

Rhetoric and The Road to Hell: The International Narcotics Control Regime and Access to Essential Medicines

Katherine I. Pettus, PhD

Abstract: *Fifty years after the formal establishment of the global narcotics control regime, 80% of the world's population has little or no access to medicinal opioids for the relief of pain and suffering, and global problems related to addiction to narcotic drugs remain unsolved. Yet, the regime commands almost universal adherence and billions of dollars in annual funding from the US and other UN member states. UN agencies as well as global NGOs have produced reports detailing barriers to medical opioid access in low and middle income countries and how these might be overcome. This article identifies the significant barriers within the regime itself and locates the source of the misalignment in the "dual obligations" imposed on the Parties by the Conventions.*

Keywords: illicit drugs, narcotics, international law, access to medicines, political theory

Introduction

This article identifies key rhetorical dimensions of the legal framework governing access to "essential medicines"¹ and analyzes how they obstruct effective public health strategies for palliative care worldwide.² The World Health Organization ("WHO"), palliative care physicians from around the world, and civil society organizations such as Human Rights

Watch, the Open Society Institute, and the Pain Policy Studies Group at the University of Wisconsin, have focused attention in recent years on the fact that essential medicines are unavailable for palliative care in "low and middle income countries" (LMICs).³ Identified barriers to access include lack of effective systems for assessing medical needs; laws and regulations and their administration or interpretation that unduly impede the availability of opioids; under-resourced health-care systems; fear of addiction among professionals and the public, and lack of up-to-date professional training in the use of opioids to treat pain.⁴

These "external barriers" are distinguished from what I consider to be the true source of the problem of access, the *internal* barriers, or tensions within the mandates of the global narcotics regime itself. Efforts to remove the external barriers will be unproductive and incoherent until tensions between the internal barriers are addressed and resolved. To begin this process key texts of the regime are analyzed as well as more recent conceptual additions such as the so-called "principle of balance," which has become an integral part of the palliative care advocacy discourse.⁵

The "Meta-Regime" and the UN Single Convention on Narcotic Drugs

The "meta-regime" that currently governs access to essential medicines is inscribed in the United Nations ("UN") system and configured by international law and UN conventions dating back to the 1960s, specifically the Single Convention on Narcotic Drugs (1961, as amended 1972), the

Convention on Psychotropic Substances of 1971, and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.⁶ Yet the key foundation and the focus of this article is the foundational 1961 Convention, which mandates that states configure their domestic law to regulate production of, and access to, narcotic drugs in accordance with its specified aims. So although states' domestic laws are the "efficient cause" of the problem of (their own) physicians' lack of access to essential medicines, the "formal cause" is the global narcotics control regime itself. The importance of this distinction will become apparent. In international law, treaties are interpreted, amended, and revised by signatory parties as a matter of course to align with unfolding historical imperatives.⁷

The Dual Obligation of Parties to the Convention

The original motivation for the creation of the global narcotics control regime – stated up front in the text of the Preamble of the Single Convention – was "*to restrict* the cultivation and manufacture of plant based opiates solely for medicinal and scientific purposes." Furthermore, "The Parties, Concerned with the health and welfare of mankind," recognized "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."⁸ (emphasis supplied)

These two phrases define the Parties "dual obligation" to, on the one hand, craft domestic laws that punish the cultivation,

manufacture, consumption, etc. of narcotic drugs, and on the other, ensure their availability for medical purposes. The International Narcotics Control Board (INCB), the independent and quasi-judicial monitoring body established by the Convention to implement the treaties, also has a dual obligation: "to limit the cultivation, production, manufacture and use of drugs to an adequate amount required for medical and scientific purposes [and] to ensure their availability for such purposes."⁹ The Conventions provide the INCB with a specific framework known as the "system of estimates" and "statistical returns system" to guide its work and "help countries achieve a balance between supply and demand,"¹⁰ but leave the Parties themselves to their own (domestic legal) devices to discern how best to adhere to the regime and avoid sanction by the INCB.¹¹

Although modern wealthy nations with well-developed regulatory and bureaucratic infrastructures can balance the tension between the dual obligations and ensure that their populations have access to medical opioids, the "developing," post-colonial, and middle-income states cannot. Most have resolved the tension in favor of highly restrictive regulations and already identified external barriers to access. Moreover, their efforts in this regard are supported by generous foreign (largely USA) financial, technical, and military assistance that underwrite the restrictive side of their dual obligation.¹² This support is not, however, offset by equivalent generosity regarding the obligation to provide access to medical opioids. Neither is the INCB sufficiently funded to

ensure that it fulfills this part of its mandate. In the words of its 2011 Annual Report:

“The Board will continue to pay attention to the subject of adequate availability of internationally controlled substances, as provided for in its mandate under the international drug control treaties. Nevertheless, the Board needs to bring to the attention of the international community the fact that the budget resources allocated at present seriously restrain the activities of the Board. The Board wishes to draw attention to the need for additional resources to carry out any additional activities and expand present activities related to ensuring adequate availability of internationally controlled narcotic drugs and psychotropic substances.”¹³

Although the 1961 Convention provided for “continuous international co-operation and control for the achievement of [its] aims and objectives” (plural), the objective of ensuring provision of opioids for medical purposes has been sacrificed to the objective of controlling supply, manufacture, and consumption. The majority of the world’s people are losers in what was not (at least rhetorically) intended to be an iatrogenic zero-sum game.

Empty Rhetoric: Harm and the Principle of Balance

In its 2003 Annual Report, the INCB claimed definitively that “The ultimate aim of the Conventions is to reduce harm.”¹⁴ Taken at face value, these words sound not only harm/less, but noble and well intentioned. The words ring hollow and false, however, as it was published more than four decades after the

Single Convention was promulgated, when over 90% of the world’s population still had no access to medical opioids for pain control.

Further, “reduce” refers to no specific metric. Indeed, no acceptable *level* of “harm” is specified nor exactly *which* harm or harms should be reduced. Legitimate questions are “what harm to whom?” More to the point, what “harm” was the system originally set up to reduce? The throwaway phrase is typical of the rhetoric that characterizes the discourse of the global narcotics control regime, the ideological apex of which was the slogan “A Drug-Free World, We Can Do It!” adopted by the 1988 UN General Assembly Special Session on Narcotic Drugs. The ideal of a “drug-free world” epitomizes the hegemonic bias in favor of eradication and prohibition at the expense of access to medical opioids for palliative care and harm reduction,¹⁵ neither of which would have any place in the collective hallucination of a drug free world.

The WHO “Principle of Balance”

The so-called “principle of balance” formulated by WHO to describe the ideal relationship between regulation aimed at preventing drug abuse and addiction, and ensuring adequate access to medical opioids, represents yet another rhetorical barrier to equitable public health strategies that integrate effective palliative care.¹⁶ It elides the ongoing harms, which are measurable, palpable, escalating, and relentless for those who suffer them, actually perpetrated by the global narcotics control system itself.¹⁷ No amount of well-intentioned “balancing” at the level of either domestic or international law seems to be reducing those harms.

Vague and problematic references to abstract quantities in related texts attempt to make the case for balance: WHO states that the public health outcome is “at its maximum” when “the optimum is reached between maximizing access for rational medical use and minimizing hazardous or harmful use.”¹⁸ Once again, no metric is specified to describe what “optimum,” “maximum,” or “harmful” actually correspond to in terms of indicators. The ethical implications of the “principle of balance,” stripped to its logical premises, are troubling in themselves. Does the goal of achieving maximum access to opioids for medical use justify minimizing “hazardous or harmful use?” (By whatever means necessary?). At what cost to justice is biomedical beneficence achieved?

Accepting Rhetoric

Yet scholars and NGOs who analyze and advocate for improved access to opioids, even those who promote a human rights-based approach to offset and ameliorate the harm caused by the drug war, seem to accept the rhetoric of balance at face value. For example, an excellent analysis of the minutiae of the treaties and Convention conclude with these sentences:

“The stated purpose of the international drug control system is to protect and promote public health by ensuring access to therapeutic opioids for medical and scientific purposes while preventing diversion and illicit use. Because each aim is indispensable to health, the legal framework for drug control is predicated on the principle of Balance.”¹⁹ (emphasis supplied).”

It then goes on to talk about the fact that, although some progress has been made, many countries still have “unbalanced laws.” The assumption being that “balanced laws” are achievable, and that a balance can actually be struck between regulation and provision in the current climate that is so *unbalanced* in favor of the global resources supporting prohibition.

Part of the problem lies in the mistaken assumption that the half of the INCB’s dual obligation pertaining to “prevention of diversion and illicit use” refers to diversion from *licit* rather than illicit sources. Article 9, Section 3 of the 1961 Convention makes it quite clear however, that one portion of the INCB’s dual mandate is “to prevent *illicit* cultivation, production and manufacture of, and *illicit* trafficking in and use of, drugs.” (emphasis supplied). The prevention of “illicit” cultivation etc. is what is colloquially known as the ‘war on drugs,’ now widely acknowledged to be a costly failure.²⁰

The assertion that “preventing diversion and illicit use” (whether from licit or illicit sources) is “indispensable to health” needs to be interrogated in the light of the problem of access to opioids in LMICs.²¹ Moreover, challenging a similar implied equivalence (framed by the Principle of Balance) begs the question: is “preventing diversion and illicit use” *just as* “indispensable to health” as “ensuring access ... for medical and scientific purposes?” If the interminable drug war has proven anything, it is that the creation of the category of the punishable category of “illicit use” has done maximum *damage* to public health.²² The corollary of the assertion that “preventing diversion and illicit use” is “indispensable to

health,” is that diversion and “illicit” use are always and under all circumstances *harmful* to health, a statement that has hegemonic ideological status in the twenty-first century. No evidence is ever presented to support this claim. Moreover, the public health *benefit* of providing all 6-7 million people currently suffering from untreated pain²³ with appropriate palliative care has never been calculated or projected. A more accurate calculation of appropriate balancing would need to include this counterfactual estimate.

The Conventions and Domestic Law

Because the Single Convention is an international treaty, it is not self-executing. The Parties (186 countries representing 99.6% of the world’s population) must craft and enforce domestic laws that are congruent with their own national constitutions in order to comply with the drug control treaties and the Vienna Convention on the Law of Treaties. States must punish the “illicit” cultivation, manufacture, marketing, diversion and abuse of opiates, and regulate their “licit” medical and scientific use. Article 36 states that Parties shall adopt distinct offenses, punishable “preferably by imprisonment.” There is no comparable Article, however, that mandates an affirmative parallel (or “balancing”) domestic legal obligation to ensure sufficient access to opioids for medical and scientific purposes. Although two Resolutions appended to the Convention explicitly address the issues of technical and financial assistance for “control” of narcotic drugs,²⁴ no “Resolution” provides for technical and financial assistance to ensure sufficient access to medical opioids. As a result, NGOs, faith-based organizations, hospices, and

communities struggle worldwide to fundraise and train clinical staff to provide this essential, Treaty mandated service. This is an unacceptable workaround for a major domestic and global public health concern.

Conclusion

It is incoherent to combine (as the language of the Convention does) the two ostensibly complimentary principles of the regime – “to prevent diversion and abuse,” and “to ensure access for medical and scientific purposes” in one sentence and then to claim that they should be “balanced” without providing any persuasive supporting arguments as to how and why this should be the case.²⁵ The empirical evidence proves that the two “principles” are at ethical loggerheads. One causes harm, the other tries to assuage it. Palliative care activists and even the UN agencies responsible for overseeing access to essential medicines are making so little progress solving the “global crisis of untreated pain,”²⁶ because the legislatively constructed category of “illicit use” is itself the cause of a global public health crisis. That category cannot also, therefore, be an integral discursive part of an authentic public health solution to the problem of access to “licit” access to opioids.²⁷ The “health and welfare of mankind,” the original rhetorical concern of the Parties to the Single Convention on Narcotic Drugs, is not served by the current regime, which needs to be revised by means of a truly participatory democratic process at the UN and the Party level. When the conceptual organizing principle is public health, rather than punishment and control harmful textual

conflicts that put the risk of failure upon those who are least able to rectify it are obviated

Competing Interests: None reported

Acknowledgments: None reported

Author(s)

Katherine Irene Pettus is a second year student in the MAS Health Law Program at California Western School of Law-University of California, San Diego. She earned a Masters degree in International Affairs, and a doctorate in Political Theory from Columbia University in New York.

Correspondence:

Katherine I Pettus, PhD, email:

kpettus@ucsd.edu

References (Blue Book)

¹ Among what the WHO calls “essential medicines” are opiates for pain relief – for post-surgery pain, cancer pain, HIV/AIDS, etc. The list of essential medicines can be found at International Association for Hospice & Palliative Care. See IAHPHC List of Essential Medicines for Palliative Care. Available at: <http://www.hospicecare.com/resources/emedicine.htm> (last visited Aug. 28, 2012).

² See Jan Stjernswärd, et al., The Public Health Strategy for Palliative Care, 33(5) J. PAIN. SYMPT. MANAGE. 486 (2007).

³ The World Health Organization (WHO) estimates that 80% of the world’s people have no or insufficient access to medically indicated treatment for moderate to severe pain, with substantial under-treatment reported in more than 150 countries. The number of persons suffering severe untreated pain from cancer and HIV/AIDS alone surpasses six million. See World Health Organization, *World Health Organization Briefing Note 1* (March 2007), available at (last visited Aug. 28, 2012). Almost 5 million people suffer from untreated moderate to severe pain caused by cancer, as do 1.4 million people with HIV, and “at least 600 million [people] will experience negative health impacts during their lifetime as a result of not being able to obtain medicines controlled under the international drug control treaties.” See HUMAN RIGHTS WATCH REPORT, GLOBAL STATE OF PAIN TREATMENT:

ACCESS TO MEDICINES AND PALLIATIVE CARE (2011), available at:

<http://www.hrw.org/sites/default/files/reports/hhr0511W.pdf> (last visited Aug. 28, 2012).. See also Corey S. Davis & Evan D. Anderson, Breaking the Cycle of Preventable Suffering: Fulfilling the Principle of Balance, 24(2) TEMPLE INT’L & COMP. L.J. 329 (2010) for an excellent analysis.

⁴ See INTERNATIONAL NARCOTICS CONTROL BOARD, REPORT OF THE INTERNATIONAL NARCOTICS CONTROL BOARD ON THE AVAILABILITY OF INTERNATIONALLY CONTROLLED DRUGS: ENSURING ADEQUATE ACCESS FOR MEDICAL AND SCIENTIFIC PURPOSES 5 (2010), available at http://www.incb.org/pdf/annual-report/2010/en/supp/AR10_Supp_E.pdf (last visited Aug. 28, 2012).

⁵ See, e.g., WORLD HEALTH ORGANIZATION, ENSURING BALANCE IN NATIONAL POLICIES ON CONTROLLED SUBSTANCES, GUIDANCE FOR AVAILABILITY AND ACCESSIBILITY OF CONTROLLED MEDICINES (March 2011), available at: http://whqlibdoc.who.int/publications/2011/9789241564175_eng.pdf (last visited Aug. 28 2012).

⁶ Those conventions are governed by The Vienna Convention on the Law of Treaties (or VCLT) 1969. See UNITED NATIONS, VIENNA CONVENTION ON THE LAW OF TREATIES 1969 (2005), available at: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf (last visited Aug. 28, 2012).

⁷ See David Bewley-Taylor, *Towards revision of the UN drug control conventions: The logic and dilemmas of Like-Minded Groups*, INT’L DRUG POL’Y CONSORTIUM SERIES ON LEGIS. REF. OF DRUG POLICIES Nr. 19, March 2012, at 1, 1, available at:

<http://www.undrugcontrol.info/en/publications/legislative-reform-series-/item/3251-towards-revision-ofthe-un-drug-control-conventions> (last visited Aug. 28, 2012).

⁸ See UNITED NATIONS, PREAMBLE, SINGLE CONVENTION ON NARCOTIC DRUGS (1961, as amended in 1972), available at www.unodc.org/unodc/en/.../single-convention.html (last visited Aug. 28, 2012).

⁹ See International Narcotics Control Board, *Mandates and Functions* (2012), available at: <http://www.incb.org/incb/en/mandate.html> (last visited Aug. 28, 2012).

¹⁰ See International Narcotics Control Board, About the International Narcotics Control Board (nd), available at http://www.incb.org/pdf/technical-reports/narcotic-drugs/2011/Nar_Repor_2011_English/About_INCB_English.pdf (last visited Aug. 28, 2012).

¹¹ Under the United Nations Single Convention on Narcotic Drugs 1961, *supra* note 9:

Article 14: MEASURES BY THE BOARD TO ENSURE THE EXECUTION OF PROVISIONS OF THE CONVENTION 1.a) If, on the basis of its examination of information submitted by Governments to the Board under the provisions of this Convention, or of information

communicated by United Nations organs or by specialized agencies [...] the Board has objective reasons to believe that the aims of this Convention are being seriously endangered by reason of the failure of any Party, country or territory to carry out the provisions of this Convention, the Board shall have the right to propose to the Government concerned the opening of consultations or to request it to furnish explanations. If, without any failure in implementing the provisions of the Convention, a Party or a country (illicit drug cultivation...)

b) Studies, technical assistance etc....to remedy; c) Sanctions.

Id.

¹² See UNITED STATES DEPARTMENT OF STATE, BUREAU OF INTERNATIONAL NARCOTICS AND LAW ENFORCEMENT AFFAIRS FY 2012, PROGRAM AND BUDGET GUIDE 235 (2012), available at www.state.gov/j/inl/rls/rpt/pbg/fy2012/index.htm (last visited Aug. 28, 2012).

¹³ See *supra* note 1 at ¶235.

¹⁴ See INTERNATIONAL NARCOTICS CONTROL BOARD, REPORT OF THE INTERNATIONAL NARCOTICS CONTROL BOARD FOR 2003 36 (2003), available at http://www.incb.org/pdf/e/ar/2003/incb_report_2003_2.pdf (last visited Aug. 28, 2012). For a critical analysis of the INCB, see INTERNATIONAL DRUG POLICY CONSORTIUM, THE INTERNATIONAL NARCOTICS CONTROL BOARD: CURRENT TENSIONS AND OPTIONS FOR REFORM INTERNATIONAL DRUG POLICY CONSORTIUM BRIEFING PAPER 7 (2008), available at: http://dl.dropbox.com/u/64663568/library/IDPC_BP_07_1_NCB_TensionsAndOptions_EN.pdf (last visited Aug. 28, 2012).

¹⁵ Harm reduction is a public health philosophy and intervention that seeks to reduce the harms associated with drug use and ineffective drug policies. A basic tenet of harm reduction is that there has never been, and will never be, a drug-free society. For an introduction to the growing literature on harm reduction, see *generally* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES (James A. Inciardi, & Lana D. Harrison, eds. 2000).

¹⁶ See *supra* note 6.

¹⁷ See e.g., INNOCENT BYSTANDERS (Philip Keefer & Loayza Norman eds. 2010); Merrill Singer, Drugs and Development: The Global Impact of Drug Use and Trafficking on Social and Economic Development, 19 INT'L J. DRUG POL'Y 467 (2008); OPEN SOCIETY FOUNDATIONS, EASING THE PAIN; SUCCESSES AND CHALLENGES IN INTERNATIONAL PALLIATIVE CARE (2010); Allyn L. Taylor, Addressing the Global Tragedy of Needless Pain: Rethinking the United Nations Single Convention on Narcotic Drugs. *O'Neill Institute Papers*. Paper 6 (2008), available at http://scholarship.law.georgetown.edu/ois_papers/6 (last visited Aug. 28, 2012); Damon Barrett & Manfred Nowak,

The United Nations and Drug Policy: Towards a Human Rights-Based Approach, in THE DIVERSITY OF INTERNATIONAL LAW: ESSAYS IN HONOUR OF PROFESSOR KALLIOPI K. KOUFA 449 (2010) Aristotle Constantinides and Nikos Zaikos, eds., Brill/Martinus Nijhoff, 2009. These represent just a few particularly good examples in a burgeoning literature

¹⁸ See *supra* note 6 at 16.

¹⁹ See Davis & Anderson, *supra* note 4 at 363.

²⁰ See GLOBAL COMMISSION ON DRUG POLICY, WAR ON DRUGS: REPORT OF THE GLOBAL COMMISSION OF DRUG POLICY (2011), available at <http://www.globalcommissionondrugs.org/reports/> (last visited on Aug. 28, 2012).

²¹ Of course it also needs to be interrogated in the light/darkness of the AIDS epidemic, but that is beyond the scope of this article. However, see GLOBAL COMMISSION ON DRUG POLICY, *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic* (2012), available at:

http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf (last visited Aug. 28, 2012).

²² See *supra* note 14.

²³ See *supra* note 3.

²⁴ See *Resolutions adopted by the United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, Resolution I and II, supra* note 9 (expressing the hope that adequate resources will be made available to provide assistance in the fight against the illicit traffic, to those countries which desire and request it, particularly in the form of expert advisers and of training, including training courses for national officials).

²⁵ I am assuming that the idea of “balance” is related to the international legal concept of the “balance of power” and the “balance of terror,” both of which had some currency during the mid-twentieth century at the United Nations, when the international narcotics control regime was being consolidated. See Miloš Vec, De-juridifying ‘balance of power’ – A principle in 19th century legal doctrine, EUROPEAN SOCIETY OF INTERNATIONAL LAW CONFERENCE PAPER SERIES. CONFERENCE PAPER #5 (2011).

²⁶ See Taylor, *supra* note 14.

²⁷ See, e.g., ALEX STEVENS, DRUGS, CRIME AND PUBLIC HEALTH: THE POLITICAL ECONOMY OF DRUG POLICY (2010) (highlighting public policy in Portugal, Switzerland, and the Netherlands, countries that prioritize a public health approach and have superior public safety as well as health outcomes).