacks evidence [9]. If annual estimates were really so flexible, then surely in its long ago year history at least some poor countries should have arrived at estimates sufficient to meet clinical needs. Yet the data show that not even a single low-income country, not even those having generalized epidemics of HIV/ AIDS and ably furnishing antiretroviral treatment, now possesses more than a derisory quota under law for furnishing pain treatment [10].

Acknowledgement

None

Conflict of Interest

None

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